Potential for prevention

Emerging case studies in Adult Social Care across the East of England

directors of adass
adult social services
eastern region
connecting innovating improving

June 2023

East of England Adult Social Care

Foreword

The phrase 'prevention is better than cure' is often attributed to the Dutch philosopher Desiderius Erasmus, in around 1500. It is now a fundamental principle of social and health care and inherent in many strategies.

The Social Care white paper 'People at the Heart of Care: adult social care reform' helpfully proposes this as a key priority and within our region this is something we have quickly responded to. Within this report you will see much evidence of this and the many and diverse examples of emerging practice of which we can be proud. The subheadings show the areas where prevention can assist in providing good care, ranging from supporting independence to technology-enabled care and support.

Whilst demand and complexity of need is increasing it's natural to focus resources on our 'front door' to make sure we can assess and support people quickly and minimise risk. This is, after all, what social care excels at. What I suggest this report demonstrates however is the importance of minimising the chances of people presenting in the first place and the parity of esteem we need to give to this alongside the front door demands.

Putting people at the heart of care and support is exactly what good prevention does.

I hope you find the report insightful – please share the good practice you will come across.

Kind regards

Stuart Mitchelmore
Chair of Putting People at the Heart of Care and Support Working Group

Contents

Cover photos: Centre for Ageing Better

Providing and raising awareness in relation to technology enabled care and support

Sharing information across partnerships

Listening and co-producing with people who access care and support to transform care

Essex County Council

Redesigning mental health accommodation pathways

Co-producing and redesigning the mental health accommodation pathways based on feedback from people who access care and support.

The problem acknowledged by all system partners was that the current model of mental health support in accommodation care no longer fitted with the direction of travel for other mental health services under the transformation model of care.

Individuals were often not placed in the right level of supported accommodation for their needs and there were problems moving people on from accommodation. Ultimately this led to significant long lengths of stay in bed-based and supported accommodation.

Essex County Council (ECC) knew that it needed to work with all systems partners to review the current pathway and fully understand the current needs of people living with mental health challenges across Essex.

The co-production officers worked alongside colleagues to review the current Mental Health Supported Accommodation offer, using their lived experience and engagement work with individuals to identify what was working well and what improvements were required.

Following on from this work, the Supported Accommodation Pathway was redesigned with the co-production officers being an integral part of this work. (Note: Co-production officer roles are paid fixed-term roles within commissioning.)

Using their personal experience and consultation with individuals, the co-production officers supported commissioners to set the monitoring outcomes of the new services using measures that focus on the positive outcomes of people in supported accommodation. They also described the skills that the staff need and how the service can be equipped to support recovery and independent living.

Crucially, the co-production officers supported the tender process by writing five case studies for the different levels of service to help potential providers to understand in detail, the level of need they would be supporting. The officers supported the evaluation of these responses, ensuring that the scores given reflected the providers' commitment to having shared values and co-production.

As part of the evaluation, the case studies written by the co-production officers highlighted how providers would handle real-life situations and helped the team to discount providers who did not fully understand personalised support and the needs of individuals.

Ensuring that the co-production officers were involved in each stage of procurement meant that lived experience was used to make significant improvements to the pathway design. This approach also supports the reduction of risk and by co-designing services, the council is ensuring that it meets the needs of those using them and that they are designed in a personalised way.

What were the challenges?

- Recruiting individuals with specific 'life experiences' can sometimes be a challenge to the traditional recruitment process.
- Time needed to upskill individuals with lived experience who had no previous knowledge of social care or working in a local authority environment.
- Managing the conflict and levels of expectation between professionals and experts by experience.

What were the conditions for success?

- Recognising individuals for their lived experience and employing them so they have an equal voice in the commissioning process.
- In terms of the engagement work carried out, the co-production officers speaking to people with lived experience built trust with those individuals and allowed for different conversations. People with lived experience are more likely to be relaxed and honest about issues.

Contact: Emily Oliver – emily.oliver@essex.gov.uk

Supporting people to have a good life and be independent in a place they call home

Central Bedfordshire Council

Ensuring safe and independent meal provision and support within the family to retain independence

It was important that roles could be retained to enable the family to function. Grandmother was adamant that she wished to continue preparing food and supporting her daughter with childcare.

A grandmother and her daughter both have Charcot-Marie-Tooth disease. The grandson has attention deficit hyperactivity disorder (ADHD) and is known to Children's Services. The grandmother uses a self-propelling wheelchair and is the main carer and main cook. She had managed a standard kitchen for some years but a reduction in her hand strength and range of movement in her shoulders was making this difficult for her to continue.

The grandmother has a supportive and key role in the family as her daughter struggles to some extent physically and with organisation due to ADHD. The kitchen was a galley through room which posed a risk to the child with ADHD running through a narrow area when food was being made. There were also food allergies to consider which meant ready-made meals were not an option.

Recognition of these relationships and roles were key to the family continuing to cope independently. Formal care was discussed as an interim due to the pressure placed on home life, but the family did not want to consider this. The property had been previously adapted with a ground floor bedroom and graded floor shower, wheelchair access and drive, so this was the only issue at the time of the assessment.

What was put in place?

The Adult and Children's Occupational Therapists worked together with the private sector housing and Howden's Building Services. A Disabled Facilities Grant (DFG) for both grandmother and grandson were combined to provide a safe accessible kitchen utilising the dining room area. The surfaces are of variable height and there are electric lowering cupboards. The kitchen is larger with no throughway to the garden. The design meets all the family's needs, both now and in the future.

The work completed resolved the issues and the family are now independent and managing without difficulty. Although they managed without care in the short term, if the adaptation had not been completed, they would have had to reluctantly accept care, changing the family dynamic and affecting their respect and self-worth.

The grandmother said:

"The Kitchen is now a safe accessible space to cook in. Thank you so much for helping us to create this. Thank you again. It has given me my independence back and enabled me to feel me again."

What were the conditions for success?

- Getting the plan right. This involved meetings with kitchen designers, the family, occupational therapist and the housing solutions officer.
- The family were placed at the centre of the design.
- Utilising the two DFGs to allow the work to go ahead without compromise.
- Excellent project management.

Contact: Helen Vermeiren – helen.vermeiren@centralbedfordshire.gov.uk

Central Bedfordshire Council

Ramping up to possibilities

Man with diagnosis of motor neurone disease (MND) experienced restricted access in and out of his home, which was impacting upon his quality of life with his wife, ease of attendance at medical appointments and potentially restricting options for provision of an NHS wheelchair.

Mr B had the rapid, progressive, neurological condition of MND formally diagnosed in August 2022, affecting most significantly at the time his upper limbs and hand function. Since diagnosis, he is demonstrating increasing issues with reduced activity tolerance, inability to weight shift when climbing steps and stairs and balance issues. He is currently using a walking frame for short distances. It is anticipated that within the next few months, Mr B will need to utilise a wheelchair for his mobility and postural needs, both indoors and outside his home. Ramped access is essential to support provision of an NHS wheelchair.

Mr B has been living in a micro-environment in the short term awaiting installation of a privately-funded through-floor lift and completion of a privately-funded level access shower facility on the first floor. Mr B is very driven to return to sleeping on the first floor of his home for normality and privacy, and this is his priority. His wife is very keen to enable him to shower and not strip wash, to support ease of access outside the home for as long as possible, and to support them as a couple to maximise quality of life within such stressful circumstances.

Access to the front of the property has been adapted by the Community Occupational Therapist with additional grab rails and temporary half-step, but Mr B is now unable to grip the rails and has fallen when exiting his home on foot. This has impacted upon his mental wellbeing as this now deters him from wanting to attempt to access social opportunities and appointments. This has also led to increased anxiety and isolation for his wife and increased potential for carer and family relationship breakdown.

Access to the front of the property has limited adaptation options due to the layout of the stairs and access internally, as there is restricted turning space within the front hall/lobby for wheelchair use in and out of the door. Access to the rear of the property could not be adapted with portable ramps due to the necessary gradient required and the end of the ramps would go directly onto grass, creating potential for Mr B's wheelchair to be grounded or tip, and to be a hazard for both occupant and carer. Mr B weighs approx. 16 stone (without accommodating additional wheelchair weight), so it was not felt appropriate for Mr B to attempt on a gradient of less than 1:20 (mindful of physical health needs). There is existing hard standing access to both the side and rear of the property/garden for a semi-permanent ramp to be sited without additional preparatory works, as a ramp would graduate with 2 x interim platforms to the side of the property. Ramped access to the rear of the property will enable access to the property boundary to access wheelchair taxi, etc.

The couple were keen to retain the existing bilateral patio outward opening doors, as these were recently installed. Mr B is very mindful of the other major adaptations being privately funded to meet this need internally and the impact upon the potential re-sale value of the house, as he is trying to be sensitive to his wife's financial situation after his death. He has a degenerative condition which has a significant psychological impact, impacting upon not only himself, but his wife and wider family.

What was done?

The Occupational Therapist sourced a quote for a semi-permanent ramp to achieve the desired gradient to support attendant wheelchair and powered wheelchair use to enable long-term suitable access to the rear of the property. Concrete ramping had been considered but eliminated due to the time to construct, permanency and size of the structure required.

The Disabled Facilities Grant (DFG) means test process was initiated and the couple were deemed not eligible for financial assistance.

An application for a Prevention Assistant Grant (PAG) was made for consideration and is awaiting approval.

What were some of the challenges and barriers?

- The quote exceeds the Prevention Assistance Grant (PAG) financial limit.
- The PAG requested must therefore be presented to panel to discuss discretionary PAG monies.
- Formal outcome of the PAG is taking time.
- DFG process would be longer as it requires comparative quotes and would be a permanent ramp adaptation, which the couple did not want. They are also not eligible for financial assistance.

Contact: Helena Price – helena.price@centralbedfordshire.gov.uk

Central Bedfordshire Council

The Independent Living Team (TILT)

Providing support to increase independence and improve quality of life.

JH is a 21-year-old woman living at home with her mum. JH has a diagnosis of Fragile X Syndrome, Asperger's Syndrome and ADHD. JH also presents with anxiety and depression.

Upon completion of JH's Care Act Assessment, she was referred to The Independent Living Team (TILT) for support with daily living activities. Initially, JH was observed spending most of each day in her bedroom; she was reluctant to access the community or complete daily living activities without support from her mum.

It was acknowledged that JH would benefit from learning to use public transport, accessing meaningful activities and building friendships to improve quality of life.

The TILT worker spent the first few weeks simply building trust and rapport, having a gentle approach and willingness to take things at JH's pace to encourage engagement. Once JH began to get to know the worker, she actively engaged in their sessions together. JH enjoyed the training sessions and grew in confidence.

By the eight-week mark, JH was ready to start using public transport to access Sainsbury's once each week. Achieving this independently improved JH's confidence further and within three months, she was considering employment opportunities.

What were the barriers?

- Poor mental health
- Isolation
- Low self-esteem.

What were the conditions for success?

- Patience – the worker being willing to take things at the right pace.
- Building rapport and trust.
- Positive feedback to build confidence.

Contact: Helen Hammond – helen.hammond@centralbedfordshire.gov.uk

Central Bedfordshire Council

Emergency Duty Team (EDT)

Providing support services and completing Mental Health Act Assessments out of hours.

AP is an 82-year-old man who has been living with his sister for the last five years. He was diagnosed with dementia in 2021. There was no history of mental illness or involvement with the Community Mental Health Team (CMHT).

There had been recent concerns regarding a deterioration in AP's cognition and an increase in challenging behaviour. His sister said that AP has been verbally abusive towards her, and having paranoid thoughts that she is taking or moving his things from his bedroom when he cannot find them. The plan was to discuss the possibility of a respite placement for AP.

Unfortunately, his sister was admitted to hospital following a fall at home. AP is not safe to stay at the home alone due to risk of self-neglect. He became agitated and was abusive towards the professionals from Crisis Resolution and Home Treatment (CRHT) who went to see him at home, and he refused to go to the hospital to a safe place when an ambulance was called for him.

Upon receipt of the Mental Health Act Assessment (MHAA) referral the Emergency Duty Team (EDT) on-call manager allocated an EDT Approved Mental Health Professional (AMHP) who carried out investigations into AP's current condition. Information was gathered from speaking with AP's sister (who was accessible via mobile phone), a neighbour/friend (who was currently at home with AP) and professionals from Crisis Resolution and Home Treatment (CRHT).

It was not deemed appropriate to speak to AP at this time as he was presenting as confused and not willing to engage in conversation via telephone.

Further conversations happened with CRHT professionals as it was not demonstrated in the MHAA referral that a MHAA was appropriate and was not deemed as the least restrictive option. The referrer who saw AP that day was not available, and colleagues were unable to provide additional information from what was included in the referral.

Discussion took place between the AMHP and EDT on-call manager and it was agreed that a an emergency MHAA late at night would not be in the best interests of AP, and there was insufficient information available to justify the need for an MHAA.

A safety plan was put in place to support AP overnight:

- AP to remain at home with neighbour/friend as he had settled down.
- AMHP to forward information to EDT social work colleagues, to follow up the next day (Saturday).
- EDT to liaise with hospital discharge team to gather information regarding sister's condition as she is AP's main carer.
- Request for AP to be seen by an out-of-hours GP as deterioration in cognition and behaviour could be caused by a physical health condition such as a urinary tract infection (UTI).

The above involved joint work between EDT and the hospital discharge social worker who provided information stating that they were not planning to discharge AP's sister and could not see any concerns regarding AP on their system in relation to discharge planning. A package of care would be considered if required on discharge.

- The out-of-hours GP visited AP at home the following day and it was confirmed that he had a UTI which is believed to have contributed to his increase in confusion and challenging behaviours. Medication was provided.
- It was agreed that family members would stay with AP over the weekend. AP was referred to the adult social care area team to follow up and consider the best support plan for AP both short and long term.

What were the barriers?

- Increased challenging behaviour of AP.
- Lack of information from health professionals who assessed.
- Risk of inappropriate MHAA.

What were the conditions for success?

- Effective professional curiosity demonstrated by AMHP.
- Joint/collaborative work with professionals – CHRT and hospital discharge service.
- Personalised approach – considering the least restrictive approach and avoidance of inappropriate MHAA referral.

Contact: Natalie Oatham – natalie.oatham@centralbedfordshire.gov.uk

Central Bedfordshire Council

North Locality Review Team

Providing support to a woman with dementia, to enable her to live at home safely for as long as possible.

MW is an 85-year-old woman who lives alone in sheltered accommodation in a small village within rural Bedfordshire. She has a diagnosis of dementia and poor eyesight due to having cataracts.

For a long time, she had the support of a care call in the evening to prompt her to take her medication, however, her cognition declined noticeably and she became unable to manage her home environment. Family became very concerned for her wellbeing and felt she was unlikely to be able to manage at home for much longer. This was of great concern because MW loves her home and loves walking to her local fish and chip shop every day, buying a newspaper and talking to the locals. This is a key part of her daily routine and a big part of her identity, and so losing the ability to do this would have been very detrimental to her wellbeing.

During a care review, it was identified that MW was declining the support provided by carers in the evening and she was not taking her medication. Her home was becoming cluttered and there were concerns about very poor hygiene in the bathroom and kitchen. Flies and maggots were found in her kitchen because she was not taking her bin out and disposing of food, and her living room had become cluttered with newspapers. Additional concerns were raised regarding fire safety and hoarding.

A mental capacity assessment was completed around care and support needs and MW was found to lack capacity.

MW's social worker had worked with her over a long period of time, maintaining regular contact and face-to-face visits to build a relationship slowly. This was helpful in supporting MW to engage, although engagement was hit and miss. Another social worker visited with the allocated worker to complete a welfare visit. The two social workers supported MW to participate in clearing out some of the items in her home, encouraging her to make decisions about what she wanted to keep and what she was happy to dispose of, highlighting the risks of keeping piles of newspapers in the flat, etc.

A referral was made to the Fire Service and several visits have been completed by the Safe and Well Team. They assessed the property to be around level 2–3 on the hoarding scale; they ensured the gas cooker was off at the mains and fitted smoke detectors to the flat. They also assessed that the area of the flat MW smoked in was safe and relatively clear of clutter, providing her with a smoking apron so she could smoke safely.

A new provider was sourced to provide two calls per day to support MW with managing her home environment, heating meals in the microwave and taking medication. The new provider was a Community Catalyst group that has only three employees, therefore, this has given MW the chance to get to know her carers better and has supported continuity of care. Initially MW was resistant towards the care increase and turned carers away, however, over time she has started to build a relationship with the carers and now lets them into her flat most of the time. MW didn't like having the carer clean parts of her home and would tell the carer to leave. To resolve these issues, it was agreed the care calls should be undertaken by two carers; one carer to sit with MW and talk to her and offer support with meals, drinks and personal care and the other to ensure the kitchen and bedroom remained clear to avoid illness, infection and poor hygiene. This has started to work well.

What were the barriers and challenges?

- Lack of engagement.
- Lacking capacity around the need for support.
- Family perceiving the risks to be too high.

What were the conditions for success?

- Working together with MW, the care provider, family, housing association and fire service.
- Communications have been kept open to ensure that any concerns are escalated and there have been several meetings with the family.
- Several care reviews with the new provider have also ensured all concerns are escalated quickly and appropriately.
- GP involved regularly.
- Being creative and flexible in terms of the care arranged.
- Building a rapport slowly.

Contact: Katharine Murray – katharine.murray@centralbedfordshire.gov.uk

Central Bedfordshire Council

Community collaboration as a multi-disciplinary team

Providing support to increase independence and improve quality of life by working collaboratively.

A referral was sent to Central Bedfordshire Council (CBC) rent department for a case where a woman was in debt with her rent. It was also noted that the property was in a poor state. CBC called the woman to gain consent to visit and to gather more information in relation to physical health care and to arrange a visit. CBC were then able to ascertain that she lived alone and she did not have anyone to support her at the meeting. Information was gathered and case notes were looked through and during this it was noted that East London NHS Foundation Trust (ELFT) were involved via the Memory Assessment Services (MAS). Contact was made with MAS and the rent department were asked to hold off on any legal proceedings so the situation could be understood.

It was clear that the woman was not engaging in support; the Community Mental Health Team (CMHT) said they had received no request for input and MAS had sent appointment requests but had received no reply.

On assessment, there was no medication at the property and no medication had been collected for over two years, even though the woman was type 2 diabetic. Prescriptions were subsequently arranged and a review of medication was undertaken. An appointment was made with MAS and an online Teams call was booked to review cognition and a CT (computerised tomography) scan referral was made.

The woman had family who supported with paying off other bills that had been found and fitted a safe so that money, etc., could be kept safely. Unfortunately, due to mental health issues the family could no longer support so a home care agency was contacted. Money management has now been applied for as the woman has received a diagnosis of dementia and is unable to cope with her own finances.

After this engagement and support, she is now thriving in her home environment and has put on weight, has daily social interaction and is taken out by carers to do her shopping and have her hair done and enjoys a much better quality of life.

What were the barriers?

- GP who had not noticed that medication was not being ordered or collected for over two years.
- Isolation.
- Low self-esteem.
- ELFT discharged due to no response which meant that an earlier diagnosis and possible treatment had been missed.
- The woman had not been able to access technology without support.
- Getting details of professionals took time.

What were the conditions for success?

- Building rapport and trust,
- Positive feedback to build confidence.
- Excellent care agency support,
- Money management support,
- Living in her own home for longer with support.
- Feeling valued.
- Working together as a multi-disciplinary team which supported good practice.

Contact: Gazala Riaz – gazala.riaz@centralbedfordshire.gov.uk

Cambridgeshire County Council

Community Navigators Supporting with Hoarding

How a personalised approach by the council's commissioned Community Navigator service was able to support someone who had previously been seen as 'hard to reach'.

Mr A was referred into the Community Navigators service by a Social Prescriber. Mr A had recently seen his GP with issues related to his physical health but was not responding to calls and letters from the surgery for a follow-up appointment. The GP had referred Mr A to a Social Prescriber who was also unable to contact Mr A. The Social Prescriber had made onward referrals to the Community Navigators and two other local organisations. Letters and phone calls had been made to Mr A by these organisations but as he had not responded to contacts his referral had been closed.

The Community Navigator was aware that Mr A was not responding to phone calls and letters, and subsequently made several home visits to gain Mr A's trust. The persistent and caring nature of the Community Navigator meant Mr A allowed them to access the property. The home visit highlighted the situation Mr A found himself in: access through the property was extremely difficult due to extreme hoarding behaviour. Furniture filled every room leaving only a small gap to walk through and every surface was covered with overfilled boxes piled on top of each other. The rooms were dark as Mr A kept his curtains closed.

The main living room had an open fire where Mr A burnt paper and pieces of wood/furniture and plastic bags. The areas around the fireplace had piles of unopened correspondence nearby and from time to time Mr A was throwing handfuls of envelopes onto the open fire. Mr A explained that he had stopped opening his post because he knew it was only people chasing him for money. One of the main reasons he kept his curtains closed, doors locked and did not answer phone calls was because he knew that it was bailiffs wanting money/goods from him to pay off his debts.

Mr A was in poor physical health. He described himself as being in constant pain which he tried to manage by self-medication with alcohol and opiates.

The Community Navigators actions included the following:

- Liaison with the Social Prescriber and GP to arrange a medication review.
- Whilst contact was made with a national debt organisation, the telephone calls were made during a home visit as the client needed to give consent. The call was on hold for 40 minutes waiting to be answered. After giving as much information as possible regarding his financial situation the referral was not accepted due to the size of the debt/complexity of the situation and lack of correspondence available. They also could not allocate a case worker until August (contact was made in May).

- Referral made and accepted to the debt organisation, StepChange. The Community Navigator was on hold for 50 minutes but was able to speak with an advisor and Step Change agreed to support Mr A. The Navigator gathered unopened mail to pass onto Step Change on Mr A's behalf.
- Liaison with the District Council and agreement of a £5 monthly payment plan for Council Tax arrears.
- Referral made to Fire Safety Officer, who had been made aware that the property was high priority, with a warning flag placed on the property. Community Navigator agreed to be present for home visit.
- Mr A refused referral to Hoarding MDT, but the referral remains open.

Conditions for success:

- The case study highlights the importance of home visits, building trust and rapport with the person.
- The case study also highlights the importance of having a proactive, knowledgeable, generalist involved who can support people to navigate several complex areas such as debt advice.

Contact: Sunny Singh – Sundeep.singh@cambridgeshire.gov.uk

Cambridgeshire County Council

Bar Hill Knit and Natter

Retired people have worked together to reduce social isolation with weekly knit and natter services. The attendees live locally and help each other to get to the location. A group of drivers regularly collect and return attendees. Refreshments are served and conversations held during the knitting services.

There can be social isolation and loneliness in communities with a lack of confidence to get involved or lack of awareness of community groups and activities. Getting involved in local activity is known to reduce the isolation people feel in their communities and hopefully lead to participation in other local activities.

The Council used the seed funding grant to help a local knit and natter group to increase their membership. Some people do not know how to knit, but providing a small grant means the organisers can assist new starters with knitting needles and wool. With the help of other attendees, new starters can learn a new skill. Existing attendees who cannot afford wool can be given wool to continue participating.

Attendees and providers explained the benefits they get from attending and why they continue providing and supporting the service:

"My arthritis makes it difficult to knit but I can talk for England and would love to help new starters learn."

"I love coming here, I have been coming for 18 years, it's a good break from caring for my husband."

"Many of us are widows and we support each other."

"I lost my husband 18 months ago and broke down in the doctor's surgery 12 months ago and they suggested I come here – I am so glad I did."

They also identified potential problems:

"The cost of wool is getting expensive and I am not sure what we can do if people run out."

What were the barriers and challenges?

- Cost of wool and knitting needles.
- Not knowing how to knit.
- Not knowing anyone in the group (40 attendees).
- Getting to the venue.
- Lack of confidence in social settings.

What were the conditions for success?

- Promotion in local newsletter.
- Invite a friend.
- Offer knitting lessons.
- Volunteer drivers can assist/a carer can escort the attendees.
- Taster sessions.

Contact: Leneva Nwachukwu – Leneva.nwachukwu@cambridgeshire.gov.uk

Strengthening and supporting the workforce to enhance prevention

Thurrock Borough Council

Blended roles

Upskilling domiciliary carer workers to undertake low level nursing tasks and to support low level mental health needs, whilst adopting a strong understanding of mental health/health conditions, preventative support options and appropriate pathways.

There is a need for further integration across health and social care organisational and service boundaries in Thurrock. Teams and services are predominantly designed on traditional structures with little opportunity for empowerment and delegated decision making. Therefore, if a person requires a nurse to change a wound dressing but also needs support with dressing and washing, they will be visited by a community nurse and a domiciliary care worker. Lack of partnership working can cause duplication of visits and tasks, handovers and referrals, the use of numerous systems and a failure to find out what matters to people means addressing or focusing on the wrong things. Lack of integration adds costs and demand to the existing system resulting in significant levels of 'failure' demand.

Upskilling internal domiciliary care workers to undertake certain tasks and activities currently carried out by other health professionals has the potential to improve continuity of care, reduce duplication and free up specialist capacity. Blended roles across traditional health and care team/organisation functions allow staff to expand their skills to enable them to undertake both routine clinical and care tasks, as well as using time allocated to focus on supporting the person to do things that enhance their wellbeing. This will reduce the overall number of visits needed, freeing up NHS capacity, and rationalising the number of people potentially involved with the same resident and improving care continuity. In addition, blended roles can have a greater role in delaying the need for health and care and helping to avoid crisis.

What was put in place?

- 'Significant Seven' training for staff to provide a baseline of prevention and recognising the signs of deterioration.
- Comprehensive training package tailored to upskill and support the competency assessment for the provision of low-level nursing tasks including catheter care, sepsis awareness, stoma care and wound care.
- Insulin administration training.
- Tailored mental health training to explore the spectrum of mental health conditions and pathways across Thurrock.
- Competency assessment tools.

This involved working with groups of health partners, commissioners and adult social care staff to explore options and barriers and meeting with a range of external partners to discuss solutions and draw on previous experience.

What were the barriers and challenges?

- Partner organisations concerned about change and the capacity needed.
- Sign-off processes that needed to be completed from health partners.

What were the conditions for success?

- Continuing to meet regularly to keep up momentum and trust in partners.
- Relationship building and being empathetic towards concerns of partner organisations.

Contact: Patsy Jones – patsy.jones@thurrock.gov.uk

Thurrock Borough Council

Trusted assessors

Upskilling of internal and external staff to complete assessments for reviews of care and support needs, ordering low level Occupational Therapy solutions and undertaking carers assessments.

Supporting internal and external staff who have a good relationship with residents to become trusted assessors reduces duplication, unnecessary delays in providing support and prevents residents from having to retell their stories.

Thurrock put in place:

- Training for internal and external staff which provides an overview of Occupational Therapy (OT) needs and equipment available which would allow staff to order the low-level OT equipment.
- Training and support packages for external carers service which allows them to complete carers assessments.
- Training and support for internal staff members working across extra care and domiciliary care services to undertake care and support reviews.

The Council worked collaboratively with internal and external staff members to understand the above support needs and training requirements to upskill staff.

What was the biggest barrier?

- Staff capacity and willingness to take part.

What was the main condition for success?

- Highlighting the benefits to staff and residents – empowerment, support provided earlier and not having to retell stories.

Contact: Patsy Jones – patsy.jones@thurrock.gov.uk

Norfolk County Council

Person profiles

Norfolk strives to support people to be independent and reduce or delay the need for support by developing provisions, services, systems, and processes which are timely and purposeful.

The council recognises that people supported alongside their carers and families are experts in their own lives. Social Care practitioners are well positioned to assist people requesting support, to navigate a complex Health and Social Care landscape. However, with the year-on-year escalation in requests, social services workers report increased demand on their time with administration tasks and pressures on their decision making.

An internal review of care outcomes indicated that Practitioners felt there were cases when an ideal outcome was not always achieved. Further exploration identified multiple factors influencing these including access to information, time pressures, delay in accessing information, challenges managing expectations due to assessment delays, and not acting earlier resulting in a deterioration in the persons independence.

The Person Profile is one part of the council's approach of continued development promoting a person-centred, preventative model of care, which encourages resilience in local community assets, enables council staff to access relevant information quickly and easily about the people and communities they support. The Person Profile consolidates information from several different, existing sources and summarises these across three areas:

- **Person Information –** Personal and community relationships/network, Current Care services and Information, relevant health conditions linked needs
- **Care Journey –** Timeline of involvement or engagement with the council, assessment activity including safeguarding events, periods of hospital admission, reablement and out of hours attendance (Swifts), time of and frequency of engagement/s
- **Community Assets –** mapped view of community assets from formally commissioned provisions to community services, Postcode view and Parish Council details, options which are potentially most relevant to the person based on their known preferences, strengths, needs, and potential options which can prevent escalation of need.

Having access to the right information at the right time enables Practitioners to promote a preventative approach, to see and understand a broad range of opportunity in their local area, to discuss options and possibilities with the person, use preventative and community assets more fully which reduces the reliance on formal care.

Contacts: Oliver Strangeway – oliver.strangeway@norfolk.gov.uk
Mark Lewis – mark.lewis@norfolk.gov.uk

Thurrock Borough Council

Integrated place-based teams

The development of four place-based locality teams aligned to the geographies of the four primary care networks in Thurrock. Teams consist of Adult Social Work, Local Area Co-ordination, Community and Voluntary Sector, Housing and Health.

Thurrock observed the following:

- Multitude of silo teams with a multitude of hand-offs, onward referrals and transfers of cases. It was important that most needs and outcomes should be met and delivered within the community regardless of primary need.
- Co-working between partners and wider teams to create collaborative human-centred and integrated solutions – including the use of community assets.
- Reduction of onward referrals for specific interventions by creating a locality-based multidisciplinary team (MDT) approach.
- Reduced delays in support, advice and guidance by upskilling staff to have shared knowledge across all sectors and not just their own.

As a result, the council put in place the following:

- **Phase 1** – Merged Adult Social Care specialist teams consisting of Complex Care Team, Adult Mental Health Team and Reviews Team into the four community-led support teams to align with Primary Care Network (PCN) areas.
- **Phase 2** – To incorporate Older Peoples Mental Health Team and the Hospital Social Care Team into the community place-based teams.
- **Phase 3** – To support partners to align frontline staff to place and integrate staff across directorates to enable multiskilled teams in each of the PCN areas.
- **Shared locality working** – for example, coming together at a new Integrated Medical and Wellbeing Centre or co-locating from community hubs.
- **Staff conference** to look at how change could happen and how staff groups could start to come together and work beyond silos.
- **Staff taster sessions** for staff across the system, led by staff to share awareness of different teams and support knowledge sharing.
- **Upskilling of staff** – for example housing staff and local area coordinators trained to carry out Occupational Therapy assessments.
- **Integrated Locality Networks** – with all frontline staff working in each locality (across health, care, housing, voluntary and community sector, etc.) coming together to raise and discuss issues and solutions and to build relationships.

Being based in the locality means being able to hear directly from people requiring support. This will enable the intelligence gathered to ensure teams develop specifically to address local requirements – moving away from a 'one size fits all' approach. The model being adopted is contained within Thurrock's Integrated Care Strategy and focuses on the adoption of Human Learning Systems. Intelligence gained locally will also help to influence what is commissioned and how it is commissioned.

What were the challenges?

- Cultural shift from more traditional ways of working.
- Organisational boundaries.
- Inhouse processes.

What were the conditions for success?

- Ensuring staff are knowledgeable and in agreement of the way forward.
- Ensuring staff are part of the decision-making process.

Contact: Sarah McCarry – smccarry@thurrock.gov.uk

Supporting people to recover after illness

Norfolk County Council

Headway reablement service

Proposal for reducing assessment times for people with brain injuries.

Headway Norfolk and Waveney who support people with Acquired Brain injuries (ABI), including stroke, have a number of people approaching them for support, where they complete an assessment with their qualified occupational therapist. Following this assessment, Headway often refers on to Norfolk County Council (NCC). This has led to additional pressure on the system, as it is taking longer than anticipated for NCC to carry out each person's Care Act assessment.

The council knows that on average it has 28 people with an ABI waiting for assessment. Whilst waiting for their assessment to be completed by NCC and a longer-term care plan to be put in place, this leaves each person with a gap in care at a important point in their recovery journey. This is particularly concerning for those with acquired brain injuries, especially as many people may have only just started to recover via some short health interventions.

- The proposal has developed a 12-month pilot to test and evidence base a preventative model of additional support for people prior to their assessment.
- Headway Norfolk and Waveney will be commissioned to provide interim support for up to 6 weeks until an assessment has been carried out.

This preventative programme (up to 6 weeks or until individuals are assessed by NCC) has now been put into place. Headway Norfolk and Waveney also carry out an initial assessment of the person's needs, through one of their qualified Occupational Therapists in the person's home. This aims to set outcomes which would be reviewed whilst the person is receiving care and support, with a focus on prevention and promoting independence.

The preventative programme would consist of:

- occupational therapy – outcome setting
- emotional support from experts in brain injury
- education of brain injury
- socialisation
- support for family/carers to prevent breakdown and encouragement to attend a carer support group facilitated by an Occupation Therapist.

In summary, Commissioning, operational and finance teams have developed this new model, working with Headway Norfolk and Waveney. As the programme is focused on reablement support for people with acquired brain injury, it is a non-chargeable service for the first six weeks. Once the Care Act Assessment (and Financial Assessment) have taken place, a longer-term package is put into place (either with Headway Norfolk and Waveney or another provider). NCC is also working with Headway Norfolk to become a Trusted Assessor, which will support the assessment process.

What are the benefits?

- Follows a Trusted Assessor model.
- Reduction in regulated provision.
- Holistic support.
- Eighty per cent of all brain injury cases are said to make most obvious progress in the first six months.
- Being proactive is the most efficient and effective approach, offering better value for money for all and improved outcomes for people who access care and support and their carers.

Contacts: Chris Scott – chris.scott@norfolk.gov.uk
Nick Pryke – nick.pryke@norfolk.gov.uk

Preventing falls

Norfolk County Council

Proactive falls prevention

Transforming the way in which Norfolk offers support to its residents. A move from reactive, formal support towards more proactive, targeted and preventative support.

Norfolk County Council (NCC) have several interventions to ensure proactive falls preventative support:

- Testing the capabilities through a fall's prevention pilot in early 2023.
- Using the latest artificial intelligence (AI) and machine learning to identify people most at risk of a fall to offer targeted, preventative support.
- Contacting people who access care and support to engage them, via a letter and holistic conversation, to best understand their personal support in order to recommend the most suitable interventions.
- Using a 'Protect Now' team, who are part of Population Management.
- Offering people falls prevention support, delivered by the appropriate services in the community, ensuring agreed capacity and using the nudge theory to engage people who access care and support including 'warm referrals' to maximise uptake.

NCC now wants to understand whether these interventions were successful in order to improve and roll out this way of working more widely. They understand that prevention means understanding people holistically and using a variety of support networks to ensure people stay well and independent. This means sharing data with partners and offering co-ordinated support from different partners. The pilot has already connected with South Norfolk and Broadland and is considering who to connect with next.

NCC recognises that people at risk of a fall are just one cohort of people. They know there are many other groups of people adding pressure to the system that could benefit from earlier support. NCC is considering who could benefit next and how they can be supported.

In addition to the above, NCC is testing out a new operating model as part of the falls prevention pilot to ensure learning and scaling up of the approach to provide proactive support to a wide range of people.

Contacts: Faye Gower-Smith – faye.gower-smith@norfolk.gov.uk
Nicholas Clinch – nicholas.clinch@norfolk.gov.uk

Cambridgeshire County Council

Falls prevention

An intervention designed to reduce the number of falls in Fenland for frail older people delivered through strength, balance and nutrition.

Falls in older adults are statistically proven to accelerate the deterioration of overall health and lead to the premature entry into more complex care systems including hospital and care homes. Falls also lead to a deterioration of mental health and independence and can complicate other illnesses including diabetes which can in turn lead to a shortened life expectancy.

As Cambridgeshire County Council (CCC) is an active member of the Integrated Neighbourhood Board (Fenland South) working group, it was decided quite early in the formation of the working group that frailty should be a focus due to the ageing population in the locality.

From the sub-group, the council devised some joined up interventions to tackle frailty and reduce falls in Fenland:

- A falls clinic was set up in Doddington offering assessments, strength and balance classes, social activity, diet planning and risk assessment.
- Satellite exercise groups through Active Fenland – strength and balance classes, forever fit, tea dances and active home booklet.
- Commissioned through Cambridgeshire County Council (CCC) seed funding, an expansion to locations of Active Fenland classes including the purchase of specialist chairs that allow the safe practice of chair exercise.
- Appreciative inquiry to support and shape the interventions and to measure success.

What were the barriers?

- Workload with other projects/workstreams going on and a much wider locality to consider.
- Systems and capacity – for example, pharmacists and doctors have little capacity to add more meetings or workload to their busy days. The systems they use make it difficult and time consuming to extract data without specialist data analyst support.
- Getting referrals and communication.
- Finding appropriate locations for exercise groups.
- Transport poverty.

What were the conditions for success?

- Active working team and active Integrated Neighbourhood Board.
- It is vital that CCC is forward thinking, open to innovation and supportive of place-based commissioning.
- Co-production and appreciative inquiry to understand the needs beyond data and speak to the hardest to reach.
- Continued analysis and agility to shape intervention to meet the needs of people accessing care and support.
- Funding to support innovation and expand established interventions.

For further information, please see the following web-links:

Exercise classes improve mobility in older people – NIHR Evidence
Active Fenland – Fenland District Council
Doddington Community Hub (cambscommunityservices.nhs.uk)

Contact: Amber Oberg – amber.oberg@nhs.net

Providing and raising awareness in relation to technology enabled care and support

Norfolk County Council

Virtual Care Agency – Alcove Video Carephone

Supporting people with low-level needs in their own home through Alcove Video Carephone.

The challenges that Norfolk faces include:

- an ageing and growing population
- difficulties with recruitment and retention of social care workforce
- challenges in transforming the health and care system from a reactive one, primarily resourced to support people once they become ill, to a preventative one focused on improving health and wellbeing
- the expectation to deliver more with fewer resources
- managing the continuing impact of COVID-19.

These challenges mean that as an organisation Norfolk County Council (NCC) needs to operate and commission differently so that it can:

- manage demand within the resources available
- reshape the offer and what is commissioned
- use technology to help keep people at home and live independently for longer.

As an organisation, NCC are looking to work with domiciliary care agencies to reshape how they support people and improve the effectiveness of services to reduce waste and to free up capacity.

Norfolk is keen to exploit technology and link with local third sector/voluntary organisations to deliver services in different ways, whilst maintaining a personalised approach that:

- sustains personal interactions
- continues to deliver outcomes
- delivers efficiencies and increased capacity within the domiciliary care market.

The Virtual Care Agency idea is that low-level care contacts, that do not need any physical activity, can be delivered using an Alcove Video Carephone. For the purposes of the pilot, Alcove did the video call and Norfolk First Support (NFS) provided any physical visits that the person accessing care and support still required.

The pilot was based in Norwich and supported a maximum of five individuals at any one time. NFS Norwich Service Manager identified potential participants for the pilot. Alcove and the relevant Reablement Practitioner then arranged to meet the person to install the device and demonstrate how to use it. Initially the NFS Support Worker attended when the first few calls were made to support the person accessing care and support.

The pilot has shown that NCC can successfully provide a blended offer of virtual and physical visits and that it can continue to support the outcomes of people accessing care and support.

The next step is to scale up the pilot to support more people and to work with the domiciliary care agencies to make sure NCC can sustain a blended offer of physical and virtual visits. This approach will then release capacity in the domiciliary care market to allow carers to support more people than they are currently able to do.

Some examples are given below.

- Morning call of 30 mins to prompt medication to ensure it is taken correctly and to monitor and support meal preparation.
- Prompt medication and provide breakfast and drink, ensure kitchen worktops are free from spillages.
- Continence management, meal and drink preparation and medication prompts.
- Support with medication, meal and drink preparation.
- Medication via MAR (Medication Administration Review) chart and meal and drink preparation, due to being blind.
- Tea – support to heat microwave meal, prompt medication, administer eye drops.
- Assist with getting dressed, making light meals and taking medication.
- Prepare meal and prompt medication.
- Assistance with night bag and medication monitoring.
- Assist with meal and drink preparation, leaving a snack for lunch, medication from MAR chart and hot meal preparation.

Contact: Chris Scott – chris.scott@norfolk.gov.uk
Stephen Boddington – stephen.boddington@norfolk.gov.uk

Suffolk County Council

Cassius – Suffolk's innovative digital care offer

This case study details the work done with a 19-year-old man and his family to support his transition into adulthood, which resulted in the provision of a digital care solution that prevented the need for commissioned support workers.

Jake (not his real name) is a 19-year-old man with diagnosed autism, dyspraxia and attention deficit hyperactivity disorder (ADHD).

At the time Jake was referred to Adult Social Care, he had always had a high level of parental support, reassurance and prompting to manage daily living tasks. On leaving high school and securing a place at university, Jake and his family were worried that he would not be able to manage independently when staying away from home for periods of time. His parents also travel abroad regularly, and now they would not always be able to take him with them, they were worried about leaving him at home alone without their support. They were worried that he would not remember to get up in the morning, would need prompting for personal care tasks and reminders to take his medication. They envisaged that this would be provided by paid carers or support workers visiting Jake daily when he was away from home.

Jake did not wish to have paid carers and wanted to manage more independently, but due to the impact of his autism and ADHD, he was unable to achieve this when he tried.

Jake was allocated an Independence and Wellbeing Practitioner (IWP) in Adult Social Care who undertook a needs assessment under the Care Act 2014. The IWP then worked with Jake and his family to consider care and support options to meet his eligible needs. The IWP considered Jake's wish not to have support workers balanced against his parent's concerns and their aspiration for him to have paid support workers.

The IWP spoke to Jake and his family about available digital care options and the co-produced solution was an Alexa Show provided through Cassius, Suffolk County Council's care technology service, which helps people to live independent, happy and connected lives. Jake now uses his Alexa Show to prompt him to wake up, take his medication, talk him through recipes for independent meal preparation, remind him to walk the dog and to undertake other tasks. Jake takes the Alexa Show with him when he attends residential events at university and is provided with a separate living space to enable him to make use of the Alexa without disturbing other students and to ensure his privacy when he uses it.

In addition to the digital care solution, Jake and his parents also work with the university to provide additional support as required and his dog provides emotional support and containment by calmly applying his body weight on Jake when he has meltdowns associated with autism and ADHD.

Due to the high level of support, reassurance and prompting that Jake's parents had always provided him with, they were certain that he would need paid support workers to support him in their absence. They were initially sceptical about the effectiveness of an Alexa Show in ensuring that Jake's needs were met but with reassurance from his IWP, they supported Jake to try this option in lieu of paid support workers.

Jake's IWP gave the following feedback: "I had to explain to J's mother that as an adult, I had to have J's consent to arrange any care and support and once I picked their situation apart with them and pointed out all the positives, she was willing to let him take the lead and become more independent."

Jake's parents initially tested this at home by stepping back from their role as his family carers to monitor and step in if required. Jake reported that he felt trusted to 'get on with it' and described the Alexa Show as a "game changer" as for the first time, he was able to manage without daily support and prompts from his parents. Jake feels that he is "being given more independence".

Jake's mother stated that, "As mothers we worry and I didn't think this would work, but it has been amazing. We would never have dreamed of him going on a residential on his own without adult support but something as simple as an Alexa has made a huge difference."

Jake's mother also reported that life is easier with the Alexa Show supporting Jake. They have fewer arguments about getting up in the morning and getting things done. She believes that Jake complies with the Alexa Show more than his parents because he feels that he is in control.

There has been a positive impact on the wider family. Jake's parents can now go abroad and have peace of mind, knowing that he will be prompted to get up and manage both his needs and the dog's, with his grandparents available locally if needed. They feel that they can gradually relinquish their caring responsibilities while Jake transitions into adulthood with autism, ADHD and dyspraxia. Jake's parents report that their own relationship has improved as they spend less time supporting Jake and are able to spend more time together as a couple away from Jake and their caring responsibilities for him.

What were the barriers?

- Jake's mother was worried that his needs would not be understood when she first referred him to Adult Social Care.
- Jake's mother found the standard process of seeking management approval and oversight for the proposed digital care frustrating as they had to wait for a decision. They would have preferred immediate confirmation.
- The family's initial lack of awareness and scepticism about the use and potential of digital care solutions in lieu of paid carers or support workers.

What were the conditions for success?

- Time to build relationships and trust with the whole family and to allow for informed and reflective decision making.
- Co-producing the solution with Jake and his parents.
- Listening to Jake's wishes and views and making these central to the outcome.
- Availability of a well-established, innovative digital care offer.
- Perseverance, reassurance, knowledge, and skills of the social care practitioner working with Jake and his family.

For further information, please see the following weblinks:

How Suffolk is building a digital platform for care and prevention – Association of Directors of Adult Social Services Eastern Region (adasseast.org.uk)

Technology to help you live independently – Suffolk County Council

About Us – Cassius (yourcassius.com)

Contacts: Sam Bassett – sam.bassett@suffolk.gov.uk
Amanda Takavarasha – amanda.takavarasha@suffolk.gov.uk

Bedford Borough Council

Reminiscence Interactive Therapy Activities (RITA) initiative in residential care homes

A digital resource to encourage independence within care homes, using large screen and tablet for either individual or group activities. This is a pilot scheme, introduced in six residential care homes, for up to 188 people with a range of different needs.

People in residential care have a range of challenges, particularly so when isolating or, during the height of the COVID-19 pandemic, were unable to have visitors. There is a high risk of falls and of admission to hospital. People can be under-stimulated because there are not enough resources to give everybody one-to-one attention. Residents will have a range of interests and traditional activities do not appeal to everyone, so some people will be unwilling to join group activities that do not interest them.

At the time of RITA's introduction, the Omicron wave of COVID-19 was prevalent locally, and residents in care homes were subject to Department of Health and Social Care (DHSC) restrictions, such as self-isolation on discharge from hospital, visiting restrictions and testing regimes.

The RITA project consisted of a large trolley-mounted screen unit and smaller tablet provided to each home for residents to use with staff or independently. The system has preloaded content covering reminiscence themes, TV and films, music, quizzes and interactive games, exercise classes and sensory and relaxation content.

Personal profiles can be added for each resident for their preferred content and to create life histories. The devices can connect to the internet and be used offline, which is beneficial as some internet provider coverage in some homes can be variable at times.

Individual use is popular with those people who do not already have their own digital device such as a tablet or smartphone, as they can download similar material. However, group activities are popular in every home, and where people do not have their own device, the individual tablet is also popular.

Residents in the council's dementia homes and Brookside (a home for older people with learning disabilities) have engaged well with RITA. The design of the units, the clarity and size of the screen and touch screen access is very compatible for use and engagement with individuals living with cognitive impairments. These individuals are also less likely to have used or have personal digital devices than those living in other homes.

RITA was successfully used to support and facilitate admissions to the reablement unit on discharge from hospital. Due to the requirement for self-isolating on discharge from hospital, this was placing pressure on the service to provide enhanced checks and social engagement to clients. RITA was used to support individuals at risk of falls when self-isolating and its format was such that many clients could self-engage with it.

A reablement client discharged from hospital was required to undertake self-isolation under current care home COVID-19 guidance. The home was concerned as she had some recent falls prior to her admission and was assessed as high risk of falls. Additionally, due to the self-isolation period required, they felt boredom could contribute further to the risk of falls and increase the need for 15-minute observations from staff. Additional staff time supporting the person's social and psychological needs whilst isolating was needed, to prevent low mood and lack of motivation. This would impact upon the progress of the reablement purpose of the discharge. Upon discharge, RITA was used daily and the person engaged with activities of their choice. The home manager reported that the person's mood remained good and that she enjoyed using RITA, engaging and interacting well with RITA. She had no falls whilst isolating.

RITA has been used successfully with some residents who display challenging behaviours. Staff have used it to provide a distraction activity when there may be other residents around whom the individual may become agitated towards, for example, playing specific music, looking at reminiscence materials or clips of sports or other interests relevant to that individual. This has helped to reduce incidents between residents, which could result in physical altercations.

The RITA project was introduced as a means of reducing the rate of deterioration amongst residents in the council's own care homes, and to promote independence and improve the physical and mental health of residents.

There are many examples of how RITA has benefitted people who are using the equipment:

- RITA has aided staff with people new to the service in gaining life history and information about an individual that is personalised to them when the resident has impaired communication skills. Its digital platform has provided greater opportunities for staff to explore content that is meaningful for individuals, including a translation function. It was used to explore a new resident's music preference; he liked guitar music but was becoming frustrated that he could not remember any groups so using the large screen RITA to show clips of songs alleviated this frustration and it became an enjoyable experience for him.
- RITA has helped to form relationships and activity groups of residents with shared interest, for example, a group of Christian residents who enjoy listening to and singing hymns together and a group of male residents who enjoy watching old sports clips together.
- It has supported younger staff with relating to reminiscence that is meaningful for individual residents. For example, RITA was used during the Queen's Platinum Jubilee for residents to share their memories of the Queen. Younger staff who do not remember older events such as the Silver Jubilee were able to 'learn' from the residents.

- The personal profile function aids new staff and agency workers, as it is a tool they can use to instantly engage with a resident when first meeting them and accessing personalised content.

What were the conditions for success?

- Willingness of staff and managers within the homes to try the initiative played a large part in success.
- Some staff were nervous of using the devices at first, but RITA is easy to use, and one member of staff described it as 'idiot proof', and it has increased staff confidence in using digital platforms.
- When completing capacity assessments, RITA has helped staff with fully trying to explore an individual's understanding by using visual and video content when questioning. Using the larger screen has helped individuals with cognitive and sensory impairments to engage with the assessment process.
- RITA has been used successfully with some residents who display challenging behaviours, as it can be used by staff to provide distraction activities.

What were the barriers?

- RITA was more successful for individuals who did not have their own digital device.
- One tablet was provided per home, which was not enough for everyone to have an equal amount of use. However, this meant that people were more likely to join in with group activities, thereby reducing social isolation.

Contact: Fleur Cullinane – fleur.cullinane@bedford.gov.uk

Thurrock Borough Council

Upskilling staff to offer technology solutions

Upskilling social workers and others working in the community to gain a wide knowledge of assistive technology available via providers and on the open market as self-purchase options. This provides preventative support to maximise independence, reduce or delay the need for commissioned services and minimise hospital admissions and calls to emergency services.

What are we aiming to achieve through a digital first solution?

- Ensuring practitioners have the knowledge required to speak confidently about assistive technology solutions when working with individuals.
- An ability to think outside the box when exploring bespoke solutions and knowledge of where to find solutions that can be explored and tested.
- To ensure support to remain as independent as possible in the community as the first option.
- To ensure the reduction of or delay the need for a commissioned service.
- To ensure all options are explored to reduce hospital admissions and calls to the emergency services.
- To ensure individual and family members have peace of mind.

What was put in place?

- Level 1: Basic understanding – online training, updated and made available to colleagues across adult social care (ASC), Health, Housing and community.
- Level 2: Face-to-face training – more in-depth training that explores specific equipment and the process of requesting technology-enabled care. (Mandatory training as part of induction to ASC.)
- All staff briefing sessions open to all staff to attend (recorded and shared across all directorates).
- Weekly support rota in place for assistive technology leads to be on hand to support with any enquiries and provide advice and guidance.
- Embedded a prompt for ASC practitioners within the Care and Support template to ensure solutions have been explored.
- Worked alongside community and directorates.

What were the barriers?

- Funding for training solutions – inhouse training to become trainers (Level 3).
- The group are all volunteers who hold cases and work within ASC teams so capacity can be a challenge.
- Individuals can be reluctant to explore technology-enabled care (TEC) due to lack of knowledge around how this works.
- Cultural shift required.

What were the conditions for success?

- Staff working group sessions to explore gaps in knowledge.
- Local area coordination and library staff included to better support community understanding.
- Working closely with TEC providers and services – Red Alert and Careline manager.
- Evaluation report submitted to commissioner, including service users' feedback ('Good news' stories).
- Thurrock coalition supported with reaching out to community to gain feedback of knowledge gaps.
- Full report provided to senior managers around benefits of TEC, including figures on substantial savings across Health and Social care.

Contacts: Sarah McCarry – smccarry@thurrock.gov.uk
Julie Curran – jcurran@thurrock.gov.uk
Ann-Marie Ibbetson – aibbetson@thurrock.gov.uk
Kate Williams – kxwilliams@thurrock.gov.uk

Luton Borough Council

MiiCare – Digital health coach for people in their own homes

MiiCare is a digital health coach which assists individuals to remain within their own homes safely and for as long as possible, whilst providing insights into behaviours that can inform proactive care and support when required.

MiiCare is a digital tool to support families, carers and care agencies, who care for vulnerable adults within their own homes (not care homes). The digital offer ensures that the person within their care can remain within their own home, safely and for as long as possible, whilst providing insights into behaviours that are able to inform proactive care and support when required.

The MiiCare kit includes 'Monica' – a digital health coach that can interact with people socially by voice to check in and offer validated support and motivation for health and wellbeing concerns or needs. This includes prompting of medication, reminders to drink fluids, help call outs to family or carers in case of emergency and data to inform proactive care.

MiiCare packages include home sensors to monitor movement and behavioural patterns to alert to changes that may imply health issues or concerns, health devices to monitor vital signs and a smartwatch to provide companionship and health and wellbeing motivation, including but not exclusively, sleep quality summary and daily steps count (goals/targets). The alerts and data are relayed to the dedicated family member, carer or care agency through a secure phone app.

The MiiCare digital device provides reassurance and peace of mind to the person accessing care and support and those who care for them. No pendants are required with MiiCare, and the device is unobtrusive, quick to install and easy to use. The system is GDPR secure, does not need home Wi-Fi and respects privacy by not recording voice or conversations or using cameras.

Some of the benefits of MiiCare are outlined below.

- Supporting personal safety: In an emergency, the user can call for help by voice command or the MiiCube button, which sends an alert call to up to three contacts. This has reduced the risk of call outs, conveyancing or admission to acute care for falls, urinary tract infections (UTIs) and other health issues monitored by MiiCare.
- Reducing the risk of UTIs: MiiCare supports the prevention and identification of UTIs by encouraging and monitoring hydration behaviour through sensor mug prompts, and checks vitals and activity for warning signs, e.g. an increased incidence of bathroom visits.
- Reduction in domiciliary calls: MiiCare prompts users to take their medication. It can monitor the medicine box for adherence and alert the person if medication is missed or the box is opened at the wrong time.

- Identifying health issues to prevent hospital admission: MiiCare can track sleep quality, sleep disruptions and habits to reassure care giver of wellbeing or inform of potential health issues, such as frequency of nightly bathroom visits to alert to potential UTIs and optimising the bedtime environment with relaxing content.

Funding has been secured for 142 MiiCare kits to be deployed across Bedford, Luton and Milton Keynes (BLMK). Luton Council's Assistive Technology Service (ATS) will install the kits into individuals' homes once a referral has been received.

Focus groups have taken place to identify the criteria of people who would benefit from this digital health coach.

Demos have taken place across each place to promote MiiCare, including to social workers, occupational therapists, domiciliary providers, assisted tech services and reablement.

BLMK have been working with the early intervention team and hospital discharge team (APT) for Luton Council to assist people coming out of hospital or when a change in need has been identified. There are six live installations within Luton. Other areas are yet to identify suitable candidates. A number of domiciliary providers across BLMK would like to collaborate.

What were the barriers?

- No WiFi within people's homes.
- Incorrect criteria for referring potential users.
- Misunderstanding of the criteria by those making referrals.
- Supporters' confidence with using the app.

What were the conditions for success?

- Dongle to enable WiFi for all.
- Criteria amended to ensure correct applicants.
- Continuous promotion and demos taking place.
- Ensuring all feel confident with digital inclusion.

Contact: Lisa Burke – lisa.burke@luton.gov.uk

Central Bedfordshire Council

Technology to enable living – AutonoMe

J is a young person who lives with a learning disability. In the Summer of 2022, J began to think about his future and wanted to set goals to enable him to live the life he wanted in the future.

J lived at home with his family. He recognised that he needed to improve his skills to enable independent living. J wanted to:

- learn how to use home appliances
- learn how to prepare some simple meals
- improve his social skills.

J was supported by an app, AutonoMe, and worked with support workers to set his own goals. These goals were then presented to J as a functional 'How to' video on his mobile phone. J had QR codes strategically placed around his home, which he could scan with his phone and easily follow the 'how to' video.

AutonoME worked well for J and when reviewed in December 2022, he:

- was successfully making scrambled eggs
- able to make ham sandwiches independently
- starting to explore videos on soft skills such as social interactions.

J said: "The videos are clear and easy to follow. The social skills video was quite helpful as it's something I struggle with."

What were the top five barriers?

- Lack of time/engagement by family to support J to work on and achieve his goals.
- J was transitioning into adulthood and wanted to have greater independence but on occasions lacked focus/engagement.
- Loss of interest due to limited attention.

What were the conditions for success?

- Once the goals were fixed and QR codes issued, J could engage and practice his goals whenever he had the time and motivation.
- J enjoys using his mobile phone and enjoyed the positive feedback he received from the app and his support workers. J was able to see tangible positive feedback and progress in achieving his goals
- The goals and videos can evolve with J's skills. J hopes to find work, so employment skills videos are currently being worked towards.

Contact: Lisa Allum – lisa.allum2@centralbedfordshire.gov.uk

Sharing information across partnerships

Thurrock Borough Council

Sharing information between housing and adult social care system

Reducing waiting times for housing and adult social care colleagues accessing information, and to ensure support is provided to residents in a timely and efficient manner.

Thurrock Borough Council put in place read-only, condensed versions of the adult social care system for housing colleagues. There was also a process to check access rights for staff members who have moved team or left the organisation.

The council worked collaboratively with the General Data Protection Regulations (GDPR) and System Support Team to ensure the correct processes were in place and the project was in line with GDPR principle and regulations.

What were the barriers?

- Housing colleagues' capacity to complete the same process.

What were the conditions for success?

- Willingness to put in the work to create the process document and share this with colleagues to make the process easier for them.

Contact: Patsy Jones – patsy.jones@thurrock.gov.uk

directors of
adass
adult social services
eastern region
connecting innovating improving