What are we proud of?

directors of adass
adult social services
eastern region
connecting innovating improving

2024

East of England Adult Social Care

Foreword

I am delighted to provide a Foreword to the 'What are we proud of' document for the ADASS Eastern region. Too often, the narrative that surrounds adult social care is a negative one, with adult care described as 'broken' or 'collapsing'. Whilst significant challenges of course exist, it is important to acknowledge and recognise that local authorities, often working in partnership, consistently seek to innovate and do things differently to meet the challenges they and indeed their communities face. It is only by celebrating and crucially sharing best practice and innovation that some of the well-rehearsed challenges facing the sector can be responded to. This document brings together some examples of the work taking place and serves to highlight the valuable role ADASS East plays in fostering collaboration and learning across councils in the region.

There are some consistent themes in the examples local authorities have shared, these include:

- A focus on how **technology** can help people and their carers, for example Bedford's work on digital inclusion, or Hertfordshire, Norfolk, Suffolk, and Central Bedfordshire Council's work on assistive technology.
- A strong focus on **coproduction** and ensuring those who receive care and support are in control of shaping the design, commissioning and delivery of those services. This ranges from excellent practice examples on coproducing plans with individuals in Thurrock, Norfolk's strategic work on an ethical framework, the Real Care Deal to Suffolk's work on supported self assessment.
- There are lots of examples of best practice that either focus on **unpaid carers** directly, for example in Thurrock, or indirectly support carers, for example through assistive technology or through work on improving transitions in Milton Keynes.
- Strong **integration across health and social care**, for example Cambridgeshire's work on supporting older people to remain independent at home, or Thurrock's locality-based model.
- Finally, councils' duties to **shape care markets and commission** responsibly are reflected in case studies from Essex and Southend, that focus both on providing support for providers now, as well as coproducing strategies for the development of the care workforce in the future.

It is great that colleagues across the region have agreed to provide lead contact details to allow for in-depth and rich conversations to take place between local authorities to learn more.

Finally, I would like to thank the members of the ADASS East team and all the contributors for their work in bringing together such a valuable, practical and insightful document.

Chris Badger

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

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Coproduction and strength-based approaches

Photo: Centre for Ageing Better

Hertfordshire County Council

The Hertfordshire Sensory Strategy

The vision of the Sensory Strategy is to provide services of excellence to support deaf, deafblind and sight impaired people of all ages to be independent, to have choice and control, and to participate fully in society.

The Hertfordshire Sensory Strategy has been developed in partnership with the residents of Hertfordshire with sensory needs in response to the statutory duties as defined in the Care Act 2014 and Children's and Families Act 2015. Several national strategies have highlighted the need to work preventatively with people who have sensory needs, and this strategy is also aligned with Hertfordshire County Council's social work assessment framework, Connected Lives.

The inequalities faced by people with a sensory need are widespread, and include challenges in healthcare settings where communication is not accessible, access to employment and job opportunities, and the everyday barriers faced in the community and at home. In many of these cases these are not preventable but are leading to worse outcomes for the resident and increased costs when minor needs become more complex. For example, where a deaf resident is unable to access their General Practice (GP) surgery, they may put off receiving early treatment, resulting in visits to Accident and Emergency after the condition has worsened.

The headline facts around sensory inequalities:

- One in six people are deaf or hard of hearing, and 1 in 30 have a visual impairment. This equates to 38,900 (3.25 per cent) of people living with sight loss, and 204,100 (17 per cent) living with hearing loss in Hertfordshire.
- In 2022, it is estimated that there are over 450,000 people in the United Kingdom (UK) who are deafblind. This is expected to increase by 25 per cent to over 610,000 by 2035.
- Seventy-seven per cent of people with accessible information needs rarely or never receive information in alternative formats.
- A third of health and social care providers were unaware of the existence of the National Health Service (NHS) Accessible Information Standard.
- Eighty-one per cent of people who use guide dogs experienced an 'access refusal' in 2021/22. This includes restaurants, retail, public transport and even healthcare settings.
- Only 17 per cent of people experiencing sight loss are offered emotional support in response to their deteriorating vision.
- More than four in ten people attending low vision clinics are experiencing symptoms of clinical depression.

The Sensory Strategy aims to work with partners on wider system improvements, aligning work with that of the Health and Wellbeing Strategy and Hertfordshire and West Essex Integrated Care Strategy.

The Sensory Team brings together partners from across the health, social care, voluntary and community sector and employers with residents' views fed into each area of work.

The focus of the strategy was coproduced with residents, with action plans focusing on the four key areas of equality:

1. **Health –** focusing on health inequalities, deaf mental health, implementation of the NHS Accessible Information Standard and accessibility of primary care.
2. **Employment –** Working with Department of Work and Pensions (DWP) to support more residents with a sensory need into employment, working with employers in Hertfordshire to raise their awareness of sensory needs, and increasing the number of employers on the Disability Confidence Scheme (DCS)
3. **Children and families –** Linkup with Children's Services and the support for children and families where there is a sensory need present. Looking at the transitions pathways into adulthood, sensory awareness for the social care workforce and wider opportunities for children with a sensory need within the Short Break Local Offer (SBLO)
4. **Home and community –** Linkup of social care and community providers to improve support, access to assistive technology, an ongoing programme of community engagement, contract monitoring of commissioned providers and access to information.

Separate workstreams focus on each area of inequality, with a strategic leader chairing each to drive change. The Sensory Partnership Board sits above these workstreams; this provides a strategic linkup between relevant stakeholders across Hertfordshire Council, Herts, and West Essex Integrated Care Board (ICB), local and national sensory needs charities, as well as experts by experience. They monitor progress of the strategy, as well as keeping a check on emerging areas of focus and national issues. In recent months, this has included the proposed closure of ticket offices in train stations and the impact it would have on residents with a visual impairment.

The strategy was launched at a public event in February 2020. Unfortunately, due to the Covid-19 pandemic, the strategy was paused as colleagues responded to the lockdowns and increasing pressure on services. While the pandemic paused work on the strategy, it also highlighted the need for such work. The increased use of face masks made communication more challenging for deaf and hearing impaired residents who lip-read, and a lack of British Sign Language (BSL) interpreters at government briefings on Covid meant many found they were being excluded from these updates. For those with visual impairment, both social isolation and rates of depression were found to have increased during the pandemic. In 2021, work on the Sensory Strategy resumed, and in 2022, it was extended to December 2024. This was accompanied by an updated action plan to further address sensory inequalities in Hertfordshire.

The focus, action plan and strategic priorities of the Sensory Strategy were coproduced with residents during the development stage, with ongoing engagement with residents and organisations that provide support, and this was a key part of the work. Regular attendance at deaf and blind clubs and community groups has given residents an ongoing

opportunity to shape the work of the strategy. Specific action plans are developed as a result of these visits, while the feedback from each group feeds into the wider understanding of the priorities for residents with a sensory need. There was also work with local charities to ensure all voices are heard, and the strategy workstreams provide forums for this feedback or challenges to be shared and acted on. Larger engagement events like the 2023 sensory conference brought together all agencies involved in the strategy and residents with a sensory need, helping to bridge the gap between the groups and foster the common goal of addressing sensory inequalities.

For example, an emerging issue for residents with a visual impairment was the challenges faced with highways and transport, the accessibility of the bus network and staff awareness, challenges with continuous crossings, pavement parking and the use of E-scooters. All of these have an impact on the independence of residents and knock-on effects that can make accessing hospitals or healthcare more challenging. Following discussions at Sensory Board, a task/finish group with visually impaired residents and highways and transport colleagues was formed to address these issues. Coproduction of the design of continuous crossings took place, with changes such as increased use of tactile paving and non-flush dropped curbs introduced to improve accessibility, and a recommendations paper for long-term improvements developed to address wider concerns. This gave visually impaired residents a direct say in what changes are needed to improve accessibility and maintain their independence.

What were the barriers to success?

- Limited awareness of sensory needs and the best practice to support residents, and statutory duties under the NHS Accessible Information Standard and Equalities Act. The size of the workforce across health and social care has made increasing this awareness challenging.
- Lack of accessible information in British Sign Language or audio for residents with a sensory need can limit their awareness of support.
- Covid-19 impacted the delivery of the strategy (launched in 2020), with agencies prioritising their response to the pandemic in the early years. Maintaining the buy-in of all agencies involved in addressing sensory inequalities is an ongoing challenge.

What were the conditions for success?

- Consistent implementation of the NHS Accessible Information Standards across health providers, with examples of residents' accessibility needs being met.
- Measurable increase in staff awareness of sensory needs across health and social care
- Increased availability of public information in accessible formats – British Sign Language and audio versions.
- Improved linkup between adults' and children's social care teams, charities, health and commissioned providers.

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Milton Keynes City Council

Supported accommodation and coproduction

Using the 'Working Together for Change' methodology to shape the recommissioning of Mental Health Supported Accommodation.

Milton Keynes is recommissioning its Mental Health Supported Accommodation and requires input from people with lived experience throughout the process. This is necessary to make sure the new service reflects what is important to people during their recovery.

The Council used the 'Working Together for Change' methodology to look at what was working well, not so well and what was important for the future.

Over two days in September 2023, 25 people came together to listen to what people living in Mental Health Supported Accommodation had said about what was important to them and to discuss how we could work together to use this valuable information to improve lives and inform the commissioning of local services. The group was a mix of people with lived experience, operational staff from adult social care and carers.

The coproduction will be ongoing; the council has had a session where feedback on what should be included in the service specification was discussed, and people with lived experience will take part in the evaluation of the tender bids.

The following outcomes will be included in the service specification:

- People feel supported through recovery, with well managed change. (I Statement: When I move between services settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements in place. I feel safe and supported to understand and manage any risks.)
- People who use Mental Health Supported Accommodation to be able to access the community, which was a key theme from coproduction (I Statement: I feel welcome and safe in my local community and can join in community life and activities that are important to me.)
- People move towards independence during recovery. (I Statement: I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals. I can live the life I want and do the things that are important to me as independently as possible.)

What were the barriers to success?

- Not everyone consented to being interviewed.
- The process was time consuming.
- Lack of trust between Milton Keynes City Council and people with lived experience.

What were the conditions for success?

- **Preparation –** the council interviewed people with lived experience to gather feedback to be used prior to the event and started building trust with them. The council was clear how such feedback was to be used and how people would be compensated for taking part.
- **Communication –** it was important that everyone at the two-day event knew what the council was trying to achieve, and that people will be kept informed of the next steps and how their input is being used.

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Norfolk County Council

The Real Care Deal (Norfolk's Ethical Framework)

A set of principles and standards that sets out working together across Norfolk.

The development of an Ethical Framework was one of the recommendations from the Safeguarding Adult Review (SAR) into the tragic deaths of three young people, Joanna, Jon and Ben at Cawston Park Hospital.

The SAR report exposed multiple serious failures in a service where the provider was paid significant sums of money to provide specialist and quality care that Joanna, Jon and Ben did not receive. The issues exposed in the inspection point to a lack of transparency in relation to where public funds are spent. The SAR recommendation was for the Council and the Integrated Commissioning Board (ICB) to develop an ethical commissioning framework structured around an ethical vision, transparency, ethical employment, localism and tax compliance.

Norfolk County Council and the ICB set about working with people with lived experience, providers and staff working in the adult social care sector to develop a set of principles and standards that would set out how everyone would work together. The framework is a coproduced approach to the commissioning and delivery of quality services, guided through agreed principles and ongoing engagement with people with lived experience. The framework will inform the strategic direction, how to do business and how people can influence decisions being made. The aim is to deliver high quality, responsive and tailored services to the local population.

The initial scope for the framework was learning disability and autism services, however, the principles and standards apply to all sectors so the expectation is that there will be whole-system adoption and roll out.

Norfolk County Council commissioned a Community Interest Company, Curators of Change, to work with people who access care and support, providers and staff working in the adult social care sector to coproduce the framework.

From the sessions and stories, key themes were collated which informed a principle which would best fit. Many of the principles were not new, such as 'no decision about me without me' and most had been around for a long time, so it was sad to hear from people that these were still not being consistently delivered.

People told the council that the most basic requirement is that we all behave in ways that are more human; get this wrong and no number of policies and procedures will deliver the outcomes that we all want to achieve.

The framework was shaped by a core group of experts by experience to ensure it was more accessible. It was clear from feedback that few understood what an ethical framework meant. The experts therefore got a group of people together to make the framework more accessible and understandable and so the 'Real Care Deal' was born.

The next steps are as follows:

- To secure funding to continue to carry out the work.
- Work with organisations in the development of service/organisational delivery plans which are then reviewed and supported by the learning process.
- To develop a set of learning and development materials that can be used to induct new staff and be part of mandatory training.
- To develop an online learning and development tool/platform.
- To establish a coproduction group/network to support the ongoing coproduction work in Norfolk.
- To design and develop a website that will support a continuous feedback loop to inform future commissioning activities. This has the potential to be developed into a live local account.
- To develop a lesson-learned policy to support a learning culture rather than a blame culture as this was a key theme that came out from coproduction events.
- Work with the Norfolk Care Association to identify how best to support providers to achieve positive cultures within their organisations as this not only improves service quality, staff and client experiences but should also help with the recruitment and retention of staff.

The experts have been busy and have developed a draft mock-up of what the website could look like including a poem, written by one of the experts supporting the work, and what the principles might look like which focus on the principle, aspiration, sub-principle and delivery actions.

What were the barriers to success?

- Many people asked how this will be different? There have been lots of promises made in the past, so people felt it was unlikely to change.

What were the conditions for success?

- Need to continue to build trust through being open, transparent and to provide regular updates on a 'you said, we did' approach.

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Thurrock Borough Council

Coproduction of an unpaid carer's strategy

Ensuring we listen to the voices of carers.

The pandemic highlighted what was working well for unpaid carers, but also what areas of improvements were needed. Multiple issues needed to be addressed:

- Post-pandemic there was a 100 per cent increase in the number of carers requesting support, yet many carers were still unknown to social care.
- Some carers are not open with the local authority about the difficulties they encounter in their caring role for fear they will be judged as not coping.
- Some carers are concerned about raising issues regarding the quality of the services they receive for fear they may not be able to continue to access them.
- Any further strategy needs to capture the needs of carers unknown to formal services/health and social care system, i.e. needs to ensure the council is not still capturing the voices of people already in the system, otherwise we will never understand the barriers to accessing support.
- The transition of carers between adults' and children's services and health and social care needs to be improved.

To address this, the council developed an all-age carers strategy that addressed the needs of both adult and young carers. They subsequently also agreed for the strategy to be a joint health and social care strategy.

The council wanted to ensure people who use services feel safe and to be completely honest about their experience of caring, the support they receive and to be able to express what was working well and not so well and what needed to improve. As such the council felt it was prudent to seek someone outside of the council to carry out the engagement.

Although young carers' and adult carers' support services were best placed to represent carers, the council felt it needed an organisation who would be independent of all existing carer support services (including internally provided social work support and carers short-break service) so that they could capture the true voice of unpaid carers in Thurrock. Healthwatch Thurrock was therefore engaged to carry out the work on the council's behalf.

The engagement exercise was comprehensive, over a long period of time and used a variety of mechanisms to engage, including school assemblies, social media, requesting that people who were new to caring (identified by social prescribers) kept a diary, public meetings, community events, videos and interviews, etc.

This exercise was so successful in capturing the voice of Thurrock carers that the Health and Wellbeing Board agreed to accept the evaluation report as the basis of the all-age strategy. It was felt that the voice of Thurrock carers was so strong in the report that any attempt to formalise the findings into a traditional strategy would dilute the voice of carers and what they felt was important locally. It was agreed that an action plan would be developed and that this, in conjunction with the Healthwatch report, would form the 'strategy' for carers in Thurrock.

The council is proud of its approach as the actions that have been taken are genuinely shaped by all carers in Thurrock, regardless of age and whether they are known to statutory services or receive formal support. We are also proud because these documents act as a conduit for the voice of Thurrock carers. The documents reflect the reality of carers in Thurrock and what they see as a priority, rather than the views of professionals, and clearly demonstrates the council's commitment to coproduction.

Examples of outcomes and impacts:

TLAP, We Statement	Outcomes and impact
We have conversations with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments.	Our strategy truly reflects the voice of all carers in Thurrock. The actions that have been identified in the plan are what matter to carers rather than professionals, from accessing a wider training offer to improved contingency planning.
We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person.	We have moved away from separate social care young and adult carers strategies and have reflected carers' wishes about better joined up working by developing an action plan that encompasses health, adult social care, children's social care and education. We are hoping to reflect this in a refreshed 'No Wrong Doors' Memorandum of Understanding and have bid for accelerated reform funding to enable a more holistic approach to the identification and support of carers across health and social care.
We work with people as equal partners and combine our respective knowledge and experience to support joint decision-making.	As well as contributing to the Healthwatch report, unpaid carers and professionals worked together to develop the action plan that will shape the future of information, advice and support to carers in Thurrock.

What were the barriers to success?

- The main barrier is often the identification (including self-identification) of carers.
- There was still a significant concern from many carers about any group work/events post Covid.
- Historically there has been a barrier to people sharing feedback about existing services if they had a reliance on receiving them.

What were the conditions for success?

- External appointment of an organisation that was not linked to the services carers received. This gave carers the freedom to identify required improvements in existing services without fear of repercussions; it also enabled the council to feel secure in its assumption that the current (young and adult) carers services were valued and providing a good service.
- A variety of engagement mechanisms that worked for different carers, both digital and in person.
- A lengthy/flexible engagement period that could adapt to circumstances (post-Covid this included additional one-to-one rather than group work if face to face) and being able to take advantages of different opportunities (community events, school timetable etc.). This meant including carers not known to services and resulted in people self-identifying as a carer and seeking support during this process.
- The anonymity of the carers to the statutory services commissioning the evaluation meant that carers could be open and honest about required improvements.

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Suffolk County Council and Suffolk and North East Essex Integrated Care Board

The coproduction of the Suffolk Dementia Strategy

The vision of the Suffolk Dementia Strategy is to create a society without stigma, where people with dementia feel safe in the knowledge that responsive services are based on an understanding of their needs and are empowered to access information, advice, guidance, and support which is readily available whenever they or their families need it.

The Suffolk Dementia Strategy has been heavily informed by the Healthwatch Suffolk Dementia Report 'A roundabout without signposts': People's experiences of dementia in Suffolk – Healthwatch Suffolk, which was commissioned to find out the experiences of people living with dementia and their carers in accessing and receiving support.

The strategy has been coproduced and developed with people across Suffolk which supports the vision and outcomes within the National Dementia Strategy 2009. In May 2022, the Health Secretary announced that there would be a 10-year plan for dementia. This was replaced in 2023 by the Major conditions strategy: case for change and our strategic framework. The strategy also considers the legislation and guidance included in the Care Act 2014, the NHS Long Term Plan and National Institute for Health and Care Excellence (NICE) guidance, Dementia: assessment, management and support for people with dementia and their carers 2018.

These strategic government documents recognise the projected increase in prevalence and the need to focus on dementia diagnosis for all ages, highlighting the importance of ensuring that people who have dementia, their carers, families and friends receive the highest quality of care and support. This includes the importance of early identification, support, advice and information. However, dementia remains a terminal condition with no current cure. Until there is a significant shift in the way that dementia is diagnosed, viewed and resourced, it will continue to negatively impact upon outcomes and experiences of people with dementia, their carers and families and the health and social care system.

Suffolk is predominantly a rural county and has a population of 760,700 (reported at the time of the 2021 Census) with approximately 305,000 people living in areas classed as rural. People living in more rural areas often find transport options more limited (such as infrequent public transport, or having to rely on expensive private transport), meaning access to key services is more difficult.

Adult populations (aged between 16 and 64 years) account for 59.3 per cent, lower than England estimates (63.2 per cent). 23.6 per cent of Suffolk residents are 65 years or over, higher than the England average (18.6 per cent).

In Suffolk:

- 2021/22 aggregated GP level data indicates 7,450 people of all ages and registered with a GP were recorded as having dementia: 0.9 per cent of the population, statistically significantly higher than England (0.7 per cent).
- October 2023 data is available for dementia estimates in those aged 65 and over. This indicated that 7,427 people aged 65 and over were recorded as having dementia, but that 13,016 people were estimated to have dementia in this age group. This equates to a diagnosis gap of 5,589 people
- 'Young' onset dementia data is currently only published at sub-ICB level, making it difficult to understand the true number of people with a diagnosis who are younger than 65 as there continues to be a focus nationally on those with a dementia diagnosis over 65 and above.

The dementia diagnosis rate does not take into consideration anyone diagnosed under 65 years old or who has mild cognitive impairment, so the true picture of dementia in Suffolk is currently unknown.

Between September 2022 and February 2023 Healthwatch Suffolk undertook extensive stakeholder engagement with people with dementia, their carers and families across Suffolk. In total Healthwatch Suffolk collected 156 people's experiences in three ways, including 19 in-depth interviews with carers, families and the person with dementia, 100 feedback forms and 28 comments from the feedback centre.

People were asked to share:

- their experiences of accessing health and care services, including getting a diagnosis, and care received in hospital, at home or in a care home
- what sources of information and support they had found useful and what was missing
- what they would like people to know about what it is like having dementia or caring for someone with dementia
- their understanding of 'dementia- friendly communities' and what is needed to make a community 'dementia friendly'

In addition, carers were asked about the support they had received in their role as a carer of a person with dementia.

Between November 2022 and June 2023 further engagement and coproduction sessions were held across Suffolk involving people with dementia, their carers and families, health, social care professionals, stakeholders and the voluntary community and faith sector.

This included the following:

- **Dementia marketplace event:** coproduced with people with lived experiences and the voluntary, community and faith sector, providing resources, information and advice for those with dementia and their families across Suffolk.
- **Dementia roadshows (8) across Suffolk:** roadshows were held to ensure that people in rural locations could access resources and information, as well as sharing their experiences of dementia.

- **Dementia groups (16) and awareness sessions (8) across Suffolk:** these were held to ensure that those with dementia and their families who are currently accessing services and support were able to share their experiences.
- **Gathered feedback from over 152 people from 48 organisations either in person or virtually:** to ensure that the people of Suffolk had the opportunity to share their experiences and have them included in the strategy.

From these co-production sessions, consistent themes emerged around communication, information and advice, support, carers, training and education.

As a result of the views expressed, the strategy follows the NHS England 'Well Pathway for Dementia': Preventing Well, Diagnosing Well, Supporting Well, Living Well, Dying Well.

From this coproduction key priorities and outcomes were agreed through this strategy:

- **Preventing Well:** raising awareness, understanding and information.
- **Diagnosing Well:** improve assessment and diagnosis.
- **Supporting Well:** increased need as symptoms develop.
- **Living Well:** providing support for people with dementia and their families.
- **Dying Well:** having the opportunity to prepare for end of life.

The Suffolk Dementia Strategy was agreed and signed off at the Health and Wellbeing Board on 14 March 2024, with the final graphic design version of the strategy due to be launched during Dementia Action Week 13-19 May. As well as sharing the Dementia Strategy there will be a spotlight on each of five priorities and outcomes each day of that week, sharing national and local advice, support and training from those with lived experiences, professionals and the voluntary, community and faith sector.

Throughout the development of the strategy there has been regular attendance at community dementia groups across Suffolk to ensure that the voice of those with dementia, carers, families and services that support them can continue to discuss the priorities and outcomes of the strategy and what is important to them in their local area.

Between May and July 2024 further focused engagement and coproduction sessions will be held across Suffolk involving people with dementia, their carers and families, health, social care professionals, stakeholders and the voluntary community and faith sector to coproduce the dementia action plan which will inform statutory health and social care organisation in partnership with voluntary, community and faith groups.

What were the barriers to success?

- Lack of free training for professionals within health and social care, voluntary and the wider statutory sector to recognise the signs of dementia and how to support them.
- The churn of and lack of workforce across health and social care has made increasing this awareness challenging.
- Stigma of a dementia diagnosis and feeling isolated by the condition.
- Challenges to access primary care for an appointment to review memory.
- Long wait lists for assessment at the memory clinic.
- Increase in digital self-referral for older people can be a challenge.
- Carer burn out, lack of respite care and support, especially if self-funded.
- Access to information and support for people of all ages who are concerned about their memory or have a diagnosis of dementia (including carers, families, and friends) at a time right for them.

What were the conditions for success?

- Increased awareness of dementia for all in the health and social care workforce – Alzheimer's Society, Dementia Research, Dementia UK sites.
- Increased awareness of the 13 modifiable risks to help prevent dementia and other health conditions.
- Ability to access information, advice and support in one place.
- Access to all dementia services and support across Suffolk, including how to create dementia-friendly resources.
- Health and social care premises to become dementia friendly, with an ambition to extend to the wider community.
- Improve partnership working between statutory health, social care, providers and voluntary, community and faith sector.

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Suffolk County Council

Supported self-assessment (Adult and Carer) co-production and engagement

From May 2023, Suffolk County Council and several organisations worked alongside adults and carers with lived experience, to develop a supported self-assessment offer. Suffolk County Council had purchased an off-the-shelf solution from a company called Imosphere but wanted input to develop this further.

Suffolk County Council (SCC) wanted to ensure development of an adult and carer supported self-assessment offer was coproduced with adults and carers with lived experience to guarantee the tool was easy to use and accessible to ensure maximum usage.

SCC purchased a supported self-assessment tool for adults from Imosphere. This was developed to support potential demand from the now delayed charging reform. More importantly, though, it was created to improve access to adult social care (ASC), placing the individual truly at the heart of the assessment process and provide greater control and flexibility when completing an assessment. SCC also wanted to mirror the offer for carers, so set out to design a supported self-assessment tool they could access.

While the form was purchased as an off-the-shelf solution, coproduced with several local authorities and adult and carers with lived experience, SCC were keen to engage with several groups of people accessing care and support to seek their feedback and views on how the tool could work for them and any alterations which were required. With that in mind, the council developed a coproduction plan with several organisations.

From May to July 2023, SCC met virtually with four organisations (ACE, Social Work Voices, Suffolk Family Carers and Suffolk User Forum), where the relevant supported self-assessment was demonstrated and sought their feedback. SCC also sent them links to access the forms online. Feedback was collated and used to develop the forms to create a user-friendly, strength-based tool.

SCC also attended several events, including one during Carers Week, to showcase the forms and use further feedback to aid development. The council also met with several adults from ACE to hold a testing session, where they accessed the adult supported self-assessment via a laptop or tablet, with one person using a screen reader, to test functionality.

This work enabled SCC to identify how to make the tool more accessible and user friendly and included:

- using plain English throughout
- creating useful guidance text and examples
- rearranging the order of certain sections to aid flow

- including key details about the purpose of the assessment and the overall process to manage expectations
- a separate section on mental health and its impact on the individual and others
- a 'celebrating what you can do' section
- the chance to test accessibility across a range of devices and tools.

Examples of outcomes and impact:

- Carers supported self-assessment went live on 30 October 2023 and adults on 5 February 2024 and to date SCC have received 2,297 portal visits and 230 carer self-assessments submitted from carers and 1,344 portal visits and 149 adult self-assessments submitted from adults.
- SCC have received the following feedback from their carer organisations: 'Carers like having the flexibility to complete the tool at a time convenient to them.' 'They like being able to access a tool to contribute to their assessment.'
- SCC have also reviewed the early data and noted the majority of carer self-assessments tend to be in the evening and early hours of the morning. Also, a high proportion are completed within 1.5 hours of being opened.
- It is too early to feedback on the adult self-assessment as this went live in February 2024.

What were the barriers to success?

- Virtual communication could be a challenge when demonstrating the tool.
- People tended to focus on the 'system' and challenges they had historically faced, which, while important, took away focus on the task.
- Concerns about people using digital tools and removal of human interface.
- Engagement – SCC would have liked to have had more people involved, for example, carers in employment struggled to take part.

What were the conditions for success?

- Virtual communications enabled the council to reach a greater number of people.
- Working with a range of groups, with varying needs helped the council to get a real breadth of feedback and views.
- Forging strong relationships – the council was able to build better connections than they had before.
- The council were asked to remain involved in the project, which was positive.

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Thurrock Borough Council

Empowerment and control for people

Empowering Mrs A to be involved in and make choices about her future accommodation and care.

Mrs A, a 71-year-old lady had suffered a significant stroke and this had left her with left-side paralysis, requiring her to be cared for mainly in bed and reliant on full hoisting for transfers. Mrs A had also been diagnosed with dementia and at times becomes confused and forgetful.

Mrs A was married and had other family members including her adult children and sister. There were difficult family dynamics and Mrs A's husband and her daughter did not agree on what was in her best interests.

Mrs A had nursing needs and was living in a nursing home out of area but close to her children. Her husband still lived in the funding authority area and was only able to visit her a maximum of three times per week due to the distance and his work commitments.

Prior to her moving into nursing care near to her daughters, Mrs A's husband had previously had support at home to try and care for Mrs A, but this was unsuccessful and there was a history of safeguarding concerns in relation to his care of her.

There were concerns raised by Mrs A's daughters about the relationship between Mrs A and her husband, stating that there had been previous domestic abuse that she had forgotten about following her stroke and due to cognitive decline in line with her dementia diagnosis.

Mrs A expressed a wish to move back to her original area, closer to her husband, but her capacity over her care and support needs were being questioned.

Mrs A's case was transferred from a community social work team to a specialist social work team due to complexities in her needs, complexities with family dynamics, prior safeguarding concerns and potential risks, as well as the long-term nature of the social work intervention required.

It became apparent that Mrs A's voice was being lost amongst more dominant opinions from family members. Mrs A was subsequently referred to formal advocacy services. Mrs A was consistently saying to social workers and advocates:

'I want to move so that I can be closer to my husband ... I'm happiest when he visits me, he holds my hand and sings to me. He is my love. I won't give him up even though they [other family] want me to ... I want to see all my family, but it would be good if there are set times when they come so that they don't come at the same time. It upsets me that they argue all the time ... I just want peace.'

Mrs A was formally assessed as lacking capacity with her care and support needs. Several meetings were held with the best interest group, including family members, to try and come to an agreement about what was in Mrs A's best interests. It became clear that family members could not agree.

Support from the legal team resulted in an application to the Court of Protection to make formal decisions in Mrs A's best interest. Further capacity assessments were undertaken. Despite lacking capacity, Mrs A was able to tell professionals clearly and consistently her wish to move from her current home closer to her husband and to spend more time with him. The rest of the family remained concerned, wanting her to remain near to them.

Social workers explored possible options that would align her wishes with what would be in her best interests. This included involving Occupational Therapy to look at a number of options:

- the possibility of her moving back home to be with her husband with the addition of formal care
- 24-hour residential care with nursing support nearer her husband or in areas between the two locations
- private tenancy with 24-hour support
- facilitating more home visits to monitor care and support.

What happened?

- Multiple professional meetings were arranged to discuss options with the best interest group.
- Risk assessments and cost/benefit analysis were completed by the social worker.
- Mrs A was kept informed with regular visits and contact with her advocate.
- Visits were arranged for Mrs A to see two viable accommodation options. This involved arranging ambulance transport due to her mobility restrictions.
- Ultimately Mrs A chose her favoured option, and the court agreed this was in her best interests.
- Mrs A moved to a nursing home with 24-hour care near to her husband. This enabled her husband to visit her every day, often up to three times a day fitted around his work.
- Sadly, Mrs A passed away due to ill health a year later. However, before she became unwell, during her last review meeting, she reported:

'Now I get to see my husband at least three times a day which is wonderful. When I lived at [previous home] there would be days where I didn't see anyone other than staff and spent so much time in my room that it got very lonely and boring ... husband is my love, he sings to me, we talk or just spend time being together. I am really happy that I have been able to move closer to him so that I can see him much more. I don't need to worry so much about him either.'

The council coproduced and provided as much self-directed support as possible by undertaking the following:

- Listening to the views of Mrs A, her daughters, her husband and those involved in her care to establish the different views and opinions.
- Ensuring that all those that Mrs A felt were important in her life had input into the discussions. This was often challenging due to conflicting views, however, multiple meetings were arranged in attempt to mediate and keep everyone involved.
- Ensuring that Mrs A had a formal advocate to support her to have a voice amongst the different views of her family members. This ensured that her voice was heard and remained at the centre of the discussions.
- Having conversations with Mrs A about what a good life looked like to her. This was being able to see her husband more often despite the historic concerns and balancing this with consideration of risk and the mitigating/protective factors of being in a 24-hours supported environment.
- Consideration of her human rights (Article 8) in terms of her right to respect for her private/family life.
- Consideration of Mrs A's strengths, which she felt was her happiness in her relationship with her husband and the time they spent together.
- Working collaboratively with Mrs A to protect her opportunities to make her own choices about her health and wellbeing, balancing this with consideration of mental capacity and empowering Mrs A to be as involved as much as possible in decisions about her life.

A number of I/We Statements were considered along the journey:

'I want to move so that I can be close to my husband, I am happiest when he visits me.'

'We will support you to look at all the future options of accommodation and support nearer to your husband.'

> **Impact:** 'I am really happy that I have been able to move close to him so that I can see him much more.'

'I want to see all my family, but it would be good if there are set times when they come so that they do not come at the same time. It upsets me that they argue all the time … I just want peace.'

'We will work with you to create a visiting schedule and talk with your family to make sure it is clear and suitable for all parties.'

> **Impact:** 'I am much happier now that my family are not arguing around me.'

'I get bored at times and would like to do some more activities such as crafts, learning to play the piano or flower arranging.'

'We will consider this as something that is important to you when exploring options as to where you live. We will liaise with the care home to ensure that they are offering meaningful opportunities to take part in activities in which you are interested.'

> **Impact:** 'I will feel less bored and be able to take part in things in which I am interested. I will be happier.'

What were the barriers to success?

- Communications between family members, willingness at times for them to be part of the same discussion and best interests' meetings.
- Strength of disagreement between family members in terms of the visiting schedule and not always sticking to the agreement.
- Distance – Mrs A lived out of area, initially making it more difficult to have repeated and frequent face-to-face conversations.
- Complexities around her mental capacity.
- Court of Protection process was time consuming.

What were the conditions for success?

- Giving Mrs A options that she could visit herself so that she could give her opinion and be involved in the decision-making process.
- Listening to all family members and mediating in order to bring the focus back on to Mrs A during disagreement.
- Looking at Mrs A's strengths and views and coproducing her care and support plan with her.

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Bedford Borough Council

Developing skills in everyday maths

Improving maths skills for people who have a learning disability as a route to employment.

People who attend a day service at Gadsby Street Centre for Independent Living as part of their daytime activity lacked skills and confidence because of their existing skills levels in maths and money management. This also made them reliant on others to manage their money and live within their financial means. Exploring the needs of people who would like to volunteer or take up paid employment led to the realisation that one of the main barriers was a lack of confidence in relation to money management and basic maths skills.

This lack of skills and confidence has limited people's ability to access opportunities independently and prevents full participation in community life. The difficulties of understanding numbers and finances affects other areas such as reading bus timetables and managing finances to support travel and lunches whilst working.

Skills for Life, the Bedfordshire Skills and Employment Academy, Bedford Council and Central Bedfordshire Council have developed a course called Multiply that is aimed at helping people to improve their maths and money management skills. Multiply is a government-funded programme to improve adult numeracy skills in order to support employment opportunities, confidence with money and living independently. Central Bedfordshire Council has partnered with Bedford Borough Council to deliver free maths courses to upskill residents aged 19 and over, who do not currently hold a GCSE or equivalent maths qualification at grade C/4 or above.

The Multiply course helps to build confidence in:

- saving money and shopping for less
- borrowing money and loans
- understanding entitlement to cost of living support
- supporting children with homework
- practising useful skills through crafts and games
- useful number skills for tasks in everyday life
- achieving a maths qualification.

As part of the development of supported employment the council worked with Mike Darby, Skills Officer from Economic Growth and Development, Bedford Borough, to explore appropriate learning opportunities that could be delivered to adults with learning disabilities or autism.

Tutors from Bedfordshire Employment and Skills Academy (BESA) now deliver the Multiply courses to twelve learners onsite at Gadsby Street, as people are familiar with the site and feel comfortable there. The course content is built into the weekly timetables of individuals to enable staff to support their learning and ensure that it is delivered in a person-centred way that supports individual skills improvement. Courses have been facilitated intermittently over the past year. The tutors are very creative and ensure that each lesson is delivered in an inclusive and fun way to accommodate all learning abilities and styles.

Each learner was individually skills assessed at enrolment and was re-assessed at the end of their course. The curriculum lead from BESA will be providing an overview skills assessment for the learners to demonstrate measurable outcomes and skills development so far. Confidence with maths is growing and as a result, two learners have secured new supported employment voluntary placements in local shops.

Working in partnership with colleagues elsewhere in the Bedford Council Economic Development Unit led to further exploration of courses or tutors that could help with this issue.

Examples of outcomes and impact:

- Courses have been tailored to meet the needs of people attending and so far, two participants have obtained jobs in local shops in the town centre.
- Learners have reported they feel more confident with numbers in areas such as reading a bus timetable while independently travelling and planning lunches.
- Learners have reported a greater understanding of their finances and the impact of the cost of living. They have been able to demonstrate financial planning and savvy shopping.

One person reflected, 'The highlight of my week is when I know we have Multiply maths sessions. It makes me feel good learning maths in a creative way and makes me want to learn more! Making the bee hotel I learnt about measurements and volume and circumferences. Maths is inspiring me.'

What were the barriers to success?

- Overcoming a lack of confidence, low self-esteem and fear of maths due to learning disabilities.
- Not having opportunities to access and manage own finances in order to develop finance skills.
- Not understanding the financial impacts of cost of living increases and how to use maths while looking for cost-efficient alternatives.

What are the considerations for success?

- Learners feel more confident and able in a workplace setting, improving their employability.
- Learners demonstrate understanding of finances to plan a meal.
- Learners feedback that they are enjoying learning maths.

Further information:

www.bedford.gov.uk/business/invest-bedford/employment-and-skills/multiply-building-confidence-everyday-maths

www.bedford.gov.uk/media/6732/download?inline

https://find-employer-schemes.education.gov.uk/schemes/multiply

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Milton Keynes City Council

Navigating adulthood: A fresh approach in adult social care

How the Working Age Adults Team are supporting young adults during pivotal life stages and recognising their unique strengths and aspirations.

The team within Adult Social Care plays a crucial role in supporting young people as they transition into adulthood. Historic issues round social work recruitment and retention and lack of pathways meant that the focus on young people's transitions to adulthood was not robust and timely. Referrals were not picked up and so the support required for a young person was not identified or in place at the right time for them. This meant that young people/family carers did not have a clear plan in advance of the young person's 18th birthday.

The Working Age Adults service has taken a proactive step by establishing a dedicated Preparing for Adulthood (PfA) team. This specialist and focused team comprises of an operational management group, social workers and social work assistants. Efforts have already yielded positive results, with a significant reduction in the backlog of referrals awaiting allocation to workers and improved joined-up working with Children's Social Care colleagues, education and health. There is close work with the young individuals and partners to create clear, person-centred plans; these plans empower young people to realise their full potential and nurture high aspirations. Referrals for young people aged 14–16 are tracked.

To support the work, a forum convenes monthly to discuss individual cases. A young person's current situation, their aspirations and the best way to support their needs are explored. Feedback from forum members has been overwhelmingly positive, and external partners have commended the robust pathways for preparing young individuals for the challenges of adulthood.

Recognising that life plans evolve, the age range supported by the PfA team has been extended to work with people up to the age of 25, allowing flexibility as circumstances and choices such as independent living and employment change, as there is acknowledgment that it may take more time for some young people to be ready for this step and they need to be able to progress to achieve this.

Planning Live in Working Age Adults has been introduced, aimed at young people who are likely to need additional support from social care into adulthood. This programme is offered by Milton Keynes City Council (MKCC) in partnership with Talkback, a learning disability and autism charity. Its design and ethos are entirely strengths- and relationship-focused. Planning Live is used to discuss and explore issues such as housing, independence, socialisation, engaging with community, education, health, work experience, volunteering and employment. Spaces have been created to support young people to set the agenda for a conversation about them, in search of what a good life

might look like as they approach adulthood. A Planning Live workshop with a small cohort of young people from one local school took place last year and formal feedback is currently being gathered. The plan is to offer this as a rolling programme throughout the academic year in identified schools.

There is a commitment to enhance services, and the council is actively working on a comprehensive strategy, set to be finalised in May 2024. The focus is on fostering a culture of coproduction in this area using the Working Together for Change methodology. Workshops are scheduled for April 2024, and these will bring together young people who have transitioned or are due to transition into Adult Social Care, asking them what worked, what didn't and what needs to change. Stakeholders and professionals have also been invited to attend and contribute. These sessions will facilitate meaningful discussions and contribute to the strategy's success as it will focus on what actions are needed in the strategy.

It is recognised that there have been developments and changes in services and delivery and to capture this a task and finish group has been set up to review and update the cross-team process for transitions from childhood to Adult Health and Social Care. This will map out the child/young person's journey and what needs to happen and at what stage of their life. The document will ensure that information and what is important to the child is captured and the Working Together for Change workshops has this as a thread throughout.

What were the barriers to success?

- Complexity of some case work.
- Working with families to ensure anxieties are not disempowering the young person's voice.
- Incorporating preparing for adulthood work in the mainstream case work of the team.

What were the conditions for success?

- Successful recruitment and retention of staff.
- A dedicated team to work with young people who are moving into Adult Social Care.
- Time to work with people in a progressive way.
- A joined-up approach between colleagues in Children's Social Care, education and health.
- Clear structure and pathways.
- Working closely with the community resource team and supported living providers.
- Ensuring timely support during critical transition periods.

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Luton Borough Council

Adult Social Care offer of early intervention and prevention (EIP) using the '3 Conversations' model

Luton's EIP offer is focused on empowering residents to help themselves, removing the complexities and silos across existing service provision. At its core, it is about putting customers at the heart of the service and creating a new social contract that moves from transactional (where customers are supported with their presenting issues) to outcome based delivery (where customers are supported to address the multiple and interrelated issues they face in their lives).

With increasing demand for services and complexities of need, EIP enables the council to meet the aspiration of resolving more contacts sooner, and reducing the demand for long term services. EIP is a 'strength based approach' driven through the '3 Conversations' model that works to people's strengths, and those of their family and community, to enable them to remain as independent as possible for as long as possible.

The customer journey (first point of contact) commences through either self or third-party referral to the Customer Services Contact Centre which has a dedicated Adult Social Care (ASC) team. The aim of the team is to triage, risk assess and stabilise the customer to divert from further ASC involvement, successfully achieving this in approximately 70 per cent of cases. This intervention will include mobility assessments, stabilisation with reablement, working closely with community assets and connecting with internal and external providers, including health, that can support benefit maximisation. Those that are not diverted progress to Tier 1.

The foundation of the '3 Conversations' model is Tier 1 in which information, advice and guidance and EIP services (including universal services) combine to provide localised support for people. This is delivered through the Prevention and Enablement Pathway (PEP) which came into fruition in April 2020. The focus of the services and the EIP team is to reduce, prevent and delay the need for long term statutory support. This is to ensure that the limited available resources are used more in a targeted way where they are really needed.

EIP is made up of the following:

- prevention and welfare
- reablement service/'discharge to assess' model
- triaging and forecasting of individuals transitioning from childhood to adulthood
- implementation of prevention through the PEP

- the Disabled Facilities Grant (DFG) that enables adaptations and building work to take place in a house to support people to remain in their homes for as long as possible
- best use of assistive and digital technology to support customers and their families to enable selfcare/self-management so that people can remain as independent as possible within their homes.

Within EIP sits the Reablement Service. Reablement is a central plank to support hospital discharge and the discharge to assess model, speeding up hospital discharge for the benefit of patients and the wider system. Data from 2022 demonstrates that the service is achieving positive outcomes, where 732 referrals were received out of which 470 people fully completed the reablement programme. Of these, 78 per cent were independent upon completion and 22 per cent left the programme on a reduced care package.

Luton became a member of the Local Area Coordination and Catalyst Network in 2020. The network works under the guidance of a local leadership group which creates and maintains a community vision for Luton. The Prevention and Enablement Coordinator, the Local Area Coordinator area manager and Local Area Coordinators form a working group which is responsible for implementing the PEP.

Both skill sets in prevention and enablement pathways focus on meaningful connections for individuals, enabling local gems (individuals who would like to give back to their community) and facilitating the use of or access to local assets (any community organisation or structure in the area). The team identifies gaps, creates awareness of community resources and links with stakeholders with regard to connections and strengths based implementation.

Examples

Customer A

Customer A had repeated hospital admission due to ill health and mental health. He has a history of drug addiction, self-neglect and a risk of cuckooing. There had been barriers caused by which team should pick this up as he was deemed not to have support needs. Customer A was referred to the EIP team due to deteriorating physical health needs that had resulted in him no longer being able to access his own flat.

EIP assessed Customer A and supported him through liaison with housing. The team worked collaboratively to support a safe move to a suitable property in Bedford which included housing related support to maintain his health and wellbeing. EIP successfully handed over the case to Bedford LA in case further support needs arise and agreed joint working in Bedford to ensure Customer A continued to receive ongoing support.

Outcome: The service prevented repeated hospital admissions, and the housing related support put in place helped maintain Customer A's health and wellbeing. He was able to receive ad hoc support as needed via housing related support and required no further input from Adult Social Care, thus avoiding the need for long term care and support.

Customer I – Contact Service Centre (CSC)

Customer I is a 45 year old man with multiple long-term conditions. He suffers daily with pain in his joints, especially in the mornings where he states it takes him two hours to recover from the stiffness. Transferring from bed, especially in the mornings, is very difficult and he describes his pain as a '10' in the morning, he has support from his wife.

His property is not adapted to meet his needs, resulting in his wife having to assist with all his daily living activities. This includes meeting his personal care needs, meals, shopping, cleaning and medication.

Outcome: Customer service explored via Macmillan Cancer Support, a range of local services to improve his quality of life. This included talking therapies, and pharmacy support. This resulted in direct support as well as referrals to other services such as physiotherapy and links to self-order equipment for safe transfers. A carer's assessment was completed for Customer I's wife, to support her needs and to put in place a contingency plan.

This in-depth work conducted by CSC via a strength based conversation enabled appropriate support and services for Customer I and his wife to support their ability to self-manage and maintain a safe habitable experience, preventing further risk.

What were the barriers to success?

- Health understanding of social care and opportunities within the community such as social prescribing
- Joined up Multi-disciplinary teams across health and social care at all levels of need, they often focus on high intensity hospital users

What were the conditions for success?

- Workforce stability.
- Training and development for staff and succession planning.
- Giving staff time to engage and understand local services to get the best services for the customer.
- MDT and joined up working internally and externally to get the best outcome for people.
- The dedication and drive of the workforce to support the people of Luton to have the best possible outcomes.
- Continuous drive for innovation and development of services to tackle new areas of demand and pressure.

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Norfolk County Council

Supporting unpaid carers in Norfolk

A flexible support service is offered to carers by Carers Matter Norfolk. Prior to the contract Norfolk had identified and supported approximately 0.5 per cent of known unpaid carers in Norfolk, meaning that many carers and families were reaching crisis before receiving help. Carers Matter Norfolk were commissioned to offer preventative support to carers, support carers' wellbeing, prevent crisis and allow people to remain independent for longer.

Norfolk CC have commissioned a forward-thinking outcomes-based contract and social impact bond. The service is delivered based on achieving particular outcomes which are then measured.

Carers Matter Norfolk are aimed at improving wellbeing for carers, preventing carer breakdown and providing effective preventative support. This was put in place in 2020 but as we reach 2024 the council can see that Carers Matter Norfolk now have supported 8 per cent of carers in Norfolk and receive approximately 400+ referrals a month. The contract ends in 2024 and the recommissioning process has begun using a comprehensive report from the Institute of Public Care. The report focuses on the experience of carers who have accessed services and carers who have been supported directly by Norfolk County Council. The council has taken the views of carers from this report and is embarking on a new project with Carers Matter Norfolk, looking for a breaks and family-based service. The delivery of this will inform service delivery and recommissioning for the future.

NCC has secured funding as a result of a successful bid submitted to Accelerate Reform. Since launching the proof of concept pilot, Tech Skills for Life West Norfolk, the Community Tech Coach Team, have helped and supported over 25,000 people in West Norfolk with a variety of different needs. A significant number of those have been unpaid carers or those receiving care and support. Supporting people to apply for a Blue Badge or carers' allowance which they were unaware of and providing devices enabling both the carer and individual being cared for to connect with the wider community.

The focus is on using digital technology as an enabler to connect people to activities, groups and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. NCC want to connect more people with information advice, guidance, activities and services in their local community using the social prescribing model but also by using wide local networks identifying those individuals who could benefit from information, advice and guidance through digital means. Where people do not wish to engage with digital tools or through the digital world, they will be supported by signposting and the development of relevant information, advice and guidance.

In addition to this, NCC want to increase access to assistive technology for carers, which will allow them to feel comfortable leaving the house or taking a break from caring and to use the tech coaches to help those who struggle with using technology.

The carers' voices were fully involved in designing the original service. In 2023–24 Carers Matter Norfolk redesigned systems and processes with coproduction and feedback. The independent report from the Institute of Public Care contacted hundreds of carers to talk about their experiences and this directly shaped the development of a service focusing on breaks for carers.

For example, carers told NCC they struggled to maintain connections and friendships and did not have enough access to leisure and breaks that they need. For this reason, the service is being expanded to ensure carers have regular and sustainable breaks, which maintains their social connection and helps them to feel valued and connected.

What were the barriers to success?

- Not all carers need the same thing. Lifelong parent carers who care for a now-adult child with a disability can have significantly different needs to a carer of an older person who has had a sudden decline in health and mobility. In addition, some prefer digital information, while others find accessing the internet challenging.

What were the conditions for success?

- Ensuring a flexible and varied offer of support as well as listening to carers. For this reason, Norfolk and Carers Matter Norfolk are developing a family approach which can support carers and their families more flexibly. They also have good links for an integrated approach over the local authority so they can link carers to digital inclusion or social isolation and loneliness prevention services.

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Digital enabled care and support

Photo: Centre for Ageing Better

Suffolk County Council

Hybrid reablement care delivery using digital technologies

Through the use of different care technologies, Suffolk County Council are building a hybrid care model with their in-house reablement service, utilising virtual calls and data-led devices to provide more personalised and bespoke care packages.

Suffolk County Council (SCC) has been delivering digital care technology through the Cassius partnership since July 2021. The partnership supports SCC adult social care (ASC) 'People at the Heart of Care' strategy and personalisation agenda, and builds on the strength-based social work practice model 'Signs of Safety'. In just under three years, it has:

- supported over 7,000 people in Suffolk to live more independent lives through the innovative use of care technologies
- helped the local authority to save over £12m through prevention, reducing and delaying other care and support
- maintained a 98 per cent minimum 'satisfaction' rating from people in Suffolk
- grown an active user base of over 4,000 people, representing over 20 per cent of people accessing care and support through SCC ASC.

In autumn 2023, Cassius began working with SCC's in-house reablement care agency, HomeFirst. This was with a view to supporting better outcomes for people, a more innovative and flexible care offer, and to support to release capacity through meeting needs differently.

Example 1

Anne had been struggling with depression, often neglecting meals and personal care. Anne was initially receiving two daily visits from her care team but it became clear that her emotional needs required more frequent interaction. Her son, although supportive, was frequently away due to business, intensifying her feelings of loneliness.

The care team introduced a dual approach to support Anne. Firstly, virtual calls were scheduled to allow daily contact with a carer, which Anne could take through her new video Carephone. This device enabled face-to-face interaction, providing a more personal connection than audio-only calls. Anne was initially hesitant and struggled with the technology, prompting additional visits and training from the care team.

Over a short period of time with the video Carephone, Anne not only engaged more frequently in calls but also showed marked improvements in her mood. She reported enjoying the face-to-face interactions and began venturing outside for walks, signs of her improving mental state. The calls gave her something to look forward to each day and helped alleviate her sense of isolation.

The video Carephone and virtual calls proved to be invaluable in providing emotional support and reducing isolation for Anne. These technologies allowed for a deeper connection than traditional phone calls, making them effective tools in care, especially for those with limited physical company. Suffolk are planning how the integration of virtual calls and video Carephones into care strategies could significantly enhance the quality of support provided, particularly for mental health and social interaction. Anne's case underscores the necessity of maintaining such services to support the ongoing well-being of vulnerable populations, demonstrating the broader potential for technology in enhancing care services.

Example 2

Stan, who is eighty-two, has dementia, and Dora has been finding caring for him becoming harder. Recently, he has begun to wander off by opening the front door. While Stan and Dora have a large extended family, most relatives live far away. Fortunately, one of their sons lives nearby. Dora is deeply appreciative of his support, although she is hesitant to rely on him too much.

After initial assessment by Stan's social work practitioner, we installed door sensors and a video Carephone in their home in just two days. This quick response is vital. It means that families who need urgent help can count on us to provide support right away, lessening their stress and worry. Being able to act quickly is key to making families feel safe and secure as quickly as possible.

The technology provided is empowering Stan's family to maintain and take over care, without needing extra care packages. Dora and her son are able to handle alerts from the door sensors, keeping Stan safe while going about their daily lives. Empowering families like this is central to Suffolk's strategies around care and support, giving people the tools they need to confidently look after their loved ones.

Installing this technology didn't just ensure Stan's safety, it also gave Dora, the main carer, the chance to take necessary breaks. The video Carephone lets Stan stay in touch with other family members too, spreading the care duties and giving Dora time to rest. This is incredibly important, offering carers the break they need to look after their own well-being while making sure their loved ones are cared for.

Stan and Dora are a powerful example of how technology can change home care for the better. It shows how quick installation, personalised tech packages, empowering families and giving carers breaks can greatly improve the lives of those we support.

What were the barriers to success?

- Focusing on technology, not outcomes.
- Not being willing to try something new.
- Lack of training/skills/education around digital opportunities (both for practice and people).
- Agility of access and offer.

What were the conditions for success?

- Providing support (including ongoing) to our practitioners and people we are supporting, to enable them to feel confident and empowered.
- Appetite and opportunity to think differently about how we support people.
- Having a flexible delivery mechanism to ensure different types of technology can be deployed quickly and safely.
- Good quality social work practice to ensure strengths-based and outcome-focused assessments are taking place, using technology as an enabler rather than a solution.

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Thurrock Borough Council

Technology enabled care (TEC) which supports independence at home

Empowering the community and workforce to explore assistive technology solutions as a core part of care solutions, and preventing, reducing and delaying the need for care and support.

TEC is an umbrella term that includes assistive, adaptive and rehabilitative devices for people while also including the process used in selecting, locating and using them.

Thurrock Borough Council set out to ensure their practitioners across Health and Care had the information, knowledge and guidance of different TEC solutions available to enable and empower them to think 'outside the box' and move away from more traditional commissioned services when assessing for care and support needs.

Over the past years, the Council has been encouraging practitioners to view TEC in its widest sense, as both an enabler of independent living and an approach to support individuals to achieve their goals and aspirations.

The original aims for the TEC were deliberately broad in scope:

- Raise community and practitioner awareness of TEC.
- Better outcomes through individualised TEC solutions.
- Support carers through greater use of TEC.
- Combat loneliness through connecting people to the wider community and family and friends.
- Maximise independence and resources.
- Encourage greater digital health literacy.
- Prevent, reduce or delay the need for social care or acute health interventions.
- Admission avoidance.

There is an emerging evidence base that shows TEC has a role to play in helping to deliver better outcomes, increased independence and demonstrate investment to save in the form of both cost savings and cost avoidance.

Individuals can access a broad range of TEC solutions in Thurrock from a variety of support sources, including practitioners from Careline, the Council's Alarm Receiving Centre (ARC), social care practitioners within Adult Social Care, as well as prescribers outside Adult Social Care such as occupational therapists, nurses, local area co-ordinators, libraries and housing officers.

How individuals are supported to access TEC is founded on one key principle, that TEC is easily accessible where it is deemed to provide the very best outcomes for the individual and best value for the local authority.

At any one time, there is an average of 4,300 people connected to Careline. In April 2022, there were 87 different types of TEC equipment in use with 2,604 pieces of kit being deployed within Adult Social Care. The equipment in use covers a wide range of uses including motion sensors, bed and chair sensors, ambient heat monitors, medicine dispensers, night lights triggered by motion, smoke, gas and flood sensors, watches providing multiple prompts a day, wrist-worn epilepsy sensors, door exit sensors as well as pendant alarms available in a variety of designs. The most common provision is baseline and pendant alarm, which costs in the region of £140.

To support health, housing and social care practitioners to consider TEC solutions, we have developed a package of information, training, simple-to-follow operational procedures and guidance notes, including:

- implemented guidance and processes
- mandatory e-learning module for all frontline staff – Level 1
- several staff briefing sessions open to all to explore low TEC, mid TEC and high TEC solutions.
- TEC assessment built into care and support assessment templates, to encourage TEC solutions to be explored
- face-to-face training for staff moving onto Level 2 – sessions where staff have opportunities to interact with different examples of TEC, case studies and group discussions
- ensuring TEC is represented at all networking events to provide opportunities for staff and community members to explore equipment and ask questions
- ensuring libraries, community hub staff and volunteers have a wide and extensive knowledge of self-purchase TEC solutions available on the open market
- ease of referral for more substantial equipment requirements
- TEC leads in every Adult Social Care team across the borough
- TEC awareness included in performance-related reviews (PRDs) to encourage individual conversations, guidance and shared knowledge.
- working with integrated community team (district nursing) to explore TEC solutions alongside care providers to upskill and encourage TEC to be explored as part of care plans.

A practitioner-led TEC group meets regularly to share good practice, explore innovative approaches and support colleagues to self-approve reasonably priced technology solutions.

Careline and social care staff attempted to contact over 40 people. However, in several cases people who access care and support were not able to provide direct feedback when contacted. Some were unwilling to discuss their situation, others were too unwell, or their circumstances had changed such as a move into residential care. Staff were very sensitive in making their approach to people who access care and support and their families.

Where the person accessing care and support or a family member were unable/unwilling to answer directly and the TEC was in use, the assistive technology (AT) leads made their own assessment of the impact of the TEC and whether any social care/health costs had been avoided because of the TEC being in place. Therefore, an additional analysis for the 15 cases was reviewed by the AT leads.

Here are some of the comments recorded about the impact of TEC:

- 'Makes me feel happier knowing it's there.'
- 'Peace of mind.'
- 'Reassurance and thank you for the support.
- 'Easier to gain help if I have a fall.
- 'Helped me gain access to an ambulance.
- 'Happy with it.'
- 'Makes me feel confident having it.'
- 'Thank you – it has made a big difference.'
- 'Pleased I have it and would recommend it to people.'
- 'Satisfied and pleased I have it.'

Feedback from Red Alert:

- 'I took a phone call from the son of a Careline Service [user] who sadly passed away recently. He wanted to thank the service for providing his dad with the lifeline and pendant and said that had it not been for the equipment, his father would have died alone on the floor. He said it has given his family great comfort knowing that the pendant triggered and enabled his father to be taken to hospital where he passed away surrounded by his family.'

Fifteen cases were evaluated by the social work team, overseen by AT leads. As explained, much more data was available to the social work team so that they were able to contextualise each case under review and assess the impact in addition to direct feedback by people who access care and support and their families. The most frequently mentioned areas were:

- less reliance on family members/reduced risk of carer breakdown
- peace of mind for the person accessing care and support and their family members.

Example of the TEC impact on one family for seven years:

- K, daughter of the person accessing care and support, explained that for around seven years her mother was able to continue to live at home safely without carers due to having a pendant alarm and door exit sensors in place with a daily visit by herself. Very recently her mother's health declined and she now requires carers daily. However, K explained that without assistive technology her mother would have not been able to live alone for so long, so the experience has been very positive for her mother and family. Pendant and exit sensors have given peace of mind, reduced the risks of her mother leaving home during the night without anyone being alerted and made her feel safe that she could press her pendant at any time for assistance.

What were the barriers to success?

- Changing the way workforce and communities think about TEC solutions on a broad scale. Staff wanted a catalogue of TEC solutions but this is not possible as each solution is bespoke to the individual's needs.
- TEC can be scary for communities and staff to understand, with forever changing solutions becoming available. This can be a deterrent for further exploration.

What were the conditions for success?

- Ensure support is available to allow individuals to explore TEC.
- Knowledge and confidence are key; no individual will know everything there is to know as solutions are extensive and bespoke.
- Upskilling, shared learning and shared experience from the roots up.

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Hertfordshire County Council

Data Inspired Living – Assistive Technology Offer

Using digitally enabled sensors, linked to a professional and families dashboard to support people to safely live at home for longer, identify emerging needs and provide additional reassurance and support for family carers.

Hertfordshire County Council (HCC) has a modern digital telecare service linked to a 24/7 monitoring centre with a 24/7 responder service that is offered to circa 12,000 residents that can react to emergency alerts in people's homes. Whilst this service is reactive in nature it does provide a safety net to residents and their families when an emergency happens, knowing that help is not far away.

In response to the growing health and social care challenges across the country, HCC developed an Assistive Technology Strategy outlining its vision to use modern digital technology to improve the provision of care services supporting Hertfordshire's residents to live healthy and fulfilling lives. The Council wanted to look at using modern digitally enabled technology so that it could use data to support social care practitioners to be more preventative in their care planning, enable care planning to be more tailored to an individual's needs and aspirations, support people to live more independently in their own homes for longer and provide additional reassurance and support to family carers.

Research consistently indicates that older people have a stronger preference to continue living independently in their homes rather than moving to residential care. However, with an increasing number of older adults with age-related frailty and long-term health conditions that limits their life choices, it has become more challenging for adult social care to enable older adults to remain independent at home.

To determine whether digital based technology could be accepted by practitioners, residents and families, two assistive technology (AT) pilots were undertaken which were evaluated by Public Health Hertfordshire. The AT pilot study was informed by a nine-month proof of concept (PoC) pilot, conducted between December 2018 and September 2019, which explored residents', family carers and professionals' attitudes and engagement with AT. The PoC intervention was a small study, conducted with 53 residents. Findings from this study highlighted that AT was an acceptable and feasible complementary solution for creating greater efficiencies in social care in Hertfordshire by providing greater support and reassurance for families and helping to improve older people's health and wellbeing.

Following the PoC intervention, the AT team submitted a further bid to HCC's Invest to Transform (ItT) fund to scale up the AT rollout across a whole locality across five districts (Broxbourne, Dacorum, East Hertfordshire, Hertsmere and Stevenage) to examine the impact of AT across a wider cohort of residents, family carers and partners. Due to Covid-

19 and government lockdown restrictions between March 2020 and April 2021, AT pilot installations were limited until these restrictions were lifted and it was safe to make home visits. The AT pilot study was a nine-month intervention conducted between May 2021 and February 2023. The overall aim of the AT pilot study was to rollout digitally-enabled AT as an integral part of an individual's care planning on a wider locality base, with a view to providing robust evidence in support of incorporating AT into a county-wide offer.

In November 2023, supported by the robust evidence from the pilot, HCC launched the Assistive Technology solution as part of the adult care offer to residents. This involved nine months of work to embed systems and processes in adult care, establishing practice policy and guidance for social workers, face-to-face and online training of the AT solution and referral process so practitioners were confident to recommend and refer their residents to use the technology and the recruitment of a small team of AT practitioners to support the roll out.

In close collaboration with practitioners and adult social care services, an in-house team at HCC have developed an AT solution to support residents to remain as independent as possible, reduce the need for hospital stays and provide reassurance for family and carers.

The solution is the Data Inspired Living Dashboard, which was developed from the ground up and rooted in social care through the collaboration of Hertfordshire County Council's adult care practitioners and technology team. The dashboard provides a near real-time online view of residents' routine at home using various data points which are gathered from a highly diverse set of sensors which are installed and analysed. These sensors include movement, temperature, smart plugs, bed mats, medication dispensers and door sensors.

The dashboard enables carers and practitioners to understand the contributing factors for elevated risks associated with the resident's health and wellbeing via a complete picture, giving a unique oversight to have informed conversations and assist with care planning. The AT solution provides individually tailored prevention alerts to practitioners and carers, which are generated when sensors are triggered. Examples include an alert being triggered because of changes in routine which could provide an early indication of illness, for example, increased toilet usage indicating a possible urine infection or decreased mobility over time to warn of possible heightened fall risk.

Some of the sensors being deployed in people's homes include:

- hubs, power supply and data stick
- TELTONIKA router, power supply and lead
- contact strips
- 2 Aerotec Smart Swich 6
- 10 Fibaro motion sensor
- 2 Door sensor with contacts PST02 – 1A (with motion)
- 1 Phillio Humidity sensor PAT02-B
- 1 Toilet Flush Kit Philio PAT02-B
- Bed/Chair Occupancy Kit Philip PAT02-B

The data from these sensors is then securely imported into a professional dashboard (called Data Inspired Living) where practitioners can understand the trends in people's activity which feeds into better tailored and targeted care planning and review. This data also generates a range of individually tailored alerts which are sent to either family members or social care practitioners for further investigation. HCC is also in the final stages of developing a family view of the dashboard which families and informal carers can use to support their loved ones.

As part of the ongoing development of the AT solution, HCC have collaborated with practitioners to build the dashboard both in functionality and appearance to ensure it meets the needs of the practitioners and the residents. Residents and carer engagement has taken place using focus groups, questionnaires, one-to-one support meetings, semi-structured interviews and data examination to gain feedback and ideas for improving and iterating the dashboard to make it accessible from a carers' point of view. HCC are aiming to build a regular cohort of carers to test new concepts and ideas with as the product develops and new sensors and functionality are added.

A consistent and continuous internal communication plan ensured staff and supporting agencies were aware of the AT work and engaged with the solution and how it could help the residents they support.

Each resident on the pilot had a case study completed as part of the Public Health Hertfordshire AT evaluation and two examples are summarised below:

- 'Richard was referred to the AT pilot following a stay in hospital with a chest infection. At time of referral, Richard had called for an ambulance four times resulting in four hospital admissions. Richard has a package of care twice a day totalling £204.35 per week to support with personal care and medication. Richard had expressed his wish to reduce or cancel his care package.'

Outcomes after AT installation:

- Medication data evidenced Richard was taking his medication regularly and on time.
- Care reduced (in agreement with Richard) to twice a week for a shower at a cost of £84.86 per week.
- No further ambulance call outs or hospital admissions at time of review.

  Summary: Had AT not been installed, it is likely that Richard may have returned to hospital more frequently, which would have meant more ambulance call outs, risk of deconditioning for longer hospital stays and increased fragility. Care costs may have either stayed the same or increased.

- 'Susan was discharged from hospital with a package of care consisting of four daily visits at a weekly cost of £303.52. A referral for AT was made alongside this to provide reassurance to her family.'

Outcomes after AT installation:

- Care reviewed one month later post-AT install and reduced to one daily visit as Susan had regained her strength and independence.
- Therefore, weekly cost was reduced to £75.88 within one month of Susan's return home.

- Support for resident/family members to help maintain wellbeing.
- No further admission to hospital at the time of review
- Family know Susan has an established nighttime routine.

  Summary: Had AT not been installed it is likely that the cost of Susan's care would have remained at £303.52 per week. Susan would not have had the reassurance of assistance being available through the preventative service and her family would not have information regarding Susan's routine unless they were with her.

According to a family carer, 'Without this technology she [mum] would have been very fearful. I would have been even more anxious ... It means someone does not need to be there 24 hours a day – mum is a lot more independent.'

Social care practitioners were also heavily engaged in both the development and evaluation, with one practitioner stating:

'The benefit of the AT is that they give a longer-term solution for residents to provide that preventative measure – such as declining mobility. A lot of families are so anxious about family members that have fallen, and this helps to give them reassurance. What I really like is that AT is versatile. It is another tool in our assessment kit and can be adapted to meet different needs. Each resident is unique – whether you are 25 or 95, AT has a benefit in one way or another for everyone if they are willing.'

What were the barriers to success?

There were several barriers (or challenges) that had to be overcome, including (not an exhaustive list):

- **Ethical issues –** as this approach entailed remote monitoring and evaluation of data which was considered as part of the research, it was important to ensure ethical approval to proceed. Activities to achieve this included full resident information and consent, one-to-one support where needed, only residents with capacity to consent were included in the pilot, withdrawal was possible at any point and resident consent obtained for disclosure of personal (anonymised) information/data.
- **Data protection –** detailed work to ensure GDPR compliance including data sharing agreements, etc.
- **Security –** equipment had to be penetration tested to ensure robustness and meeting security requirements.
- **Practitioner engagement/acceptance –** it was vital to ensure practitioners were signed up to this pilot, were aware of its intended use and limitations and were engaged at all points of the pilot's development and implementation.
- **Resident/family consent/acceptance –** residents needed to be assured that this was not going to replace a carer and that the whole system was safe, secure and robust.

What were the conditions for success?

The pilot study had one overarching primary outcome and five secondary outcomes as presented below:

Primary outcome:

- Achieve efficiencies (cash and time releasing) from investment in AT.

Secondary outcomes:

- Reduce the number of avoidable emergency admissions and readmissions into hospital.
- Reduce or delay the use of care homes.
- Improve or maintain resident independence.
- Improve care planning using AT.
- Reduce pressure on family carers and improve their quality of life.

Objectives of the evaluation:

- Identify whether the AT pilot is achieving its intended outcomes.
- Explore whether AT is acceptable to residents, family carers and professionals involved in residents' care.
- Explore what unintended outcomes (positive and negative) have been produced.
- Demonstrate which residents AT can effectively support and who it cannot effectively support.

To help develop this offer further HCC is offering another local authority a trial opportunity to work in partnership to develop and iterate this offer as an early adopter. Any authority wanting to discuss this opportunity should contact HCC using the contact details in the case study.

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Suffolk County Council Adult Social Care and Public Health, SNEE Integrated Care Board (ICB) and Optum Ltd

The 'Woodbridge Holistic Assessment Team' – falls prevention enabled by data integration

Teams across Suffolk and North East Essex (SNEE) ICB, the public health team at Suffolk County Council and Ipswich and East Suffolk Alliance have used data to understand the population, drive action and improve outcomes for many years. However, this work has often been siloed, using disparate datasets which don't provide a holistic picture. In the summer of 2023 SNEE ICB partners including adult social care at Suffolk County Council created a linked, longitudinal dataset combining adult social care, primary care, community services, acute hospital and mental health trust data at person level.

To explore the insights this powerful dataset could offer, SNEE partnered with Optum Ltd to provide the Population Health Management Reporting Suite (PHMRS). This tool includes a series of dashboards which visualise these linked data, allowing teams to explore:

- cost segmentation to identify high and rising risk
- risk stratification
- impactability modelling and gaps in care
- patient-level Theo graphs to analyse individual care pathways and provide personalised care at system or local level.

As the SNEE team began to explore the Optum PHMRS, and the sophisticated analytics within it, it was found that every integrated neighbourhood team (INT) in the Ipswich and East Suffolk Alliance area (8 teams covering 415,000 patients, including adult social care and community health) had falls as the primary driver of high-cost service use in that population.

Using the SNEE One Team leadership development programme, INTs brought together different elements within our system including clinical specialists, social workers, mental and physical health teams, primary care clinicians including nurses, therapies, pharmacists, the voluntary sector, the faith sector, analysts from public health, social prescribers and staff from district and borough councils. Participants were released to spend dedicated professional time together developing projects using linked data to improve outcomes across the local population.

One of these projects focused on developing a multifaceted, holistic approach to falls prevention, the key driver of high care needs and costs, and to create a plan of interventions that needed to cross organisational boundaries and have personalisation at its heart. This created the Woodbridge Holistic Assessment Team (WHAT), and this new holistic approach, which uses sophisticated linked data to identify people who could benefit from a holistic adult social care and health assessment to reduce the risk of falls, is now working in practice.

What was the impact and outcomes?

This work was awarded a Silver Medal in the National Health Service Journal Partnership Awards in March 2024, in the category 'Data Integration Project of the Year'.

Although falls and fragility fractures are more common in older people, they are often preventable and shouldn't be seen as inevitable. Using the PHMRS allowed the team to understand why falls are a powerful predictor for high system usage across primary care, acute, social care and community services using linked data in a way that had never been achieved before in SNEE. The analysis explored the demographics of those who had experienced a recent fall compared to a similar cohort who had not fallen including a comparison by key health conditions, risk factors, the average number of contacts with services in the year, and the average costs per person per year by service used. Population projections from the Office of National Statistics were combined with this data to forecast future falls activity and cost to the system.

The analysis identified a high prevalence of falls in the Woodbridge area which drove the conception of the Woodbridge Holistic Assessment Team (WHAT) project; an early intervention for first fallers, near misses, stumbles and people who are anxious around falling. The 'one stop shop' team comprises multidisciplinary professionals who undertake any assessments needed. They offer health and care advice, support, and guidance to minimise the need for several appointments and visits to multiple professionals over several days with much longer waits, instead minimising the risk of further falls and offering a unique quality service for their community.

Information packs were prepared for each patient, which included a summary of discussions and recommendations. The service team were aware of the value they were providing in this unique experience through supporting the patients directly as well as raising awareness of support available to partners and carers. The single service offer has improved relationships across partner organisations and has resulted in a scalable model of care.

Feedback from patients includes:

'The whole session was first class and met a real gap in care. I am so grateful for this opportunity to get so many questions answered.'

'Excellent from start to finish.'

Feedback from ICS staff:

'Our partnership with Optum has been invaluable in getting us to this stage. Access to linked data which provides new insights has enabled us to take associated action to improve wellbeing and outcomes across our population.'

The inception of the WHAT provides a cost-effective community-based, multi-disciplinary approach within a single setting. This reduces multiple appointments and associated cost as well as minimising the risk of further falls. Crucially, using the linked data which updates every month, we will be able to monitor and measure the impact of the intervention on local falls rates going forwards.

What were the barriers to success?

- Creating the sophisticated and comprehensive linked data set (as part of population health management) and providing the analytical dashboards to allow the practitioners to analyse their own data, and design and implement their own solutions.
- Time for practitioners to do this innovative work.
- Aligning different organisational priorities.

What were the conditions for success?

- Long-standing and trusted relationships between adult social care and community health staff, enabling a close and creative working environment, with time and space to innovate.
- Analytical support for practitioners.

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Norfolk County Council

How artificial intelligence (AI) has helped with falls prevention

Norfolk County Council's proactive approach to preventing, reducing and delaying demand.

Residents have told Norfolk County Council they want to live independently at home, close to friends and family, for as long as possible. Through the Connecting Communities transformation programme, NCC have identified an opportunity to take a preventative approach. They want to support residents to be more proactive about their health and wellbeing and remain connected to their local community. This will mean NCC can prevent, reduce or delay their need for long-term care.

NCC started by asking how they could be more proactive and prevent falls for the following reasons:

- One third of adults over 65 experience at least one fall per year which is usually distressing to that individual and their family.
- On average, a hospitalised fall results in £3,358 additional care costs per annum.
- There are 4,150 falls-related hospital admissions in Norfolk per annum.
- Intervention can prevent 30–35 per cent of serious falls.

To identify those who would benefit from proactive support, the council needed to better understand its residents. The council built a secure platform that quickly and safely connects information about residents across systems. The platform uses Natural Language Processing (NLP) to scan through hundreds of thousands of records. In phase one and phase two the council used social care, housing, council tax and other data in partnership with district councils. NLP extracts information about a person's strengths, needs and interests from free text such as practitioner case notes. This would be impossible for a human to do at scale.

NLP enables the council to understand multiple aspects of an individual's life, from living conditions and family situations to their health and wellbeing. The council take action using artificial intelligence, specifically machine learning technology (MLT), to predict who is most likely to need support. This started by monitoring computer information on people's strengths and needs, and notes on who had or had not fallen previously. The council asked MLT to work out the best way of differentiating between those who had and had not fallen. This involved analysing hundreds of millions of data points.

MLT is now able to make a prediction for every individual. Tests show the model is correct up to 70 per cent of the time and the council carried out a sample test to ensure it was performing as expected. The council follows these steps to deliver proactive intervention:

- Contact – understand support needed through a personalised conversation to offer relevant, preventative support.

- Bespoke interventions including environmental adjustments, mobility and keeping active and health services.
- Follow up, to connect the individual so that support is offered and feedback on the impact is obtained.

The process included involvement of people who access care and support, business support and frontline staff. The programme has been developed across the local authority and wider place. For example, social care practitioners provided context and clinical input and designed ways of working; communities teams brought deep knowledge of support available; information governance (IG) supported safe data sharing and processing; IT connected data analysts and third parties built the natural language processing and machine learning models. The council partnered with communications, health, fire service, district councils and the voluntary sector for outreach and interventions.

Prevention is difficult to measure, however, the council is confident this will have a long-term benefit to residents and has put measures in place (full results will take time). Residents are positive. Seventy-seven per cent who were identified as being at risk have answered the council's calls, with 52 per cent agreeing a holistic conversation about next steps. Of those, 42 per cent have taken up a referral.

The council has seen:

- 15 per cent reduction in people fearing the impact of a fall following an intervention
- 100 per cent quoted no recent falls since their intervention
- 71 per cent of people thought the support was beneficial
- 53 per cent of people said they continued with their changes.

What were the barriers to success?

People's perception of artificial intelligence (AI) and the ethical debate:

- Is it right to use technology in this way?
- What about the impact on the workforce?
- Where is the balance between care and control?
- If the tech exists, do we have a moral imperative to use it?
- Are the outputs impacted by biases in the data or algorithms?
- How transparent should we be about using the data and technology?

What were the conditions for success?

NCC are still learning from this. As things move forward, the council are keen and excited to share their story and what they have learnt so far about using AI, including Information Governance (IG), legal, cultural and ethical considerations which are important to discuss as a sector. NCC have shared their experience, including presentations with the National Children's and Adult's Social Care conference, regional ADASS networks and engagement with the Department of Health and Social Care (DHSC). They view this as a key part of further developing their approach and playing an active leadership role in the sector.

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Central Bedfordshire Council

Alexa helping people to stay independent

Ensuring technology enabled care (TEC) is future-proof.

TEC has always been a part of the offer to people to maintain their independence, but it was a challenge to get staff to feel confident in both identifying and prescribing possible solutions. Promoting a culture of TEC first to minimise intervention, dependence on services whilst promoting safe independence has involved a culture change which included embracing new systems and a greater focus on integrated working for health and social care colleagues. This integrated approach has resulted in fewer referrals being made between service borders, but more importantly reducing the individual's need to re-tell their story and being passed from team to team. TEC first and readily available prescribers of TEC have contributed towards consistency of support for the people supported.

A small TEC team of one was established in 2022, comprising a senior occupational therapist, as a bridge between services to support prescribers. In 2023, two additional team members were recruited. The current TEC Team comprises a senior community assessment officer and a full-time administrator. Their role is to support staff and help them consider the art of the possible, raise the profile of TEC and promote its use. As they have gained traction, they have also brought together TEC converts from front-line social care teams as TEC champions who have been equally proactive in supporting and promoting TEC within their teams. The TEC team offer twice weekly TEC drop-in sessions to support prescribers and to help prescribers understand and feel good about the work they are doing with TEC.

A TEC board has been established which involves commissioning, external TEC providers and operational staff. This is chaired by a head of service and has ensured that TEC remains a high priority and that the level of activity/prescribing has oversight, with associated efficiencies, to ensure it continues to be considered and utilised to maximise independence. Outside of the board the individuals' stories are used to inspire new TEC prescribers to aid their understanding of how impactful TEC can be. The service aims to be prescriber-led and the TEC champions play an integral role in sharing information with and from their teams. All prescribers are regularly communicated with to ensure they feel part of the evolving service and able to contribute ideas and flag areas for development.

Staff are being trained to prescribe TEC, the culture is shifting and TEC conversations are happening earlier in the process and although there is always room for improvement, there are over 300 staff covering the Central Bedfordshire Council area. In 2024, the team responsible for supporting staff with TEC (TEC Team), grew by 200 per cent. With three members of staff and greater resources more front-line staff have been offered more support to empower them to feel confident with TEC. The TEC Team collect data and establish which teams to target for support or additional training on the less frequently ordered items for instance.

The change from 'Why do I have to do TEC?' to 'Why wouldn't I do TEC?' is evident, for example:

'Whilst on maternity leave a 38-year-old mother, X, noticed some changes in her swallowing and arm and hand function. Nine months after the birth of her baby she sought medical investigation and was diagnosed with Motor Neurone Disease (MND). X lives with her husband, toddler and new baby in a two-storey house. Her husband works from home (upstairs). X is mostly downstairs. X remains mostly in her chair downstairs and her goal is to remain safely independent. People frequently call on the household, including professionals, child carers, friends and family. X's husband is regularly disturbed by callers when working as he comes downstairs to grant access. The couple are under significant stress.

X is and was initially supported by health colleagues in the Community Neurology Team. Despite not wishing to engage in social care support, previously she would have been referred to Central Bedfordshire Council's' front door service, the first response team for TEC.

With the TEC team support, instead of referring person X onto First Response, they explored the TEC options during a drop in and attended a TEC on Tour event. With support, they ordered a non-catalogue special Alexa Show (with screen) and Ring Doorbell with Key Safe. From X's armchair, she can see a screen showing who is at the door and let them in if she wishes.

The TEC reduces the need for her husband to come downstairs during his working day to answer the door. Additionally, he uses his phone to check-in on the Alexa and communicate and see his wife who is downstairs with the children. This helped ease some of his concern about being in a different part of the home. Smart light bulbs and curtain openers, linkable to Alexa, were also considered on review.'

In the example above, the TEC supplied helped X to grant independent access to callers and reduced disruption to her husband when upstairs working. The occupational therapist understood the progressive nature of MND and obtained consent for integrated working with X, including multi-agency involvement, early on. This early intervention allowed future proofing to be considered regarding TEC and in consequence X's voice was banked, so it can be used for voice-activated TEC in the longer term.

The professionals involved were mindful that this couple desired independence and normality. The couple had previously refused TEC, such as a pendant alarm, as it was viewed as medicalised and something they perceived as being needed for older people.

Making use of everyday TEC such as an Alexa de-medicalised the help provided. Additionally, the family were encouraged to use existing TEC creatively, such as using phones to drop in on the Alexa.

Examples of outcomes:

- Having a conversation with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments.
- Working with people to make sure that their personal plans promote wellbeing and enable them to be as independent for as long as possible.
- Working with people to manage risks by thinking creatively about options for safe solutions.
- Talking with people to find out what matters most to them, their strengths and what they want to achieve, and to build these into their personalised care and support plans.

What were the barriers to success?

- Service – the initial TEC ordering process was bureaucratic and time consuming. Once this was streamlined this had a positive impact on workers placing orders.
- Service – increasing the TEC team resources and providing more input to promote TEC and support prescribers.
- Person – the time taken for the TEC to be supplied if it was a non-catalogue item – it took longer than was ideal to be sourced and installed which impacted the time it took for the person to receive the TEC.

What were the conditions for success?

- Service – recognition of the benefit of and investment in a dedicated TEC team.
- Regular engagement with frontline staff and evidencing the positive impact via people's stories.
- them and alleviate any concerns.
- Person – the professionals reviewing the TEC prescription and issues identified quickly. Sadly, deterioration was rapid and from making the order to installation X's function and language had deteriorated. This issue was identified quickly, due to regular reviews and multi-agency working.
- Future proofing for X's loss of speech meant an iGaze was issued by speech and language colleagues, using X's own voice, meaning she could utilise the Alexa and associated peripherals to prolong independence.

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Bedford Borough Council

Participating in technology advances for health and wellbeing

People with a learning disability taking part in a digital inclusion pilot to develop technology responses for health and wellbeing.

Some adults with learning disabilities report that accessing medical care through hospitals and GPs can be extremely difficult due to their cognitive difficulties and that they experience difficulties in communicating their physical health concerns or improvements for the medical professionals to monitor. Some adults with autism can find clinical settings impossible to access due to their sensory needs which in turn can prevent them from accessing proper assessment and treatment for their health care needs. Adults can find it increasingly difficult to retain their medical history information for periods of time to be able to confidently communicate how their health has been when asked by the medical professional at the appointment.

There is a well-established practice within the daytime activities for people with learning disabilities of membership of different working groups and forums. This includes being part of the Bedford Hospital Learning Disability Forum, an ongoing Working Together group and more recently, the Improving Learning Disability Services conferences run by East London Foundation Trust, to support positive voices and improve services and changes within health services for people with learning disabilities.

This gave the group the platform throughout the day to voice their experience directly with Ruth Cooper, Operational and Strategic Lead for Learning Disability, East London Foundation Trust and Dr Sanjay Nelson, Clinical Director and Consultancy Psychiatrist for Learning Disabilities, East London Foundation Trust and to bring about positive changes for people with learning disabilities and autism. As a result of the group participation in health service discussions they were invited to trial the Medii App and feedback as part of a pilot project.

Through this forum the group were invested to take part in a 'Your Day, Your Say' conference as people participants. One of the areas discussed at the conference was the development of a new digital Medii App which is a health resource for adults with learning disabilities and autism.

This group has been providing feedback on the Medii App and its functionality and are now part of the tests before it goes live. The design of the app and the commitment to digital inclusion enables people with learning disabilities and their carers to record and monitor conditions such as epilepsy, asthma, bowel management and diabetes to name just a few, along with diet, exercise, hydration and many other important health records that are often lost in communication during a traditional GP consultation. The app has been designed as easy-to-read and enables records to be shared directly with health professionals. It is sure to improve learning disabilities health services and wellbeing.

People with lived experience have been supported by the day centre staff to work with the health service People Participation Team to feedback on design and how to use the digital app. The day centre staff are supporting the group to actively use the Medii App as individual pilot subjects who can record their physical health conditions and medical concerns such as seizures, asthma etc., daily which is stored ready for them to use at their individual medical appointments.

As part of the ongoing coproduction Dr Sanjay Nelson, who designed the Medii App, came to visit the group at the day centre to discuss the app and their user experience so far.

What were the barriers to success?

- People with lived experience with a learning disability being digitally excluded from medical recording software due to it being too complicated to navigate and not understanding the medical terminologies used.
- People not feeling confident to voice their past experiences with high level clinical professionals.

What were the conditions for success?

- People with a learning disability to have the opportunity to implement positive change at a clinical level.
- People with a learning disability to have a voice and opinion on how to improve their medical appointments.
- A recognised system that supports adults with learning disabilities and autism to record and relay medical history to medical professionals.

Further information:

Link to Medii App Guide

Twitter link for Dr Nelson

Contact: Julieann Peck – julieann.peck@bedford.gov.uk

Norfolk County Council

Tech Skills for Life

How Norfolk is helping people who are digitally excluded.

Digital inclusion is the ability to interact with the online world fully, when, where and how an individual needs to. It is influenced by factors such as cost, skills, confidence, motivation and access to services. Digital inclusion is essential for social and economic participation, as well as for health and wellbeing.

Norfolk County Council Digital Inclusion Strategy and Programme, launched in January 2022, has been working in partnership with various stakeholders to provide a range of services, support offers and change initiatives that help Norfolk residents to overcome the barriers to digital inclusion and benefit from the opportunities of being digitally included. The programme has five strategic themes and objectives, and has delivered many achievements to date, such as improving broadband access, providing free and refurbished devices, increasing digital skills and confidence in the local community and developing the digital skills of staff.

Tech Skills for Life was an innovative proof-of-concept pilot funded by the council through the Norfolk Investment Fund (which ran until 31 March 2024) and had a team of four Community Tech Coaches who worked with local partners and residents to improve access to and use of technology. The pilot has helped and supported over 3,072 people (the initial aim was 1,000 people), including 712 referrals, by providing devices, data, connectivity, skills and training. The pilot has also had a huge impact on people's lives, such as reducing loneliness and isolation, improving health and wellbeing, enabling access to services and information, and increasing employment and education opportunities.

There is a Digital Inclusion Strategy Board chaired by NCC which meets monthly. This Board is represented by colleagues from NCC, the ICB, District Councils and the voluntary sector. Examples of outcomes and impact:

- Making sure that people can stay connected with family, friends and people in their area who are important to them.
- Gifting a tablet and showing a man how to use online shopping so he can be at home with his terminally ill partner. Whilst the coaches were there, they were able to show the couple how to video call far-away loved ones from the comfort and safety of their own home.
- Enabling an individual to keep a litter of beloved kittens together by showing the person how to Google search for spay and neutering options. They discovered the charity Cats Protection offers significantly reduced prices for those on low incomes.

- Social isolation – J lives in sheltered housing but had not been able to communicate with his fellow residents very well as he was unable to talk following an illness. NCC gifted J a tablet and held several sessions to show him how to use it and the immersive reader function. J was able to type out a shaky 'thank you' and squeezed the coach's hand. J is now able to 'talk' with his fellow residents using his tablet.
- Gifting a smartphone and showing an older couple how to use the talk-to-talk function, enabling the lady who had lost her hearing 25 years ago to see her husband, friends and carers respond instantly. No need for a pen and paper (or more recently, whiteboard). She sent NCC a short note followed by a longer six-page letter and said, 'It has given me my life back.'

What were the conditions for success?

NCC have used this model in their funding application to the Accelerating Reform Fund. They have been successful with the application and will be looking to expand this service into further areas in Norfolk including Great Yarmouth and the surrounding area.

Although the concept will be the same as in the West of the county, there will be an added focus on identifying and supporting unpaid carers as well as those being cared for.

Further information:

Video showing the impact

Contact: Gail Harvey – gail.harvey@norfolk.gov.uk

Equality, diversity and inclusion

Photo: *Centre for Ageing Better*

Hertfordshire County Council

Diversity conversations through Diversity Guardians

Supporting teams to grow in terms of equity, equality, diversity, and inclusion (EEDI).

The council was trying to find solutions to several issues:

- Challenges some teams experienced discussing expert equity, diversity and inclusion-related issues.
- Fears of some individuals and the concern in some teams about EEDI and what to say and what not to say.
- Lack of knowledge about some EEDI-related issues.
- Variance in teams that had an identified diversity champion (the previous title) and those that did not.
- Difficulty diversity champions had in fitting their role in with their day-to-day work.
- EEDI support and peer support available to diversity guardians.

The Hertfordshire County Council (HCC) wanted to tackle this as teams in adult care services tend to be made up of people of different sexes, different identities, education levels and socio-economic backgrounds. Teams also vary in terms of age range, religion and belief, ethnicity and caring responsibilities. HCC wanted all colleagues to feel included and that they belong; being able to discuss issues of identity, cultural practices and beliefs can support people to feel they are accepted and appreciated for who they are.

With the support of their team manager and an EEDI Lead, diversity guardians can encourage and promote conversations, share information and learning with colleagues and support the overarching strategy for individual and collective EEDI growth.

Hertfordshire is increasingly diverse across a range of protected characteristics. To do their best work with the people and communities they serve, adult care services colleagues need an understanding of the diversity of people they work with and how that diversity might be expressed in their normal practices and interests.

Diversity champions shared that they felt unsupported in the role, and that they were all doing things slightly differently. In addition, they were not necessarily clear about their remit and what they could and couldn't do. Finally, there was no link between the diversity champions and the departmental Diversity and Inclusion Board.

What were the barriers to success?

- Confidence of people to take up the role of diversity guardian.
- That people who choose to be a diversity guardian may do so because of their own lived experience and a passion to support positive EEDI change, and in the role they might encounter views that are triggering, difficult to respond to or manage.
- Fear that conversation might lead to disagreement and adversely affect team relationships.
- Aversion to EEDI as a topic and a feeling that it is not something that should be discussed in the workplace.

What were the conditions for success?

- Active support from the team manager so the diversity guardian is empowered to fulfil the role.
- Colleagues who are receptive and understand there can be individual and collective growth even when there is some discomfort in having a conversation.
- A community of practice so diversity guardians can get together to discuss the learning points.
- An evaluation so the impact of diversity guardians can be analysed, any potential improvements can be identified and introduced.

Contact: Liz Fergus – liz.fergus@hertfordshire.gov.uk

Hertfordshire County Council

Open to talent

Improving the diversity of the workforce

Many employers are missing the rich pool of talent and skills that disabled people can bring to the workplace. Hertfordshire County Council (HCC) is committed to making inclusion part of their DNA, both as a large employer of people and as a provider and commissioner of services. The council strives to positively promote diversity and inclusion within the workforce and services. They want everyone at work, regardless of their background, identity or circumstances, to have a sense of belonging to the organisation. A joint initiative headed by the Diversity and Inclusion Team, Head of Intelligence and Step2Skills Employment Services team presented a proposal to the Resource Directorate in HCC to offer work rehearsals for people in Hertfordshire with barriers to employment. The headline was 'Let's do something real. Something impactful. Provide a "work rehearsal" to a person who has faced barriers to employment.'

This initiative would continue to strengthen the councils' values to be an employer of choice and build a diverse and engaged workforce, providing more employment opportunities, better outcomes and support for people with barriers to employment. This would impact on the ongoing work to decrease the disability employment gap in Hertfordshire and the importance of leading by example to encourage more businesses in Hertfordshire to create a diverse workforce.

The proposal summary was as follows:

A: Insight Days

- Sets of work experiences/activities in the Resources Directorate, e.g. the work environment, participating in meetings, exposure to delivery in one or more areas.
- Allows the individual to consider/help identify their next career goals.
- No onboarding required; provision of IT equipment if required.

B: Work Tasters

- The opportunity to experience a role within the Resource Directorate.
- Allows the individual to consider if that role (or similar) would be a good fit for their aspirations and comfort level.
- Provision of IT equipment if required.

The next steps included:

Initial workgroup set up to

- Set out sample sets of work experience/activities
- Set out vision
- Plan-on-page and process outline
- Set out samples 5 Resources role profiles
- Identify support to the hosts to profile the kind of 'work rehearsal'.
- Tailor the rehearsal to best meet the assessments of specific individuals.
- Identify an Employment Adviser to support both the individual and the team.

The feedback for example included five work rehearsals completed in line with the brief, in technology, intelligence, legal operations and register office. Outcomes included a certificate of success on completion for all five participants to use on their CV and future application forms. As a result of the initiative:

- one participant has secured employment
- teams hosting the work rehearsal shared that they discovered new energy within the team and the value of their work
- people reconnected as a team
- increased appetite for working
- an impactful experience was had.

The Resources Management Board has now given the resources team the mandate to look at running the work rehearsal project for a second cohort.

What were the barriers to success?

- The main barrier was getting the right people on board but once a designated team was in place, the barriers were minimal.

What were the conditions for success?

- To ensure the correct person was matched with the right department to help aid a successful placement. Our main consideration is that the participation and the employer have a positive experience and both gain from the programme.

Further information:

https://www.step2skills.org.uk

Contact: Emma Gladdish – emma.gladdish@hertfordshire.gov.uk or step2skills@hertfordshire.gov.uk

Hertfordshire County Council

Shaping services through an Equity, Equality, Diversity and Inclusion (EEDI) lens

A programme to transform the council's approach, practice and delivery of adult social care in Hertfordshire.

HCC were seeking to challenge themselves about the inclusivity of adult social care and how well they were responding to the evolving demographics of Hertfordshire and where gaps were found to be able to address those.

The vision is for:

- transformed care provision that reflects the demographic and social change underway in Hertfordshire
- care and support services that are inclusive, accessible to all Hertfordshire residents and equitably meet the needs of the diverse population.

HCC have launched a new programme called Equity, Equality, Diversity and Inclusion (EEDI) in Shaping Our Services.

The programme has four workstreams to ensure activity across the adult social care system is considered:

- commissioning
- community and specialist services
- data
- operational (social care practice teams).

The ambition is to ensure solutions are coproduced, meaning:

- at micro-level between people, service providers and social care practitioners
- at macro-level by adult care services (ACS) commissioners, ACS operational leaders, people who draw on care and support and strategic partners.

What were the barriers to success?

- The constant pressures that impact the adult social care system may limit the opportunity to focus on this agenda.
- A lack of resources, people, time and money may impact on the ability to implement the work.
- Strategic stakeholders do not embrace the vision for embedding EEDI in 'Shaping Our Services'.

- Breadth of work that needs to be done and the range of partners needed to engage with.
- Challenge of maintaining the transformative work over the long term.

What were the conditions for success?

- Endorsement, commitment and participation of senior leaders.
- A culture of optimism where stakeholders believe that despite the pressure and constraints there are opportunities to transform the approach, practice and delivery of adult social care.
- A clear vision that can be articulated to people drawing on care and support and other stakeholders.
- Connected Lives assessment framework that enables people who draw on care and support to be active partners in care.
- Culturally competent social care practitioners who are passionate about working with people in all their diversity.

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Hertfordshire County Council

Recruitment Inclusion Ambassadors (RIAs) to support recruitment processes

There was a sense that recruitment processes were not always fair and that some people could be disadvantaged at application or interview due to their protected characteristics.

HCC appointed seven Recruitment Inclusion Ambassadors (RIAs) to support recruitment processes. The role was developed to help the diversity thinking, approaches and involvement in recruitment.

The focus for RIAs is to support recruitment of people into entry-level management roles (and above) and in doing so, support the creation of a talent pipeline. The ambition is to increase representation in management roles of people from global majority backgrounds and disabled people who across Herts and West Essex Integrated Care System are understood to experience more barriers to progression than their peers.

The RIA role is a voluntary one; interested colleagues need their manager's agreement before stepping forward. RIAs can use up to one day a month to complete their role. A brief conversation then takes place to understand something about their interest in the role, what they feel they will bring to it and what equity, equality, diversity and inclusion (EEDI) means to them.

Adult Social Care Service provides a range of EEDI learning opportunities which RIAs are expected to attend. The senior EEDI project manager supports a community of practice which meets quarterly so that updates and learning can be shared. An evaluation of the role, informed by RIAs, hiring managers and other panel members will be completed to consider the extent of the impact of the role in supporting recruitment decisions.

What were the barriers to success?

- The idea that some applicants may be disadvantaged during recruitment processes due to their protected characteristics is a difficult one for individuals and organisations to consider and accept.
- Establishing a process to ensure RIAs are invited to support recruitment in advance of the job advert being sent.
- Having insight into whether recruitment into management roles is taking place without the involvement of the RIA.
- Availability of the RIA to support recruitment processes, due to requests late in the process or the time they can take to complete.
- Potential reluctance of hiring managers to listen to the views and insights from RIAs.
- Potential reticence of RIAs to speak up if they see something they consider problematic.

What were the conditions for success?

- Leadership that endorses the role of RIAs and makes clear their expectation that people will invite RIAs to support recruitment.
- Support for RIAs in the form of a person/people they can escalate concerns to.
- A community of practice so RIAs can get together to discuss learning points.
- Communication to managers about the role, its purpose and how they can recruit an RIA.
- An evaluation to analyse the impact of RIAs and identify and introduce any potential improvements.

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Norfolk County Council

Work placements developed within NCC

Employment support and skills development.

Lydia and her colleagues within the Norfolk Employment service, Skills and Employment Team created employment options for clients including work placements, work trials and interviews etc., with the aim of creating natural routes into employment for clients who fall within the specified criteria.

Client referrals come via Preparing for Adult Life (PFAL), social workers and assistant practitioners to support adults within the criteria of having a disability or a long-term health condition and in receipt of a care and support package.

Working with external companies within the community opportunities have been built for clients to access work placements.

More recently Lydia has created some internal work placements and is in the process of expanding the placements on offer within NCC. There are currently four departments offering work placements including Social Care Community Enterprise (SCCE), Information Management and Technology (IMT), Libraries and Museums. There is guidance in the form of a step-by-step guide outlining the process for managers at NCC who would like to facilitate a work experience placement within the department.

Those who access work experience have an assigned work placement officer who continues to visit and support the person on the work placement. The work placement officer regularly liaises with the employer to ensure the placement is proceeding well.

Work experience is beneficial both to the employer and the person accessing care and support as it helps employers to recruit and retain people with a diverse range of disabilities and provides experience within the workforce, often resulting in a natural transition into paid employment.

Examples of outcomes and impact include:

- a person accessing a work placement secured paid employment
- being in paid employment has a huge impact on people as it gives an individual confidence and a feeling of self-worth
- being in paid employment has a beneficial impact on adult social care with the person reducing or no longer needing support from services.

What were the barriers to success?

- Not enough placements on offer.

What were the conditions for success?

- Enough placements on offer.
- Supportive work placement officer.
- Supportive employers.

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Housing and adaptations

Photo: Centre for Ageing Better

Thurrock Borough Council

Complex Housing Intervention Programme (CHIP) team using a human learning system approach

A new integrated and multi-disciplinary team supporting people with very high needs in the community to prevent homelessness and maintain social housing tenancies.

Agencies within Thurrock identified a cohort of individuals who have mental illness and behavioural challenges which, despite multiple attempts by various agencies, have not achieved improved outcomes or stability using mainstream statutory services.

The initiative is an 'experiment' that tests applying a human learning systems approach to designing the best solutions for individuals and in doing so redesigning service and systems around the person. This is part of a wider approach the council is taking around system redesign.

In the majority of cases, the individual:

- has a diagnosed mental illness
- presents a risk to themselves
- has challenging behaviour that negatively impacts their quality of life and the ability of agencies to meet their needs within the mainstream service offer
- has high usage of multiple statutory services
- has behaviour that causes disruption to their local community
- has an inability or unwillingness to acknowledge and act upon the impact that their behaviour has on others.

Very often the behaviour leads to potential or actual eviction, and subsequently homelessness perpetuating the cycle of chaos and disengagement.

It can also lead to distress and anxiety for neighbours and the surrounding community and has a disproportionate impact on valuable emergency and local health services.

The CHIP is a dedicated multi-agency team set up to work intensively and exclusively with the people who fall into this group.

The team consists of:

- psychologist (team manager)
- substance misuse worker
- housing specialist social worker
- local area co-ordinator
- community mental health practitioner.

Thurrock Council and Essex Partnership University (NHS) Trust jointly support and fund the project, which is a two-year pilot.

The team work intensively with the individual to identify and meet their support requirements, irrespective of their formal diagnosis or willingness to engage with statutory services.

This approach is consistent with Thurrock's Integrated Care Strategy 'The Case for Further Change', which is informed by the belief that every resident accessing one of the services is a complete, complex and unique individual with a unique set of strengths and needs (based on the principles of human learning systems),

Capturing outcomes, not outputs, is a key component to measure the success of the project. Case studies and reviews of before and after behaviours, with measurement of the associated costs to the system, will be used. It is anticipated that these measures will indicate good outcomes with a reduction in reliance on statutory services.

Due to the nature of historical disengagement by this group of people, engagement with potential people who can join the programme was not possible. However, the council drew on the experience of its existing Housing First project and of the knowledge of partners across many services including Drug and Alcohol Services, Probation, Housing, Social Care, Mental Health and Anti-social Behaviour (ASB) teams. The resulting steering group provided a clear pathway for how the project would be commissioned, set up and maintained.

The project started at the end of September 2023, and so far, twenty-eight people have been referred. Examples of the difference it has made to people's lives can be seen below.

Person A

Person A is a middle-aged man with ongoing ASB, drug and alcohol misuse and self-harm. He was at risk of losing his council tenancy and had lost a previous tenancy in similar circumstances. He has no furniture; his front door is in disrepair and his utilities have been disconnected due to non-payment. Drug paraphernalia can be seen in the property through the windows. He is often seen in the town centre intoxicated but refuses to engage with any agencies. A brief assessment was achieved more recently when he reported being threatened by extra-terrestrial beings. His behaviour had caused much concern to neighbours, and his acts of public disorder have affected others in the community.

The team took a flexible and responsive approach and have worked with him for the past three months. The substance misuse worker has built a good relationship with him and visits him every time he is sighted in town and intelligence is provided by police, ASC officers and community engagement officers to enable the worker to respond quickly. Client A now sees him as a familiar and trusted face and is beginning to engage more regularly. Next steps will be to support him to attend appointments with the mental health services in the community and to engage in treatment. They will also support him to maintain his tenancy.

The team has made a difference through:

- consistency – same professional supporting the person to encourage trust
- collaboration with other services to receive intelligence which can be promptly acted upon

- persistent engagement attempts at short notice and out of office hours
- person-centred goals that do not impose what the team think best but encourage the person to consider his own goals.

This will be a long and slow process, but the intensive and consistent support that is available through the CHIP team provides the best chance of ensuring person A can obtain a better life for himself.

Person B

Person B has paranoid schizophrenia and alcohol dependence syndrome. He is currently detained under the Mental Health Act following a period of homelessness and an acute psychotic episode.

Person B lost two previous tenancies due to hoarding, chaotic behaviour, alcohol abuse and rent arrears and has been admitted to hospital several times. However, he had not engaged meaningfully with any mental health professional.

The team have been visiting him in hospital and were able to support him with a visit to his new home to sign up to a new tenancy. In readiness for his discharge from hospital, they have been building a trusting relationship and providing a person-centred care plan involving all professionals, including mental health and housing. They have enabled him to identify his needs and goals.

The ability to engage and proactively prepare for his return home, providing a consistent contact and care plan, will enable a smoother transition and the best opportunity to sustain his tenancy and mental health in the future.

What were the barriers to success?

- Recruitment of professional staff has been difficult as due to general staff shortages across the NHS, this has taken longer than anticipated. However, all posts are now filled and the team is fully functioning and working to a high standard.
- Organisational barriers such as information sharing and budget control have been a challenge and will require ongoing cultural shift to ensure a fully integrated approach between different organisations, particularly back-office departments such as Human Resources, Finance and Information Technology.

What were the conditions for success?

- This project is dependent on a willingness by professionals to think and act outside of traditional pathways, to support clients to reach their best life.
- A joined up, integrated and flexible approach from all partners to ensure the breakdown of barriers preventing the clients from receiving the best support.
- Ongoing funding to ensure project longevity.

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Bedford Borough Council

Innovative solution through Occupational Therapy – installation of the first Washpod installed in Bedford

Thinking outside the box to install a Washpod in the dining area of a property to enable a person receiving end-of-life care to have a shower and remain at home.

The challenges were as follows:

- A person diagnosed with a degenerative disease, that is a life-limiting condition.
- It was not possible to extend their property due to space and time constraints.
- The person's wish was to stay at home and to main dignity by having a shower and to wash her hair (very important to her quality of life).
- Person wishes to remain in her own property as long as possible.

The following solutions were put into place:

- The occupational therapist (OT) thought outside the box and explored alternatives to 24-hour care in a care home or specialist placement. The OT looked into and obtained a quote from a specialist supplier.
- Occupational therapy worked in collaboration with the council's home improvement team to get a Washpod installed using new technology to support the person. This is the first time this innovative product has been used in Bedford Borough, funded via a disabled facilities grant.
- The pod was ordered, the house prepared, and it was installed in the person's sitting room in just two days.
- When the Washpod is no longer required in the person's home it will be removed by the contractors, stored safely, and re-used for others needing these facilities. The house will then be returned the way it was prior to the installation (this then becomes an asset for Bedford Borough Council).
- The only requirements are a dedicated power supply and proximity to a waste pipe. As there are no major building works required to install the wash pod, this is an excellent resource to assist clients who need help urgently.

To achieve the above:

- the council worked with the person's family, company representative and home improvement team to find a solution.
- the person was happy to have a Washpod installed in her dining area to enable her to have a wash and access to a toilet
- the most important factor was that it met the desired needs of the person as well as the fact that it can be removed when no longer required and will be available for someone else.

The person is delighted and said 'What an amazing product, the installers were fantastic, and this is going to make my life so much easier. Thank you to everyone involved.'

What were the barriers to success?

- A person must be eligible for the means tested disabled facilities grant.
- The council needs to think about what more it could do if they owned several of these Washpods as they could provide them through other funding routes and not just those eligible for disabled facilities grant funding
- Space in the property. The team worked with the rep to find solutions and to ensure the Washpod was able to be connected into the waste pipe.

What were the conditions for success?

- Ensuring all the paperwork was completed for the grant.
- Ensuring the installation team were available from Dignity Access.
- Arranging a time with the person and family for it to be installed.

Contact: Grants Team – grants.team@bedford.gov.uk

Norfolk County Council

Independent Living – purchasing and adapting a home for one person as part of the Transforming Care Programme (TCP)

Norfolk operational teams had been tracking progress in supporting discharge and had identified that the cohort of existing inpatients who have had prolonged stays in independent sector hospitals have the most complex needs and behaviours that existing provision is unable to meet.

The Norfolk County Council housing team aimed to support an individual to move out of a hospital environment into a bespoke environment and to have specialist support built around their needs to enable them to live comfortably and happily in the community.

Funding was provided by NHS England, Norfolk County Council and a Registered Provider (Golden Lane Housing) to purchase and adapt a bungalow in Spixworth (just north of Norwich).

Key staff within Norfolk County Council's housing team, NSCHC, the Registered Provider and Care Provider (Voyage Care) worked together to source a suitable property which was then designed specifically around the individual identified for this property. Once robust timescales had been put into place the individual's parents were invited to the property and a visit was arranged for the individual moving into this property to also visit.

Bi-weekly meetings, monthly site visits and feedback sessions were arranged between all parties to ensure the smooth running of this housing project.

To help manage expectations and to reduce anxiety, regular updates were also provided to the individual by means of photos and an additional site visit was arranged once works were nearing completion and the property was safe to visit.

The building contractor was selected via a tendering process in which one of the key criteria was experience of supported living accommodation. This proved to be invaluable in how the contractor was not only able to understand the design requirements, but also how to accommodate the parents and individual when visiting the property.

The project started by all parties assessing the needs of the individual and what type of property would be suitable, ensuring that the area to be chosen also benefited from local shops, community hubs and was an area that would allow the individual to thrive. Consideration was also given in terms of the works to be carried out to ensure that all the key factors surrounding the individual could be met within budget.

This collaboration continued through the project lifecycle from design stage through to the tenant moving into the property.

The impact was one of totally open communication between all parties, combining ideas/solutions regarding any issues faced by the project as well as positive feedback from NCHC to the group including the beneficial impact it was having on the individual (from site visits and viewing photographs of the works being undertaken in the property).

What were the barriers to success?

- The purchase of the property took longer than anticipated, delaying the moving in date for the individual.
- Delays in the delivery of the furniture from the company caused some anxiety regrading moving in times but was expertly managed by NCC's Adult Learning Disability Transforming Care Team.

What were the conditions for success?

- The property was built as per the design specifications and to the timescales.
- The tenant was extremely happy with their new home.

Further information:

Norfolk Supported Housing

Contact: Robert Elvin – robert.elvin@norfolk.gov.uk

Norfolk County Council

Helping victim-survivors to feel and be safe in their own homes

New Burdens Funding (NBF) has been used to fund a Sanctuary Scheme for victim-survivors assessed as standard to medium risk. Norfolk has a Sanctuary Scheme in place for those at high risk (commissioned by Office of Police Crime Commissioners Norfolk (PCCN)) as part of the Norfolk Integrated Domestic Abuse Service (NIDAS).

There is a gap for victim-survivors who wish to stay in their own homes who are assessed as being at standard to medium risk. The new district-led Sanctuary Scheme helps victim-survivors assessed as standard to medium risk to stay safely in their own home; this is available to those in any tenure and in any district.

The funding has provided training to ensure one qualified officer is available in each local authority area. The new officers can undertake assessments for target hardening measures and arrange for the works to be undertaken. Target hardening includes measures such as smart doorbells and additional locks.

The service ensures that a victim-survivors can remain safely in their own home providing the perpetrator is no longer living in the home. The benefits are that the victim-survivors may be able to continue in employment, maintain support networks and, where there are children, education. In addition, these interventions can prevent risk of escalation, reduce the likelihood of homelessness and lower the demand for domestic abuse safe accommodation which is under pressure.

The new assessment officers work closely with victim-survivors to assess what will help them feel safe, as well as to be safe. The officers also look to engage them in domestic abuse support and signpost them to appropriate services. Once the target hardening measures have been undertaken there is a follow-up to ensure the work is satisfactory and they are able to live safely in their own home.

Examples of outcomes:

- Children had been placed in care because it was no longer safe for them to live at home. Once the target hardening measures had been completed the children were returned to their mother.
- The new service has helped a serving army officer remain safely in his barracks when the perpetrator was due to be released from prison.

Quotes provided by people include:

- ‘It is amazing, I’m so happy about this.’
- ‘I feel safe – thank you for all your help.’
- ‘Thank you for the work you have completed.’
- ‘Over the moon.
- ‘Could not thank you enough.’
- ‘This has helped me very much.’
- ‘I would like to thank the Sanctuary Scheme – I feel much safer in my home and that means so much – thank you all.’
- ‘The works have immediately increased my feelings of safety ... amazing service.’
- ‘Thank you for this and thank you to your colleagues for their diligence and persistence.’

What were the barriers to success?

- It took a while to get the service up and running.
- Getting the service known without officers becoming swamped.

What are the condition for success?

- Continued New Burdens Funding post-31 March 2025

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Shaping and responding to gaps in the market

Suffolk County Council

Connecting with Community Catalysts (Social Enterprise) to help meet demand for social care

Suffolk County Council experienced difficulties in sourcing homecare and meeting demand which was exacerbated by the Covid-19 pandemic. This required an innovative approach outside of traditional commissioning to respond to unmet demand, particularly across large swathes of a significantly rural county such as Suffolk.

This need saw Suffolk connect with Community Catalysts (CCs) which is a social enterprise and community interest company working across the UK to enable people who need care and support to live their lives and access help in ways, times and places that suit them, by providing a choice of attractive local options. CCs facilitate local people using their talents to deliver sustainable community micro-enterprises that can support other local people, creating jobs and volunteering opportunities in a localised geographical area, making the opportunity particularly well suited to Suffolk.

The CCs Programme in Suffolk provide a commissioned service supporting micro-enterprises in establishing and developing care services. The programme has resulted in 75 micro-enterprises being established in Suffolk since September 2022, with 44 of these providing direct care to people.

Key features of micro-enterprises:

- Local people providing support to other local people.
- Very small scale (eight or fewer workers – paid or unpaid).
- Independent of any larger organisation.
- Run on a range of models, on a continuum from voluntary to commercial.
- Can be run by anyone including people who use services or their families.
- Includes established enterprises and new start-ups.
- Provide greater degree of resilience and flexibility to the care market.
- Personal and tailored support.
- Rooted in communities.
- Coproduced services.
- Flexible and responsive to change.
- Real choice of diverse services and support that helps people to live their lives.
- Help people to link to their community and build social capital.
- Helps the money go further.

The development of micro-enterprises within the care market aligns firmly with Suffolk adult social care's 'People at the Heart of Care Strategy' supporting the council to further develop their personalisation agenda through increasing choice and control for residents and increasing uptake of self-directed support. The development of micro-enterprises in the care market is also supporting the development of a more diverse and sustainable market alongside benefitting our local economy.

What were the barriers to success?

- Integrating direct payments and e-brokerage into the new enterprises to unlock the full potential of direct payments with enterprises.
- Ensuring there is strong ongoing communications to continuously get the message out regarding not only the opportunity for individuals to create their own enterprise, but also embedding the new enterprises into the care market requires constant reinforcement. There has been some success using social media to promote the programme, and more recently word of mouth has led to a number of new enquiries.
- Lack of development funding for new enterprises. Some new enterprises would flourish with small of amounts of additional financial assistance to develop their enterprise effectively.

What are the conditions for success?

- Good communications and engagement.
- A supportive process and approach.
- Integrating with personalisation agendas.
- Strong personalisation agenda.

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Hertfordshire County Council

Care home pathway for people with non-cognitive symptoms of dementia

Step down from mental health inpatient unit to nursing dementia care home setting.

It was known to the council that considerable numbers of older adults with significant non-cognitive systems of dementia have been 'stuck' in the wrong care settings, including mental health hospitals, because they often cannot be effectively supported in care home settings. This was known to lead to poor outcomes for both the person and unpaid carers.

Work to understand the issues identified the following:

- There was a need to improve the multi-disciplinary team approach and align the practice of the entire partnership to an evidence-based model that delivered psycho-social intervention as a first-line approach.
- Care home environment itself needed to be conducive to the care of people with non-cognitive symptoms of dementia.
- Care home staff needed better training to empower them to support people with non-cognitive symptoms of dementia.

In response, the council:

- commissioned twenty-six nursing dementia beds in care homes to support an enhanced pathway
- project designed a countywide enhanced nursing home dementia pathway to optimise treatment and care for people with non-cognitive symptoms of dementia to improve person-centred outcomes and wellbeing
- developed a model which includes a multi-disciplinary team approach including the GP, psychiatrist, community mental health nurse, frailty nurse consultant, occupational therapist, social worker and care provider clinical lead to support people with medium to high behavioural and psychological needs stepping down from a mental health inpatient unit into a care home setting.
- embedded the project in a wider evaluation of care home support for people with high frailty and dementia, and the learning is being used to shape the model towards a more personalised, strength-based approach.

By working in partnership with health and social care practitioners and care providers across the system, the council was able to identify the problem and work together to deliver true collaboration and integration of services by using a holistic approach with a focus on outcomes for the person.

- NCC commissioned a Public Health Research and Evaluation Lead who collaborated with adult social care practitioners and commissioners, mental health trust, primary and community care provider and care home provider to research and develop a best-practice model of care for people with non-cognitive symptoms of dementia using a strength-based approach and psychosocial interventions to support wellbeing and prevent crisis.
- Commissioners worked with the care home provider to commission a nursing dementia bed base unit to implement the enhanced model of care.
- The council mapped how to implement the model of care using a multi-disciplinary team approach (MDT) and identified dedicated resources to support the service. It also developed and delivered enhanced dementia care training to care home staff to embed the approach and model of care.
- The council embedded a project manager and research and evaluation lead into the MDT to continuously monitor the implementation of the care model and approach and gather learning to support the evaluation.

The council worked closely with people who access care and support, families and providers, for example:

- it worked directly and indirectly with people, their families and carers to understand how the approach was working and how it could be developed. The wider care model evaluation involves coproduction with people with lived experience of dementia.
- through the wider care model, the council was able to support people to be cared for and enabled in a far more appropriate setting and helped them to return to their local community
- using a strength-based model enabled people to achieve better outcomes through connections, forming friendships and understanding their strengths to support them to make choices and participate in their care.

Examples of outcomes and impact:

- Service mobilised from standstill in two months and in operation for three months.
- Sixteen people supported in a community setting that would otherwise have not been accessible to them.
- One hundred per cent of people discharged to service remain out of hospital.
- Thirty per cent of the people admitted to the service have been discharged and are now in a lifetime home, which was previously not considered possible.
- Fifty per cent of people discharged from the service were assessed at lower need level than at admission.
- Average length of stay for people discharged is thirty-one days (including a person who had stayed in hospital for over one hundred days longer than necessary due to a lack of community care options).
- Improved individual wellbeing and reduced social isolation for people and their carers.
- People actively participating in their care.
- Enhanced MDT approach utilised non-medical interventions to manage behaviours successfully; tailored care and support and investment in non-pharmacological interventions.

- Individual preferences and choices supported socially and not treated as clinical symptoms.
- Continuity of approach whilst transferring to new care settings.
- Mutual learning and exemplar 'MDT' working in action; breaking down primary/secondary care barriers, engaged and highly motivated MDT with common, clear goals and able to better forward plan for individual care needs.

What were the barriers to success?

- Uninclusive/inaccurate language sometimes used to describe people's needs.
- Outdated referral information.
- Lack of person's background and life history work.
- Lack of timely mental health support before crisis.
- Lack of focus on prevention and support for provider to prevent escalation and crisis.
- Planning person-centred care.
- Choices and social needs misidentified as clinical symptoms.

What were the conditions for success?

- Evidence-based approach with defined aims, values and professional activity addressing non-cognitive symptoms of dementia.
- Dedicated MDT support from mental health professionals, GP and social care to provide holistic care and support and put in place preventative measures and plan for escalation to provide timely support to the individual.
- Individual outcomes dependent on highly collaborative decision-making with participation from social work, mental health/psychiatry, frailty, general medical and care home practitioners.
- Access to timely and accurate information is fundamental to MDT success.
- Inclusive, strength-based language and assessment essential to positive outcomes.
- Up-to-date referral information and recent assessment based on how the person presents currently, their behaviours, preventative measures and care plans.
- Sufficient life history information about the person to support care planning.
- Equity of access relies on MDT working together to bring the service to the person.
- Care home staffing model allows for highly individualised care needed to secure outcomes.
- Care home nursing staffing complement and staff training provides professional oversight, knowledge and skills to positively respond to significant non-cognitive symptoms.
- Care home household layout, space, and environment is very important.

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Bedford Borough

Support to vulnerable prisoners under Section 76 of the Care Act 2014

The development of a support pathway for vulnerable prisoners to access care and support in Bedford Prison.

Bedford hosts HMP Bedford in the locality, a Category B all-male prison with a current population of more than five hundred prisoners, which faces increasing challenges of overcrowding and poor conditions. HMP Bedford has come under significant scrutiny of HM Inspectorate of Prisons and the Care Quality Commission.

Under Section 76 of the Care Act 2014 the delegated function lies with the council's adult learning disability team (ALDT) and it has been working collaboratively with the prison and its onsite health team to ensure prisoners who may have care and support needs under the Act are identified and helped to access an assessment of their needs.

The council put the following in place:

- An agreed pathway for referral and access to assessment, support planning and review has been developed with partners in the prison and has worked well to identify and respond to need. This was to support the current Memorandum of Understanding.
- Referrals designed for staff on site to utilise and access the Adult Learning Team as the first point of contact and a template for self-referral for prisoners that is part of the information shared at the start of their journey within the prison, to ensure they can self-refer to our service.
- The Care Act advocates to support the needs of prisoners and to ensure that they have appropriate and independent support throughout the process.
- Reasonable adjustments to support the prisoner and the process of assessment in terms of the environment, support and any communication needs, aids or other adaptations to fully engage the prisoner in their assessment. This is completed in partnership with prison staff and the health team and planned for at the earliest opportunity once a referral is received to the ALDT.
- Operational meetings between the ALDT and the head of healthcare and clinicians as well as safe custody staff to look at any issues or barriers to assessments or support being provided. The outcomes feed into quarterly meetings with the Director of Adult Services and the Prison Governor as to the response needed, and the insurance that those who are most of need within the prison setting are being identified and supported through the process of assessment under the Act.

- Continued joint work with the onsite health and safe custody team to provide assessment and recommendations for parole hearings and to ensure appropriate support is quantified and personalised to the individual. This will enable the next step back to the community, will be safe and support positive outcomes for the individual. This includes communication with the appropriate local authorities to which the prisoner will return to at the end of their sentence.
- ALDT feeds back outcomes to the Prison Partnership Board to be transparent in line with current needs, pressures and to address any concerns.

What were the barriers to success?

- Access and security to the prison to complete assessments and/or reviews can be challenging and needs the continued support and engagement of colleagues on site to ensure access is not impeded or delayed.
- An understanding of the Care Act by prison staff and the health team regarding assessments for vulnerable prisoners, and when referrals are needed and are appropriate.
- Staffing issues at the prison can impact on the opportunity to set up assessment and review times with prisoners so continued liaison with the MDT to improve this process based on current prison pressures and an emphasis on meeting the needs of individuals is needed.

What were the conditions for success?

- Coproduction with the prisoner to their ensure needs, wishes and aspirations can be met and working in partnership with MDT on site as well as the broader communication with the relevant local authority.
- Skill building which increases the prisoner's opportunities to develop independent life skills prior to release wherever possible. Such work enables exploration by the prison and health team to increase opportunities for the prisoner's successful return to the community.
- Single point of contact through the triage of the health team direct to ALDT rather than random referrals from all parts of the prison. This centralises the information and provides a single point of contact for the process, timely response and reduces the risk of needs being missed or referrals not being made.

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Norfolk County Council

Proactive Intervention Project

Demonstrating innovation through the design and delivery of a creative forward-thinking approach to prevention.

With a view to support residents to be more proactive about their health and wellbeing and connected to their local community, the Norfolk County Council (NCC) is looking to prevent, reduce and delay demand for long-term care.

The Proactive Intervention Project aims to identify at-risk groups from the population of Norfolk and provide an approach to proactively support them before their care needs escalate.

At-risk groups are identified and prioritised for preventative interventions, for example, mobility classes and assistive technology to ensure the person is receiving the level of support that reduces their risk of escalating needs. The identification process uses advanced analytics to leverage existing adult social care (ASC) data. ASC records are pseudonymised and analysed to extract risk and resilience factors. Within NCC's systems the data and analysis can be used to identify individuals at risk and prioritise those who would benefit from proactive interventions and by collaborating with local partners across the Integrated Care System (ICS) to offer proactive interventions to individuals.

The next steps are phase 2 and phase 3.

Phase 2

- Being delivered by South Norfolk (SN) & Broadland District Council (BDC) using their data with more of preventative contact.
- User research to explore detailed insight into individuals' lives.
- NCC, SN and BDC highlighting specific ideas for future work, e.g. social isolation and loneliness.
- Scoping process in development to identify focus and resources required for each project.
- Ongoing analysis of the impact of interventions.

Phase 3 and beyond

- Social isolation and loneliness – scoping workshop.
- Continuation of falls project bringing in additional parties, streamlining the cohort, exploring a range of interventions and benefits mapping.
- Digital inclusion aligned with the Digital Inclusion Programme operating in the West and looking at the use of tablets/pedometers.

- Overlap – there will be an element of overlap between falls and social isolation and loneliness risks and this will provide an opportunity to work with more elevated risks, ensuring people are only contacted once.
- Health data – in discussion with the ICB regarding the use of certain health data within a continuation of the falls project.
- Supporting learning disability and autism (LD&A) colleagues to identify individuals who could be supported into employment opportunities.
- Norwich Complex Health Enhanced Social Support (CHESS) project – identifying individuals on the Norwich locality holding list who are at risk of escalating needs whilst waiting for a Care Act Assessment. By identifying individuals, they can be referred into the CHESS project to prevent a crisis.
- Holding lists/review lists – this technology could assist with added risk assessment analysis for those waiting for assessments or reviews.

Being in contact with a range of people is key to engage clients, and involves change management skills via a holistic conversation and understanding their best personal support to recommend the most suitable intervention.

The intervention is delivered by the appropriate services, ensuring there is an agreed capacity, and using nudge theory to engage with clients and warm referrals to maximise uptake.

NCC followed up with clients to understand where interventions were delivered and if they were successful and if not, why not. Examples of outcomes:

- Early results show this is improving outcomes and residents' lives. NCC have seen a 15 per cent reduction in people fearing the impact of a fall and 100 per cent quoted no recent falls since their intervention.
- One person said, 'I was very pleased with the support provided as I'll now be able to access my garden more freely.'
- User and staff engagement is helpful to the council to learn and going forward it is helping the council to collaborate with more partners and the local system.

What were the barriers to success?

- Escalation of clients' needs which resulted in them being too advanced for a preventative intervention.
- Clients with lower needs felt this support did not relate to them.
- Scripted nature of the phone calls.

What were the condition for success?

- Client fully engaged.

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Please also refer to page 53 (as this is similar).

Norfolk County Council

Achieving Care Quality Together (AQT) provider conference

Care leaders coming together to shape the future of Norfolk Adult Social Care.

Care quality in the adult social care market is a key priority for Norfolk County Council (NCC), the Integrated Care System (ICS) and partners.

The aim of the conference was to bring together key organisations from the voluntary, community and social enterprise (VCSE) and care market, statutory organisations and councillors to share work to date including best practice, engage on future projects, priorities and strategies for the social care and health system, celebrate care quality achievements and engage on areas of improvement. A further aim was listening to and supporting care providers to develop, shape and continuously improve care quality for the benefit of providers, care staff and individuals that access services and to sustain the Norfolk care market for the residents of Norfolk.

This is turn would strengthen the relationships between our commissioners, integrated quality improvement service and care providers and improve Care Quality Commission (CQC) ratings across services.

As part of the Social Care Quality Improvement Programme, the council held a full day's conference for 600+ providers across Norfolk.

This conference provided a valuable opportunity to bring together key organisations from the Norfolk adult social care market along with health and social care system leaders to focus on delivering the best possible care provision for the county. The conference provided the opportunity to consider the national and local social care agenda, challenges and opportunities, as well as share best practice and celebrate care quality achievements. The day focused on leadership and provided the opportunity to work together on priorities that leaders across the social care sector had highlighted as important to achieving good quality care for Norfolk.

The conference had keynote speakers from both a national and Norfolk perspective. With representation from the CQC, the single assessment framework was a key driver for conversations.

The afternoon was dedicated to a series of workshops that were coproduced with partners from Norfolk Care Association, Healthwatch Norfolk and others. Themes for the workshops had been suggested by the care providers:

- Workforce strategy, recruitment and retention, the new National Care Workforce Career Pathway
- Delegated healthcare interventions
- Peer support with Norfolk Care Association

- CQC Single Assessment Framework
- IT support for providers
- Feedback with Healthwatch Norfolk
- The Real Care Deal/Ethical Framework with Curators of Change.

Through regular provider engagement sessions over the previous 12 months the conference was designed to meet both the needs of the providers and the strategic aims of Norfolk County Council to improve the CQC quality rating across regulated services for residents in Norfolk.

Some of the key drivers were for providers to:

- feel engaged, valued, inspired and listened to
- hear and reflect on the innovative practice going on in Norfolk
- have a clear sense of travel for care quality in Norfolk
- be motivated to engage in care quality planning.

What were the barriers for success?

- Norfolk is a large rural county so putting on a large-scale event had to be in an accessible, central location.
- Targeting key groups, e.g. hard-to-reach providers to encourage attendance.
- Being able to pinpoint the priorities for the day and how they are measured.

What were the conditions for success?

- Number of attendees. The audience were registered managers, directors and owners of care settings and care agencies.
- A targeted survey for the workshops was developed; the key themes from this will shape future engagement and targeted support.
- Feedback from the workshops will develop individual projects, help inform the social care quality improvement programme (SCQIP) in the year ahead and input into the adult social care market quality improvement strategy.
- Positive feedback from the attendees.
- A variety of media coverage to highlight that NCC are supportive and value the care workforce.

Further information:

Norfolk & Suffolk Care Support (norfolkandsuffolkcaresupport.co.uk)

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Essex County Council

Market shaping in Essex

Through the development of a one-stop-shop provider hub and a forward looking market shaping strategy the council is seeking to create a diverse and sustainable care market in Essex.

In Essex there is a wide range of care providers and voluntary and community organisations that support and provide care to frail older people, adults with learning disabilities or autism, those with mental health support needs and those living with physical and sensory impairments. It is the council's duty to understand the local market of care provision, to stimulate a diverse range of care and support services, ensure that the market is sustainable, and to prepare for any provider failure.

Essex County Council (ECC) produced the Market Shaping Strategy which covers the next seven years. The strategy includes:

- why a strategy is needed
- an overview of the Essex care market and how it is already changing
- future vision for social care in Essex, and what this means for how the market needs to change
- key strategic challenges and market gaps, and the associated actions needed to address them.

The council also produced a Care Workforce Strategy that was designed to empower the social care workforce in Essex to understand and respond to the challenges and opportunities it faces against a backdrop of a number of local, regional and national drivers.

Furthermore, the Provider Hub is a newly developed online resource for providers to find these strategies, as well as other products such as the Market Position Statement. This statement provides an overview of adult social care's current commissioning intentions, market pressures and ambition that support existing strategic objectives for ECC. The Hub also includes resources such as an interactive map that gives an overview of the care services ECC provides in each district of the county.

The Market Shaping Strategy was developed over 12 months through workshops and input from providers, adults with lived experience, the NHS, Adult Social Care Operations and Commissioning, Procurement, Data & Insight and Finance. The Care Workforce Strategy was also co-produced.

ECC has developed a set of principles that will be utilised as part of their existing service delivery and support the future commissioning of services across Essex. The accompanying principles for the statements will also help ECC to stay focused on the outcomes they are supporting.

What were the barriers to success?

- Breadth and scale of the project.
- The council's work to support the market covers large and numerous areas and required the engagement of a lot of stakeholders, who also needed to provide agreement on the products. This ultimately turned out to be a positive and engaging process but was a difficult barrier initially to work through.

What were the conditions for success?

The quantitative and qualitative measures to assess the success of our Market Shaping Strategy include:

- a reduction in permanent admissions to residential care
- a reduction in the supply of care home beds
- an increase in the use of short-term services
- an increase in the percentage of people supported to live in their own home/community
- an increase in care market recruitment and retention rates
- an increase in the percentage of care providers rated 'good' or 'outstanding'
- an increase in satisfaction with services for care users and for unpaid carers
- an increase in the number of people supported via care technology to live as independently as possible
- an increase in adults with learning disabilities accessing paid employment
- continued high levels of satisfaction on quality of care, value for money and choice
- readiness for the Social Care Reforms and these reforms land well across Essex.

For the Care Workforce Strategy, the council wants to see:

- robust recruitment and retention tools
- good supply of skilled workforce
- continuous professional career development
- health and wellbeing investment in our staff
- system-wide working through digital and data.

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Southend City Council

Social Care Provider Hub (website)

A one stop shop for all social care providers to access essential resources to support them to deliver excellent person-centred services.

Social care providers did not have a single point of access for important updates or information from Southend City Council (SCC) regarding what was available for their service development and workforce support.

Providers were unclear of the structure of the commissioning team and how to contact individuals and were not aware of the free training that SCC can offer to develop their workforce. Access to important resource documents, along with being able to view messages or services from the broader commissioning team, adult social care team or useful updates from health was via a large volume of emails, that may be overlooked.

The focus had previously been on older people's residential services and some essential information, updates and opportunities had not been accessed by supported living, home care or day opportunities services.

The council needed to be able to reach out to all provider types and actively engage with them to promote service development, deliver essential information and workforce support.

The Social Care Provider Hub was developed so that all of the essential services and information delivered could be accessed by all providers across SCC in a one stop shop.

Developing the hub has allowed the council to advertise all training that is offered to support social care providers across the whole city, where they can also book their place onto each training session.

The council has a resources page where all essential documents are available to social care providers that have signed up to access the hub; these range from PowerPoint presentations on person-centred support planning to operational teams falls guidance, along with information from Skills for Care and the Care Quality Commission.

Weekly updates and monthly newsletters are stored for social care providers to review along with the emailed copies that they receive using a Mailchimp template, enabling the council to implement new branding for the commissioning function of SCC.

There is a rolling banner on the home page of the hub that is displayed with the EDAS vision for SCC Services, but it also promotes events that the principle social worker operations team plan such as service-user forums along with any important updates from partners within health and the Integrated Care Board.

SCC are currently running campaigns for the digital transformation offer with a video which can be accessed from the banner on the home page along with health notices.

There is also a careers page with different career paths within social care and details and links for partners that can support with recruitment within social care, one of these being SECHA, the local care association. The council details all the training partners that social care providers can access and book to strengthen their workforce.

There are specific links to the new social care provider portal, so again a one-stop-shop method can be delivered. This allows all providers to access the portal directly to complete financial claims from SCC and they do not have to try and search for the related links or updated information from the contract/payments teams.

SCC have chosen to implement a professional slick hub to trickle down the quality standards the council expects social care providers to engage with to ensure they mirror a professional, well-presented position.

The provider hub was always solely aimed at providers and the staff teams that work within them; it does not contain information that would necessarily be useful to people accessing care and support other than understanding what support and guidance SCC offers to their contracted providers.

SCC recognises from social care provider feedback that they wanted one place that was easy to access to gain information detailing the support that could be offered to them to develop their services and workforce, and so they could understand the vision and expectations from SCC.

Feedback from providers was also that they had difficulty in retrieving any resources that were offered, so the hub is able to offer a resource section where providers can easily retrieve any information that they require. This section also enables providers to promote their own good news stories and updates detailing the positive career and roles within social care.

Internal and external feedback:

- Easy access and booking of social care provider training and developmental workshops.
- One stop shop for all important resources.
- Showcases important messages from health and operations team.
- Delivers clear messages on SCC expectations and vision.
- Positive messages about different jobs within social care
- What support social care provider can access from SCC and health partners.
- What support providers can access to assist recruitment of new staff.

What were the barriers for success?

- Not all social care providers understanding the importance of accessing the provider hub and registering to access resources and the monthly newsletter and weekly updates.
- Internal and external colleagues understanding the purpose of the hub.

What were the conditions for success?

- All providers signing up to the hub.
- Providers reviewing and booking training events and developmental workshops.
- Positive feedback from providers that the information contained on the hub is useful and informative.
- Providers sharing their good news stories.

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Workforce and service redesign

Photo: Centre for Ageing Better

Cambridgeshire County Council

Let's 'Care Together'

Supporting an ageing population to maintain independence at home.

To support an ageing population to maintain independence at home, helping to delay demand for adult social for over 50s the council recognised the need to:

- make its commissioned early intervention and prevention offer more evidence-based
- develop commissioning practices to become more localised, with coproduction at the heart
- find ways to work more closely with other council services to support older people, including public health, libraries and communities teams
- pursue opportunities for greater collaboration with health and other partners as the Integrated Care System introduced the Integrated Neighbourhood model.

The council invested in a two-year place-based pilot in East Cambridgeshire to explore the above. After extensive engagement with a broad range of older people, several projects were created to address gaps in care and support in the local community and test new approaches. These included improving accessible transport, introduction of Individual Service Funds and Care Micro-Enterprise (CME) development. A wide range of partners (including district councils and primary care networks) joined with adult social care (ASC) commissioners, libraries staff and locality coordinators to lead and deliver the projects.

The decision was made to expand the Care Together Programme countywide and with a four-year investment, a formal programme structure was created with senior leadership support across key council teams. This had a clear vision and set measurable benefits to deliver by the end of year four.

The investment funded a small team of place-based commissioners and Care Micro-enterprise development officers. They work closely with colleagues from public health, libraries and communities teams to develop and implement a programme, supported by the Council's Programme Management Office. The investment also offered £250K in seed-funding per year (in year two of this four-year programme) to stimulate innovative ways of working and expansion of community assets so there are more local opportunities, as well as redesigning contracts and other grants to reflect locally identified needs and allow for place-based delivery with the right partners.

Alongside this, the council undertook a public health evidence review to understand what works in encouraging people to 'age well' and trained all ASC commissioners in evidence/literature skills to ensure the commissioning practice is evidence-based.

At the time of writing (March 2024), the Council are mid-way through the four-year programme.

The Care Together Team has engaged in Appreciative Enquiry with older adults and their carers at third party events (such as Golden Age Fairs, Lunch Clubs, Knit and Natter Groups, Dementia Cafes, Coffee Mornings and many more) as well as drop-in sessions at local libraries. They also sit on the Integrated Neighbourhood Delivery Boards, engaging with social prescribers, GPs, community navigators and other voluntary and community sector partners. By actively building relationships of trust in the communities they serve, the Care Together team has been able to identify challenges and establish shared priorities, coproducing solutions in place-based ways. The learning from this has been cascaded into the wider ASC Commissioning Service, with all staff offered training in coproduction and Appreciative Enquiry.

A number of 'We' statements have been followed:

- We talk with people about what they want from life – this has been done using Appreciative Enquiry as a tool and is an ongoing and regular process, rather than a one-off consultation type activity, which has led to seed-funded projects that closely match the needs, gaps and expectations of each community.
- We think about their care, support and homes – Care Together is aimed at people who need care and support in their own homes or in their local community. The council has over 40 CMEs offering a combination of personal care (both CQC registered and exempt sole traders) and holistic care and support offers. This offers more choice, flexibility and personalisation for people.
- We make sure that people's plans talk about being healthy and happy – our evidence review highlighted physical activity and social inclusion are key to ageing well. We transformed day opportunities by introducing Older Adult Social Inclusion (OASI) grants. The grants were coproduced with partners and older people and require a physical activity offer (including chair-based exercises) along with staff training in Making Every Contact Count. The OASI grants are expected to almost double the number of older people benefitting from these day opportunities for the same level of investment.

The focus on physical activity and social inclusion is central to the projects seed funded too. For example, one of the seed-funded projects is a Mobile Gym which tours rural villages, offering opportunities for exercise and social interaction to older people where there are no gyms/infrastructure in their communities. The seed funding enables the Mobile Gym to offer a number of sessions for free before reverting to charging. That way, the service is sustainable rather than dependent on continued seed funding.

The council plans to build on the evidence-led approach by introducing similar physical activity and social inclusion requirements into future Homecare specification as the recommissioning of Homecare DPS over the next 2–3 years.

Further 'We' statements include:

- We keep people safe without stopping them from doing things that are important to them – the council created strict minimum standards for the Care Micro-enterprises in terms of safeguarding, health and safety, first aid and other training and policies they must meet before being listed in the directory. They enable and support anybody over 18 (including those with learning disabilities, physical disabilities and other needs) to do the things they want to do.
- We help people to get together in groups to share their stories and ideas – both the annual seed funding and OASI grants involved stakeholder panels which included

providers, health colleagues, people with lived experience, carers and commissioners, who first identified gaps and demands in each locality, then reconvened to agree how underspent funds should be allocated in Round 2.

- We welcome ideas about using personal budgets in a new and different way – the Care Together Programme is linked to the Self Directed Services Programme, which promotes Direct Payments and Individual Service Funds, in turn linking to the services provided by CMEs who can be paid by a Direct Payment. It also supported an Integrated Neighbourhood to pilot personal budgets for admission avoidance over winter, with CMEs being available as part of the support offer.
- We find ways for people to do things with their community and help other people – Care Together funded over 20 projects in its first year, creating hundreds of volunteering opportunities and benefiting almost 1000 older adults in just over six months of activity. One example is the Community Hubs project in East Cambridgeshire, which has secured long-term funding for 10 volunteer-led community groups where, on average, 77 per cent of attendees are over 65. Over 300 people on average attend these groups each month, supported by almost 40 volunteers. Locality coordinators from Communities Service have been pivotal in connecting local stakeholders, facilitating conversations and supporting the development of community assets through Community Makers and other asset-based approaches.

What were the barriers to success?

- At the outset there was a need for more joined-up working, not only with health and VCSE organisations (in the spirit of coproduction), but also between and across local authority departments that had previously worked independently of one another.
- As a result of this so-called 'silo-working' it took time to build trust and reach the point where partners felt confident with co-funding initiatives and sharing data.
- Finding ways to measure the impact of the programme has been challenging. To overcome this, the council has used several tools to define success and benefits including Social Care Value Portal's Themes, Outcomes and Measures, a balanced scorecard and Managing Successful Programmes approach.

What were the conditions for success?

- The place-based approach evidenced by Care Together is only possible when there are sufficient resources to engage with partners and experts by experience in each locality.
- Adopting the Cambridge City and District Council boundaries to define localities. This allowed meaningful engagement with City and District Councils, as well as Integrated Neighbourhoods.
- Another essential success factor is investment in funding pots that enable support for new initiatives and expansion of successful projects in new areas.
- As with all new ways of working (change programme) an indisputable condition is buy in and political will from both elected members and senior officers to explore new ways of working.

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Southend City Council

Connected Southend – A vision needs work

Designing and implementing a new modern service structure with a strong focus on prevention whilst connecting people with the community.

The way organisations manage change can say a lot about their ability to support, develop and care for their workers. One of the things Southend adult social care has always been proud of is loyalty to its workers, which is reflected in a very low staff turnover and a very low dependence on agency workers. This meant that there was a lot at stake when the process was begun to deliver significant change across social care operations in Southend City Council.

Under new senior leadership adult services have developed a new model called 'Connected Southend'.

Connected Southend is a whole-service approach to community practice, personalised enablement, new models of commissioning and social care support across the city; in essence it is a new approach to providing the very best information, advice, prevention, support and social care. Alongside this, Connected Southend has the heart of the city embedded within, through the use and support of voluntary and community groups as well as the arts, culture, leisure and heritage.

Bringing together practitioners, commissioners and providers, as well as the wider culture, arts and leisure services, the council aim to change the way they support and enable people to live the lives they choose to live. Connected Southend is underpinned by the core concepts of the Care Act, ensuring community opportunities, citizenship and personalised outcomes and is now core to Southend's social services plans for the future.

The existing structure needed to be modernised to ensure that the priorities of this model could be delivered. The council also took the opportunity to update and evaluate all job descriptions. In addition, the service re-design needed to deliver savings while the council invited applications for voluntary redundancies as part of a council-wide programme.

This presented a huge mountain to climb for all involved. The council is sure it will say more about the positive impact the model is having for its residents in next year's contribution. This year the focus will be on the change process itself and on those who enabled and delivered it.

Supporting a workforce of over 180 colleagues through times of significant change required a clear plan, effective communication, sensible negotiations and strong leadership.

The council are immensely proud of the team that came together to lead and manage this complex and challenging programme of change. This set the foundation for the delivery of 'Connected Southend'.

The so-called 'middle management' often gets overlooked when it comes to identifying factors for success. Here is an example that highlights how important heads of service and service managers are for the successful delivery of social care services, especially for change programmes.

SCC have chosen this example to shine a light on the huge amount of work that needs to be undertaken to enable organisational change. Every vision needs work and people who do it with dedication.

The process can be described in three phases:

1. Design phase: In the first phase heads of service were asked to develop a structure that would meet the requirements for service that can deliver on the priorities of the new Connected Southend model. This was done in a collaborative way. Drafts were produced, reviewed, updated and finally signed off in a short period of time.
2. Staff consultation phase.
3. Implementation phase: This phase is currently ongoing and will take approximately six months.

The consultation process included:

- Four consultation briefing sessions with directors.
- Five consultation update briefing sessions with heads of service.
- Heads of service and human resources responded to 146 questions and produced 70 frequently-asked-question responses.
- Communicated Q&A and the FAQ via a specific consultation Microsoft Teams channel.
- Countless one-to-ones with heads of service.
- Responded to 30 separate emails via a consultation mailbox.
- Received, considered and responded to three alternative design suggestions.
- Offered shadowing opportunities to colleagues to inform their decision-making.

Most of the work was undertaken in six months with a very busy period of about eight weeks. The council is proud of the managers who have delivered the re-organisation under difficult circumstances. They have inspired the workers, managed challenges along the way and are now best placed to implement an innovative service model.

A part of the restructure process required the council to undertake a public consultation. The feedback from the public has resulted in changes to the original plan.

Examples of outcomes and impact are:

- a service structure that supports the vision for a new service model 'Connected Southend'
- stronger focus on prevention
- enabling and unleashing the full potential of social work and occupational therapy practice.

What were the barriers for success?

- Political priorities had to be considered during design and implementation of the new structure
- Negotiations with trade unions had an impact on the process.
- Fear of change.
- Financial limitations.

What were the conditions for success?

- A good plan.
- A clear communication strategy.
- Good communication and negotiation skills.
- A strong values base.
- Hard work and dedication.

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Thurrock Borough Council

Thurrock's locality-based working model – One place, one team

Locality-based approach to integration using the principles of Human Learning Systems.

The 'Case for Further Change' is clearly set out in the Better Care Together Thurrock (BCTT) strategy (2022–2026) and the collective plan to transform, improve and integrate health, care and third-sector services focusing on Thurrock's adults and older people to improve their wellbeing. The approach taken has been inclusive, bringing together commissioners, providers and colleagues from Thurrock Council, the NHS, third/voluntary sector and Healthwatch.

The BCCT strategy outlines the case for change; it demonstrates the space in which the Mid and South Essex (MSE) Integrated Care Services (ICS) and Thurrock Integrated Care Alliance (TICA) operates is a multi-factorial environment that is often messy in its approach. Challenges such as ill health or homelessness are caused by a tangled web of different but interdependent causes. Systems have been designed in a complicated way and often not designed to deliver the outcomes people want. They often deliver silo 'interventions' and traditionally apply a 'one size fits all' approach to a problem.

The Better Care Together Case for Further Change identifies a solution to the current system and doing public management differently, and using Human Learning Systems is a means by which to achieve this. It provides an outline of how public service can be undertaken and organised differently (see Chapter 2, pages 17–25). As agreed by all the TICA partners the overarching commitment and desire is that this transformation reflects ongoing comprehensive engagement with residents including codesign and coproduction approaches.

The Better Care Together Thurrock Strategy recognises that the space in which health, care and wellbeing providers operate in is a complex and often messy environment because it is based on human relationships, and each one of Thurrock's residents is unique and complex.

Currently Thurrock has multiple organisations each with their own referrals, thresholds and standard operating procedures. People needing support will have to meet set criteria and thresholds. The support that they then receive, if deemed eligible, will be standardised and focused on a single need, and rarely sufficiently tailored or personalised. Residents' lives are rarely like this. They often have multiple interconnected needs requiring support from different teams and organisations. They need an integrated solution but are required to navigate a bewildering public sector landscape to try to access multiple different services, each likely to be provided in isolation and each having its own referral route and eligibility criteria.

An integrated community-based approach that is tailored to the individual rather than to the system will focus on preventing, delaying and reducing the need for care and support and deliver the most effective use of resources. The approach will be built on the principles of Human Learning Systems and continues the significant and successful work already started by the council, for example community-led support, blended roles, co-located teams across health, housing and adult social care, etc.

The approach was based around the following principles:

- Reducing bureaucracy – collaboration and reducing referral processes.
- Right person, right time – residents not having to repeat their story multiple times.
- Shared responsibility, shared resources and skills – joint working approach and a bespoke solution to complex individual cases.
- What matters most to residents regarding local priorities.
- Unlock challenges and systems barriers and find solutions as a collective.
- Exploring any gaps in services that are identified.

The objectives are as follows:

- To create a new Integrated Locality Network of professionals for each of the four Thurrock localities, aligned around each primary pare network (PCN) and where possible have agreed collocated sites based on three underpinning pillars of place as an organising principle, adopting a new workforce culture and bespoke coordinated care. Align more specialised social care teams to place.
- Development of four integrated health, housing and care and primary care networks (one per PCN) to include named individual links from across the wider health and care system to be engaged.
- Agreement and introduction of four shared spaces with collated working across health, housing and care.
- Creation of a shared sense of understanding of the aim and establish a collaborative culture within localities.
- Review all current multiagency forums to support alignment and capacity with ultimate objective to reduce meetings where possible and support local earlier intervention and support.
- Ensure primary care and the principles around integrated neighbourhood teams and the clinical strategy is aligned to this work.
- Ensure all new roles across health, care and housing, where relevant, are inducted into the approach and are aligned as they arrive.
- This business case aligns with all sub-business cases aligned to integrated working.

Desired outcomes:

- Residents can achieve more of what matters to them.
- Support is provided in collaboration with the community and focuses first and foremost on what the community can offer.
- Residents maximise opportunities to stay as healthy as possible and require fewer interventions from services.

- Residents can find the right solution for them first time and in the right place.
- Residents are empowered to achieve their version of a good life.
- The alliance and system resources achieve better outcomes through earlier intervention and prevention integrated solutions that reduce 'failure demand'.
- Integrated systems – departure from silo-based working.
- Reduced bureaucracy and failure demand.
- Quicker decisions and less onward referrals and hand-offs.
- Integrated and personalised solutions rather than service-based solutions.
- Reduced spend per solution.
- Increased examples of early intervention as opposed to crisis intervention.
- Increased staff satisfaction and satisfaction of people who access care and support and their families and carers.

Thurrock Adult Social Care (ASC) has adopted a strengths-based approach to social work for many years. This approach was developed further during 2018 with the introduction of community-led support (CLS) which led to the Early Intervention and Prevention Teams being relaunched as four community-based teams.

During the pandemic, significant change was experienced with teams feeling further liberated and empowered to 'do the right thing' and empowered to flex criteria and thresholds. It is the expectation of this business case that the council takes the learning from the pandemic and the work in communities (as part of the transformation approach) to further progress change.

The plan was to focus on expanding and joining up the work tested, applying the learning to develop an integrated and coordinated health and care model that wrapped around each PCN and core services delivered by GP practices.

The mode operates in line with the BCTT integrated locality working principles and meets the three pillars of place as an organising principle, creating a new working culture and providing a co-ordinated bespoke model of care for the individual.

What we put in place:

- Human Learning System approach.
- Adult Social Care CLS teams based in each primary care network, with a merged multiskilled team of mental health practitioners and complex care practitioners to allow shared knowledge and skills to be available in place, reducing onward referrals between teams.
- Created four integrated locality-based teams (ILT) across the borough in line with PCNs with teams consisting of members form primary health, adult social care, children's services, housing and a wide range of teams, services and link workers.
- Local team directories and solutions sessions for all frontline staff, to build relationships and explore collaboration together.
- Frontline staff improvement meetings – opportunities to share learning, ideas for efficient working, guest speakers to explain teams, roles and referral processes helping to improve staff knowledge and understanding of interconnecting roles.

- Colocation sites based in communities for staff across a multitude of teams and services to work in unison.
- Merging of the housing ASC team into the CLS teams to ensure longer-term care and support assessments are carried out at the right time and in the individual's home environment following a period of recovery, and not undertaken in the acute setting whilst in crisis.
- Linking the acute sector with the ILT teams to ensure care coordination from acute to community is seamless.
- Strengthening the relationship with community and voluntary sector (CVS) via collaboratively working on projects to ensure the community voice is heard and is leading on direction of travel for Thurrock integrated working strategy
- Shared care records workstream.
- Asset mapping workstream with focus on community strengths, local treasures and voluntary organisations.
- Thurrock Council has been working with the local carers service provider to pilot a new Trusted Assessor model – supporting the Carers Service to undertake Carers Assessments on behalf of adult social care where appropriate.
- Focus on self-directed support – Essex frontline service – data base of assets and services available to self-refer into.
- Approved occupational therapy (OT) assessor training to enable ASC and housing colleagues to request basic OT equipment as part of initial conversation to eliminate the need for an onward referral to OT services.
- Training and upskilling practitioners across all directives on awareness and benefits of assistive technology and low tech solutions to support independence and reduce/delay the need for care.

A collaborative approach drawing on existing relationships with the community members to ensure their voice is heard is key to leading change to delivery of services:

- Healthwatch – lived experience
- Thurrock Carers Services
- Thurrock CVS – Let's talk
- Thurrock coalition
- Examples of outcomes (I/We statements):
- 'We feel that relationships with each other have never felt so good.'
- 'I know where and who we can speak to for guidance and navigation support.'
- 'We feel that we have been empowered to build integrated teams that work for us as staff and the communities that are embedded within.'

What were the barriers to success?

- System sharing/access to information across directives.
- Merging different strategic actions into one workstream.
- Sharing sensitive information (GDPR).
- Changing deep-rooted practice and system change.

What were the conditions for success?

- Clear aims/vision for all involved.
- Clear governance and structure to support with unlocking barriers and challenges.
- Workforce to lead on change (grass roots up approach).
- Workforce empowered and supported to make change.
- Organic growth.

Further information:

BCTT Strategy: The Case for Further Change (2022–2026): www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026

Essex frontline service database: https://thurrock.essexfrontline.org.uk/login

Healthwatch: https://www.healthwatchthurrock.org

Carers Service: http://www.thurrockcarers.org.uk

Thurrock CVS: https://thurrockcvs.org

Thurrock coalition: http://www.thurrockcoalition.co.uk

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Essex County Council

Working with partners: Connect Programme – Discharge Outcomes and Home First approach

Essex has implemented transformational work with NHS partners across the three integrated care systems via the award-winning Connect Programme to introduce and embed ways of working that promote 'home first'.

Essex County Council (ECC) give thousands of people great care every day, however, sometimes people find themselves with the wrong kind of support. The Connect Programme was developed following a 2019 review that showed that adults were more likely to use bedded interim care in Essex than in other authorities and that decision-making and limited access to support and information led to around 44 per cent of adults not achieving ideal outcomes following adult social care assessment and review. Connect gives the council a window of opportunity to work together to transform care and improve outcomes for older adults.

The programme's workstreams included:

- improving discharge outcomes
- supporting independence
- improving the efficiency and effectiveness of reablement services so that more people can benefit, and more people are supported to be as independent as possible.

The programme's approach and new ways of working have included the following:

- A 'Perfect First Week' to support adults in interim care home placements to achieve their most independent outcomes. This initiative encourages early case allocation and contact with an adult to develop a care and support plan by day 7 of their stay in the placement.
- New ways of working within reablement services, helping to improve the effectiveness of interventions, as measured by the reduction of hours of need from when an individual enters the service to when they leave.
- Development of 'professional family trees' to identify team members' strengths and interests, supporting better allocation of work and informal support between team members.
- Regular supported independence discussions for teams to reflect upon how best to respond to people in complex situations.
- Realignment of teams to NHS neighbourhood footprints allowing them to work more effectively in local communities and draw upon health and voluntary provision.

- Performance improvement cycle meetings, where the council can keep continual focus on the key outcomes of the programme and the new ways of working, and implement any mitigations if outcomes start to slip for any reason.

The council has developed ways to capture much more extensive insight on people's lived experience with 2,200 user surveys undertaken and working groups established to drive improvements. They have worked with partners to improve the use of data, this includes connected dashboards that visualise system flow, outcomes data, staff experience data and lived experience data which are all available for use across the social care leadership structure.

The council has also worked with partners to maximise prevention services such as frailty teams and improve referral rates, resulting in 1,300 people receiving good standards frailty care in 2022.

Examples of outcome and impact include Essex supporting timely discharge to social care from the five Essex acute hospitals. All Essex hospitals perform better than the national average for the proportion of beds occupied by people who do not meet the criteria to reside, and the council has once of the lowest rates of delayed discharges per 100,000 population in the country. Essex also has a low and improving rate of admissions into permanent residential or nursing care (349 per 100,000 in 2022/23 against a national average of 560 per 100,000 population)

Essex offers reablement to a relatively high number of older adults on discharge from hospital (5 per cent in 2022/23 against an England average of 2.9 per cent) and reablement services in Essex perform highly in terms of the proportion of adults who are still in their own home 91 days later.

Through the initiatives of the Connect Programme, the council has seen:

- improved ability of the main reablement provider (ECL) to support recovery in adults, leading to a 45 per cent reduction in care needs exiting reablement compared with the baseline period in 2021
- an 8 per cent increase in people returning home from bedded interim care alongside an eight-day reduction in length of stay in bedded interim care for adults who leave hospital into another bed
- 545 fewer people admitted to long-term residential care each year – 230 through more independent outcomes following Community Care Act Assessments and 315 through better hospital discharge outcomes.
- 2,000 hospital admissions avoided as a result of an 87 per cent increase in people accessing urgent community treatment services in the community.

What were the barriers to success?

- There was some variation in approaches and performance between geographical areas, which the oversight and governance processes have helped to address to improve consistency in outcomes.
- Initially there was limited direct engagement with the data dashboards with staff often relying on the Connect Team to view and analyse the data.

What were the conditions for success?

- Governance and management: new ways of working which have been important to supporting improved processes and decision-making across health partners and adult social care.
- Learning, improvement and innovation: the programme has introduced approaches and pause points that allow more considered and deliberate decision-making, where staff were provided a more supportive approach.
- Understanding the system and discharge processes: as part of the programme the council undertook a review of all the discharge processes and the outcomes it was delivering to understand how many people were discharged to another bed from acutes, what kind of out of hospital bed was being used and whether improved outcomes were being achieved from out-of-hospital beds.

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Peterborough City Council

One City One Community

Adult social care in Peterborough has always had a strong focus on early intervention and prevention, via the council's wide transformation programme and it has developed a strategy to align the preventative approach across the council.

Peterborough has a population of 215,700, this is an increase of 17.5 per cent over the last 10 years making it one of the top 10 local authorities for growth in England. Unusually Peterborough has seen a big growth in both its older and young populations. There has been a 24 per cent increase in children and a 23 per cent increase in those aged over 65. Peterborough has a range of deprivation with some very deprived areas in the city centre and some less deprived areas in the outer areas of the city. At the time of the 2021 census, 59 per cent of residents identified as White British, 14.6 per cent as Other White, 14.3 per cent as Asian or British Asian, 4.1 per cent as Black, Black British, Cariibbean or African and 3.5 per cent as mixed or multiple ethnic groups.

Peterborough has great strengths, it is a place of energy and diversity and assets, thriving business, a passionate and committed voluntary community sector, good public services with a long history of people working together with people who live in the city. The council wants Peterborough to offer a more equal future for its residents, a place where everyone, whatever their background, can thrive.

The council is committed to working together with partners across Peterborough to ensure that tackling inequality is at the heart of everything that is done. The council aims to build a more equal future, identifying and providing effective early support to prevent issues escalating into more complex and costly responses with poorer outcomes. Effective early intervention from birth to adulthood and beyond can prevent problems occurring and reoccurring, thereby reducing pressure on public services and instead building resilience in communities.

Early intervention and prevention are about working with communities proactively rather than reactively to break down barriers and build capacity, relationships and resilience to change lives. PCC has developed a strategy and delivery plan to provide a clear and shared vision and ambition for early intervention and prevention.

One City One Community is across the council's prevention approach and focuses on four delivery areas:

- **Targeted prevention programme –** work to develop a clear understanding of the prevention-focused work that is being carried out by the voluntary and community sector and then carry out a gap analysis of what further services are required. Work with the Integrated Care System to facilitate and commission prevention support in a coordinated and evidence-based way.

- **Integrated neighbourhoods –** intervene early to support residents to prevent them from slipping into crisis. Providing a community-based early intervention and prevention offer will ensure effective conversations with people living in Peterborough and help them define their idea of a better life (support to reduce debt, income maximisation, better housing and employment, reduced social isolation, access to coordinated health and care support to maximise independent living).
- **Preparing and enabling independence into adulthood –** developing higher education opportunities that are linked to securing employment and ensuring that apprenticeships and placements are inclusive and capable of supporting all. To work more collaboratively and focus on codesign with key partners t o ensure no barriers to education, lifelong learning and employment, including those with a learning disability or mental health issues.
- **Improve use of digital and assistive technology –** further developing the digital response to improve resident experience in cost-effective ways including self-assessment, financial assessment, resident and provider portals, shared care record, electronic provider records and a brokerage management system. Further development of assistive technology care offer to improve independence and reduce the need for traditional care.

The strategy is in the early stages of delivery, but the following are some examples of the wider working so far:

- Integrated Neighbourhoods system design workshop, including primary care clinical leads and North Integrated Care Partnership Directors.
- Coproduction with partnership boards and users' voice groups around how to improve accessibility of information and advice.
- Staff engagement survey and coproduction on the assistive technology offer supported by Outcomes Matters.
- Learning disability visioning coproduction to help inform work around opportunities into employment.
- Building on existing coproduction work with parent carers and young people to improve preparation into adulthood.

In the strategy, PCC has set a number of outcome targets for each focus area:

Targeted provision:

- Percentage reduction in health risk factors among targeted cohorts.
- Number of community organisations achieving quality standard certifications.
- Increase in self-reported wellbeing scores in community surveys.

Integrated communities:

- Increase in number of people supported to maximise income.
- Increase in number of people referred to the VCS who take up the offer.
- Increase in number of individuals supported to engage in preventative health programmes (e.g. health checks, vaccinations, health education sessions).

Preparing and enabling independence into adulthood:

- Increased number of people with a learning disability in employment.
- Increased number of people with a mental health diagnosis in employment.

Improved use of digital and assistive technology:

- Improvement in national survey results around access to information and advice. The 2023 carers survey rose from 56.3 per cent in 2021 to 64.2 per cent in 2023 of carers finding it easy to find information and advice.
- Increase in people supported to live independently at home directly through use of assistive technology.

What were the barriers to success?

- Forming a truly aligned strategy across the council has been challenging whilst the council is focusing on a range of challenges including decoupling services from Cambridgeshire. However, the commitment of the chief executive and the corporate leadership team to cross-council working has allowed the programme to make progress on widening the work with active engagement from housing, communities and children's services in addition to adult social care.
- The digital and assistive technology landscape is changing rapidly and it would be easy to not keep up to date or to proceed with untested technologies. The council has engaged external support jointly funded by health to review the strategy and support implementation.

What were the conditions for success?

- Corporate leadership and programme support to continue to drive a council-wide rather than adult social care focused approach.
- Good engagement with the right people in the local health system.
- External technology enabled care review.
- Continued focus on coproduction with staff, communities and partners.

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Workforce – improving practice and quality

Photo: Centre for Ageing Better

Central Bedfordshire Council

Tackling waiting lists

Through effective triage and prioritisation, the council has been able to consistently keep Care Act, occupational therapy and Deprivation of Liberty safeguards (DoLs) assessment waiting lists low.

With increasing demand and recruitment challenges the risk was that people who were new to adult social care would have to wait longer for a Care Act or Occupational Therapy Assessment to determine eligibility and/or for urgent support due to a crisis. Delays often result in individuals having increased needs, heightened anxiety (for the individual/or their carers) and a high level of dissatisfaction. People approaching adult social care for the first time often only approach when they have experienced a significant and difficult change which has impacted their ability to be totally independent and is a particularly stressful time. As a service, the council wanted to ensure that they were responding and supporting people in a timely way and not delaying support where it was urgently needed. Additionally, it is well known nationally that the DoLs process is far from perfect, however, with robust processes in place, this has been managed by the council with no backlog or waiting list for DoLs authorisations.

As a local authority, the council's approach was to not accept a waiting list if it could be at all avoided. The main areas of challenge have always been around requests for Care Act assessments, occupational therapy assessments, and the number of DoLs referrals received, so these were the areas that were given particular focus.

The approach taken:

- **Care Act assessments –** all new requests for a Care Act assessment are triaged by the First Response Service (the adult social care front door) within one working day. First Response will identify if there are other supports that could be provided via the voluntary sector, etc., to meet a person's needs (prevent, reduce, delay the need for social care) and will signpost the person as appropriate. The council follows the principle 'we support them to live healthier lives, and where possible reduce future needs for care and support'. Where it is evident that the person is likely to have eligible needs they will pass to the relevant locality team with a request for a Care Act assessment. If, however, the person requires urgent support they will make contact and arrange support immediately and then draft a support plan confirming the support that has been put in place, and the reason why, which is then sent through to the relevant long-term locality team with a Priority 1 rating for a full Care Act assessment to be completed. By triaging in this way, the service has been able to maintain a Care Act waiting list of below 50, and whilst individuals may need to wait for contacts with the service for a few weeks for an assessment, where needed, support has been put into place to mitigate risk, carer breakdown and repeat contacts with the service whilst a person is waiting for an assessment.

- **DoLs –** developed excellent working relationships with care homes within the local area, ensuring that the team is contactable to discuss any concerns or queries. In addition to this, there is a small, dedicated pool of independent Best Interest Decision (BIA) assessors who are also able to contact the team at any time to discuss assessments, request advice or guidance or just to share information from their visit. There is a small team of Section 12 (S12) doctors with whom the council has also developed good working relationships with and supported communication between the BIAs and S12 doctors. This ensures queries relating to S12 assessments are addressed in a timely manner. To reduce waiting times, the council has accessed previous assessments, ensuring that they are used wherever possible, but also acknowledged that a new assessment may be required, and have encouraged BIAs to communicate the need for a new S12 assessment as soon as possible.
- **Occupational therapy –** people had waited over six months for an assessment of their house to enable adaptations. This plays a vital element of prevention and maintaining people's important goals of remaining independent and at home for as long as possible. Daily duty triage is in place and the referrals coming through are prioritised for who needs to be seen first based on their needs and circumstances. This has worked well; however, the council is only allocating new people for assessment every two weeks which has meant potential urgent needs could be waiting longer than the target of 15 days. The service reviewed the allocation process and worked with the team to accept weekly allocations. In addition, they looked at the processes, recording and templates being used. The processes were refined, and the recording templates are being changed to make them proportionate to the assessment as well as efficient and focused on being the person's record of information. The combination of changes is leading to improvements and people waiting less time for assessment. The number of people waiting for an assessment and waiting times have now dramatically reduced with average waiting times for all referrals of 25 days. This is a great improvement for people requiring assessment and supports people to be safe and independent and live life as they choose to.

In terms of engaging with people who draw on care and support, commissioners and providers, it was following a review of the complaints and subsequent review of how many people were contacting the council more than once to 'chase up' a referral that the council sought to improve the approach to requests for a Care Act assessment to ensure that people were not left without much needed support whilst waiting for a full assessment.

Examples of outcomes and impact include:

- Currently the longest wait time for a Care Act assessment is 10 weeks, however, support has been put in place to ensure the person and their carer are able to continue to remain in their own home and not face the risk of the situation deteriorating.
- OT waiting list has reduced from over 100 people to between 20 and 30 people with an average waiting time of 25 days.
- BIAs tell the council that when they visit care homes they are frequently asked, 'You are from Central Bedfordshire Council, aren't you?' They are told by home managers that they know this because 'requests from Central Bedfordshire Council are always responded to'.

I/We statements for monitoring outcomes for people include the following:

- We support people to manage their health and wellbeing so they can maximise their independence, choice and control.
- I feel safe and am supported to understand and manage any risks.
- We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support.
- We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured.

What were the barriers to success?

- To maintain this level of performance, the council needs to ensure that the vacancy rate does not increase. Whilst support could still be put in place (where urgently needed) waiting times for an assessment could increase.
- The House of Lords Select Committee reported in 2014 that the DoLs were not fit for purpose. Ten years on, we are still trying to navigate the system.

What were the conditions for success?

- Effective signposting.
- Demand does not incrementally increase over time.
- The DoLs team are a small team, which at first glance appears to be simply providing an administrative role; however, the team strive to foster the importance of the role across the whole of adult social care.
- Ensuring the workforce and people supported feel valued.
- Clear consistent communication in relation to expectations and requirements.

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Hertfordshire County Council

Practitioner audit

A piece of work to support what the council is most proud of using learning from the practitioner perspective.

The council has regularly been asking practitioners for examples of good practice but generally received few responses. Hertfordshire County Council (HCC) were keen to develop a library of examples of good practice, to ask practitioners to take a view of their practice and to share with the council their reflections.

The practitioner audit helped to identify the variety of complexity of current practice whilst also understanding the experiences of practitioners about the work they are doing. Its purpose was also to understand how practitioners reflect and explain their practice and how they recognise their skills and approaches used.

The audit was aimed at supporting practitioners to identify good examples from their practice. This is different to the regular audit which focuses on assessment and practitioner knowledge and legal compliance. The audit questionnaire consisted of 17 questions. The first half of the questionnaire looked at the type of work completed as well as demographics and actions taken, including what other agencies/professionals were also involved.

The second half of the questionnaire asked practitioners to reflect on what they were proud of and the approaches they used. They were also asked to reflect on the Think Local Act Personal (TLAP) I/We statement: 'We talk with people to find out what matters most to them, their strengths and what they want to achieve and build these into their personalised care and support plans.'

The council could not have anticipated the richness of the responses that practitioners gave to these questions. Something about the invitation to write about a practice example that they were proud of, in combination with clarity about what the council was looking for, and very open questions, e.g. tell us anything, seemed to have created the conditions for the richness to emerge. The findings highlighted the skills and qualities that practitioners are using as well as the feelings and emotions that are associated with the work the council is doing.

The learning has been shared in reports with practitioners and managers to celebrate the practice, qualities and skills in place and further development opportunities have been highlighted to support staff to recognise the fantastic work they are doing.

HCC received 165 audits completed in December 2023 and January 2024, a particularly pressured time for ACS. The findings were reported to the Practice Governance Board who welcomed the audit and where very positive about the report.

Quotes from the auditors included:

'Due to their faith (which is the same as mine) I was able to understand. I was able to connect them with local services where she could interact with people of the same faith and language.'

'When I relayed to the person that being able to recognise areas you are struggling with is an actual strength they were taken aback and very happy.'

'It was a wonderful case to work on as it enabled the couple to continue for a little longer as independently as they could. It also builds the foundation for future workers from social care if their needs changed. He had been very short with anyone who was initially introduced to them as they felt professionals were a threat to their way of living.'

Although the audit was aimed at practitioners and did not directly involve the people who access care and support, it is anticipated by promoting reflection this audit will enable practitioners to better understand the impact of their work with people. By using the TLAP statements concerned with ensuring personalisation and referencing the council's Connected Lives approach, which again places people and their views and wishes at the centre, the practitioners were supported, via the audit tool, to focus on the individual and their outcomes. Practitioners will then appreciate the learning and apply this to their practice going forward. This audit will also support the practice and quality team to identify future areas for learning and how to support staff wellbeing.

What were the barriers to success?

- This was not a mandatory audit and therefore it was uncertain how many responses would be received. Practitioners were encouraged to complete the audit and were given two months to complete it.
- Consideration had to be given to how the data would be analysed and how this information would be used to ensure that this was meaningful and of value to the council's learning. It was important to highlight that the purpose was to celebrate good practice and encourage a wider sharing of learning.

What were the conditions for success?

- The completion of the audit was encouraged through the monthly newsletter and intranet pages as well as through practitioner forums.
- It was an opportunity for practitioners to reflect and share their good practice examples so that these could be shared more widely and promote learning about practitioner experience.

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Workforce – growing and supporting the care workforce

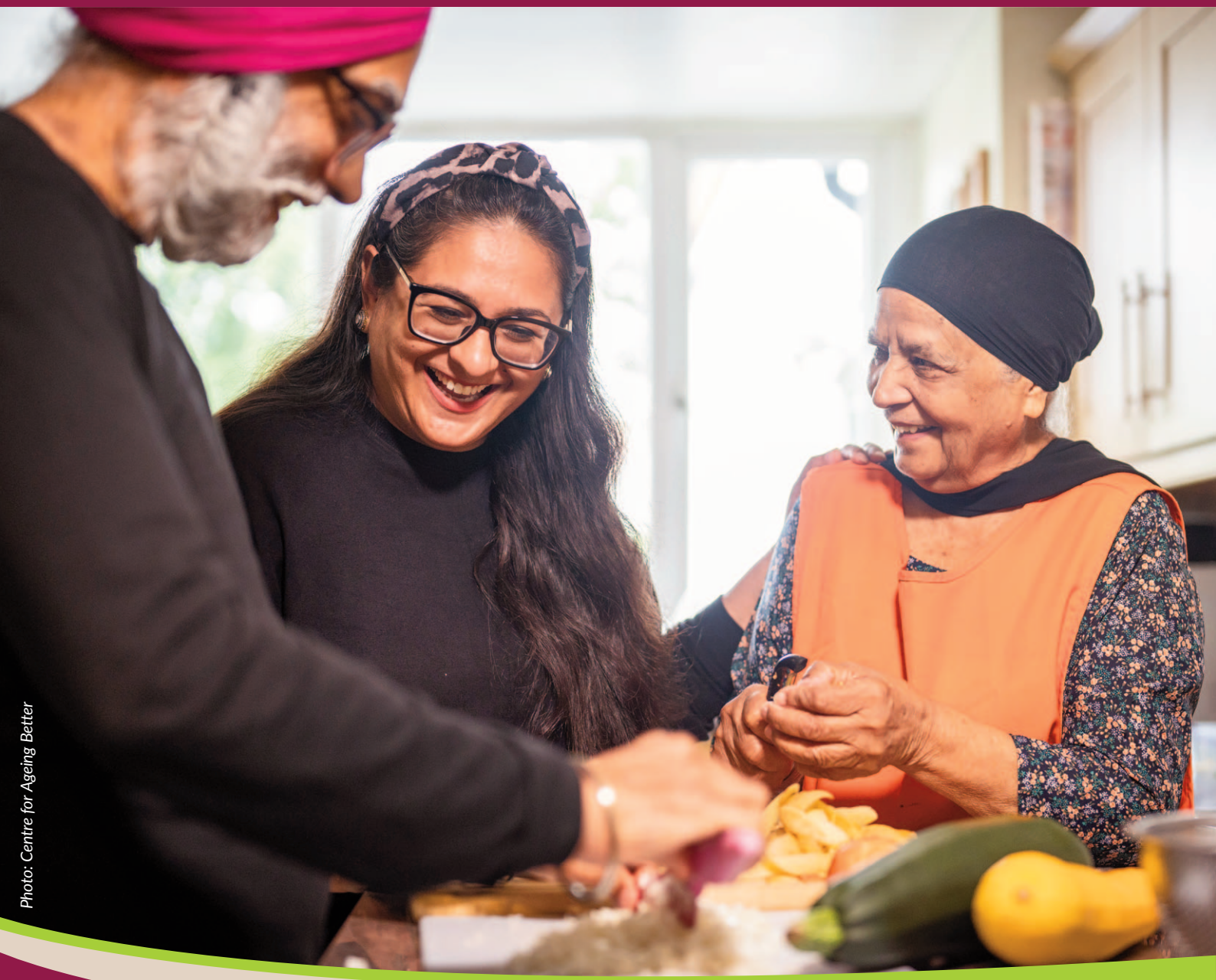

Photo: Centre for Ageing Better

Luton Borough Council

Adult social care workforce plan refresh

Luton's workforce plan required a total refresh to ensure that it was aligned to our overarching People Strategy. It was crucial to hear from the workforce about our strengths, what could be better and agree how to strive to work on our improvements.

Luton Council had a workforce plan which was first drafted in June 2022, which sets out the current workforce challenges, the impact on the system and the actions required to overcome such challenges. Given the challenges faced nationally regarding recruitment and retention, the council needed to try a new approach in refreshing the plan. They wanted to engage with staff from a range of services to ensure that voices were heard. The aim was to work together to celebrate what Luton already has in place but also to identify solutions to improve the recruitment and retention of staff.

Luton Council asked for a number of volunteers from across the whole of adult social care (ASC) who would be willing to work with the council on the refresh. It was made very clear from the beginning what the council had set out to achieve and how they aimed to achieve this within a specified timescale. The following top priorities included:

- on boarding and talent management
- reward, recognition and benefits
- engage, listen and learn from the workforce
- opportunity, skills and growth for all.

Workforce placements

An initial workshop was held whereby the council heard from staff about what was good and not so good. Whilst this was very insightful, more importantly, it created suggestions for improvement. These sessions were very engaging and gave staff the opportunity and time to really tell the council how they felt.

All feedback was taken into the refreshed plan and there was another meeting with staff to finalise the format and content.

Luton Council now has a workforce plan which has been developed by the workforce clearly setting out what needs to be achieved, how to do this and the action needed.

Examples of impact and outcomes include:

- staff were engaged and eager to contribute to the sessions which boosted morale
- staff felt positive about the experience and example of feedback included, 'I love the Luton Workforce Plan. I was actually smiling when reading it'; 'I like it, especially the breakdown of the workforce and outcomes and measures section'; 'Overall, I think it looks and reads very well.'
- Staff will assist in launching the plan through the ASC live session.
- This is a live document which is owned by the workforce and their input is ongoing and essential in delivering the plan.
- The plan defines actions which will be accountable for implementation, aiming to improve recruitment, development and retention.
- The plan will be updated yearly with an appendix featuring deliverables to ensure work continues positively and achieves delivery objectives.
- Actions have started to take shape by way of celebrating assessed and supported year in employment (AYSE) and planning a social event to celebrate Social Work Week.

What were the barriers to success?

- Freeing up staff time to engage in the exercise.
- Listening to a variety of viewpoints and drafting the plan to include these.
- Defining the different terminology which is used and making the plan more user friendly.

What were the conditions for success?

- Clearly setting out objectives and why these have been set.
- Giving staff the time to engage.
- Active listening without judging.
- Delivering on what was agreed.
- Joint communication to an ongoing action plan.

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Suffolk County Council

I CARE Campaign

The I CARE Campaign was an initiative created during the Covid-19 pandemic. At this time much of the moral support and recognition for the heroic efforts of the public sector were aimed at the NHS and health partners, meaning that social care staff, who were working in exceptionally difficult circumstances, were often overlooked by politicians, the media and the wider public.

Since the I CARE brand was designed and launched in December 2021, the council has made good progress in embedding the principles of the campaign, as well as its branding. Work has begun to introduce the campaign to care providers, partners and the public.

The initial aim of the campaign was to create a visible brand for social care to enable everyone to easily identify people, organisations and services which were part of the wider adult social care (ASC) sector. By using a range of channels including social media, traditional media, internal channels and public events, the council wanted to ensure the professionally designed Social Care/I CARE branding was shared and used widely so that the public and partners could easily see the work of the social care workforce, especially those who were out and about providing personal care in people's homes, keeping them safe and well, and sometimes the only person they saw during the pandemic.

Another aim of the campaign is to create a community around social care, where people, providers and the public can come together to create a louder voice for social care, showing its complexity and the range of services provided.

The campaign has also been used to help promote and boost recruitment across ASC, and help the sector stand out as a key employer in Suffolk.

Having been embedded well internally, the campaign was used as the basis for the transformation work within ASC, forming a part of the new 'People at the heart of Care' branding. It has been used to get key messages out to the public and to date at least 500,000 people have had the opportunity to see and engage with our various social media messages, and three full-page articles on ASC have been written referencing the campaign directly.

There has also been engagement with the care market, many of whom have adopted the community logo for their own websites and as part of their own recruitment efforts.

A range of videos have been created, called 'Coffee and Care', which showcase the wide range of roles and careers within ASC. People have been interviewed from across the sector to talk about their jobs, career choices and experiences of working in ASC. These videos have also been used to help attract applications for a range of Suffolk County Council vacancies and were especially effective during the work to recruit more occupational therapists, an area which has been a struggle for the council in the past.

The campaign was used as both a launch vehicle for, and a way to help communicate, social care messages to the public over the winter, using the strapline 'Show Social Care a little love this winter.' The campaign promoted preferred behaviours to the public when looking to contact the council, an issue which is present all year round, but is especially significant during winter. During this campaign, the council introduced to the public short and easily understood facts and information about the complexity of the social care sector. They were careful to challenge any misinformation or misunderstanding about social care, and approached this positive campaign in a way that wouldn't confuse people or generate any negative backlash. They also wanted to use the campaign to show their thanks to providers and their staff who were working hard to help and support people over the Christmas period and at times when the weather was particularly bad.

The Campaign is being recognised by other local authorities and indeed European authorities. In June 2023, Suffolk County Council attended a European Social Network conference in Malmo, Sweden, to present its experiences of creating the I CARE campaign. Off the back of this visit, in April 2024 Suffolk County Council were pleased to host a delegation of 14 senior social care professionals from across Sweden, who over the course of their three-day visit, received an update on the campaign's success to date. Following these discussions the lead of the Swedish delegation described the I CARE campaign as 'inspirational' and described Suffolk County Council as a 'leader' in this area.

What were the barriers to success?

- Funding to enable the marketing and branding to build the community in the future.
- Resistance from parts of the care market who are wary of any interaction with the local authority.

What were the conditions for success?

- A passion for promoting the adult social care workforce and celebrating all its different parts.
- Having merchandise to promote a community branding in Suffolk.
- Bringing all parts of the market on the journey of the I CARE Campaign in Suffolk and celebrating the great work of ASC.
- Sharing with the wider public just what a great service ASC provide, with a focus on the individuals who provide care and support to those who need it in Suffolk.
- Promoting the aspirations of our transformation work, and the 'Keeping People at the Heart of Care' strategy.

The creation of social media adverts helped boost the various key messages of the campaign, including:

- recruitment and careers
- celebration of success in ASC
- messages to boost awareness of issues in social care (e.g. winter pressures)
- promotion of being a proud provider of ASC services in Suffolk.

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Milton Keynes City Council

Admiral Nurses supporting carers

Admiral nurses providing specialist dementia support to carers.

Milton Keynes City Council acknowledges that there are growing numbers of residents in Milton Keynes living with dementia. Many of these people are being supported by informal carers, family, friends and loved ones. These carers often manage the complex needs of their loved ones, and they require access to tailored professional support and advice according to their needs. Therefore, providing services which empower carers with the skills and knowledge to support their loved ones is critical. Helping them to design a self-directed care plan addressing emotional and psychological support, allowing carers to maintain their own wellbeing and promote greater resilience and the knowledge of where to get hold of support and when.

The Admiral Nurse service in Milton Keynes was created to support carers who are living with a person who has dementia and is managed via a service collaboration agreement held between Milton Keynes City Council and Dementia UK. The service supports any carer of a person living with dementia when they are residing within the Milton Keynes City Council boundary and are providing a significant level of care. The service comprises of three nurses:

- 1 x Clinical Lead Admiral Nurse
- 1.5 x Admiral Nurses

The Admiral Nurse will provide practical and emotional support/advice to carers, empowering them to work with their loved ones to create their own care plans which reduce risk for all and promote self-care and resilience. They help carers and families navigate the support, care and services available, provide support to families and carers in complex situations and advise other professionals.

In addition to case work the Admiral Nurse Service:

- runs the dementia-friendly support café twice a month
- supports the dementia-friendly male and female walking football group alongside Milton Keynes Dons
- supports the Brooklands Carers Group fortnightly
- provides one-off education and support sessions
- supports best practice
- provides partnership working to support other groups with activities and carer support.

The direct feedback the service has received evidences the impact that the Admiral Nurses have had with the carers they work with:

'I think that having the support of Admiral Nurses has been fundamental in my ability to cope with the increasing pressure of coping with a partner with advancing dementia. Sometimes, it is necessary to have a person outside the immediate situation to see and explain what is happening, and to make one aware of what changes are happening, as being so close to the sufferer makes it very hard to be aware of the incremental and progressive changes that happen.'

'The Admiral Nurse was a huge support for me and [I am] going to miss her greatly. She went a step above to ensure I was confident with my caring needs for my mother. She made me feel I was not alone and said how I felt was normal. She has been a great asset to our family and [I am] so grateful to her.'

'Being able to drop in to see ... the Admiral Nurse at the Carers Café and be able to see a social worker too was so helpful, I was offered 1-1 support by both. I felt very welcome and listened to. I didn't feel hurried, both spent quality time with me. From 1st contacting the Admiral Nurse team by email and subsequent information sent by email, every correspondence was professional and timely. Information was up to date and relevant and addressed the queries I had when I met face to face.'

What were the barriers to success?

- Professionals and partners understanding the depth of the role and responsibilities of an Admiral Nurse and making sure they purely are there as a carer's support and the specialist focused role they hold. A clear vision of what an Admiral Nurse does has to be shared and implemented early on to allow for their highly-skilled interventions to be a success.
- Balancing customer demand and service capacity while still maintaining the quality of conversations and interventions with carers is a management challenge.

What were the conditions for success?

- Specialist skills and experience of the Admiral Nurse.
- Committed to making a different to carers.
- A joined-up approach between Milton Keynes City Council and Dementia UK and sharing the vision.
- A strong emphasis on training and sharing this with colleagues and other agencies.
- A passion to be creative and try new approaches and implement new ideas.

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Norfolk County Council

Growing our own social workers

In 2020, the council recruited the first cohort of 20 Social Work Apprentices (10 for Adult Social Services and 10 for Children's Services), with two cohorts now completed. In January 2024, the scheme was expanded to recruit 35 Social Work Apprentices (16 for adults and 19 for Childrens). In September 2024 the council will recruit to a new Level 7 (Masters) programme.

Norfolk County Council (NCC) along with other employers, face ongoing challenges to recruit social workers and have particular challenges due to Norfolk's geography. In 2020, 18 per cent of staff were in the 50+ age group range, who may have been considering retirement/semi-retirement.

The recruitment to social worker roles prior to 2020 focused on:

- recruiting newly qualified workers to the recognised 'Norfolk Institute of Practice Excellence' Assessed and Supported Year in Employment scheme. A significant proportion of new workers came through the Teaching Partnership with the University of East Anglia (UEA) and University of Suffolk
- sponsoring places for MA Social Work study through the OU and UEA
- external recruitment campaigns.

However, even with these in place, there were still vacancies to fill.

The implementation of the Apprenticeship Levy (April 2017) and the associated increase in Degree Apprenticeships, gave the council the ideal tool to grow their own social workers. Working with Skills for Care and the Institute for Apprenticeships and Technical Education, the council led the development of the social worker standard so that they could set up their own scheme.

They wrote a specification detailing content, location, timing, support, etc., designed a job description, secured apprenticeship salaries and designed a robust selection process. The initiative, one of the first and largest for social work, was initially contracted for three cohorts of twenty apprentices.

As a key outcome was to grow social workers, they recruited current employees. They now run an assessment centre annually for 60 shortlisted applicants (from a pool of over 100), a challenge, but crucial to selecting applicants with potential and the resilience/ enthusiasm to take a degree and work in a demanding role. These have been run in person and online due to Covid-19.

NCC encouraged a diverse cohort to apply, aiming to attract talented people with vocational/life experience. To achieve this, they:

- focused selection on vocational qualifications and for people without these, they advised on level 3 or 4 Apprenticeship progression
- encouraged all ages to apply and now have apprentices aged 24–58
- are now advertising externally and attracting a more ethnically diverse cohort.

Recognising the challenge for apprentices of juggling work, study and family responsibilities it was vital implementation consisted of comprehensive support. This is provided by NCC's Social Work Early Career co-ordinator, practice educators, line managers, learning hubs, NCC apprenticeship team and by college/university tutors. Support has been crucial, particularly when Covid-19 impacted. With the first cohort starting in January 2020, teaching and work moved online initially, so this group did exceptionally well to graduate.

The scheme was runner up in the 2023 'Best Talent Programme' category in the Public Service People Managers Association Awards and winner of the 2023 Chartered Institute of Personnel and Development Best Apprenticeship Scheme Award.

People who access care and support sit on interview panels for the scheme and each apprenticeship provider also has a service user group involved in delivering the curriculum.

Examples of impact and outcomes:

- Provided a route for employees to follow their chosen career.
- Ensured the apprenticeship levy is spent on critical roles.
- Provided an annual intake of social workers, with no additional recruitment or induction costs, which contributes to a stable workforce and reduced agency spend.
- Added quality practitioners to the workforce, even during training, with positive feedback regarding practice and impact.
- Encouraged employees to take English, mathematics and vocational qualifications.
- Provided development opportunities for social workers as speakers and seconded tutors delivering the degree.
- Raised the organisation's profile, having provided advice to Social Work England, the Social Work Degree Apprenticeship Knowledge Network, DHSC, Northern Ireland Social Care Council, HEIs and employers.

What were the barriers to success?

- As there was no Social Work Apprenticeship in place, the council had to help get this put into place.
- Had to develop a strong case for the investment in apprentice salaries.
- Internal applicants did not all have the required English and mathematics pre-requisite qualifications; some had to complete these before being able to apply for the programme.

What were the conditions for success?

- The introduction of the apprenticeship levy made the programme possible.
- Norfolk County Council's apprenticeship strategy supported the spend of the levy on this programme.
- Local training providers were able to develop apprenticeship programmes that could be delivered locally.
- Having in place robust support to enable the apprentices to succeed.
- Having strong director-level sponsorship and an operational group comprising of service leads, apprenticeship team representation, learning and development consultants and training provider representatives (City College Norwich and UEA).

Further information:

Norfolk celebrates achievements of social work apprentices – Norfolk County Council

Results 2023 – CIPD People Management Awards (cipdpmas.co.uk)

Excellence in People Management Awards 2023 – PPMA

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Essex County Council

Workforce ambassadors

Championing the voice of the workforce through workforce ambassadors.

We work in a challenging context and workload levels are high, with 81 per cent of staff reported finding their job moderately to very stressful in a 2022 survey. It is also recognised that discrimination continues to be an issue in Essex County Council (ECC) and adult social care (ASC), as it is in society. Representation varies across the grade ranges, with senior roles Grades A to C having no representation from ethnically diverse or disabled colleagues.

Promoting good wellbeing and continuing to embed equality, diversity and inclusion initiatives and listen to employee voices so that everyone can feel that they belong are therefore of high importance.

In 2021, ECC created a Wellbeing Champion group to ensure that wellbeing was highlighted across the function. Since then, this has been developed further by bringing together all workforce forums to create workforce ambassadors (WAs).

The WAs engage with their colleagues across the function and then advocate for them through a joined-up approach. They also champion and represent the employee voice within campaigns and initiatives across ASC as well as across the organisation. Wellbeing is at the core of this approach in ensuring that colleagues' voices are being heard and that where there are concerns, they can be raised in a secure way.

The WAs have a senior leader sponsor and service manager lead, who provide a strategic lens, but the day-to-day organisation is completely run by the employees themselves. In addition to this, there is also a service manager lead for wellbeing and both managers work closely together to ensure that there is a collaborative approach.

Examples of outcomes and impact:

- The 2023 survey showed the workforce felt that they belonged in adult social care, that their wellbeing was cared about and that they had job satisfaction as they love what they do.
- The focus on wellbeing and inclusivity has been recognised in numerous Guardian articles which has also led to links being made with other local authorities who want to learn from what the council is doing.

What were the barriers to success?

- Employees feeling able to take time out from their busy workloads to get involved.

What were the conditions for success?

- Encouraging employees to join the WA network from all the different teams in ASC to ensure a range of representation and to give every team a voice.
- A clear and consistent focus on wellbeing is at the core of what the WA are there to support.
- Senior leaders championing the initiative and encouraging staff to take time out of their usual duties to participate and to look after their own wellbeing.

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Peterborough City Council

Care Academy

Establishing a Care Academy to support access to training and benefits for care staff and to provide a care passport to support care workers moving between employers.

Peterborough City Council like many other areas of the public sector has experienced workforce pressures to deliver care services. Attracting and retaining the right calibre of staff has been a cause of concern for most providers and affected a number of areas from capacity to service quality. This is compounded by the rising cost of living, and specifically in Peterborough, by the competition for entry-level jobs from the local high level of fulfilment businesses.

In addition to the issues noted above, the Care Certificate is not standardised, and oversees recruitment at entry-level roles has meant a higher number of staff with minimal training.

In considering all these factors, the council explored how they could support providers to recruit, retain, improve training standards and support the impact of current financial pressures.

Peterborough used the workforce fund to commission a portal where individual carers and organisations could register, access a list of approved training providers, and additionally upload training certificates which would be verified by the portal provider.

Each verified training certificate which is uploaded is rewarded with points, and these points can be traded for high street benefits. This reward system can be used in conjunction with other benefit schemes such as the Blue Light Card. There are five tiers to the scheme, each tier allows access to a wider range of savings opportunities.

In addition, the portal acts as a passport and allows the carer to retain a verified history if they move from one provider to another.

The care provider is also able to register and link carers to their organisation. They benefit from having a visible record of staff training which identifies in advance when training certificates need to be refreshed as well as a comprehensive list of training achieved by their staff. These records can be used when monitoring the provider or by CQC when they undertake an inspection.

The council was overwhelmed by the number of providers who joined at the launch of the care portal this January, and by their feedback as to how the service would be able to benefit them with recruitment and retention of staff.

As things move forwards with implementation of the portal use, the council will be monitoring its impact on recruitment, retention and quality of services and staff training.

What were the barriers to success?

- Clarity about monitoring performance and effect on driving quality.
- Larger providers who have their own systems may be reluctant to encourage the staff to use the portal.

What were the conditions for success?

- Sign up of carers and care providers to use the portal.
- Agreement to trust the training passport when a carer moves from one organisation to another.
- Contract performance of the care portal.
- Long-term commitment to the portal if evidenced to be successful.
- Routine communication and feedback from providers about efficacy of the portal to inform service improvement.

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Cambridgeshire County Council

Our journey to support and improve quality of care through the implementation of the Care Professional Academy

Cambridgeshire County Council's implementation of a Care Professional Academy.

Nationally there is an increase in demand for social care services and the whole sector is challenged with recruitment and retention. In Cambridgeshire, staff turnover rate remains high. There is also a lack of quality training with under 50 per cent of care workers having achieved (or working towards) the basic Care Certificate. The care sector in general struggles to promote a 'professional career' in care.

Cambridgeshire County Council's Adult Social Care Workforce Strategy identified the following issues when it comes to monitoring take-up and quality of training:

- **Recording –** whilst the Adult Social Care Workforce Data Set (Skills for Care) is a valuable source of data, there is not yet a way to monitor the training and qualifications held by individuals and it is difficult to map where there are skills gaps in the system. This reduces local authorities' ability to be targeted with investment in training and development to meet local needs.
- **Lack of portability –** although Skills for Care endorse quality providers, the Care Certificate was not accredited or quality assured by CQC and therefore there is a lack of confidence between care providers regarding the training new employees have received when recruiting from across the sector.
- **Repetition of training –** as a result of the lack of portability care workers are often required to repeat Care Certificate training alongside other mandatory training.

Roles within social care are more skilled and complex than ever before, so investing in workforce development and an infrastructure to support careers in care seemed critical. There is evidence to suggest that investing in learning and development can reduce average turnover for care workers by 9.5 per cent according to Skills for Care.

In order to address these issues and also encourage the take up of good quality training the following objective was set as one of the six strategy objectives in the Adult Social Care Provider Workforce Support Plan: 'To establish a support model for delivering and recording training e.g. Care Academy.'

The aims of the model are to:

- provide information and training and a list of recommended training providers
- provide a mechanism for individuals and care providers to log training achieved
- provide incentives for individuals and care providers to participate in recommended training,
- provide a mechanism for quality assuring the delivery and assessment of the Care Certificate that the contracted care providers are carrying out.

Examples of best practice have been researched in partnership with Hertfordshire Care Providers Association (HCPA) to further develop their professional care academy launch in Cambridgeshire.

In January 2024, the Cambridgeshire Care Academy for Reaching Excellence (CARE), a care professional academy was launched. This is a platform where care professionals can log training certificates and qualifications and gain access to exclusive rewards and discounts. Employers can also utilise the platform to track and monitor staff training and development and access good quality training, in particular the Care Certificate and assessor packages that have been developed by the Learning and Development Team.

The Care Professional Academy model is a membership one, where individuals can log their own training and collect points depending on the training and provider. There is a tier system and access to discounts with national organisations such as Tesco, transport, Amazon, hotels, and spa breaks, as progression is made up the tiers.

Some benefits of this model include:

- provision of training record and matrix for employers
- provision of quality assurance as certificates uploaded are spot checked
- increased portability via a training passport
- benefits for employees including a tier system of training with points to be spent on shopping discounts, transport and holiday and spa breaks
- improved communication with providers, monitoring team and direct access to carers (as they sign up with their personal emails).

In April 2023, the council ran four focus groups and invited 221 contracted providers in both residential and home care. During these focus groups, the council established low pay, wellbeing and training ranked high as the reasons for high turnover of staff. The CARE Academy addresses all three of the following top challenges:

- providing rewards and benefits stretches pay further
- rewards and incentives also contribute towards staff wellbeing, giving care workers a sense of being appreciated and feeling professional
- providing information and access to quality training and encouraging staff to participate through rewards and incentives.

The following were also considered as important measures of working together:

- We think about their care and support and homes – the Care Academy will improve consistency of the care provision and allow for easier monitoring of staff training and development. It will also incentivise the gaining of qualifications for staff.
- We work with organisations so that everything works well for people. Working with contracted providers ensures that this initiative will aid in improving the consistency and quality of care provision.

Already, only two months after launch, the following has been achieved:

- 34 provider sites
- over 12 organisations signed up to the Cambridgeshire Care Professional Academy
- 90 care workers have registered.

What were the barriers to success?

- The challenges really start now in promoting the benefits of the academy to the contracted providers as they are independent organisations of varying sizes.
- Larger providers may already have learning and development systems or benefits schemes.
- Smaller providers may perceive they do not have the time to get involved.
- There is also a challenge around engaging with personal assistants.

Through marketing, events, forums and webinars, the messages are getting out and providers and care workers have started to sign up and are already realising the benefits.

What were the conditions for success?

- Based on the challenges above, continuous engagement with the providers and building relationships through the commissioning and monitoring teams will ensure success.

Further information:

Cambridgeshire Academy (careprofessional.co.uk)

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Suffolk County Council

Kick Start a Career in Care Incentive

In response to recruitment pressures within Suffolk's adult care sector, the Kick Start a Career in Care incentive was set up and first launched in July 2022. The Kick Start programme is funded by Suffolk County Council and managed by Care Development East and offers a £750 incentive to people who have not previously worked in social care. The scheme supports new starters working for Care Quality Commission-registered adult care providers in Suffolk and new starters need to remain in post for 12 weeks and be employed for a minimum of 8 hours per week to be eligible for the grant.

The primary aim of Kick Start is to attract and retain new staff into the care sector and so help care providers fill vacancies to ensure they can operate at capacity, particularly during the winter period and times of increased pressure. This has been well received by care providers in Suffolk.

The Kick Start recruitment incentive has been very successful with over 560 applications having signed up by the end of March 2024 and a total of 365 participants having received bonus payments for being in post for 12 weeks. Monitoring after the grant is awarded shows that retention after 12 months is around 70 per cent.

This comprehensive approach to monitoring both during and after the programme ensures a thorough assessment of its effectiveness over time. This has been done by maintaining and collecting feedback from both social care workers and care providers.

The scheme's success has been recognised locally, regionally and nationally with the publication of an article in the May 2023 issue of Care Talk magazine.

Provider feedback has been very positive, and some quotes are included below:

'They are still with us and doing wonderfully well! They are both enrolled on the Level 3 Diploma in Adult Care and making great progress.'

'This has been a wonderful incentive for our carers and was a huge boost, our staff retention so far has been good, and our carers appear to have settled well into their new roles.'

'The Kickstart incentive has been not only a great recruitment bonus to be able to offer but a wonderful way for employers to say, "Thank You" to the people who are reliable, dedicated and deserve recognition for the amazing role they play in our communities, providing vital care to vulnerable people, allowing them to remain happy and safe in their own homes.'

'This is a great scheme which has helped recruit from outside the care sector.'

'They are all doing really well, they have made lovely carers. A is a real asset to the team, she has just enrolled on a Level 2 qualification. She is excelling as a support worker and is a bubbly vibrant character that our customers love being with.'

Without the Kick Start Bonus we would have been reluctant to recruit anyone who didn't have experience, but this has allowed us to uncover these hidden gems of staff who are born to be [a] carer and just needed the opportunity.'

What were the barriers to success?

- Overcoming limited knowledge of adult social care.
- Expectations of applicants.

What were the conditions for success?

- Clear criteria and ease of application for care providers as the employer (who applies on behalf of the member of staff recruited).
- Prompt payment of the bonus money.
- Care Development East will work with the care provider to ensure that the individual is eligible and that they are still in post at the end of the 12-week period.
- A supportive process and approach.

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