What are we proud of?

directors of adass
adult social services
eastern region
connecting innovating improving

2022

East of England Adult Social Care

Foreword

We are proud of our collaborative work in the East of England, and believe it has supported real improvement and innovation both locally and regionally. We put considerable time and effort into our Sector Led Improvement Programme, and identify both the challenges and what we're proud of. For reference, previous reports from 2016/2017 onwards can be found here: What we are proud of since 2016-2021

Adult Social Services continues to have a value that is distinctive and important: through our improvement work we put the people we serve first: in our duty to safeguard, to promote independence and to support communities to grow.

Despite particular pressures on our services during the Covid-19 pandemic, it remains important to promote work that we're proud of– spreading learning and challenge for further improvement, recovery and reform – and to make the case for investment and recognition of the role of Adult Social Services.

Although we are yet to fully recover from Covid-19, it is clear that the huge amount of good work carried out in response to the pandemic continues to be built upon. This will ensure that we continue to learn from our experiences and, where appropriate, find new ways to provide the best solutions and outcomes for people.

I hope that you find these examples useful. Please contact the relevant council or the ADASS East Branch directly if you would like further information.

Chris Badger
Chair of the East of England Directors of Social Services and the Executive Director of Adult Social Care, Hertfordshire County Council

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Photo: Centre for Ageing Better

Essex County Council

The Adult Social Care 'lifeboat crew'

An extended team of 48 front-line workers in Adult Social Care who volunteer to be available to support adults at times of market failure.

In 2020 during the second wave of Covid-19, market conditions became much more pressurised. Some residential homes had very high levels of staff sickness and both Essex County Council and providers were becoming very concerned about their ability to safely care for residents, as staff reported sick at short notice, having tested positive. As the pandemic progressed, a similar situation affected the domiciliary market where capacity to care for people in their own homes as well as supported living settings came under strain. Essex County Council has 'provider of last resort' arrangements in place but there were occasions when the number of people reporting sick at short notice in settings across the county meant that all available capacity was exhausted, and a rapid response solution was needed to manage emergency situations.

Working together with providers the Council thought very differently and creatively about how they could manage this situation and developed their own emergency response 'lifeboat crew'. It was so named because the Director leading the initiative lives by the sea and knew that an effective lifeboat service requires people that live locally and are skilled and available at short notice when needed. This seemed to fit well with what was needed and the name stuck.

The Council sought volunteers from within the service who had experience of providing care, were fully vaccinated and able to respond as part of a stand-by rota 24/7. All volunteers were Disclosure and Barring Service (DBS) checked and had two days' training. They were fully equipped with a 'grab-bag' of equipment which included PPE and scrubs so that workers could just grab and go when they were called. The Council also established a robust approach to de-brief workers via our Essex Social Care Academy (ESCA).

Each member of the lifeboat crew received a voucher as a token of thanks and were paid a reward if they were 'deployed'.

In addition, an approach was established for providers to access cooking, cleaning and domiciliary support for care homes should this be needed in an emergency. This sat alongside the lifeboat crew to ensure that there was a robust approach to supporting the market to cope with the pressures. All aspects of support were linked into the local multidisciplinary care hubs which met daily to provide wider support to the market.

Due to their success, the 'lifeboat crews' continue to be on stand-by in case they are ever needed!

So far, the lifeboat crew has supported on 15 occasions and has been approached many more times. They have supported residential settings, complex needs supported living settings and worked in people's homes to ensure that people are safe, well and have their needs met.

Support from HR colleagues and business planning also allowed the approach to form part of a wider offer of volunteering at a time of unprecedented local and national challenges.

The lifeboat crew was developed quickly, discussed widely, and was well-regarded. The links to the care hubs also ensured that commissioners, procurement colleagues, on-call leaders, providers and a range of local system partners were aware of the service and could access it in a timely way.

What were the conditions for success?

- An excellent and committed workforce.
- A joined-up approach between colleagues sharing the vision.
- A robust approach to training and de-brief.
- Creativity to try new approaches.
- Structure in set-up and focus on delivery.

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Cambridgeshire County Council and Peterborough City Council

Driving practice improvement in care homes

Addressing a need and resource pressure around supporting care homes with identified quality of care issues and risk of failure.

It was identified that a small but significant number of care homes required focused input from both contract management and operational staff to address quality and practice issues. This had a significant impact on resource in frontline and contract teams as well as presenting a number of risks to both Councils:

- poor quality of care and poorer outcomes for people we support
- provider failure
- potential reputational damage.

Some providers were unaware of what improvement was required or lacked the knowledge to drive that improvement forward. This specifically related to compliance with key legislation such as the Care Act 2014, Mental Capacity Act 2005 and Human Rights Act 1998. Particular gaps in practice were around achieving good care and support planning, risk assessing, mental capacity assessments, Deprivation of Liberty Safeguards (DoLS), safeguarding, safe admissions to their home, ensuring meaningful activity for residents' wellbeing, use of technology enabled care, appropriate recording skills and linking with their local communities.

Historically social workers had been utilised from operational teams to support care homes who required intensive practice support. This was having an impact on capacity in operational teams where there was already high demand and pressure. As social workers could only be re-deployed for short periods of time, homes could not be provided with longer-term support to achieve sustained improvement.

There was a clearly identified need for social workers to work alongside care home managers to ensure they developed robust systems that could deliver quality practice, in line with current legislation. A business case was developed and approved to establish a Care Home Support Team (CHST) consisting of a team manager and five social workers to enable this work to happen without impacting on capacity elsewhere.

The team was established and provides support to nursing, residential and supported living providers, prioritising intervention based on risk and ensuring that there is sufficient capacity available to provide the intensive support needed to achieve improvement. Initially, they supported settings to provide good quality care despite the challenges of Covid-19. More recently, the team have moved to their 'business as usual' model with a focus on the following:

- Completing a series of observations to understand how the setting operates on a daily basis.
- Talking to residents, their family and staff to gather feedback, identify themes and tailor advice accordingly.
- Ensuring care and support documentation is up to date and meets the needs of all, including self-funding residents, and is proportionate to ensure agency staff and others are able to understand how to meet residents' needs (particularly important given the high use of agency staff across the sector).
- Supporting the provider's understanding of consent (in accordance with CQC Regulation 11) and mental capacity.
- Supporting adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards statutory duties and providing practical support with assessments and recording.
- Considering robust medication management from the perspective of mental capacity, chemical restraint and ensuring appropriate documentation in relation to covert medication.
- Ensuring high-quality, person-centred risk assessments are in place and that the setting is taking a preventative and risk-enabling approach to managing risk.
- Supporting to embed more general principles of proportionate and person-centred recording.
- Supporting providers to consider improved admissions processes, to ensure placement suitability and resident safety on admission.
- Liaising with safeguarding teams as appropriate and supporting the care home to understand their safeguarding duties and what documentation and recording they should have in place.
- Identifying opportunities for use of assistive technology to support practice and resident independence.
- Supporting homes to ensure meaningful activities are taking place for all residents, including links to community resources to improve social and recreational opportunities for residents.
- Working collaboratively with Integrated Care System (ICS) colleagues where services are being commissioned by both health and social care.
- Working alongside home management to ensure they understand what is required and are able to take the changes forward positively using systems theory, strengths-based practice, social learning theory, crisis intervention theories and others as appropriate.
- Taking a supportive rather than a monitoring or auditing approach, providing information and advice, practical support such as upskilling sessions with staff members and a documentation review function so that care providers know that they are on the right track.
- Implementing a process of regular review to ensure that changes are maintained and embedded into long-term practice.

Gaining the views of people who draw on care and support, and their families, is embedded into the practice of the Care Home Support Team (CHST) as part of their initial engagement with providers and is something that the team hopes to increasingly focus on moving forwards.

The primary focus of CHST's work is with providers. Feedback is gathered from each provider worked with and provides good evidence for the impact of the team:

> *"I am glad that I asked for the care home support team to get involved with parts of our home, as I was at one point very insecure about what are we doing right, are we doing enough, are our support plans sufficient, are our MCA what they should be? The feedback I am getting is not only constructive but also accompanied by support of finding a solution if something doesn't work as well as we would like. Working with Lucy has also given me the encouragement to go through our support plans with a different point of view and applying the approaches we discussed. The manager also said she would like to pass her thanks on to whoever created the care home support team."*

When asked if the manager would have seen improvement without CHST, responses have been:

> *"Not around MCAs no. Steffi was very helpful and knowledgeable and gave us the knowledge and confidence to do MCA's and record them right now."*
>
> *"Katie does not feel that the improved practice would have been achieved without the intervention"*
>
> *"I believe Leigh's involvement has made us take a more person-centred approach. The work would have been done but not to such high standard"*
>
> *"100% useful – It's easy to get complacent and even though we always strive to be better, there is nothing like having fresh eyes with different experience to get new ideas and discuss different options and outcomes"*
>
> *"I had no idea of some of the areas we needed to improve on, I didn't think about TEC to be less restrictive, we didn't think about amending our admission checklist and our care plans, MCAs and risk assessments have 100% improved, we wouldn't have done this without the support"*

In terms of working together across the local authority (LA), activity is closely co-ordinated between the CHST, the Contract Monitoring team and more widely with ICS colleagues, where both the LA and ICS are both commissioning in the setting. In some situations, contract monitoring (from LA or ICS) identifies practice concerns and CHST then provide support. In other situations CHST identify practice improvement needs in response to referrals from other sources, such as locality teams.

There are fortnightly operational leadership team meetings, where all relevant teams meet to share information, discuss the known risks and consider the appropriate response. CHST have also worked hard to engage operational teams across Adult Social Care, Learning Disability Partnership and Mental Health, to share information and gather evidence on themes within care homes as well as using these links to promote a more consistent approach and message when working with providers.

The team frequently provide intensive input for providers who are identified as a 'Provider of Concern', a jointly agreed operations and commissioning procedure, where significant concerns have been identified about the quality of care. It was evident from the very first examples of CHST intensive intervention with these providers that significant progress could be made around longstanding areas of concern where no progress or change had been seen previously. It is reasonable to assume that these homes could have otherwise been considered unsafe to continue to support people and there would have been a need to move people to alternative settings, potentially leading to provider failure. Prior to the CHST's creation a care home had failed in 2019 as a result of longstanding quality issues that led to residents moving to alternative provision. Costs to the LA of increased care costs for those residents who had to move at short notice and temporary consultant input to support the home amounted to £122,826.15. This figure does not take into account the resource need the provider failure created in operational teams and senior management. It is reasonable to assume that since its inception, the CHST has contributed to avoiding similar costs with providers who have been at risk of failure, but with support have not failed.

What were the barriers to success?

- **Working with resistance:** Trying to reassure providers of our supportive function where they had reservations about our purpose and were concerned that we were there to audit or inspect.
- **Ensuring a consistent message:** Lack of a consistent message has been reported as a barrier to providers understanding the quality needed in some areas of their work. There have been challenges in trying to develop a consistent approach and message when working with providers, particularly where there are multiple teams, agencies and professions involved, all with different perspectives and ways of working.
- **Sector-wide staffing challenges:** Trying to ensure long-term embedding of quality improvement when sector-wide staffing shortages and heavy reliance on agency staff have meant that staff teams are often changeable.
- **Impact of Covid-19:** Trying to promote residents' human rights and autonomy following the lifting of Covid-19 restrictions and balance these rights against understandable concerns from providers relating to the risk of Covid-19 infections within their settings.

What were the conditions for success?

- **Values:** A clear team focus on the social work values and ethics that underpin our work – respect for human dignity and human rights, respect for people's autonomy and rights to make their own decisions and a focus on ensuring the highest quality care for people who use our services.
- **Evidence base:** Being clear on the evidence base that guides our professional judgements – drawing on relevant law, policy, theory and research to ensure our support and advice is based on current best practice.
- **Skills in relationship building:** Drawing on social work theories and skills, for example, communication skills, person-centred and strengths-based approaches and adapting these to work with providers and staff groups. Recognising that supportive and collaborative working relationships are more likely to achieve long-term change.
- **Time:** Having sufficient time to work in an intensive and preventative way.
- **Flexible approach:** Being able to adapt our processes and ways of working to meet the needs of the provider as well as the needs of the wider local authority.

Further information:

Our teams – Adults – Cambridgeshire County Council

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Hertfordshire County Council

Improving nursing home care for people with high frailty and dementia

In 2018, Hertfordshire County Council set out its 15-year plan for Adult Social Care Services. One aim of this plan is to ensure that all citizens with a frailty or dementia-related care need would be supported to live a connected life.

Hertfordshire County Council has decided to develop new care homes in the communities experiencing the most significant shortages of good quality, affordable care.

Broxbourne Nursing Home is the first home in a new programme of delivery and provides 77 nursing/dementia nursing beds to the Broxbourne community, 35 of which are for Hertfordshire-funded residents.

Hertfordshire County Council aims to ensure there are sufficient residential and nursing care home places available, of the highest quality for both the Council's funded and self-funded residents.

Hertfordshire commissioners have carried out detailed assessments of care availability, both now and what is expected in the future. The Borough of Broxbourne has a very pronounced, long-term shortage of nursing care, which has made it difficult for the frailest members of the community to remain in the area of their choice, irrespective of whether they fund their own care or are eligible for council-funded care.

Hertfordshire County Council invested in land and £10.9m of capital funding to build a 77 bedded high-specification purpose-built nursing home and sought a provider partner via public tender to operate the home. The quality of the home build was considered central to the care offer, so the tender for a developer was timed to enable the successful care operator to participate in the finalisation of the design and build.

The Council is very pleased to have awarded the care contract to Gold Care Homes, who are now operating the home to deliver the very best standard of care to local people. The partnership has allowed for 35 places in the home to be secured for Hertfordshire-funded residents, which increases Hertfordshire-funded places in the area by 350 per cent.

The build of the home placed a large emphasis on sustainability, energy and the environment. As part of the sustainability brief, the home was designed using a Passivhaus standard fabric-first approach in relation to quality construction, orientation, natural ventilation and renewable technologies. This included incorporation of photovoltaic solar panels, a combined heat and power unit, extensive green roofs, low energy lighting design, recycling and waste management. This work focused on both the construction of the building and its use, including the use of smart technologies to allow monitoring of the building's energy and water consumption during its lifetime.

The home has been built to the Building Research Establishment Environmental Assessment Method (BREEAM), meaning that the home offers outstanding luxury accommodation, excellent amenities and exceptional care, creating a safe and enabling home environment.

A key part of the design brief involved a review of all recent local care homes, along with visits nationally to learn from development outside of Hertfordshire.

The resulting home has five households, each containing fifteen ensuite bedrooms split into seven and eight-bedroom corridors, accessed from a lounge diner with a kitchenette at its centre. Each corridor end forms a destination, offering a seating area, place of interest or balcony, many overlooking the New River. Each household has direct access to either a garden or balcony, offering a choice of external spaces.

Set over two floors across five households, the home surrounds a central courtyard garden and sits on the New River, as well as being close to local amenities. It offers ensuite accommodation throughout, together with a café, cinema, hairdressing salon, shop, gym and a variety of communal lounges and smaller sensory and quiet spaces. Communal rooms and bedrooms open out over a number of amenity gardens, terraces and balconies, allowing residents to retain their independence in style. All rooms are spacious, and the design has also included a plus-size room.

The large central balcony, accessible from two resident lounges, offers a covered external area overlooking the central courtyard with both roof lights and open apertures with planters below. This allows residents to access fresh air, sun or even snow, without being exposed to the vagaries of the British weather and provides a true indoor/outdoor space.

During the early design stage, workshops were held with residents of existing care homes, relatives, carers and staff to ascertain 'what good looks like'. Commissioners ensured stakeholders from across Adult Social Care were involved in the tender evaluations. The timing of the award for the care provider was deliberately set to enable Gold Care Homes to participate in the finalisation of the build and design. People in the local community were also involved in the design of the home.

What were the barriers to success?

- The build commenced during the global Covid-19 pandemic, which impacted in several ways, including the availability of building materials and workforce of skilled labour and limitations on access and viewing of the build. Hertfordshire County Council worked closely with partners to overcome the challenges through strong communication links and utilisation of remote working for mobilisation meetings to ensure the project remained on schedule.

What were the conditions for success?

- The home designers worked directly with care home residents, families and staff to understand 'what good looks like'.
- Commissioners closely involved local social workers in the procurement process to ensure that the experience of local practice influenced the result.
- A very proactive project implementation approach, with a considerable amount of work done alongside Gold Care Homes.
- Working closely alongside Gold Care Homes to gain the support of health partners.

Press release (28 July 2022):

Hertfordshire's newest nursing home opens in Broxbourne

Broxbourne Nursing Home has opened its doors on Wednesday 27 July to residents needing care in Hertfordshire.

This £10.9m investment from Hertfordshire County Council will help to meet the increasing demand for care services in Hertfordshire, more than doubling the provision of council-funded beds in the borough. Forty per cent of the 77 beds in the nursing home are council funded, ensuring local people enjoy the very best standard of care within their local community.

The nursing home, which is wholly owned by Hertfordshire County Council and managed by Gold Care Homes, has been built with sustainability and innovation at the heart of it.

"We are looking to raise the bar in the care sector with Hertfordshire's newest nursing home," said Cllr Richard Roberts, Leader of Hertfordshire County Council, at the official opening event. "Broxbourne Nursing Home showcases best practice in design, build, innovation through technology and personalised care. It also helps local people to stay within their community, retain their independence and carry on living healthy and fulfilling lives."

Cllr Roberts was joined by Ravi Gidar, Chairman of Gold Care Homes, and Margaret, the very first resident of Broxbourne Nursing Home, who cut the ribbon to officially open the nursing home.

Ravi said: "The delivery of this flagship home has been a fantastic achievement and testament to the commitment of the team at Gold Care Homes who have worked in close partnership with Hertfordshire County Council over the past couple of years. We look forward to enriching the lives of residents in our care by bringing them joy, happiness and fulfilment."

Broxbourne Nursing home takes care to the next level. This brand new care home offers outstanding luxury accommodation, excellent amenities and exceptional care creating a safe, happy, and fulfilling living environment. It offers residential, dementia, nursing and respite care. Set over two floors across four residential suites, surrounding a central courtyard garden it offers ensuite accommodation, a variety of communal lounges and in-house facilities and smaller sensory/quiet zones, opening out over a number of amenity gardens, terraces and balconies, allowing residents to retain their independence in style. All of this is underpinned by exceptional person-centred care delivered by Gold Care Homes.

Cllr Tony Kingsbury, Executive Member for Adult Care at Hertfordshire Council Council also visited the home to talk to residents and family members. He added: "Having looked around today, it's really clear that Broxbourne Nursing Home exemplifies our approach to care for older people in Hertfordshire.

"We want to help people to carry on being independent as they grow older and to be looked after in a place that really does look and feel more like home, in somewhere they feel comfortable and safe."

Additional quotes:

"We were extremely proud to attend the opening ceremony for Broxbourne Nursing Home. After months of working closely with Hertfordshire County Council and the wider project team to construct this luxury residential facility with the end-user experience at the forefront of our combined approach, it is extremely heartening to see that the home is now up and running and has welcomed its very first residents, who are now in the very capable hands of Gold Care Homes." – Ross Crowcroft, Pre-Construction Director – Clegg Construction Ltd

Further information:

Grand opening.

Views from the Hertfordshire Director.

It's what's inside that counts.

Hertfordshire's newest home opens in Broxbourne.

- More than 800 people worked on the site, many of whom were local people supported through work during the pandemic.
- Over 750 m3 of concrete, 84,000 bricks and 59,000 blocks were used in the creation of Hertfordshire's newest and most innovative nursing home.
- Architects: RDA Architects
- Project Managers: Aedifice
- Construction: Clegg Construction

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Milton Keynes Council

Providing a brokerage function for Adult Social Care and children's social care across all placement types

A new brokerage team (Community Resource Team/CRT) was established in 2018 to provide support in allocating home care provision, care home placements for adult social care and residential places for children's social care. The team has grown to encompass all Adult Social Care and Children's Social Care commissioning for all types of placements and client groups.

Commissioning care (care home placements and home care packages) was carried out by the Adult Social Care (ASC) and Children's Social Care (CSC) teams. The process was inconsistent and inefficient, and social workers wasted precious time trying to source providers instead of delivering their core tasks and duties. Due to the capacity difficulties in the market, sourcing each package/placement took a long time and required extensive searches.

Long waiting lists started to build up and there were hospital discharge delays, which negatively impacted on both the lives of the people who access care and support and the system as a whole. The process also lacked robustness, transparency and fairness from a procurement point of view. In addition, the lack of negotiation did not ensure best value for the Council.

In response, a small CRT was set up (manager and four officers), based on the estimated number of referrals and the allocation process. The team was given clear guidance and protocols on the commissioning of each type of placement.

Suitable frameworks and a dynamic purchasing system were procured and set up, to ensure that the processes of allocation were clear to the team and the providers. Regular meetings and forums were conducted to ensure that the team had a good understanding of the provision and the providers in the market.

The full remit of the team has increased to now include the following:

- Home care placement ASC/CSC
- Care home placements ASC
- Supported living LD/MH
- Residential placements CSC
- 16+ CSC
- IFA CSC (Independent Fostering Agency CSC)
- Secure provision CSC

The team has been fundamental in meeting demand during the extremely challenging period of the Covid-19 pandemic over the last two years. CRT has also been crucial in managing the flow of clients out of hospital at crisis points during the Covid-19 waves. The team has also been able to deliver considerable savings through cost avoidance and negotiations.

In addition to the above benefits, ASC and CSC have gained back hundreds of social care hours, previously spent sourcing provisions. The team provides invaluable market intelligence and insight into ASC and CSC provision and availability, which informs future requirements and commissioning activities.

CRT has a huge positive impact on the service delivery to the clients. By working more efficiently, care is put in place within days (and on the same day when required). In addition, the Council has noted the following benefits:

- The Council has managed to continually meet demand without the need to create waiting lists.
- Knowledge of the whole market has helped the Council respond in a more timely and consistent allocation.
- Working across both the ASC and CSC is helping with the transition of those aged 16 and 17+, as early notification enables ASC to prepare for upcoming demand.
- The consistency of contracting and allocation has provided best value for money to the authority and ensured compliance with procurement regulations.
- Providers are working with one team rather than hundreds of members of staff across the social care teams, which is helpful and consistent.

What have been some of the barriers?

- Setting up the correct size team and the infrastructure for the team to be established (systems, guidance, contracts, etc.)
- Social workers reluctant to let go of allocation/choosing the provider on behalf of their clients.
- Redirecting the providers to CRT and avoiding side negotiations with the social care teams.
- Capacity in the market is limited, leading to difficulty in finding the right provider.
- Staying on top of referrals/demand (across both ASC/CSC) and juggling workloads.

What have been some of the conditions for success?

- Social workers/managers buy in. Working closely with ASC and CSC teams (attending team meetings, keeping social workers updated with changes in the process, clear protocols).
- Networking with providers and building up the knowledge and the skills of the team.
- Good negotiation skills of the team members.
- Working closely with the Quality Team to be well informed of any quality concerns/suspensions (and vice versa, reporting back to the quality teams any providers' concerns that CRT encounters).
- Working closely with the Contract Team to ensure that the allocation is in line with the contracted frameworks and DPS in place, and pricing schedules agreed.

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Safeguarding and assessing needs

Photo: Centre for Ageing Better

Milton Keynes Council

Improving the timeliness of annual reviews

Completing reassessments for all older people as part of the implementation of a replacement Adult Social Care management system and ensuring that there is now a programme of annual reviews evenly distributed across the calendar year.

There were two issues facing the older people's review team, firstly, the continual battle to ensure annual reviews are completed in line with the Care Act legislation and, secondly, the fact that reassessments, rather than reviews, had to be completed so that all relevant information was held on the new Adult Social Care management system.

The team of reviewing officers, with the support of a dedicated management team, drew up a project plan with agreed milestones. These milestones were successfully achieved, meaning that from April 2022, all older people's reviews were scheduled for the coming year, in an even spread of reviews that could be readily allocated to the officers within the team.

Following a restructure, the Council had a dedicated team of reviewing officers and sufficient resources to manage the annual requirements. The team manager drew up a clear project with key milestones that were to be met. The plan was clearly communicated to the team and implemented within a significant degree of precision.

All officers understood their role and the objectives to be achieved; all were aware that the additional task of reassessing in 2021/22 would reap benefits from 2022/23 onwards as information would be pulled through to the system.

The review activity was regularly reported to the adult leadership team performance meeting on a monthly basis so that the progress could be tracked. There is now a formal schedule of review activity for each month that effectively ensure annual reviews are completed.

What were some of the conditions for success?

- A robust project plan detailing the measures to be taken and incorporating milestones to review progress or otherwise.
- Excellent communication within the team setting out expectations and requirements.
- Providing continuous performance updates, resulting in increased motivation
- Close monitoring of individual performance which robustly addressed any performance concerns.

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Milton Keynes Council

Improving the timeliness of Deprivation of Liberty Safeguards (DoLS) cases and renewals

Endeavouring to ensure that the Council was complying with the DoLS legislation wherever possible.

It is acknowledged that completing urgent DoLS requests in a seven-day timeframe is a significant challenge. However, DoLS renewals can be planned in such a way that the re-assessment is completed in plenty of time to allow for the quality check and signatory to be completed prior to the existing DoLs expiring.

The Council has established a process within the DoLS team that ensures that DoLS renewals are managed more effectively. The DoLS team are pro-active in contacting managing authorities with regard to a request for a renewal, ensuring that this is received in plenty of time to allow the best interest assessor and a s.12 doctor to complete their assessments, and for quality checking and signatory to be conducted ahead of the current DoLs expiring.

The Council has increased the requirement for signatory work from a specific group of colleagues. Together this group ensure that all signatory work received is completed by the end of each working week.

What were the barriers to success?

- Commitment to completing signatory work – this can be seen by some colleagues as an additional task rather than a task that is within their job role.

What were the conditions for success?

- Well-organised business support within the DoLS team, who liaise with providers to ensure that the managing authorities request DoLS renewals within plenty of time.
- A strong pool of best-interest assessors and s.12 doctors to complete the work required.

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Norfolk County Council

Norfolk Safeguarding Adults Board Tricky Friends animation

A bespoke three minute animation to help people to understand what good friendships are, when they might be harmful, and what they can do to stay safe. The primary focus is safeguarding adults and the audience is for those with learning disability and/or autism, but also taken up by others for use with children.

Norfolk County Council (NCC) is a key and active partner with the Norfolk Safeguarding Adults Board (NSAB). The Board wanted to raise awareness of, and to reduce the risk of, harm and exploitation in groups who may be less able to recognise the intentions of others and may find other methods (digital and written material) harder to access. The vision was to create a digital film to inspire some real change. The Council wanted to use animation instead of live-action footage to keep the tone light, and the messaging accessible, without damaging the credibility of the subject matter.

The NSAB worked with an animation company and a user led organisation to develop the messages and images, creating a three minute video animation which can be used by anyone to start conversations about positive relationships and keeping safe with friends and others that people may come into contact with.

NCC is one of the key funding partners, within the NSAB, and very much recognises the value of the Board and its Business Team, particularly in driving forward initiatives like “Tricky Friends”. There was a budget for the animation but as there was no budget allocated for promotion, it was launched by showcasing at day service hubs in the county, and promoting through a wide range of channels, including across NCC, so social media, websites, newsletters, local safeguarding adults partnerships, and other network or partnership meetings NSAB are involved with. NCC supported this by providing a dedicated communications officer time to help plan and directly support the launch which was invaluable.

The launch proved incredibly successful, and other local authorities/Safeguarding Adults Boards (to date around 30) have adopted it (with NSAB’s permission) for their own areas. Based on the success of Tricky Friends, Children’s safeguarding has adapted Tricky Friends for Norfolk school children aged 9 to 13. The launch attracted over 120 schools via a webinar and will be included in Citizenship courses as part of the school curriculum.

NSAB worked with a local user led organisation to develop the animation as they felt it would be a valuable resource supporting safeguarding with people with learning disabilities and/or autism, so there was input and review to help develop meaningful words and images to support the most appropriate and effective outcomes for the person using the animation.

This worked well and positively initially, but there was an issue very near the end of the process with organisation proposing a range of changes on images they had previously agreed. A decision was made that such change would have required a significant amount of cost and time delay disproportionate to the whole project so the animation was not quite as the user organisation would have wished. However, the unexpectedly wide and enthusiastic response to the animation since launch would indicate that their input still had a very positive impact on the final product.

What was the barrier for success?

The main barrier was time, this process took several years as the project began when NSAB only had a Board Manager in post to lead on this, the team has since expanded with direct support of NCC but work pressures did impact on the delivery.

What was the condition for success?

The main condition for success was having a really strong safeguarding network in Norfolk, with very supportive partner organisations such as NCC, whose active engagement in the development and work of the Board makes a significant difference and enables innovative projects like this, as well as good links to regional and national forums which have helped to share the piece of work more widely.

The animation can be found here: Tricky Friends animation | Norfolk Safeguarding Adults Board

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Thinking differently about meeting people's needs

Photo: Centre for Ageing Better

Milton Keynes Council

Meeting the needs of the deaf community

Milton Keynes partnered with the British Sign Language (BSL) interpreting service to offer a new option to reach customer services teams and Adult Social Care teams through a BSL interpreter.

Birmingham Institute for the Deaf (BID) are commissioned by Milton Keynes Council (MKC) to provide a Sensory Service for Adults, Children/Young People and unpaid carers and parents who meet eligibility requirements and who are residents of the borough of Milton Keynes.

Following a comprehensive review of the contract/service between the Commissioner and key representatives from the deaf community, several gaps within the service aimed at the deaf community were identified. One significant gap was that the current contract does not include BSL support for translation.

The issue the deaf community raised regarding the current contract is they feel they are only provided with equipment, whereas they face barriers to communication in their day-to-day living because members of the Council are unable to use British Sign Language and therefore support with everyday issues is lacking. This has a negative effect on service users' mental health and wellbeing.

The identified problem was a lack of support, communication and inclusion available to members of the deaf community due to MKC not having the required systems and communication processes in place to meet these people's needs.

The commissioner and Contracts Manager for MKC's Adult Social Care Sensory Services Contract liaised with the Head of Communications for MKC to discuss identified gaps and concerns. Following a series of meetings, a senior member of staff within the Corporate Communications Team worked with the manager to help resolve the issues. A work plan was produced with achievable timeframes. Costings were sourced from several providers who could deliver the services we were looking for.

Following a brief consultation period, a SignLive was appointed on a six-month basis with a view to extending this contract if the desired outcomes were achieved (i.e. the communication gaps were bridged). Contracts and costings were agreed and signed off. A 'go live' date was agreed, and all necessary stakeholders were informed of the process. This process was also adapted into a video suitable for deaf service users and shared via the MKC website, LinkedIn and the contract provider's Facebook page and newsletter. This information was also shared during a provider forum organised by the commissioner and held one evening with members of the deaf community.

People who use MKC services, the relevant providers and the commissioner all met via Zoom on four separate occasions (Zoom was the chosen platform for the meetings, as requested by the service users, primarily due to lockdown and Covid-19). At each meeting, independent BSL interpreters from Sign Live were commissioned to help facilitate the meeting and interpret the conversation between the commissioner and the person accessing care and support. (It was the deaf service users who requested the use of a service like Sign Live, as this approach has been used by other government organisations, the NHS, Police and the Care Quality Commission, among other organisations.) Regular feedback is being gathered by the commissioner, from users of the service and Sign Live. As with all new systems there are 'teething problems' which are being resolved.

People who access care and support of the deaf community are pleased with the implementation of SignLive and several events are currently being planned, for example, SignLive will be visiting MKC and delivering training to users, holding Q&A sessions and hosting a general marketing event to help support new users to their service. These events will be held at the offices of our contracted provider, located in central Milton Keynes and therefore easily accessible for the client group.

What were the barriers to success?

Colleagues within the Council not understanding the gaps in service provision and not being aware of the importance of a BSL interpreter.

Time Constraints – this project took approximately 18 months to implement, and this was frustrating to users within the community.

What were the conditions for success?

The Council will now build on the successful implementation of this service and utilise it to achieve the best outcomes for the deaf community of Milton Keynes.

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Milton Keynes Council

Providing end-of-life care at home

Providing end-of-life care to people living in their own homes so that they can fulfil their wish to die at home.

The area identified as needing improvement was end-of-life (EOL) care, so that support could be offered to allow people to remain in their own home if that was what they wished to do.

In many cases, where clients were nearing the end of life, the only viable options open to them were remaining in hospital in unfamiliar surroundings or being moved from their home to either a hospital or hospice for medical support.

This was not always in the person's best interests or was against their wishes. The Council found that most people, both with and without capacity, would prefer to pass away at home in familiar surroundings supported by people and carers they know.

What did we put in place?

We held discussions with our residents regarding advance care planning. This included conversations with families where the resident lacked capacity about their wishes.

We worked in partnership with GPs and District Nurses to establish good communications and build trust in order to liaise when the health of the resident deteriorated and they were nearing end of life.

The Council adopted 'Planning Ahead for Care and Treatment (PACT)', developed by Milton Keynes University Hospital NHS Foundation Trust, for those thought to be in the last 12 months of their life. We worked within the model of End-of-Life Care: ('Living well today 2021–23') produced by Central and North West London NHS Foundation Trust, using an action plan for improving care for dying patients.

To achieve our objective, staff were provided with training and encouraged to obtain further qualifications. Care teams have acquired the following qualifications:

- NCFE (Northern Council for Further Education) Level 2 Principles in End of Life
- City & Guilds Level 3 Awareness of End of Life
- Dying Matters, Willen Hospice
- 'Principles of End of Life', Milton Keynes College
- NCFE Level 3 in Palliative Care.

Milton Keynes is developing a plan that aims to 'Build a culture in Milton Keynes where end-of-life care is based on the preferences and wishes of the patient and their loved ones.' This includes the following ambitions:

- Each person is seen as an individual.
- Each person gets fair access to care.
- Maximising comfort and wellbeing.
- Care is co-ordinated.
- All staff are prepared to care.
- Each community is prepared to help in the local setting. Registered managers within Sheltered Housing with Care Schemes (Extra Care) promote advanced care planning with their teams to make this accessible to clients and their families.

This has had a very positive impact in the delivery of EOL care and in achieving the ambition of people to be able to die at home if they wish. Since implementing EOL care we have received very positive feedback from families:

"We wanted to let you know how much we appreciated J's help with mum on the day that she passed away. J stayed well beyond the end of her normal shift to ensure that we had help should we need it, she supported not only Mum but also us. Her compassion, dedication and professionalism were so very much appreciated, as we had to come to terms with the daunting prospect that Mum was coming to the end of her life. J helped us to ensure that our mother's passing was done with dignity and respect, and in a setting that Mum was familiar with, allowing us to comfort her as she took her last breaths. We will forever be eternally grateful to J for this."

"Please pass on our gratitude to all the staff at the scheme for all they have done for mum over the years, but especially to J who truly did an amazing job and gave us the opportunity to be with Mum as she peacefully slipped away."

"This very special thank you is coming to express much appreciation for all the thoughtfulness, for looking after 'J' and now me. Just so fortunate that we came to live here with such great staff."

What were the barriers to success?

There were some barriers which needed to be overcome in the early days so that we could successfully introduce the concept of EOL care at home. These included:

- difficult conversations with residents and their families about advanced care planning when they first joined the service
- initial reluctance from some health professionals to acknowledge that a person was EOL and therefore being able to obtain 'just in case' medication in a timely way.

In response to these barriers, the Council looked at the culture and sensitivities associated with EOL. We live in a society where, for much of the population, talking about death and dying is taboo. It is recognised that this is not only an issue for the public as professionals, too, are not always comfortable discussing the subject. In breaking down these barriers, the Council will support the achievement of better care outcomes for patients and families. (MK Together: Milton Keynes End of Life Care Strategy Refresh 2020–23).

What were the conditions for success?

- Personalisation and person-centred care.
- Early recognition of EOL.
- Staff training.
- Really getting to know and understand the person as a whole, not just as a service user and by their diagnosis. Ensuring that a service user's advance care plan was captured and recorded.
- Ensuring relationships are in place with GPs, district nurses and hospices to support the service users' preferences and wishes for their care. (MK Together: Milton Keynes End of Life Care Strategy Refresh 2020–23)
- Adopting an integrated policy so everyone has the same ethos and objective.

Further information:

NHS Central and North West London NHS Foundation Trust – 'Living well today 2021–23'.

Milton Keynes Council

Supporting day services provision and enabling adults back to services

Understanding the needs and views of people following the closure of day services during the pandemic.

Day services in Milton Keynes closed in March 2020 due to the Covid-19 pandemic, and transport closed permanently. The Learning Disability Team focused their energies on contacting those who attended a day service to understand their immediate care and support needs and, where necessary, to implement an increase in care in their own home, for the duration of the day service closure. Like many councils, nobody expected the situation to last so long.

Unfortunately, the pandemic hit just a few weeks after Milton Keynes had started consulting with day service providers. The Council was keen to understand their views on what was being provided to people that attended their provision and how progressive the support they provided was. The Council were looking to understand whether the existing providers would work with the Council to consider the progression model and how that might work within what they were delivering.

Whilst not ideal, the closure of the day provision gave the Council an opportunity to get to know providers better, their strengths within what they provided and what they were not able to provide. Once services partially re-opened, the Council was able to support those most at need of support back into their provisions and restart conversations with providers.

The Council's initial problem was supporting providers to regain their previous capacity in order to keep them financially sustainable, while keeping staff and attendees safe as Covid-19 was still prevalent.

Like many organisations, where possible, people were restricted to one service provision to prevent the risk of the infection in multiple provisions, prioritising those adults that still lived with their parents or in their own home. The Council worked closely with the providers to increase capacity as the Covid-19 restrictions eased. Financial support was given to prevent some of the larger providers from having to make redundancies and/or struggle to pay for their buildings and regular contact with providers was maintained.

The Council had regular meetings with providers, jointly with the lead commissioner and a finance business partner. These meetings helped the Council to understand the financial pressures of day provisions, staffing issues, safety concerns and to work with providers to increase their numbers of attendees as Covid-19 restrictions eased.

Having now met with all providers face to face, the Council has been able to gauge their opinions on the way forward regarding delivery of day provisions and to discuss the Council's vision around education and employment and how providers can support this. Having worked so closely with providers over the last two years, the Council is now able to understand the gaps in the current provision. This will help us move forward with writing the specification for the re-tender of day services.

What were the barriers to success?

- The speed at which people returning to provision could be facilitated; sometimes it was not quick enough for providers.
- System issues with payments for returners.
- Transport was difficult to arrange for some adults and continues to be a work in progress while the Council liaises with the transport team.

What were the conditions for success?

- The success of the service remains reliant on good partnerships with day service providers and regular communication.

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Supporting our workforce and achieving best practice

Photo: Centre for Ageing Better

Essex County Council

The Quest for racial equality in Adult Social Care

A group of Adult Social Care (ASC) employees from Essex County Council volunteered to take part in a five-week inclusion and diversity 'quest', which specifically focused on race. The Quest involved a deep dive into all parts of the service to identify any barriers and possible solutions, and then to create a report with recommendations for how the service could improve.

Ethnically diverse colleagues within the workforce were experiencing challenges which limited them achieving their full potential and impacted on their wellbeing. There were racial disparities, and Essex County Council wanted to understand how these could change. There was a need to undertake a deep dive so that the issues could be understood and addressed and ensure that diversity is continually embraced with inclusion for all.

Traditional methods of enquiry were not effective and needed a listening forum with the corporate leadership team fully visible and engaged. A different approach was necessary which would allow volunteers within the workforce to participate in the process.

The Quest team was set up after a call for volunteers from within ASC. The adult leadership team committed to release volunteers from their day-to-day jobs for five weeks to complete the work. The Quest team had administrative support, a sponsor and project management input to help them complete a table top audit of quantitative data, conduct-focused interviews for qualitative data and to further examine the issues experienced by ethnically diverse colleagues.

The Quest had three clear aims:

1. To explore the challenges and experiences that ethnically diverse colleagues face within ASC.
2. To identify any barriers that stop them achieving their full potential.
3. To determine what adult social care can do to ensure that diversity is continually embraced and there is inclusion for all.

Their findings and the recommendations were fed back to the ASC leadership team as well as the wider Council. These were themed around the four key areas of:

- career progression
- language and culture
- health, safety and wellbeing
- recruitment and retention.

A 10-point plan was agreed to ensure that Essex County Council would become an inclusive, anti-racist and anti-discriminatory employer. A role was created for a Race Lead to lead on the delivery of these recommendations, as well as the planning of policies and procedures that ASC should adopt to ensure anti-racist practice.

The team has improved outcomes for the workforce, colleagues and peers as well as outreaching to partners. Examples include anti-racist forums, supporting individual instances of racism and supporting the development of approaches linked to staff becoming allies.

The success of the Quest for race has led to ASC adopting the same approach in order to launch a Quest on disability.

Here are some reflections about the Quest:

> *"Essex County Council understood race inequality cannot be tackled half-heartedly or by sporadic, one-off, disconnected initiatives. Essex County Council as an organisation needs to be strategic and committed for sustainable change. The Council must all stand against the cause (racism) and the effect (inequality). It is therefore everyone's business within adult social care for creating and maintaining an inclusive workplace."*
>
> *"The communities we serve need to hear the message that Essex is an inclusive local authority. We know that lasting and effective change is a result of people working collaboratively towards a shared goal. The issue of race and inclusion requires the Council to do the rewarding but sometimes difficult work of collaborating within the community"* – Quest Report
>
> *"The Quest has been an incredible opportunity for us to focus on race and our workforce. They have come together as a fantastic team and have helped us to develop our thinking around this issue across adult social care and the wider organisation. The personal challenge for the team have been immense, and emotional investment has been without parallel. The work they have done and the recommendations they have made need to become foundation for adult social care and the whole council. We should all be incredibly proud of what they have achieved and their personal commitment to this work"* – Nick Presmeg, Director of Adult Social Services

What were the barriers to success?

- A culture of mistrust and anxiety, resulting in non-engagement from some stakeholders and parts of the organisation.
- Lack of support by middle managers at the outset to release volunteers to undertake the Quest work. However, this was resolved very quickly.
- Identifying the relevant stakeholders took valuable time and could have been identified prior to commencement.
- Individuals not having the relevant skills and knowledge to start the project, for example, data analysis skills.

What were the conditions for success?

- Commitment to allow volunteers to work on the programme outside their day-to-day jobs.
- Administrative support, sponsorship and project management support so that the Quest team could focus on the findings and recommendations.
- Sharing the recommendations widely across Essex County Council, displaying commitment from the leadership team.
- Leadership buy-in which resulted in sustained Quest work and real change, rather than this being a one-off activity.
- Appointment of a Race Lead to carry forward and lead on the delivery of the recommendations and to lead on planning of policies and procedures.
- Those who took part in the Quest continue to support and mentor other colleagues across the service when they experience issues with race.

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Milton Keynes Council

Incident Review Forum and Positive Behaviour Support programme for carers

(Day Services, Short Breaks and Shared Lives)

The Incident Review Forum was established in 2021 and takes place monthly. Representatives across all services attend (manager and team leaders). Themes and particular incidents are focused on with the aim of prompt reflection on practice and ways of working to identify solution-focused approaches as well as prevention based on guidance and current information from CQC, Skills for Care and NICE guidance. Positive Behaviour Support and active support is a regular focus of the meeting.

The services wanted a safe culture where staff can be open and transparent to discuss incidents, reflect, action plan and monitor the implementation of lessons learnt. The Council wanted to make sure that there was shared knowledge, experience and safer ways of working to support large and diverse staff teams to provide safe services to 175 people accessing care and support.

The Incident Review Forum also proactively discusses people who access care and support and who experience service issues, with the aim of checking current practice, risk and management to support prevention. For example, in the April 2022 forum there was a focus on the CQC paper on caring for people at risk of choking, to consider practice in supporting people with dysphagia and our response to any incidents. Forums have also focused on the Positive Behaviour Support approaches, which led us to implement service-led training for all staff early in 2022. In the Learning Disability Services, many people who access care and support attend day and respite services, so we wanted to ensure that our teams worked jointly to provide improved and consistent outcomes for people. This has led to us planning and offering a programme of 'light touch' bespoke training to support families and Shared Lives carers. The programme highlights the importance of active support and promoting independence, as well as looking at restrictive practices and the importance of working holistically to improve outcomes for people.

The Incident Review Forum is a working group of managers and team leaders across all the services. The agenda typically covers the following:

- analysis of recent incidents with lessons learnt and consequent action plans
- debrief outcomes for staff and service users
- how incidents are reported, with a focus on transparency, duty of candour and creating safe spaces to report incidents

- current themes from the Care Quality Commission, National Institute for Clinical Excellence, etc.
- health and safety within services
- positive behaviour support – analysis of training needs, outcomes for people who access care and support and areas for development – 10 families/Shared Lives carers are joining the light touch training programme in September 2022

Tools have also been created to assist staff. These include flow charts on how to report and communicate an incident and debriefing forms. Detailed records are kept of incidents with lessons learnt and outcomes for monitoring as well as action plans for reference and for CQC purposes.

Milton Keynes Council have worked closely with the British Institute of Learning Disabilities (BILD) accredited training providers, managers and families/carers. Families and Shared Lives carers have responded positively about engaging with the Positive Behaviour Support and Active Support training on offer.

What were the barriers to success?

- Challenge of ensuring all managers and team leaders can attend due to the requirements of a busy operational service (although attendance is expected, minutes are sent out after the meeting for those who cannot attend).
- Working with families to dispel any anxiety and encourage engagement and participation with the proposed Positive Behaviour Support programmes starting in September.

What were the conditions for success?

- Creating a culture where people feel comfortable to openly share and discuss incidents and concerns which directly relate to their service areas.

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Norfolk County Council

Norfolk Institute for Practice Excellence (NIPE)

Norfolk Institute for Practice Excellence (NIPE) is a specialist team within Norfolk County Council Adult Social Care that supports practice of frontline social care colleagues who are new to their role.

NIPE was developed in 2016 within Adult Social Care (ASC) in Norfolk to support newly qualified social workers (NQSWs) through their assessed and supported year in employment (ASYE). The original purpose of the team was to attract NQSWs to Norfolk, offer a tailored programme of support in their first year and ensure a more consistent offer across teams. However, frontline teams do not just employee social workers, and with the pressures in frontline social care teams in Norfolk over the past couple of years, the inconsistency of induction and support for other practitioners in frontline teams became more apparent.

Expanding the scope of NIPE and the role it played in supporting other practitioners in frontline teams started in the early part of the Covid-19 pandemic, when it offered some sessions to support virtual inductions. Since then, the team has expanded further and now not only offers support to NQSWs but to occupational therapists, assistant practitioners and teams promoting and supporting wellbeing.

This year the NIPE team has developed and introduced a preceptorship for newly qualified occupational therapists, over an 18-month period for full-time equivalents. This was developed along similar lines to the social work 'assessed and supported year in employment'. It includes reflective practice, regular supervisions, learning opportunities and direct observations.

NIPE have continued to develop and improve the induction sessions. This has involved creating podcasts as a way of introducing different teams and senior managers, as well as providing 12 sessions over a 3-month period to colleagues to support their induction. The objectives include but are not limited to:

- identifying different teams and professionals' roles
- networking with colleagues joining at a similar time to build connections
- apply legislation and social care approaches to everyday practice
- identify strengths and learning needs
- a commitment throughout to promote equality, diversity and inclusive practice.

NIPE has recruited a wellbeing facilitator, in collaboration with the Human Resources Business Partner, who is part of the team. They offer a different service to the corporate wellbeing team by being specifically focused on ASC. Their role is to support both individuals and teams with wellbeing, making sure this is at the heart of the conversations individuals and teams have or consider. The work currently being undertaken includes delivering a wellbeing session to all new staff and a bespoke session to new team managers and practice consultants, wellbeing picnics, offering one-to-one support to managers in terms of advice, support and resources as well as working with wellbeing champions to ensure they have the knowledge and support to empower their teams.

The most recent initiative for NIPE has been the introduction of the legacy social worker and occupational therapist role. The concept is to attract colleagues who are considering retirement to continue working for the department a little longer, imparting their vast knowledge and skills towards newly qualified social workers or occupational therapists. The role includes mentoring, delivering induction sessions and providing advice to teams. There are opportunities to support the principal social worker or principal occupational therapist in projects, too.

What were the barriers to success?

- Funding for the role.
- Time for the development of the preceptorship.
- Recruiting into the legacy posts, as little is known about them, so it has been harder to attract applicants.

What were the conditions for success?

- Practice improvement.
- Retention of staff.
- Reduced pressure on frontline teams.
- Career progression.
- Staff wellbeing.
- Recruitment and attracting more applicants to the department.

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Norfolk County Council

Sustainable Adults Future Event (SAFE)

SAFE was department wide and involved all teams working in Adult Social Care (ASC) to focus on key areas of priority, challenge and improvement for a four-week period, although the learning and improvements would then be embedded as 'business as usual'. Adapted from NHS multi-agency discharge event methodology and made relevant to social care, it was led by local teams and their managers to provide time and space to address key operational risks and matters.

Since the Covid19 pandemic, ASC has seen a steady increase in holding lists of referrals for people waiting for an assessment of their social care needs. This is further exacerbated by the removal of lockdown barriers, resulting in an influx of referrals combined with care market challenges and a significantly pressured emergency care system absorbing lots of social care resource.

In planning the department's response to recovery, SAFE was viewed as a launch platform into wider recovery actions to start to reduce the various backlogs, focus the energy of staff and managers on their key priorities and the timely resolution of new referrals to the social care front door. Additionally, the Council wanted to reduce the number of people waiting for a long-term social care assessment (community and hospital discharge). The high numbers of referrals were already having an adverse impact on the experience of people and their informal carers in need of support and the social care team's wellbeing, so by focusing on this particular concern we would reduce departmental pressures and support staff wellbeing.

SAFE was delivered either though local teams or clusters of teams, led by a member of the Director Leadership Team, with each person who accesses care and support contacted and those starting the journey critically reviewed. Each team or cluster chose their own priority area of focus and recovery to promote ownership and ensure this had a local impact. In preparation for the event, the council:

- gave permission to only attend critical meetings
- arranged for temporary redeployment of staff/employed agency staff to support with the specific focus
- put direct leadership in place to support a locality or service and escalate/unblock issues
- reviewed and cleansed lists by redeploying social workers and assistant practitioners.

The purpose of SAFE was not to introduce lots of new ways of working, but to enhance current focus and practice to maximise impact, make a difference to people we are supporting, and collate the learning and share this with the wider department. Where learning and successes were identified, these were considered for roll out across the department.

During the SAFE, teams focused on 'business as usual' approaches through an enhanced framework of reflective learning meetings and checkpoint meetings to demonstrate what went well and agreeing plans for the following day/week. This was supported by a member of the director leadership team for each area. Learning was then collated and shared across the department. While the majority of teams and service areas chose reducing new referral backlogs as their key area of focus, the methodology allowed for diversity, so the Learning Disability Service focused on employment and alternatives to respite care as their key areas.

SAFE was focused within the locality to ensure:

- better outcomes by applying best practice
- decision making and resolution earlier in the pathway
- every contact counts
- the 'living well' ethos is applied.

Locally-linked commissioners supported creative engagement with the care market using a range of means to meet need identified through assessment work including, for example, clustering rounds and targeted provider conversations. Internal departments within Adult Social Care such as Assistive Technology and Transport worked closely together towards the shared SAFE purpose.

The impact saw an improvement in staff wellbeing scores, particularly for duty social workers and managers, gathered by a short survey at intervals throughout the event. In addition, some teams saw a reduction of 5–10 per cent in the holding list backlogs (people waiting for assessment).

The key barriers were simply resource and time, and each locality/service focused on how they would solve issues locally. However, given the welcomed approach of being able to focus on a key area important to local teams, there was considerable personal and professional investment of time in the event.

Some of the key successes:

- Engagement and enthusiasm from frontline staff and leaders welcoming some ringfenced focus and priority time.
- A reduction in meetings was beneficial. The Council is looking at this in general and rationalising/cancelling nonbeneficial meetings going forward.
- Focusing both resource and time on specific goals has delivered some real change.
- 5-10 per cent reduction in new referral holding lists
- Reshaping of roles to support operations in the Learning Disability Service and introducing a Microsoft Teams channel to share knowledge and resources across the county, including additional training for Living Well Officers who will be completing transport and respite task, removing those pressures from the duty team.
- In addition, the Learning Disability team have centralised respite information, ensuring that everyone has access to the same offer.

Some of the outputs and follow-up will see:

- a new approach to risk stratifying backlogs and sharing this risk routinely with the Director Leadership Team
- a refreshed recovery plan developed to manage backlogs to sustainable levels within 12 months
- local teams and services feel empowered and have a greater understanding and visibility of challenges and progress on recovery.

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Norfolk County Council

Workforce strategy pilot

Review of Approved Mental Health Professional (AMHP) workforce strategy to meet increasing and fluctuating demand and to support the wellbeing, retention and resilience of the wider AMHP workforce.

There is increasing demand for Mental Health Act Assessments (MHAAs) alongside increasing complexities of managing appropriate and timely admission due to system-wide pressures and resource. As a result, Norfolk County Council (NCC) acknowledged that it had to review the Approved Mental Health Professional (AMHP) workforce strategy to meet increasing and fluctuating demand and to support the wellbeing, retention and resilience of the wider AMHP workforce.

NCC has a statutory duty to provide 24/7 AMHP cover to both consider and provide timely responses to MHAAs and manages this duty via the provision of the core daytime AMHP service and the Emergency Duty Team. In summary a workforce review considered that the previous model of AMHPs being released from locality teams for 30 sessions a year is neither an efficient, equitable or adequate way for the local authority to meet its statutory duties or to provide an appropriately responsive 24/7 service.

Through the challenges of seasonal pressures and those identified during the Covid-19 pandemic, NCC acknowledged that an alternative view of AMHP workforce was required to support staff, enable the service to be resilient to demand and to enable Norfolk County Council to be a strong and responsive partner.

Whilst NCC has been successful in maintaining a stable number of AMHPs via retention, recruitment and ongoing training, the demand on the service continues to outgrow the capacity of the current model. Having reviewed and considered national guidance from ADASS, DHSC and SWE, NCC completed a review of the AMHP workforce strategy. Whilst NCC initially completed AMHP workforce audits in April to December 2018, further review was delayed pending the publication of national standards, evaluation and a mapping toolkit. This was published in September 2020 and the findings from the NCC review was increasingly relevant given the short-term and long-term impact of Covid-19.

Following the workforce review, NCC supported the proposal for the AMHP service to be enhanced by the addition of five whole-time equivalent AMHPs which would enable the core AMHP team to have capacity to cover 50 per cent of the current optimum rota requirements across the county. This provision would reduce pressures of locality AMHPs whilst also providing capacity to provide structured overlap/extended hours to support the Emergency Duty Team (EDT). This model would also provide system flexibility in managing other planned/unplanned demand such as winter pressures or further Covid-19 restrictions.

Following a review of the pilot in July 2022 it was widely acknowledged that it had been very successful with the core AMHP team able to cover 50 per cent of all AMHP duty requirements, with the average daily provision increasing from 6 to 8. It was also considered that whilst only providing 50 per cent of the rota cover, the core team were able to pick up 72 per cent of referrals, many of which were complex and ongoing cases. The core team have successfully been able to shield the locality AMHPs and have also been successful in protecting the EDT from work being handed over. NCC has highly valued the pilot and is looking to secure ongoing funding, having identified it as a model of good practice.

Drivers for change

- AMHPs, Mental Health Act Assessments & the Mental Health Social Care workforce (2018), published by ADASS/NHS Benchmarking
- National Workforce Plan for Approved Mental Health Professionals (2019), published by Department for Health and Social Care/Social Work England
- National Approved Mental Health Professional (AMHP) Service Standards – Evaluation, Mapping and Planning Toolkit (2020), published by Department for Health and Social Care/Social Work England
- The Five Year Forward View for Mental Health (2016), published by NHS England
- Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care (2016) published by NHS England
- AMHP Audit 2018, published by Norfolk County Council

As a key partner of the Urgent and Emergency Care (UEC), the proposal was considered and reviewed at the appropriate operational and strategic elements of the UEC which is attended by partners and commissioners.

What were some of the barriers for success?

- AMHP service provision cannot be completed in isolation and is reliant on timely provision of s.12 doctors, beds, and MH transport.
- All the above factors place significant pressures on AMHP capacity and have had a detrimental impact on NCC managing to recruit and retain AMHPs.
- Whilst AMHP resource is a statutory duty for NCC the number of AMHPs required has increased due to many pieces of work having to be duplicated due to lack of timely resource from health partners.
- Securing funding for both the pilot project and the ongoing project has been a significant barrier and consideration of wider support from the UEC may need to be considered.

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Southend City Council

Co-production strengths-based revamp

Southend City Council has worked collaboratively with staff to reshape the way they assess, record and practice.

Since March 2022, staff from across Adult Services have come together to consider a number of key practice agendas to ensure that they reflect how the council assesses, records, makes decisions and audits practice. As part of the launch, the council will introduce a robust suite of help guides and practice guides to assist staff in being able to demonstrate strong social work and occupational therapy interventions.

These standards have been co-produced through conversations with staff and are informed by design principals. Now that the council is able to fully embrace the full functionality of LiquidLogic and the business intelligence reporting mechanisms, a new quality assurance framework is being piloted before mass roll out across the service.

In order to future-proof services as the Council looks towards the new agendas on the horizon (Care Quality Commission Assurance, Liberty Protection of Safeguards, the Fair Cost of Care, Cap on Care, Social Care Reforms, Charging Policy and revision of the Mental Health Act), views of staff have been pulled together to ensure systems allow for best practice to be captured.

Through the continued expansion of a strengths-based model approach, the council has reshaped all the assessment forms, and also led a root-and-branch revision of the suite of safeguarding forms to ensure 'Making Safeguarding Personal' and 'Making it Real' are strongly embedded.

The Council will launch the full set of forms in September 2022, alongside a full integration of the strengths-based model across Adult Social Care.

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Listening to the experience of people accessing care

Photo: Centre for Ageing Better

Central Bedfordshire

Adult Carers Strategy Co-production

Using a process called 'Working Together for Change' to co-produce the Central Bedfordshire Carer Strategy (funded through the regional sector-led improvement programme).

In the development of the local five-year Adult Carers Strategy (2022–27), Central Bedfordshire Council volunteered to trial a process called 'Working Together for Change' as a way of building local capacity for co-production, to develop the strategy and to train and develop facilitators. The project was funded by the regional sector-led improvement programme and supported and facilitated by Simon Stockton and the regional 'Count Me In' programme.

During the process a questionnaire was sent to a representative sample of carers. The information from this was collated and anonymised, retaining the original wording used by the respondents.

A mix of people including carers, local providers and a small group of staff were then invited to two online workshops to help understand the data collated and decide how best to use it. During these workshops, themes were identified from the data and work was then done to understand why things were not working and what the impact would be if things could be improved. The group then identified what was in place already, thought about what changes would make the biggest difference and identified what could be done that could help to improve the lives of local carers. The best ideas were selected and action plans were developed with leads and stakeholders identified.

The information from this process was used to develop the Adult Carers Strategy, integrating the results of the Survey of Adult Carers in England (SACE) and surveys completed by the Council's commissioned Carers Support Service. The group of carers, providers and staff have now agreed to meet regularly to monitor, review and evaluate the delivery of the strategy.

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Cambridgeshire County Council and Peterborough City Council

Developing a shared local approach to co-production

The aim of the project has been to agree a shared local approach to how co-production is applied in Cambridgeshire and Peterborough related to Adult Social Care practice, commissioning practice and system development across the local health and social care system.

Stakeholders across the health and social care system within Cambridgeshire and Peterborough wanted to embed co-production into their everyday practice and commissioning. This was because everybody understood that working together on an equal basis in a co-productive way would lead to better outcomes for all stakeholders involved.

However, there was a concern that without a shared approach to doing this, guidance and training to understand what co-production is and the tools to apply the principles of co-production in their daily work, any co-production that might take place would be inconsistent, piecemeal and would lack endorsement from system partners.

Therefore, it was essential that a co-produced shared approach be developed by local stakeholders including:

- experts by experience representatives
- voluntary and community sector representatives
- council representatives – both from Adult Social Care practice and commissioning
- health representatives.

To carry out this work it was important to have a partnership group involved that could co-ordinate and facilitate the project activity. The group that undertook this role was the Adult Social Care Forum, which discusses issues about health and social care services in Cambridgeshire and Peterborough. The Adult Social Care Forum looks at key themes raised by experts by experience and uses this information to help improve local health and social care services, taking action where needed.

The Adult Social Care Forum had already a shared annual priority for 2021–22 which was support to embed co-production into council and health activities.

This priority had three objectives, supported by an action plan:

1) To raise awareness and understanding of co-production amongst council and health staff.
2) Training on co-production to be provided to council and health staff so that they are confident to use co-production in their work.
3) Service users, carers and experts by experience to be involved in the design, delivery and evaluation of the local services they use.

This meant that the Adult Social Care Forum was ideally placed to support the development of a local shared approach to co-production.

In July 2021, the locally co-produced SUN Network (Service User Network) Co-production and Involvement Best Practice Guidance was shared with the Adult Social Care Forum and agreed as the basis of its co-production approach.

However, the Adult Social Care Forum was aware that co-production was being discussed by local partners across the health and social care system in a range of different projects and work streams and so it was important to ensure that work was not being duplicated or different ways of approaching co-production developed which could create confusion. Therefore, work was undertaken to bring together this local interest in co-production into developing a shared approach.

Two task and finish groups were set up to take forward this work:

- Group One – To agree how to apply the SUN Network Co-production and Involvement Best Practice Guidance in Adult Social Care practice within Cambridgeshire County Council and Peterborough City Council.
- Group Two – To agree how to apply the SUN Network Co-production and Involvement Best Practice Guidance within commissioning practice and system development across the local health and social care system.

The purpose of these task and finish groups was to agree:

- what was in scope for co-production
- what support would be required to make this happen (e.g. training, toolkits, etc.)
- how we would monitor that the agreed co-production approach was happening (e.g. a set of standards, checklist, etc.)
- how we would show our shared commitment to making co-production happen (e.g. a pledge or a charter)
- how we would report back on our progress (e.g. an annual 'We Said, We Did' report on how co-production has been used)
- who would need to endorse our agreed approach (e.g. system sign-off for what was agreed).

This work took place from January to April 2022.

The outcome of this work has been that the Councils have:

- adopted the SUN Network Co-production and Involvement Best Practice Guidance as the basis of the shared approach to co-production
- adopted the SUN Network co-production training offer to support this
- co-produced and agreed a Cambridgeshire and Peterborough Shared Commitment to Co-production document
- co-produced and agreed a Co-production Standards Checklist document, using the SUN Network Co-production and Involvement Best Practice Guidance: Steps to Success: A Commissioner and Services Co-production Plan for Achieving Success
- agreed the health and social care groups/boards/teams who would be asked to endorse the shared approach to co-production
- agreed 'I' and 'We' statements describing the outcomes that individuals would like to happen related to the Adult Social Care needs assessment and review processes. TLAP's co-produced 'Making it Real' model was used as the basis for this approach.

What has been the impact of this work so far?

- The recommended shared approach to co-production has been endorsed by a range of health and social care groups, boards and teams across Cambridgeshire and Peterborough.
- The SUN Network Co-production and Involvement Best Practice Guidance has been referenced in the draft Cambridgeshire and Peterborough Integrated Care System People and Communities Engagement Strategy and the Shared Commitment to Co-production appears as Appendix Four.
- A feedback form is being co-produced that will include the 'I' statements as a benchmark to rate people's experience of the Adult Social Care needs assessment and review processes, in order to check how well Cambridgeshire County Council and Peterborough City Council are delivering person-centred care and support.

What were the barriers to success?

- A lack of consistency in how co-production has been approached locally until now, so even when system partners have wanted to work in a co-productive way, how this has been undertaken and its effectiveness in the past has been variable.
- A lack of a locally agreed definition of what co-production is and the guidance to support best practice around co-production (until the locally co-produced SUN Network Co-production and Involvement Best Practice Guidance was adopted).
- The risk of duplication in the work undertaken to develop an approach to co-production or work taking place in a segmented way. This was especially a concern as the work coincided with the development of the new Cambridgeshire and Peterborough Integrated Care System

What were the conditions for success?

- System partners will need to continue to commit to endorsing the agreed shared local approach to co-production and implementing the approach within their services.
- System partners will need to continue to raise awareness of the agreed shared local approach to co-production with their staff and other local stakeholders, to minimise the risk of people trying to 'reinvent the wheel' by developing alternative approaches
- Local stakeholders will need to be able to see the impact of having an agreed shared approach to co-production, for example through moving from 'You Said, We Did' to 'We Said, We Did' feedback on the co-production activities that take place.

Further information:

Adult social care forum and partnership boards – Cambridgeshire County Council

The SUN Network Co-production and Involvement Best Practice Guidance – April 2021

Training – The SUN Network

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Norfolk County Council

This is my life – learning from disabled and autistic people and carers in Norfolk

A face-to-face shared learning event to enable Norfolk County Council officers and councillors to meet with experts by experience and carers of people with a disability and/or autism to hear from and respond to their lived experiences and work together in agreeing possible ways forward.

In spring 2021, Norfolk Adult Social Services began a process of engagement with autistic people and representatives of the disabled community aimed at joint working to increase understanding of people's lived experiences of disability and/or autism. They also wanted to explore ways of rebuilding relationships and developing greater trust with the people they support – relationships which had been damaged by a judicial review brought by disabled people in response to a change in the charging policy. A key ambition of participants from the community was to enable Norfolk County Council officers and councillors to increase their understanding of Norfolk people's lived experience of disability and/or autism.

As a result of this engagement, the Council developed some powerful learning materials entitled, 'This is my life: learning from disabled and autistic people and carers in Norfolk'. In partnership with the independent Reference Group set up to represent the various disability forums in Norfolk, the Council organised a shared learning event to draw on those materials for the first time.

The campaigners felt strongly that councillors did not understand the issues and, to a lesser extent, some of our officers also didn't understand the real impact of living with a disability, and so the goals in using the 'This is my life' materials were to explore ways to:

- deepen understanding and grow empathy for autistic people and members of the disabled community
- support Council officers and councillors to understand the joys and challenges that disabled people experience, and the behaviours and actions that can best support their enablement
- develop greater understanding and improved ways of working together
- prepare the ground for a growth in co-design and co-productive approaches.

This round table style learning event with 46 attendees (a further 10 people were unable to attend on the day) was aimed at allowing time for people to engage with the 'This is my life' materials and to listen to one another as part of developing greater understanding and better ways of working together.

To enable a shared mix of experience and expertise on each table, a seating plan was drawn up to enable councillors, operational staff from adult services, commissioners, finance team members and members from disability forums to work together in the group discussions. There was an expert by experience on each table, supported by a facilitator to lead the discussions and record feedback and ideas shared.

The event was led from the front but the bulk of the learning and working together was focused on different activities carried out through small group discussions on each table, either through looking at one of the stories from 'This is my life' or through face-to-face conversations with the expert on their table. The group then worked together to share ideas for making service improvements and improving agreed ways of working together.

Members of the independent Reference Group were part of the planning group to co-design how the shared learning event should work. As a result of this, they established 'agreed ways of engaging' that would be shared at the start of the session. It was also suggested that as well as using the 'This is my life' materials in the session, the Council would seek to involve experts by experience to share their own experiences as part of the session. They organised for each table of delegates to include an expert by experience who would be supported by a facilitator. Two pre-event planning sessions with the facilitators and experts were held to agree how this would work, with particular attention focused on the accessibility needs of the facilitators, experts and other delegates attending on the day.

By allocating people to set tables, the council was able to ensure a range of expertise and experience was available at each table and able to respond to the range of disabilities represented in the materials and by the experts. As well as engaging with one of the stories from the 'This is my life' materials and the questions raised in the materials, each table also had time to ask the expert by experience on their table about their personal experience, either as someone with lived experience of a disability and/or autism, or as a parent or carer. Delegates fed back on the impact of speaking with people directly on their tables and coming to a greater understanding of the importance of including experts when seeking to make service improvements, recruit new staff and plan for future co-design and co-production.

The final group discussion focused on identifying 'what is working well', 'what needs improving' and 'how might things be done differently' and so was able to involve councillors, commissioners, operational staff and people who use our services in exploring ways of making improvements. All the written feedback from the group discussions as well as the individual learning objectives and personal reflections on 'one thing that has struck me today' and 'as a result of being here today, one thing I am going to do' are being collated as part of a larger review and planning for further use of the materials. In September 2022, the event planning group, experts by experience and facilitators will hold a meeting to start this initial review and this will also be shared with the Reference Group as a whole as part of agreeing next steps.

What were the barriers to success?

- Organising a face-to-face event rather than a virtual event and putting in place protective measures to ensure the safety and wellbeing of a large range of people, including clinically vulnerable adults and carers of clinically vulnerable people, as well as all the accessibility requirements to enable delegates with a disability to attend.
- The 'This is my life' materials are not anonymised and it was agreed that the stories can only be shared as part of Norfolk County Council training and cannot be shared more widely.
- This has meant that only specific stories could be shared at the first face-to-face event, and the Council is exploring how they will use the 'This is my life' materials more widely.

What were the conditions for success?

- It is planned that the 'This is my life' materials might be used as part of the pre-learning for the mandatory Oliver McGowan training for all adult service officers carrying out face-to-face work, as part of providing Norfolk stories.

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Transforming and integrating adult social care

Photo: Centre for Ageing Better

Thurrock Council

Developing a person-led, integrated and place-based health and care system

Better Care Together Thurrock – The Case for Further Change is a strategy that sets out a hugely ambitious and collective plan to radically transform, improve and integrate health, care, housing and third sector services. It is built upon the 2011 Thurrock transformation plan called 'Building Positive Futures'.

Thurrock has significant experience of change, establishing its initial transformation programme 'Building Positive Futures' back in 2011. A number of initiatives designed to shift the system from a focus on deficits to one focused on strengths and from one designed to respond to crisis to one designed to embrace prevention and early intervention have been implemented since this time. 'Better Care Together Thurrock – The Case for Further Change' is aimed at the Borough's adult population and designed to improve their wellbeing.

The strategy's overarching goal is to achieve 'better outcomes for individuals that take place close to home and make the best use of health and care resources'. The strategy describes an overall model of integrated care, with the constituent elements described in detail within each of the chapters based on a human learning systems (HLS) approach. In adopting an HLS approach, the strategy aims to transform radically the way that public service is delivered. Where historically, multiple fragmented teams of professionals were constrained to deliver pre-determined interventions in silos, in the future they will work collaboratively with each other and residents to co-design bespoke and integrated solutions that solve residents' problems. Over time, new 'blended roles' will be created with the ability to deliver functions such as housing, addictions and mental health, which were historically dealt with by different teams and organisations. Bureaucracy, assessment and onward referral will be kept to an absolute minimum, freeing up more time, capacity and resources to deliver frontline care.

Importantly, the strategy aims to reduce the number of 'front doors' people have to go through to access the support they require, developing a response that provides integrated solutions that can span functions. The strategy also aims to strike a balance between what the community can offer and what the individual can do for themselves, ensuring that services are not always seen as the default first option.

At the heart of the model sits transformed primary care networks (PCNs) and an integrated locality network of community support that wraps around it. Through four new integrated locality networks based around PCN geography, professionals that historically fragmented into distinct teams and functions across the NHS, Adult Social Care, housing and the voluntary sector will instead collaborate to build relationships with residents and design strengths-based solutions to meet their needs. This builds on the already highly successful approach of our community-led support teams and community-based 'Talking Shops'.

There are plans to transform care from reactive to proactive and preventative through population health management approaches and better use of data and intelligence. Integrated care and support at home is delivered via a new health and wellbeing teams model that brokers support from the integrated locality network and also encompasses reablement and proactive hospital discharge planning.

There is a new vision for residential and intermediate care, and like wellbeing teams, the model also encompasses clinical in-reach from the integrated locality network and supports hospital discharge. The power of people, communities and assets, and of 'doing with' not 'doing to' runs through the entire strategy, but the approach to community development and co-design and leveraging the power of communities is a huge focus, with strong links to the Collaborative Communities Framework.

What were the barriers to success?

- A significant change in culture is required across all organisations and within the community if we are to succeed. Making this happen across the organisations involved – and with communities – is a significant challenge and needs to be managed exceptionally well for any change to become embedded.
- Organisational sovereignty has always been cited as a potential barrier to integrated systems. Moving to integrated budgets and the ability to work across organisational boundaries to develop effective solutions for people that are individual to them is a key aspect of the strategy's success.
- We have a principle of subsidiarity, where we state that the majority of activity should be delivered at place. We recognise the challenge in identifying and ensuring that those things best delivered and organised at place get to be delivered and organised at place – particularly in the current environment of restructured NHS organisations and other key organisations with geographies that do not map those of the local authority.
- Truly transformational system change is not a quick process. As such, our strategy is based over five years. Public sector organisations are extremely stretched and there is a risk that the focus shifts to prioritising what can be done quickly rather than what will have the greatest impact.

Further information:

To find out more please visit Better Care Together Thurrock.

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Cambridgeshire County Council and Peterborough City Council

Adult Positive Challenge Programme and its legacy

A major change programme which balanced demand management with delivering positive outcomes through embedded strengths-based practice and information on how the programme delivered both concrete financial benefits and the foundations for best practice moving forward to care reform and post-Covid-19.

The Adult Positive Challenge Programme was an ambitious transformation programme across both Cambridgeshire and Peterborough Councils' Adult Social Care functions. The programme commenced in 2018/19 following diagnostics carried out by Impower during 2017 to identify demand management opportunities. The diagnostics work looked at activity trends and demand patterns as well as staff behaviours and culture. The exercise identified that in up to 54 per cent of Cambridgeshire County Council (CCC) and Peterborough City Council's (PCC) social care cases, there was opportunity to prevent, reduce or delay the need for social care services. In approximately 40 per cent of cases, it was felt that something could maybe, probably or certainly have been done sooner that could have increased independence and reduced demand on social care services.

The focus of the programme was to change practice to embed a strengths-based approach and to apply that practice effectively to all points of the customer journey. Rather than focusing on monetary targets alone, the principle of the programme was to deliver better outcomes:

This approach recognises that:

- people have better outcomes when they are supported to remain as independent as possible in and by their communities
- better outcomes for people cost less
- better outcomes influence the level of demand placed on Councils and the wider system in a way that does not rely on cutting services or restricting access.

This was achieved by:

- looking for potential and helping people to realise their goals
- recognising achievements by reducing formal support where appropriate, preventing a reliance on paid-for services
- acknowledging that paid-for services can be intrusive and disruptive – most people don't want this
- utilising what is available – the default was not a paid-for service; instead creative and tailored options which were not limited by a 'menu' of services were facilitated.

The programme was established around a number of key work streams which set the basis for practice change. These work streams were tracked by a blend of key metrics, case studies and financial deliverables. The focus was, however, always on practice and outcomes first, trusting that savings and cost avoidance would be the result.

Changing the conversation

This work-stream was the foundation of the programme and focused on changing the practice across the organisation and partners to move to sustainable strengths-based practice. Workshops were held across the entire adult social care frontline workforce (CCC, PCC and Cambridge and Peterborough Foundation Trust Mental Health (CPFT MH)) to introduce a 'changing the conversation' approach which focused on meeting people's outcomes differently by considering a variety of options, rather that providing services as a default.

This introduced the MINDSPACE behavioural science method as a tool to aid conversations by understanding and influencing people's behaviour. 'Huddles' were introduced for teams to meet and have peer-to-peer discussions about cases, sharing knowledge, experience and new ideas. Change champions were also recruited from the service to support the huddles and to embed the approach within frontline teams. A two-year pilot of targeted reviews following a stay in hospital was also put in place. A method of tracking cost avoidance through a quarterly dip sample log was successfully implemented with some key learning around the interventions that work.

Carers

Workshops were held across the entire adult social care workforce (CCC, PCC and CPFT MH) to improve carer support through early identification, proportionate carer conversations, carer assessment and a creative and strengths-based approach to support planning.

The weekly carers huddle was established to bring together practitioners from across the services to explore different ways of working with carers, challenge each other and share good practice and new ideas. A new all-age carers' service across Cambridgeshire and Peterborough was commissioned.

Examples of what our carers said:

"I no longer feel that I am coping with my husband's dementia myself. I had no idea that there was any support out there ... I now have access to a range of support groups thanks to my assessment."

"This time I just felt like [the carers assessment] was about me, my feelings and my situation and the conversations were with someone who really empathised with my situation. This was really important to me. She was also able to recommend some really beneficial local resources, like a local social club which dad has been visiting every week and gets so much out of a community mobile warden. She has such great knowledge and knew exactly what would be supportive for me when I told her what I was worried about."

Expanding the offer

Other work streams included 'preparing for adulthood', 'technology enabled care', and 'targeted reablement'. All took the core principles of strengths-based working and looked to embed them into day-to-day practice in a sustainable and enduring way.

Latterly a further work-stream was established to bring the adult positive principles into the redesign of day opportunities following the significant impact of the Covid-19 pandemic.

Embedded in the heart of the programme was engagement with staff and people who access care and support to focus on what worked for them and to learn from the outcomes they shared.

In the diagnostic it was learnt that up to 44 per cent of staff saw their role as providing people with the services they asked for. The implementation of regular staff huddles though 'changing the conversation' transformed how staff perceived their role, encouraging and supporting an outcome-focused mind-set.

Hurdles were introduced as a safe, collaborative space for social care teams to discuss and reflect on cases and share ideas, experiences and knowledge on how to problem solve and create innovative solutions. Some reflections from staff around their experience of the programme and its enduring impact are shared below:

> *"I have learnt that reviews should not just be focused on 'reviewing the formal care package' but should be more so about what the individual is able to achieve for themselves, then with the support of family, friends and community. I have learnt that in general people who access care and support are much more focused on what they can't do and to turn the conversation round to a strengths-based approach can really make someone feel better about themselves."*

> *"It has been rewarding to be part of something new and be given the freedom to try new things and take time to work on outcomes with people who are using services and try different ways of working."*

> *"I found the post hospital discharge huddles very helpful ... to closely work together on cases, support each other and it felt like a safe enough space to challenge each other."*

> *"My initial thought was it will be a moaning session and will turn negative, leaving me feeling stressed that I am wasting my time. However, after taking part in the programme my perspective completely changed. It was great to talk about a couple of cases and get other workers' views and ideas. It made me feel that looking for advice is actually a good thing, not negative. It gave me the feeling that we can all support each other."*

Examples of situations and outcomes for people accessing care and support

Example 1 – J

Situation – J was admitted to hospital late last year with a urinary tract infection and as a result of her stay she had reduced mobility. J was assessed in hospital as needing the support of a hoist and two carers (double up) for all transfers. A day care package with four calls was put in place to meet this need. Pre-admission J was supported with a twice daily single care package.

What did we do? – During the review it was noted that J was feeling slightly better in herself and had been working with the physiotherapist to rebuild her strength and mobility.

It was also identified that care calls were not taking the full amount of time allocated. As I had met J before at her previous reviews, I was aware that she lives with her son who provides a lot of daily support for her. After some discussion it was clear that her son would be waiting around for the carers at teatime to turn up and not complete any care tasks. J's son was directed to the information and advice website for support in his caring role. Although he is well informed already about services available to him, this allowed him to keep up to date with services and events on offer and to access information in case his needs changed.

Outcome –J and her son were both happy to cancel the tea time call which disrupted their own routines. I asked the OT to visit and assess for single carers, which was completed promptly, and all calls were reduced to single carers. By reducing care back to single carers, J was able to reconnect with her long-time care worker from the agency, who she had missed due to being placed onto a 'double-up' round.

Example 2 – C

Situation – C had had a breakdown with her family, who previously supported her with shopping and finances.

What did we do? – We successfully nominated C to access the 'Be Kind Fund' run by her housing association to support her to purchase an iPad/tablet with a dongle to connect to the internet.

Outcome – Th iPad enabled C to complete her shopping online and allowed her more independence over her finances. C learnt a new skill and become confident in using an iPad; she has been completing shopping online resulting in a positive outcome and enabling her to have more control.

What were the barriers to success?

- One of the biggest challenges for the programme was being able to evidence financial benefit in order to gain the confidence of finance colleagues to invest in the programme. It is very difficult to show that something has not happened that might otherwise have happened to evidence cost avoidance. Whereas our trajectory management approach worked pre-Covid-19, the pandemic changed the pattern of service delivery in a way that made pre-existing demand measures unreliable. This led to work with team managers and practitioners to create the cost avoidance impact logs, using Microsoft forms, which turned out to be really useful in understanding which interventions could be evidenced to drive cost avoidance.
- This is learning we have held onto despite the end of the programme, and are continuing in Peterborough for a new cost avoidance focus around hospital discharge and reviews.
- There was also some initial resistance from staff who felt they were already working in a strength- and assets-based way. For these workers we focused heavily on being able to evidence and share the good outcomes they delivered and the benefits of having a safe space for practice discussions.

What were the conditions for success?

The key to success was having a programme which focused on delivering better outcomes which everyone could sign up to, alongside a focus on robust impact tracking. Involving workers in the work streams and using change champions drawn from the teams to embed the changes in the teams was also an important factor for success.

The changes have been well embedded and have set the Councils up well for responding to care reform, including working in strengths-based ways with self-funders and a focus on strengths-based practice in integrated teams. As part of the programme, workshop sessions have been provided to social prescribers and primary care professionals as well as library workers. The approach will also be integral to the place-based working programme, Care Together.

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Suffolk County Council

New Mental Health Social Work model

Suffolk County Council have developed a new model for Mental Health Social Work as it was felt that the focus of the integrated Mental Health Service had moved more towards health and a medical model, with the social care element being diminished.

Suffolk Council's Integrated Mental Health Services were conceived to ensure that both health and social care worked collaboratively to support people with serious and enduring mental illness. This cohort had the poorest health and social care outcomes and were often on the margins of society.

It was believed that by ensuring social care professionals were at the frontline, working directly with mental health colleagues, social care services could improve social engagement, access to housing, and employment. It was felt that this model would address those social issues which, in some cases, were contributing factors to mental ill health.

Suffolk Council recognised that the introduction of the Care Act changed the landscape for Integrated Mental Health Services and the Council now had clear expectations and guidance on how social care must be delivered. The Care Act provided a metric to measure the impact and effectiveness of social care in the integrated model.

It became clear that the integrated model made it more difficult to maintain the identity and values of social workers. The care co-ordination model resulted in blurring of professional roles that meant people who access care and support were not benefitting from the unique skills and knowledge that social workers bring to multidisciplinary team work.

In place of the integrated model, the Council maintained a specialist mental health service, with the primary focus on social care and social work values. Colleagues who returned to the Council focused on wellbeing, strengths-based interventions and safeguarding.

The service is open to anyone with complex mental health needs (in the integrated model social workers could only work with people who were open to secondary mental health services).

Both the Council and Trust recognise the need to work collaboratively, and although each organisation works to a specific remit, it recognises that joint working is crucial. Both organisations are looking at the most effective ways of working jointly to best serve people who need care and support.

To maintain the Council's relationship with the Trust, social work team managers attend clinical meetings throughout the county. Senior managers meet to discuss systems issues and the service director of the Trust and head of service meet to discuss operational service issues.

The Mental Health Alliance Board supported an engagement exercise with people who access care and support and this exercise highlighted that there were challenges in delivering social care within the integrated model. This information was considered as part of a wider review of the integrated service. This engagement process contributed to the decision to separate health and social care as feedback received suggested that there could be more effective ways to deliver social care for people with mental health challenges.

What were the barriers to success?

- When the Mental Health Service returned to the Council a proportion of Council colleagues terminated their employment and transferred to the Trust (this presented a risk in terms of establishment numbers, but it also created an opportunity to review the service model).
- On separation the Council and the Trust had to create systems to ensure both organisations worked collaboratively.
- Both organisations faced structural changes and new ways of working.

What were the conditions for success?

- The Council and the Trust have committed to work collaboratively to ensure people who access mental health support receive high-quality health and social care.
- The Council and Trust are working towards a formal agreement to ensure services are joined up and effective.
- The Trust and Council have an information sharing agreement in place.
- The Council and the Trust have a range of interface meetings and an oversight meeting to support collaboration.

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Central Bedfordshire

Enhancing integrated working to improve outcomes for people

A collaboration of services has joined together to improve outcomes for the local population it serves.

A multidisciplinary approach between Central Bedfordshire Council and Bedfordshire Community Services was first developed in 2017. Paused during the Covid-19 pandemic, it was reignited and expanded in September 2021. The town of Leighton Buzzard with a population of 50,000 was selected to host the first collaborative team – One Team at Place – Working Together – Leighton Buzzard (WTLB).

The team wrapped around the primary care network and included representatives from East London Foundation Trust Mental and Physical Health Community Services, Central Bedfordshire social workers, Bedfordshire Hospital Foundation Trust social workers, Bedfordshire Rural Communities social prescribers and matrons from each of the three GP practices.

The team commenced daily huddles at the beginning of November, accepting referrals from professionals and the public alike. To date it has proved very successful in providing a joined-up approach to the delivery of care to the residents of Leighton Buzzard.

Population health data was reviewed to identify the relevant population segments noting baseline expenditure per capita. It was noted those in cohorts with two or more co-morbidities required increased expenditure to support them.

Examples of personal case studies to demonstrate the impact:

A patient required discharge from hospital, but normal place of residence was a care home that was struggling to manage the patient's mental health needs. The WTLB team discussed what extra support could be provided to enable the patient to be discharged back home. The Community Mental Health Team linked with the care home and offered extra support to them to manage the resident. This meant the patient was discharged from hospital once medically fit.

A woman was being supported by her husband at home, although he was struggling with moving and handling and she had fallen a couple of times. The WTLB team reviewed her case and initiated a joint visit with community occupational therapist and social worker, who assessed both the patient and the carer and initiated additional support. The case was brought back to the team and a referral was also made to the social prescriber who was invaluable in offering supportive groups that the husband could attend. This review prevented the possibility of carer breakdown, which may have meant the patient would have been either admitted to hospital or into urgent respite care.

This multidisciplinary approach enables resources to be utilised effectively and in a timely way. Co-ordination of care means the right professional takes ownership of the care plans, utilising any information gathered from other members of the WTLB team. Onward referrals to specialist services are made but oversight and co-ordination remains with the WTLB team.

Feedback to date from staff and residents alike is positive. A co-production workshop with the residents of Leighton Buzzard has taken place and work continues to support the development of the team going forward.

Future steps include:

- the development and coaching of the team
- recruitment of a care navigator to support the service
- a review of population health data so anticipatory care can be initiated for those identified residents who are frail, experiencing long-term conditions or on outpatient waiting lists to prevent deconditioning while waiting.

The model is to be rolled out across Central Bedfordshire imminently.

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Supporting people with accommodation needs

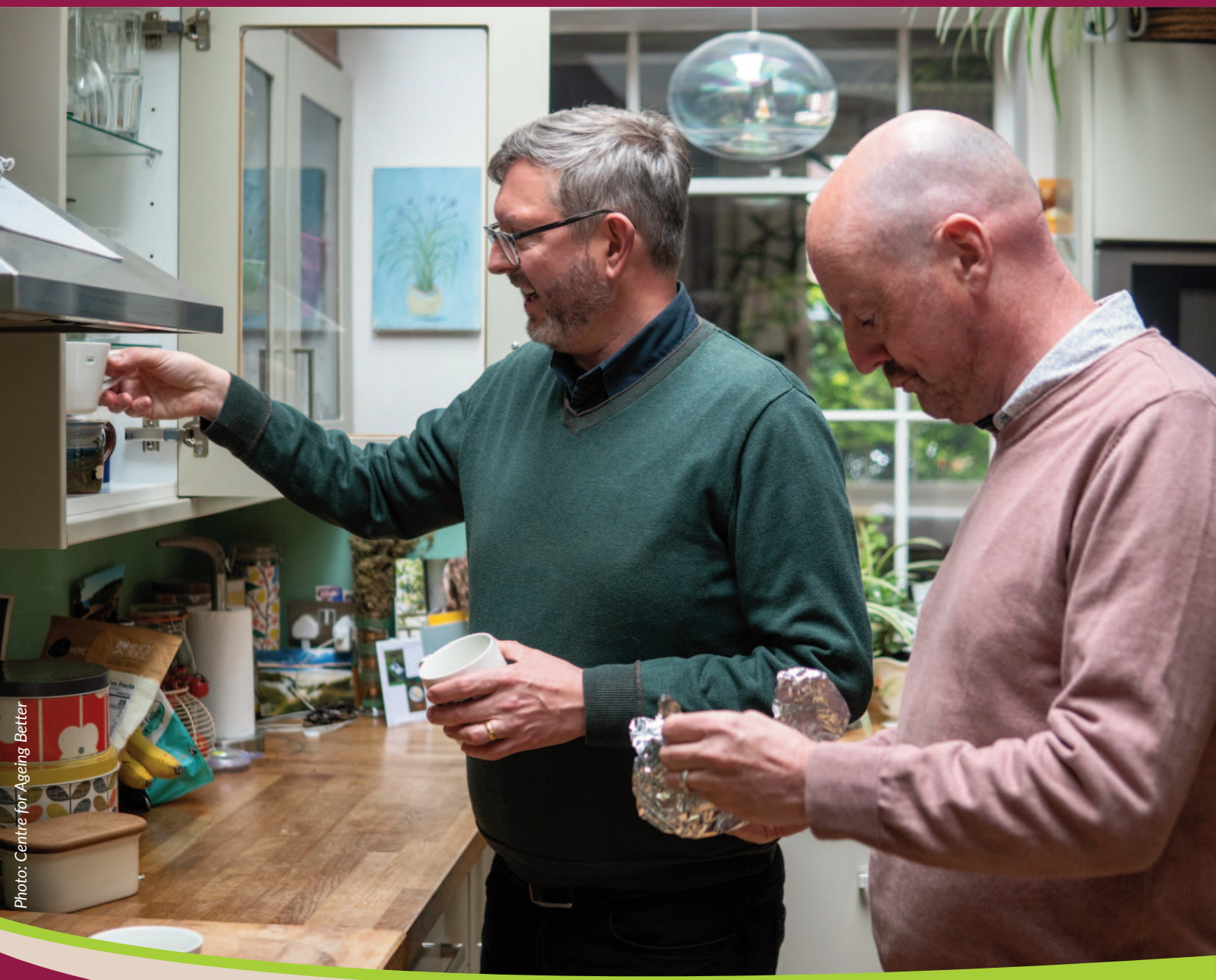

Photo: Centre for Ageing Better

Bedford Borough Council

Supporting people to have a home of their own (Mental Health)

A development of 18 self-contained flats with floating support for people with a mental health challenge. A partnership between Bedford Borough Council, East London Foundation Trust and Grand Union Housing Association.

For some time, those living with severe mental health challenges have experienced difficulties in finding a home locally to call their own. Residential care, shared accommodation and overlong stays in hospital have often been an outcome for those without their own home or unable to live with their family. For those that did have a home , it may have been in sub-standard accommodation with a shortage of amenities that others take for granted, such as a working washing machine, a comfortable sofa, and a table at which to eat meals or enjoy hobbies such as painting or sewing. The living environment has a direct impact on wellbeing and on physical health, and people with mental health challenges are no different to the rest of the population in this respect.

Adults who are capable of living independently with some support did not have access to their own home, and a significant cohort were in shared accommodation or in residential care. This was recognised by Bedford Borough Council, Grand Union Housing Association and people with lived experience.

The Council worked with developers to ensure inclusivity in the community. Grand Union Housing Association built a large residential development on the site of an old ironworks in Bedford town centre. The Council set out to change the existing housing deficit to support better housing options. The development is a short walk to the town centre and is opposite Bedford hospital. In one of the integrated blocks are 18 self-contained flats developed to support the housing needs of people with mental health challenges. There is open access to onsite floating support. It has meant that people have hope for their future, away from more formal settings. Already, since people moved in, we are seeing the positive difference it has made to individual lives.

On a visit to the scheme, two of the tenants visited the office to talk about their day and say hello to the staff as they were going about their everyday business. One member of staff said that she “loved working here” and that she could see the progress that people had been making since they moved in.

Every flat has been fitted with white goods, a sofa and table and chairs, and there is help to furnish the rest of the flat and to buy the essentials of everyday living such as kitchen equipment and bedding. For many, it has meant a more hopeful and settled future in housing that meets their needs and doesn’t add to the challenges they face.

The flats are integrated into a larger block where the remaining 31 flats are available for rent or to buy. There is nothing to prevent other people with mental health needs from renting these. The people who live in the 18 flats are all long-term users of mental health services.

Housing developments go through many iterations before they are ready and are a plan for the future rather than an instant solution. Anvil House is no exception, but the commitment to working together across different organisations and involving people using services did not waver.

Asking people what they would need if they were to move into a self -contained flat, commissioners working on support specifications and supporting providers to say how they could be flexible in their approach were integral to the process.

There are now 18 people who are enjoying their own front door. One man said that although residential was 'alright', "in your own house you can eat when you want, go to bed when you want and talk to who you want."

Furthermore, Adult Services in Bedford Borough Council are now working alongside commissioners and housing service colleagues to use this scheme as a successful model to build on and develop more homes for the future.

What were the barriers to success?

- The length of time that the project took to come to fruition had an effect as the original tenant group had to be replaced several times
- The Covid-19 pandemic had an effect on the timescale and also on the willingness of some people to consider alternatives to their current living arrangements.

What were the conditions for success?

- Enthusiasm of frontline staff who made sure all potential tenants received timely assessments.
- Using strengths-based approaches to build confidence and put the person at the centre of the assessment, ensuring a co- produced plan.
- Diligence of commissioning and procurement staff in developing and implementing the service specification for the building and the support provider and working closely with the housing provider.
- Development of the care and support model used to procure the support provider, resulting in the delivery of an effective and efficient support service within budget.
- Communication to prospective tenants by the housing association, developed in partnership with the Council, to ensure that the flats have been viewed as a positive choice for the future.

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Milton Keynes Council

Male Night Provision at the Old Bus Station (Homelessness)

The male night shelter provision provides crisis overnight accommodation for up to 19 males who are at risk of rough sleeping or homelessness.

Rough sleepers represent the 'tip of the iceberg' of homelessness and are the most visible group affected. Milton Keynes ranked 31st out of 313 local authorities in England in 2020; this figure is based upon an annual count of people who are found to be rough sleeping on a particular date in November. Milton Keynes Council supported more than 200 people during the Covid-19 lockdowns and the Government's Everyone In policy.

Significant progress has been made in terms of identifying and supporting people who are or have been rough sleeping in Milton Keynes. Eighteen people were seen or assumed to be rough sleeping in Milton Keynes at the last county on 4th November 2021; this is the same number of people seen in 2020. The numbers of people who are rough sleeping fluctuates from night to night. Milton Keynes has seen a gradual downward trend in numbers of people rough sleeping from a high of 48 in 2017.

Milton Keynes Council has adopted a 'No Second Night Out' policy. This is an agreement that no rough sleeper should have to spend a second night on the streets unless this is their preference. It is not, however, a standalone power or duty (as in it is not governed or regulated by a specific Act). Instead it relies on provision of accommodation under another power of duty.

Since September 2021, Milton Keynes has supported over 217 people who presented as rough sleepers and 117 have been resolved. Prior to the opening of the male night provision, single men were accommodated in hotels that were used as emergency accommodation at a cost of over £1.047m in 2020/21 and over £0.084m in this year to date.

Milton Keynes Council is committed to ending rough sleeping by 2027. By setting up a male night provision the council hopes that it can work together with partner agencies in achieving its aim of ending rough sleeping by providing emergency accommodation where individuals can receive support and advice.

Since the Covid-19 pandemic Milton Keynes has lacked an off-the-street emergency accommodation provision. The Somewhere Safe to Stay hub was closed as it did not meet social distancing requirements and since that time rough sleepers have been primarily accommodated in hotels.

The Council reconfigured an existing building to accommodate 19 male rough sleepers with associated facility requirements, including state-of-the-art air filtration throughout the pandemic.

The Old Bus Station provides an alternative to expensive rental of hotel rooms with the additional benefit of staff being available to provide support and advice to try and end rough sleeping 24/7. It will be more suited to vulnerable people and as well as offering access to staff, will have access to Unity Park Station and the activities provided on the ground floor by Winter Night Shelter (WNS) including the provision of food. Staff will provide onsite care support without the need to search across Milton Keynes.

Milton Keynes Council work closely with the voluntary sector to support a 24/7 provision for rough sleepers in Milton Keynes and work in collaboration with WNS to support those who access the Old Bus Station male night provision. The WNS provide volunteers who work alongside the evening staff to offer social support and hot food and refreshments.

There is now a dedicated Outreach Service who provide support at the Old Bus Station but also go out into the community to support rough sleepers and monitor wellbeing.

What were the barriers to success?

- Access to building materials during the Covid-19 pandemic delayed the project by several months, which meant that the Council were not able to open the provision during the winter months. The initial aim was to open in November, but unfortunately this was delayed until March 2022.
- Delays to recruiting support workers meant that the Council was initially reliant on agency staff to provide evening and night support.
- Delay in recruiting volunteers by the Winter Night Shelter to support the evening provision led to evening support staff providing additional care within the new purpose-built space rather than Unity Park Station as envisaged.

What were the conditions for success?

- The Council will continue to work in partnership with the voluntary sector, Thames Valley Police, drug and alcohol services and mental health services to successfully support rough sleepers.

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Supporting people to recover from a hospital stay

Photo: Centre for Ageing Better

Southend-on-Sea City Council, Mid and South Essex Foundation Trust and Essex Partnership University Foundation Trust

Enhanced discharge service

Southend City Council has collaboratively developed a pilot model of support for people leaving hospital on Pathway One.

There was significant ongoing pressures on Southend-on-Sea City Council (SCC) Adult Social Care and Mid and South Essex NHS Foundation Trust (MSEFT) where demand was outstripping capacity and there was an increase in the number of patients being discharged with higher levels of health/complex needs requiring a higher level of provision.

To address these pressures one area identified for improvement was the hospital discharge services on Pathway One. This created an opportunity to realign the hospital discharge process to the 'Discharge to Assess' policy, with the aim of improving people's experiences and outcomes as well as relieving pressures on the system upstream (the hospital) and downstream (Adult Social Care) and improving the use of the home care market through a 'home-first' approach.

The Southend Enhanced Discharge Service (SEDS) was implemented in 22 working days from initial concept and is being piloted, using a test-and-learn approach, for 12 weeks from 13th June 2022. The service will be monitored, evaluated and developed, based on feedback from the multidisciplinary team until September 2022.

The SEDS was co-produced with MSEFT, who manage Southend Hospital, and with Essex Partnership University NHS Foundation Trust (EPUT), who provide community services. It is jointly funded by Southend City Council and Southend Clinical Commissioning Group, via the Better Care Fund.

The SEDS is intended to help people to leave hospital sooner and be better supported at home. This innovative service brings together hospital staff, occupational therapists, physiotherapists, social workers and community workers to collectively support people to return and remain at home after a hospital stay.

The service is delivered by MSEFT and by SCC Social Work and Occupational Therapy Teams. Its primary aim is the provision of a therapy-led assessment service at home to Southend-on-Sea residents who have been discharged from hospital, for up to 14 days.

The service also picks up people who have been discharged without support but where support is necessary. The service is delivering effective strengths-based, person-centred interventions to help people to meet their personal goals. After the service, people who need additional or ongoing support will move into either reablement or ongoing homecare.

A SEDS multidisciplinary team is in place, meeting three times weekly to review people's progress and make decisions regarding referrals, best onwards pathway and provides a seamless link to EPUT Community Coordination Centre (CCC) or handover to SCC ASC.

After the first month of service increased systemic pressure was identified in the multidisciplinary team. This was escalated and action was taken which provided MSEFT SEDS with five assessment beds to manage and use flexibly to ease issues with capacity.

While the pilot is yet to complete, it has nevertheless provided a significant amount of learning which will shape the future service.

What were the barriers to success?

- Rapid implementation timescale.
- Level of risk identified due to timescale: For example, a risk around service capacity was identified before going live. After the first month of service increased systemic pressure was identified in the MDT, with action taken to resolve this by providing MSEFT SEDS with five assessment beds to manage flexibly to ease capacity issues.
- Maintaining constant communication and updates from a diverse group of stakeholders across several organisations.
- Time to implement specific information sharing arrangements.
- Recruitment of staff to meet desired level of capacity.
- Engagement with the project management framework dropped off following implementation.

What were the conditions for success?

- **Leadership buy-in and steering:** Having a Transformation Project Board and establishing a Strategic Steering Group ensured obstacles were removed, corrective actions and decisions were made and communicated in a timely manner.
- **Provision of project management from hybrid SME project manager/business analyst:** A dedicated resource to ensure project products (e.g. stakeholder analysis, project planning etc.) were completed which provided a solid foundation for successful go live.
- **Robust project management methodology and approach taken:**
  - ensured implementation in a compressed timescale
  - risks and issues captured and monitored
  - allowed flexibility which encouraged innovative solutions to mitigate risk/systemic pressures presented.
- **Identifying and engaging key operational stakeholders:** Stakeholder analysis was carried out across the organisations to ensure the right resources were involved at the right time to support pre- and post-go-live activity.
- **Ensuring activity required to enable go live was identified, resourced and actioned:** Robust project planning with stakeholders to establish activity required and resources required and to set timescales within the desired deadline. Weekly task and finish group held to ensure activities were completed on time.

- **Operational stakeholders:**
  - commitment of time and effort to improve outcomes for Southend residents
  - willingness to quickly mobilise and embrace changes required.
- **SEDS multidisciplinary team:** Established MDT and terms of reference were agreed pre-go live to enable case management approach on which to base patient discussions and decisions. This supported a seamless handover into and out of the service for patients. The MDT provided a route for direct feedback from operational colleagues for:
  - the baseline process and capture of improvements
  - the live service having a positive impact reinforcing the model of service delivery and motivating the team.
- **Development and design of service operating model:**
  - Co-production – key operational stakeholders were identified and engaged in the task and finish group to agree service protocols and developed the standard operating procedures (including the service operating model and process maps) which captured (and improved) how the services interface.
  - Underpinned the alignment of services around the SEDS provision across organisations.
  - Provided clarity re practice and expectations for operational colleagues at point of go live.
  - Embedded change in working practices and culture (e.g. strengths-based practice).
- **Defined data requirements:**
  - Data requirements were defined which informed the development of the 'Patient Tracker' to manage and monitor cases live, track between systems downstream and upstream and provide management reporting which would allow identification and/or analysis workflow issues and allow for mitigation.
  - Provides quantitative data to evaluate the pilot, support strategic-level decision-making, benefits realisation and the Commissioning Lead to develop the local Southend D2A model and full service specification.

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Luton Borough Council

Recover to reable model to reduce the need for longer-term care

Luton Borough Council piloted a new recover to reable model to achieve improved outcomes for people who were discharged under Discharge to Assess (D2A).

Since the implementation of the D2A model in March 2020, Luton Borough Council Reablement Team noticed a significant change in the acuity and complexity of the people they supported following hospital discharge. This clearly impacted the individual's outcome in regaining independence, the data demonstrated that there was almost a 20 per cent decrease in the number of people who completed the reablement programme either self-caring or with reduced needs.

The evidence indicated that achieving positive outcomes for individuals was reduced due to the fact that shorter hospital stays and readmissions result in slower recovery, coupled with the lack of therapy that people may have also received during their hospital stay and post discharge.

It was very evident from the analysis that there was a need to explore alternative pathways into reablement to enable people to:

- receive reablement at the right time
- receive the full benefit of reablement
- support hospital flow and avoid hospital admissions.

Luton Borough Council decided to pilot a recover to reable model which aims to enable people to have a period of recovery in their own home with the right support prior to commencing a reablement programme. It was agreed that professionals such as hospital therapists and social workers would identify people who would be suitable for discharge under this model.

The person was advised that they would be given some time at home to recover further with support from a domiciliary care agency. When their general health and wellbeing had improved after a few weeks at home they would then engage in a reablement programme with the aim of regaining further independence.

It was anticipated that this pathway into reablement would optimise the potential for people to achieve improved outcomes which would reduce the need for longer-term care.

The pilot entailed working with various professionals such as hospital therapists, social workers, hospital intake team (a private domiciliary care agency) and the reablement team. It was critical that all professionals involved were committed to the model and were fully engaged in planning and agreeing the process. The emphasis was to work closely in partnership to achieve the best outcomes for people applying the home-first model.

The overall impact has been very positive in that 100 per cent of people who used the pathway achieved positive outcomes.

What were the barriers to success?

- Limited resource to draw-up processes and evaluation tools.
- Lack of commitment to the model and dedicating time to meetings.
- Limited number of people were suitable for the pathway.
- Effective communication in improving the person's experience to achieve a seamless transition.

What were the conditions for success?

- People had the right support, at the right time to maximise their potential for independence.
- Eighty-four per cent left reablement able to self-care, with no long-term care needs.
- Sixteen per cent left with a reduced care package.
- Strengthened system-wide partnership by working towards common objectives.
- Professionals are committed to continuing this approach to achieve positive outcomes.

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Supporting people with digital technology

Photo: Centre for Ageing Better

Suffolk County Council

The roll out of the UK's leading digital care technology service

In just one year, Suffolk's Cassius Service has supported over 1,600 people to live safe and well, and in their own homes for longer. Cassius is now embedded in social care practice and making a real impact on people's lives.

Suffolk County Council recognised the value of technology, data and connectedness in everyday life and wanted to bring these opportunities and benefits to people in Suffolk at scale.

The current analogue telecare model does not leverage benefits of digital and data effectively, so Suffolk wanted to develop a digital by default approach which utilised data to support better outcomes for people, meeting people's needs in a blended way using traditional care services and digital technology, focusing on keeping people in their homes safely for longer and reducing and differing the need for additional care and support, such as long-term placements.

Most importantly, Suffolk wanted to devolve the model around care technology into core social work practice, so that it isn't seen as an 'add on' or 'nice to have', but a fundamental and important means to support people to manage their care and health needs in new and better ways.

The integration agenda was also incredibly important to the Council, especially given the increasingly digital and technology focus. Suffolk are looking at how they support hospital discharges and admission prevention to enable quicker and safer discharges and preventing readmissions, as well as embedding a data-led care and health offer in the community space.

The Council engaged with the market to commission a true partnership approach utilising the expertise of best-in-class providers to build the best service. This resulted in Cassius, which went live in July 2021. The Cassius service offers the latest technology with a range of products including sensors, smart watches, wearables, falls prevention devices and other technology to address specialised needs. These are digital devices, provided with connectivity, allowing permission-based access to data and information to support the proactive management of people's care needs. They also support people to stay connected and be more digitally included, growing this agenda and digital skills in Suffolk across people who could be in crisis or people who may have not had the means to access this.

The service continues to evolve and looks to the market to ensure the Council is using the most innovative of care technologies available. The tech agnostic approach and data platform meant that whenever technology is agreed it supports people to achieve the best outcomes.

The Council has progressed some significant work with the Suffolk care and health system already, with the development of the new Cassius service in West Suffolk Alliance to enable people with long-term health conditions to monitor them safely and independently at home, meeting both care and health needs. In addition, the Council has a tech-enabled discharge route pilot, with specialist resource based in one of the hospitals, to assess for and provide technology.

In addition, a pay route for private customers has been developed. People who are not eligible for ASC funding can also benefit from the Cassius service.

The Council has collaboratively designed the service with partners in Cassius as well as with the business. Cassius was commissioned as a partnership approach, to make sure that expertise was used from the care technology market to give people in Suffolk the best possible service. This includes not just the technology, connectivity and data but also the logistics, culture change support, communications and training support, and a monitoring and response service to help those without their own networks.

The Cassius champions have been key to the success. These are people within the Council who are championing technology and helping the council to embed it as an integral part of social care. There is representation across the business in every social work team, which is helping to drive the model of devolved knowledge into operations and practice.

Work is being undertaken by all parts of Suffolk care and health ecosystem to ensure that everything done is in collaboration and consultation. It is recognised that if this is not done, then there may be an offer created which is not fit for purpose to people accessing care and support. The aim is to have a single consistent offer across all partners in Suffolk. This will mean that a person accessing care or health technology to support them will have the best outcome.

To date the Council believes it has achieved cost avoidance savings over £3.4m but these could possibly be higher. It has also saved £340,000 to date in reduction costs. Additionally, the council has generated savings to the whole health and care system, with savings of around £150,000 alone in the last six months to ambulance and hospital pathways. The importance of the savings is that the Council is still enabling people to have the best outcomes (often a better outcome) while freeing up capacity and funding for other services to deliver to those that cannot benefit from care technology.

Here are some real-life stories showing the impact on people's lives:

Example 1 – K

K has early-stage dementia and his family were worrying about him wandering.

He was provided with a Cassius Sensor package so that his family could keep track of when he was leaving his house and to understand whether this was during the night hours, putting him at risk.

They set-up alerts through the portal to let them know when he was opening and closing the front door. The data showed that he was leaving the house at night, so the alerts gave them huge peace of mind.

To further support K's independence, he has now also received a Cassius Smartwatch, ensuring he can continue to go out in the community while the family can be reassured he is always safe and well.

Example 2 – T

T is unable to read and has been given a Cassius Reader Pen by her social worker.

T used the Reader to learn how to knit and read instructions. T now spends her spare time knitting woollen animals and recently completed 'Knitivity'.

This simple intervention has supported T to gain independence, giving her a better quality of life and making her less reliant on other services.

What were the barriers to success?

- **Digital exclusion:** Suffolk is a rural county, so communicating the opportunity and access routes to those in hard to reach areas is a challenge.
- **Digital adoption:** Some of the people the Council wants to support have never accessed technology before, so providing the right offer and help to achieve the right outcomes has been critical
- **Technophobia:** People (and that also includes staff and peers) can be really scared of technology – particularly those that use data. Providing the right communications and confidence around things like data sharing, security, permissions, etc., is key.
- **Mind-sets around technology:** Conversations around the use of technology, data and connectivity with some cohorts (e.g. the elderly) still evidence outdated mindsets and common misconceptions, such as that someone won't use/adopt/be successful with something new. This is a myth and relevant to the small minority rather than the vast majority of people – yet is still used as a barrier. Providing good case studies (e.g. we have several people aged over 100 using our connected solutions and video calling loved ones) is a good enabler to break these barriers down.

What were the conditions for success?

- **Good culture programme for workforce:** Culture change starts at home, and it's important to recognise the value and impact this has – and to resource it appropriately.
- **Streamlined processes:** When rolling out a large change programme like this, people will be at different stages of the change curve. It is important to make the processes they will be using as easy to complete as possible so that there are no additional barriers. One example of this is that the Council integrated ordering into the existing assessment pathways and then used robotic process automation to take referrals from the case management system to be fulfilled. For a practitioner in Suffolk, there is no change to what they normally do, but lots of good technical process behind the scenes have been employed to make it feel that way.
- **Exceptional communications:** Consistent and impactful communications are key to sustaining the right messaging and narrative, and breeding the right grounds for change culture.
- **Good support network of champions:** Peer-to-peer support is invaluable, as not everyone will be convinced that centrally-driven change is good for locally-driven operations. Investing and growing your champion networks gives you the right engagement through the right people.
- **Practical demonstrations and face-to-face immersions:** Suffolk talks confidently about care technology all the time – but letting people touch, see and understand it in real life is a big enabler to getting referrals. Without seeing it, it is always a concept rather than something real.

Further information:

Suffolk Cassius

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Essex County Council

Outcome-focused care technology services

A transformational care technology service focusing on prevent, reduce, delay as well as financial and non-financial benefits to keep people living independently for longer.

Essex has an ageing and growing population with a higher proportion of people aged over 65 than the national average.

The ASC vision of 'putting communities at the heart of Adult Social Care: enabling people to live their lives to the fullest' aims for a shift from reactive, long-term care and support to a greater focus on prevention and early intervention to support better health and wellbeing.

The Council recognised the potential that care technology could have in helping them to achieve this ambition, but the county did not have a comprehensive or satisfactory offer, which the Council resolved to change at scale.

Essex County Council (ECC) commissioned a new, countywide care technology service which went live in July 2021. We used learning from some test and learn pilots within Essex to shape the specification for the new service with a procurement approach focused 100 per cent on quality of which 20 per cent was Social Value. This meant we had a lot of focus on outcomes for adults as well as achieving potential savings of £17.8 million over three years.

Essex County Council, in partnership with Millbrook Healthcare and Provide Community Interest Company, implemented a major transformation to the delivery of technology enabled care (TEC) across Essex, using a digital first, proactive/preventative approach to health and social care which is data-led and outcome-focused. Prescribers can choose a mix of TEC and traditional care and a benefit measurement model which looks at quality of life outcomes alongside actual and predicted financial savings is built in.

Essex County Council linked with other transformation programs such as the award-winning Connect Programme which is transforming how older adults experience interim and community social care services. For example, through the Connect programme the local reablement service providers were able to link to the new care tech service and improve the impact of both programmes on achieving independence outcomes for adults.

The Council are just over a year on from the launch of the contract and have realised £11.9 million of avoidable financial savings for Adult Social Care. They have trained over 980 internal and external prescribers and have a total of 4,936 residents benefitting from the service. The falls pick-up team has supported 428 adults who have fallen over, saving approximately £600K to the NHS in ambulance call outs and days in hospital. Over £5.5 million has been achieved in Social Value by using the national TOMs framework. Areas of increased Social Value benefit to Essex has been in sustainable employment, training and employment of specific cohorts, supporting communities with green projects and reducing public service demand.

The Council's hard work was recognised at the International Technology Enabled Care awards in March 2022 which was hosted by the TSA where the service won the Transformation Award for introducing next generation TEC countywide to support our most vulnerable residents to live as independently as possible.

The Council's own First Anniversary Awards event celebrated the contribution of key individuals who have embraced the new TEC First model. The awards recognised: Individual Customer Service, TEC Innovation, Outstanding Achievement and a partnership award to highlight Best Practice within Reablement.

The Care TEC service is available countywide for anyone over the age of 18 but by using a framework agreement we have the opportunity to explore further partnerships across health, housing and children's services.

Millbrook Healthcare have a dedicated Community Health and Engagement Role which supports collaboration and partnership working alongside Essex's TEC team.

All partners understand the need to include the entire ecosystem of service providers and partners to meet changing citizen needs. Close collaboration with Essex Cares Limited (ECL), Essex County Fire and Rescue Service (ECFRS), digital champions, dementia pathways, mental health services, local business, TEC Mate's project and all available community resources helped to identify gaps and opportunities to utilise TEC.

The Council has created end-to-end engagement with commissioners, professionals and service users to create a sharing platform, with health and social care prescribers feeling confident to recommend innovative solutions for home-living and quality-of-life improvement.

The following case study demonstrates innovation:

A is a 93-year-old lady who lives alone in Basildon. She was struggling to use the phone or TV due to loss of sight and as a result lost her independence and became reliant on carers. A had Carers visit her four times a day to help with personal hygiene and meal preparation. This was often different carers. The carers didn't always know where to put things back and as a result, A was unable to find things when she needed them. A explained how she felt: "I was in a dark world reliant on others for all my daily living needs, what kind of life is that? My life was depressive, and I felt a burden to my family and friends. I felt like giving up unable to do so much, I was sad lonely, isolated and vulnerable. I tried to end my life, with an overdose I felt that low."

A was provided with an Alexa to support her with her daily routine, so when she said 'Alexa' it would start her morning routine on a daily basis. A was able to listen to the news, while talking books, daily quizzes and a joke of the day are just a few of her favourite pastimes. She was also able to change what she was listening to and increase/lower the volume. When A was not able to find something, she was able to call out and find out where it was. She was also able to call her GP and her family, thus providing her with the independence she had previously enjoyed.

A explained what the Alexa solution has meant to her: "If I have woken up scared not knowing where I am, I ask Alexa whether if it is night or day." It allows her to contact family and friends if not given items requested, which she explained as "My friends and family were able to see in my room, advise where drinks had been placed."

What were the barriers to success?

- The engagement from frontline practitioners against the growing workloads experienced during the Covid-19 pandemic.
- The challenge of having three different systems for the end-to-end process.
- Preconceived ideas around technology in general, i.e. older populations can't use technology, etc.

What were the conditions for success?

- Shared vision and outcome across partners of the consortium and Essex County Council's project team.
- The growth of technology throughout the Covid-19 pandemic.
- Multiple channels available to engage with key stakeholders.

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