Emerging practice from the use of the Better Care Fund

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Integration and Better Care Fund

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East of England Adult Social Care

Foreword

As demand for health and social care services continue to grow, integration and joint working becomes increasingly important. Unprecedented levels of complexity and demand, an ageing and increasingly frail population and increasing numbers of people diagnosed with mental health conditions are putting pressure on all services, but by working together, we can ensure the best outcomes for people.

Wherever possible, people should be cared for in their own home or place of residence, with the right services supporting them to remain independent for as long as possible and reduce the need for hospital admissions and, when they are admitted to hospital, helping them to return home as soon as possible.

The Better Care Fund is a tool to drive integration and joint working and the planning process for 2023–25 emphasised this. In the East, systems developed joint plans which included some fantastic examples of projects and programmes which have been funded by the Better Care Fund. We are delighted to highlight some of this work here and would like to thank everyone who contributed.

We hope you find these examples useful. If you would like further information on any of this work, please contact the relevant system lead or the regional Better Care Fund Manager.

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Bedfordshire Care Alliance/Bedfordshire Hospitals NHS Trust

Silver Phone – Geriatric support to primary care and community teams

Older residents with complex needs and multiple co-morbidities can be higher users of ambulance and A&E services. This can lead to an extended hospital stay and reduction in independence following discharge. The Silver Phone project was developed to provide ready access to advice on alternative treatments and support to safely avoid conveyance and hospital admissions, within Central Bedfordshire's commitment to promoting independence and remaining at home where possible.

What was put into place and how was the Better Care Fund used?

The Silver Phone project is a baton phone held by Frailty Advance Care practitioners and supported by hospital consultants between 08:00–20:00 Monday to Sunday. It is available to support referrals from 111; Urgent and community care/rapids teams, GP liaison services and EEAST. Silver Phone provides staff with advice and guidance about the management of frail and complex patients and alternative options to hospital admission can be explored. For example, a patient discussed on the Silver Phone can have a diagnostic test requested and be admitted to the frailty virtual ward for further follow-up of results and a management plan. Alternatively, the patient may be seen in Frailty SDEC (Same Day Emergency Care) as an urgent review by the frailty team, instead of as an emergency. The philosophy is to 'assess to admit' rather than 'admit to assess' and to ensure that the right care is provided in the right time and place.

What were some of the outcomes?

The Silver Phone project was a piece of collaborative work across health and care. The Silver Phone links acute hospital-based specialists with community-based health and care teams as well as ambulance, 111 and GPs in primary care. It forms part of wider collaboration across system partners to develop frailty services that are intended to reduce inequalities and improve timely access to specialist assessment and intervention. Healthwatch colleagues have contributed to frailty service developments in frail and complex care alliance meetings.

To date, 53 per cent of patients referred via the Silver Phone have avoided conveyance by exploring alternatives such as the Frailty SDEC service which supports rapid access to diagnostics and comprehensive geriatric assessment.

What was the shared learning?

- To offer an alternative to admission, the frailty virtual ward and Frailty SDEC team both had to be in place with ring-fenced capacity prior to the launch of the Silver Phone.
- Ongoing communication between partners is critical, particularly with regard to paramedics – 'call before you convey' messaging has been consistent.
- Evaluation/feedback from staff that have used the Silver Phone has been (and continues to be) helpful and extremely positive.
- As an urgent and community response 'offer' is developing, it is essential that acute and community teams collaborate to develop complimentary services. The community 'step up virtual ward' can call Silver Phone to access Frailty SDEC and equally the Acute frailty team can admit to a community virtual ward via the rapids teams. Ensuring operational models are integrated.
- Data/metrics are collected weekly for patients who have not been conveyed and who are later admitted ensuring any learning is identified. Similarly, any incidents arising are reviewed in detail to determine whether any change to practice is required and these are recorded through the usual processes and procedures.
- It is essential for all partners to share the same values and goals to ensure patients maintain their independence and function and time spent in their preferred place.
- It is essential to ensure there is sufficient capacity to meet demand, especially when scaling up the service, both in terms of access to specialists, but also in terms of demand for onward support, such as the Frailty SDEC.

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Cambridgeshire County Council

Implementing Integrated Neighbourhoods

Providing care and supporting independence at home at a place-based level through implementation of an Integrated Neighbourhoods approach.

Core to delivery of the vision is the move to delivering and commissioning at a local place-based level. Primary care and Integrated Neighbourhoods are the cornerstone of this model, very much in line with the vision outlined in the Fuller Stocktake report. The journey has been commissioned to implement Integrated Neighbourhoods and the plans for 2023–25 continue to build on and accelerate this work.

To deliver this vision, the council needs to make sure that they support people at all points in their journey and this includes people dealing with a range of different issues, whether that be physical disability, older age, mental health or learning disabilities. This ultimately aims to ensure people receive the right level of support at the right time, in the right place and by the right person.

Local vision

- Support people to stay at home to remain independent for as long as possible (Fuller stocktake vision: neighbourhood teams aligned to local communities, streamlined and flexible access to people who require same day urgent access).
- When someone needs support, their care will be personalised and joined up and they will have choice and control (Fuller stocktake vision: Proactive personal care with support from a multi-disciplinary team in neighbourhoods from people with more complex needs).
- When someone has a crisis situation, provide access to rapid support to prevent them having to go to hospital unnecessarily, but when they have to go to hospital, support them home safely and quickly (Fuller stocktake vision: More ambitious approach to prevention at all levels).

The aim is to deliver a model which supports people to remain as independent as possible within the community and ensures that carers can be supported to look after their own health and wellbeing and to have a life of their own alongside their caring responsibilities.

What was put in place and how was the Better Care Fund used?

The council adopted a Prevent – Reduce – Delay approach to managing care, recognising that supporting people early with targeted information and advice and low level and community support is key to supporting the best outcomes for people. This includes the following:

- Providing information and advice, signposting to voluntary and community sector organisations and/or onward referral to the wider Early Intervention and Prevention services. Examples of this include Adult Early Help services, social prescribers, community navigator services, online digital information, and advice.

- Early Intervention and Prevention services are designed to improve or maintain people's independence, to support people to recover from illness or injury and help people re-learn lost skills, abilities and confidence and are delivered through services such as:
  - Technology Enabled Care (TEC)
  - Reablement and Intermediate Care
  - Therapy, including Occupational Therapy and Sensory Rehabilitation
  - Housing Services including Care and Repair/Home Improvement Agencies (HIAs).

When people need more support, including long-term care and support, it is personalised and keeps people connected to their local communities. In terms of both our mental health and learning disabilities support the council already operates an integrated model of care assessment and planning as they have an existing joint health and social care service which has been in operation for a number of years. This is delivered under a section 75 agreement by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). In Cambridgeshire, the learning disability service is also supported by a fully pooled budget arrangement with health to offer a fully integrated model of delivery to people.

What does an Integrated Neighbourhood aim to result in?

- Partners working closely together to help people access the care and support they need and to coordinate this.
- Moving care closer to home.
- Focusing on inequalities and making sure care and support is more proactive and personalised.
- Making changes to how we work in partnership with communities (embedding co-design).
- Understanding our population and services, support and assets that exist in neighbourhoods.
- Reduce health inequalities and increase the years that people enjoy good health.
- Local businesses and communities benefit from social value by working together to deliver positive benefits to communities that extend beyond health and care services.
- People are discharged from hospital to their own home wherever appropriate and stays in hospital are no longer than necessary.

A key element of the vision is supporting carers by identifying local activities and services that help prevent carer breakdown. For example, in East Cambridgeshire, a co-funding agreement is in place with Ely Primary Care network for a Neighbourhood Carers Social Prescriber post, serving the whole district for a three-year period from 2023. In other localities, teams are working with local partners and engaging with older adults themselves, to identify other gaps and opportunities in support for carers.

What have been the outcomes?

In autumn 2022, East Cambridgeshire Integrated Neighbourhood received notification of incoming funds from NHS England and Improvement (NHSE&I) that would be devolved directly to Integrated Neighbourhoods to support locally identified cohorts that were deemed most vulnerable and at-risk during winter.

Following collaborative discussions with local partners, project resources such as Personalised Care and Support Plans (PCSP) were co-developed. There was agreement to commission partners (across the health, social, community and voluntary sector) to facilitate a 'What Matters to Me?' conversation and to develop a PCSP (including the consideration of informal carers) with eligible individuals. Information gained from this personalised and holistic approach supported the coordination of any required planned care and support for the individual, including uptake of the PCN's offer of a health check, long-term condition(s), and medication reviews.

Collection of Measure Yourself Concerns and Wellbeing (MYCaW) pre- and post-outcome measures were written into the commissioning arrangements to measure the impact of this approach as well as allocation of non-means tested personal budgets (coordinated by Care Network on behalf of the project). It was agreed that personal budgets would enable timely access to anything identified in the planned support within agreed parameters that would support an individual to stay happier, healthier, and safer at home this winter.

A fortnightly face-to-face Central Health and Wellbeing Hub was formed with representatives from each partner organisation including Adult Social Care, Age UK, Care Network, Caring Together, CPFT, Ely PCNs and Littleport Town Council. This enabled discussion and the exchange of referrals (in accordance with information governance conditions) as well as relaying PCSP outcomes to inform next steps and seek expertise from the group.

A 'Team Around Me' meeting model was developed to enable dedicated time for person-centred discussions (with the individual present) if the person's needs were deemed complex and requiring multi-agency input.

Conversations with Cambridge University Hospitals NHS Foundation Trust resulted in their engagement in communicating whether any of the cohort had accessed unplanned health care to enable responsive follow up with the individual and re-review of their requirements.

Case study

An 87-year-old woman with multiple long-term conditions (LTCs) moved house and, when contacted as part of the Winter Pressures Project, said she would like some support. The personalised conversation about what mattered to her flagged that:

- **her new housing better met her physical needs, but she was still very lonely and worried about the future.**
- **she was sleeping in her chair at night which raised concerns around her COPD and respiratory compromise.**
- **she had previously refused a wheelchair because she feared going out which also meant she had not received her COVID-19 vaccination.**

Bringing together partners at the Central Health and Wellbeing Hub allowed a different conversation to take place, flagging that:

- while she did not meet financial thresholds for social care there were other options to support her
- she had not had a COPD review in a while and needed one.
- a COVID-19 vaccination was needed, but it was recognised that the root cause was that she was fearful of going out and not easily able to access the community and this needed to be addressed.
- voluntary and community sector partners identified a range of support to help reduce her social isolation and focus on what mattered to her, for example, mobile library, warden scheme and befriending as well as how to support her with accessing the community.
- a personal budget can now be used to provide a wheelchair to help improve her access to the community and support/services.

What was done differently?

- Facilitating open conversations and focusing on what mattered to the person.
- Health, social care, and voluntary and community sector professionals came together to discuss and identify gaps and opportunities for support that no single organisation could have done alone.
- Preventative support could be put in place around LTCs, and vaccination and wider health and wellbeing support could be put in place before the point of crisis.

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Further information: First annual integrated neighbourhood report has been published for East Cambridgeshire

Central Bedfordshire Council

Use of the Better Care Fund to provide prevention assistance to prevent hospital admission

The Central Bedfordshire Council Housing Assistance Policy enables the Private Sector Housing Team to provide Prevention Assistance Grants (PAGs) of up to £4000 to fund urgent works required to prevent admission to hospital/residential care and to prevent delayed discharge from hospital/residential care.

PAGs are fast-tracked grants without a Test of Resources or charge placed against the property and can be referred to the Private Sector Housing Team by any social care or health professional and can be used to adapt or improve living accommodation, and therefore are not restricted to adaptations.

The following case study relates to a PAG provided to deliver an urgent adaptation to prevent admission to hospital.

Case study

Mr W was becoming increasingly frail and weak due to oesophageal cancer. Mr W's stair mobility had decreased, and he had a near fall from the top of the stairs despite the fitting of a second banister rail. A suitable micro-environment could not be created downstairs as his wife (main carer) cannot sleep downstairs and is hard of hearing and therefore would be unable to support Mr W with his frequent toileting needs at night, from upstairs. Additionally, Mr W could not remain upstairs due to needing to attend hospital appointments. Therefore, an urgent solution was required to enable Mr W to access his sleeping and washing facilities upstairs safely and independently, without jeopardising his access to the community and required hospital appointments.

Without an urgent solution to the problem Mr W could have fallen down the stairs whilst trying to access his sleeping and washing facilities, resulting in hospitalisation. This would be a traumatic experience for Mr W and his family and would put increased strain on the health service.

What was put in place and how was the Better Care Fund used?

The Occupational Therapy and Private Sector Housing Teams at Central Bedfordshire Council work very closely with each other both strategically and operationally. The teams worked together to create and implement PAGs as a tool to prevent delayed discharge and admission to hospital/care and meet regularly to refine and improve practices for the benefit of residents. This extends down to individual case work where staff from both teams work together to find the best solution for each resident.

As Private Sector Housing provided suitable awareness sessions and documentation relating to PAGs to the Occupational Therapy Team, the OT working with Mr W was able to quickly identify a PAG as being the most appropriate course of action to provide a stairlift for Mr W to mitigate the imminent risk of him falling and being admitted to hospital. In this particular case, the delay that would have occurred if it had proceeded down the standard route of a mandatory Disabled Facilities Grant with the associated Test or Resources, would have put Mr W at unnecessary risk.

BCF funding is used to fund PAGs.

What were some of the outcomes?

The referral for a PAG led to a stairlift being installed within 5 working days, making a big difference to Mr W's life, as he is now able to access his sleeping and washing facilities independently without falling and being injured, and is still able to access the community and appointments at the hospital when required.

In this case, because private sector housing provided suitable awareness sessions and documentation relating to PAGs to the Occupational Therapy Team, the OT working with Mr W was able to quickly identify a PAG as being the most appropriate course of action. This has made a big difference to Mr W's life as he is now able to access his sleeping and washing facilities independently without falling and being injured and is still able to access the community and appointments at the hospital when required.

What has been the shared learning?

- Some cases require a rapid solution.
- Preventing hospital/care admission has a positive impact on health and wellbeing.
- It is more cost-effective to fund prevention work than to deal with the consequences of inaction.
- Collaborative working is important in the design and implementation of services.
- DFG monies can be used flexibly, and councils should exploit this to the good of their residents.

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Further information:

For details of the range of housing grants provided by Central Bedfordshire Council Private Sector Housing Team please see the Housing Assistance Policy.

For information specific to Prevention Assistance Grants please see our Prevention Assistance Grant webpage and subpages.

Central Bedfordshire Council

‘Working Together – One Team at Place’

An integrated team taking a multi-disciplinary approach to working at Primary Care Network (PCN)/neighbourhood level.

The testbed for this approach is the Working Together Leighton Buzzard (WTLB) collaborative model which was developed to improve outcomes for the population of Leighton Buzzard. It brings together health, social care, and other public sector services, and seeks to deliver preventative and proactive care to those at risk of developing more acute needs.

The overarching ambition of our initiative is:

> ‘To build an integrated team of health and social care staff equipped and able to provide support to people at risk of deteriorating health and wellbeing, identified by using a population health management approach. Together with the person and/or their carer, the team will proactively assess, develop, and implement appropriate care plans and monitor their needs, to limit or delay any decline in their condition.’

There is strong evidence that the quality-of-care people receive is improved if services are joined up around their needs. Central Bedfordshire has an ageing population and complexity of care needs is increasing. Joining up health and social care would allow those who are vulnerable or have complex care needs to be better supported at home for longer. Maximising existing resources to provide an integrated community response to a discrete population for proactive care coordination and reactive urgent care response delivered through Integrated Community Teams at a Primary Care Network footprint could facilitate effective hospital discharge, prevention of hospital admissions and more locality-based support. This collaborative approach streamlines access to care and support. It facilitates timely proactive care locally, using population health information to identify those most at risk of deterioration in their conditions. It also enables roles and resources across multiple provider organisations to be maximised through multidisciplinary working.

What was put into place and how was the Better Care Fund used?

As a precursor to the ‘One Team’ at Neighbourhood level, a multidisciplinary approach bringing together primary care, community and mental health services, social care and the voluntary sector was established. This involved team building. Key leadership roles were established to oversee a new way of working. This included a clinical lead and a care coordinator to support a daily huddle of the multidisciplinary discussions. Population health analysis was commissioned to inform key areas of target and high intensity activity. This includes waiting list data to enable support for people to ‘stay well’ at home. A programme management framework is in place to support the programme. Social prescribing ‘Community Referral’ is a key resource for supporting people in the community and is funded through the BCF.

What were some of the outcomes?

The impacts to date have been anecdotal although more robust forms of measurement are being introduced.

The team meet daily in a virtual huddle to discuss referrals from professionals and residents alike to explore ways to support the management of their health condition, recognising the value of exploring the wider determinants of health and the invaluable support of social prescribing. The feedback has been very positive. Professionals have built good trusting relationships and staff feel they can make a difference for a resident in real time. Links with the Primary Care Network have been valuable and open access to the daily huddles has meant professionals can quickly refer a resident and know the case will be discussed and supported. The outcomes are focused on ensuring:

- support is Integrated and responsive to the specific requirements of each person's needs.
- there is an equal focus on physical and mental health services to support people to manage their health and social care issues in the community.
- people are empowered to better manage their condition and have control over the decisions made regarding their health and wellbeing.
- a reduction in admissions to residential and nursing homes
- a reduction in avoidable admissions to hospital
- improved operational working between partner organisations to enable services to be more flexible, proactive and responsive to individual needs.
- better use of resources to improve cost effectiveness and efficiency.
- the council has a robust approach that can be rolled out across the rest of Central Bedfordshire.

Feedback from people who have gone through this type of discussion and support has been positive, with one resident stating, 'I have been seen as a whole person which includes my mental and physical health alongside the house I was living in and how that was impacting my health.'

What was the shared learning?

- Embedding this approach takes time and effort.
- Communication is vital.
- Engagement of GPs proved challenging, but their support is intrinsic.
- Importance of communicating and promoting the MDA approach.
- Measurement of both qualitative and quantitative outcomes is important.
- People's experience needs to be captured.
- Investment in building the relationships of the 'Team at place.'
- Demographic and population health data support proactive case management.
- Digital enabled technologies support this work.

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Hertfordshire County Council

Hospital Community Navigation Service

How the social prescribing Hospital and Community Navigation Service has worked closely with John, who had recently been discharged, readmitted, then discharged again after a fall. It shows how John has been supported with his wider wellbeing and independent living needs.

John was referred by Lister Integrated Discharge Team (IDT) after a Multi-disciplinary Team (MDT) meeting for urgent support with shopping and a query over an issue with his fridge not working. John had recently been discharged, readmitted, then discharged again after a fall. The aim for the Hospital and Community Navigation Service was to:

- support John with his immediate physical needs
- support John with wider wellbeing needs and support with independent living.
- reduce the risk of readmission to hospital and create provider time/cost savings to statutory services as a result.

A link worker visited John on the same day the referral was received. John would not answer his phone. The link worker entered the property via a key safe. Upon entering, the link worker discovered John sitting in soiled clothing in his chair, flies surrounding him and within the wider property. The link worker spoke with John at some length, which was very challenging as he suffered from substance misuse and did not appear to understand much of what was being explained to him. The link worker also checked the fridge which was not working and was found to contain an infestation of insects and mouldy food.

What was put into place and how was the Better Care Fund used?

The link worker was concerned and urgently called his social worker and daughter. A new fridge was purchased using the Personal Health Budget. A £150 shopping voucher was arranged through Age UK Hertfordshire, who also completed a joint visit with the link worker to carry out benefits check and attendance allowance application for John. The Hospital and Community Navigation Service provided three weeks of shopping support and Communities 1st continued to do this hereafter.

John had no clean clothes as his washing machine was broken. The link worker applied for a grant to have this replaced and kept the next of kin and social worker informed.

On the next visit John was more engaging and opened up about how he loved gardening, although his garden was overgrown with brambles. The link worker arranged for the voluntary group Kaotic Angels to clear and tidy up the garden.

What have been the outcomes?

Several outcomes were achieved through the engagement of the Hospital and Community Navigation Service:

- **Improved wellbeing:** As a result of taking steps to reduce neglect, John was so grateful and felt more in control of his life and felt he had some of his dignity restored. John also became more interested in his surroundings and wanted to get out in his garden, giving him an interest in something he loved. The link worker's ability to apply for grants and work in partnership with other organisations, such as Kaotic Angels for gardening support, to support John with other holistic needs resulted in a better outcome for him.
- **Reduced hospital admission or readmission:** Having the fridge cleared and replaced and arranging for volunteers to support John with shopping during that period reduced his risk of gastrointestinal issues, which could have led to him being hospitalised.
- **More appropriate use of primary care:** Link workers were able to use voluntary sector partners to help clear the garden and prevent the risk of future stomach issues or falls, which reduced the need for statutory services having to be involved. The close working relationships the link managers have with the IDT teams ensure that when issues like this arise, immediate support is provided at pace giving time back to hospital services.

What was the shared learning?

Some of the barriers:

- Additional workload generated from crisis-related issues (previously COVID-19 and now refugee resettlement schemes and cost-of-living-related issues), increasing pressure on both providers and staff.
- Increasing volumes and complexity of cases, resulting in a further strain on capacity to respond to both current and future demand needs.
- Short-term funding commitments via the Better Care Fund, resulting in provider concerns around staffing and funding security.

Some of the conditions for success:

- Integrated working and commissioning between the Integrated Care Board, council and voluntary and community sector is fundamental to responding to a person's wider needs, not just their clinical needs.
- Preventative services, such as HCNS and engagement with people at the right time, is key to preventing early re-admission.

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Luton Borough Council

A collaborative approach to improving flow in Luton

A collaborative approach to improving flow through early discharge planning.

The Luton Adult Social Care Strategy outlines a five-year vision for Adult Social Care in Luton: People in Luton with health and social care needs will lead a 'good' everyday life with the people they value in the community they call home, with an equal voice in planning their own care and support. This is supported by a clear set of priorities about how the council will support people to stay connected, maximise their independence and have a greater say in how services are designed and delivered.

The strategy is accompanied by an implementation plan and will be kept as a live document to provide transparency on progress and current position. As this progress is made, it will continue to move in alignment and draw on overarching principles set out by Bedfordshire, Luton, and Milton Keynes Integrated Care Board (BLMK ICB), Luton 2040 and the Population Wellbeing Strategy.

What was put in place and how was the Better Care Fund used?

The Prevention and Enablement Team within Adult Social Care oversees enablement and local area coordinators who empower and equip people with the right skills and connections to have choice and control in achieving their unique outcomes. Local Area Coordination is being embedded, with monitoring and evaluation happening in the coming year.

The team are also working with sheltered housing to deliver regular ongoing classes and workshops for both individuals and their carers. This includes a fibromyalgia group, an arts and crafts group led by two people from the community in their eighties, luncheon club, carer's group, and chair exercise. From recent evaluation of the prevention and enablement pathway (PEP), the work of the Team contributed to cost avoidance of £400,000.

Shared Lives offers people who require care and support the opportunity to live independently in the community and can be an alternative to living in a care home, housing with care or housing with support. The Shared Lives scheme registration has been extended to include older persons and mental health to support demand management. The aim is to utilise the service for hospital avoidance or to support timely discharge. Monitoring and evaluation are still to be put in place.

The Learning Disability and Autism team have worked with LeDeR (Learning from Lives and Deaths) to develop learning to deliver workshops for frontline practitioners. This has led to an increase in the number of health checks and health action plans, resulting in us being above the national average in this area. Data capture is at a Bedford, Luton, and Milton Keynes (BLMK) level.

The Luton Public Health team are supporting adult social care to embed Making Every Contact Count (MECC) and encouraging staff to support and signpost people to appropriate services to maintain their health and wellbeing. This will be led by the frontline teams.

A BCF-funded local area coordinator (LAC) works with a defined community approaching or being introduced to people who may be isolated, causing concern or at risk of needing formal services. The LAC supports people to build their own vision for a good life, finding pragmatic solutions to problems and drawing on family and community resources. Luton's first LAC is now established in the Leagrave area, with a second post being recruited to in High Town. The community are active within these recruitment processes. Monitoring and evaluation are in the process of being embedded and stories of difference are being collated to evidence the outcomes that the role achieves throughout 2023–2025.

As part of the essential upstream preventative work, a prevention coordinator is currently in place supporting early intervention and long-term planning teams with a strengths-based approach and implementing the adult social care prevention agenda. The post is critical in identifying and connecting people to key assets within the borough. This includes local voluntary sector and faith-based organisations. From recent evaluation of the role invested in, a cost avoidance of £260,000 was identified and a direct cost saving of £18,000.

The Integrated Neighbourhood Working – High Impact BLMK ICB Programme, Next Steps for Integrating Primary Care, was co-designed with partners and residents and is a golden thread through At Place Board plans. The Adult Social Care Board are working closely with the ICB and wider system partners in the planning, development and implementation of this Programme and the Luton Borough Council Community Network programmes.

The Integrated Neighbourhood Working – High Impact BLMK ICB Programme and the Community Network programme are collectively built on an ethos of helping people to help themselves. The Community Network programme is seeking to develop a strong community connection, through a range of diverse and accessible hubs across all sectors and communities, as places to go, to talk and to do. The ambition is to work collaboratively with the PCN Neighbourhood teams to understand the determinants of a health support system in order to provide a cohesive system. Luton is currently socialising the proposed neighbourhood footprints, identified through the comprehensive data source, Luton Insights, before developing a formal plan that will interconnect with the Primary Care Integrated Neighbourhood Working – High Impact BLMK ICB Programme.

Partners including the Bedfordshire, Luton, Milton Keynes Integrated Care Board, the Bedfordshire Hospitals Foundation Trust, Primary Care, Adult Social Care and the voluntary, community and social enterprise (VCSE) sector worked together to implement strength-based working, as a result of which the Preventative and Enablement Pathway (PEP) was established. As part of this, the Side-by-Side pilot was implemented in 2018. This worked well and demonstrated some positive outcomes through joint working by preventing demand for long-term support. This work informed a restructure in ASC that was implemented in April 2020, which included the creation of a permanent Early Intervention and PEP team.

What were the outcomes?

- Developed a new skill set at the front door to work in a more integrated and cohesive way and to achieve better outcomes for the resident.
- Joining the local area coordination and catalyst network developed our learning in working more closely with the community, allowing for a better strength-based approach, and enabling people to have meaningful connection within the community.
- Closer working with reablement so that cases can be dealt with on a short-term basis, avoiding demand for long-term care.

- Better understanding of gaps in the community that supported the development of community self-care groups across various social and health determinants, for example, fibromyalgia, dementia, etc.
- Increased our skills around secondary prevention, enabling the service to target individuals who are at risk of developing long-term needs. Support was put in place both practically and through the self-care groups in the community.
- Increased the number of Enablement Coordinators from five to seven FTE to support people to develop their independent skills such as travel training, maintaining tenancies, money management and seeking employment.

What was the shared learning?

Some of the barriers:

- Transport is a significant barrier to assisting people to access provision. Need commissioners to assist and develop community volunteer transport.
- We do not have pooled direct payments so that people can pull their resources together to secure collective support, for example, one personal assistance to support 3–4 people in a common activity.
- Lots of referrals coming from back door asking for shopping requests and minor tasks that help people remain independent. Floating support workers would be helpful to respond to these minor requests to prevent them becoming long–term needs.

Some of the conditions for success:

- Moved from a deficit model to a strength-based model – people are happy to take part in community-based provision.
- We found a vast number of resources in the community at grass roots level; therefore, we need to work better to understand these local communities and link with them.

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Luton Borough Council

Early Discharge Planning in Luton

A collaborative approach to improving flow through early discharge planning to support prevention and early intervention

Demand on all services remains high and is expected to do so for the foreseeable future, having a huge impact on the National Health Service (NHS) and social care services. Home First and Discharge to Assess (D2A) principles are well embedded in Luton and a number of schemes, funded through the BCF, are focused on early discharge planning, to ensure that patients are able to be discharged as soon as they are medically ready, thereby improving patient flow and freeing up capacity within the acute trust.

What was put in place and how was the Better Care Fund used?

Luton continues to remain in a good position for discharge planning and patient flow. Although the health on-costs following the pandemic and care provider market resilience will generate challenges for some time to come. In support of patient flow, length of stay, timely discharge to normal place of residence, reablement and recovery, the adult social care team, directed by the co-produced Adult Social Care Strategy, as a collaborative system are working to continue and expand the iterative agenda set out below:

- Integrated Hospital Discharge Hub, service integrated within and outside the Trust – holistic reach across the system, including the new Virtual Ward managed by Cambridge Community Services. Key roles within the Integrated Discharge Hub continue to be jointly funded through the Better Care Fund. In addition, a Placement Team Broker will be funded throughout 2023-2025 by the Additional Hospital Discharge Grant.
- The Hospital intake team, continue to effectively and in a timely manner take Luton patients out of the hospital and support for a period of six weeks. The continuation of 'Recover to re-able' (Intake Team (APT) and Reablement) see the Reablement team continue to work collaboratively to support the Hospital Intake Team if they are unable take on the individuals and visa-versa. The 2023-2025 Additional Hospital Discharge Grant continues to support additional capacity to ensure Intermediate Care meet the ongoing increase in demand.
- Patient tracking and monitoring of Length of Stay (LOS) continues to be carried out every day with dedicated staff member visiting wards to discuss the care treatment review (CtR) patients.
- Continuation of the twice weekly Patient Tracking List (PTL) meeting in place with all relevant system partners, including colleagues who have a focus in the 'front door' to ensure a seamless service
- The Hospital PHEW application is now linked with Community PHEW APP

- DRP (Delirium Recovery Pathway) is now established and along with D2A beds, is partially funded through the 2023-2024 Additional Hospital Discharge Grant. Spot purchased beds are funded in 2023-2024 with ambitions for a reduction and cost savings in spot purchase use in 2024-2025
- Full embedded escalation calls remain in place across the system.
- Ability to flexibly work when system under pressure.
- Daily whole system quick fire calls
- "Perfect week" approach is utilised with system partners when hospital goes into Opal 3 or Opal 4 status, facilitating a collective resolution.
- Discharge Officer on every ward attending daily board rounds.
- 2 x weekly patient tracking, with system partner's involvement
- Ward 'buddy' system in place with Service Managers and General Manager involvement
- Frailty Service – Patients are identified when they come into the hospital, with the ambition to provide support in the early days of their stay and with a focus on shortening their length of stay. Most patients have packages of care in place to support early discharge. SDEC and Silver phone-line are reducing the number of patients admitted. The implementation of the Frailty Framework for care homes continues to be funded through BCF.
- Trusted assessor process is followed, rather than a trusted assessor role. The Luton Integrated Hospital Discharge Hub relationships with community services, care providers and the voluntary and Community sector is historically strong and built on trust and co-operation. A Trusted Assessor role was piloted but benefits were lost.
- Robust end of life service on site to expedite discharges, supported by Keech Hospice, including a new programme of work underway through Keech to holistically and collaboratively support life limiting diagnoses.
- On call Medical Director – including weekends to support decision making re discharge
- Virtual wards, led by CCS (contracted community service provider) the ambition is to create 340+ virtual beds across Bedfordshire and Milton Keynes to support Respiratory, Frailty and Cardiology patients in the place they call home, by December 2023. Virtual Wards provide a safe and efficient alternative to NHS bedded care that is enabled by technology, to prevent avoidable admissions into hospital and support early discharge out of hospital.
- Clinical navigation is supported by Adult Social Care and Therapy cover for Emergency Care 7 days a week. Clinical navigation is also linked with CCS Rapid Response service and the Virtual Ward provision. If a patient needs to be discharged but they are on IV antibiotics for example they can go home with Virtual Ward support.
- An electronic referral system via PHEW is currently at implementation stage and will provide clear oversight on the individual patients pathway progression.
- Accuracy of bed availability is to be improved via interconnectivity between the hospital placement app and the community placement app, providing the ability to forecast the need and availability more accurately moving forward. The new Discharge ready date will be available on app. This date is set even if the patient is not medically ready to leave. The Integrated Hospital Discharge Team will be expected to manage the patient to discharge on this or around this date.

- A dashboard is in development to enable community colleagues to see how many of their patients are in the hospital – the patients may not be medically fit to leave hospital – but community colleagues (LA & CCS) will be able to monitor who will be coming their way from the point of admission. This will include new patients and current patients known to community services within the geographic area that they cover.
- In-reach specialty consultants in ED supporting specialist decisions and discharge decision if needed, example Respiratory and Cardiology
- Infection control Nurses support and advice 7-day service.
- Additional Transport, extra crews in times of surge continues to be supported through the 2023-2025 Additional Hospital Discharge Grant
- Noah Homeless discharge support, working with the Integrated Hospital discharge Hub, social workers, housing officers, ResoLutions (contracted tailored support for those who are struggling with alcohol and/or drug use) and the VCSE to support those homeless or at risk of homelessness whilst they are in hospital and facilitate temporary accommodation up to 5 days (with an option of extending if required) to enable safe and timely discharge from hospital. The Scheme is a successful continuation of the offer set up with the ASC Hospital Discharge Grant in 2022-2023 and is now funded through the 2023-2025 Additional Hospital Discharge Grant.

Bedford, Luton, and Milton Keynes Integrated Care Board (BLMK ICB) and Luton Borough Council continue to carry out a comprehensive self-assessment against the 9 High Impact Change Models, including a set of actions for each domain and continue to work as 'One Luton' regarding progressing the maturity of the individual models.

What were the outcomes?

Luton is part of the daily quick-fire system calls, which are inclusive of leads from health, social care, community services, the ICB East of England transport, East of England Emergency Transport and the Acute. The meetings take place first thing in morning, providing a status update on all system partners, with opportunities to assess mutual aid needs. The meetings pin down how many people are safe to be discharged, any barriers which could cause delays & what solution we could pull together when working collaboratively. The inclusion of transport allows us to assess the outpatient's schedules to check capacity and to assess whether private crews are required to facilitate discharge. The meetings have facilitated partners understanding of each other's core business and contribution to the system and how we are able collectively to flex and adapt to meet ongoing needs of patient. In addition, this has facilitated stronger relationships, understanding and interconnectivity, enabling teams to easily reach out, lean in to supporting each other. The Luton focus remains D2A and is built on relationships, forward planning, and collective solutions in the best interests of the patient.

An example of the approach in operation is:

The Recover to Reable approach – A particular days ask of Reablement impacts their capacity to meet demand. The question of system partners is are we able to discharge elsewhere, for example, APT Domiciliary Care, contracted to Luton as D2A discharge support. APT will support until transfer to Reablement.

The working as whole system approach ensures the ability to discharge effectively & quickly in to ongoing care.

In addition to the Quick-Fire meetings, Luton Phew is now linked to the Community App to, providing a 'one version of the truth' for partners.

What was the shared learning?

The learnings from the journey are simple; strong relationships and understanding of each partner's expertise, remit and flexibility within the pathways are the foundation stone of collaborative planning. Every part of the system has an essential role to play in effective early discharge planning. Connectivity and communication are the key tools. The Quick-Fire meetings enable this.

Benefits of the approach far outweigh the barriers. Of course, there are times where the complexity of need, ensuring the right services are commissioned and the curve ball of changing the changing needs for some patients means that delays do happen. What the Quick-Fire meetings do, is to minimise the delays by opening the issue up to the whole system.

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Suffolk County Council

Integrated Neighbourhood Team (INT) development

Suffolk Adult Social Care has worked with Suffolk Community Services to develop Integrated Adult Social Care and Community Health Teams (Integrated Neighbourhood Teams) who work alongside the voluntary sector to deliver collaborative responses to the specific needs of the local population across Ipswich and East and West Suffolk.

The intention is that the INTs make best use of resources to provide a joint response to people's health and social care needs, promoting independence and enhancing quality of life, delivering the right care in the right place and at the right time.

The development of INTs has been in response to the challenges presented by increasing demand and the frustrations of duplication, silo-working, gaps in services and recurring concerns about 'having to tell your story over and over again'". Responses were more reactive than preventative. This was compounded by a lack of knowledge and understanding of different approaches to care management between health and social care professionals. Working through INTs allows for much easier case finding and joint case management. The team were serving the same local population but were not sharing knowledge and understanding individuals' needs. This meant that health and carer teams were working together with the same direction of travel to support people to live well in their communities.

What was put into place and how was the Better Care Fund used?

The Better Care Fund has been utilised to support social work team budgets and community health contracts. This funding has helped to underpin an infrastructure from which INTs can develop. Each of the place-based Alliances is developing multi-professional, and increasingly multi-agency, Integrated Neighbourhood Teams to deliver the shared Integrated Care Services ambitions of true integrated care to local communities of typically around 50,000 people. The Better Care Fund has also been used to further enhance the reablement offer, creating a more responsive and accessible service.

There are eight INTs in Ipswich and East Suffolk Alliance and six in West Suffolk. The intention is to increasingly delegate responsibility and resources to local INTs. The development of the teams has been facilitated by the 'One Team' shared leadership development programmes.

In the West, each INT has a co-ordinator who has responsibility for drawing up the INT offer for the person together with their family, working closely with Urgent Care Referrals and the Transfer of Care Hub. Each INT has developed close working relationships with the wider health and care community including housing, mental health services, the voluntary care sector, etc. Locality leads provide strategic oversight to the work of these communities.

In Ipswich and East Suffolk, BCF has supported the continued development of co-located INTs with support in place to help them thrive and develop, including project and co-ordinator roles. The Transfers of Care Hub in Ipswich Hospital works across seven days to facilitate timely and proactive discharges. There is also a strong admission prevention approach via the Reactive Emergency Admission Community Team (REACT team) who are community and admission and emergency based. Combined these initiatives support a well-functioning integrated system that keeps people at home and independent for as long as is possible. The approach continues to be enhanced, monitored, and developed to respond to the changing needs of the population and the systems that support them.

What have been the outcomes?

The INTs have been developed through the strategic oversight of the Ipswich and East Suffolk and West Suffolk Alliances. The overriding purpose of these Alliances is to provide the focus for planning and delivering meaningful integrated care and services to the local population, with partners working closely with the voluntary and community sector, independent sector organisations and communities. Alliance plans have been built on discussions with the public and staff, together with partnership working between organisations over many years.

There is extensive work undertaken across the local CONNECT area to consider population health data and the unique needs of the local population in commissioning and sharing services and responses. Learning from initiatives is shared and evaluated.

The development of INTs and co-location of teams has allowed for clearer shared-care planning and information sharing. Co-working allows for immediate responses to changing circumstances, reducing duplication and 'not having to repeatedly tell the same story.' In this way people are better able to receive a more joined up, coordinated and proactive response to their needs.

The capacity for early identification of and response to changing needs is substantially enhanced, with risks and safeguarding issues better identified and managed. INTs are increasingly utilising opportunities presented by digital care to enhance people's capacity and capability to maintain their independence and quality of life. These are all enhanced by the way in which INTs are increasingly working in tandem with the wider health and care systems including housing services, leisure services, social prescribing and the voluntary and community and independent sectors.

What was the shared learning?

- Information technology systems (case management plus calendar and teams' channels).
- Shared skills, knowledge, and training.
- Human resource policies (seven day working, leave authorisation, etc).
- Co-location and access to offices.
- Shared funding of teams and initiatives.
- Relationships building.
- Respecting different organisational culture and being inclusive of each other's differences.

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Further information:

Working Together in Neighbourhoods – Suffolk & Northeast Essex Integrated Care System (sneeics.org.uk)

Ipswich & East Suffolk Integrated Neighbourhood Teams | Lets Talk SNEE

West Suffolk Alliance – Suffolk & Northeast Essex Integrated Care System (sneeics.org.uk)

Suffolk County Council

Reactive Emergency Assessment Community Team (REACT)

REACT provides the urgent care response service for the Ipswich and East Suffolk area and has constantly evolved and grown as a multi-disciplinary service.

As the pressures on the acute care systems have grown, it has become increasingly clear that whilst most of the demand for urgent care response is triggered by a health episode, the reality is that these situations are often exacerbated by underlying social care needs. REACT was established in 2016 as an urgent care response service with a strong health focus (nursing and therapy), aligned to social care.

What was put in place and how has the Better Care Fund used?

As the service has evolved, the social care dimension has grown in recognition of the extent of social care needs underpinning the needs for urgent care response. The Better Care Fund has continued to provide funding support to the team, along with funding to support social work and reablement services. The core team now includes not only social workers, but also independence and wellbeing practitioners, social prescribers, and specialist support from the voluntary sector. It includes two social workers based in the community, along with a third social worker based at the hospital front door.

What have been the outcomes?

The oversight and the development of REACT as a service has evolved over time, with clear strategic direction from the Ipswich and East Suffolk Alliance and the Suffolk and Northeast Essex Integrated Care Board. This oversight has been underpinned by performance management data including data around patient flow and the extent/nature of social care needs. In response, the core team has grown and evolved as highlighted above. The core team dimensions enhance the capacity for a 'whole system response' to realise the aspirations for the right care, in the right place, at the right time.

People being supported by REACT can draw on effective and timely health and social care response, with urgent care needs being effectively responded to in a holistic fashion. This not only avoids the need for acute interventions, but also supports people to better retain their quality of life and independence at home.

What was the shared learning?

- Health episodes requiring an urgent response often have a social care dimension.
- The importance of a holistic, aligned response.
- Sharing of knowledge and skills between health and social care practitioners
- The importance of aligned information technology case management – and the difficulties of this.
- Working with and through different organisational policies – Human Resources – seven days working, governance, etc.
- Matching supply to demand (particularly supply for ongoing care needs).

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Further information:

REACT – East Suffolk & North Essex NHS Foundation Trust (esneft.nhs.uk)

REACT – YouTube

Population health management to keep people well in their communities longer

Thurrock Borough Council

Improving cardiovascular disease (CVD) management in Thurrock

Thurrock Public Health team and local General Practices (GPs) have developed and implemented a programme to improve outcomes for residents with cardiovascular disease. The application of resources from the Better Care Fund and public health grant has given excellent results, as well as significant learning.

Thurrock has been on a journey to improve CVD management and outcomes since 2016. In 2014–15, a sizeable proportion of Thurrock's GP practices had below England average CVD quality measures as measured in the Quality Outcomes Framework.

The Thurrock CVD programme has resulted in some of the best Quality Outcomes Framework results in England in 2021–22 for a range of CVD quality measures including hypertension management, health failure management and recording of smoking status.

This has been achieved against a background of Thurrock having the third highest list size per GP in England (Nuffield Trust data, 2022).

What was in place and how was the Better Care Fund used?

The key funding point is that the CVD programme was jointly funded from the Thurrock Better Care Fund and Public Health grant. This helped secure the ownership of both NHS and Public Health colleagues.

Thurrock Council Public Health team co-produced with GP practices a systematic, data-led population-based approach to reducing CVD risk and disease in primary care, using population health management principles.

What have been the outcomes?

In 2016, data showed that Thurrock was consistently worse than the England average for CVD management. The Thurrock Annual Public Health Report 2016 focused on improving the outcomes for residents with long-term conditions.

This was a jointly developed programme between Public Health and Primary Care. Each GP practice implemented the initiatives in a way that worked for them (e.g., hypertension detection in practices) with support from Public Health.

Hypertension checks delivered by community and voluntary sector organisations worked well, but less well in Improving Access to Psychological Therapies (IAPT) service and pharmacists. The evidence base shows that payment incentives and links to primary care information systems are key for successful pharmacy models.

Case study 1

Mr T (69-year-old male) – Risk factor modification

Mr T had a history of hypertension, Type 2 diabetes, acute coronary syndrome, acute myocardial infarction, and multiple related medication. He presented with anxiety at the check in, had a new cough but was otherwise well. It was discovered that he smoked ten cigarettes per day. Vital signs and medications were reviewed. The follow-up activity included healthy eating advice, smoking cessation advice, physical exercise as tolerated advice, weight reduction programme encouraged, advice on blood pressure control and good diabetes management control.

The patient received advice and referrals to adjust behavioural risk factors which were increasing the risk of a serious CVD event. Anxiety around health, particularly cough, was reduced.

Case study 2

Mr X (68-year-old male) – undiagnosed clinical risk and poorly-managed coronary heart disease

Mr X had a history of previous cardioversion, CHADS2 score of 2, QRISK2 – 21.5%, previous blood pressure of 145/90, heart rate of 45–50 beats per minute irregular and a body mass index of thirty-six. When seen he was well, had never smoked, was reasonably active, had a good diet and was a light drinker. New findings showed that he was high risk and not on cholesterol lowering therapy and had bradycardia with history of flutters and raised blood pressure.

Advice was given from the consultant to perform an electrocardiogram (ECG). An ECG performed at the surgery showed atrial flutter (prolonged) with a heart rate of forty-two beats per minute.

After discussing with the patient CVD risks and statin treatment as per guidelines, Atorvastatin 40 mg was prescribed. The patient was advised to avoid drinking and to seek medical advice in case of developing chest pain, palpitations, dyspnoea, syncopal or pre-syncope episodes.

The active invitation has allowed early detection of uncontrolled arrhythmia and has resulted in directing the patient to the right pathway and appropriate treatment (statins) at an earlier stage than would normally have been the case.

What was the shared learning?

Resourcing activity above the QOF threshold (performance up to QOF 100% on CVD indicators) using both BCF and Public Health funding:

- Facilitated both primary care and public health commitment
- Focused on harder to reach and more marginalised groups

Current focus is on medium-risk cohort as a preventative strategy:

- Early findings from GPs are that some patients are at higher risk than their data and clinical records indicated eg additional conditions were opportunistically diagnosed

Impact on general practice:

- Despite initial increase in demand on practices, benefit of the approach recognised and continued
- Additional ARRS roles key to being able to deliver more holistic care

Co-production between public health, primary care and CCG/Alliance fundamental:

- Building trust requires an investment of time
- Allowed the model to be data and clinically-led, but with a sufficiently flexible approach that allowed change of focus eg Thurrock's shift from management to detection in 23/24
- Funding streams for joint working have been a challenge, but use of BCF has been helpful in building shared commitment

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Further information:

Thurrock Annual Public Health Reports –

2016 Report – Outlines the challenge

2022 – Outlines action taken to improve CVD outcomes

Integrated health and care in the community

Central Bedfordshire Council

Grove View Integrated Health and Care Hub

Grove View Integrated Health and Care Hub in Dunstable was funded and built by Central Bedfordshire Council (CBC) in partnership with the Bedfordshire, Luton, and Milton Keynes Integrated Care Board (BLMK ICB). It aligns with the BCF policy objective 2023–2025 to provide the right care in the right place at the right time.

The Hub provides a focal point for bringing together a wide range of services across primary, mental health, community, and social care services to work in a more coordinated way to transform the way services are delivered, particularly for people with complex care needs or long-term conditions. The co-location of health and social care teams is enabling more integrated care delivery models, information sharing and decision making.

The co-location of health and care teams at the Grove View Integrated Health and Care Hub has maximised the opportunity to deliver transformation and use of new models of care. We want to reduce the reliance on hospital services by bringing together a wide range of services in a 'one stop' hub where people can access high-quality care and services seven days a week, close to where they live.

Central Bedfordshire is experiencing disproportionate levels of population growth. In the past five years its population has been growing at twice (+8%) the rate of the population of England (+4%) (ONS Population Estimates, 2019). We also have an ageing population. As a predominately rural area, access to health and care services can be fragmented and, as a result, access to key health and care services can be difficult and experience variable. We identified a need for co-located, accessible services to improve access to key services and streamline care pathways.

Grove View Integrated Health and Care Hub provides the opportunity to understand and improve the available but fragmented pathways for these service users and develop community-based offerings that could monitor or meet their specific needs, reducing the risk of an avoidable admission and delivering multi-disciplinary care close to their residence.

What was put in place and how was the Better Care Fund used?

Grove View Integrated Health and Care Hub opened in Spring 2023. Over twenty health and care services are now co-located and delivering services from the Hub. Alongside primary care services, these include social care, Bedfordshire Talking Therapies, Childrens and Adolescent Mental Health Service, out-of-hours GP clinic, blood clinic and other out-of-hospital services.

The team have developed an integration programme at Grove View Hub based on partnership working across health, community-based and social care services which will result in fewer appointments, more multi-disciplinary appointments, less repetition for patients to have to articulate their issues with multiple professionals and the associated stress and time required to manage within the existing systems and processes.

The Grove View Hub enables co-location of services across health and care, and continues to support pathways and promotes greater joint working, while reducing pressure on existing and secondary care services. BCF Funding supports the transformation programme that is shaping the blueprint for integrated working in a hub environment and maximises the potential for multidisciplinary working and workforce development.

What were some of the outcomes?

The Hub enables local populations to access services closer to home, by bringing together services that have historically been fragmented or provided in multiple locations under one roof. It will improve people's experience of accessing health and social care by streamlining pathways and reducing the time required to access multiple providers. Population health information was used to identify the key areas for initial focus. Three workstreams were identified as part of the blueprint for this new way of working that maximise the opportunity of co-location. These workstreams are:

- **Frailty (Keeping Well) Pathway:** This was identified as a priority by Chiltern Hills PCN, and a working group was established in May 2022 with representatives from acute, primary care, community care and social services. The pathway was piloted in Autumn 2022 by an Acute Geriatrician with regular input from a GP with Special Interest (GPwSI) and supported by a Care Coordinator, seeing ten people at home for a proactive assessment. These individuals were identified as at-risk of admission. They were given a comprehensive, holistic assessment and were provided with the necessary onward referral to specialist, community, and social services. Based on findings from the pilot, the workstream has scoped resource requirements for a scaled-up clinic. They are now putting into operation the proactive care clinic within the Hub, to initially run one day per week, and the PCN has agreed to allocate care coordinator and clinical pharmacist time to support, alongside the Geriatrician and GP. The intention is to expand the team to incorporate MDT working including a physio, occupational therapist, and community matrons.
- **Children's Mental Health Transformation pathway:** The pathway will support MDT relationships between GPs, Children's Complex Care and Neurodevelopmental teams to enable early diagnosis and ensure appropriate follow-on support. The PCN is working with ELFT Children and Adolescent Mental Health Services and Cambridgeshire Community Service's Neurodevelopmental Team to agree on workstream focus, including co-location with the GP surgery in the Hub.
- **Long-term Conditions pathway:** This will improve continuity of care, by increasing multidisciplinary working between primary, community and secondary care in line with the priorities identified in the Fuller Report (2022). It is also hoped that increasing preventative care will ease pressure on acute services by shifting activity into the community. The team have conducted risk stratification based on data from practices to identify a suitable cohort – this would be approximately twenty-five patients per month and virtual MDT huddles are underway; once the cohort is established, the workstream intends to refer into the huddles.

What was the shared learning?

- Engagement from GP member practices and system partners – practices and partners need to support the clinic model to ensure continued engagement and commitment to the development of the pathways.
- Explore alternative available funding streams provided to Primary Care Networks that are offered to enable transformational development.
- Explore transport opportunities with local authority and VCSE that would support these individuals being able to attend appointments.
- Assess how existing working models can be reviewed to accommodate transformation without the need for additional recruitment.
- Ensure measurable benefits and indicators which matter most to the individual are identified by the teams' developing pathways from the perspective of the service users, carers, and staff.

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Further information: Integrated Health and Care Hub (groveviewhub.co.uk)

Out of hospital reablement and intermediate care

Milton Keynes Council

Seacole Community Virtual Hospital

Seacole Hospital is a fifty-two bedded virtual hospital set over a nineteen bedded inpatient unit and thirty-three other beds across three care homes within Milton Keynes. The primary purpose of the Seacole beds is for the management of sub-acute conditions, rehabilitation, and discharge to assess beds. This is usually for care of the frail elderly but can be for anyone over the age of eighteen with rehabilitation needs that cannot be met at home. The four different units allow for the management of different needs including those with cognitive difficulties including dementia in the most appropriate environment.

Windsor Intermediate Care Rehabilitation Unit (WICU) is a nineteen bedded unit run and managed by Central and Northwest London Milton Keynes (CNWL MK) Community Services and has been part of the intermediate care offer for many years in Milton Keynes. The Seacole Virtual Hospital was created at the time of the COVID-19 pandemic in 2020 to increase the number of non-acute beds to support the system surge plans.

WICU consists of nineteen individual ensuite rooms with no room or potential to increase the bed base and there was no other inpatient unit in Milton Keynes to support this increase in bed base. So, the model was to take the care and rehabilitation to the patient.

In addition to this there are nineteen recuperation beds commissioned in Milton Keynes managed by Milton Keynes County Council (MKCC).

What was put in place and how was the Better Care Fund used?

The nineteen beds in WICU continue to be run and managed by the CNWL MK Community Services. The Care Homes are commissioned at an appropriate financial rate to provide the bed, care, and nursing input for the patient and CNWL community services are commissioned to provide the therapy, rehabilitation, and discharge planning. The General Practitioner (GP)/medical cover is provided by the GP practice covering the care home and the Consultant Geriatrician cover is part of the Community Consultant Geriatrician cover commissioned by Milton Keynes University Hospital. Social care support is provided to the beds to ensure appropriate and timely discharge planning to prevent blockages in flow. In addition, CNWL MK Community Services are commissioned to provide the bed management for the fifty-two Seacole beds. This ensures a single point of access for all referrals into the health beds. The nineteen recuperation beds remained under the management of Milton Keynes County Council.

Regarding the discharge to assess pathway, the care home bed-based services, Seacole and recuperation, have been crucial in ensuring that choice and independence are of the highest importance for individuals. Decisions about long-term care needs are made out of an acute setting and most importantly recuperation/recovery is maximised. This allows for the promotion of

independence and self-care, whilst enabling choices to be made in a non-acute environment. At the same time de-compensation is reduced and there is a more effective use of rehabilitation and reablement.

The Better Care Fund is utilised through commissioned care homes for nineteen recuperation beds, of which three are dedicated to dementia care, and fifty-two beds through Seacole, therapy and a nurse-led service. Both bed-based services allow minimal hospital stays and provide support to enable people to maximise their independence.

It has been recognised, as part of the review process, that the approach is not fully integrated, is provided across multiple sites and at peak periods of the year demand exceeds supply (evidenced by capacity and demand work). As a result, there has been a decision to rationalise the bed base and integrate the support provision. The expectation is to move the focus away from inpatient bedded support to support in a person's own home.

This will also require a further integration of community bed stock bringing together the recuperation and rehabilitation beds to be managed by the bed managers under a single process and to integrate the support services with one operational line management structure to further reduce organisational and professional barriers and allow maximising of resources and preventing duplication.

What were the outcomes?

The Integrated Care Board, Milton Keynes County Council and the CNWL senior leadership team have worked together to develop the Seacole Hospital and now to refine the model further. Through regular meetings the system stakeholders have openly shared their frustrations about current blockages in flow and have come together with key clinical teams to develop a shared vision with the aim of improving pathway 1 and 2 discharges.

The impact of this work has been in bringing together teams, sharing knowledge, and learning and promoting an understanding of each other's services, knowledge, and skills. This work has been done alongside Healthwatch Milton Keynes to gain understanding from the patient perspective and some of the barriers and issues they face too, and this information has been fed into workshops to ensure that discussions retain the patient at the centre of plans.

What was the shared learning?

- Senior level buy-in across the system to enter into the process is essential.
- Strong communication lines with care home providers and other stakeholders.
- Respect for partners and their day-to-day operational challenges.
- A shared vision.
- Listening to the clinicians working in the system every day and understanding their frustrations.
- Learning how those working in the system would change things, allowing them to have the ideas and to bring those ideas to life for them.
- Providing a safe environment for discussions to take place to understand this is not about blame but about continuous improvement.

- ‘Perfect is the worst enemy of better.’
- Understanding the changing landscape and the need to recognise that what was done a few years ago may not work now and that is no one’s fault.
- The financial envelope.

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Norfolk County Council

Norfolk First Support – Successful Occupational Therapy input into reablement services

Norfolk First Support (NFS) is a reablement-at-home support service for people over the age of eighteen who have spent time in hospital or are facing difficulties with physical or mental health whilst living at home. Occupational therapy is attached to the service and will support reablement assistant practitioners to work with individuals with a personalised support plan.

The Norfolk Council reablement approach helps individuals to retrain or regain skills to become more independent in their own home, build confidence to learn to manage after a period of illness, and to manage long-term conditions. Support is available for up to six weeks although many people return to being independent before then. Sometimes practitioners realise that the person they are supporting would benefit from a different service to reablement and will be able to support to get the right help.

Case study

Sally (pseudonym) was a 78-year-old lady with Parkinson's disease who had been in hospital for almost four weeks following a fall at home. She was discharged home with two Norfolk First Support workers visiting four times a day. Following her stay in hospital, Sally was very anxious which was impacting on her reablement progress and ability to live independently on her own.

During the first reablement occupational therapy (OT) visit Sally completed some chair-based exercises and practised moving from her chair to a rollator frame. She also practised marching on the spot.

A follow-up OT visit had Sally practising mobilising forwards with one worker assisting and another following with a wheeled commode (used as a wheelchair) to get Sally back to her chair or bed if needed.

Following this second OT visit, care was transferred to the reablement support workers (RSWs).

Sally gained further confidence in transferring with a rollator frame and assistance, a Ross return had not been required to use for transfers. Sally had also started to move further with assistance.

During the next visit Sally asked if she would be able to access her conservatory to look into her garden. With the assistance of the reablement OT, Sally was able to negotiate the step and threshold from the hallway and move into her conservatory to sit and look out onto her garden.

During the most recent visit, Sally talked about how she would like to be able to go outside with her neighbour. Her neighbour, who visited several times a week, expressed a wish to take Sally out in the wheelchair for fresh air, to see the countryside and to visit some horses kept nearby.

A joint visit was organised with the OT and Sally's neighbour. Sally's movement to her front door was observed, at which point minimal assistance was required to help her move down the two steps to get out of the door and transfer into the waiting wheelchair. Her neighbour was then able to push her in the wheelchair along the country lane they live on. Sally was able to climb the steps to get back into her house, and her neighbour is happy to help Sally with this on her own. No equipment was identified to assist Sally with completing steps, however the technique of managing the steps was discussed and practised.

With visits from the OT and RSWs to build confidence, Sally is now mobilising between care calls. She can mobilise independently with her frame around the ground floor of her property and has returned to completing some light domestic tasks such as dusting.

The OT discussed with Sally how she would be able to prepare her lunch independently. Sally was able to access the fridge, place items on the caddy and move them to the kitchen table as the kitchen worktops were too high to use a perching stool to sit at. Sally was able to make her own lunch, generally a sandwich whilst sitting at the table. After the support workers had observed Sally successfully preparing her lunch for a few days they had the confidence to cease their lunchtime visit.

Now her mobility had improved, Sally wanted the freedom to be able to get herself to bed at the time she wanted, however, she was concerned about being able to get her legs and feet out of her trousers. The OT talked her through standing at the bed and undoing/lowering trousers, then sitting back on the bed and if necessary, using the 'helping hand' tool to assist.

Sally was initially very anxious about doing this independently but within a few days of practice and observation from the RSWs, Sally was then able to complete this independently and the evening care call ceased.

This significantly improved Sally's wellbeing, as she was able to complete her evening routine the way she wanted including being able to watch the television programmes she enjoyed and to take herself off to bed when she wished.

During NFS and Reablement Occupational Therapy input, Sally's package of support reduced from double up (two workers visiting together, four times a day) to single assist (one worker visiting twice a day).

What was put in place and how was the Better Care Fund used?

Reablement support workers and occupational therapists were all funded through BCF as part of the adult social care's reablement service Norfolk First Support.

What were the outcomes?

Through a multi-agency weekly meeting the case was discussed and an OT visit was identified. Following the Norfolk First Support package and Reablement Occupational Therapy input, Sally's package of support was reduced from a double up to single assist. There was also close work with the reablement practitioner who set the initial goals.

What was the shared learning?

- Engagement with the person.
- Identify a goal that is personal to the individual.
- Importance of listening.
- Break goals down and work on one at a time.
- Use any support network around the person to assist.
- Use of unqualified staff and qualified staff working in partnership.

Contact: Denise Forder – denise.forder@norfolk.gov.uk

Further information: Norfolk First Support – reablement support at home – Norfolk County Council

Norfolk County Council

Community step-down flats

The development of Housing with Care flats (that were empty and had no one identified to move in) to provide people with a place to stay and receive care, whilst the Council/Social Services sourced their home care package, so they can return home. People would either be in an acute or intermediate care bed and identified as being able to return home with a care package. The aim was for people to stay in these units for a brief period of time (no more than four weeks).

At the time, reporting on intermediate care beds in Norfolk showed that there were several people at any one time who required a long-term home care package to return home but there were delays in sourcing this care. The aim was to enable people to return home when they had come to the end of their recovery, rehabilitation and/or reablement pathway. The main benefit identified was to discharge a person into one of these flats, so that the intermediate care bed could be used to support a discharge from one of the three hospitals in Norfolk. This proposal was developed as one of the initiatives, as part of the Winter Plan for the Norfolk and Waveney Integrated Care System.

Another benefit identified was to provide people with a place to stay (short term) that promoted independent living, within a 24/7 care environment. This ensured that people could continue to receive care and support that promoted their independence, in line with the Adult Social Services strategy. The aim was to reduce the requirement for formal care and support, as much as possible, whilst ensuring their assessed needs were met.

What was put in place and how was the Better Care Fund used?

Twenty-three fully furnished self-contained flats were developed across several Housing with Care schemes. Within Norfolk, most of the care in these schemes is provided through a single care provider (NorseCare). Each flat also included a profiling bed and mattress, to ensure that these were available, should that be required for an individual. At the height of the project, twenty-three flats were made available and due to the success, funding has been made available to continue with five flats for the whole of 23/24. Work is underway to understand requirements to increase this number, as part of the winter planning preparations.

The project included a working group which had representation from the following key stakeholders, who all had a part to play.

- **Registered Social Landlords (RSL) –** They provided permission to use empty flats for this purpose and a lease was put in place between Norfolk County Council and those housing providers. This also included elements such as the service charge to cover utility costs.
- **Care provider –** They provided the main care and support to individuals staying in these flats.

- **Meal's provider –** As part of the arrangement, meals were also provided to people, so they received breakfast, lunch, and an evening meal.
- **Exercise specialist –** Within some schemes, additional in-reach support was provided through an organisation who specialised in exercise support. This enabled people to continue their reablement and recovery pathway during their stay at the flats.

An Operational Instruction was also developed as well as information that could be shared with the individual. Every person was also required to sign a License to Occupy, which made it clear the circumstance in which they were staying in the flats.

Discharge monies that came via the Better Care Fund were used to fund the following costs, associated with the project:

- rent and service charges.
- additional care costs and specialist exercise support
- fixtures and fittings
- additional project management and legal costs
- catering/ meals provision
- cleaning costs.

What were the outcomes?

The existing care contract in place for Housing with Care (HwC) schemes with NorseCare was used to provide the necessary care and support to people. In addition, a Trusted Assessor model was put in place who was employed by the care provider. They worked directly with the Home First Hubs to identify suitable people, review their Transfer of Care form, and liaised with different scheme managers about any potential referrals. This ensured there was a seamless, consistent, and single point of access into the available flats.

As part of the lessons learned review, service user feedback was captured by the care provider:

- Forty per cent of people were worried about leaving hospital and over 75 per cent of people, knew very little about the Community Step-down flats.
- One hundred per cent of people felt welcomed when they arrived at a scheme and one hundred per cent of people felt that the care and support, they received met their needs.

In addition to this, it is also important to note the following.

- Several people ended up staying in a HwC scheme longer term. Following their initial stay, they made an application to move into the scheme and hold a tenancy with the RSL.
- Additional in-reach exercise support was provided to twenty-seven people. The impact of this support has been impressive and the following case studies have been included to demonstrate this, with one hundred per cent of participants improving their leg strength and seeing improvements in their Falls Efficacy Scores.

Case study – JH

JH arrived in HwC following the amputation of one of her legs. Her other leg was giving her lots of pain. We started off by increasing the mobility in her legs and some gentle strength exercises. After 4–6 weeks, the pain in her leg had completely gone and she was able to transfer herself to the chair, bed, and toilet. JH has also increased her arm strength, so she can use her wheelchair more easily. She was able to be discharged and live back at her home with the relevant adapted facilities.

Case study – JB

JB started with very weak legs and poor balance. She improved these over the weeks and found it easier to walk. Her family commented that they saw her walk further than she has done in the last few years. She is now able to stay living in HwC.

What was the shared learning?

The following learning was identified from the lessons learned workshop held with stakeholders.

- Ensure the working group has strong representation from the key stakeholders. These also needed to be people who can make decisions.
- Have a single point of access and where possible put in place a Trusted Assessor model. This helps to manage referrals and ensure consistency in who is being placed in the flats.
- Put in place exercise specialist in-reach support. The impact of this type of initiative is impressive in improving individuals' mobility.
- Ensure follow-up support is in place from operational/social work teams. It is important that people have an allocated worker, who is focused on exit planning and ensuring the person returns to their own home at the earliest opportunity. We did have a situation where someone was refusing to leave, and it took several weeks for them to move.
- Communication is key to ensure that people/key stakeholders are aware of the service and type of support available. Use different communication methods to do this. For example, we have now developed a video that can be shared with people, so they can see for themselves what the flats/schemes look like. This can be access via the following link https://youtu.be/18Ro88oECnE

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Southend City Council

Southend Enhanced Discharge Service

The Southend Enhanced Discharge Service (SEDs) is a therapy-led assessment at home for Southend residents who have been discharged from hospital, but do not have any support. This includes people who may be at risk of falling at home, people with chest infections or those with mobility issues.

Prior to the launch of SEDs, Mid and South Essex NHS Foundation Trust (MSEFT) and Southend City Council (SCC) were in an unsustainable position with regards to the management of Pathway 1 hospital discharges. There was a consistently high and growing number of people delayed in hospital, awaiting care for more than 24 hours. Through joint agreement, Southend City Council and Mid and South Essex Integrated Care System (MSEICS), as the commissioning bodies and budget holders, agreed with MSEFT, to work together, to design and deliver a Pathway 1 project called 'Southend Enhanced Discharge Service', known as SEDs. The SEDs project is built on the shared purpose of implementing a discharge service as part of a vision to develop and deliver aligned care across Southend.

What was put in place and how was the Better Care Fund used?

The aim of SEDs is to provide short-term, wrap around care and therapy post discharge fully aligned to the principles of Discharge to Assess (D2A). It provides an interim care service for people following their return home from hospital to meet individual support needs and re-establish independence, before a longer-term reablement or domiciliary home care service is established.

The core provision of SEDs is fully funded by the Better Care Fund, 50 per cent local authority funded and 50 per cent Integrated Care Board funded. Following on, additional winder capacity funding was used to increase capacity.

What have been the outcomes?

Prior to the launch of SEDs, MSEFT and SCC were in an unsustainable position with regards to the management of Pathway 1 hospital discharges. There was a consistently high and growing number of patients delayed in hospital, awaiting care for more than 24 hours. Patients who were categorised as Pathway 1 were discharged with a multitude of providers with a varied offer of D2A, i.e., people were discharged to providers based on capacity and not the need for reablement and therefore were ending up with a domiciliary care provider with no access to therapy.

This service is jointly commissioned to deliver improved outcomes for people and a more efficient use of resources across the local health and social care economy. The outcomes are intended to meet D2A guidance and the Home First model of care and discharging to a standardised offer to domiciliary care to allow for recovery and rehabilitation prior to the assessment of longer-term needs.

Home First/Discharge to Assess: Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means people no longer need

to wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

The pathway ensures that where people who are clinically optimised and do not require an acute hospital bed but may still require Adult Social Care services (via Pathway 1 and Pathway 0 breakdown), they are provided with short-term support to be discharged to their own home (where appropriate) or another community setting. All individuals that no longer meet the clinical criteria to reside for inpatient care in acute hospitals are discharged as soon as possible on the same day.

Outcomes:

- The Southend Enhanced Discharge Service provides personal care and/or therapy-led assessment and/or rehabilitation to individuals who are ordinarily resident in Southend-on-Sea Local Authority and have been discharged on Pathway 1.
- Following the Discharge-To-Assess principles, the service provides timely assessment and discharge post discharge from hospital.
- To establish and regularly review a personalised co-produced care and/or therapy plan to meet the needs of the individual.
- Improving patient flow by supporting individuals to be discharged from hospital to their own home as soon as they are medically optimised.
- The service delivers effective strength-based, person-centred interventions to enable individuals to meet their personalised goals and maximise their potential to carry out their desired outcomes through activities of daily living.
- To work with partner agencies via the multi-disciplinary team to provide a holistic overview of case management and to plan onward referrals applying the individual service criteria.
- To ensure individuals transfer into the most appropriate service, on the right pathway, at the right time to i) improve patient flow, ii) improve patient outcomes and experience and iii) improve reablement/domiciliary care capacity utilisation within the market.

The SEDs pathway spans the commissioning of a range of options to meet patient needs following discharge from hospital. SEDs focuses on the following:

- Under Pathway 1 patients requiring new POC (Point of Care) discharged into SEDs (+ Pathway 0 breakdown).
- Wrap-around care and therapy will be provided aligned to D2A policy/principles:
  - D2A assessment and intervention
  - rehabilitation and reablement
  - reduce readmission – stronger links to Acute/UCRT/CCC
  - promote independence and reduce care needs/frequency.
- Three weekly MDT (EDS, ASC, Community Therapy, CCC):
  - jointly establish best onward pathway
  - seamless handover of care and therapy to ASC/community providers
  - link into CCC for wider signposting and ongoing coordination of care.

This data shows improved care market capacity utilisation which positively impacts on hospital performance in terms of length of stay (LOS) and discharge delays. Most importantly, the biggest benefit of SEDs is that it brings a positive outcome to our patients and residents which is the overarching aim as an Integrated Care System.

What has been the shared learning?

Data sharing: Whilst MSEFT use a live tracker to record the patient pathway, SCC do not at present have access to this and therefore duplication of work is required to share information and data metrics which poses a risk of inaccurate information sharing, time delays and increases staff workload. Whilst we are currently in the process of rectifying this issue by granting honorary contracts to SCC SEDs colleagues, it would be beneficial to have this in place prior to launching similar projects.

Capacity: Whilst initially in the pilot phase of the SEDs pathway, there were lower numbers of patients entering the service which was commissioned for twenty-five slots. During the winter months of 2022/2023, the service expanded at great pace and was increased to fifty commissioned slots but continues to go over this. To support with this, MSEFT have onboarded third-party providers but due to difficulties within SCC/recruitment, the ASC team has been unable to expand beyond this and this has caused delays within the ASC element of the pathway. Improved forecasting/strategic planning will help support this.

System wide issues: For example, delays in information sharing, incomplete D2As and patients discharged without medication/equipment.

Managing the expectations of the patient/NOK: What the service can provide and is intended for and implementing an information leaflet for patients prior to discharge. Currently, basic information is being collected from people who have been through the SEDs process from MSEFT after six weeks. Southend City Council are now working with MSEFT to collate details to understand if expectations have been met and where improvements can be made.

Cultural shift: Changing the mindset from assess to discharge to discharge to assess.

Robust governance: Implementing strategic oversight and operational oversight and identifying the importance of good project management to achieve rapid implementation.

Additional information

In 2023 Health and Social Care partners have commissioned an independent review of the arrangements.

The report has been received. The feedback it contains is positive while partners are considering a set of recommendations. Here 2 quotes from the report:

- "While the service has only been active just over a year, it has already established a strong reputation for managing common discharge issues and facilitating a good transition to independence or ongoing care for individuals.
- With a few tweaks to approaches, SEDS will be in a strong position to continue to support individuals out of hospital, even in the winter period." (from SCIE SEDS review, Oct 2023)

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Further information:

https://carelinelive.com/nhs-discharge-reducing-bed-blocking

https://www.yellowad.co.uk/southend-patients-can-leave-hospital-sooner-with-better-support-at-home-scheme

Safeguarding people

Southend City Council

Mental Health Safeguarding

John (real name withheld for data protection) is 83 years old. He lives alone in a sheltered housing complex. John has a diagnosis of Korsakoff dementia. John was always independent. John was known to the Harland Centre, but he had no active input from the Mental Health Team. He was able to access the community independently and go to the bank, shops, and local restaurants. He is also known to other residents in the housing complex.

The housing officer and other residents raised concerns about John just after the COVID-19 lock down was lifted as he appeared emaciated and more visibly confused. John had commissioned care for care providers to carry out daily welfare checks as he declined support with other aspects of his daily living.

The extent of John's circumstances was only discovered at the annual review of his care by his allocated social worker. Commissioned care was ended, and he was supported by personal assistants' support funded by a direct payment managed by Vibrance. John's personal assistants both resigned as John was not engaging with services. Recently John experienced further decline in his cognition, disorientation in time and place and self-neglect with personal hygiene as he appeared unkempt, has lost more weight and visibly dehydrated. He was living in an uninhabitable home environment; he was at high risk of food poisoning due to scavenging for food in bins in the community. John also had a history of unwitnessed falls and injuries which appeared to be from a possible assault in the community although he had no recollection of the chain of events. He also had a history of non-engagement and non-compliance with support services. John is also at high risk of financial abuse and exploitation as he is unable to recall his bank card details and pin numbers.

Residential care was initially explored as one way of reducing the risks of harm but John refused to go into residential care. It was felt that an urgent Multi-Disciplinary Team (MDT) is required with professionals from health and social care to discuss best interest and least restrictive options of care that will keep John safe but maintain his autonomy.

John was also supported by an Independent Mental Capacity Advocate (IMCA) as John was assessed as lacking an understanding of his care needs and lacked the mental capacity to make informed decisions around these.

What was put in place and how was the Better Care Fund used?

Addressing immediate concerns and risks

Due to high level of risks and John's vulnerability, social workers and housing have been taking turns in providing food and fluid to John to maintain his daily nutritional needs. An immediate strategy meeting in the form of an MDT followed by weekly MDT's involving the advocate, GP services, Essex Partnership University Trust (EPUT), housing officer, social workers, social work

managers, and care staff to discuss how best to address risks in a person-centred manner and explore least restrictive options of care to keep John safe in the community. Care providers keep a daily log and provide a daily update and the options that have been tried are evaluated weekly by all professionals and other options suggested and explored. Care providers have direct access to other professionals, especially social care staff, to obtain advice and support.

Empowerment and personalisation

John lacks an understanding of risks, his own vulnerability, and his care needs. He has, however, consistently stated he does not want to live anywhere else but his flat, which he refers to his hotel. John has an IMCA who ensures that John's views and wishes are included in all decision making and supports with ensuring that decisions made are in his best interest and least restrictive option of care. Personalised care and support are the best options to explore to ensure that John's needs are safely met at home, and he does not lose control of his home environment.

Building trust and encouraging John to engage in services.

The social worker discovered John would not engage with "professionals" supporting him and would not engage with any services. He declines medical intervention, even for emergency support. The social worker and his advocate introduce themselves as 'his old friends' when bringing him food or 'hotel staff,' as he will not engage if told they are health or social care professionals. A key safe is installed but John does not like professionals accessing his flat via key safe. Social care staff do not wear their ID badges and care staff do not wear any uniforms. He will open the door if the care staff knock and announce that they are "cleaners who work in the "hotel" and have just brought him something to eat. John is more willing to engage with people who praise his writing and talk about his childhood and work life.' The same familiar staff are maintained throughout this engagement as John does not like change and becomes unsettled and anxious whenever he sees new people he has not met before.

Physical, mental, and emotional wellbeing

John has had physical injuries and refused medical care. Fortunately, his wounds have healed over time. John was not registered with any GP service. The social worker and advocate supported John to register with the GP service. Following an MDT with the GP services, the GP is now liaising with the advocate to carry out a physical health assessment. Due to John's decline in cognition, delusions, and hallucinations, he has been referred to the Harland Centre for mental health support. John has also been referred to the DIST Team and EPUT for his mental and physical health needs.

Managing and meeting nutrition needs

Due to cognitive decline, John is unable to safely prepare food and drinks. He has a fridge freezer and a microwave, but he is unable to safely operate any electrical appliance and has been known to throw away any food stored in his fridge. Due to inability to access and manage his money he could no longer purchase food from the shops.

John was reported to be malnourished and sometimes scavenging for meals. John had two personal assistants who were unable to engage with John to support him with his nutritional needs. The social worker and housing officer took turns to take meals to John daily but found that this was unsustainable long term. Any food put in the fridge or freezer was binned by John. John was at high risk of malnutrition, dehydration, and food poisoning as he resorted to scavenging and going to shops, cafes and restaurants asking for food or leftovers. When asked what he would like to purchase, John said he preferred to eat bread, cheese and ham but refused to store these in the fridge. To reduce the risk of food poisoning, especially in the hot weather, ready meals and food items were delivered daily. Southend Care was commissioned as Provider of Last Resort to work

with John on a personalised plan and using a person-centred approach to support John with his nutrition needs. John was accepting food and fluid delivered daily by the care providers who explored options such as fast foods (McDonalds, fish and chips and KFC), hot meals from Brook Meadows Kitchen delivered using heated lunch boxes and ensuring he had adequate amounts of fluids (mostly his preferred diet coke) in the property. Southend Care has used a creative and person-centred approach in exploring a variety of food and fluid options and using a 'try and elimination process' in understanding what John likes and dislikes whilst ensuring his nutritional needs are adequately met with a sustaining diet. Staff are aware he does not like fruit and vegetables and prefers to drink Coke. Staff keep a record of food and fluid intake based on what is delivered to John and the empty containers and food wrappers staff retrieve on subsequent visits.

Maintaining a habitable home environment

John agreed to a deep cleaning service. He is also allowing 'staff' to clean his room daily but will only allow this if care staff give him fast food to eat. During these times, he will allow care staff to make his bed and clean his toilet, kitchen and living room area. Care staff empty the bins daily, minimising the risk of clutter build-up.

The housing officer has also been supporting, working with other professionals for necessary repairs to be completed and we have found that since the cleaning and repairs have been done, John is no longer going out as much and care staff often find him at home engaging in his hobby, which is writing.

Maintaining personal hygiene

John appears unkempt and has not been taking care of his personal hygiene. Despite several attempts by care staff to engage him in support he has declined. It is felt that this is an aspect of care that will require a lot of flexibility. The care agency has purchased toiletries and left them within eye view to encourage John to wash daily. Care staff are asked to observe for signs of any skin breakdowns or foul smells as this would give them an indication, he is experiencing skin breakdown and to report this to the GP and district nurses.

Care staff and social workers have donated bedding, towels, and clean clothes to John. Unfortunately, John has been throwing away the clean linen and clothes. Care staff now leave out clean clothes for John to change. Old dirty clothes are usually thrown away or laundered, depending on the state of the clothes. Staff continue to build trust to the goal of encouraging John to be compliant with personal care support.

Financial safeguarding

The social worker was concerned about John's understanding of his finances as he could not tell the social workers his sources of income, how he accesses his money and what he spends it on. The social worker found out that he had unopened letters and a care bill from SCC, but he had no idea what the care bill was for and how to set up payment for his care. The social worker found a new bank card in his property, but this was still attached to the letter indicating that it had not been used.

A mental capacity assessment for management of finances was completed, and John was deemed to lack the mental capacity to manage his finances. However, on one of his bank statements, a withdrawal of £40 was consistently made weekly and John could not confirm if he made these withdrawals. John's bank was contacted, and they confirmed they had concerns about his understanding of his finances as he could no longer recall his pin. As a result, the bank had put in a contingency to allow John to withdraw £40 weekly every time he visited the bank, as they were concerned, he was at risk of financial abuse or extortion but also mindful that he needed access to his money for his daily needs.

A best interest decision was made for John to be referred to the SCC Court of Protection service who can support him to safely manage his finances through Deputyship. Whilst the application for Court of Protection Deputyship is ongoing, the SCC Court of Protection Service has issued a prepaid spending card which is topped up weekly for purchases. This card is safely stored by the care agency who give an account of the weekly spending and purchases.

Family and social connections

John does not appear to have any family or any known friends locally. John told us he was born in Southend but evacuated to Yorkshire during the war. He said he still has family dotted around but could not recall their names or where they lived. The social worker referred him to a genealogy specialist agency who traced that John was born in Yorkshire but estranged from his entire family. The genealogist retrieved a copy of John's birth certificate to confirm his identity as he had no other means of identification.

Social inclusion and mental stimulation

John is known to other residents in the housing complex, and they have been updating housing and social care staff of any concerns regarding him. John is not known to have any hobbies or people he calls friends but is known to spend time with local rough sleepers. It is suspected that some of the injuries he sustained in the past may be from physical assault in the community. Care staff have observed him visit areas in the community that are deemed 'high risk' areas.

Care staff are working on building a trusting relationship with John and to eventually introduce him to day care services and other activity groups where he can safely maintain social relationships and engage in mentally stimulating activities. In the meantime, the care staff supply him with writing materials to maintain his hobby and this has reduced the number of times John goes out to these high-risk areas. They also encourage him to discuss his past life and ask him about his writing. Through these conversations, John is asked what he would like on the shopping list for the next day, and he will often make suggestions on the things he likes and dislikes.

Care staff realised that John's delusions and hallucinations are the reasons he does not use his bed to sleep as he believes that about '13 people have died in that bed'. He also believes that he has 'Russians' in his flat waiting for him to complete a piece of writing project.

Long-term care planning

Southend Care are a Provider of Last Resort and often only provide reablement support or provide interim support where there is a provider failure. However, given John's history of non-compliance and Southend Care's record in achieving positive outcomes for John, it is felt that Southend Care should continue providing care for the foreseeable future as any change in care providers is likely to undo all the positive outcomes that have been achieved with John so far. John will find it difficult to familiarise and engage with new faces as he has created a positive bond with his current carers. Southend Care has a track record in providing personalised care for people with complex needs such as John.

Contingency plan

Southend Care to start introducing John to other services such as the Day Centre. Brooks Meadows is to be considered first should John require residential care in future due to John's complex needs and the providers understanding of his complex needs and creative approach in working with John.

What were the outcomes?

- Multi-disciplinary work, drawing from the expert knowledge of other professionals through weekly MDT, daily updates and analysing outcomes whilst putting the needs of John at the centre.
- Making safeguarding personal by respecting John's wishes and views and supporting him through advocacy in ensuring that in making a best interest decision, the least restrictive option of care is at the centre of any decision making.
- Employing a flexible and creative approach to care delivery.
- Ensuring John maintains control of his life in a familiar environment and encouraging positive risk taking.

What was the shared learning?

- The importance of multidisciplinary working.
- Using a system approach even in crisis intervention
- The importance of personalisation.
- Involving advocacy services as part of empowerment.
- Making safeguarding personal.
- Flexible and creative care planning and delivery of personalised care and the importance of recording, reviewing, and analysing outcomes.
- The importance of care providers to raise concerns with social care when someone is not engaging with services.
- Emphasis on duty of care to all care staff to raise concerns in a timely manner and safeguarding concerns raised against the agencies where this duty of care has not been met.
- The importance of agencies and third sectors (such as the bank) to have knowledge of the social care process when they suspect that an adult is at risk.
- Frequency of social care reviews to be increased for adults who do not have families and are not in residential or nursing care as annual reviews may not be sufficient to identify concerns and ensure early interventions.
- Care staff and social services staff to ensure people are registered with GP and health services.
- GP services to be more flexible in their criteria for home visits as John was declined a home visit on several occasions when the GP was called out as they stated he is mobile and should be able to attend the GP surgery.

Contact: Delphine Etube – delphineetube@southend.gov.uk

Further information:

Southend Care – https://southendcare.co.uk

Estate Research – https://www.estateresearch.co.uk

South Essex Homes – https://southessexhomes.co.uk

South Essex Advocacy Services – https://www.sosadvocacyhub.org

Southend City Council – https://www.southend.gov.uk

Supporting unpaid carers

Bedford Borough Council

Examples of the impact of support from Carers in Bedfordshire

Experienced charity supporting carers of all ages across Bedfordshire.

A former carer had very recently lost his wife and was very concerned about the practicalities of being on his own, how to use IT, how to keep himself busy and how he will manage financially. He was referred to Carers in Bedfordshire where he was provided with emotional support, referred to the Former Carers Support worker and the Benefits advisor for financial support. Information was provided for the ELFT Recovery College. 'Thank you so much for your help, I wouldn't have known where to go without you.'

A cared-for was turned down for Personal Independence Payment (PIP) and had no entitlement to Carer's Allowance due to PIP not being awarded. Carers in Bedfordshire discussed the Tribunal appeals process and encouraged the carer to continue pursuing this. Follow-up telephone calls to check and encourage the carer to continue with the appeals process were made, as well as links sent to apply for Carer's Allowance and to apply for a Blue Badge.

PIP and Carer's allowance was awarded and back dated, with a lump sum of around £14,500. The household was better off by £227 a week and Blue Badge entitlement was guaranteed for the cared for. 'It's so nice to speak to people who understand what is going on, thank you so much.'

Further information: https://carersinbeds.org.uk

Hertfordshire County Council

Helping carers cope and improve

How Carers in Hertfordshire Care Support Advisors have assisted a carer to feel more confident, increase social contact and better cope with their caring responsibilities in challenging circumstances.

A carer who is in her sixties was supporting her husband and stepson with mental health issues, as well as raising her own teenage son. The carer was also working part-time. Her husband also had complex physical issues, including back pain, heart issues and diabetes.

When a Carers in Hertfordshire Carer Support Advisor met the carer at one of its regular Hubs in October 2021, the carer was at the end of her tether and was distraught and angry. She had attended the meeting the month before and had not felt heard but was encouraged by the Hub Leaders to continue with the group and to speak directly with a Carer Support Advisor. There had been a misunderstanding over her request for mentoring and the carer said she just did not want anyone else to feel like that. The carer was overloaded with many things and her capacity had been reached. She also had a stepson with mental health issues living with her and her own teenage son. The carer was a lot happier at the end of the meeting as she felt heard and valued. The carer was then referred for peer mentoring (another service offered by Carers in Hertfordshire) and matched thereafter.

What was put in place and how was the Better Care Fund used?

Before starting mentoring in November 2021, the carer described a range of physical and mental health issues that her husband suffered from, including difficulty walking and anxiety. She wanted help with balancing work and her wider life, coping with stress, emotional support and building her confidence as a carer. She found the fact that her husband's condition had so far not been recognised by medical professionals was causing her emotional stress. She was looking for someone with experience of similar complex medial health issues as well as being able to empathise about bringing up a 12-year-old boy at the same time. She felt more positive just for having completed the application form. She commented, 'My husband is so completely wrapped-up in this condition, he has little ability to reflect on how he comes across or affects family members or understand other people's feelings.' She did feel sustained in part by her faith and shared friends.

The carer was also nominated for and received a Christmas Box delivered by Carers in Hertfordshire in December 2021 to acknowledge the difficult time she had that year. The mentoring relationship lasted seven months. At the end of the relationship, the carer's scores had improved from four to five for knowledge of where to go for support; three to eight for increased confidence (this can vary from day to day); four to seven for increased social contact and two to three for isolation. She commented that she did have good friends with whom she could be open and that although her sense of isolation was not great, she had a job which enabled her to keep balanced. At the end of the mentoring relationship, the carer felt she had found time for herself, received emotional support, felt less isolated and had improved her social contact. The carer had also received one-to-one therapy outside of Carers in Hertfordshire.

What were the outcomes?

This carer accessed a variety of services offered by Carers in Hertfordshire, some of which are commissioned or part-commissioned using the Better Care Fund (mentoring, support from a Carer Support Advisor) whilst other services are funded from other sources (the Hubs). This example demonstrates the benefits of an integrated carers' support service, able to meet a variety of needs and which can in turn fundraise to expand its offer outside of commissioned funding.

The carer said, 'We made a trip to the theatre, which was nice. I think I have become aware of the value (and my need) to offload more than I would do naturally.' She found the mentoring helpful. "To be able to talk with someone who could relate to the particular difficulties I am experiencing – and who also had come through the other side, and still smiling.' She would recommend mentoring because, 'It has been most helpful speaking with T, as she could relate to my experience. She has been an invaluable support. A listening, patient ear.' In July 2022, the carer sent a thank you card, in which she said thank you for the hamper and the mentoring and wrote: 'All these kind gifts have helped me realise that I am not alone but have also shown Carers in Hertfordshire to be a great organisation, so a big thank you.'

What was the shared learning?

- Support for carers can make a real difference to their lives and those of the people they are caring for.
- The importance of face-to-face contact in forums and of peer support to enable people to feel they can speak out about their circumstances.
- That it is important to acknowledge that identifying and dealing with the problem can come from social care and the voluntary sector rather than medical diagnosis.
- Continuing to offer support and encouragement in the face of initially negative engagement can pay dividends.
- Improvements in lived experience across the board can arise from mentoring support, with tangible, measurable benefits.

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Technology enabled care

Bedford Borough Council

Promoting Independence and Technology Enabled Care – Reminiscence Interactive Therapy Activities (RITA)

RITA was introduced to six care homes in January 2022. At the time of introduction, the Omicron wave of COVID-19 was prevalent locally, and residents in the homes were subject to DHSC restrictions, such as self-isolation on admission from hospital, visiting restrictions and testing regimes. The homes in the pilot total 188 beds to a mix of client groups.

- Rivermead and Southway provide specialist dementia care to individuals living with moderate to advanced dementia (75 beds).
- Brookside provides care and support to older adults with learning disabilities (19 beds).
- Puttenhoe provides care to older adults, people living with dementia and short-term reablement care following hospital discharge (29 beds)
- Highfield provides care for older people and adults with physical disabilities (34 beds).
- Parkside provides care and support to older people (31 beds).

A large trolley-mounted screen unit and smaller tablet were 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 also create life histories. The devices can connect to the internet and be used offline, which is beneficial as network coverage was variable at times in some of the homes.

What were some of the outcomes?

RITA was well received when introduced to residents in all homes. During the pilot period residents at Parkside and Highfield became less engaged or interested in using RITA for individual activity, as many of them already use personal tablets, laptops, and mobile phones, enabling them to access similar content. Group activities such as quizzes and exercise classes were preferred in these settings.

Residents in the dementia homes and Brookside 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 in other homes.

Tracking of specific areas

During the pilot specific areas were tracked using RITA, including falls, weight loss, management of behaviours which challenge, delirium, hospital and A&E admissions and general social engagement.

There were no significant changes regarding residents' nutritional intake when RITA was used prior to or during meals.

Hospital admission rates remained static with no reduction directly attributable to RITA, although it has potentially reduced the risk of falls and associated injury in some cases. While fall rates did not significantly change, there was interaction with RITA by some individuals which the homes in question felt reduced the risk of them falling. An example of this is Resident C:

Case study – Resident C

> C is living with mild to moderate dementia and often would walk around the home daily for long periods. She would often approach other residents, which often resulted in confrontations and staff would need to intervene. Since having the large RITA placed within the unit, staff have observed that when she starts to walk, she will self-engage with RITA and play music and other activities. This has greatly reduced her confrontations with other residents, and she now self-engages with RITA daily. Staff have reported that C would often walk even when tired and as she is no longer doing this, they feel it has reduced her falls risk.

RITA was used with residents who were at high risk of falls or who were at risk due to infection and delirium temporarily negatively affecting their mobility. In some cases, residents engaged with it, and it was able to distract and engage them where they may have been trying to get up and walk unaided. It was felt that RITA did have benefits as a preventative tool for falls management for some individuals.

During the pilot, one resident at Highfield, due to deterioration in his mental health and cognition, experienced increased falls. In addition to the usual interventions RITA was tried with him, but he did not wish to engage with it and would push it away with force and appeared irritated by the unit. His falls have decreased with other interventions and ongoing changes to his health.

RITA was successfully used to support and facilitate admissions from hospital to Puttenhoe's reablement unit. Due to the requirement for self-isolating on admission from hospital this was placing pressure on the service in having to provide enhanced checks and social engagement to these 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.

Case study – Reablement client

> A reablement client admitted from hospital was required to undertake self-isolation under current care home COVID-19 guidance. The home was concerned as she had 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 her falls risk and increase the need for 15-minute observations from staff. Additional staff time supporting her social and psychological needs was also needed whilst isolating to prevent low mood and lack of motivation, which would impact upon the progress of the reablement purpose of her admission. Upon her admission RITA was used with her daily and she engaged with activities of her choice, The home manager reported that her mood remained good and that she enjoyed using RITA, engaging, and interacting well with it. She had no falls whilst isolating.

Benefits of RITA

- Although there were no direct cost savings identified using RITA, there were numerous benefits identified to residents' psychological wellbeing and engagement within the dementia and learning disability homes. This in turn indirectly improved physical wellbeing.
- During the summer RITA was used for group activities in the homes' garden areas. Some residents who were usually very reluctant to spend time outdoors now did so when engaging in RITA activities. This was a benefit to these residents as they were accessing fresh air and the benefits of being outdoors such as exposure to Vitamin D, which has many health benefits for older people.
- Armchair exercise has been very popular with residents across all homes and staff have found using the exercise content with residents very easy. They feel confident that they are leading such classes safely.
- Some residents living with dementia who would not engage in group activities were more likely to do so when RITA was connected to a large screen. Often these individuals would observe and then ask to join in; others who would usually wander off during activities stayed for longer periods of time.
- The activities have helped to reduce anxiety in some individuals. A resident with learning disabilities and epilepsy, who is very active and becomes very agitated and over-excited which increases the risk of a seizure, now engages daily with content on RITA such as the aquarium and safari. He will engage with this for several hours at a time and it has a very relaxing effect on him. He recently had COVID and self-isolated in his room using RITA, which reduced the risk to the residents of cross-infection. When he previously had COVID in early 2021, he refused to self-isolate and stay away from other residents during that period at all.
- Sensory and relaxation content has been used with residents who can become agitated and during end-of-life care. A resident was receiving palliative care and staff had observed that she was anxious and agitated. This did not appear pain related, and they were concerned that as she had full capacity and understood her prognosis that this was the cause of her anxiety. In addition to providing her with direct comfort and reassurance, they set up RITA in her bedroom using the sensory content when she was alone and found that this had a calming effect and reduced her agitation. This reduced the need for a one-to-one or having additional medication prescribed to relieve her anxiety.
- 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 to that individual. This has helped to reduce incidents between residents which could result in physical altercations.
- When completing capacity assessments, RITA has helped staff with to fully explore an individual's understanding by using visual and video content during questioning. Using the larger screen has helped individuals with cognitive and sensory impairments to engage with the assessment process.

- RITA has aided staff with new admissions 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.
- A resident with learning disabilities previously would spend most of his time in his bedroom and had to be encouraged to come out of his rooms for mealtimes. Often staff would find him asleep, and he refused to engage in activities in or outside of his room. Staff knew of his love of Western films, so they began showing these using RITA when he came down for mealtimes. Now this resident comes down for breakfast, mostly without prompting and asks if he can use the computer to find his favourite films. He spends more of his day out of his bedroom and he does not sleep through the day so much as he is downstairs using RITA. He is more motivated, has improved interaction with other residents and is less withdrawn.
- RITA has helped residents to form relationships and activity groups 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.

What was the shared learning?

- The use of RITA as digital engagement for residents did, in some circumstances, reduce pressures on staff with reduced need for one-to-one support or enhanced observations of residents, as it engaged residents' attention when staff were not present.
- RITA is very user friendly, and this appealed to staff who were unconfident and wary of engaging with digital media. One carer described it as 'idiot proof' and was amazed how easy it was to navigate. It has increased staff confidence in using digital platforms.
- RITA has improved the staff's communication process with residents as they have gained confidence using media to support residents.
- It has supported younger staff in relation to reminiscence that is meaningful for individual residents. For example, RITA was used during the Jubilee with residents to share their memories of the Queen. Younger staff, who do not remember 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 their personalised content.

Conclusions

Residents living with dementia, cognitive impairments and learning disabilities engaged the most with RITA. Its clear visual format held residents' attention and was user friendly for many residents.

The larger unit which is attached to a portable trolley was most effective and could be used anywhere; the smaller tablet was not as user friendly for some residents.

The pilot provision of units (one small and one large) per home did not enable homes to explore the maximum benefit for all residents within the home due to the use of units by specific residents, which limited the ability to explore RITA fully with all residents on an individual basis. Group activities with groups of residents using RITA were well received.

Staff have enjoyed using RITA with residents and trying new activities and interaction. It has helped some staff to think more creatively when interacting with residents and to engage in more meaningful activity with individuals. Being able to use the units and witness immediate engagement from residents quickly established to staff the benefits of RITA.

RITA has proved an ongoing supportive resource when residents are self-isolating, as some residents unfortunately may have to continue occasional periods of isolation due to COVID.

Whilst the pilot has not shown a decrease in numbers for key areas such as falls, it is highly probable that the use of RITA to engage or distract as described will have had a preventative benefit for falls and with managing behaviours which challenge.

Moving forward we have identified that the dementia care homes of Rivermead and Southway and the dementia unit at Puttenhoe would benefit from additional large trolley units to enable them to use RITA with more residents on an individual basis. This would be a total of seven units.

Further information:
https://www.bedford.gov.uk/news/2023/bedford-borough-care-homes-win-rita-awards

Central Bedfordshire Council

Digital – YCDIT! (You Can Do It!)

The programme of YCDIT! is delivered by Beds RCC and is a project which will redistribute smartphones and tablets donated by organisations to those currently unable to access digital health and social care resources because they do not own such a device.

Increasingly health and wellbeing services are providing a digital offer to people who can access the internet. This trend has been accelerated by the emergence of COVID-19 and more recently the cost-of-living crisis. For example, GP practices now routinely offer appointments via video link and offer more of their core services online, such as management of prescriptions. Other examples include a variety of apps and services aimed at maintaining and managing mental health. Whilst a number of these examples have been available for some time there has been a huge increase in their use by both providers and users in the last year.

Wider determinants impact the accessibility of a Wi-Fi connection or working device. We identified a lack of IT confidence from working age adults to older people. YCDIT! will offer light touch IT support to enable a resident to access email, open a browser and attend an online call.

What was put in place and how was the Better Care Fund used?

The funding from BCF has allowed us to offer new iPads with a protective cover. Market research indicated iPads are easy to use as they have a larger screen and flexible font size to support those with reduced vision.

The YCDIT! Coordinator identified the iPad recipients from our thorough holistic assessment of those who had signed up for the scheme. We advertised the offer of iPads through the Community Referral Social Prescribing service. These Community Wellbeing Champions work in a person-centred approach to improve the health outcomes of their clients.

What were some of the outcomes?

As the provider of Community Referral Social Prescribing, commissioned through our local authority, we were able to share the health inequalities identified in our work with residents across Central Bedfordshire.

In a collaborative approach the BCF funding gave additional resources to an existing programme.

Through the development of our Community Referral Social Prescribing service, a portal was created for residents and professionals to access services, including YCDIT! – see link below.

What was the shared learning?

- Following COVID-19 we saw a resistance from older people to join a community group for one-to-one learning. Through our programme we have reflected and adapted where we can meet the needs of our older population.
- Availability of reconditioned devices.
- Older people living rurally on a low income with no access to transport were unable to confidently use public transport due to its poor reliability.
- We received requests from working-age adults who wanted free one-to-one support with Word and Excel and who preferred not to join a funded class in a college. We continuously tweaked our promotion to clearly state what we offer support with.
- Our programme model requires volunteers with IT knowledge to offer their time to their local community YCDIT! Group. Volunteers are offered a comprehensive volunteer induction, training, and oversight from our coordinator. Volunteer morale has been a priority for this programme.
- Our existing relationships with the NHS, local authority, town councils and VCSE organisations have enabled us to reach vulnerable adults in need.

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Further information:

Improve your health and wellbeing – Your Wellbeing Bedfordshire

You Can Do IT – Your Wellbeing Bedfordshire

Our social media pages, linked with all partner organisations, regularly post about the offer: Bedfordshire Rural Communities Charity | Bedford | Facebook

We have posters in all libraries and public spaces as well as advertising in town and parish newsletters or on notice boards.

We have a direct telephone number for those not currently accessing online services.

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