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East of England Adult Social Care

Foreword

This document outlines various initiatives and strategies implemented by different councils in Adult Social Care across the East of England to enhance social care services, with a particular focus on supporting unpaid carers, improving service delivery and integrating technology to better meet the needs of individuals. The report is designed to follow the Care Quality Commission key themes which are Working with People, Providing Support, Ensuring Safety and Leadership.

A few of the examples within the report are summarised here:

Unpaid carers

Essex County Council has redesigned its support model for unpaid carers to improve identification and support, resulting in the Essex All-age Carers Strategy 2022. This strategic framework aims to enhance the support available to unpaid carers and ensure they are integrated into the overall care system. The new model includes the Essex Wellbeing Service as the first point of contact, providing support for lifestyle issues and identifying carers in need of assistance.

Southend City Council engaged with unpaid carers to inform their Caring Well, Living Well, and Aging Well Strategy. They focused on improving the identification and assessment of informal carers to enhance their wellbeing and sustainability. The council co-produced the Caring Well Strategy with local carers, outlining key priorities for the next five years.

Coproducing care and support and technology enabled care

Cambridgeshire County Council partnered with Social Care Futures to adopt the 'Working Together for Change'model, aiming to improve engagement with unpaid carers. They conducted surveys and workshops to gather feedback from carers, helping to identify barriers and develop solutions for better support

Peterborough City Council developed the 'Hey Geraldine' AI assistant to support social workers and improve efficiency in decision making. This innovative tool allows staff to access knowledge and information quickly, streamlining processes and enhancing the overall user experience.

Enhancing workforce capacity

Milton Keynes City Council has implemented a multi-faceted approach to recruit and retain social workers, including a social work progression scale and retention payments. They aim to recognize experience and expertise while addressing the challenges of recruitment and retention in the sector.

Central Bedfordshire Council focused on building a professional pipeline through apprenticeships and training programmes. They have established a social work pre-apprenticeship programme to better prepare staff for the role, resulting in a reduction in vacancies and increased retention.

Data-driven decision making

Suffolk County Council utilised linked data to analyse the impact of their Home First reablement service. This initiative aims to support individuals post-hospital discharge and prevent unnecessary admissions. The analysis revealed significant reductions in emergency admissions and improved health outcomes for those who received reablement support.

Hertfordshire County Council developed a Frailty Risk Assessment Tool to identify frailty in individuals with learning disabilities. This tool helps practitioners provide timely interventions and support, ultimately improving health outcomes and reducing the risk of avoidable deaths.

The document highlights the efforts of various councils to improve social care services through innovative approaches, strategic planning and a focus on supporting unpaid carers. By leveraging technology, enhancing workforce capacity and utilising data-driven decision making and co-production, these councils aim to create a more integrated and effective social care system that meets the diverse needs of their communities. The ongoing commitment to co-production and engagement with people who access services, and their families and carers remains a cornerstone of these initiatives, ensuring that the voices of those affected by social care are heard and valued.

We hope you find the report an informative and useful read.

Victoria Collins

Director of Adult Social Services, Milton Keynes and the Association of Directors of Social Services (ADASS) Eastern Region Directors Branch Chair

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Working with people: support to unpaid carers

Essex County Council

Redesigning the carers' support model with unpaid carers

Essex County Council has re-designed its support model for unpaid carers to increase identification and support for the vital contributions delivered by unpaid carers.

The council had the following challenges:

- Opportunities for practitioners to identify carers, and self-identification of carers, was not being fully utilised.
- Unpaid carers had a more limited support offer available and sometimes were waiting too long for that support.
- Unpaid carers were unsure of where to go for support, and the support was not as integrated with other parts of the system.

The first step of the carers' model redesign was to give it a strategic framework. Following extensive consultation with carers and partners the council co-produced and published the Essex All-age Carers Strategy 2022. The commitments within the strategy formed the basic objectives of what the redesign offer wanted to achieve.

More about the new model

Since the publication of the All-Age Carers Strategy in May 2022, there has been extensive engagement with practitioners, system partners, providers and carers of all ages to understand how the commitments can be best delivered. As a result, Essex County Council has developed the Essex Carers Model. The four key components of this model are set out below:

1. **Essex Wellbeing Service as first point of contact:** The council's Essex Wellbeing Service is delivered by an alliance of specialist organisations whose aim is to help residents be healthy, safe and well. Since September 2023, it has been promoted as a first point of contact for unpaid carers. Residents can call for support with lifestyle issues such as smoking, social isolation, weight management or help with day-to-day needs. As part of their conversations with people accessing the services, staff work actively to find out if callers are unpaid carers and then ensure they are signposted to the help available.
2. **Essex Carers Core Offer of Support (ECCOS):** ECCOS is a specialist offer to support carers, now delivered by the charities Action for Family Carers (West Essex), Essex Carers Support (North Essex) and Carers First (Mid and South Essex) to provide information, advice and guidance as well as practical solutions to address specific wellbeing support. ECCOS partners are also facilitating regular peer support networks and providing grants to facilitate breaks for carers.
3. **Digital offer for carers:** Carers have increased opportunities to engage with and access good quality information, advice and support through the virtual carers offer, which features virtual cuppas, peer support groups, news and information, and direct pathways to specialist support services. The offer has been particularly impactful in identifying previously unknown carers, especially men and working carers who hadn't identified as carers.
4. **Listening to carers:** Carers are now able to share their lived experiences with an independent, countywide engagement team of people employed by Healthwatch to listen to carers' views and feed them back to decision makers and encourage them to become involved in the decisions that impact their lives.

Stakeholder engagement

Stakeholder engagement and co-production were key to the success of the project. When launching the strategy, the council convened the following:

- All-age Carers Partnership Board: Wider organisations are now better informed about work happening across the system to integrate solutions through the Partnership Board, which meets regularly and brings together commissioners, social care, health and the voluntary sector around shared commitment to make change for carers in Essex.
- Essex Carers Support Project Group: This was a weekly meeting of internal staff from across multiple areas (commissioning, operations, project management, finance, procurement, legal, etc.). Multi-agency buy-in, led by senior managements, ensured the project group maintained momentum and ambition.
- Experts by Experience Group: Through a range of focus groups and interviews with carers, the council explored what 'good' looks like. Carers worked alongside a range of professionals and organisations at five locality-based workshops to jointly determine the principles of the core offer. From the initial group of carers involved in the design, a group of eight carers volunteered their time to work with commissioners to design the details of the model. Plenty of time was built in so that carers had time to engage in a meaningful way and at times to suit them.

The impact

All elements of the re-designed model have had a significant impact. Below provides an indicative snapshot:

Essex Wellbeing Service as the first point of contact: Between April and December 2024, the service engaged with and supported 1,400 carers with light-touch information, advice, guidance and navigation to specialist support when needed.

> *'Your support came at a time when I was feeling very low and cut off from society so I would like to say a big thank you.'*

Essex Carers Core Offer of Support (ECCOS): Having listened to what matters to carers, even more support is now available for carers through newly launched services, available since April 2024. Ambitious targets have been set to identify and support more unpaid carers. The target is to support 4,150 carers by April 2025, and 12,500 carers by April 2027. Since going live in April 2024, the providers are on track to exceed targets for this year.

'I am so grateful to have you by my side and for all your support. This will help me to find the strength to keep supporting my mum as well as knowing you are behind me and supporting me.'

A digital offer for carers: Between April and December 2024, the Mobilise digital platform has received over 50,000 views by carers and engaged and supported 6,000 carers. Since going live in December 2022, the Mobilise Carers Allowance checker tool has been used by over 1,300 carers and it is estimated that if all those identified as eligible went on to claim carers allowance, they would be entitled to £1.75m per annum.

'Just to be able to have a laugh with other people who are living really challenging lives and understanding where they're coming from ... it's been a fabulous thing.'

Listening to carers: Since the new involvement team started their work in October 2024, Essex has engaged with over 2,400 carers through a range of focus groups, workshops, engagement events and surveys. They are now hearing the voices of previously unheard carers with key themes and issues being escalated to decision boards.

'I felt listened to and I mattered.'

What were the barriers to success?

- Increased levels of investment required.
- Conflicting priorities between carers and the system partners.
- Evidencing the full range of benefits of preventative services.
- Multiple different touchpoints and support offers for carers.
- Lack of awareness by front-line of the support available.
- Time constraints.

What were the conditions for success?

- Simplification of the previous offer through a central point of contact.
- Listening to carers' feedback to expand on the specialist support available.
- Personalised support offer which is responsive to carers' needs.
- Equitable, accessible and flexible support.
- Empathetic and knowledgeable staff supporting carers.
- Integrated working with wider system partners.

For further information: All Age Carers Strategy 2022 and progress report

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Southend City Council

Listening to unpaid carers and partners to inform the Caring Well, Living Well and Aging Well Strategy

How Southend listened to their carers and partners and worked together with Carers First and staff to improve identification, delivery and support to carers.

Southend identified that they wanted to improve their identification, support, and assessment of informal carers to ensure the wellbeing and sustainability of the role of carers. To support this journey, they focused on embedding the principles of the 'Connected Southend' model to underpin their strategic approach to drive up performance.

The Connected Southend model sets the strategic tone and direction for the council's three strategies, Caring Well', 'Living Well' and 'Ageing Well', which underpin everything the council does to ensure that care and support services in Southend, alongside partner organisations, are consistent, make a difference and enable people to live the lives they want to live. Connected Southend is driven to provide the very best care, support and advice for the people in the city, and to truly embed the first line of the Care Act 2014 statutory guidance: The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life.'

The Connected Southend approach is underpinned by the Caring Well Strategy, which was developed in consultation with the people of Southend, co-produced with unpaid and family carers and developed in partnership with the Integrated Care Board (ICB).

The council recognises the significant role that carers provide, and that supporting carers is the responsibility of everyone, including organisations working directly with carers and the cared for across the statutory and voluntary sector, and with the community. The council has a shared responsibility to provide an effective, efficient, and co-ordinated service to support carers' health and wellbeing.

The Southend City Council Caring Well Strategy has been co-produced with Southend carers who have helped to develop eight priorities for the next five years. The strategy sets out the commitment to carers from the Council and the NHS and describes how the council intends to meet the key priorities that carers and the people they care for have told us are most important to them.

The Caring Well Strategy sets out how the council will deliver a comprehensive Carer's Pathway in partnership with Carers First, as part of their preventative service delivery for informal carers. The early identification of carers allows the council to maintain regular contact with carers and support them with a robust prevention offer. The Carer's Pathway is a key component of the Connected Southend model and works to prevent, reduce and delay the need for long-term care, as well as build resilience and effective demand management to support the ageing demographic.

The Carers Pathway commits to making every contact with informal carers meaningful, as well as ensuring that carers only tell their story once. To ensure carers receive quality advice, information and support, practitioners identify carers when meeting with people and they actively promote carers' assessments. The council has also developed a new service through the carers support service, Carers First, to act as trusted assessors for carers who want a single-carer assessment and who are not known to social care services.

These initiatives have led to a significant increase in carers' assessments from 460 in 2022–23 to 1,171 in 2023–24. Carers First are commissioned to provide support for carers to take breaks from their caring role as well as being able to access necessary appointments. This service enables carers to sustain their role (preventing carer breakdown), to maintain good health and wellbeing (physically and mentally) and to have time for themselves.

How do we know what we do is working well?

- Southend ranks within the top 20 local authorities (LAs) for three key metrics in the 2023–24 ASCOF: Southend outperforms the national average in 15 out of 22 metrics and matches the national average in one indicator.
- Quality of life score is the second highest in the country, reflecting significant improvement since 2021–22.
- We rank in the top 10 of all Las, with 38.6 per cent of carers reporting they have as much social contact as they would like.
- The council has proactively redesigned the way they identify, support, and interact with carers, resulting in early and proactive identification and high levels of carer satisfaction.
- Year-on-year increase in delivery of single carers (100 per cent increase) and joint carers assessments (144 per cent).

What is the experience for carers?

The Carers Lived Experience Group was involved in the design and distribution of the Carers Relief Fund. The key point carers shared was they did not want the council to distribute the money, nor was it the belief that giving money was the answer. The group worked on a proposal that looked at using the money more sustainably via Carers First and Southend Association of Voluntary Services (SAV). It was agreed that the council's internal teams and monies would be allocated to the organisation. For Carers First, the money was used mainly to buy technological equipment to support carers in their role, while SAVS were allocated money to support seed funding of local support groups for carers.

Feedback from carers:

- *'It [epilepsy machine] has made a difference already, I am still a bit anxious but am sleeping a bit easier at night, thank you.'*
- *'Thank you for the vouchers [used for a new washing machine], such wonderful help and I really do appreciate it. What an amazing help they will be.'* ***JS carer***

Unpaid carers play a crucial role in preventing the need for formal care. Supporting carers is a shared responsibility across organisations and the community. The Southend Joint Strategic Needs Assessment (JSNA) estimates 17,880 adult carers in Southend, with the largest group aged 50– 64. Working with Carers First, the quantity of carers registered with their support service has grown from 1,442 in March 2023 to 1,961 in September 2024, with 91 per cent of new referrals receiving contact within five working days. Carers First also carry out Care Act 2014 assessments, with 93 per cent of reviewed carers confirming their circumstances have improved because of their contact with the provider.

The Caring Well Strategy and Action Plan has been developed to ensure that ambition and support for carers is a focus area.

This strategy has been co-produced with Southend carers, and they have helped develop the following priorities:

- Identifying and respecting valuable carers – we increased from 7000 to 9000 carers registered with GPs in 2023–24.
- Information and support – a carers' resources booklet has been created, detailing the service offer to carers.
- Carer's voice, knowledge and understanding – 86 per cent of carers reported an improvement in their caring responsibilities (Carers First 2023–24 data).
- Assessing carers' needs – through a joint partnership with the council, Carers First have been delivering carer assessments.
- Maintaining balance – Carers First continues to support carers in accessing breaks to attend medical appointments and special occasions with friends and family. In the period 2023–24, 136 breaks were provided.
- Helping carers stay in, enter or return to work, education, or training.
- Workplace health offer has been promoted in the community to support businesses and organisations to sign up.
- Prepared for changes – all carers completing a carers' assessment are offered a contingency planning session to help them plan for an emergency.
- Integration and partnership – Carers First registers all carers with a GP or supports them to do this independently if they wish, and as a result they have greater support from GP services.

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Working with people: support to unpaid carers

Cambridgeshire County Council

Improving support to unpaid carers

Working together to improve how the council supports unpaid carers in Cambridgeshire in partnership with Social Care Futures and adopting the 'Working Together for Change' co-production model.

The results of the Survey of Adult Carers in England 2023–24 showed that in Cambridgeshire the proportion of carers who report that they have been included or consulted in discussions about the person they care for had declined from 75.9 per cent in 2018–19, 72.7 per cent in 2021–22 to 68 per cent in 2023–24. While this remained above the regional average of 66.5 per cent for Shire Authorities, the council wanted to understand how they could improve this outcome.

The council partnered with Social Care Future to adopt an approach called 'Working Together for Change' to help them to understand and act on the barriers to carer engagement and to identify the action needed to start to make changes. The programme has also been widely used and supported across the Association of Directors of Social Services (ADASS) in the East through the Regional Sector Led Improvement Programme since 2022–23 and is part funded by the region.

In undertaking this work they joined up with a national programme co-ordinated by Social Care Future to support people and organisations trying to make progress with difficult issues which they call the 'plumbing and wiring of social care'. The purpose statement was: 'Working Together for Change to understand what matters most to unpaid carers of adults and use that understanding to improve how Adult Social Care services ensure unpaid carers are included or consulted in discussions about the person they care for'.

In summer 2024, the council sent 192 questionnaires to unpaid carers who had accessed Adult Social Care support in Cambridgeshire over the last 12 months and had indicated within the Survey of Carers that they were willing to be contacted. They also approached the Carers Partnership Board and attended carer forums to discuss and complete the questionnaire face to face. The council asked carers what was working well for them now, what was not working so well and what was important for the future. Fifty responses were received. Carers and representatives from organisations that support carers were invited to attend two workshops in July, where issues to be explored were identified. Together, people thought about what it would look like if issues could be fixed and what could be drawn on to help make a positive difference.

On the second day of the workshop, the group focused attention on what could be done to make a difference. They began by listing things that were already in place which could help to make progress. Next, they generated a range of different ideas about what else they might do that could make a difference and voted on which ideas would have the most impact. They also thought about what changes they would like to see nationally that were outside of the ability to control locally. After everyone had chosen their favourite ideas, the top votes were plotted on to an investment grid to see how much of a difference they would really make and how much effort would be involved. Finally, the group thought about which of the top-voted ideas made sense to work on first and chose three ideas to take forward and created action plans.

One of the top three voted ideas by carers was to 'kickstart more unpaid carers groups and self-help groups for unpaid carers across Cambridgeshire'.

To achieve this outcome, the council approached the Care Together team. Care Together is a place-based, co-produced programme to support older adults to live happily for longer in the community they call home. One of the ways Care Together helps shape the market and support the Voluntary, Community and Social Enterprise (VCSE) sector and other partners, is to offer grant-funding. This takes different forms but is always focused on locally identified needs. It supports projects which are co-produced with older adults and community partners. Seed funding was offered through the 2025–26 grant funding process to kickstart more unpaid carers groups. Successful bids include a carers café in Cambridge City, a peer support group for people living with dementia and their carers for people living in East Cambridgeshire and peer support for carers living in Fenland provided by Cambridgeshire Action for Communities in Rural England.

The council is also seeking to initiate further co-production activities through the carer support providers to understand additional needs and gaps in current carer support groups and to make existing groups more accessible.

One of the other top three voted ideas was to develop and finalise a charter of principles to help develop more seamless support and improve navigation between services for unpaid carers. The council is currently working with partners to initiate further co-production activity to develop materials to support training for professionals to understand carer need and improve support, focusing on co-ordination and navigation between services to simplify the system for carers.

While the new peer support groups for carers are currently being mobilised, the carers who participated in the workshops identified that carers would benefit from increased emotional and peer support by talking to 'somebody who understands your situation, who knows what you are experiencing – by offering more opportunities to bring people together.' It was also identified that this approach would 'take pressure off services, save money, save resources'.

What were the barriers to success?

It became clear that the original purpose statement was too narrowly focused, so we amended it to better reflect the concerns and shared ambitions which people voiced. The updated broader and more succinct purpose statement became: 'Working together to improve how we support unpaid carers in Cambridgeshire'.

The third priority identified by carers was to 'overhaul existing process to bid on properties'. While the council was able to share feedback with partners in housing to make improvements, they had less influence over these services which are managed by different services and councils.

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What were the conditions for success?

The success of this activity was dependent upon the willingness of the carers who generously shared their experience and suggestions for improvement and committed their time in completing the surveys and attending the workshop sessions.

Cambridgeshire County Council's ambition to improve support for unpaid carers is captured within the All Age Carers Strategy 2022-26. Realising the key strategic intentions has been a system-wide priority which has resulted in a climate in which the commissioning and provider partners have been able to flexibly support the priority areas identified by the carers. It is hoped that when these changes are implemented, they will make a real difference to carers' lives.

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Peterborough City Council

Caring for carers

Working across the Integrated Care System in Cambridgeshire and Peterborough and with voluntary sector partners and carers to improve the offer to carers, particularly around joined up information, advice and signposting support.

Unpaid carers are an asset in society, helping to support people's independence and meet their social care needs. The value of unpaid care now exceeds the value of the NHS budget in England and Wales, demonstrating just how substantial and significant the contribution of carers is. While providing care can be a rewarding experience, it can also have an impact on the carer's own health, education, ability to remain employed, relationships and social life.

Following engagement with carers and carers' groups, the council learnt they are often unaware of the support available to them or are reluctant to ask, or not sure who to ask. Many carers felt they were not receiving enough support, both physically and emotionally. Carers felt there was a significant lack of communication between services, making it difficult for them to navigate the system and access the support they needed. They also struggled to find information to support them with their caring responsibilities.

What did carers say?

'It would be helpful for unpaid carers to know if/what information/support is available when there are a number of different scenarios to navigate. The website lists different categories, each with a long wait on the telephone, and the "advice" is very general and not tailored to the individual. A link to the person's GP, who and where to go for assessment of dementia, mobility, emergency support, respite'.

'More information at the beginning would have been helpful to know what is available. Information just came out drip by drip. Then having accessed one piece of information, there were large gaps in accessing the next step. Departments didn't know what the others had done/were going to offer. (Joined up thinking)'.

What did the council put in place?

Bridgit: In collaboration with Cambridgeshire County council a new platform was created called Bridgit. Bridgit has been designed specifically for carers to enable them to access information as and when they need it. The platform enables carers to create their own bespoke support plan, access events/support group information and sign up for biweekly emails. The platform can be accessed any time of the day, which carers found useful during the nights when they feel most alone. Additionally, there is a carer support coach available via WhatsApp. The platform streamlines all the information available to carers into one easy-to-use portal. Carers can access a wide range of resources, including support for their caring role, care providers, emergency planning, managing work/life balance, carer's allowance, mental health support, and more.

The platform was launched across Peterborough with the Integrated Neighbourhoods managers being a core part of the project alongside carers' groups. The council is now signing up GP practices following a pilot of SMS text referrals by a local practice.

A BBC News report can be accessed at: Virtual Assistant

The Bridgit platform is only one part of the focus on working with carers to provide the support and tools that they need. This work has already begun to show evidence of improved outcomes for carers, with all aspects of the most recent national carers' survey showing a marked improvement and all carers' Adult Social Care Outcomes Framework indicators ranked in the top half of England's results overall.

The council recognises it still needs to do better though, and to focus on further changes that are of most importance to carers, we have engaged in work with the 'Working Together for Change' co-production model.

Working Together for Change – co-producing current priorities: This programme has been part funded through the Regional Sector Led Improvement Programme and the council. The council held co-production workshops involving Peterborough carers and local partners in the decision-making process, ensuring their voices are heard and their needs are addressed. A venue was selected which is run by a local Black Minority Ethnic (BME) community group as a safe space for discussions. Prior to the workshops the council asked unpaid carers what was working well, what wasn't working well and what was most important in terms of supporting them in their role as an unpaid carer. This initiative helped improve communication by fostering a collaborative environment where carers were able to share their experiences and suggestions. The survey and workshops created a safe environment for carers to be honest about their experiences navigating health and care services in Peterborough. The outcomes of the workshops highlighted four action plans that will be implemented as the priority work over in the coming year.

The council worked in partnership with carers and organisations by:

- having regular meetups with carers, sending a simple survey to understand what was working well, what wasn't working well and holding face-to-face workshops with carers and organisations that support carers
- speaking to statutory and third sector services to understand their needs to help them provide supportive services.

Examples of outcomes and impact have included:

- creation of an action plan with carers to deliver a service that they need.
- creation of a platform that is easy to access and use, and which joins up information from various health and care partners.
- development of a relationship with carers that ensures continuous development
- valuing co-production with partners, care staff and carers themselves.

The council also uses the Think Local Act Personal (TLAP) Making It Real (MIR) 'We statements' to reflect on practice:

- We provide accurate and up-to-date information in formats that we tailor to individual needs, face to face if necessary.
- We talk to people to find out how much information they want and follow up to find out if they want more detail.
- We provide information and advice about health, social care and housing which is tailored to a person's situation without limiting their options and choices.
- We provide information to make sure people know how to navigate the local health, care and housing system, including how to get more information or advice if needed.
- We tell people about person-centred approaches to planning and managing their support and make sure that they have the information, advice and support to think through what will work best for them.
- We provide information about what's happening in the local community and how people can get involved.
- We make sure we share information about what we do and how people can access the service with other relevant organisations so we can all work more effectively.

Feedback from carers:

'The idea seemed so simple and yet perfect. Meeting all the faces behind the names that you know humanised what can be very challenging interactions sometimes. I mean in the way that getting to see people with their barriers down face to face I could really see how unpaid carers are cared about. It's just tangible you aren't able to show that due to policies, restrictions, finances, etc. It must be so hard. I think the concept of acquiring and analysing feedback in the way that we did was such a good idea. I know things aren't going to change overnight and you can only work with the money/resources available, but this is a massive step in the right direction.'

What were the key barriers to success?

- Engaging partners, care staff and carers in co-production and understanding what this means.
- Getting 'buy in' from carers.
- Ensuring engagement with carers from diverse and seldom-heard communities.

What were the conditions for success?

- Creating an open and honest environment, allowing negative feedback with being defensive.
- Peterborough City Council being open minded and really listening to carers with lived experiences.
- Adapting ways of thinking and using technological advances to provide support.

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Central Bedfordshire Council

Co-producing day service and creating employment opportunities

Supporting people to progress from learning skills in a supported day service that lead to meaningful employment.

Within the council Learning Disability Day Opportunities Services, they are lucky enough to have a horticultural centre, café and small shop selling produce to the local community. People who attend produce food from farm to fork on site and love manning the café and doing outreach gardening and horticultural projects. However, the council recognises that although the service is the perfect safe space to learn life skills, they had some work to do to help those who wanted to move onto meaningful employment. To this end the council decided to relaunch the employment offer for people with a learning disability.

The aspiration was to co-produce the Supported Employment Service with the people who attend Learning Disability Day Services in Central Bedfordshire.

The council employment lead has undertaken a series of workshops within the day services to engage the people who attend, to obtain their ideas and suggestions to be brought forward and considered during the planning and implementation stage. The objective of this exercise is to ensure the needs of those accessing Central Bedfordshire Council Learning Disability Day Services and who are considering seeking employment opportunities are met moving forwards.

It is vital that the people affected are included in this process and the service must be accessible, flexible and adaptable to meet their needs. There is no better way for us to learn what this means for those accessing the service than engaging with the people themselves to find out what matters most.

The team delivered four sessions across three-day opportunities services. The sessions included easy read/visual prompts to aid discussion about specific questions. The aim was to engage participants in structured, meaningful discussions, facilitated and captured by flip chart paper for all participants to record key points. Senior staff supported people to record their comments where necessary.

The information captured from these sessions provided a broader understanding of the challenges faced by people with learning disabilities when they consider employment opportunities. The aim was to reflect on these suggestions and formulate a response that ensures that relevant training and development opportunities are accessible to those who are referred into the service, to encourage their development and to work towards coping strategies, with a view to eliminating some of these barriers.

As part of the engagement sessions, the council asked people to consider a new name for the Supported Employment Service, and they voted for the top three suggestions. The council plan to take this forward and encourage people to become familiar with it by using it on action plans and documentation used during a person's employment journey.

During this work, the council also focused on the Think Local Act Personal (TLAP) statements as follows:

- Having the information, I need, when I need it (information and advice).
- My support, my own way (flexible and integrated care and support).
- Keeping family, friends and connections (active and supportive communities).
- Living the life I want, keeping safe and well (wellbeing and independence).

Here is an example of work with Brian:

Working with Brian to create 'Brian's Job Journey' board, for him to share his employment experiences. The board will be placed on the wall for people to read and hopefully be an inspiration to others to consider paid employment opportunities.

What were the key barriers to success?

- Navigating people and their families' anxieties around benefits and the impact of having a job rather than attending day services.
- Ensuring people feel supported and have enough information and advice to take a leap of faith into new adventures.

What were the key conditions for success?

- Enthusiasm, trust building and working together to support people to get the lives they want rather than the services they are referred to.

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Milton Keynes City Council

Direct payments: empowering together

A co-produced group dedicated to increasing the uptake of direct payments. The council's mission is to empower individuals by providing them with the knowledge, resources and support needed to manage their own care and support. Through collaborative efforts, the council aims to create a more inclusive and accessible system that benefits everyone involved.

The council is committed to working with people who use services, their families and carers to make improvements to existing services and to co-design and implement new ones and have developed their 'Stronger Together' co-production board to support this. The Stronger Together board is co-chaired by the Director of Adult Social Services and a person with lived experience. Members of the board help identify areas of focus and work with council colleagues to achieve positive outcomes. One area of focus identified at the board was work required around direct payments as, slowly over time, the council has seen a decrease in take up. Because they know how such payments can positively affect a person's outcomes, the council wanted to ensure this was turned around.

A member of the Stronger Together board, who is a user of direct payments and commissions their own group of personal assistants, agreed to support this work and take on the role of co-chair alongside the Head of Service for Working Age Adults, and the Direct Payment Together project group was formed.

The council wanted direct payments to be a key focus, and the following important areas were identified:

- Work to be carried out with an understanding that people who need care and support are the experts.
- A collaborative, fully co-produced, project.
- Implement the identified changes through the Working Together for Change programme to improve direct payments for people.
- Increase autonomy, flexibility and control for direct payment users.
- Make direct payments more accessible by producing clearer guides and information about how they can be used, linked to people's outcomes rather than task focused.
- Education for staff so that they can see the value direct payments can bring, ensuring staff have it high on their agendas, as well as demonstrating how people can meet their outcomes creatively and be in full control.

Working with people: supporting the use of direct payments

The Working Together for Change (WTfC) model is a structured approach used to drive inclusive strategic change in social care. It involves engaging with people who use services to review their experiences and determine priorities for change. The model has been used across the region through Regional Sector Led Improvement since 2022/23 and is part funded by the regional programme.

The WTfC model is a highly developed, tested process that really supports co-production to its fullest. The council invited people who use direct payments to talk about what is working, what isn't and what they would like to change. They then used this information to produce an action plan which will support and enhance direct payments. The project group was made up people who use direct payments, commissioning, staff from across all adult social care services (older people, mental health and working age adults), the external commissioned direct payment support service and direct payment finance colleagues.

What were the key barriers to change?

- **Resistance to change:** Some people and care providers were resistant to moving away from traditional service delivery models.
- **Financial concerns:** Worries about managing budgets and the financial implications of direct payments.
- **Lack of awareness and understanding:** Many individuals and families are not fully aware of direct payments or do not understand how they work. This can lead to hesitation or reluctance to use them.
- **Insufficient support and guidance:** Without adequate support and guidance, individuals may struggle to navigate the system. This includes understanding their rights, managing finances and hiring personal assistants.
- **Direct payment rates:** Care providers charging direct payment users above the council's rate, so they are having to top up which is affecting take up.
- **Direct payment support services:** Making sure there is a strong support service in place that can help people with advice and information around employment laws and helping to advertise for PAs.
- **PA market/register:** Lack of available PAs to meet demand and people's needs.

What were the conditions for success?

- **Truly co-produced:** The council needed to understand from frontline staff and from people with lived experience what was and was not working. People with lived experience can provide unique insights into the practical challenges and needs that the system should address. This ensures that the solutions developed are more relevant and effective.
- **Empowerment and inclusion:** Involving individuals with lived experience in the design process empowers them and promotes a sense of ownership and inclusion. It helps to break down barriers between service providers and users, fostering a more collaborative and respectful environment.

- **Improved trust and engagement:** When people who access services see that their input is valued and has a direct impact on the services they receive, it builds trust and encourages greater engagement This can lead to higher satisfaction and better outcomes.
- **Innovative solutions:** Co-production can lead to more innovative and creative solutions, as it combines professional expertise with real-world experiences. This diversity of perspectives can help to identify and address issues that might otherwise be overlooked.
- **Sustainability:** Solutions co-produced with those who have lived experience are more likely to be sustainable in the longer term, as they are grounded in real needs and practical realities.
- **Leadership and commitment:** Strong leadership and a clear commitment from councils and their partners are crucial. This includes setting clear goals and demonstrating a commitment to making direct payments a standard option within social care services.
- **Straightforward systems:** Simplifying the processes and systems involved in direct payments can help increase uptake. This includes making the application process user-friendly and ensuring that the systems in place are easy to navigate
- **Learning and development:** Providing training and development opportunities for staff and people can help build confidence and competence in using direct payments. This includes ongoing support and education to ensure everyone involved understands how to effectively manage direct payments
- **Communication:** Effective communication strategies are essential. This involves raising awareness about direct payments, providing clear information and ensuring that service users understand their options and the benefits of direct payments.
- **Clarity on usage:** Being clear about what direct payments can be used for is essential. Move away from task focused to outcomes.

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Central Bedfordshire Council

Co-producing a dignity in dementia charter

This collective effort has strengthened the council's commitment to dignity and respect, ensuring that everyone who attends and works at the service feels valued and heard.

In 2024, all dignity champions were tasked with completing an environmental dignity audit and supporting the people who attend services in creating their own dignity charter. As part of this process, each champion met with their service manager to review findings and develop an action plan.

At Biggleswade Older People's Day Service, the audit highlighted that the welcome leaflet lacked information on whistleblowing and complaints, and that dignity was not covered in the induction process. This led to the decision to refresh the council's welcome leaflet, making it more engaging and informative. A team member and the people who attend the service worked together to co-produce a new version, ensuring it truly reflected their needs and voices.

It was a busy and exciting time, as alongside redesigning the leaflet, people were also developing their dignity charter. Meanwhile, the dignity champion, supported by a group of people, took on the challenge of designing a dignity training session.

All this hard work paid off, every member of staff signed up to become a dignity champion, inspiring several people who attend the service to do the same!

The service recently welcomed a new team member, and the dignity champion, along with others, had the opportunity to present their co-produced dignity training. The new team member reported, 'Having people with lived experience lead on the training felt really engaging, you could see that people felt empowered. The training was enjoyable'.

Empowerment and dignity is central to how people are supported and co-producing solutions with the people who attend is a core service value that is firmly embedded in the day opportunities offer.

What was the key barrier to success?

- Ensuring everyone's voice was heard.

What was the condition for success?

- Commitment to working together for positive change.

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Working with people: equity in access and equalities, diversity and inclusion

Southend City Council

Curating confidence in the community

Project designed to develop transferable skills and promote enrichment.

After the success of community co-curation projects, and in response to the radical transformation in how the council works as a department that oversees social care, culture, heritage, leisure and tourism, the council embarked on the creation of a project designed to develop transferable skills and promote enrichment. This involved working with heritage professionals on a project to conserve significant waterlogged archaeology, excavated from the Thames Estuary.

The council believes passionately that more women from underrepresented backgrounds should see heritage, arts and culture roles as viable career options. With this ambition in mind, the council felt it would be meaningful to work with 10–15 local women, from a diverse range of backgrounds, including those with caring responsibilities, such as single parents and those who are new to the UK.

Individuals from these groups are often forgotten and frequently experience barriers to employment. The council contacted a Southend-based charity, Welcome to UK, established in the city since 2014 and has worked in partnership with them for the past year.

The charity started through the personal experience of its founder and was set up to support families from overseas to positively engage in their community. They offer support and training, including English classes, help with school applications, health advice and community events, such as visits to museums, where the council invited them for tours of the art, archaeology and local history displays. Working with participants during weekly sessions, the council covered aspects of collections care, such as object handling, first aid for marine finds, packing and storage, for example.

Since 2014, Welcome to UK has helped more than 250 families from 16 different nationalities overcome the challenges newcomers face when they move to a new country. The charity has plans for expansion and to work with more partners in local schools and religious and cultural centres, which is where the project comes in.

After securing funding for the conservation treatment of a group of objects excavated from the Thames Estuary, which are currently stored in water, the council felt this was an ideal project for ‘collections careers’. They felt confident that there would be a beneficial outcome for participants, the charity and for museum services.

The council aimed to provide access to this maritime collection through a series of training and development workshops designed to provide useful experiences and skills for the group’s settlement and career prospects.

Alongside the theoretical and practical learning, the council were keen to develop the so-called ‘soft skills’ such as communication, teamwork and decision making, and benefited from an interpreter joining at each of the sessions to support these outcomes.

To support the group, most of whom had school-age children, the sessions took place during term time and on days linked with the usual programme of events at Welcome to UK, as well as alignment with the museum services regular volunteers programme.

From these sessions the council hoped to not only provide transferable skills but also encourage conversations and shared stories and experience. Each of the participants received a certificate at the end of the project and hopefully gained some valuable new transferable skills.

The council also hopes the sessions encouraged the development of existing skills and knowledge but ultimately that participants enjoyed the experience and were left feeling more confident and comfortable in their new community.

The project has been a resounding success, with the participants being happy and grateful for the chance to work with the collections and practise their English in a relaxed environment. It is hoped that this will provide the springboard for a long-term partnership with Welcome to the UK, that will expand to other areas of the collections and to other community groups and participants.

Not only has the project made an impact on the citizens of Southend but it has positively impacted museum colleagues. This transformation in practice is just the beginning, opening up many opportunities to deliver socially inclusive projects with the potential to create lasting legacies.

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Bedford Borough Council

Promoting sexuality in care homes

Supporting the staff team in a care home to support individuals' sexuality.

A care home supporting older people had a transgender resident and also two male residents who formed a relationship after moving to the home. The staff group felt it important that that they were fully supported to express their identity and relationship in a safe and enabling environment.

While staff had undertaken training, as the staff team was culturally diverse they may benefit from reflective and educational in-house workshops to enable them to support residents in care homes with knowledge, confidence, compassion and empathy.

These workshops would reinforce staff confidence in Bedford Borough Council as an employer who actively celebrates and supports diversity and inclusion in their employees.

The Home Manager, who is also the LGBTQ+ champion in the home, held workshops with staff which covered the following:

- Sexual needs vs ageing.
- Changes to sexual needs – what is normal?
- Causes of sexual problems – chronic pain, dementia, diabetes, heart disease, arthritis, incontinence, stroke, depression, medications, alcohol.
- HIV/AIDS – am I too old to worry about safe sex?
- LGBTQ+ community and sexual needs – how to support residents from this community, including negative events and attitudes they may have experienced.
- Discussion after presentation of the 'Sexuality: Desire, activity and intimacy in the elderly' report from the Department of Psychiatry.
- Capacity and consent.
- Discussion about how residents can be supported in the care home to meet their sexual needs.

The actions agreed included improved sexuality care plans, privacy signage for bedroom doors related to sexuality/intimacy needs, GP reviews if needed, for example if a resident wished to discuss Viagra, talking therapies, etc.

By implementing the actions from the workshops, residents' wishes were discussed with them and respected, for example, discreet signage which only staff would understand was used when the male residents wished to spend time in each other's bedrooms overnight. Residents' sexuality needs are discussed with them as part of the care plan process and their wishes respected, with staff actively and respectfully encouraging them to discuss these needs if they feel comfortable doing so.

Working with people: equity in access and equalities, diversity and inclusion

Outcomes included:

- Older people feel their sexuality is respected and staff do not display ageist attitudes regarding the sexual needs of older people and have greater understanding and empathy when supporting these needs.
- Staff feel more confident in discussing sexuality with residents and their colleagues.
- Registered manager is rolling out the workshops to the other care homes for adults in 2025.

What were the key barriers to success?

- Unconscious bias and cultural beliefs, ageist attitudes regarding older people and sexuality.
- Overcoming residents' fears to express their sexuality based on previous life experience.

What was the condition for success?

- Education and building confidence with team members to support residents' sexuality through reflective discussion.

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Thurrock Borough Council

Supporting complex and multiple needs

Development of an integrated and collaborative approach to supporting disengaged people with the most complex needs.

Agencies within Thurrock had for many years identified a cohort of individuals with severe and enduring mental illness, behaviours that were deemed challenging, and substance misuse, which despite multiple attempts by agencies, had not achieved improved outcomes or stability using mainstream statutory services.

Most of these individuals have a dual diagnosis of mental health with drug and/or alcohol abuse, and a history of anti-social behaviour (ASB) leading to a cycle of homelessness and interactions with the criminal justice system.

They are high users of statutory services such as A & E and mental health crisis intervention teams and present a disproportionately high cost to the system as a whole.

Their families, neighbours and others living around them, experience anxiety and distress due to the impact of their behaviours, indicating far-reaching effects beyond the individuals themselves.

In September 2023, a new Complex Housing Intervention Programme (CHIP) was implemented with a team who started to work very intensely with some of the individuals described above who were already council tenants, but in danger of losing their tenancies.

CHIP is an integrated team consisting of a psychologist (team lead), a drug and alcohol worker, social worker and local area coordinator. An assistant psychologist complements the team, providing expertise around statistical analysis. Each team member brings their own specialism and while they remain employed by their individual organisations, they are committed to only working for the CHIP, allowing them to provide 100 per cent intensive support to the people they support. The commitment to integrated working from their employers was vital to the successful development of the team.

In February 2024, this approach was further developed with the addition of the Enhanced Housing First Programme, working with the same cohort but specifically those who were already homeless or living in inappropriate settings. This added an experienced mental health practitioner. Although the schemes are separate and target different groups, they integrate and work very closely together, providing the necessary specialisms to meet individual needs.

Access to the government's Accelerated Reform Fund has enabled further funding for a new carer support worker. This role supports informal carers (usually family members) of the client groups with the aim of setting up a future peer support group.

Alongside the above, the council's original Housing First team continues to provide daily support through another external support provider, enabling use of a further range of specialist knowledge and skills, particularly around support with daily activities.

Working with people: equity in access and equalities, diversity and inclusion

The future ambition is to develop a single integrated team which incorporates all the above elements, although this has already started to develop naturally through the close-knit working established. Therefore, any further mention of the team in this paper incorporates all the above.

Key to the success of the approaches outlined above is the commitment from all services to finding bespoke solutions and improving outcomes for clients, their families and communities. This included the council's housing and social care teams, the local NHS trusts and external providers of support services, including drug and alcohol support.

Access to databases across all services was enabled as the team maintained their employment with their original service. This enabled data sharing (with consent) across the team, allowing a fuller picture and greater knowledge about the individual to be shared.

The team were given the autonomy to develop bespoke solutions for each individual, with no limit on support hours. This allowed the team to provide a holistic approach, enabling appropriate support at the right time with no hand-offs to other teams or services. For example, if an individual needed cognitive behaviour therapy (CBT) but would not engage with the team, then support leading to them accessing that therapy would be given. When they were ready to engage, rather than being placed on a waiting list for the therapy, the psychologist was able to provide CBT sessions immediately, making best use of the opportunity. This enabled a bespoke solution in terms of the right support at exactly the right time.

An example of a qualitative outcome is shown in the following case study, indicating the difference that the CHIP team made to one family:

Client X had spent most of his life dependent on alcohol. He had untreated mental health concerns including suspected psychosis, ongoing difficulties maintaining his daily living skills and was close to losing his tenancy due to rent and utility arrears. He was someone who refused to engage with services and had fractured family relationships; someone for whom there seemed to be no hope of change as he grew closer to old age.

The CHIP team stepped in and began providing intensive support daily, chipping away at years of self-abuse and poor self-esteem. One year later, client X had stabilised his alcohol use, his tenancy was safe, and he had rebuilt his relationship with his sister. The CHIP team had supported X to make the changes needed to turn his life around.

Unfortunately, client X died some weeks later from liver disease, but peacefully in hospital, with his sister, whom he had recently reconnected with, by his bedside.

His sister told the team:

> *'I always thought that one day I would get a knock at the door, and it would be the police telling me they have found my brother's body in the woods somewhere … and I knew he would have been somewhere on his own and that would have been horrendous. But that didn't happen. He passed away knowing he was safe and had his family around him. That wouldn't have happened without CHIP.'*

Quantitative outcomes have been measured through data relating to individuals, captured pre- and post-CHIP intervention, by measuring the number of negative interactions that individuals had with services and their cost.

This included:

- number of A&E attendances and ambulance usage
- number of prison stays
- number of police, ASB and tenancy management interactions
- number of in-patient hospital stays, both voluntary and under a mental health section
- number of missed appointments and unplanned emergency appointments with professionals
- number of repairs to property caused by damage from the individual.

What were the key barriers to success?

- Recruitment of professional staff was difficult, due to general staff shortages across the NHS, but this has now been overcome.
- Organisational barriers, such as information sharing and budget control, have been a challenge and will require an ongoing cultural shift to ensure a fully integrated approach between different organizations, particularly back-office departments such as HR, Finance and IT.

What were the conditions for success?

- Commitment to the aims and principles of the projects from all services involved.
- Allowing teams the greatest autonomy and as much time as needed with service users.
- Understanding this was an experimental project (in line with HLS principles) and that ways of working will develop over time as bespoke solutions and outcomes are met.

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Southend City Council

Contemporary Elders

Supporting people to have great lives through Focal Point Gallery.

Southend has a unique and rich cultural heritage which is the backbone to a fiercely proud community. In Southend, arts, cultural, heritage and tourism service is part of Adult and Community Services. Supporting people to live great lives is underpinned by the Connected Southend approach towards seeing a person holistically while ensuring they are connected to the people and the things they love. Arts, culture and heritage play a key role in developing civic pride and Southend and the surrounding area has an amazing provision of museums, heritage sites such as Southend Pier (the longest pleasure pier in the world) and the resting place of the Prittlewell Prince. The Focal Point Gallery is South Essex's only public contemporary art gallery and is open to all. Offering an exciting and ambitious programme of largely free workshops, talks, outdoor film screenings and offsite projects, the gallery also presents major exhibitions featuring both international and local artists. The gallery believes in building a community and a safe space to enjoy art and the creative process, where everyone is valued.

The aim of the Focal Point Gallery is to inspire curiosity by producing and presenting thought-provoking art made today that explores the locality, sense of self and the importance of communities through investigating current concerns that resonate internationally.

The Contemporary Elders Group came about organically, driven through the passion of the local community who wanted to connect, learn and grow together.

Focal Point Gallery's 'Contemporary Elders': The gallery held workshops to liberate the term 'elder' from the stigma of 'elderly' and encourage people to embrace wisdom as a path to growing whole, not old.

Workshops, guided tours, walks and picnics encourage coming together, life-long learning and enjoyment of the arts in all its forms. In the beginning, workshops started with six people, while the present attendee rates are stable at around forty people each session, with a database of over eighty Contemporary Elders. Focal Point Gallery has recently increased its offer to two sessions each month to accommodate numbers. Contemporary Elders have now become Digital Ambassadors and work with people outside of the group to support and develop their own online skills.

The project that started Contemporary Elders was in partnership with South Essex Homes. Hilda, Sally and Phyllis were the first three Contemporary Elders that became digital ambassadors to their fellow elder tenants in South Essex Homes. They created a short film about their journey which was shortlisted to the last eight films in the National Digital Awards run by National Arts Council England, in the Digital Storytelling category.

The Focal Point Gallery built on the success of Contemporary Elders: Digital Connectivity film, with an innovative project called 'Online Cracking Code', which provided creative skills sessions for a group of Digital Ambassadors from South Essex Homes supported by artist Laura Trevail and puppetry artist Claire Brooks.

> *'I have learnt new things and gained completely new perspectives, and I go home with new ideas and thoughts, i.e. I 've been woken up out of my static state, and I like it.'* ***Contemporary Elder's participant***

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Working with people: supporting wellbeing in communities

Suffolk County Council

Therapeutic Gardening Group – getting back to roots

Occupational therapists (OTs) from both adult social care and community health teams in rural Suffolk established a therapeutic gardening group at the local health centre for people who were known to their services or waiting for support.

Health and social care staff frequently reported anecdotal evidence of an increase in loneliness and social isolation among the people they supported following the Covid-19 pandemic.

A group of health and social care OTs with an interest in social and therapeutic horticulture were keen to find creative ways of reducing isolation which could also improve other outcomes for people including upper limb strength, increased mobility, improved balance and reduction in falls risk.

A small six-week pilot project ran between October and November 2023. Health and social care OTs facilitated weekly one-hour group sessions in a specially curated garden space with the support of a volunteer.

Social care practitioners identified participants who could benefit from a reduction in their social isolation and increased interaction with others outside the home environment. Health practitioners also identified participants who were on a waiting list for rehab and could be seen in a group setting rather than an individual home visit.

The agreed objectives of the therapeutic gardening group were to:

- promote meaningful occupation as a benefit to health and wellbeing
- promote aging well, reducing the need to access health and social care services
- enhance community networking between voluntary, third sector, NHS and social care.

A small central courtyard at the health centre, which was previously unused and overgrown, was developed with input from staff and volunteers to create a peaceful garden courtyard that is accessible to all and safe for use by those with limited mobility and wheelchair users. Raised beds were added along with a path and patio area for tables and chairs using monies from a social prescribing fund.

The initial pilot group included five participants identified from health and social care (three from health and two from social care), three were female and two were male, with a mean age of 77.6 years. Two people attended once, two people attended twice and one participant attended all five sessions.

Health and social care OTs worked together to prepare and facilitate the groups along with volunteer support and other multi-disciplinary team members as required, dependent on need.

A standard operating procedure was written to help guide the group, ensuring compliance with health and safety and risk assessment. Three sessions were run indoors and two were run outdoors. One week did not run due to adverse weather. The sessions were varied and on days when the weather meant the outdoor space could not be used, indoor sessions were arranged. The activities included:

- planting layered bulbs
- planting hanging baskets
- planting succulents in teapots
- 'snail planting' – learning how to plant seeds effectively for a strong root structure
- planting pansies
- planting tomatoes and courgettes – with a competition to see who could grow the biggest
- stone painting (rainy day activity)
- making potpourri (rainy day activity)
- activity planning using magazines, etc. (rainy day activity)
- feedback session to explore how people had found the sessions and how learning could be incorporated into future sessions.

All sessions aimed to encourage interaction and conversation between participants while supporting therapy goals such as improving dexterity, increasing focus and motivation, improving mobility and reducing risk of falls.

Notes were written using a care plan which was generated prior to the group with a view to saving admin time. A simple data collection sheet was completed by staff after each session to capture each person's details, goals, wellbeing distress scores and cost savings.

Following the success and using learning from the pilot to inform the sessions and how the adults were supported, the group started again in May 2024 and ran until October 2024 (when it had to stop due to weather). During this time six people attended.

The plan is that the group will restart again in March 2025 and staff are currently being encouraged to consider people who could benefit from attending (five people have been identified to date).

The council believes the gardening group is a good example of collaborative and innovative working, highlighting the importance and value of meaningful occupation and is promoting this for consideration in other areas. There is interest in a therapeutic music group in another location.

What were some of the challenges faced?

The project faced a number of early challenges that required working collaboratively and creatively between colleagues from social care, health, NHS Property Services and the adults joining the group to find solutions.

Working with people: supporting wellbeing in communities

Transport: Enabling people to get to the health centre is a challenge. Currently transport links to the health centre are limited and there is no resource specifically for those attending the gardening group. Adults must be able to get to the health centre to attend. One person was offered support to use his powered wheelchair, but he managed to complete this independently the first time and continues to attend.

Weather: This has been a challenge, as poor weather limits the opportunity to be outside and indoor activities are limited due to what can be done in the environment without causing too much mess or disruption. Funding has now been gained via a grant to purchase an awning to enable more activities to take place outside, even in wet weather.

Garden preparation: The space in the courtyard needed to be prepared for use, including raised beds, woodchip, slabs and a small threshold ramp to enable people to access the space and participate safely. This was supported by the Local Men's Shed, the Social Prescribing Fund and a local builder who supports the group with minor adaptations. Staff also used their own time to help prepare the space.

Feedback

Those who attended the group have provided positive feedback about the impact on their well-being. Practitioners have also noticed an improvement in people's overall mood, ability to interact with others and physical wellbeing including balance and dexterity.

- Feedback gained from the survey included comments such as: 'I'm not outside so much in the winter but like the garden for sitting in if I get a chance. Has made me more cheerful. I'm doing something I feel is worthwhile. I've been able to interact with company that's present.'
- A participant who comes independently in a powered wheelchair reports the group is 'everything' to him and the one thing he looks forward to each week.
- A woman who attended all five pilot sessions has asked to attend the next group when it starts again in spring 2025.
- A woman who has mild dementia has been able to attend, giving a break to her family for a short period and helping her to adapt to being with other people.
- Participants who were nervous and more reserved are seen to actively engage with others and enjoy the time.
- One participant enjoyed the supportive nature of the group and asked to return as a volunteer when the adult group begins again in Spring 2025.

What were the barriers to success?

- Transport for people to be able to get to the garden.
- Weather restricting access to the garden and the type of activities possible due to having to be inside.
- Staff resource meant that some work for setting up the group needed to happen during lunch breaks and bank holiday to ensure 'business as usual' work could continue.

- Competing priorities and demand between health and social care meant that ideas were not always aligned. This was overcome through understanding and negotiation about the group's aims and use.
- The small garden space available meant that only six adults could safely use the space at any one time, which limited the size of the groups possible.

What were the conditions for success?

- Willingness of all to collaborate.
- Pooling of skills and knowledge to be able to establish, prepare and run the group.
- Volunteer support – enthusiasm and experience to prepare and encourage people to participate.
- A culture of creative practice.
- Availability of space and grants available to support the group.
- Practitioner skills and drive to successfully apply for grants.

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Working with people: supporting wellbeing in communities

Luton Borough Council

Placed-based approach for physical activity

Adult social care has collaborated with Active Luton, local faith centres and the local community to promote physical activity. The project enables partners to address health inequalities and promote movement in Luton where physical inactivity is significantly higher than the national average.

In Luton, the level of physical inactivity is significantly higher than the national average. The most current active lives data tells us that 30.5 per cent of the town's population do less than 30 minutes of moderate physical activity a week, compared with 23 per cent nationally. Luton has four wards which are amongst the most deprived in the country, and a population where those from a culturally diverse background exceeds the white British population, with the largest numbers being of south Asian descent. Supporting these populations to be more physically active, working alongside other partners in a systematic, collaborative way is critical to the preventative approach. This will help address health inequalities that may lead to long-term conditions and support the system to prevent, reduce and delay the need for long-term services across the system as well as in adult social care.

The council are keen to support a community-led approach where local resources and groups are created and accessed by local people. The ethos of the project is to encourage movement of any form to improve health and wellbeing. Adult Social Care partnered with Be Active, a regional charity affiliated with Active Luton, who had already carried out some research on the impact of physical inactivity locally. The local wards of Farley Hill and Warden were identified as the most appropriate areas to start working with as this is where most need was identified.

As a result of initial discussions, it was agreed to allocate some funding towards a new community role called a Sports Ambassador. The Sports Ambassador works alongside the local area coordinator appointed to the Farley Hill area to engage with the local community to establish preferences and barriers in order to start the process of setting up activities that encourage movement.

The post is located within the adult social care (ASC) local areas coordinator's team, located in Farley/Stockwood – a top priority area for ASC and also one of three priority areas within the top 10 per cent in Bedfordshire as identified by Sport England. The part-time role will educate ASC colleagues, share intelligence, map assets and improve communication across different parts of the system.

In addition to the above mentioned work, the collaborative project has discussed and identified groups of individuals in the community who would benefit from the opportunity to improve their wellbeing through movement. There are five projects underway:

1. **Fun and Games –** for young people with learning and physical disabilities.
2. **Moving it, Shake it, Live it –** for younger people in transitions.
3. **Live and Virtual –** for individuals with head injuries and surviving a stroke.
4. **Strong and Steady –** falls prevention and balance.
5. **Silver Strength –** exercises in sheltered accommodations.

It is envisaged that these projects will impact in a way that is preventative, improving fitness and encouraging independence for as long as possible.

The council collaborated as a partnership through a place-based approach to develop shared strategic priorities, partnering with faith centres and the community to promote physical activity. This included identifying geographical hotspots that provided Active Luton with an opportunity to support the most vulnerable communities by introducing physical activity to these audiences. The council's approach included providing opportunities to educate, influence and change behaviours, not only among service users, but also within workforces across the health and care system.

Key actions:

- Participation in the 'Stepping into My Shoes' programme to foster understanding and collaboration across the system, to create public services that are more integrated and based on the needs of the local population.
- Establishing gender-specific activity sessions at local mosques and gurdwaras.
- Allocating resources to expand physical activities across faith centres in deprived areas.
- Development of a Smartsheet-based tracker to capture data and evaluate progress, enabling reflection and evidence-driven actions. These specifically reference impact in relation to the enablers of change, considered to be so important for delivery, an effective systems-based way of working, as well as capturing knowledge and intelligence and recording key conversations and actions.
- Establishing a process and offer to develop capacity in and across the system that builds knowledge and understanding about the benefits of physical activity, how to access opportunities and provide continuing professional development and qualifications within settings.

The support provided was carried out in a collaborative way with the activities of the groups being determined through consultation and user involvement. The first project, Fun and Games, commenced in September. Volunteers and two Active Luton staff run this group weekly. It is expected that other groups will progress in this way. Aims of the project include:

- integrating efforts within the Luton Strategic Vision for Sport and Physical Activity governance framework, to ensure that physical activity becomes part of the conversation
- embedding physical activity conversations and delivery within existing practices of those professionals working with ASC
- developing a sub-group for the work which includes stakeholders from a variety of settings including public health, housing and social care, which will oversee and guide progress.

Working with people: supporting wellbeing in communities

Examples of impact and outcomes:

- Trusted relationships have been formed with the Prevention and Enablement Team in ASC, promoting a positive and collaborative working environment. Previous learning has shown the value of embedding capacity within services directly responsible for supporting and caring for residents. It became apparent that embedding this capacity within social care would be instrumental to the success of influencing change and creating positive outcomes for those accessing services.
- Rolling out the active medicine awareness across key partners and stakeholders has helped build knowledge and understanding of the benefits of physical activity and how to access opportunities.

Quotes from participants

- *'Movement brings great things like greater health, friends, and community.'* ***Miss A***
- *'If we are going to make that change for generations to come, we need to go to the communities.'* ***Mr C***

What were the barriers to success?

- Building trusted relationships and understanding local challenges is crucial.
- Initially limited partner engagement and governance inefficiencies, which were addressed over time.
- Securing local champions with community connections is vital for sustained impact.

What were the conditions for success?

- Effective partnership working.
- A common understanding of the Marmot Review and the Marmot Adult Social Care 2040 vision.
- Trusted relationships in the community with capacity built within the community to lead and support the programme.
- Ensuring there are dedicated resources in place across the system to sustain the programme and achieve a long-term impact.
- Having a systematic approach to evaluate impact and outcomes for individuals and communities.

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Southend City Council

Southend Community Investment Board – Improving life and wellbeing

Southend-on-Sea City Council established a £1.5 million Community Investment Fund (CIF) to support wellbeing.

The three-year fund shifted funding control from the council to the community to deliver improved outcomes for residents. This was a new approach for the council. CIF's objectives are to:

- enhance young people's health and wellbeing
- improve public spaces for health and wellbeing
- reduce poverty by making sure residents realise their aspirations
- enrich arts and culture
- enhance a thriving voluntary sector.

In 2021, the council worked with the Southend Association of Voluntary Services (SAVS) to establish a Community Investment Board (CIB) to deliver CIF. The board consisted of 12 residents with lived experience of community, health and social care services. A Community Reference Group, comprised of voluntary sector organisations, provided insights to CIB, making sure it was well-informed and heard from diverse voices. SAVS funded a CIB Facilitator to provide training, engage with the voluntary sector, and learn about strategies, funding and community needs. The council also provided expertise, such as contract tendering.

Monthly CIB meetings developed CIF's direction, explored funding sources, evaluated bids and reviewed outcomes.

CIB received £1,512,446.50 funding across three years. It also attracted £94,000 funding from other sources, including the City Celebration Fund, Active Southend, Smarter Travel, Carers Relief and Southend Educational Trust, enhancing its capacity to provide support.

The application process made sure applicants set clear targets linked to funding and standardised budgeting templates enabled CIB to review spending. The council was kept informed through regular monitoring and reporting.

Outcome

CIB-funded proposals minimise dependency on statutory services, provide accessible support and involve beneficiaries in the design, delivery and evaluation of plans. It has allowed citizen-led social development using an asset-based approach and focused on what is most important to the people of the city and who are most likely to spot the gaps and needs that they can help resolve.

ASC funding of the CIB has effectively managed a CIF and several other specialised funds, delivering over £1.5 million in investments across 237 projects (totalling £1,433,618.17) that have directly impacted over 130,000 Southend residents.

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Working with people: supporting wellbeing in communities

Working with people: digital technology and technology-enabled care

Peterborough City Council

Hey Geraldine, a personalised artificial intelligence assistant

Peterborough City Council has developed an innovative artificial intelligence (AI) assistant, 'Hey Geraldine', designed to support social workers and social care staff.

Peterborough City Council developed an innovative AI assistant, "Hey Geraldine" designed to support social workers and social care staff. The tool is based on a real member of staff within the Council's Therapy Services, Geraldine, who has over 30 years of experience in providing equipment and technology enable care. The idea for Hey Geraldine stemmed from the frequent requests social work teams made to the real Geraldine for guidance and support. By leveraging AI, Peterborough City Council has created a virtual assistant that can provide instant access to knowledge and information, improving efficiency and decision making. By basing the AI on a real person, the council has significantly increased user adoption. This approach has made it easier for the council to introduce the tool and gain buy-in from staff.

The council initially explored commercial AI solutions but had concerns about data privacy and the ability to address local nuances. To overcome these challenges, they developed Hey Geraldine, a bespoke AI tool.

The council's existing systems relied on manual updates. By implementing an AI-powered solution, the council was able to streamline processes and improve the overall user experience. The AI system can support timely updates to training materials with the latest information, ensuring accuracy and relevance. It can also personalise the experience for each user, delivering tailored content based on their specific needs. Additionally, the AI can analyse user interactions to identify knowledge gaps and areas for improvement, allowing the council to refine its offerings.

The development of Hey Geraldine was a collaborative effort between Peterborough City Council, Outcomes Matter Consulting and Datnexa. Together, they were able to bring this innovative solution to life in just six weeks.

Through the development of Hey Geraldine, the aims were to:

- upskill the workforce by enhancing staff knowledge and confidence in using technology-enabled care and digital solutions
- alleviate the workload of occupational therapists by automating responses to common queries
- increase occupational therapists' productivity by empowering them to focus on complex cases and strategic tasks
- promote technology adoption and encourage the wider use of technology-enabled care and digital solutions across the service.

The development of Hey Geraldine was part of a wider ambitious transformation programme aimed at exploiting the opportunities that AI technology provides in managing demand, increasing workforce capacity and increasing the uptake of assistive technology.

Datnexa has guided the council through the complexities of AI governance, assisting with the completion and sign-off of crucial documents such as Data Protection Impact Assessments (DPIAs), Data Processing Agreements (DPAs) and service agreements. Furthermore, they proactively collaborated with the information governance team and other relevant stakeholders to complete necessary information security processes before the testing period began, mitigating potential data protection concerns and risks.

The project has placed a strong emphasis on engaging frontline staff, including occupational therapists and commissioners. Hey Geraldine has undergone rigorous testing to ensure accuracy and reliability. Over a six-week development period, feedback on the tool's responses was collected through twice-weekly huddles and feedback forms. This allowed the council to iteratively improve the tool, ensuring it provides the most up-to-date and accurate information.

During the testing phase, the tool was trained to:

- define solutions and their use
- identify solutions to meet the needs defined by the practitioner
- respond to contextual and practice-based questions (e.g. 'I am working with a person who is forgetting to turn the oven off, what is available to support them?').

The occupational therapist team were introduced and trained on the back-end functionality for the system and the insights dashboard. This means internal teams are now able to easily update content and glean relevant insights from the application, understanding what staff are frequently asking and where more support may need to be allocated.

The council recognises the importance of building user confidence in the AI assistant. To encourage further adoption, the council aims to leverage a group of technology enabled care champions to foster trust in Hey Geraldine. Integrating the application into Microsoft Teams will also make it more accessible and easier to use for social care staff in their daily roles.

Initial impact of Hey Geraldine

Hey Geraldine has been proven to save the OT team 15 minutes per conversation. This saving has been used to manage caseloads, allowing priority to be given to cases that require additional support. During the testing period, over 1,200 questions were asked. While many were for testing and demonstration purposes, a significant number were genuine queries. In addition to the time saving a range of positive feedback has been seen from across the service:

> *'The answers were exactly as Geraldine would advise. The chatbot is quick and easy to use.'*
>
> *'Just wanted to share with you my moment of pure joy this morning. Geraldine is on leave for two weeks, and first day of her leave I'm approached by a number of staff with multiple technical questions … ask Hey Geraldine ... well, it was like talking to Geraldine herself, even gave me the part number of the equipment I needed!'*

Additionally, the tool provides a valuable insights dashboard, enabling the calculation of time savings and the identification of key themes and trends in user queries. This data-driven approach allows for the maximisation of return on investment through targeted training and communication strategies.

During the testing phase, staff feedback highlighted additional opportunities for Hey Geraldine's application, including:

- supporting the development of broader practice
- enhancing practitioner decision making
- reducing the volume of incoming queries to other service areas.

As the adoption of Hey Geraldine grows within the council, they are exploring ways to expand the AI assistant's impact across various service areas. As the tool continues to evolve, it has the potential to significantly improve Peterborough City Council's Adult Social Care services.

The Council used the Think Local Act Personal Making It Real 'We Statements' to help with measuring progress:

- We make sure that staff working in short-term settings or situations understand people's care, treatment and support requirements and work in a person-centred way.
- We work with people to manage risks by thinking creatively about options for safe solutions that enable people to do things that matter to them.
- We make sure people feel safe and comfortable in their own home, which is accessible, with appropriate aids, adaptations, technology and medical equipment.
- We know how to have conversations with people that explore what matters most to them – how they can achieve their goals, where and how they live, and how they can manage their health, keep safe and be part of the local community.

What were the barriers to success?

- Ensuring robust governance and data protection.
- Getting buy in from Adult Social Care staff.

What were the conditions for success?

- Increasing capacity of the real Geraldine.
- Maintaining the same quality of advice and expertise.

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Working with people: digital technology and technology-enabled care

Hertfordshire County Council

Data Inspired Living (Assistive Technology Offer)

Digitally-enabled sensors linked to a dashboard enabling Hertfordshire's residents to live at home for longer, identify emerging needs and provide reassurance and support to family carers and share data with professionals.

In response to the growing health and social care challenges across the country, Hertfordshire County Council developed an assistive technology (AT) strategy outlining its vision to use modern digital technology to improve the provision of care services and support Hertfordshire's residents to live healthy and fulfilling lives. The council wanted to look at using modern digitally-enabled technology so that they 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 unpaid carers.

Hertfordshire CC already has a digital telecare offer which serves circa 14,000 residents across the county and provides a range of emergency alerts linked to a 24/7 monitoring and triage centre. In addition, they operate a 24/7 mobile response service which regularly attends and supports circa 200 residents in their own home each month. They have also developed pathways into community health services for those residents who are triaged as needing urgent health interventions. However, this service is mainly reactive in nature hence the council wishing to develop a preventative offer as well.

Research consistently indicates that older people have a strong preference to continue living independently in their homes rather than moving to residential care. However, with the 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.

With the successful completion of two pilots to test the concept of AT, agreement was secured to transfer to business as usual. To support this the Assistive Technology Pathways (initially drafted in 2022) which document and support referrals resulting from both emergency alerts and emerging trends, have been reviewed and updated.

Hertfordshire County Council recognised that AT presented an opportunity to not only provide support to those who were experiencing a health emergency through emergency alert pendants and motion detectors but could also build a picture of a person's daily routine. This data could then be used to identify changes to their daily routine and contribute to the prevention of health conditions before they arise.

To support these two identified benefits the council worked collaboratively with health and social care partners to create integrated referral pathways across Hertfordshire.

The commissioned service, Herts Careline, may be the first contact a person has following a fall or other health emergency. Careline will complete an initial assessment and then contact the relevant organisation to either send an ambulance or provide community-based services.

Where an emerging trend is identified that has not yet become acute or a crisis there is the opportunity for preventative or proactive interventions to be put in place. These trends are monitored via individually tailored alerts and are triaged and responded to by a small team of assistive technology practitioners. They liaise with families and statutory and non-statutory partners to put in place early intervention services where required to support residents at an early stage.

Both the emergency pathway and the proactive pathway are supported by community health care providers operating in Hertfordshire: Hertfordshire Community Trust, Central London Community Healthcare Trust, Hertfordshire's Mental Healthcare provider and Hertfordshire Partnership Foundation Trust.

Emergency pathways are also supported by Hertfordshire's Emergency Intervention Vehicle (EIV) which brings together health and social care practitioners. The EIV attends calls instead of an ambulance, to give people both the medical support they need and provide a rapid response to their social care needs. This supports people to stay well at home and avoids the need to go into hospital. In addition, the British Red Cross, via Herts Careline, support in-person assessments where Herts Careline identify that such support and information is needed.

As part of the ongoing development of the AT solution, the council has collaborated with social care practitioners and families to build the dashboard both in functionality and appearance to ensure it meets the needs of the practitioners and the residents.

The council uses supporting Think Local Act Personal Making It Real 'We Statements' to help monitor progress:

- We work with people to manage risks by thinking creatively about options for safe solutions that enable people to do things that matter to them.
- 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.
- We work with people to make sure that their personal plans promote wellbeing and enable them to be as independent as possible.

The council has also engaged with residents and carers via focus groups, questionnaires, individual one-to-one support meetings, semi-structured interviews and data examination to gain feedback and ideas on improving and iterating the dashboard that is accessible from a carers' point of view. The council aims 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. The council works with people as equal partners and combines their respective knowledge and experience to support joint decision making.

The council has engaged with health and social care partners to review and update the pathways to reflect the current processes and referral routes supporting the TLAP statement: 'We work in partnership with others to make sure that all their services work seamlessly together from the perspective of the person accessing services'.

Working with people: digital technology and technology-enabled care

The innovative nature of AT has necessitated the updating of internal policies and procedures and the creation of policies to support the implementation of AT to embed this new offer into social care practice. As the council has drafted and signed these off they have made sure that organisational policies and procedure reflect the duties and spirit of the law and do not inadvertently restrict people's choice and control.

Each resident on the pilot had a case study completed as part of the Public Health Hertfordshire AT evaluation. 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 had 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 installed:

- 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 frailty. Care costs may have either stayed the same or increased.

Susan was discharged from hospital with a package of care consisting of 4 x 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 installed:

- Care reviewed one month later post AT install and reduced to 1 x daily visit as Susan had regained her strength and independence.
- Therefore, weekly cost reduced to £75.88 within one month of Susan's return home.
- Support for resident/family members to help maintain wellbeing.
- No further admissions to hospital at time of review
- Family know Susan has an established night-time 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 around Susan's routine unless they were present with her.

Both case studies support the following TLAP Statements:

- We make sure people feel safe and comfortable in their own home, which is accessible, with appropriate aids, adaptations, technology and medical equipment.
- 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.

- We work with people to make sure that their personal plans promote wellbeing and enable them to be as independent as possible.
- We know that the place where people live, the people they live with, and the support they get, are important to their wellbeing and often interlinked. We have conversations with people to make sure we get all aspects right for them as individuals.
- We make sure that the organisational policies and procedures reflect the duties and spirit of the law and do not inadvertently restrict people's choice and control.

'Without this technology she [mum] would have been very fearful. I would have been even more anxious … It means someone doesn't need to be there 24 hours a day – mum is a lot more independent. ***Family carer***

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

'The benefit of the AT sensors 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 give them reassurance. What I really like the most is that AT is versatile. It's another tool in the 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.'

TLAP Statements Explore Making It Real – Making It Real

What were the barriers to success?

There were several challenges that had to be overcome, and the following is not an exhaustive list:

- **Ethical challenges –** this entailed remote monitoring and, due to the evaluation considered as research, we needed to ensure we had 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 at any point, resident consent to disclosure of personal (anonymised) information/data.
- **Data protection –** detailed work to ensure GDPR compliance including Data Protection Impact Assessments (DPIAs), data sharing agreements, etc.
- **Security –** equipment had to be penetration tested to ensure robustness and to meet 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 implantation.
- **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.

Working with people: digital technology and technology-enabled care

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 pressures on family carers and improve their quality of life.

The evaluation sought to:

- identify whether the AT pilot is achieving its intended outcomes
- understand how AT can be incorporated into excellent social care practice and enhance current services/practice
- 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.

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Central Bedfordshire Council

Independence Day

The use of technology-enabled care has maximised people's independence, minimised intrusion and also reduced costs.

The council have explored how to enable people to be more independent when in the community and promoting social inclusion and wellbeing, while not increasing the need for commissioned support and subsequent costs.

As part of embedding technology enabled care (TEC), the Oysta Pearl + was made available for staff to prescribe and was promoted by the TEC team to showcase the benefits.

The Oysta Pearl+ is a Global Positioning System (GPS) enabled mobile phone and personal safety device that allows users to call for help and be monitored 24/7. It's designed for people who want to maintain their independence while feeling safe.

Features included:

- **GPS location:** The device can locate the user in an emergency.
- **Falls detector:** The device can detect a fall and send an alarm.
- **SOS button:** The user can press the SOS button to manually trigger an alarm.
- **Safety zones:** The user can set safety zones where an alert will be sent if the user leaves the area.
- **Carer circle:** The user can set speed dial numbers for friends, family, or carers.
- **Remote configuration:** The device can be updated remotely without the need for an engineer visit.

The council worked in a strength-based way with individuals and their families, where appropriate, to build confidence in the TEC and to consider risks and how to mitigate them.

Some examples of impact can be seen below:

> *'I can live the life they want and do the things that are important to me as independently as possible.'* ***L***

L is 23 and lives with her mother and grandmother. She has a learning disability, is shy and lacked self-confidence but wanted more independence. L wanted to find employment rather than attending the day centre, but the family were concerned about L being out in the community without support.

L agreed to use the Oysta Pearl+. The family could see, if needed, where L was when she was in the community. This meant L felt safe, knowing that her mum knew where she was. L now uses public transport to get to work. She has also been to other places in the community including visiting her other grandmother in the next town.

Working with people: digital technology and technology-enabled care

L no longer needs the day centre service or the support to access the community. She is happier and more independent and contributing to society.

What were the barriers to success?

- Gaining the confidence of L and her family in the TEC.
- Frontline staff understanding how the TEC could be used.
- Concerns that monitoring was overly restrictive and could be seen as a deprivation of liberty.

What were the conditions for success?

- Giving staff and people using services time to understand the TEC and how it works.
- Promoting TEC as a route to independence, not as a 'cut' in support.

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Norfolk County Council

Rolling out tech skills for life

Enabling everyone to have access to and use technology confidently and securely through the implementation of the model.

Over the past three decades the personal computing revolution and internet access has transformed society, changing the internet from a place we visit to an essential part of the economy and our everyday lives.

The pandemic increased the rate of digitisation across the economy and society, benefitting many but exacerbating digital exclusion for those people who didn't have the tech, skills, confidence, financial means or connectivity to use and benefit (economically and socially) from using technology.

Digital inclusion is no longer a 'nice to have', it's an essential. Being digitally excluded isn't just an inconvenience, it compounds and exacerbates social and health issues. A lack of digital skills and access can have a huge impact on someone's life and can ultimately lead to poorer health outcomes, increased loneliness and social isolation, less access to education and jobs and a lower life expectancy.

Research and evidence from sources such as the Good Things Foundation's Digital Nation report and the Lloyds Bank Consumer Digital Index highlight a strong correlation between digital inclusion and possessing good digital skills. Digital technology impacts every aspect of home and work lives, from staying in touch with family and friends, online shopping and banking, to finding cheaper deals when finances are tight. It also enables studying, job applications and the use of assistive technology to support daily living.

Norfolk is a large rural county with a higher-than-average older population – 24 per cent over the age of 65 out of a population of 931,943 (ONS, 2023). There are also areas of deprivation in Norfolk, with Great Yarmouth one of the most deprived towns in England. These are indicators of digital exclusion which along with 'Not' spots and limited access to digital support means this is an issue we would like to solve.

The council's Digital Inclusion Strategy was agreed in 2018 and updated and refreshed in December 2021. A partnership programme was launched in January 2022 to implement this strategy. Its aims support the outcomes of the council's 'Better Together for Norfolk', by enabling residents to have digital skills for work and life, engaging with their communities and accessing information and resources to thrive in today's digital world.

The council is passionate about digital inclusion and its vision is embedded at the heart of its strategy. 'Every Norfolk resident is provided with the appropriate digital access opportunities to meet their needs and enable them to be digitally included in all aspects of their lives'.

Working with people: digital technology and technology-enabled care

Following a successful bid for funding in 2023 through the Norfolk Investment Framework, an innovative proof of concept pilot was launched. The pilot service is called Tech Skills for Life. This is a place-based approach working with residents and partners in the local community to improve access to and use of technology. It provides access to devices, data, connectivity and digital skills through a simple assisted referral route. Tailored, wraparound support is provided by one of the Community Tech Coaches using a 'trusted place, trusted person' approach.

The pilot launched on 10 July 2023 with four Community Tech Coaches. The pilot has been successful and through further funding from the Department of Health and Social Care (DHSC) we have been able to continue and expand its reach this year.

The pilot has been phenomenally successful, and key points are as follows:

- Remit is to provide place-based individual tailored support to anybody who is digitally excluded in some way or another.
- Covers access to devices, data, connectivity and digital skills to enable safe and confident use.
- Provides one-to-one appointments, drop-ins at various community and public places and communication events.
- Expanded to North Norfolk, Great Yarmouth and East Norfolk, Thetford and Swaffham in June 2024 with funding from DHSC, and continues to cover West Norfolk.
- Have 7.6 FTE Community Tech Coaches.
- Up to 17 April 2025, the council has supported and engaged with 11,438 people and there have been 2,317 assisted referrals.
- It has gifted 1,744 devices, mainly refurbished laptops, but also sim cards, second-hand smartphones and mi-fi (mobile hot spot) devices.
- Number of carers supported from 100 to over 110 previously unknown unpaid carers.
- In partnership we have developed an AI Assistant 'Sarah' who provides 24/7 information and advice from publicly-held information on the website and others accessed through a WhatsApp conversation, which is currently being tested by users.

The council's digital inclusion programme was set up from the start as a partnership programme with colleagues from the council, health, district councils and VCSE included. The project Tech Skills for Life was developed agilely with partners taking roles on the project and the service was built and continues to evolve. The feedback from people who access care and support was key, and information was gathered and still is to help shape the offer.

What has been the impact?

- The council has collected 'impact stories' from many customers and a video Making a difference – tech skills for life, which shows the impact on people's lives as well as success stories on the website page Tech skills for life success stories.
- The project won the 2024 Smarter Working Awards for Best Digital Project and has been shortlisted for Small Team of the Year in the upcoming LGC awards 2025.

What was the barriers to success?

- Funding – this is an externally funded programme and project and although we have been successful in bids and grants for over £915,000, it's an ongoing challenge to keep this key work going.
- Setting up a completely new service from scratch.

What were the conditions for success?

- Passion and commitment from all those involved, whether the Community Tech Coaches themselves, or Digital Services staff who refurbish all the laptops for onward gifting.
- Partnership working.
- Clear objectives, goals and targets.
- Open and frequent communication.
- Celebrating success.

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Bedford Borough Council

Preparing a 'forever home'

Occupational Therapy and Home Improvement Team working with families to develop suitable accommodation for younger people with a disability.

Young people who were due to leave residential colleges had no alternative accommodation arranged. Accommodation would not necessarily be their choice or the choice of their family, and they would not be able to specify with whom they would live. Families were concerned that the future for their young people would be unsettled, and they wanted to resolve this and provide a settled environment that would be fully adapted to avoid them having to move into residential care in the future.

It was a parent carer who came up with a solution. They were able to purchase a house for their son and approached the Occupational Therapy service to ask what could be done if they were to do so, in relation to making sure that the house would be suitable as a 'forever home.'

They also wanted their son to live alongside other disabled young adults of a similar age for companionship and it was decided that three young adults (two female and one male) would be invited to live in the property with their son for as long as they wanted. They would live independently but with 24-hour care to assist them.

The Occupational Therapist contacted the Home Improvement Team and detailed discussions between the council services and the families began.

The level of work required in the purchased property, a bungalow, was huge, but the enthusiasm of the Occupational Therapist was infectious, and the Home Improvement Team was keen to join in the project.

The requested works included:

- safe means of escape from the property (lowered threshold patio doors) x 4
- ramped access
- wider lowered threshold front door
- access to the garden with a patio area
- level access shower room
- wash dry toilet
- a rise and fall bath with incorporated changing mat
- H track hoists
- updated technology to connect Alexa to the lights.

The chosen builders worked hard to achieve exceptionally high standards of work. The homeowner said they took the time to measure all the wheelchairs and ensure the pathways were wide enough to accommodate the clients and carers. The builders put their heart and soul into the job and were helpful, thoughtful and exceptionally tidy on site.

It has taken a lot of planning, organisation, communication and behind the scenes work to undertake all the required works in time. The project was time critical as all four young adults had to move in as soon as they left their existing educational accommodation, or they would be homeless.

The project is an example of how collaboration between different departments can achieve great things when they work closely alongside each other.

> *'This is a job I can truly say I was proud to be involved with and it would not have been possible without the dedication of both the OT, the builders and the homeowner.'* ***Home Improvement Team member***

All the families were involved during the refurbishment, providing input, ideas and suggestions as it was to be their forever home too. They provided information on sizes of wheelchairs, enhanced technology and what they wanted from their home, such as private space and communal space. The result is a beautiful and welcoming home full of colour, noise, light, laughter and joy. It is a busy house with multiple carers and visitors on site at any one time. Two wonderful teams of dedicated carers, along with a site manager, help to keep things moving smoothly along. The young adults are thriving in this environment which is both safe and practical. There is enough room for the inhabitants to have their own space but socialise when they want to. It is a welcoming, social and friendly environment where a parent's dream has become a reality. It is truly a forever home.

- The young people have been 'treated with respect and dignity.'
- They have 'a place I can call home, not just a "bed" or somewhere that provides me with care.'
- They 'live in a home which is accessible and designed so that I can be as independent as possible.'
- They 'can live the life I want and do the things that are important to me as independently as possible.'
- They "have people who support me, such as family, friends, and people in my community."
- They 'can choose who supports me, and how, when and where my care and support is provided.'
- They 'are supported by people who listen carefully, so they know what matters to me and how to support me to live the life I want'

The parent has been in touch regularly. She informs us of how easy it is for the young people to live in this home. Access is superb, communal living is helping with morale, and they have picnics in the garden to strengthen bonds. All the hoisting equipment really assists the carers and families in providing excellent care to the young people. Accessible shower room, toilets, a special bath and changing table have been a game changer. She sent this message to the council just after Christmas:

Working with people: housing and accommodation

> *'I honestly can't thank you and H enough for all the help you gave us. The Disabled Facilities Grant (DFG) process was a dream compared to some of the other obstacles we encountered. If you ever need a reference or a testimonial then please don't hesitate to ask, All the best,'*

What were the barriers to success?

- This was an ambitious plan, and careful discussions took place as to whether it would be achievable.
- This was a large-scale conversion and managing the workload was a challenge.
- The timescale was a further challenge as the work had to be completed and the house ready to move into by the time that the young people were ready to leave full-time education.

What were the conditions for success?

- The ability of one of the parents to purchase the property.
- The willingness of other families and young people to join the project.
- The enthusiasm of the Occupational Therapist and Home Improvement Team.
- Working together to achieve the objectives.
- A building firm that was enthusiastic, willing, and able to listen to the needs of the people who would be living in the house.
- Willingness to work to a tight deadline to complete the work on time.

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Providing support

- Commissioning and workforce
- Commissioning and managing demand through technology
- Commissioning and co-production
- Commissioning and care provision
- Moving between services and supporting continuity of care
- Commissioning and quality

Suffolk County Council

Voluntary, Community, Faith and Social Enterprise (VCFSE) Project

Increasing the knowledge of support available from the Suffolk County Council, Waveney Area, Voluntary, Community, Faith and Social Enterprise (VCFSE)

From October 2023, Suffolk County Council (SCC) started working on a project to increase the knowledge and use of VCFSE Care and Support Services by social work staff in the Waveney area of Suffolk. Waveney is a largely rural area in north-east Suffolk and includes the towns of Lowestoft, Halesworth and Southwold.

Suffolk County Council wanted to increase the uptake of VCFSE sector care and support services in the Waveney area and improve the experience for people through more personalised care and support plans.

Using external funding, a seconded post was created within the Waveney Contracts and Service Development team to facilitate these plans.

Following recruitment, mapping of VCFSE organisations started in October 2023; this will be an ongoing process as VCFSE services are an ever-changing landscape.

To gather this information, initial meetings took place with the District Council and other organisations already working with VCFSE services, such as Community Action Suffolk (CAS), Lowestoft Rising and Citizens Advice. In addition, some of the larger services were visited along with community venues such as libraries. Ensuring regular attendance at networking meetings hosted by these organisations has also been a good source of information and attendance at these continues. This work enabled the council to identify what services were in the area and to start collating the information.

The information gathered was collated in a newly added local area of SharePoint to enable social workers to search for services by geographical location or support area. Contact details of the VCFSE services, service offers, eligibility criteria and access routes are included. In addition to this, short-term activities and new events have been uploaded as information documents. To date there are 258 services listed, plus 150 information leaflets. This resource is regularly added to and updated to ensure currency.

The information has also been shared with other internal teams such as the Placement and Brokerage team and the Customer First Intervention and Prevention team.

To aid cascading of information, VCFSE champions have been identified in each of the social work teams and regular meetings take place. It is hoped that as well as cascading information the champions can ensure that a legacy of promoting these services is in place. Regular attendance at operational team meetings also took place as well as encouragement of practitioner contact to discuss options for individual adults.

In July 2024, a successful event to highlight the range of VCFSE provision available in the Waveney area took place. The purpose of this event was to enable social work practitioners to meet with VCFSE services in the area. Twelve services attended and the format gave them the opportunity to deliver a presentation as well as informal networking time with the 50 practitioners who attended. Positive feedback was received from both services and practitioners. The services welcomed the chance to be valued, showcase their work and have meaningful discussions. The practitioners felt that they had gained valuable knowledge of services that were available in the area in an effective and accessible way. A second event took place in January 2025, this time aimed at health colleagues working in the area. The collated resources have also been shared, including with social prescribers.

Feedback was received from attendees:

> *'Thank you for organising the VCFSE marketplace event earlier this week – my colleague and I found it very useful and made some good contacts on the day'.*
>
> *'Thank you for the invitation to the event last week, it was very productive and informative.'*
>
> *'Thank you for the invite and the afternoon which was most useful and interesting. I do hope something similar can happen again in the future'.*

The project fits in with Suffolk County Council's 'People at The Heart of Care' approach which aims to continually evolve services, ensuring we provide the best support we can to help people live fulfilling, independent lives as part of their communities. Discussions are in place to ensure that the work started by the project continues through the champion network and it becomes everyday practice to work with VCFSE services and communities to join up support for individuals and make this the focus of how we deliver social care in Suffolk.

An example of a difference that has been made to an individual through use of VCFSE provision has been the case of a customer who wanted to attend a day service to increase her social contact. The customer needed transport but also wraparound help to prepare, leave the house and lock up, which a taxi service could not provide. The practitioner enquired about options from the VCFSE sector and details were provided of a small community enterprise that could provide this support. This joined-up support has meant that the customer can attend the day service, and her independence has been promoted whilst ensuring her safety.

What were the barriers to success?

- The ever-changing VCFSE landscape and the need for constant updating.
- Widening people's view of providers of care and support from the contracted framework to the wider community.
- Ensuring there are strong ongoing communications to continuously get the message out.

Providing support: commissioning and workforce

What were the conditions for success?

- Improve partnership working between the local authority and the VCFSE sector.
- Increased awareness of the local VCFSE sector.
- Forging strong relationships with members of the sector.
- Ability to access information about the VCFSE sector in one place.
- A legacy route to continue this work going forward.

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Providing support: commissioning and workforce

Norfolk County Council

A new era for Norfolk Care Careers – rebrand and relaunch of the Norfolk Care Careers website

The goal was to provide a one-stop shop for candidates, workforce and providers to access vacancies, career development opportunities and receive support and guidance on recruitment and retention within adult social care across Norfolk and Waveney.

The aim of the project was to replace and rebrand the Norfolk Care Careers website with a new platform that was fit for purpose and enabled a better customer journey for all visitors. The previous platform was hosted externally and had originally been built in 2017. Technology, industry standards and the council's requirements had since developed. However, due to the funding required the platform had remained in place without keeping pace. This meant it was now failing in several areas, including security compliance and accessibility, with a poor user experience and perception issues. Updates and patch work had becoming costly and resource intensive to manage.

The website formed the basis for key elements of the implementation of the Norfolk and Waveney workforce strategy and the council's commitment under the Care Act. All local marketing campaign efforts for the external care market were driving traffic to this platform. Whilst the user traffic generated from the campaign efforts was positive, the customer experience was less so.

As such, the council sought to address the following:

- Improving the user experience.
- Updating design and functionality.
- Enhancing the brand image.
- Boosting the search engine positioning (SEP) and online visibility.
- Addressing technical and accessibility issues, such as slow load times, security and accessibility vulnerabilities.
- Integrate with new technologies.
- Aligning with the workforce strategy goals both locally and nationally.
- Address compliance and security issues.

The council utilised funding from NHS England and the social value offer from Goss (the council's new corporate web provider), to enable a bespoke website to be created in line with the required technical specification. This in turn facilitated the rebrand of Norfolk Care Careers.

How did the council work with people who access care and support, families, carers, and providers to explore challenges/find solutions?

- Conducted surveys and focus groups with key stakeholders to understand their experiences of using the website to identify positives and areas for improvement.
- Carried out a tree jack exercise (i.e. testing and evaluating the navigation structure and information hierarchy of the website) to understand whether the new proposed website structure would be meaningful for users and enable content to be easily found.
- Held one-to-one meetings with providers including screen shares to understand their journey.
- Used Google analytics to identify the web user journey.

Examples of outcomes and impact included:

- more robust reporting on conversion rates and analytical insights
- now meeting security and accessibility standards
- creating awareness and building knowledge and understanding of career opportunities in the sector in line with the local workforce strategy
- enhanced brand perception and greater engagement
- fully mobile responsive
- faster load times
- reduction in manual inputting for all parties.

Stats since launch on 4 September 2024 to 31January 2025:

- 7,316 web users, with 1,570 returning users.
- 204 jobs adverts placed since
- 1,573 clicks on apply now
- 83 clicks on call now
- Higher engagement – average engagement time is 3 m 18s.
- 427 active users of the 'Employers hub'.

Quote from a provider: *'the advert response has been great, better than I could have imagined'* ***Tai, QCM Healthcare***

What were the key barriers to success?

- Funding.
- Engagement with the external care market.
- Cross departmental working and priorities.
- Resources.
- Low technological awareness with the external care market.
- Ownership of the domain registration and transfer from existing provider.
- Perception issues.
- Data protection.
- Accessibility requirements.
- Integration with existing systems.

What were the conditions for success?

- A shared vision with clear objectives.
- Stakeholder involvement.
- Partnership working.
- User centred, responsive design.
- Content and engagement strategy.
- User acceptance testing and quality assurance.
- Post launch support.
- Analytics and tracking.
- Meeting the Norfolk County Council Security and Accessibility Standards.

For further information:

Norfolk Care Careers Jobs
Norfolk Care News autumn winter 2024 – electronic version (page 17)

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Essex County Council

Using technology to manage demand

Essex County Council is enabling people to live as independently as possible by deploying care technologies, reducing dependency on long-term, higher cost care and support.

Essex has an ageing and growing population with a higher proportion of people aged over 65 than the national average. Care technology is a key enabler to both the vision and Home First Commitment within the council.

The Care Technology Service is available to anyone over the age of 18 who is eligible under Prevent, Reduce, Delay or full Care Act eligibility. The service is countywide across Essex and delivered in partnership with Livity Life (formally Millbrook Healthcare) and Provide Community Interest Company (CIC).

The Care Technology service has innovation at the core of its contract and some of the test and learns which we are currently undertaking are as follows.

- **Data-driven reablement:** Short-term assessment kits are installed at the beginning of the reablement service, and the data is then used to help inform the assessment of progress, independence and ongoing care needs. This has the potential to better inform the care workers on the ground and to speed up, slow down, increase or reduce the ongoing care and support based on data-driven evidence.
- **Scaling-up falls detection in care homes:** Rolling out technology to 435 people in care home settings to identify all types of falls and support quicker response and reduce ambulance call outs and A&E admissions.
- **Hybrid care:** The existing Long-Term Domiciliary Framework is set-up on a time and task basis which does not allow the flexibility to use technology. The project is scoping what 'good' looks like and working with the market to shape future costing of telephone/video calling or referral incentives through a gain share model.
- **Social Care App catalogue:** Co-produced with frontline teams to promote apps which could benefit residents of Essex.

Predictive analytics

Essex is looking at utilising care technology data in a more predictive way:

- The first phase looked at individuals' journeys within the system, pulling data from a case management system and matching this with care technology interventions and data from daily living monitoring and alerts.
- The second phase was to match this data with benefits realisation information to see where the council is achieving best outcomes in terms of escalating costs and assess long-term trends and patterns of the impact of technology.

- The final phase was to use this data to identify risk and changing needs alongside helping the council to manage future demand by finding similar people in review and social care assessment waitlists.

The council now has the personas identified and is looking at how they can implement their findings into a test and learn for those on the review and assessment waitlists.

How did the council work with people who access care and support, families, carers, and providers to explore challenges/find solutions?

- Workshops to explore the proposed concept, aid the narrowing of scope and discuss particular considerations for implementation.
- Co-design for forms and processes.
- Evaluation of both financial and non-financial support
- Survey feedback.

Examples of outcomes and impact

Since 1 July 2021, the Care Technology programme has achieved £40.93m of gross savings. We have seen a return of ~£10.36m in Social Value. For example, the service so far has enabled 957,500 miles of car travel to be avoided and has supported 53 Essex residents to gain employment.

Care Technology is currently supporting 12,968 residents (as of Dec 2024). The service will continue to grow, and it is estimated that there could be up to 18,000 individuals being supported with Care Technology by March 2028. The average age of people in receipt of Care Technology in Essex is 78.2 with 96 per cent of people advising that technology improves them feeling safe and secure, 93 per cent of people advising that technology improves quality of life and 97 per cent advising that the service feels like more people are supporting them.

What were the barriers to success?

- Providers' selection process on who could and could not participate in the test and learns.
- Individuals thinking technology is not for them.
- Capacity to support test and learns with competing priorities such as winter pressures.

What were the conditions of success?

- A strong culture change programme that supported all prescribers with awareness, adoption and processes.
- Providing regular touchpoint opportunities including TEC demos and skills sessions.
- Being flexible to meet providers' timings around shift patterns.
- Co-producing documents.

Further information: Case Study: 0524_EE_Care_Tech 16x9 v03.mp4 on Vimeo

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Providing support: commissioning and managing demand through technology

Suffolk County Council

Suffolk Marketplace e-brokerage

A revolutionary new way of brokering care packages in Suffolk.

When this project was initiated, providers had already come a long way on the journey of working more digitally, through the rollout and adoption of the Suffolk Provider Portal. However, the Suffolk County Council (SCC) brokerage team still used a very manual process to place packages of care with providers, which was time consuming and not very efficient. By implementing Marketplace, a new technology platform, the council aimed to:

- improve the information people in Suffolk could access on care provision and make this easy to find
- streamline and automate the process for SCC staff, releasing capacity to allow staff to handle additional demand for placements and improving the transfer of data between systems
- move towards a point where people will easily be able to broker their own care and support through this single platform.

These objectives support SCC's 'People at the Heart of Care' strategy through enabling the council to better promote independence and treat people as experts in their own care. It will be a key enabler supporting the council's objectives to increase the use of direct payments over time.

Suffolk Marketplace is a free-to-use web-based e-brokerage tool and directory of services provided by SCC Adult Social Care. It allows care providers to list their services on the directory, showcasing their services effectively, therefore reaching a broader audience across Suffolk. It covers homecare, residential and nursing, extra care housing, live-in care and supported housing and will allow residents to search the directory using a search bar and key terms and will return service listings based on their search criteria. The directory of services has been in place in Suffolk since March 2024.

The e-brokerage tool, which went live in November 2024, automated the previous manual process the SCC brokerage team used when placing packages of care with providers. This new tool allows providers to see packages of care they are eligible to make an offer for, which are issued throughout the day and provides a live view of the package status. The tool will offer a streamlined workflow, enhanced speed and productivity, improved fairness and, overall, a better experience for providers.

Suffolk Marketplace also offers e-brokerage functionality for residents looking to source their own care which is called Care Finder. Residents will answer automated questions regarding their care needs and receive offers from providers who are willing and able to meet those requirements. This feature is currently being tested, with further engagement sessions planned.

The work fits into the long-term vision for Adult Social Care (ASC) and sits within the Individual Budgets programme of the 'People at the Heart of Care' strategy. ASC are looking to expand the avenues through which people can utilise direct payments to purchase and manage their own care, whilst supporting greater independence and resilience for residents. Suffolk Marketplace will serve as a key tool for facilitating these processes and will become a significant channel for people to access care and support in Suffolk.

The Suffolk Care Association and Care Development East supported provider engagement, and the platform was piloted with providers and staff members before it went live. Comprehensive feedback was gathered and reviewed to identify any issues, and work was undertaken to improve these, while family carers reviewed and fed back on the directory of services and tested Care Finder's self-service functionality.

People who draw on care and support have benefited from having a comprehensive directory of information on care provision to assist them in identifying care opportunities within their local area.

As of 15 January 2025, 684 packages of care had been sourced through the e-brokerage system.

As e-brokerage has been implemented, care providers have benefited from:

- a more responsive process, with quicker response times and a reduced wait for the outcomes of bids, which means they can consider other packages more quickly
- better feedback on the reasons why bids are unsuccessful
- an improved audit trail allowing providers to monitor and track their own performance, allowing for informed business decisions.

As a result, people who draw on care and support are also more able to access care provision and receive this more quickly when it is needed.

What were the barriers to success?

- The integration between Marketplace and LAS (the Adult Social Care Case Management System). To link these systems a workaround was developed through the use of robotic process automation (RPA).
- A critical dependency for the Suffolk Marketplace e-brokerage tool was multi factor authentication (MFA), and this caused an initial delay due to the finalising of the licensing model.
- In addition to these technical barriers, progress was slower than anticipated for home care providers completing their registration to the directory and further communications and engagement were required to increase take up.

Providing support: commissioning and managing demand through technology

What were the conditions for success?

- A well-thought-out communication plan, which focused on a multi-channel communication approach, whilst utilising the relationship the contract managers had with the providers.
- Having a strong test plan and engaging providers to work through the testing phase, to be able to understand issues from the providers' perspective.
- A core project team made up of relevant stakeholders across the business, such as IT support, system development support and subject matter experts.

Further information:

Home | Suffolk Marketplace
Suffolk Marketplace for Suffolk care providers – Suffolk County Council

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Peterborough City Council

IMPACT Co-Production Project – 'Commissioning Differently'

In partnership with Sheffield University, Peterborough City Council (PCC) are holding sessions with people with lived experience across six months to understand what they can do differently, using co-production in commissioning practice and procurement needs that require improvement.

At the beginning of 2024, PCC put together a bid for funding to be part of a project running out of Sheffield University called 'IMPACT'. The Council was successful and has been working with IMPACT to run a co-production project with people who have experienced adult social care in Peterborough.

The council is holding sessions with people across six months, to understand what can be done differently in commissioning for better outcomes for the people in Peterborough. Through this project the council can hire a venue, provide refreshments and reimburse people for their time, allowing the council to demonstrate how valuable their contribution is.

As a result of the project, the council is hoping to have a better understanding of what needs to be changed in relation to processes to ensure services are co-designed in the best way possible. This involves explaining what the council does, and then handing over to the group on what they think is working and what needs to change. An action plan for short-term to long-term changes is then co-created, including SMART actions with owners and accountability.

Find out about IMPACT

IMPACT is the new UK Centre for Implementing Evidence in Adult Social Care

IMPACT's aims are to:

- support more widespread use of evidence – with a broad and inclusive understanding of evidence as research, practice wisdom and lived experiences
- build capacity and skills in the workforce to improve care outcomes
- facilitate sustainable and productive relationships between stakeholders to co-create change and innovations.

Improving understanding of what helps and hinders effective implementation in practice.

Find out about the IMPACT Networks

- IMPACT Networks are one method to create change. IMPACT is piloting to achieve change in adult social care.
- The aim of the Networks is to improve practice and outcomes in adult social care at the local level and solve common, yet complex challenges and to pull together practical solutions at the community level to create solutions that can be scaled up to help inspire and inform change across the UK.
- In summary, there will be local networks across the four nations of the UK. Local networks:
  - will include 8–10 people
  - meet four times over a period of six months
  - discuss a particular issue using materials provided in advance
  - be a space for members to share experiences and suggest practical ideas for positive change.
- After each meeting, a short note from the meeting will feed into a report to be discussed at the next meeting.
- The aim is to produce a local action plan of next steps by the final session.

IMPACT Network meetings' rules

- Everyone is here on an equal basis.
- We want to ensure that everyone gets a chance to contribute and that we respect each other's views.
- We recognise that we all communicate in different ways, and we will support one another to take part.
- Let's learn together – alongside the council's own experiences we also want to hear other people's point of view.
- We want to create a comfortable and relaxed environment – please don't be nervous – we really want to know what you think!

Working with people

So far there have been two sessions dedicated to fleshing out the landscape to provide context, then finding the gaps and identifying issues. Next, the council will be working on solutions which can have short- and long-term impacts.

The next session will look to bring in wider partners from the system to discuss the issues raised so far to drive change collaboratively.

What were the barriers for success?

- Funding was limited to 10 attendees. More people came forward, but their participation could not be financed.
- Some of the challenges faced will take a longer term and need system-wide buy-in.

What was the condition for success?

- Identifying the issues which affect Peterborough's population and having a meaningful impact on addressing these issues.

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Providing support: commissioning and care provision

Luton Borough Council

Shared Lives – making a real difference

Growing Luton's Shared Lives service enabling people to live a beautiful ordinary life.

With residential beds in Luton reducing due to providers exiting the market, there was a need to develop alternative options to support people with respite and alternative living arrangements. Furthermore, internal respite provision had started to reach full capacity, and it was essential to look for other options aside from building-based provision in order to continue to support carers with their well-deserved breaks.

Shared Lives provides a unique, flexible form of accommodation and support, either on a permanent or short-term basis. It offers people the chance to live with a family, receiving individualised support, achieving positive outcomes by developing independence and social connections. This reduces the need for people to move into a care home which is often costly and institutionalised. Luton's vision was to grow the service to enable the council to manage demand and support people to live in an alternative provision,

Shared Lives already has 12 carers supporting 11 people and offering respite service to 2 families and using the Accelerate Reform Fund (ARF) Luton took the opportunity to achieve the vision.

The service recruited a full time deputy manager on a fixed term contract to focus on overseeing referrals for both carers and people requiring support. They are also responsible for leading on and progressing new marketing campaigns to attract people to become Shared Lives Carers. This involved working with the communications team to produce a video, attend local job fairs, assist with the design of a local advert which reached 60,000 households, a newsletter going out to 35,000 residents bi-weekly and advertising on local buses.

The deputy manager reviewed all pathways into the service to ensure that it was as seamless as possible. In addition, they attended different teams in Adult Social Care and transition meetings to spread the Shared Lives Stories, showcasing to practitioners the difference this type of support can make to a person's life.

How did the council work with people?

- Worked together with Shared Lives carers and people supported to develop marketing adverts which people were very keen to be a part. This was extremely positive and has enabled the service to onboard an additional five new Shared Lives carers.
- Met with families and carers who were identified as potential transfer to Shared Lives for respite including time spent with families to explain the service and support with an introductory session and tea visits to aid the transfer.
- Worked with people to explore personalised technology which would further enhance independence within the Shared Lives setting.
- Arranged regular focus group meetings with Shared Lives to redesign the license, finance monitoring and carer's agreement and newsletter celebrating all the positive outcomes.

Examples of outcomes and impact

LO is a 47-year-old man with a visual impairment. He was placed as an emergency in a residential home following hospital discharge. Shared Lives co-productively worked with him to ascertain all areas of his support and how he wished these to be met. Referring him to specialist teams and using personalised technology has resulted in his first long-term placement with Shared Lives. He is able to live life far more independently and now goes out independently and spends time alone in his new home. He has improved quality of life and is working towards living completely independently in the future.

LO has stated, 'I am looking forward to moving into Shared Lives, I know that I will get the support I need to start living my life.'

MP had to leave her family home due to safeguarding concerns and moved in with a Shared Lives carer. There was a court order in situ and Shared Lives supported her to maintain contact with her family, rebuild confidence and independence by way of travel training which has aided her to go to her favourite nail bar for pampering sessions. She has also commenced volunteering in a local charity shop which she hopes will give her the experience to apply to work in a perfume shop. Shared Lives have seen a positive change in MP as she has started to open up to others as she was very private. She is now more outgoing and loves her new cat in her new Shared Lives home as she had not had the opportunity to own a pet before. Speaking about Shared Lives, MP says that 'the support can help someone like they helped her'.

People living with Shared Lives carers are supported to live a beautiful ordinary life and have been assisted to have holidays of their choice to Devon, Mauritius, Spain as well as a safari in Kenya and a cruise. One person got their first ever passport and is planning a trip to Egypt. People are supported with social activities, such as visits to concerts including Steps, Abba and 80s Mania. People have developed in confidence, joined a choir group, started voluntary work and an apprenticeship and now go out independently to visit family or friends.

Families say Shared Lives is a better option as it provides opportunities for growth, independence and choice. Feedback includes 'respite will help prepare my son for when we feel we can no longer manage as we get older' and 'Shared Lives helped me with benefits advice'.

What were the barriers to success?

- A lack of understanding regarding the Shared Lives scheme from both professionals, families and people.
- The on boarding duration for carers can take time due to the application process.
- Matching a carer with a person and family can also take time to progress to ensure we get the right fit.
- Ongoing budget for marketing campaigns.
- Lack of resource to progress with service development.

What were the conditions for success?

- Having a dedicated resource focusing on service development has enabled the council to progress with the scheme.
- An increase in the number of people accessing the service. Since July 2024 the number of respite arrangements have increased from two to eight individuals.
- An increase in the number of Shared Lives carers – currently a further five people are onboarding, taking the total from 12 to 17 carers.
- Increased awareness through the marketing campaign – up to ten people have made contact to express an interest.
- The service is cost effective. For the eight people that are accessing Shared Lives for either respite or permanent placement, this has achieved a significant reduction in spend with an estimated cost saving of £75,315.20 per year.

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Providing support: commissioning and care provision

Bedford Borough Council

Day-time activities for people living with profound and multiple complex disabilities

Supporting people with profound and multiple learning disabilities, syndromes and autism.

The day opportunities market in and around Bedford was unable to meet the day-to-day needs of people living with profound and multiple complex disabilities. This was because they did not have the appropriate range of moving and handling equipment required or the specialist team skills to meet the sensory, complex healthcare conditions and positive behavioural support needs that people required.

Some family carers felt the only option available to them when their son or daughter transitioned into Adult Services was for them to move many miles from home into a term-time specialist residential college or specialist neurological residential home where their needs could be met by specialist trained staff.

Many local parent carers stated that they had their own healthcare needs, and some were ageing and really needed confidence to let go and to feel assured for others to take over care. A person with complex autism, a learning disability or life-threatening complex healthcare needs can only be cared for safely by someone with the specific skills and in-depth knowledge of the person to keep them safe and happy in the absence of their primary carers. Carers reported that they often feel there is nobody who can provide the levels of care or monitoring required or that services cannot manage complex needs and behaviours as well as the associated risks that may be presented. As a result, carers may not ask for support when it is needed, or even when a crisis occurs.

Kempston Centre provides day opportunities to 64 people with moderate and profound learning disabilities, moderate and profound autism and a wide range of complex syndromes. Many people at Kempston Centre have a dual or multiple diagnosis of learning disability, autism or Down Syndrome amongst many other syndromes that impact on their life experiences. The aims and objectives of the day service are to offer opportunities and experiences to encourage independence, mental wellbeing and positive outcomes in a safe environment where a person's disability or complex healthcare needs are met instead of them being a barrier. Despite the many medical 'labels' attached to a diagnosis, this isn't the focus; instead meeting needs and providing positive experiences is the key to success, working in a co-produced and strengths based way.

The team is made up of a care team of 21 staff who form the care and support team working from a non-medical perspective alongside people with a vast range of complex medical healthcare needs such as hydrocephaly, diabetes, respiratory distress, epilepsy and other neurological, renal and vascular conditions. The care team link in with a range of services where this is a required to inform how best to work with an individual.

The service knows that informal family carers have placed their trust and confidence in the Kempston Centre team to be able to meet the needs of their loved ones, monitor and respond to any medical emergencies while offering a purposeful and meaningful timetable of fun and achievable activities and experiences.

Kempston Centre offers a range of local centre-based daily sessions focusing on continued development of skills and learning opportunities which promote and maintain independence, physical health, positive mental wellbeing and personal achievements. They offer adults with profound and complex learning disabilities, autism and other syndromes every opportunity to benefit from social inclusion and community life in their local area, promoting family life and friendship, with the building as a base. Staff skills and specialist training packages enable the people of Bedford with the highest level of care and support needs to safely and independently access a day opportunity whilst remaining a part of family life.

People are supported to have choice and control over how they receive their support and spend their time. Once the person becomes part of a group, they are supported by the care team to explore and partake in development and sensory-based group activities that they may enjoy. Staff meet the assessed support needs that they may require to enable them to partake in different activities and experiences such as hand-over-hand participation, scheduling, picture exchange communication and adapted sessions.

People who do not wish to work as part of a group can be offered person-centred activities in an environment supportive of their sensory requirements to achieve positive outcomes using task boxes, concentration bins or preferred choice tailored activities based on their unique specialist subjects or hobbies.

The care team work to a defined care plan which supports the safety and wellbeing of individuals to enable them to reach aspirations and positive outcomes independently from their primary carers. The care team at Kempston Centre work collaboratively with specialist health services such as community nurses, physiotherapists, sensory team, speech and language and positive behaviour therapists to ensure that each support plan is inclusive and person-centred, ensuring a holistic approach is offered throughout the day, enabling people to feel safe and supported whilst engaging in tailored activities.

How does the council involve people?

People who use the service are involved in any decisions that are made about the provision of their care and support using inclusive communication. To achieve this, staff members understand the importance of working closely with the person, families, carers and other agencies and organisations. Kempston Centre recognises and respects the differences between all people and promotes awareness to instil a sense of belonging and pride in their individuality. The Kempston Centre team continuously strive towards inclusive opportunities for all, regardless of diagnosis or complex medical support required. All adults are supported to celebrate their achievements and are visible, heard, respected members of the community.

Providing support: commissioning and care provision

What were the barriers to success?

- Local day service as an option had a silent label with a perception by professionals and some families that services may be institutionalised and not person-centered, instead referring to old systems and ways of working.
- Concerns that support may be overly medicalised was common in people's minds, and some people thought moving away would better meet the complexity of the individual's needs.

What were the conditions for success?

- Expertise and passion in the staff team has grown and developed over time, with people championing individuality and going the extra mile to create the conditions for trust, developing person-centered activities and working alongside carers.
- Problem solving by thinking outside the box.
- Involving specialist support to promote individuality in meeting needs as well as aspirations.
- A small success in one person's eyes is a major achievement to another – this is celebrated.

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Providing support: commissioning and care provision

Cambridgeshire County Council

Older Adults Inclusion Grants

Strengthening the preventative day opportunities offer for older adults using the Older Adults Inclusion Grants.

The council introduced a programme called Care Together to strengthen the preventative offer in the community and enable more older adults to remain living at home for longer. A review of older adults day opportunities (often called day services or day centres) was conducted between April 2022 and January 2023 as part of Care Together and it found the following:

- Historic grants given to organisations providing traditional day care had significant differences in impact, equity, uptake and value for money.
- People attending traditional building-based day services valued this offer but older adults in the community and in contact with Early Help Teams told us they wanted more choice and services which were better connected to local communities and networks.
- Physical activity was not included in the day opportunities requirements despite evidence of its positive on impact on independence and wellbeing.

The council introduced a new Pseudo Dynamic Purchasing System (PDPS) to address inequitable access to building-based day services for older adults with eligible needs. This added to existing in-house day opportunities and incorporated a new banding system based on need.

The council co-produced a new range of place-based grants called Older Adults Social Inclusion (OASI) grants. Focused on social inclusion and physical activity, these grants strengthened the preventative day opportunity offer for older adults with emerging (not eligible) care needs.

The OASI grants awarded 31 co-produced and community-based projects £1.4m of funding over three years. Projects ranged from lunch clubs and day centres to physical activity sessions for older adults and mobile pop-up hubs and community transport schemes in rural communities. All funded day centres were required to offer physical activity (such as chair-based exercise) and all projects received Making Every Contact Count training with a specific focus on older adults and physical activity.

The review included extensive engagement with people with lived experience at day opportunities venues, Golden Age Fairs and other community spaces. The council involved older adults with both eligible and emerging care needs and unpaid carers as well as district and parish councils, Integrated Neighbourhoods and local VCSE providers. In addition to a survey, appreciative enquiry was used to understand gaps, opportunities and preferences of older adults in each community.

The new place-based OASI grants were co-designed and awarded by a stakeholder group in each district, comprising of people with lived experience and colleagues from district and parish councils, primary care networks and local VCSE groups.

The OASI grants have stimulated innovation and co-produced a more diverse and evidence-led preventative offer for older adults across Cambridgeshire. In addition to day centres, there are now digital inclusion sessions, improved community transport and pop-ups in rural areas offering physical and social activities for older adults. The offer is tailored to the specific needs and opportunities of local communities.

A much wider range of VCSE groups have received funding including eight not previously funded by the council. Several of these are grassroots volunteer groups and social enterprises within local neighbourhoods who responded to the opportunity with innovation and creativity.

Access and uptake have improved considerably. By Q3 of Year 1, access had increased by 217 per cent (from 415 to 1316) compared to the historic offer. This suggests the new offer is more locally relevant and attuned to the preferences of older adults. It has also increased value for money and impact of services without additional investment.

Co-designing and awarding the grants with partners and local people in each district has brought the council's commissioning closer to the communities it serves. Commissioners now have closer relationships with community groups.

What difference did the council's actions make for people accessing care and support and service delivery?

Including older adults as equal and active participants in design and development of local services has made the offer more attractive, easily accessible and locally relevant. For example, lack of accessible transport to existing community activities was highlighted as a gap by people with lived experience, particularly in rural areas. In response, grants for accessible community transport were included in these areas, stimulating a social care scheme and expanding Dial A Ride services.

Embedding a requirement for physical activity and/or social inclusion within grant criteria has created new opportunities for physical activity such as 'Box and Brew' and Mindful Motion sessions for older adults in their local community. These are proving successful in attracting older adults to 'have a go' and see improvements in their physical health and mobility.

What were the barriers to success?

- The transformation had implications for the local VCSE sector, particularly those affected by the ending of historic grants. We sought to improve the day services offer without negatively impacting the individuals who attended them or destabilising the VCSE providers who delivered them.
- The council began market shaping conversations early and gave providers at least one year's notice. All VCSE partners were invited to help co-design the new grant arrangements. Regular provider forums were held throughout the project to keep the VCSE updated and to promote the new grants when they became available.
- The council worked closely with providers to successfully manage the transition to the new grants and together ensured all service users continued to receive the same or comparable offer.

What were the conditions for success?

- Capacity and time to build relationships and networks with local people and partners and undertake co-production.
- Effective stakeholder management throughout, to build support for the transformation and encourage local VCSE to develop innovative and creative service ideas.
- Establishing baselines and undertaking ongoing monitoring to capture impact and success. Videos and testimonies have proven effective in demonstrating the impact on individuals.

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Providing support: commissioning and care provision

Hertfordshire County Council

Enhanced Nursing Dementia Service

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

The council was addressing the following issues:

- Ongoing pressures with sourcing appropriate nursing dementia provision for people with non-cognitive symptoms of dementia in Hertfordshire.
- Providing a placement option for people where the council had exhausted all other placement options which had resulted in them waiting in an inappropriate setting (delayed transfers of care).
- Improving health and wellbeing outcomes for people by avoiding delayed discharge as a result of no available provision.
- Developing a best practice model of care and treatment for people with non-cognitive symptoms of dementia in a care home setting and upskilling care staff across the provider market.

The following were put into place by the council:

- Local authority commissioned 16 nursing dementia beds in a care home to support enhanced pathway.
- Countywide enhanced nursing home dementia pathway developed to optimise treatment and care for people with non-cognitive symptoms of dementia to improve person-centred outcomes and wellbeing.
- Enhanced multidisciplinary team including 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.
- Used learning to shape a local system model to offer a step down and step up service to avoid delayed discharge and prevent hospital admission.

How did the council work with people?

- By working in partnership with health and social 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 focus on outcomes for the person.
- The council commissioned a Public Health Research and Evaluation Lead who collaborated with adult social care, 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.
- Working together the council mapped how to implement the model of care using a multidisciplinary approach and identified dedicated resource to support the service. They also developed and delivered an enhanced dementia care training programme 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.

Examples of outcomes and impact

- Service mobilised from standstill in two months and in operation for nine months.
- Twenty-nine people supported in a community setting that would have otherwise been inaccessible to them.
- Twenty-five people (78 per cent) referred through the step-down pathway from mental health unit and seven people (22 per cent) from the step-up pathway from community settings.
- Ninety-one per cent of the people admitted to the service have been discharged and are now in their lifetime home, which was previously considered not possible.
- Forty-three per cent of people discharged from the service were assessed at lower need level than at admission.
- The six-week reviews revealed no significant issues that could not be handled by the current long-term home of the individuals.
- The majority of people were reported to have settled in well and were taking part in activities within their long-term home.
- Improved individual wellbeing and reduced social isolation for people and their carers.
- People actively participating in their care.
- Enhanced multidisciplinary team (MDT) approach utilised non-medical interventions to manage behaviours successfully, tailored care and support and investment in non-pharmacological interventions.
- Thirty-four per cent of medications were deprescribed, reducing the average medication per individual from 11 to 3.75 (minimum from 5 to 1 and maximum from 18 to 11) medication per individual.
- 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 to break down primary/secondary care barriers and an engaged and highly motivated MDT with common, clear goals and able to better forward plan for individuals' care.

What were the barriers to success?

- Referrals with poor language.
- Outdated and lack of referral information.
- Lack of understanding and clarity of the step-down community pathway.
- Individuals admitted through the community step-up pathway had multiple complex needs with various physical health and mental health problems and high comorbidities.
- Lack of frailty reviews and assessments made it difficult to understand the full scale of the needs of individuals being referred.
- Admission without any frailty reviews completed meant that members of the MDT had to undertake these assessments after admission, which prolonged the process of treatment and the approach.
- Lack of person's background and life history work.
- Lack of timely mental health support before crisis – what can providers do before the situation reaches that point?
- Lack of focus on prevention and support for providers to prevent escalation and crisis.
- Lack of identification of people with highest risk of deterioration and subsequent need for enhanced care.

What were the conditions for success?

- Evidence based approach with defined aims, values and professional activity addressing non-cognitive symptoms of dementia.
- Consistent MDT support from mental health professionals, GP and social care to provide holistic care and support and put in place preventative measures, with a plan for escalation to provide timely support to the individual and prevent crisis.
- Individual outcomes dependent on highly collaborative decision making with participation from social work, mental health/psychiatry, frailty, general medical and care home practitioners. Professionals with good knowledge and understanding of frailty and dementia were essential.
- Access to timely and accurate information was fundamental to the MDT success.
- Inclusive, strength-based language and assessment essential to positive outcomes.
- Up-to-date referral information and a 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 the MDT working together to bring the service to the person and address gaps in service provision.
- Prevention and early identification were key.

- Care home staffing model allows for the 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.
- Protected time dedicated to attend the MDT and admin time was crucial for professionals.

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Hertfordshire County Council

SWH Prevention of Admission Service and ENH Community Rapid Response Team

Urgent social care support to residents facing circumstances that may lead to a hospital, residential or inpatient admission within 48 hours.

In response to the NHS Long Term Plan which puts an emphasis on helping more people to live independently at home for longer and developing more rapid community response teams to prevent unnecessary hospital spells and speed up discharges home, Hertfordshire County Council (HCC) launched a social care prevention of admission service in East and North Hertfordshire in April 2022. Following a successful pilot and service evaluation it became business as usual and also led to a further role out of the service in the south of Hertfordshire in September 2023.

The service aligns to the new Neighbourhood Health Guidelines, that will deliver more care at home or closer to home.

Social care prevention of admission teams have been developed and implemented across Hertfordshire since 2022. The teams, run by social care practitioners from the Adult Care Services Older People's Teams, provide urgent social care assessments and support to people aged 65 and over and/or have a dementia diagnosis, to maintain the person's wellbeing outside of hospital. The service operates Monday–Friday 9.00 am– 5.30 pm (excluding bank holidays).

The service aims to support the nationally mandated two-hour rapid response target for community services and enhance existing multi-specialty teams to prevent hospital admissions. The service also aims to avoid escalation in people's care needs and respond in a timely fashion when carers cannot continue or are at risk of carer breakdown. This is achieved by working in an integrated, person-centred way across Hertfordshire.

The team's primary focus is on helping individuals remain independent, healthy and safe in their usual place of residence by offering rapid assessment and support in the community.

ACS collaborated with community providers such as Hertfordshire Community Trust and Central London Community Hospital to establish a single point of access and direct referral routes to ensure quick access where rapid response support is required.

Feedback

> *'[it is] much easier and faster to get in touch with a social worker to discuss a patient – patients have also fed back that the response/action they've had has been very fast – this has been very beneficial for our Hospital at Home service as it provides a full MDT response to the patient in crisis'.* ***Health Professional, Community Provider, Hertfordshire***

'Rapid Response is a wonderful service; it's reassuring to have colleagues that can reach a person within two hours to assess their situation and put support in place to prevent an avoidable hospital admission. Rapid Response have a very quick response time.' ***Deputy Team Manager, Adult Care Services***

'Prevention of Admissions work is fast paced and rewarding. It's an honour to support people to remain at home where possible with the right supports in place.

'Deteriorating health and mobility can be difficult for individuals to manage, particularly if they live alone or perhaps have their own caring responsibilities.

'Being able to support people in difficult times and reduce the stress and worry they may be feeling gives great job satisfaction.' ***Senior Social Worker, Community Rapid Response Team***

Jacob was an 84-year-old man, he had a cancer diagnosis and was palliative but living independently. He experienced a rapid deterioration in his health. His house was very cluttered, and he was struggling to care for himself. Jacob reported that he was often too fatigued to prepare food, or drink so was not eating regularly and was dehydrated.

Jacob wasn't taking his medication and had no family or friends to support him. He felt depressed and isolated.

District nurses were concerned about Jacob and referred to POA Service at 4 pm.

POA team did a joint assessment the next morning with district nurse colleague. Jacob wanted to be surrounded by people whilst he felt unwell and to have support with meals, hygiene and medication.

A short stay was arranged, and Jacob entered the nursing home the same day.

The team was able to liaise with health colleagues and arrange continuing health care funding and support to support his chosen plans as he entered end-of-life care.

Had Jacob remained without care his health would have likely deteriorated to a point whereby hospital admission was unavoidable, and his choices were very limited.

Rachel was 91 and lived independently, she experienced recurrent UTIs and sometimes falls.

She had restricted mobility and avoided getting up to eat and drink throughout the day.

She often waited till her daughter visited at 6 pm to use the toilet and have a proper meal.

She told the team she has been embarrassed to ask for help.

The POA team visited following a referral from her GP and talked through all her concerns.

Rachel accepted an enabling support package and therapy input from ICT colleagues.

She had a meal service five days per week and continued eating with family at weekends.

Her daughter set up food and drink for the following day on her evening visits now she is aware of Rachel's difficulties.

Rachel has enjoyed improved health for a sustained period and not required ambulance or hospital intervention.

Providing support: moving between services and supporting continuity of care

Sarah was 85 and lived with Alzheimer's disease. Her son James was her main carer and lived with her. James suddenly became unwell with suspected stroke.

Taking him to hospital would mean leaving Sarah without care and very vulnerable. He refused to let the ambulance take him; he would not leave his mother alone.

An urgent referral from the Ambulance Service was made to the GP surgery and the social prescriber referred to the POA service at 16:35.

An assessment was actioned immediately and by 17:30 a care provider had been commissioned to stay with Sarah overnight, ensuring her safety and allowing the team to understand her needs better and plan ongoing care.

Only when this was confirmed James allowed the paramedics to take him to hospital for essential further assessment and treatment.

The team visited Sarah at 10 am the next day to complete further assessment and arranged a short-stay bed in a nearby care home. Sarah moved to the care home the same day.

What were the barriers to success?

- Technical: Hertfordshire County Council and NHS partners have different electronic systems which impacted sharing of information. This was overcome by granting read-only access to partners.
- Staffing: General national challenges in recruiting and retaining care staff. This was especially visible due to the small size of the team.

What were the conditions for success?

The primary outcome of this work is to help individuals remain independent, healthy and safe in their usual place of residence by offering rapid assessment and support in the community.

The secondary outcome is to reduce non-elective admissions through integrated health and care approach. A service evaluation of the pilot with the East and North Herts Team from April 2022 to November 2023 based on these outcomes evidenced the following:

- Improved resident experience and outcomes: The pilot supported 1,020 people.
- Reduction in ambulances, hospital attendances and admissions: The pilot supported 92 per cent of people referred to avoid hospital admission.
- Improved and aligned multi-agency working across health and social care.
- Reduced blockade at social care front door. In East and North Hertfordshire, 100 per cent of referrals were actioned within two hours.
- Ongoing support and monitoring in a person's own home: Supported 96.5 per cent of people referred to remain in their own homes.

For further information: A video about the Prevention of Admission Service can be found at the following link Community Rapid Response Team – Impact and Outcomes

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Bedford Borough Council

Moving to short breaks in adult services as a young person

Supporting younger adults and their families manage the move from short break provision in children's services to short breaks and respite in adult services and increase their understanding of how the support may change once they are an adult.

George Beal House is a registered service providing residential short breaks and respite to people with learning disabilities and autism. Some people transition to the service from their current provision provided by Children's Services when they are 18. This is usually through regular introductory visits to George Beal House ahead of transitioning at 18. The council found that some younger people and their families were not fully aware of the differences in the mechanisms for delivery of support for adults such as how the Mental Capacity Act and best interests requirements may change the support provided to them as an adult as opposed to being a child. The principles of least restrictive support and the need to respect their rights and wishes as an adult were not always well understood. An example of this was a family who could not understand that safety measures used in Children's Respite Service would not be appropriate and would be seen as restrictive when their child became an adult. Ahead of transitioning, the service worked with the Children's Service to try alternatives which would be least restrictive, and this was done very successfully and with no impact upon the individual's safety.

The team at George Beal House produced a guide to transitions in addition to the regular information they routinely provided, including an expanded section detailing the Mental Capacity Act in a manner which was sensitive to the person and family, explaining the differences, and to encourage open and transparent dialogue with the service.

George Beal House has attended transition fairs in the local community to promote awareness of the service. This has enabled families to find out about respite before a referral is officially made, enabling them and the child, who is preparing for adulthood, to visit the service to see whether they feel it is suitable. Once a referral is received, the team work extensively to plan the transition to George Beal House. This involves meeting with the people accessing care and support, their family and visiting services such as the current children's respite provision and education establishments.

The feedback received from families regarding the transition process has been extremely positive.

How did the council include people?

- Provided clear information with an easy-to-read option.
- Worked alongside families, people who access care and support and Children's Respite Services.

What was the impact?

- Respected the individual's rights as an adult and the principles of the Mental Capacity Act and need to be least restrictive.

What was the barrier to success?

- Lack of understanding of the Mental Capacity Act by families and how this would influence their child's care and support as an adult.

What were the conditions for success?

- Open and honest conversations.
- Providing jargon-free information.
- Making suggestions ahead of transitions of how the care and support may look.

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Bedford Borough Council

Preparing for adulthood (PFA)

The promotion and development of best practice, to support the journey of young people to the Adult Learning Disability Team.

The Adult Learning Disability Team (ALDT) is an established community team, consisting of qualified social workers and community learning disability nurses. It is a small team covering the locality of Bedford Borough for adults with learning disabilities and provides care and support to around 680 adults. To provide a further snapshot of the impact of transition to the team, the council is currently providing care and support to approximately 215 young people between the ages of 18 and 25 years.

The council recognises that preparing for adulthood spans far wider than the learning disability team and experiences. The process of transition affects far more adult teams and the impact in terms of resources continues to be significant, as the council manages the diverse and complex needs of young people and their families in the community.

The year-on-year referrals continue to increase, further emphasising the importance of preparing for adulthood and the needs of people that require support, as well as the impact on team resources. Such demand highlights where there are strengths and weaknesses in the local provider market responsible for providing specialist services for those with the most profound and complex needs.

The council wants to ensure, as a team, they are reflecting the key principles set out in the Care Act and the Special Educational Needs and Disabilities (SEND) code of practice. This will ensure earlier planning (from age 14 years) and prompt and timely assessments and support that link in clearly with outcomes and the aspirations of the individual, as their voice and view is central to the work the team undertakes.

Separate to this example, the council has collated some case studies that evidence the work and outcomes for young people in transition.

The council cannot and do not work in isolation, so continued collaboration with agencies and commissioning teams and multi-disciplinary work is key. This will allow the council to continue to support and influence strategic development of new services, as well as engage with current providers to ensure engagement and sustainable services for young people.

The Learning Disability team has a dedicated role in Preparing for Adulthood (PFA), of an Advanced Social Work Practitioner. This is a fundamental role to support the timely and effective transition for young people to adult services. The role provides a strategic overview of the needs of young adults already within services but is continually engaged in the process of identifying the needs of the new cohort of young adults that will require support year on year.

Providing support: moving between services and supporting continuity of care

This is achieved through quarterly tracking meetings, that are held with the multi-disciplinary team, including members from health, education and children's social care, identifying and monitoring the progress of support for those affected by PFA. This in turn supports the financial forecasting undertaken by the ALDT, to give a realistic projection of the presenting needs that are forecast where support and care are likely to be required year on year up to 2038.

For example, the council forecast the referrals the ALDT anticipate receiving for the next four years as follows.

2024/25 = 55

2025/26 = 49

2026/27 = 50

2027/28 = 54

Through the tracking of cases, the PFA lead in the ALDT provides advice and guidance to support other professionals involved with individual cases that have complex needs. Providing the steer and prompt for timely applications to continuing health care (CHC) – referrals for specific support services for health and social care needs – to ensure a move away from disjointed or delayed transfers of care from children to adults.

Supporting young adults with profound and complex needs can present significant challenges in managing risk proactively in the community. Robust case management and multi-disciplinary work is a priority in supporting need and progressing support and development for the individual as they move into adulthood.

The early identification of these cases is often key in negotiating a sometimes complex pathway to engage the correct support for the individual. A collaborative approach across children's and adult's services is essential in shaping and planning how and what support will be meaningful to the individual and their presenting needs.

Cases are also referred to the dynamic risk register managed by the complex care lead in Bedford Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) to ensure risk and vulnerability is captured monthly, supporting a robust and proactive multi-disciplinary team (MDT) approach in managing those most at risk, who could also provide a wider risk to the community in which they may be placed.

This can also include young people who may not have a diagnosis of learning disability, but may have associated vulnerabilities and mental health, that will impact on their ability to function safely in their local community. The council aims to work proactively in supporting and developing the workforce's knowledge of key elements of law that impact directly on practice, for example the mental capacity legislation and deprivation of liberty safeguards.

What have been the outcomes?

- Promoting best practice through positive outcomes for the young people and their families the council supports.
- The ALDT have provided shadowing and observational practice opportunities to colleagues in children services, in the completion of mental capacity assessments and best interest decisions – in line with the legal requirements of the Mental Capacity Act 2005.

- This also supports the requirements for application to the court of protection for Deprivation of Liberty, for a young person moving up through to adult services.
- Applications to adult CHC when children's continuing care is already in situ for a young person, is also facilitated in partnership with the ALDT.
- Termly transition meetings with two special schools continue and are very proactive, enabling a key focus upon years 14,13,12 and11. This is attended by the wider MDT and involves collaborative work to support and plan the transition for young people, to reduce the risk of anyone being overlooked or missed in the operational work the adult teams are engaged with through the process of PFA.
- This also includes attendance at the young person's Education Health and Care Plan (EHCP) review for years 14,13 and12 at two special schools.
- A PFA protocol between children and adult services has been updated this year. This is to ensure co-production is completed in a meaningful way to provide a clear pathway for the process from child to adult.
- Easy-read leaflets and guides have been developed within the ALDT, to ensure accessible information for those that utilise services. This includes information on college options, day opportunities, developing independence and where to live.
- This coincides with the open house events held locally each year – a recent event offered the opportunity for young people to visit and explore respite/supported living and day opportunities. They were also given an opportunity to speak to other young people about their lived experience of these services.
- The team continue to support transition events that are hosted by SEND, Children's Services and a parent carer forum to name but a few. At the PFA event in November and February the team saw a steady stream of families and young people, keen to discuss future options and pathways. The team also regularly attend coffee mornings, parent carer forum events and school events promoting ongoing partnership work for young people.
- The team are regulars at the Festival of SEND and the Bedford River festival – with passionate practitioners giving up their own time to support and engage with young people and offer the time and opportunity for families to talk and gather vital information for the young person's transition.
- Direct payments and personal budgets are a particular area of interest for many, to enable the next steps to independence and to have more choice and control over their support as they become young adults, accessing adult services within the borough.
- Carers are a critical component to the support and outcomes for the young people we support, so we promote the profile of carers assessments for families – if this has not been completed through Children's Services, it is part of the Care Act assessment and offer to carers.
- The team continues to contribute but also encourages local care and support providers to utilise the service to increase resource information of the locality, to support and enable this to continue to be a meaningful resource to children, young people and their families.

Providing support: moving between services and supporting continuity of care

- The ALDT are also very aware of the increasing number of vulnerable adults that are coming through to adult services for assessment. In partnership with peer teams in adult social care services we have introduced PFA referral meetings. This is a fortnightly meeting where the council can agree which team can pick up the referral to complete an assessment. This is to ensure that vulnerable adults that risk falling between teams are appropriately engaged, assessed and, if not eligible for support, are still provided with information, advice and signposting to services and agencies that can support them in the future. This has been informed with lessons learnt from the previous safeguarding review by the Safeguarding Adults Board (SAB) for the BLMK footprint – and the tragic SAR for Max case (see pages 11–18 of the Safeguarding Adults Board Annual Report 2022–23).

ALDT are also mindful of the findings of the LeDer review and the premature deaths and health inequalities that can be faced by people with learning disability and autism, so work closely with the specialist clinical services for learning disabilities at Twinwoods to continue the collaborative approaches and MDT. This ensures that annual health checks are promoted along with joint work with health partners to reduce the over medicating of adults with learning disabilities (STOMP) and other higher risk health needs are reflected in assessments/reviews and referred to specialist clinical services.

The council has, as part of a wider review of aspiration pneumonia and LeDer, introduced a checklist for practitioners to cross reference, to ensure prompts are there to support robust and holistic assessment, that captures the nuances and complexity that an individual may have in terms of their physical and mental health.

The intelligence collated through the PFA lead role supports the strategic planning that sits with commissioners, including Bedfordshire Luton and Milton Keynes (BLMK) ICB, as the needs identified through tracking and forecasting is cross-referenced with the Transforming Care Programme (TCP), providing clear indication of need and highlighting risk and service deficits for those with complex and/or forensic needs.

It also promotes the early identification of complex needs and how the council will plan and develop local services to meet those needs. Therefore, the continuation of collaborative work with other commissioners and agencies is essential, to enhance and promote new developments and interest in the local market, to support diverse need that will be proactive and sustainable.

What were the barriers to success?

- The main area of challenge for adult services is the development of provision that can meet the needs of a significant cohort of young people and adults with profound and complex needs. These main areas are the provision for specialist respite, education, day opportunities as well bespoke care and support services including supported living that can meet needs that are challenging. This includes complex multiple health and physical needs, alongside associated learning disability and autism.
- Increasing the awareness of other service areas that preparing for adulthood is not just a learning disability experience and that the engagement and support of all areas of adult health and social care are critical to bridge the gaps to ensure no young person falls between services.

- Resources across the social care teams is affected by the volume and demand on frontline service, therefore robust risk analysis and prioritisation for all referrals is needed to manage the impact on the team, while aiming to respond to need in a timely and proportionate manner.
- There is not a specific service to meet neurodivergent needs in the local population, including appropriate clinical diagnostic services. The ALDT and PD team are currently covering this deficit, but it is not a long-term solution for these young people. Further consideration and prioritisation is needed within BBC and ICB to meet this area of need, effectively and appropriately with the necessary expertise of professionals across the MDT that have specialism in this area.

What were the conditions for success?

- In collaboration with adult social care commissioning and the BLMK ICB commissioners, the team has been able to consistently provide information from forecasting of complex needs that will influence future service development. The council experienced increased demand and has suffered from deficit in the borough.
- It is positive that the council has seen new providers develop specialist respite services in the locality, in recognition of the need and demand, offering a person-centred service that promotes the growth and development of the individual with complex needs.
- The ALDT continue to work closely with adult commissioning, colleagues in Children's Services and with local providers in all care settings to ensure opportunities to access support are done in a timely and well managed way to support the individual's pathway as an adult.
- The review and update of the PFA protocol also supports a consistent approach to the transition process. This ensures a timely response to need and is planned well in advance of the person's eighteenth birthday, thereby supporting young people and their families who may otherwise see adult services as a 'cliff edge'.
- Promotion of co-production with young people and their carers through collaborative work in network groups and that the council utilises tools that enable meaningful engagement for all young people in the statutory process of assessment, etc.
- Creatively utilising opportunities to develop independent life skills through internal teams and agencies, to prepare and enable young people to have every opportunity to maximise and prepare for their next steps to independence.

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Providing support: moving between services and supporting continuity of care

Essex County Council

Transitioning those most at risk in adult services

Focusing on improving the transitions experience for people with autism and young people experiencing poor mental health.

Young people with needs or a diagnosis related to emotional trauma, mental health, autism and learning difficulties (or a combination of these) with needs likely to impact or impair their independence for adulthood, pose the greatest challenges and difficulties in transition planning into adulthood.

We noticed a growing number of young people in the services with complex presentations who did not fit into the council's well-established transitions process for those with significant learning disabilities. The existing processes were being challenged by a growing number of autistic young people, in the absence of a learning disability, that were also struggling with their mental health.

As well as a lack of confidence with the transitions experience for this group it was also noted that there were challenges in joint working with health and mental health colleagues in this space, who were also struggling with the transitions from Children's to Adult Services for this cohort. The council therefore sought a way to improve the outcomes for this cohort and bring the right people to the discussion, improving pathways and processes to do this.

The council introduced 'working together groups.' Their focus is to provide clarity around each agency's roles and responsibilities and improve joint multi-agency working arrangements between Children's and Adult Services to prevent delays in assessment, planning, and support for this cohort of young people transitioning into adulthood.

The council has also held working together workshops for Children's and Adult Services to come together to understand each agency's remit and their services pressures and strengths, to make valuable connections and plan a way forward together.

In Children's Services, the council commenced collating a data picture for this cohort of young people in October 2022, which also has the dual function to support in the effective planning and delivery of the working together groups. They have built a dashboard to support analysis and reporting. Strengthening the data set continues to be a work in progress as this is currently reliant upon requesting updated information from social work teams.

The council is still on a journey to improve pathways, planning, and interventions (where required) in this space. There are many stakeholders, and the council is working to link work together. They are linked with mental health colleagues who are currently focusing on tackling high demand for inpatient beds and the growing prevalence of autistic individuals in inpatient units. This has involved developing working principles when supporting this cohort and developing a resolution process for some of the most complex discharges. The council also continues to work closely with the health inequalities team who are supporting those with learning disabilities and/or autism to avoid hospital admission or be discharged in a timely way if requiring admission.

Work is still ongoing, and the council is yet to realise the full, positive impact they will be able to have in this space, they will continue to link with Eastern regional colleagues to share best practice and models.

What were the barriers to success?

- Getting buy-in from all relevant stakeholders.
- Identifying a resource that can cover the transitions space both strategically and operationally, for example Children's Services reaching into adulthood space, or Adult Services reaching into children's – is a targeted resource needed instead?
- Gaps in skills and commissioned services in this space.
- Health and social care not being integrated.
- Lack of resources and expertise.

What were the conditions for success?

- Everybody wanting to see improved outcomes for this cohort.
- Willingness to collaborate.
- Opportunities being created to come together as a system to discuss young people who are challenging the current systems.

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Cambridgeshire County Council

Care home transformation

The transformation approach the council undertook with the homeowners, driven by core values of collaboration, accountability, respect and excellence.

Since registering with the Care Quality Commission (CQC) in 2018, The Firs Care Home had never been fully compliant. Following increasing concerns and ongoing work with the service, CQC visited and the report in September 2023 was damning. Colleagues were exasperated and anticipating a home closure. The council re-assessed their approach to change the way they help providers.

The focus was clear. The Firs, a small care home supporting 15 people, needed to shift dramatically from failing to becoming excellent. The engagement with Cambridgeshire County Council (CCC) contracts team was pivotal in setting the foundation for this transformation.

To improve The Firs Care Home in Cambridge, several actions were taken:

- Tailoring on-the-floor messages through various sprint forums such as daily operational priorities meetings with the home manager and specialist council teams.
- Weekly strategic meetings were held with commissioning, CQC and the homeowner, along with on-demand safeguarding meetings involving the care home support team, health and the home manager. Open discussions with the homeowner addressed risks, motivation and expectations, emphasising the need for full commitment.
- A master resident list was created and regularly updated with changes to care plans, health status, safeguarding, training and contingency plans.
- Face-to-face residents' meetings were supported, followed by letters providing updates and contact details for feedback.
- The service was assisted in developing an urgent action project plan, and a system-wide co-ordinated transformation approach was ensured, including a single information-sharing platform extending to GPs and community nurses.

Recognising that collaboration is essential to overcome challenges, the council proactively sought the involvement of various stakeholders including care home staff, CCC commissioning team members, care home support team, families of cared for people, the home manager and the CQC. The collaborative nature of the work allowed the council to obtain valuable insights into practices, ensuring that the solutions developed were comprehensive and aligned to the needs of The Firs' residents, their supporting families and the statutory and recommended practices CCC requires from service providers. Some of the measures implemented included:

- listening and engaging families to prioritise improvement areas
- using feedback from families and professionals to embed what works well
- applying a phased opening-up plan to balance destabilising the service and financial sustainability.

The Firs, known for its compassionate and dedicated staff, had long aimed to provide a nurturing environment for its residents. According to the provider's website, The Firs emphasises creating a home-like atmosphere where residents feel safe, valued and engaged. This ethos became a cornerstone of the improvement strategy. By incorporating these values into the approach, the council supported the provider to ensure that every resident received not only high-quality care but also a sense of belonging and community.

Continued investment in staff training and the enhancement of facilities further consolidated the progress made. The introduction of new recreational activities and better support systems fostered a greater sense of well-being among the residents. Ultimately, the collaborative efforts and shared learnings have turned The Firs into a model of excellence in care. This was reflected in the CQC formally declaring the service as Good in October 2024 at the first time of assessment.

The success of all efforts is substantiated by evidence from both the CQC-based service report and the service user report. These reports highlight the tangible improvements in care quality and user satisfaction. For instance, the disruption to 15 lives was effectively mitigated through co-ordinated efforts, showcasing the practical benefits of the approach.

The CQC report provides a comprehensive overview of the improvements achieved. Key metrics such as care quality, user satisfaction and service efficiency have shown significant enhancement. Additional data from the CQC website indicates that the care services have consistently received 'Good' ratings in all domains, further validating the council's approach.

According to the CQC: 'The improvements in care quality have been substantial, reflecting a commitment to maintaining high standards and person-centred care'. This further emphasises the success of our initiatives and the positive outcomes for the residents.

The service user report offers a firsthand account of the positive changes experienced by individuals under the council's care. The feedback highlights the increased sense of security, well-being and satisfaction resulting from a personalised and collaborative approach.

Residents and families recounted to CQC that they felt that they were treated with kindness and compassion and that the staff were able to support residents and their families. Furthermore, steps were being taken to improve staff facilities and support the wellbeing of staff members, alongside residents.

By working with The Firs Care Home, the council was able to assist the home to obtain a 'Good' CQC score. Alongside this, they were able to help with the implication of improved care service within the home. The impact of these actions led to The Firs Care Home continuing to serve its residents, who otherwise would have been disrupted by the site closure.

Providing support: commissioning and quality

Residents and their families felt that they were feeling safe and were confident that they could raise concerns with staff members and feel listened to. People under the home's care were being supported by staff that knew them well and had developed person-centred care. Staff actively supported residents, both with internal assistance and supporting accessibility of external aid from health professionals to promote and maintain the resident's wellbeing.

When looking at how the council could apply lessons learnt, one of the significant outcomes of the collaborative efforts was the application of the revamped approach to preventing service failure to other local care services such as Hill House and St Georges. Hill House too has benefited from the same transformation over the same period. Its rating was declared as 'Good' in December 2024, following an 'Inadequate' rating in February 2024. This has helped lift anxiety from a further 11 families. These initiatives involved detailed analysis, and the adoption of best practices identified during the council's engagement with stakeholders, as well as implementing change at pace. The positive impact on Hill House and St Georges not only validated the council's approach but also provided models for replication in other care services. The integration of these learnings into the standard operating processes has enhanced the overall quality of care, benefiting numerous individuals and families.

The Firs care home has been described as a 'beacon of hope and excellence in the community', by the BBC, highlighting its commitment to providing top-tier care and support to residents. This endorsement underlines the transformative approach the council undertook with the homeowners, driven by core values of collaboration, accountability, respect and excellence.

The collective efforts have not only resolved current challenges but also paved the way for innovative sprint processes that benefit work across adult social care. As the council move forward, they remain dedicated to enhancing care services and contributing to the well-being of the individuals and families they serve.

What were the barriers to success?

- Provider fully implementing the Care Act 2014 requirements.
- Structural issues within the buildings.
- Poor incident reporting.
- Poor communication.
- Poor resident engagement and recreational opportunities.
- Lack of consistent management.
- Special measure notice given.

What were the conditions for success?

- Improving the CQC rating from 'Very Poor' to 'Good'.
- Improve response from service users.
- Focus on person-centred care.
- Development of best practice, through values of collaboration, accountability, respect and excellence.

The core condition for success was to improve the CQC rating of this site, to a standard which matched the requirements the council sets for its service provisioners and its statutory requirements as a local authority. In addition, the council strive to improve the lived experience response of their cared-for people and their families. To be successful the council wanted to align with CQC standards; this meant that the care provision needed to be improved substantially and that the focus on person-centred care needed to be re-established, developing improvements to the resident's sense of being.

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Providing support: commissioning and quality

Bedford Borough Council

Supporting a non-regulated provider to remain open

Describing the process of supporting a daytime activity provider through the serious concerns procedure so that they could continue to offer support to a large group of people.

Bedford's Care Standards Team in Adult Services was contacted by the trustees of an independent local organisation with concerns raised around safety and service viability due to alleged management and governance issues. The organisation was asking for help. The service was popular and well used by over 50 people from Bedford and neighbouring authorities.

The key issue for the council was consideration of balancing risk of maintaining the service for people who used the service, while guaranteeing the safety of those attending.

Following concerns shared by the organisation with regards to the governance arrangements within the establishment, the serious concerns protocol was initiated. This procedure is usually reserved for regulated providers, but it was felt to be the most suitable framework within which to work in this instance.

What action took place?

- Staff from the care standards and monitoring team went onsite and made regular visits to the service over a period of time, to gather the views and hear the voices of people attending.
- Regular face-to-face meetings with the trustees were established to offer advice and support from managers from the care standards area, and to offer clarity about the standards required for the wellbeing and safety of people attending, which was of highest priority.
- An action plan was developed in association with the trustees, which was monitored at each meeting and progress was reported.
- The trustees were encouraged to obtain support from the umbrella organisation for voluntary services and groups, which they did.
- The service was supported over a twelve-month period to improve their management and governance arrangements.
- This was a non-regulated service, therefore the council contract with the care providers was key to establishing the support needed for improvement and sustainability in the longer term for positive outcomes for people who used the service.
- It was important to establish a positive working and collaborative communication by all concerned.

- The working group brought Care Standards, operational social care, commissioning team and the care provider together from the start of the process.
- A Provider Assessment and Market Management Solution (PAMMS) assessment was completed at the beginning to provide a starting point for improvement. This established the variables to consider and examined how best to minimise risk and disruption to people attending the service.
- People attending and their families were encouraged to offer feedback to the care standards team, and the trustees were open with the families and attendees about the challenges faced by the organisation, including the possibility of closure. The voice of the people who attended the service was really important, valuable and central.

As a result of this intervention and collaboration the long-term impact is that the service now thrives with a new management group and attendance remains steady. Changes have been made to the physical environment to maximise safety for people, and the trustees have been encouraged to take up training and other opportunities that will help them in their role.

The whole process was dynamic and inclusive of all parties with a positive outcome for people who attend the service and for its longer-term sustainability. It was a positive outcome.

What were the barriers to success?

- Balancing the presenting risks with people's choice to continue accessing the service.
- Ensuring that improvements were made on a regular basis.
- Carving out enough time for relevant services within adult services departments to give this improvement plan the attention it needed.

What were the conditions for success?

- People attending the service on a regular basis who can do so with confidence and in safety.
- Achieving a positive working relationship with the care provider.
- Ensuring that the organisation has a secure and sustainable basis for continuation into the future.

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Bedford Borough Council

Ensuring high standards within a residential care setting

Maintaining a transparent and supportive relationship with local care providers to minimise the risk of provider failure.

It was identified through a safeguarding referral and quality assurance issues from partners that there were concerns regarding care delivery with a care provider within Bedford. This was a residential care home with over 50 residents.

On the collation of information from partners, the Care Standards Monitoring Team sought agreement from the Director of Adult Social Services (DASS) to instigate the Bedford Borough Serious Concerns protocol.

The Care Standards Monitoring Team then ensured they had a presence to support, observe and guide, basing themselves in the home at the beginning of the process and following this they then continued with twice-weekly visits. This was a real team effort.

The local authority, along with a core multi-disciplinary team of partners, worked in a collaborative way with the provider to gain necessary support and the care provider engaged in the process.

A core team of dedicated professionals pulled together, ensuring the right mix of clinical and social care members to provide support to those with lived experience and to identify those people most at risk due to complexity of need or specific and wider health needs.

To ensure everyone was up to date there was joint communication from the care provider and local authority with people and their next of kin to keep them informed of the situation. The Care Standards Team met with some families on an individual basis to offer reassurance to all and to address any concerns with the care provider.

Without this support there was a risk of a care provider failure and a high potential of people with care and support needs being displaced and having to be moved from their own home to alternative accommodation, which would have been extremely disruptive.

What was the barrier to success?

- The initial mobilisation of a team with the appropriate skills mix was complex.

What were the conditions for success?

- Although this was an intense piece of work in the first week, this stabilised and the high risk situation reduced.
- The care provider engaged throughout the process and was transparent.

- CQC completed an inspection three weeks later and made reference to those actions taken by partner agencies and the care provider which otherwise could have impacted on the outcome of CQC findings as part of their assessment.

In conclusion, collaboration and key skill mix enabled the home to remain safe for the people who lived there and partnership working ensured that everyone pulled together to meet this aim.

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Ensuring safety

- **Safeguarding practice and quality**

Ensuring safety: safeguarding practice and quality

Hertfordshire County Council

Mental Capacity Act (MCA) week 2024

A week focusing on MCA with webinars, workshops and drop-in sessions

Audits identified several recuring themes in terms of areas to improve the quality of practice in undertaking Mental Capacity Assessments (MCAs) and Best Interests Decisions. Learning themes were also identified via Safeguarding Adults Reviews (SARS), Domestic Homicide Reviews (DHRs), complaints and queries from practitioners.

Key learning themes to be addressed:

- Ensuring that sufficient preparation ahead of the mental capacity assessment is given including being clear about the decision at hand and consideration of practical steps to support decision making.
- Understanding legal duties to undertake MCAs where there is reason to doubt someone's capacity, including where there are concerns about executive functioning.
- Ensuring that section 4 of the best interests checklist is followed, and sufficient consideration is given to the person's past and present wishes, feelings, beliefs and values.
- Being clear about legal roles and responsibilities related to decision-making.
- Appropriate, proportionate and legally compliant recording of the MCA assessment.
- Clarification on equipment that restricts or restrains and Deprivation of Liberty Safeguards (DoLs) and Community DoL.
- Understanding executive function.

To address the main learning areas the Practice Quality Team collaborated with the Practice Development Team to develop and run a practice week in September 2024 which was advertised to all Adult Care Services (ACS) staff.

There were online webinars and smaller, in-person workshops offering a range of topics and forums to learn more about the Mental Capacity Act, and to receive clarification of HCC's practice position on specific areas of practice including Executive Functioning and Community Deprivation of Liberty. Each day there were practice resources and messages shared across ACS. The sessions were well attended, with some webinars attracting over 100 attendees. Smaller workshops on how to frame the decision and best interests also received good feedback. There was lots of interaction in the best interests workshop, which was supported by a Purple Allstars performance, which is a local advocacy group delivering role plays.

All webinar sessions were recorded and made available, along with the presentations that were used during practice week, on the intranet pages which contained helpful resources for professionals, the person being supported and their family/friends, as well as videos and links to other websites. The webpage itself has been viewed over 372 times since it was published in September.

Evaluations of the practice week were completed by attendees and feedback was very positive, with some further feedback about future sessions that would be helpful.

A follow-up MCA audit will run in February 2025, which will seek to measure the impact on practice. Further MCA workshops are planned to focus on key topic areas as a result of some of the feedback as well as other learning obtained from independent management reviews and ombudsmen complaints.

Teams have also reported that staff have benefitted from the Practice Quality Team facilitating and delivering workshops with staff in small sessions which support staff knowledge and confidence.

How did the council work with people?

- Worked with Hertfordshire's County Council (HCC) experts by experience to identify key resources to be shared as part of the practice week webpages.
- Worked collaboratively with Purple Allstars, a learning disability advocacy group, who delivered roleplays as part of the small workshops.

What were the barriers to success?

- Promoting staff attendance at events and engagement with the web pages.
- Small team within practice quality team delivered most of the webinars and workshops inhouse.
- There was no funding available to invite external speakers.

What were the conditions for success?

- Opportunity for staff to extend knowledge on a specific area of practice – Mental Capacity – and reflect on the challenges in practice with colleagues.
- Small workshops enabled a relaxed setting with group work to explore ideas for practice and extend knowledge.
- Combined resources in dedicated webpage for knowledge to be re-visited.

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Bedford Borough Council

Ensuring Deprivation of Liberty Safeguards (DoLs) right are upheld

Collaborative solution to ensuring Bedford's statutory duty of managing the Deprivation of Liberty Safeguards and ensuring the residents of Bedford Borough have their rights upheld

Supporting managing authorities to uphold their duties under the Deprivation of Liberty Safeguards and ensuring the residents of Bedford Borough have their rights upheld.

The council focused on the following challenges:

- Increasing number of requests received by the team.
- Staffing pressures and increasing costs.
- A need to maintain the current gold standard service with no waiting lists to ensure best interests of local people.
- Increasing pressures on advocacy services to provide paid persons representatives and visits to those people who are unbefriended.

The following was put into place:

- Quarterly meetings with the advocacy provider to discuss, focus and work on a solution, with an emphasis on any ongoing barriers and how these may be overcome.
- Seek spot providers for current 1.2 representatives to improve the situation.
- Use shared expertise with other local authorities by attendance at ADASS Eastern Region meetings to discuss trends, patterns and emerging themes within the Dols arena.
- Ensuring knowledge is shared within the forum along with any information from the national meeting which team members take it in turns to attend.

To ensure practice remains solid for the best outcomes of people the council emphasised the importance of the following agreed actions:

- Ensured regular group supervisions were in place with independent best interest assessors (BIAs) as well as access to training.
- Prioritised a robust inhouse support team and clear workflows.
- Maintained regular engagement and good relationship with providers.
- Recognised and invested in staff who were friendly and knowledgeable, ensuring they are accessible to carers, families and providers which in turn supports best outcomes.

The team supports managing authorities to uphold their duties under the Deprivation of Liberty Safeguards and to ensure that those who are unable to consent to their care arrangements have their rights upheld.

What were the barriers to success?

- Costs.
- Increasing numbers of referrals.
- Recruitment of staff.

What were the conditions for success?

- Ensuring a regular pool of independent BIA.
- Robust team.
- Regular review/revision of processes and willingness to change if alternatives existed.
- Engagement with providers and partners.

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Ensuring safety: safeguarding practice and quality

Hertfordshire County Council

Closing the gap, preventing premature disability

People with learning disability are dying around 20 years younger than the general population on average due to health inequalities; these actions aim to help close the gap.

The council knows from the Learning Disability Mortality Review (LeDeR) that people with a learning disability die on average around 20 years younger than the general population. For those people from non-white British communities the figures are worse. Although the aim is to reduce this gap in age expectation, the immediate aim is to reduce known health inequalities. This is the vision of the Learning Disability Nursing Service.

The Learning Disability Nursing Service, based within the council, has been engaged in a number of initiatives to address these concerns:

Training

The council knows that equipping people with a learning disability and their carers where appropriate, as well as NHS, local authority staff and other professionals with the requisite knowledge and skills to address health inequalities can raise awareness of this issue and lead to proactive interventions.

The council has put the following in place:

- Via the Health Improvement and Prevention Nurses provided RESTORE training which teaches how to identify the early signs of ill health to encourage preventative health care actions to be taken and potentially prevent hospital admission.
- 'Was Not Brought' policy introduced by both hospital trusts to ensure that any patients flagged to have a learning disability were contacted by the Acute Liaison Nurses to understand why they didn't attend, who then put in any reasonable adjustments to enable them to attend and will rebook a rapid appointment.
- The Training Lead Nurse has worked with Experts by Experience to enable them to train NHS staff in hospital settings regarding how to work with people with a learning disability effectively, utilising reasonable adjustments. Experts By Experience have also been supported by nursing to train primary care staff through the Purple Star Strategy initiative, which promotes good practice and quality standards for people with a learning disability and they also advise on the development of easy read documentation.
- The nurses have provided training to social care providers for older people who offer a service for people with a learning disability, for example on the importance of facilitating annual health checks with GPs.
- The nurses have also been engaged in the Supporting the Work Force Project which has extended student nurse experience into a wider social care context, which in turn has led to a more rounded learning experience and greater understanding of both the health and social care needs of people with a learning disability.

Resources

The Learning Disability Nursing Service has also produced a range of resources online, on video and paper to support work in health care for people with a learning disability. These include the following:

- The nursing service administers the Purple Folder, which every person with a learning disability registered with a Hertfordshire GP is entitled to have. It is a form of patient held record that the person owns, and which lays out key information about their health needs and how best to promote healthy outcomes for them.
- Working with Herts Care Providers Association and local provider forums in raising awareness of the tools that the council has available to address health inequalities, for example 'Know Your Wee'.
- The nurses have used digital technology to improve nursing practice, for example developing an electronic version of dementia screening for people with a learning disability which has improved efficiency.
- The two senior nurses in primary, secondary and tertiary care have developed a ReSPECT Good Practice and Guidance Tool which supports the provision of appropriate nursing and clinical decision making, for example in relation to the Mental Capacity Act, and which has been ratified by the ICB and Hertfordshire's Safeguarding Board.

Promoting a Connected Lives/person-centre approach to achieving best outcomes for people with a learning disability

- Using the creative arts through nursing support of the creative practitioner to work with the Purple All-Stars, a song and theatrical approach by people with a learning disability to get across key health promotion messages, for example regarding hand hygiene and dealing with loneliness.
- The nurses also work proactively with social care colleagues across all safeguarding processes to ensure the individual's health needs are paramount when concerns are raised, such as in addressing provider failure issues.
- The health equality nurses have made significant progress in enabling access to mainstream health programmes through their proactive work with primary care regarding cancer screening, proactively encouraging the uptake of annual health checks (recognising the important support to carers that this provides) and methodically reviewing and reducing or stopping the over-prescription of psychotropic medications through the award-winning STOMP programme, where feasible.
- The community nurses were nominated for an award in the East of England Learning Disability Awards for their work on triage, where referrals are proactively managed alongside social care colleagues to identify the most appropriate service at the earliest opportunity and to minimise risk.

How did the council work with people?

The Learning Disability Nursing Service, working within the context of the council's Connected Lives approach, have worked with people with a learning disability, including through Experts by Experience and the Purple All-Stars, to engage with people with a learning disability and their families/carers to take on board positive health messages to address health inequalities.

Challenges have come through various means, not only through individual case work, but increasingly through LeDeR priorities as co-ordinated by the council's Improving Health Outcomes Group, which has multi-disciplinary and multi-agency approach representation.

Solutions are developed through this process and individualised nursing practice. For example, the council has developed health promotion activities around healthy weight management in response to the LeDeR themes and there have also been resources developed by nurses around diabetes care to raise awareness of healthy eating, etc.

There have been some significant outcomes:

- The use of the 'Know Your Wee' resulted in an early diagnosis of bladder cancer and subsequent treatment. This gentleman would not have indicated this to the care staff had he not been educated on the importance of telling someone if your urine is certain colours on the chart.
- The reduction of psychotropic medication for one person resulted in them speaking again after many years of not being able to articulate verbally.
- Nursing involvement in a safeguarding/provider failure improvement programme eventually enabled a man with learning disabilities to venture outside and engage in his local community, something he had not done for some time, with the concomitant benefits for both physical and mental health.

What were the barriers and conditions for success?

- **Attitude:** People with learning disabilities are still being discriminated against. This requires a cultural change which the nurses are engaged in and advocate for. For example, addressing inappropriate Do Not Attempt Resuscitate (DNAR) orders. Could be measured by reducing numbers of safeguarding referrals for attitudinal reasons.
- **Social barriers:** Reasonable adjustments can be promoted to tackle social barriers, for example advocating for longer GP appointment times when required. These can be captured in an individual's Purple Folder.
- **Improving knowledge and skills:** By raising awareness through education and training, for example in mainstream cancer screening and providing the resources to generally increase knowledge and skills. This can be measured through training and educational feedback.

For further information:

Help with your health | Learning disabilities | Hertfordshire County Council
Learning disabilities and health – Information for professionals | Hertfordshire County Council

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Leadership

- Practice, governance and performance data
- Management and workforce planning
- Culture
- Management and workforce training
- Whole systems transformation and innovation

Hertfordshire County Council

Learning Disability Frailty Risk Assessment Tool

The Frailty Risk Assessment Tool uses indicators to highlight where social care and health practitioners can support a person with a learning disability and identify frailty and reduce their risk of frailty sooner.

In 2019, Hertfordshire County Council, in conjunction with health and social care partners identified through Learning from Lives and Deaths Reviews of people with Learning Disabilities (LeDeR) that frailty was a contributing factor in their avoidable deaths. In 2019, the median age of death for people with learning disabilities was 60 years of age while the median age for the general population was 85. Depending on the level of learning disability the median age for death could be as low as 40 years of age.

A decision was made to investigate what tools already existed in identifying frailty risk. One of the most commonly used tools is the Rockwood Clinical Frailty Score, however this has not been validated for use with people who have chronic long-term conditions such as learning disabilities, physical disabilities or autism, or people under the age of 65 years.

Hertfordshire County Council identified that there was a gap in tools and with health and social care partners across Hertfordshire designed and developed the Frailty Risk Assessment Tool (for people with Learning Disabilities).

The project timescale covered June 2021 to September 2023 and was broken into four distinct phases:

1. **Phase 1a** (June 2021 – June 2022): A small initial pilot was completed using the frailty assessment tool with people with learning disabilities who received support from the Welwyn and Hatfield Community Learning Disability Nurse Team (target 50 assessments). This pilot was to develop supporting processes and documents (e.g. training material, processes and procedures, data collection methods), collate initial assessment data and identify and implement changes and lessons learnt ahead of a larger pilot. This enabled an iterative approach to the pilot and allowed us to evaluate the effectiveness of the interventions in place and implement improvements during the project life cycle.
2. **Phase 1b** (July 2022 – July 2023): A larger phase pilot was completed using the frailty assessment tool with people with learning disabilities who received support from all Adult Disability Service Teams in Hertfordshire (target 200 assessments). This phase implemented the lessons learnt from Phase 1a and included updated processes, procedures, training material and supported documentation. Phase 1b also saw an increase in project team membership to support the increase in activity.
3. **Transfer of assessment tool to business as usual** (July 2023 – September 2024): This phase included a review of lessons learnt from both 1a and 1b phases. The tool was validated by the University of Hertfordshire, and this subsequently enabled the tool to be rolled out as business as usual in ACS. As part of the transfer to business as usual the following was completed:
   - Transfer of the tool from a paper-based assessment to HCC's client management system ACSIS (Liquid Logic).
   - Updated processes, procedures and policies.
   - The creation of a dedicated Frailty Risk Assessment Tool intranet page.
   - Engagement with health and social care partners across Hertfordshire to update referral pathways.
4. **Embedding assessment tool in practice** (September 2024 onwards) (ADS owned activity): This phase has included the development of updated training material, frailty tool webinars and recordings of how to use the new ACSIS version of the form which will be available via the Frailty Tool intranet page.

Examples of impact

'I have care and support that is co-ordinated, and everyone works well together and with me.'

This statement in particular links with how working as a multidisciplinary team allowed the person to be at the forefront of their care and involved every step of the way. Providing positive outcomes for those being cared for and enabling them to live a healthier longer life.

One case that was reviewed had further risk management assessments implemented to ensure the safety of the person and others was optimised. This has allowed care provider staff to engage with the individual, working alongside other care professionals and the person's care plan. Doing the frailty assessment triggered a full social care review/ assessment with the individual wanting an outcome to build their confidence and mobilise safely.

'We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services'.

More services have become available for those with learning disabilities with the use of the tool and linking teams together, providing a clearer communication path between services to better support the LD population and the inequalities they can face. The frailty clinic overseen by health partners is one service that will now review and accept referrals from the LD community as a result of the frailty assessment tool being developed.

When a practitioner completes the tool alongside the referral it allows them to capture the views, needs and wishes of the individual to ensure these can be met from the outcome of the referral. This could be due to them scoring a high or a medium and needing ongoing services, or to have on their personal record to share with other professionals to ensure continuity of care across all services.

Leadership: practice, governance and performance data

Feedback from practitioners regarding the assessments are that is an easy tool to complete and that it is straight forward and relevant to the individual and it 'gives a good indicator of the services that can be applied'.

One individual scored Medium on the assessment tool – this in turn prompted a referral to Speech and Language Therapy (SALT) as some concerns of swallowing were raised. There was a memory screening completed alongside a request for occupational therapy regarding moving and handling and a GP review was also requested. This shows positive outcomes from the frailty assessment tool, allowing a holistic approach and partnership working to ensure the needs of the individual are met.

'We review people's personalised care and support plans with them regularly, focusing on whether they are doing the things they identified as important to them'.

After discussing a case with a colleague regarding their completion of the assessment it was noted that the practitioner did a review as they were concerned about the health of the individual due to their complex health needs. The individual was in between an LD diagnosis so the practitioner wanted to utilise the tool when reviewing what was important to this individual.

This is when the Frailty Assessment tool can also be used to establish a baseline for the individual, allowing the workforce to create a picture of their health needs which can show any further deterioration or decline that may occur over time for that person's health. This provides a focus for that individual and the team around them to consider next steps and a relevant action plan such as actively working to reduce falls and subsequent impact on mobility. These are individualised holistically to that person and their own needs and or wants. Explore Making It Real – TLAP Statements.

What were the barriers to success?

- A system culture change regarding age-related frailty perceptions. The Herts and West Essex Integrated Care System Frailty Culture Change Strategy 2024–2027 supports a shift in these perceptions.
- Development of the tool was a new endeavour for HCC, with no existing roadmap to success, so the team were learning throughout the project from experience and as the project progressed.
- Finding and engaging an organisation with the experience in assessment tools to complete the external validation.

What were the conditions for success?

- An externally validated tool (completed by University of Hertfordshire with support from Health Innovation East (formerly Eastern Academic Health Sciences Network)).
- System agreement in Hertfordshire that people with learning disabilities are at increased risk of frailty developing at an earlier age and Frailty Service eligibility criteria are integrated to reflect these needs. (This system change was supported by the Herts and West Essex Integrated Care System Frailty Culture Change Strategy 2024–2027.)
- Upskilling the social care workforce to complete Frailty Risk Assessment (internal training completed by Frailty and Falls Advanced Practitioners and Frailty and Falls Learning Disability Nurse).
- Collaboration and engagement with system partners to achieve positive outcomes for people with learning disabilities (via ICB Frailty Board, Hertfordshire Improving Health Outcomes Group and East and North Herts Frailty Board).
- Transfer of the tool from paper based to HCC's client management system ACSIS (internal systems development from HCC Liquid Logic trained developers).

For further information:

LeDeR Learning from Action National Report 2023-2024
Care Quality Commission Hertfordshire Adult Care Services Assessment 2024

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Bedford Borough Council

Reviews performance

Meeting targets on planned and unplanned reviews to ensure people were getting the support they needed.

The council recognised that there was a need to focus on reviews with the aim of getting performance back to pre- pandemic levels. Pressures including recruitment had diverted staff to wider areas, and a revised internal structure had taken place. Performance reports indicated completed reviews within the timescale fell significantly short of the internal 60 per cent target.

Analysis identified several contributing factors:

- Reassessments were being completed in place of reviews.
- Reassessments were not captured in the performance report for reviews.
- Absence of a written framework to ensure consistency and support quality assurance.
- Limited proficiency in database usage and lack of refresher training.
- Staff adhering to out-of-date criteria for completing a review vs. reassessment.
- Documentation required a review.

The council put in place the following:

- Full review and update of performance reporting to ensure capture of all relevant data.
- Development of a review framework to support consistency in approach across the directorate.
- Refresher training on a rolling basis for all staff, including mental health colleagues, to understand how to complete a review on database.
- Updated the review form to meet current guidelines.
- Simplified the review process to prioritise reviews from the outset.
- Provided training for managers on review expectations, including the importance of completing reviews at an earlier stage.
- Building confidence in alternative review formats beyond face-to-face meetings.

The above measures led to an increase in the review performance from 47.7 per cent in February 2024 to 68.8 per cent in February 2025. This was an increase of 20.1 per cent over 12 months.

- National guidelines and co-produced work was fully utilised in the process.
- Operational teams were consulted for the development of the framework.

What were the benefits?

Care Act Reviews are a positive opportunity to take stock and consider if the care plan is enabling the person to meet their needs and achieve their wellbeing outcomes. It allows people the opportunity to reflect on what aspects are working, what areas require improvement and what might need to change. By keeping plans regularly updated and aligned with the individual's evolving needs and aspirations, Care Act Reviews promote a strength-based approach and personalisation, confidence in the system, reduce the likelihood of individuals reaching a crisis point and provide transparent and accountable services at Bedford Borough Council.

Keeping plans under review is an essential element of the planning process. Without a system of regular reviews, care plans could become quickly out of date, meaning people may not obtain the care and support required to meet their eligible needs. Care plans may also identify outcomes that the person wants to achieve which are progressive or time limited, a periodic review is vital to ensure that the care plan remains relevant to their goals and aspirations. In a care plan review, opportunities may also arise to identify needs that could be met through additional internal referrals to services such as occupational therapy or telecare, potentially reducing reliance on statutory services. Occupational therapy teams play a vital role by promoting participation in daily activities, implementing environmental adaptations and supporting individuals in maintaining their routines and independence.

What were the barriers to success?

- Lack of understanding around the data system.
- Review form not meeting current guidelines.
- Adherence to ‘old’ unscripted internal rules based on an internal review team ethos.
- Work completed not being captured for data reports.

What were the conditions for success?

- Review of data capture and analysis.
- Review of all data forms.
- Written framework.
- Staff compliance.
- Training.

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Leadership: practice, governance and performance data

Suffolk County Council

Using linked data to understand the impact of reablement services

Integrated care cannot be effective without integrated data. The council undertook a groundbreaking use of linked data to understand how the Home First service influences outcomes following discharge from hospital, including NHS service use and long-term residential care.

Home First is the name of the reablement service provided by Suffolk County Council. Reablement consists of a package of non-chargeable, short-term care for up to six weeks, with the aim of supporting people in their home after a hospital stay, preventing hospital trips that are not needed, and helping people avoid moving into a care home before it is necessary.

The Home First team were keen to understand the impact of the service on NHS service use and long-term residential care, but until recently this question had been impossible to answer as, historically, NHS health data and local authority adult social care data were not linked.

The formation of Suffolk & Northeast Essex ICS (SNEE) saw teams working collaboratively to create a linked, longitudinal dataset combining adult social care, primary care, community services, acute hospital and mental health trust data as part of a population health management (PHM) approach.

To explore the insights this powerful dataset could offer, SNEE partnered with Optum to provide the PHM Pathfinder tool. Pathfinder includes a series of dashboards which visualise these linked data, allowing teams to explore:

- holistic health and care needs
- cost segmentation to identify high and rising risk
- service use across multiple organisations
- impact modelling and gaps in care
- patient-level data to analyse care pathways and provide insights at system or cohort level
- outcomes and impacts following interventions, in order to inform evaluation and a continuous cycle of improvement.

Bringing data together from partner organisations across the Integrated Care System (ICS) provides a more complete picture of which factors have the largest influence on health and care outcomes within the population and allowed Suffolk County Council to understand the impact of reablement.

In October 2023, the Home First reablement team began working with the Public Health and Communities team to explore the impact of reablement on outcomes and NHS service use using the PHM dataset.

The project focused on Home First customers over the age of 75 years who were resident in Ipswich and East Suffolk and West Suffolk Alliances. Analysis showed that Home First customers were more likely to have a number of health conditions than other over 75s, including chronic kidney disease, hypertension, cancer, heart disease, stroke, diabetes, a history of falls, dementia and a mental health condition.

A cohort of 217 individuals who had received Home First reablement services in April 2023 was identified. It has been possible to track this cohort over time to observe subsequent service use and outcomes.

This is the first time that health data and adult social care reablement data have been fully linked in order to understand the impact of services. There are further opportunities to expand this analysis and to use evaluation to shape service planning across adult social care. Home First are continuing to work with the Public Health and Communities team to continue to understand how reablement interventions affects customers and the services they use post reablement. This will help inform changes to reablement practice driven by data to ensure customers remain independent for longer.

Taking a population health management approach has required significant cultural change at every level of the system, through principles of integration and co-production, including transparent linking and sharing of relevant information and analysis with those who need to take action to improve outcomes, and with the population who are the subjects of the data.

No single organisation can influence all the factors that determine health, which is why the council took a proactive approach to work together as an integrated health and care system to deliver health and care benefits. PHM has offered new opportunities for practitioner teams to take evidence and intelligence-based action to improve outcomes; for analysts to bring together local data on multiple conditions or risks in innovative ways; for financial teams to understand and predict system costs more precisely; for commissioners to use PHM data to make the case for prevention and early intervention; and for system leaders to deliver on their mandate of improving outcomes.

With this knowledge, the council is working with local people and local teams to create better integrated health, care and support services and make better use of public resources. The PHM Strategic Group advises and supports all levels of the PHM infrastructure to deliver these requirements. A monthly PHM Operations Group meeting supports the work of the Strategic Group, working closely with all key partners. During implementation of the PHM data dashboards, the Operational Group ran a series of collaborative exercises to refine the requirements of reports. Optum and the ICB and local authority team worked closely throughout the project via weekly touchpoints, enabling valuable input for further developments which have been incorporated by the talented team of data scientists and developers at Optum.

When comparing the six-month post-reablement period to the six-month pre-reablement period, A&E service use reduced by 23.5 per cent and emergency admissions reduced by 32.8 per cent in Home First customers. However, it is important to note that the emergency admission which necessitated the reablement service would be included in the pre-reablement period. A shift towards community-based services was observed, with a 16.9 per cent increase in GP appointments, a 107.9 per cent increase in community services contacts and a 266.1 per cent increase in mental health services activity, post-reablement.

A comparison was made between customers who had received reablement from Home First and those who had received care from external providers that Home First declined due to capacity. In the nine months following reablement, readmissions reduced by 43.3 per cent in the Home First group but increased by 70.8 per cent in the external provider group. However, in other metrics, the Home First group had less favourable outcomes. For example, the Home First cohort were statistically significantly more likely to have an avoidable A&E attendance post-reablement, than the external reablement cohort.

What were the barriers to success?

- **Data governance:** The effective flow of information across the system is integral to delivering joined-up care pathways and ensuring effective allocation of resources. However, when datasets are inaccessible by care providers, this can create barriers to integrated care. Clear and comprehensive data-sharing agreements are needed between the NHS and local authorities.
- **Data quality and standardisation issues:** NHS and social care data are often recorded using different formats, terminologies and classifications, making integration complex. Each local authority has different recording systems, making it harder to create a nationally consistent data set.
- **Developing skills and capability:** Getting access to new sources of data meant the analytical teams needed to upskill quickly in order to understand the most efficient and effective ways of linking and analysing health and care data, drawing out useful insights for operational teams.

What were the conditions for success?

- **Strong legal and governance frameworks** including clear data-sharing agreements, transparent privacy notices and secure processes which were put in place to protect confidential data.
- **Data standardisation** and cleaning including documenting each dataset, deduplication and reformatting to ensure data was accessible and useful. The inclusion of the NHS number in adult social care data was critical for data linkage.
- **Effective cross-organisational collaboration** including Joint Governance Boards for PHM and information governance, close links between NHS and local authority analytical and operational teams, and a shared PHM strategy.
- **Investment in analytical and technical capacity:** PHM data and dashboarding is funded cross-organisationally and is supported by a dedicated PHM team. A shared intelligence function, hosted by Suffolk County Council, supports detailed analysis across the health and care system. The intelligence function delivers technical and soft-skills training, both to analytical and non-technical consumers of PHM data.

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Central Bedfordshire Council

Building a professional pipeline

Workforce Strategy and career pathways utilising apprenticeships.

The adult social care (ASC) workforce is central to providing care and support to the people who need it. In line with the national picture, recruitment into social care roles within the council, particularly to registered social work and occupational therapy roles and in-house direct care services, ASC workforce capacity in Central Bedfordshire is facing significant challenges arising from the growing demand and increasing complexity of care and support needs. Managing the impact of the demographic pressures in Central Bedfordshire is a key challenge.

The council is proud of its workforce and is committed to ensuring that they continue to provide excellent adult social care support and that they plan to ensure that they have the right people, in the right place, at the right time with the right values, skills and experience to deliver the care and support needed both now and in the future. Whilst turnover has been relatively stable, the length of time that posts remain vacant has increased due to a reduced availability of skilled workers.

The council aims to support ASC, meet rising demand and improve social work recruitment and retention by providing a future pipeline of well trained and motivated social workers to:

- reduce social worker vacancies
- improve retention
- reduce agency spend
- provide a clear, attainable and supported career pathway for ASC otherwise qualified staff.

Budgets are tight and the work of a social worker is becoming more complex. If the council could develop a clear, attainable and supported route into social work for the internal workforce, they should be able to fully utilise the existing ASC workers' current experience and skills. Through workforce strategy and planning, the council started to produce a future social worker/occupational therapy pipeline to meet future as well as current needs.

The council was aware that in the past those applying for social work apprenticeships were not always fully aware of the depth of the role or prepared for the rigors of the social work apprenticeship. The council knew it had to improve support to potential in-house applicants on limited resources, to make recruitment and induction onto the apprenticeship more effective and efficient.

To help with thinking and planning, the council took part in the Strategic Workforce planning sessions delivered by the Local Government Association (LGA) which helped to set the space for thinking and an action plan was created to overcome the challenges faced. The Social Care Workforce Strategy outlined how Central Bedfordshire Council (CBC) will attract, retain and support the development of a stable, skilled and committed workforce which has the skills, knowledge and motivation to improve outcomes for the people we support.

This was followed by the Director of Adult Social Services (DASS) asking for a critical friend appraisal of the workforce strategy led by Partners in Care and Health (PCH) in order to inform improvement strategies. The appraisal framework and methodology drew on the Care Quality Commission (CQC) single assessment framework (SAF) and learning from PCH direct support work with councils. The feedback from the appraisal process is helping the Adult Social Care Directorate to prioritise areas for improvement and help with preparations for CQC assessment.

In relation to apprenticeships, the council started with an understanding of what the past recruitment and retention data was telling them and worked with senior management team (SMT)/HR business partners to create a simple apprenticeship workforce plan for the next 3–5 years. Together they developed a social work pre-apprenticeship programme delivered over six sessions, to better prepare staff interested in applying for the social work apprenticeship and put together a placement improvement plan to improve the placement experience of both apprentices and students. All apprentices now have access to a legacy mentor for current and post-apprenticeship support and career planning.

The council has (and continues to) work closely with the university provider on developing a Level 7 social work apprenticeship for delivery September 2025/January 2026.

Feedback has been used from people who access care and support via the apprentice practice observations process to improve placements and training offer. People who access care and support are also part of the apprentice recruitment interview process. People who access services participate in delivery of 'skills days' for apprentices. People who access care and support are also part of the university curriculum development process.

The workforce strategy appraisal was conducted by interviews with key officers of the council to help to understand what is working well, where there may be gaps and where we may be able to support to help influence the strategy.

Examples of outcomes and impact

We see people as individuals with unique strengths, abilities, aspirations and requirements and value people's unique backgrounds and cultures.

- Over the last 12 months the apprenticeship has contributed to a 47 per cent reduction in overall ASC social work vacancies and 54 per cent reduction in agency staff, with more social workers delivering support.
- Currently, there are ten social work apprentices with three completing in 2024 and more opportunities to train being made available in 2025. The council has plans to provide ongoing support for those who will access services in the future.

Leadership: management and workforce planning

- A very good Annual Health Check rating for continual professional development and career development ('We have competent and motivated staff').
- A former adult social care apprentice won the national newly qualified Social Worker of the Year 2024 (we offer a great programme to attract the best who in turn support residents).
- We have collaborated in developing a Level 7 apprenticeship with the local university for approval in 2025/26. (We will have high quality social workers trained and available in a shorter timeframe.)
- 'I' statement: 'I have considerate support delivered by competent people.'

Central Bedfordshire Council has had a great focus in developing the workforce offer in occupational therapy. In 2024, the Occupational Therapy (OT) team in CBC had two level 6 apprentices achieve their degree in Occupational Therapy through the University of Northampton, with one person sponsored through adult care services and the other person through children's services. Following the completion of the degree the OT team in adults have recruited one graduate into a level one post.

In September 2024, two new apprentices started their degree apprenticeship with one person within reablement, and the other person is within the core therapy team within community assessment services. Both apprentices have a dedicated OT mentor from their team to support them. It is now planned that every three years there will be an opportunity for a member of staff to apply for the OT apprenticeship as there is a dedicated apprentice post within the structure of community assessment service which minimises the impact on service delivery and the need to back fill with agency staff to address a shortfall in resource.

In addition to the development of the OT apprentice opportunities, the OT department have introduced a preceptorship for OTs which will be on a par with the Assessed and Supported Year in Employment (ASYE) programme for social workers. The introduction of the preceptorship provides guidance and support for the newly qualified therapist, ensuring standards and quality of practice are understood and achieved. The OT team currently have two newly qualified therapists working through this programme. The ability to offer preceptorship is a great advantage for the offer in CBC when it comes to recruitment, as there is a specific programme that they can refer to and be supported to improve their experience and knowledge as emerging therapists at the beginning of their career progression.

Additionally, the OT team have accredited professional educators who will support degree students on placement from Northampton University. This helps to increase awareness of opportunities for therapists within the local authority to attract newly qualified therapists. Such student opportunities allow students to appreciate and learn the impact of social care within the wider arena of health and social care, the importance and influence it has system wide in supporting people with health and social care needs and seeing the person as a whole, not just treating the medical disabilities they may have.

Finally, as part of OT career progression CBC has supported an OT from core therapy in secondment to the reablement team therapists for nine months. This will provide an opportunity for them to learn different skills but also take their experience in adaptations across to reablement and support cross learning. This will benefit both areas of therapy and will have a positive impact for people who draw on care and support services as professional relationships improve and the learning is exchanged.

What were the barriers for success?

- Funding was, and continues to be, very tight which prevents having the desired infrastructure to support more apprentices.
- Capacity to develop the apprenticeship programmes further.
- Far more demand than places for the apprenticeships.

What were the conditions for success?

- Senior management team and team manager commitment and support.
- Highly competent learning and disability team.
- Workforce strategy and planning.
- High quality and well-prepared apprentices and assessors.
- Very good collaboration with the university provider.
- Ease of movement between children and adult's social care for apprentices.

Feedback from the workforce strategy appraisal:

- Stand out is the culture – a focus on creating a great place to work for the whole workforce.
- Very strong ownership for workforce strategy across the piece and particularly with heads of service.
- Consistency of understanding and narrative.
- Richness of data – quantitative and qualitative – which is well understood and informs all that is done.
- Good recognition of the link between a happy workforce and good quality care – if we look after the workforce the workforce will look after the local population.
- Strong focus on EDI with good emerging work to ensure issue of representation at more senior levels is addressed.
- Regular and ongoing review to ensure the plan remains current and live.
- Good connections across different leads within the council to join everything up – HoS, PSW, Head of Integration, HR Business partner.
- Strong sense of staff voice – not as a one-off to develop the workforce plan but as an ongoing part of what we do.
- Some great examples of initiatives to support workforce experience and development, for example, shadowing, mentoring, apprenticeships.
- A robust, joined-up approach around quality improvement that puts the voice of people being supported at its centre.
- Consistent feedback that staff feel psychologically safe to get involved and contribute ideas.
- Positive approach of securing workforce engagement and ensuring Central Beds continues to be a great place to work, recognising that this provides the foundations to flex and change how the workforce works.
- Alignment across different strategies and recognition of workforce plan as an enabler.
- An underlying theme that 'Central Bedfordshire is a good place to work'.
- A sense of a strong and steady ship.

Recommendations from the appraisal:

- Keep doing what we are doing internally and build from it.
- Consider how we share the learning and explore opportunities for a more joined up approach with partners in the private, independent and voluntary sector and NHS.
- Work alongside commissioners to ensure we are influencing the commissioned workforce.
- Think about how we draw on learning from other places nationally about different models of care.
- Connect with other localities to explore alternative funding models for teaching partnerships.

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Leadership: management and workforce planning

Central Bedfordshire Council

The only way is up

The development of a successive planning programme pilot to support and inform adult social care's approach to identifying and growing talent to fill future leadership and service critical positions.

Data collated on the age range of staff within key positions, during workforce planning, evidenced a number of areas where vacancies are likely to arise across key roles within the next five years. If the pilot is successful, it is likely to be a key attraction element for future recruitment into adult social care.

A small pilot programme to investigate the viability of a targeted development programme that supports retention and enables succession planning for a fixed number of hard to fill roles within Central Bedfordshire Council (CBC) adult social care (ASC) (identified as part of the Local Government Association (LGA) workforce planning and subsequent workforce action plan). Results from the pilot will then be analysed to see if a wider rollout of the proposed pilot would be appropriate.

The Workforce Development Team will support the individuals and managers of those on the pilot to put together a development plan for the individuals utilising current workforce development activities, in-house and external shadowing, mentoring arrangements and a bespoke project to increase exposure to other parts of the service and enhance management skills.

What are the barriers to success?

- Any formal development activities will need to be drawn from existing workforce development resources and capacity as there is no separate/additional budget for this proposal.
- Managers need to apply appropriate, inclusive criteria consistently regarding the selection of staff deemed suitable for career progression. Criteria will be agreed with SMT/HR business partners.
- There may not be opportunities to progress at the exact time a programme has been completed, so expectations must be set early in the programme.
- Some managers may be reluctant for staff to participate as progression of a high performer to another role could be seen as a disadvantage of the programme.
- The above risks are acknowledged but need to be set against the risk of not being able to retain (and recruit) hard to fill roles in ASC in the mid to longer term.

What are the conditions for success?

- Clarity on expectations will be important so as not to demotivate staff.
- Staff not included in this initial phase could resent the fact that not all staff can be involved with this pilot programme. Managers need to effectively and sensitively communicate programme aims and objectives.
- Senior management support for the programme and recognition and celebration of success will be important to mitigate concerns of some managers.

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Milton Keynes City Council

Learning offer

Revised learning offer for staff, based on their feedback and analysis of performance.

The council's aim was to make learning accessible, interesting and inspiring for front line workers in order to improve the quality of service delivery.

The council put in place the following:

- A revised learning offer for staff based on role including a bespoke rolling programme of 12 months for Assessed and Supported Year in Education (ASYE) social workers, including peer support and workshops on equality, diversity and inclusion (EDI), strengths-based practice, professional curiosity, etc.
- Workshops which focus on practice learning and take the format of action learning sets, as opposed to 'classroom learning' settings.
- A blended approach of online and face-to-face sessions.
- A bespoke programme of guest speakers held as seminars in the council chamber including leading thinkers, for example, Professor David Orr on self-neglect, Claire Lightly discussing sex and relationships, tailored around the emergent needs of the workforce.
- Bite-sized safeguarding training series 'safeguarding unlocked' to allow access to supplementary safeguarding training and the 'Milton Keynes City Council (MKCC)' way of learning.
- A new learning directory and booking system to make it easier for workers to access learning.

For example, the council had several Mental Capacity Act (MCA) training courses which were not improving the quality or quantity of the assessments that were being undertaken. They designed a bespoke course on the practical application of the MCA 2005, undertaking an MCA, MCA report writing and consideration of executive functioning, based on MKCC anonymised case studies to bring the session to life.

The council consulted with front line staff who stated that they felt that traditional classroom learning was dated and was not assisting them with relating theory, policy and legislation to real-life practice. Hence the programme of workshops, action learning sets and seminars was developed.

In order to include the workforce in the ongoing design and delivery of sessions, the feedback form was changed to be more concerned with how they would put their learning into practice, self-evaluation of confidence and competence before and after the session cooperatively, and what needed to happen next in terms of support to assist their development further and allow for future planning of the learning offer.

What was the barrier to success?

- Time for the new approach to embed – initial teething issues with a new system which we worked through using the expertise of the business analyst.

What were the conditions for success?

- Continued engagement from the workforce in the design of future learning events, emergent based on needs and tailored to feedback.
- Training experienced social workers and practice leaders to engage with the inhouse upskilling of the workforce.
- Good communication via updates, Teams channels and the management team to support the embedment of the new learning offer.

The council has seen their compliance improve and continue too, for example from 56 per cent to 93 per cent for the multi-agency safeguarding course, between May 2024 and January 2025.

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Leadership: management and workforce planning

Milton Keynes City Council

Social work recruitment and retention

A multi-faceted approach to the recruitment and retention of the social work workforce.

In 2023, Social Work England published that there was a shortage of approximately 7000 social workers nationwide. The council was experiencing issues with recruitment and retention of social workers in keeping with the national trend.

The council put in place the following:

- A social work progression scale based on consultation with the workforce who stated that they felt experience and expertise should be recognised and valued, not just additional formal learning in order to progress.
- Recognising continual professional development (CPD) opportunities within the business to retain staff.
- Benchmarking of pay with 14 boroughs including London, in order to assess if wages were in keeping with offers elsewhere.
- Introduction of 'retention payments' for staff who were not under any formal performance monitoring.
- A new recruitment and retention strategy, including 'golden hello' payments for agency staff.
- Review of all landing pages for recruitment and advertisement of roles and inclusion of 'express an interest' quick links, testimonials from existing staff and clear outline of benefits packages.

Succession planning included:

- an increased number of apprentices – 'grow your own' model for succession planning
- increased ASYE uptake, based on value-based recruitment.

A progression scale was designed based on feedback from the workforce and an internal survey and corporate feedback was sought to ascertain job satisfaction – it was rated 7.8 out of 10 on average.

What were the barriers to success?

- The complexity of the multifaceted approach which focuses on the 'here and now' in terms of reduced agency spend, attracting and retaining experienced social workers at the same time as meeting the demands of the future workforce and succession planning.

What were the conditions for success?

- The rate of social workers leaving per annum has dropped considerably over the past three years, from 23 in 2021, 17 in 2022 and ten in 2023. Of the ten in 2023, one was the end of a fixed term contract and two were retirements, taking the figure to 7.
- We have now fully recruited to some teams which previously had experienced reduced capacity as a result of low numbers of experienced social workers.

For further information: Social Worker Recruitment and Retention Strategy

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Suffolk County Council

Caring Companies

Encouraging the provider workforce to value staff who have caring roles outside of work.

Suffolk's workforce includes over 65,000 unpaid family carers, meaning 1 in 8 staff members are supporting someone outside of work. Recruitment and retention have been historically challenging as unpaid carers try to balance their caregiving responsibilities with their job demands. This can result in a reduction in the local workforce, impact individuals' development, and lead to a decrease in valuable transferable skills and knowledge for employers.

Adult social care (ASC) have worked with Suffolk Family Carers (SFC) to develop 'Caring Companies', a joint project between ASC and SFC whereby we are engaging in and working with the care market to help them develop their policies and cultures within the workplace to support staff who have a caring role. Attendance and engagement will earn the 'bronze award' which ASC will give a badge for, and then 'silver' and 'gold' which are bespoke, paid for packages that can be bolted on for organisations that wish to work directly with SFC. We are following this up with an award at the Care Awards through talks with CDE.

How did the council work with people?

- By directly engaging with them to find out what is important to unpaid carers in the workforce.
- By understanding barriers to recruitment and retention.
- By co-producing learning and training for the care market to better support the workforce.

Outcomes:

- The project aims to improve recruitment and retention by providing employers with the skills and equipment to be flexible, compassionate and supportive of staff who have a great deal to offer their employer whilst also being family carers.

What are the barriers for success?

- A lack of understanding from employers about how to best support their staff who also have caring responsibilities outside of work.
- Engaging with the employer market and achieving buy-in.

What are the conditions for success?

- Engagement from employers/unpaid carers.
- Flexibility and willingness to learn and improve for employers.

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Essex County Council

Supporting and developing the workforce

Adult Social Care Workforce Ambassadors continue to amplify the voices of the workforce and maintain a strong relationship with the Directors of Adult Social Services – leading to outstanding results.

Hearing the voices of the workforce has always been important in Adult Social Care (ASC) and over the years they have introduced a number of forums for the workforce to collaborate and engage with leaders. Such forums have included an employee forum, Inclusion and Diversity Quests (which you can read more about in another case study), ways of working champions and wellbeing champions. Whilst the different groups were all individually successful, the council felt that there wasn't consistency in how they were supported and had access to their leaders. It was important to address this to ensure that the service fosters and maintains a sense of belonging, respect, and value for the workforce.

In the summer of 2023, the council decided to bring together the range of workforce forums to create Workforce Ambassadors. This was part of the core Workforce Strategy to drive positive change and engagement within the workforce. They wanted the workforce to bring their genuine selves to work, so that they can deliver great outcomes for the residents of Essex and enable them to live their lives to the fullest.

The Workforce Ambassadors engage with their colleagues across the function, listen and then advocate for them through a joined-up approach. They also champion and represent the employee voice within campaigns and initiatives across ASC and corporately. The Workforce Ambassadors have a senior leader sponsor and service manager lead, who provides a strategic lens, but the day-to-day organisation is completely run by them. Whilst the Workforce Ambassador group is still only 18 months in, it was felt that this will provide the council with the opportunity to grow the workforce and develop as a function supporting future needs.

Employee wellbeing is at the core of the approach.

The council is also keen to focus on the following areas of activity:

Employee voice

- Ensuring colleagues are heard and action is taken to address concerns.
- Ensuring all areas are represented.

Recruitment and retention

- How to support the retention of colleagues throughout their career lifecycle (academic support, parenting, carers, job share, mentoring).

Equality, diversity and inclusion

- How the Workforce Quests can influence corporately and externally (for example, inclusive interview panels).
- How cultural sensitivity can be incorporated into practice.

Ways of working

- Reflecting on office relocation and whether it meets the Quest ambitions (e.g. accessibility).

Confident and appreciated workforce

- Training and development for Workforce Ambassadors to support Care Quality Commission assurance.
- Celebration events.

The key to the approach has been an open and honest dialogue between the Director of Adult Social Services (DASS) and the Workforce Ambassador forum. It is a safe space for colleagues to raise concerns to the senior leadership team and to highlight the great work that colleagues do to support the residents of Essex. It is a forum that provides constructive challenge and mutual learning.

Outcomes

The council undertakes a regular 'Your Voice' survey through the corporate Human Resources (HR) function. The results for ASC in 2024 are particularly impressive:

- Nine per cent increase in response rate from 2022.
- Amongst the highest scores it was positive to see the workforce citing their 'manager trusts them' to do their job (92 per cent) and they 'feel safe' at work (92 per cent).
- The workforce have told the council they 'feel proud to work for ECC' (85 per cent), with 80 per cent saying they would recommend it to others and 87 per cent saying they are 'treated with respect' at work
- ASC reported the highest score for wellbeing overall across the organisation (+4 per cent), especially 'the workplace culture supports my wellbeing' (+ 6 per cent).
- Through the Quests the council has had a significant focus on inclusion and protective characteristics and ASC reports the highest scores for inclusion overall (+5 per cent) especially 'feeling a sense of belonging' (+9 per cent)
- The Council has made a strong push for more 'visible leadership and communication', with the DASS and Directors frequently meeting employees physically and virtually, addressing their questions. The council has the highest scores for communication overall (+10 per cent), including 'senior leaders respond to feedback' (+10 per cent).
- The global majority colleagues rated higher in most areas of the survey than ASC. Responses to note which all rated higher than ASC as a whole were:

  'I feel as if I belong to ECC' (82 per cent)

  'I can be myself at work' (86 per cent)

  'At ECC, everyone can succeed to their full potential, no matter who they are (for example, all ages, cultural backgrounds, genders, races, religions)' (78 per cent)

  'My manager values my perspective, even if it is different from their own' (90 per cent)

  Ninety-five per cent of respondents feel they can discuss their wellbeing with their manager.

These very impressive results are a testament to the hard work and focus that the Workforce Ambassadors undertake in collaboration with the senior leadership team. There is a genuine feedback loop between the workforce and the DASS that allows us to address the challenges together in an open, honest, and informed way, enabling the council to make a difference every day.

The Workforce Ambassadors were also instrumental in the preparation for CQC assurance. They contributed a lot of their time and were really engaged with the process. They were offered a lot of support from the SLT, who reminded staff of the values of why they do the work that they do. Across the whole of the service the importance of supporting residents in communities was at the heart of the message.

Workforce Ambassadors were part of engagement sessions prior to the CQC visit and took part in the official focus groups. This was where the council was able to hear the passion the workforce has for helping people. The council eagerly awaits the final report but is confident that the Workforce Ambassadors really shone throughout the process.

What were the barriers to success?

- Ensuring all voices are heard within meetings – mitigated by utilising Teams functionality to allow for interactions via chat function.
- Confidence of workforce to constructively challenge senior leaders. Frontline colleagues can be very vocal but can sometimes need encouragement to challenge leaders in a constructive way.

What were the conditions for success?

- Openness and honesty and having a safe space to raise concerns.
- DASS trusting the group to engage with meaningful conversations relating to sensitive issues.
- SLT taking action to address concerns but also being honest when elements might not be within their gift to resolve.

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Leadership: culture

Essex County Council

Inclusion and diversity quests

Quests encourage the workforce to explore diversity and inclusion challenges and opportunities within the service to lead to positive change – led by employees and supported by leaders.

The Inclusion and Diversity Quests were born from the inequalities being demonstrated across the world, particularly in response to George Floyd and the Black Lives Matters movement. The council knew that, as a service, they could do something to better recognise and address inequalities for the workforce.

The Quests emerged from discussions with ethnically diverse colleagues following the murder of George Floyd in the US in 2020. His death had a profound impact globally, prompting ethnically diverse individuals to share their lived experiences. In ASC, the importance of these conversations were acknowledged and provided opportunities for colleagues to discuss their experiences as people of colour. These discussions were eye-opening and a call to action, revealing that discriminatory behaviours remained not only in society but also within Essex County Council (ECC) and Adult Social Care (ASC). Now the council had heard those stories, they couldn't simply do nothing. As a result, the Quests were born.

Since 2021, the council has conducted five Quests focusing on the protected characteristics of race, disability, LGBTQIA+, age, and most recently, neurodiversity. For each Quest, ten volunteers from any team across the service are invited, who are released from their usual duties for five to six weeks. These volunteers, known as Questers, dedicate this time to investigating and researching issues important to them and their ASC colleagues.

At the conclusion of each Quest, the Questers present their findings and recommendations to the Adult Leadership Team and Corporate Leadership Team. They are then supported in implementing their recommendations across the service and join the ASC Workforce Ambassador network.

The Questers engaged with the workforce through surveys, interviews and presentations at events to gather their perspectives on the specific protected characteristic being explored. This data, combined with independent research and the Questers' own lived experiences, shape the findings and final improvement recommendations for the service.

Each Quest highlighted unique thematic areas for improvement for each protected characteristic. For example, the Disability Questers focused on access to Work, while the Age Questers concentrated on the impact of menopause. There were also clear areas of intersectionality across all Quests, with similarities in both challenges and potential solutions.

What difference are the Questers making?

The Questers have made a significant difference to the workforce and service overall and continue to do so. Some of the activities that they have supported/led include:

- regularly presenting and attending events to raise awareness of protected characteristics and Quest findings/recommendations
- collaborating with local partners at events (including Pride events)
- working with internal employee networks
- delivering training, aimed at educating people and sharing lived experiences at large scale Leadership and Learning events for example.

Notable outputs also include updates to the council's case recording system to be more inclusive and the development of the service EDI policy statement. Questers are now part of the Workforce Ambassadors, continuing to drive positive changes and engagement.

Questers recommendations also continue to inform corporate strategies and policies which has positively impacted the wider organisation.

What were the key barriers to success?

- Tackling unconscious bias across the service.
- Accessibility – technology can often be a barrier for Questers with physical and sensory needs, as well as the wider workforce.
- Governance/structure – early Questers found it difficult to navigate governance across such a large service.
- Workforce communications – not all of the workforce were aware of the Quest work and what it aimed to do. This has improved as the Quest work has developed.
- Time – 5–6 weeks is a short amount of time to conduct a deep dive into the impact of a protected characteristic.

What were the conditions for success?

- A committed leadership team – to guide and support the Questers.
- A committed and enthusiastic group of Questers who are passionate about making change.
- Dedicated administration support.
- Regular communications and updates about Quest progress and events, etc.
- Working and collaborating with employee networks and other services across ECC, for example Children and Families Service.
- Taking an intersectional approach through the development of a Quest Network (which all Questers are a part of).

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Leadership: culture

Norfolk County Council

ShinyMind for all

Introducing the ShinyMind App to support the Norfolk care workforce.

As outlined in the National Adult Social Care Workforce Strategy, the wellbeing of social care workers is crucial to reduce stress, burnout and improve care quality. Poor wellbeing leads to higher vacancies, lower care quality and increased sickness absence (8.1 million days lost in 2022–23), and impacts on the NHS.

The council wanted to equip and empower the workforce with tools to help them improve their own wellbeing and resilience. This is part of a wider programme that includes signposting providers to health checks and helplines, leadership development and interactive sessions on wellbeing.

However, it was recognised that there was a gap in the provision of something in the digital space that was available 24/7. In recognition of the app's availability to the NHS, investment was made for a one-year pilot of free licenses to access the ShinyMind app to the adult social care workforce in Norfolk and Waveney.

The app, underpinned by science and research, offers users interactive exercises, advice and resources that improve wellbeing and resilience, and includes topics like stress management, coping with anxiety, assertiveness, menopause and confidence building.

Over 50 organisations have been reached with 350 participants to date with another month to go.

The next steps are to recommission for a further year, increase awareness and expand the take up of the app, sharing understanding of the benefits and to co-produce a bespoke adult social care version of the app going forward, and enable greater impact measurement.

How did the council work with people?

- We discussed the offer with Norfolk Care Association and Norfolk and Suffolk Care Support to understand potential need for the app.

Feedback from an employee of a home support provider:

'I have worked in health and social care for over 15 years and believe this area of work truly shapes you as a person. Both the good and bad days builds our resilience but can be extremely stressful at times.

Thankfully, the conversations around mental health and support is far greater than ever before. I previously worked for a care agency in Norfolk who used ShinyMind to support domiciliary care workers in their daily role. I line managed a small team and was the mental health first aider for staff. Having tools such as ShinyMind is a great help for everyone who may need additional support or who wants to learn new techniques to self-manage their mental health alongside any medical support they may have needed.

I also used the app myself to learn better ways of managing my own anxieties and worries. It gave me a much greater insight into my triggers and how to recognise these. Being able to access this support in my own home and at my own pace was extremely helpful to me and I am so pleased that this is available for those who may need it.

Thank you ShinyMind for creating this support for those who need it.'

What were the barriers to success?

- Communication – reaching the workforce, keeping the offer present.
- Digital skills.

What was the condition for success?

- Provider/manager awareness and buy in to help to promote to staff.

For further information: Free ShinyMind sign up

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Cambridgeshire County Council

Palliative/end-of-life care training

Cambrideshire and Peterborough is empowering professionals to facilitate meaningful and supportive conversations to support people at the end of their life.

A learning gap was identified amongst social care professionals who are often a main point of contact for people with caring responsibilities, yet these professionals find it difficult to relate to people with caring responsibilities for someone living with a life-limiting illness or who is end of life. The initiative focused on producing content in the form of training sessions, literature, videos and podcasts. The goal was to empower professionals in facilitating meaningful and supportive conversations to be able to more effectively support people with caring responsibilities for someone with a life-limiting illness or who is end of life. This is a particularly sensitive and potentially difficult role for professionals for whom this is not their core business.

The proposal sought to ensure practitioners gain relevant experience so that they can demonstrate an understanding of the values, attitudes and behaviours essential to be conscientious and confident in good communication skills and the ability to interact with people with caring responsibilities supporting people with a life limiting condition. Additionally, it is hoped that once developed, the resources can be seamlessly integrated into council induction programmes for new recruits and as refresher training sessions.

Providing comprehensive support and resources for people with caring responsibilities is one of the priority objectives in the system-wide all-age Palliative and End of Life Care strategy. The partners of this initiative are all members of the Programme Board overseeing implementation of this strategy. The training programme is a key contribution to achieving both this objective and Cambridgeshire County Council's All-Age Carer Strategy.

Cambridgeshire County Council and Arthur Rank Hospice Charity have an established constructive relationship. The Local Authority has seconded an experienced social worker to be part of Arthur Rank Hospice Charity's Patient and Family Support Team, providing palliative care social work services for patients and those who love and care for them and to the wider teams within the hospice.

Having identified the need and secured funding through the Accelerating Reform Fund, colleagues from the Hospice Charity and the Local Authority collaborated to develop and then deliver the training programme.

The training was designed using the core competences for end-of-life care as a starting point. These competences recognise that the delivery of end-of-life care services to people with caring responsibilities requires nothing less than a cultural shift in attitude and behaviour within the health and social care workforce. These describe the ideal qualities needed for any role supporting unpaid carers such as excellent communication skills, being able to recognise people's needs and deal with emotional circumstances.

The council drew on the feedback that both organisations continually seek from people accessing services, including the experiences of the colleagues leading the programme who themselves have experience of caring responsibilities. Feedback from carers from various forums were captured to understand what people accessing their services say is important to them. Feedback via the hospice from carer conversations using the Carer Support Needs Assessment Tool Intervention (CSNAT-I) enabled carers to tell us what the important aspects of support were for them when caring for someone with a palliative illness.

The key outputs of this project revolve around the effective engagement and empowerment of the Carer Working Groups, ensuring that the training translates into tangible outcomes and benefits. The success will be gauged through various channels, with a primary focus on the feedback and insights gathered from these groups. The council recognise the sensitive nature of the work and therefore prioritise surveys to understand the nuanced impact of initiatives.

The success metrics include the demonstrable improvement in the skills and confidence levels of practitioners, evidenced by their active participation and contributions. Additionally, the council aims to measure the broader impact on the community through qualitative and quantitative assessments.

At this stage it is too early to be able to demonstrate impacts for people with caring responsibilities or the people they are supporting. The council are working on how they can effectively measure the impact of the training for the people social care professionals are supporting.

The council has identified the following TLAP statements as most relevant to the project:

- I have people in my life who care about me – family, friends and people in my community.
- I have people who support me, such as family, friends and people in my community.
- I have care and support that is co-ordinated, and everyone works well together and with me.
- If I move from my home to another place, the people who are important to me are respected, listened to, supported and involved in decisions.
- I am supported by people who listen carefully, so they know what matters to me and how to support me to live the life I want.

To date, the council has had 85 colleagues, primarily from Cambridgeshire County Council and Peterborough City Council, and a smaller number from the NHS and voluntary sector within the locality have attended the training. Two further programmes are scheduled by which time they anticipate 60 colleagues from across the system will have benefited from the training.

The feedback from colleagues has been universally positive, with colleagues indicating that following the training they are more confident having conversations about death and dying and better informed about local services they can signpost people with caring responsibilities to. The council believes this will be of great benefit to people with caring responsibilities and those they are supporting.

What difference did the council's actions make for people accessing care and support and service delivery?

Through working collaboratively with Arthur Rank Hospice Charity and other system partners (Peterborough City Council, the voluntary sector and Integrated Care System) the council is improving the skills and confidence of its own social care workforce, thereby improving support for people with caring responsibilities and those they are caring for.

The partnership has demonstrated the positive outcomes that can be achieved when system partners collaborate and bring their key strengths and skills to the partnership, for example, Arthur Rank Hospice Charity's specialist skills and knowledge in palliative and end-of-life care and the council's reach and support for its social care workforce.

The council is recording the training programme and plan to offer this to other Local Authorities and Integrated Care Systems on a commercial basis. Any funds realised will be shared between the Local Authority and Arthur Rank Hospice Charity to benefit local people.

What were the barriers for success?

- Traditionally, end-of-life care has been viewed as a specialist area of work, beyond the scope of most core workers. However, it can incorporate all elements of the daily lives of those people nearing the end of their lives and those with caring responsibilities. The biggest challenge identified in the initiation part of the project was concern about practitioners' ability to attend face-to-face training. The council is pleased to report that due to the support of all partners, colleagues have been released to attend and have valued highly the face-to-face aspect of the training. Early engagement with stakeholders in the programme inception with regular updates and inclusion throughout the process has mitigated this concern.
- Capacity within the teams to design and deliver the programme.

What were the conditions for success?

- A strong, effective partnership between Cambridgeshire County Council and Arthur Rank Hospice Charity.
- Ensuring engagement with teams through senior management and ensuring appropriate time is allocated, enabling practitioners to attend face-to-face training sessions which are at suitable locations or aligned to work placements.
- Skill and knowledge of the trainers.
- Clarity of purpose.
- Support from leadership within the partner organisations.
- Funding!
- Capacity within teams to design and deliver the programme. We conducted a thorough resource assessment and planning phase to identify potential gaps early. Contingency plans articulated in the eventuality of resource restrictions at the time of training delivery.
- Excellent training facilities available at Arthur Rank Hospice Charity.
- Capable and willing volunteers to support with filming.

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Thurrock Borough Council

The potential of Human Learning Systems to transform commissioning

Using the learning to adapt, respond and change to increased complexity.

The council could not continue to do the same thing and expect different results. How the council operates and the needs and wants of people who use services are not the same as when they first started commissioning home care decades ago. There is still largely a traditional time and task approach to home care within Thurrock and this does not match the council's operating model or the aspirations of people who draw on services.

Thurrock was an early adopter of strengths and asset-based working. As a wider health and social care partnership the council later adopted Human Learning Systems (HLS). The HLS approach to public management continuously explores the messy reality of how the outcomes that matter to each person might be achieved in their unique life context. The job of public management (of organising this work) is to create the conditions whereby public service makes this possible in the most efficient and effective way. Although these approaches have led to greater integration between ASC, health and housing and VCS and less bureaucracy for people needing support, it has not been adopted as widely in the external market and embedded fully in commissioning/contracting functions.

In addition to this the council is facing several immediate and mid-term issues and there are some things that simply aren't working. They have high levels of reported loneliness, a fragile market, a growing issue with attracting and retaining people to work in care (one third due to retire in the next 10 years) and one of the highest rates of zero hour contracts in the region. Commissioning had contributed to these issues. Mid-term the council was also concerned about the impact on service demands of people ageing without children.

Like many places in the UK, Thurrock has experienced changes in and presenting need. Thurrock has seen a significant increase in the amount of domiciliary care commissioned and it is very likely with demographic growth (45 per cent predicted increase in the 80+ population who are the main users of home care) that this will continue. A decade ago, the council commissioned or provided around 5000 hours of home care per week, this is now 9000.

Although demographic changes are one factor, most of this increase in home care occurred with the change in hospital discharge criterion from medically fit to medically optimised. The 80 per cent increase in home care hours detailed above has largely occurred since this change was implemented in 2020 as part of the response to the pandemic. This alteration to criterion has created a change in both the complexity of those requiring services and the level of care that needs to be delivered to support people effectively and safely, i.e. people are coming out of hospital earlier and with more complex care needs requiring larger packages of support.

From a person who accesses care and support perspective, feedback shows that consistency of staff and timely visits are commonly the most important elements of a service to the client. However, retention of staff remains a fundamental challenge in Thurrock. Care work is often viewed as low status and attracts low pay. This, coupled with the extremely competitive labour market locally (both in care and the wider economy), makes it difficult to achieve continuity of care for clients – this will only ever be achieved with a valued and retained workforce. The council's number one risk to sustainability and the delivery of care in Thurrock is the ability to attract and retain a social care workforce both now and in the future.

The council needed to do something different if they were ever going to get different results, so decided to apply an HLS approach to the commissioning and future delivery of home care. They took the decision to apply an HLS approach to the commissioning of home care. When taking such an approach to commissioning it is advised that barriers to change are likely in areas where there are 'significant and restrictive external reporting and compliance requirements'. Home care must be one of the most regulated areas of activity in care! Although this may not appear to be the smartest idea, the council felt it was still the area they had the most to gain. As such, they decided to accept the limitations, but also direct energy to those areas where there is room to manoeuvre.

The council knows that 'place' is the future organising principle for the entire health and social care system in Thurrock and that integration and alignment of services provide better outcomes for people. In terms of home care, this means that care is organised and delivered within four localities. These localities reflect where the Primary Care Networks (PCNs) and social work teams already operate. The Integrated Locality Teams (ILTs) approach in Thurrock had already evidenced that co-operation in an area leads to less fragmentation, complexity and duplication of effort. The council wanted to commission with the external market in such a way to create this same co-operation, i.e. move away from competition.

It was agreed that the council would move from providers to partners. This is not just a change in language, but a change in behaviour (trust) and relationship. They wanted organisations who can work alongside the council and people who draw on services as an equal partner. There was an expectation that they would 'test and learn' and adapt to changing needs and aspirations. They wanted partners to be fully embedded into the ILTs and have a 'seat at the table' with an equal influence when discussing an individual or how the system operates. They wanted partners who would add to the communities they serve, not just use the assets already available. They wanted partners to be innovative and put forward ideas. They wanted partners who are willing to test new approaches and develop their role to both identify gaps in community resources and help stimulate solutions.

Using these aspirations as the basis for decision making, the first thing the council reviewed was the contract length. Recurrent tenders are time consuming, costly and do not foster joint working between providers but instead put them in competition with each other. As Thurrock declares the rate for care, this frequent procurement activity adds little benefit or value for money for either the authority or the user of commissioned services.

Leadership: whole systems transformation and innovation

It was agreed that if the council was to enable all partners to build strong relationships and to give greater assurance, allowing providers in turn to give more security and to invest in those they employ, the contract should be for a period of 10 years, i.e. the over reliance on zero hours employment contracts will not be addressed by the council continuing to issue short-term contracts.

The council has removed all competition between providers by organising care on a locality basis and declaring the price. Doing this, they have seen the benefits of collaboration in place based integrated working (ILTs) and wanted to ensure home care becomes part of this ethos. As they declared the price, the tender evaluation was able to focus on 100 per cent quality.

In addition, the council has tried to commission for learning. Utilising an HLS approach, the council is moving away from fixed ideas (the static 'specifying') on how they support people and has instead accepted that the model of care will continuously adapt and change over time in response to need. The council will experiment with partners and those that use services to shape support and care to better meet outcomes, although they accept that not all experiments will be successful. However, they will use this learning and if something doesn't work or stops meeting need, they will change it. In essence, the council has commissioned for learning. As such, the specification has been designed to evolve and change over time.

Although the council may not know where this approach will lead them, they do know that people who use home care want a service that is flexible, treats them as a whole person, is based on long-term relationships and is joined up, minimising the number of people coming into their home.

By always keeping what people who use services want as the main driver, they have shaped a number of experiments in different localities which are all in various degrees of implementation. In one locality they are currently focusing on trusted assessor (equipment and care assessments). In another, the council is just scoping blended roles (to minimise the number of people coming in). All four localities will be responding to the growing issue of loneliness and social isolation (nearly two thirds of existing home care clients report being lonely and only 10 per cent of clients can access their community). The council has introduced payments for up to seven days for people admitted to hospital (after negative feedback from providers pre-tender about the council's commissioning practice) but this funding/hours is being redirected to those service users who are chronically lonely. Each partner can decide how to address loneliness and shape the response to their locality, but it is an opportunity for the council to start introducing a wellbeing component to externally commissioned home care service.

Over time, as providers move to the role of partner, the commissioning approach will also adapt to reflect this. The possibility of moving the commissioning of services from an hourly basis to a more flexible payment arrangement will be explored, allowing the provider to operate as a trusted assessor, staffing with some security and having inherent flexibility to adapt and deliver care to people whose needs may fluctuate/change over time, for example, reductions as people re-able/recover and increases in response to an episode of illness.

How did the council work with people?

- Before considering any changes/re-tendering, the council went out and met with providers and had an informal chat about what was working well, what needed improvement, etc., and discussed some initial ideas. They then returned for a follow up chat and to explore more firmer thinking. At this point, they asked their view on what the council was planning (i.e. is anything we are suggesting unworkable/just plain stupid!?).
- Running alongside the provider engagement were various co-production activities with people who draw on services and/or their carers. The council carried out a survey of home care users which also sought volunteers for a focus group.
- The User Led Organisation (ULO) then undertook focus groups on the council's behalf (independent of the council and providers)
- The council also utilised every contact they had with people who use home care over a six-month period. Social worker and support planners were asked to have a conversation covering the following three areas of interest but in a conversational way: 'What is working well?' 'What isn't working well?' and 'What would you like in the future?' as part of any review of support. This was replicated by contract officers who undertake monitoring visits to client's homes. Based on this the council developed the approaches detailed in the previous section.
- The council gave much more weighting to the experience of people who use services in this tender and 15 per cent of this weighting was given to a presentation/questions component – the marking of this component was led by a user of services. Twenty per cent weighting was given to randomised visits (i.e. the council picked who they visited) to clients of potential partners to ensure that what was included in the written submission matched the reality of service delivery. In total they gave 35 per cent of the total mark to these activities.

Outcomes

The council is at the start of their journey so only time will tell, but their success criteria is that people who use home care report that their aspiration (in wanting 'a service that is flexible, treats them as a whole person, is based on long-term relationships and is joined up, minimising the number of people coming into their home' has been achieved.

- The council has made a difference to people's feelings of loneliness and isolation and has enabled people to access their community and create and build relationships with people other than paid staff.
- Clients have a consistent worker (long-term relationship), with improvements in security of employment hopefully becoming a benefit for the client and the member of staff.
- They have a flexible service (again, this may have a benefit for partners in that the council's payment arrangements will need to move away from 'time and task' if they are to achieve this).

- The person using the service can have both their low level health needs met by someone they trust (blended roles – thereby minimising the number of people coming into their home) and service is more joined up, for example, trusted assessor for equipment, AT, etc., ending the back and forth to different departments and time delays for low level and preventative interventions.

This process has already developed a plurality in partners, with different sizes (small and medium sized enterprises and partners with a local and a regional presence) and structures (profit and not for profit).

What are the key barriers to success?

- **Understanding:** Although as a council they tried to articulate the vision and approach in person and in writing, there were some providers who could not grasp what the change to partner would entail. Even though there is significant challenge from representative bodies about a time and task approach to home care and emerging good practice elsewhere in the country, some providers could not themselves envisage an alternative reality/flexibility.
- **Funding:** In the current climate it is always difficult to secure more funding. Most experiments/test and learn require some sort of seed funding. As such, the council has had to be creative in securing funding to progress some of these ideas. Where there is potential benefit to the wider system, other partners have supported social care to test improvements.

What are the conditions for success?

- **Groundwork:** Had the council turned up 'cold' with a desire to change established ways of commissioning and delivery of services we would not have been successful. As stated at the beginning of this case study, Thurrock has been on a journey for over a decade to reach the point where HLS could be adopted as the operating model. When this was presented for decision, elected members understood the context of this change (front line services/social work teams had already embedded this change in approach, and commissioning and contracting were simply the next step in that evolution).
- **Trust:** Both internally with senior management and elected members being prepared to move away (albeit incrementally to reduce risk) over time from the traditional (but known) time and task approach but also externally between the council (and health, housing and VCSE who form part of the ILTs) and partners as we move to an equal relationship.
- **Early involvement:** Involving functions early and explaining the reasons for the change, i.e. why it is necessary, as well as good legal and procurement advice is essential. Procurement were keen to help and supported the council to overcome any barriers from the beginning. Because of the evolving nature of the specification, the council did have to access specific external legal advice to minimise any risk of challenge in the future. This gave senior management and elected members the confidence to support the change.

- **Recognising areas where there is 'room to manoeuvre':** As a heavily regulated area, the council identified those parts of home care that would be difficult to change, accepted limitations and instead focused activity and energy on those areas where there is flexibility.
- **Time:**
  - **Thinking time and peer challenge:** It is difficult within a local authority setting to find the space (intellectually and sometimes just in your diary!) to consider what could and should be done differently. Having the space to come up with new ideas and an environment where they can be shared and challenged (i.e. 'Is this a great idea or a really stupid one?') is always a worthwhile question! It is essential if you are ever going to 'fix' what you know is 'broken'. When sharing ideas, different viewpoints must be considered – providers operate services and are a mine of useful information that can shape your solutions, for example, as part of the early engagement, providers identified that there had been a change in how long people require care for (historically most people had home care for five years, yet currently two thirds of people no longer receive care by the end of year 2). This information changes how you organise care and the skills needed by those supporting clients.
  - **Time to implement:** Change doesn't have to be reckless, ill-conceived or not thought through. The council knows that in care risk increases when change occurs, and as such they have given themselves a 10-year period to change the service incrementally in response to learning.

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Leadership: whole systems transformation and innovation

Thurrock Borough Council

Place-based working

Place-based working across health and social care and Integrated Locality Teams.

People have different strengths and skills and face unique challenges that they respond to in a myriad of ways. For example, challenges such as obesity, diabetes, mental ill health or homelessness are impacted by a tangled web of interdependent factors and causes.

The systems in place to respond are complicated and not designed to deliver the outcomes people want. The interventions are often delivered in silo and traditionally apply a 'one size fits all' response to the immediate 'problem', often reacting at crisis point.

The system is typically fragmented into thousands of different services that operate independently of each other and inhibit the ability to co-ordinate and develop solutions that respond to the complexity and variety of the individual. Prevention is often separated from treatment: we wait for people to be 'sick' enough or 'needy' enough. Most services are set up to wait until a resident deteriorates to a point where they meet the threshold for intervention. The system is largely reactive, which has the effect of exacerbating, rather than reducing demand.

Consequently, a significant part of the demand is placed on the most expensive parts of the system. The historical approach has failed, and a new approach is a must.

The Human Learning Systems approach, an alternative paradigm for Public Management, was adopted and underpins Better Care Together Thurrock's Integrated Care Strategy (Better Care Together Thurrock is a health and care partnership consisting of NHS, local authority and third sector partners).

Recognising the range of people and organisations involved in creating desired outcomes for residents is usually beyond the management control of a single person, service or organisation, and the plan was to transform the current system architecture to develop Integrated Locality Teams (ILTs).

Expanding on work the council had already undertaken and tested, they applied their learning to developing an integrated and co-ordinated health and care model that wrapped around each Primary Care Network – which in doing so complimented the Fuller Stocktake report for next steps for integrating Primary Care.

Better Care Together Thurrock's Integrated Care Strategy: the Case for Further Change sets out a collective plan to transform, improve and integrate health, care and third sector services aimed at the borough's adults and older people to improve their health and wellbeing. The strategy was developed and agreed by the Thurrock Integrated Care Alliance (TICA).

Partners across Thurrock have a long history of working together to agree and deliver shared outcomes. The approach taken had been inclusive, bringing together commissioners, providers and colleagues from Thurrock Council, the NHS, third/voluntary sector, Healthwatch and Thurrock Coalition. It also reflected on-going comprehensive engagement with residents including co-design and co-production approaches.

The vision and proposals set out are ambitious and comprehensive and describe a fundamental shift in the way we have traditionally delivered health and wellbeing services from one that is siloed and top down, to one which is resident centred and integrated.

TICA is the highest strategic level responsible for health, care, housing and third sector service strategic transformation across the borough including developing and overseeing the deployment of the Better Care Fund.

A robust governance and delivery structure supports the ambitious vison and proposals set within the Better Care Together Thurrock Strategy to be realised.

In April 2023, the Better Care Together Thurrock Executive Board, consisting of key representatives from all partners, set out the action plan objective to create a new integrated locality network of professionals for each of the four Thurrock localities, aligned around each PCN based on three underpinning pillars of 'Place as an organising principle' 'Adopting a new workforce culture' and 'Bespoke coordinated care' (Phase 1).

A joint transformation project plan was created and delivered via the Integrated Locality Working Delivery Board.

Representatives from all partners participated in networking, staff engagement and ILT launch events, bringing together as many people linked into the relevant locality and encouraging them to not only participate, but influence and be part of the journey in shaping phase 1 of the ILTs.

A collaborative approach, drawing on existing relationships with community members, was utilised to ensure their voice was (and continues to be) heard and recognising this is key to leading meaningful and relevant changes for each of the communities.

The initial aim was to create a single Integrated Locality Network of professionals who would be empowered to collaborate effectively with each other to design integrated solutions with residents without the need for onward referrals. The concept of ILTs emerged, focusing on collaboration among professionals to create bespoke and tailored solutions for residents. There was a need for a 'one team, one place' approach to health and care support that leveraged the power of people by promoting community engagement, community empowerment and community solutions.

A 'think big, start small' approach supported the development of Thurrock's ILTs. Starting with one area, a test and learn pilot was initiated. An intensive programme of staff engagement set the scene and provided the platform for growth from the 'bottom up'.

Staff built healthy relationships with each other and residents. This negated the need for referrals and allowed residents with complex and overlapping problems to have bespoke and integrated solutions, thereby reducing, preventing and delaying the need for care and support.

Leadership: whole systems transformation and innovation

The ILT grew organically and quickly, with members identifying others that needed to be part of the group. Better practice, better outcomes and happier staff was observed. ILT members were able to discuss cases with one another more freely, provide support for each other to navigate systems and support each other with joint visits to enable quicker access to wider integrated support options – reducing the need for residents to retell their story.

Each ILT has a Microsoft Teams page with the contact details of every professional aligned to that team. Where a team member has concerns about an individual, they can easily approach others and convene a multi-disciplinary meeting to discuss and identify solutions.

Staff have fed back significant benefits, with staff feeling liberated to 'do the right thing' and empowered to 'flex' criteria and thresholds to achieve better outcomes for residents.

Examples of improved opportunities for residents

- Libraries visiting sheltered housing complexes to explain borrow box services and free delivery for those unable to visit libraries.
- DWP service supporting substance misuse recovery and getting back into employment.
- Sheltered housing offers GPs new IT systems to display health advice and hold drop-ins.
- 'Reach Out for Mental Health' now has a stand with contact details in every HUB.
- Housing is collaborating with a virtual school to support a family with a 13-year-old excluded from school and reports of ASB.
- A hospital patient facing eviction being supported by the housing team and all members of the ILT.

Ongoing work with library staff to understand mental health pathways, avoid escalation and provide Mental Health First Aid training.

The council has learned that while the delivery of a 'bespoke' solution(s) may be considered a more expensive approach, it can provide a more cost-effective interaction and intervention by providing the right response first time, which in turn limits failure demand and the revolving door experiences reported by residents and staff. The approach helps to shift solutions from crisis to prevention, identifying chances to act at the earliest opportunity.

The council has also discovered that what residents need to achieve their outcomes is often much less expensive than delivering multiple 'one size fits all' functional interventions, such as onward referrals, repeated conversations and repeated assessments by multiple system actors (staff).

Benefits to residents and the community where they live:

- **Residents can achieve more of what matters to them:** They have easy access to a huge range of teams and service that now have healthy relationships and can co-work in unison.
- **Support is provided in collaboration with the community and focuses first and foremost on what the community can offer:** Community strengths built upon, gaps in service highlighted via ILT and supported via aligned commissioners.

- **Residents maximise opportunities to stay as healthy as possible and require fewer interventions from services:** Local place-based services, easily accessible to residents, held within their own community, bringing the service to place.
- **Residents can find the right solution for them first time and in the right place:** Reduced duplication and need for residents to retell their story to numerous professionals who are working in silo. Principles of 'one team, one response' and 'right person, right time'.

Benefits for the system:

- **The alliance and system resources achieve better outcomes through earlier intervention and preventative, integrated solutions are explored that reduce 'failure demand':** Reaching residents faster at the first sign of need and ensuring residents have access to the correct support before reaching crisis and the need for services/intervention.
- **Reduced bureaucracy and failure demand:** 'Right person, right time', so no onward referral required or limited due to joint visits and co-working.
- **Integrated and personalised solutions rather than service-based solutions:** Professionals thinking 'outside of the box' empowered and trusted to work differently.
- **Reduced spend per solution:** Encompassing and building on community strength and local resources.

Feedback from staff has been overwhelmingly positive, reporting vastly improved relationships, new human connections and smoother operations to support what matters to residents.

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 unlocking barriers and challenges.
- Communities and frontline staff to lead on change (grass roots up approach), with organic growth.
- Human Learning System approach where staff are empowered, and supported, to learn.
- Adult Social Care CLS teams based in each primary care network, with a merged multi-skilled 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.

Leadership: whole systems transformation and innovation

- Integrated locality teams (ILT) aligned to PCNs with teams consisting of members from primary health, adult social care, children's services, housing and a wide range of teams, services and link workers from the third sector.
- 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.
- Co-location sites based in communities for staff across a multitude of teams and services to work in unison.
- Alignment of acute sector with the ILT teams to ensure care co-ordination 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.
- New homecare model focused on the principle of commissioning of learning.

For more information:

BCTT Strategy: The Case for Further Change (2022–2026)
Essex frontline service database
Healthwatch
Carers Service
Thurrock CVS
Thurrock coalition

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