Department of Health & Social Care

CARE

Priorities for accelerating reform in adult social care in England

Adult Social Care Innovation and Improvement Unit

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Contents

Foreword

Together we are transforming adult social care in England.

Our 10-year vision set out in People at the Heart of Care, published in 2021,[1] focuses on 3 objectives for people who draw on formal care and support, their families, unpaid carers and the social care workforce:

1. People have choice, control and support to live independent lives.
2. People can access outstanding quality and tailored care and support.
3. People find adult social care fair and accessible.

In April 2023, as part of Next Steps to put People at the Heart of Care, we announced we were establishing an innovation and improvement unit to develop and define clear priorities for innovation and improvement across adult social care.[2] As part of the unit, the government is setting out a list of priorities for innovation and scaling in care and support, including identifying, recognising and supporting unpaid carers. This document sets out these priorities.

Each priority sets out an example of a model or approach which local authorities could adopt, accompanied by a case study example. References to specific products or organisations are for illustrative purposes only and local authorities remain responsible for making decisions based on relevant statutory duties and legal requirements.

While this list has been developed in consultation with the sector, we recognise there will be a significant amount of activity taking place which is not reflected. As this work develops, we would encourage you to get in touch and share other approaches or ideas which can support us to build the evidence base for positive change within adult social care and understand the best way in which we can provide support to implement, embed and scale innovation. In the future, this list will continue to develop and evolve with input from the wider sector.

In taking forward any of these priorities, we strongly encourage local authorities to work with each other and consider how to work collaboratively with their local integrated care system (ICS), the NHS, care providers, and voluntary and community groups. In addition, development of projects within these priorities should consider co-production with people drawing on care as well as with unpaid carers – ensuring they are inclusive of the diverse needs of your local populations.

If you have any questions on any of the above or would like to share an example of innovative work taking place in your local area, get in touch with us at ascinnovationimprovementunit@dhsc.gov.uk.

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1 People at the Heart of Care: adult social care reform white paper, https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper, 2021

2 Adult social care system reform: next steps to put People at the Heart of Care, https://www.gov.uk/government/publications/adult-social-care-system-reform-next-steps-to-put-people-at-the-heart-of-care, 2023

Each of these priorities can benefit people across adult social care. To indicate where priorities might target specific groups, we have included a key on each page:


People drawing on care and support


Unpaid carers


Social care workforce

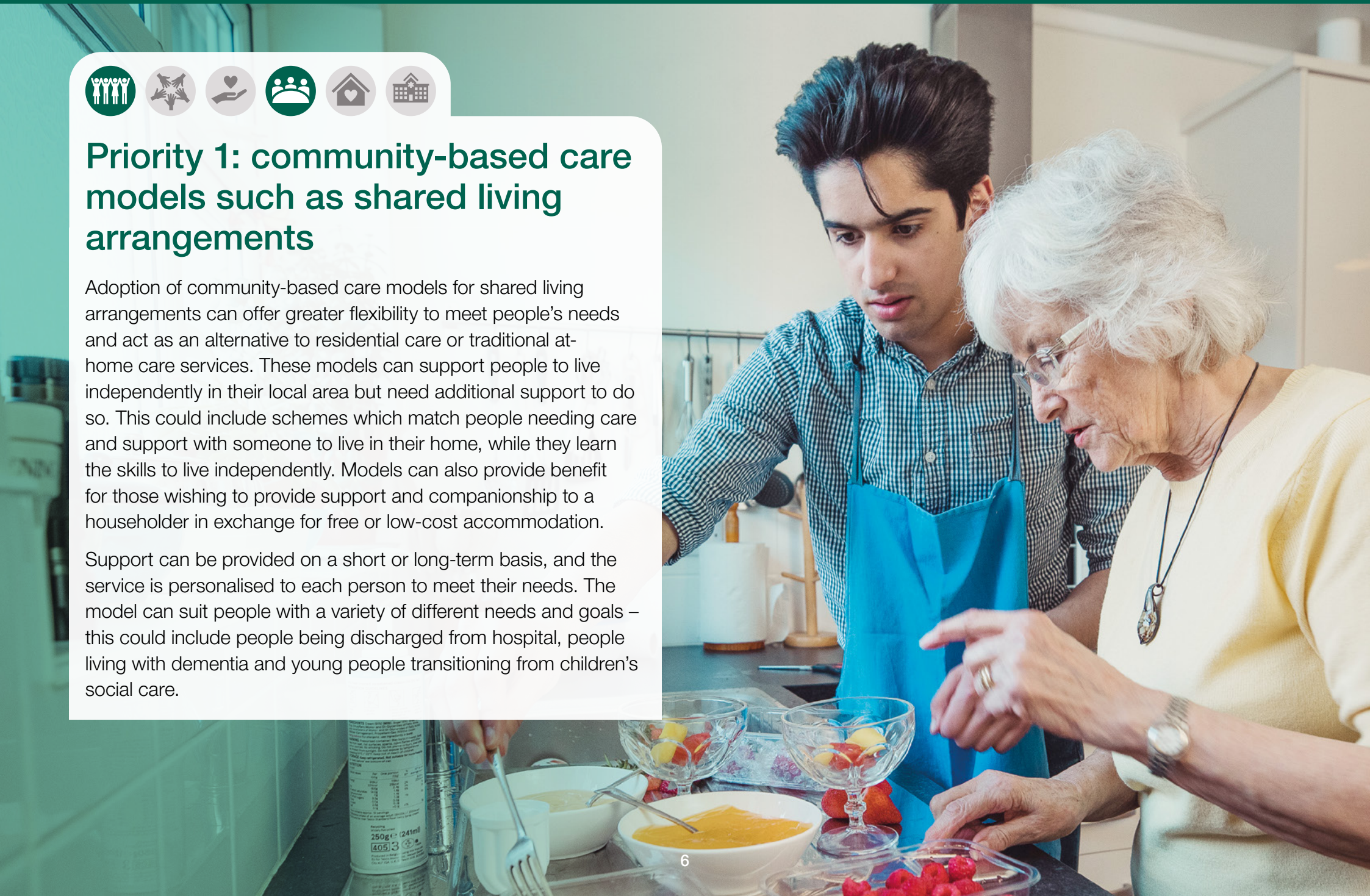

Local authorities and commissioners


Care providers and voluntary organisations


Integrated care systems and health partners

Objective 1: people have choice, control and support to live independent lives

We want people who draw on care and support and unpaid carers to have real choice and control over the things that matter to them, enabling them to live healthier, happier and more fulfilling lives. This means making sure that people can access a range of personalised support that reflects their own choices and circumstances – including finding new approaches to improve on the ways we have traditionally delivered care and support. This includes ensuring that unpaid carers have access to appropriate support that suits their needs, such as carer breaks.



Priority 1: community-based care models such as shared living arrangements

Adoption of community-based care models for shared living arrangements can offer greater flexibility to meet people's needs and act as an alternative to residential care or traditional at-home care services. These models can support people to live independently in their local area but need additional support to do so. This could include schemes which match people needing care and support with someone to live in their home, while they learn the skills to live independently. Models can also provide benefit for those wishing to provide support and companionship to a householder in exchange for free or low-cost accommodation.

Support can be provided on a short or long-term basis, and the service is personalised to each person to meet their needs. The model can suit people with a variety of different needs and goals – this could include people being discharged from hospital, people living with dementia and young people transitioning from children's social care.

Case study: growing Shared Lives in the north-east of England

'Shared Lives' is a care and support service that matches people aged 16 and above who want to live independently in their community, with Shared Lives carers. People move in with their Shared Lives carers and are supported within the context of the carer's home and family. The model traditionally supports adults with learning disabilities, mental ill health or other needs which can make it harder for them to live independently.

Support can vary depending on what suits the person, but can include temporary care and support, a day service, or longer-term overnight care.

An independent cost comparison of Shared Lives found that it has significantly lower costs for people with learning disabilities and people with mental ill health than other forms of regulated social care, such as residential care. Research by the Social Care Institute for Excellence found that Shared Lives can result in an average saving of £8,000 for people with mental health needs and £26,000 for people with learning disabilities.[3]

Shared Lives Plus (https://sharedlivesplus.org.uk/) worked with the Association of Directors of Adult Social Services (ADASS) and the 12 local authorities in the north-east of England to develop its regional approach to Shared Lives.[4] This was intended to help local authorities develop and grow both the traditional adults with learning disabilities offer and new models of Shared Lives.

Key activities to support growth included:

- the development of communities of practice which will explore the growth, development and diversification of Shared Lives across the region
- cost-benefit exercises to inform the business case for investment in growth
- a redesign of forms and training to support increased referrals to Shared Lives and tailored and targeted marketing strategies to boost Shared Lives carer recruitment

Al McDowell, Director of Adult Social Care and Integrated Services, Newcastle City Council, said:

> *"One of the successes of the project so far, led by Shared Lives Plus and involving 12 local authorities, was establishing communities of practice, exploring ways we can scale up from a regional perspective so that everybody feels it is moving positively rather than competitively."*

Providers have also been supported to embrace growth and diversification through a sequence of workshops, using people with lived experience to inspire and encourage stakeholders to consider how they can expand their service.

3 Scaling up community-based models of care in Northern Ireland https://www.scie.org.uk/transforming-care/innovation/community-based-models, 2019
4 Shared Lives Plus https://sharedlivesplus.org.uk/

Priority 2: supporting people to have greater control over their care options, such as by using digital tools to self- direct support or communicate needs and preferences

Digital tools, such as apps, can support people to have more choice over their care, particularly for those receiving direct payments or using an Individual Service Fund.

Direct payments and personal budgets are a vital way in which people can have more choice and control over their care and support. However, data from March 2023 shows that the number of recipients of direct payments (including part- direct payments) has fallen for each of the past 5 years.

Innovative tools can support people to have better access to up-to-date, relevant information and advice and help people feel supported to make informed decisions about the support that suits them. Research by IMPACT found that in addition to accessible information, visual tools can also help people understand how their support package is designed and their personal budget is being spent.[5]

5 Choice and Control, Improving Adult Social Care Together (IMPACT) https:/impact.bham.ac.uk/our-projects/networks/choice-and-control/

Case study: Bexley Care Finder app

The London Borough of Bexley has been developing a 'Care Finder' app which is designed to support people to exercise full choice and control over how their needs are met. This could include options for people:

- in receipt of direct payments
- looking to purchase private care and support
- who wish to find a preventative service or additional support to supplement their care package

When fully launched, the app will be a platform for local and community groups to list their offer and lead to a wider range of local options that provide personalised care and meet a diverse range of needs.

The app will provide the user with an end-to-end process, enabling them to complete their enquiry online either via computer, tablet or mobile device.

Once the user specifies their requirements, a series of options are generated. The user can then select which provider or service they prefer and make direct contact with them.

The app is currently going through user testing. Bexley will be working on populating the content over the next few months and aims to make it available for public use early next year.

Stuart Rowbotham, Director Adult Social Care and Health and Bexley Place Executive Director, London Borough of Bexley and South East London Integrated Care Board said:

> *"The Bexley Wellbeing Partnership (Bexley's local care partnership) is committed to making 'choice and control' real and meaningful for our residents and communities. Locally, Bexley has 'cracked' the Individual Service Fund conundrum and developed that as a proper alternative to direct payments. We recognise the need to go much further in creating the right environment in which personal budgets, in whichever form, become the natural default by which people take control of their support needs.*
>
> *"The Care Finder app is being developed in partnership with Oxford Computer Consultants and will provide an accessible, real-world tool that gives people access to not only social care specific services, but a far wider array of voluntary, community and commercial services from which to tailor their support, with the look, feel and functionality that we have all become used to in a digital world."*

Priority 3: investment in local area networks or communities to support prevention and promote wellbeing, enabling people to age well in their communities

Communities are central to people's lives and wellbeing, particularly as we grow older and spend more time at home. Our immediate environment can have a significant impact on our health, wellbeing and the quality of our lives. Ensuring people have the right support in their community can enable them to remain feeling connected to those around them and able to live a fulfilling life. Community networks can reduce social isolation and loneliness, prevent the escalation of care needs and support people to live independently for longer.

One way of supporting people in local areas is to develop age-friendly community initiatives. Age-friendly communities are places where age is not a barrier to living well and where the environment, activities and services enable older people to have opportunities to enjoy life and feel well; participate in society and be valued for their contribution feel safe, comfortable and secure at home; and access high quality health and care.

Local authorities have a key role to play in enabling communities to find new ways to maintain health and wellbeing and ensure that everyone can feel well and has opportunities to stay socially connected throughout later life. This can include building on existing community assets and neighbourhood networks which promote social connections and ageing well for a growing diversity of older people, for example people from ethnic minority backgrounds or LGBT+ communities.

Case study: Holbeck Together – neighbourhood networks, Leeds City Council

Leeds has a shared agenda across the council and health services to involve local voluntary organisations and community groups in key aspects of health and social care service delivery.

Leeds neighbourhood networks aim to support older people to live independently and participate in their communities through a range of activities and services provided at a local level. An evaluation of Leeds neighbourhood networks by the Centre for Ageing Better found that the networks help support members to manage their long-term health conditions and reduce the pressure on formal services.[6]

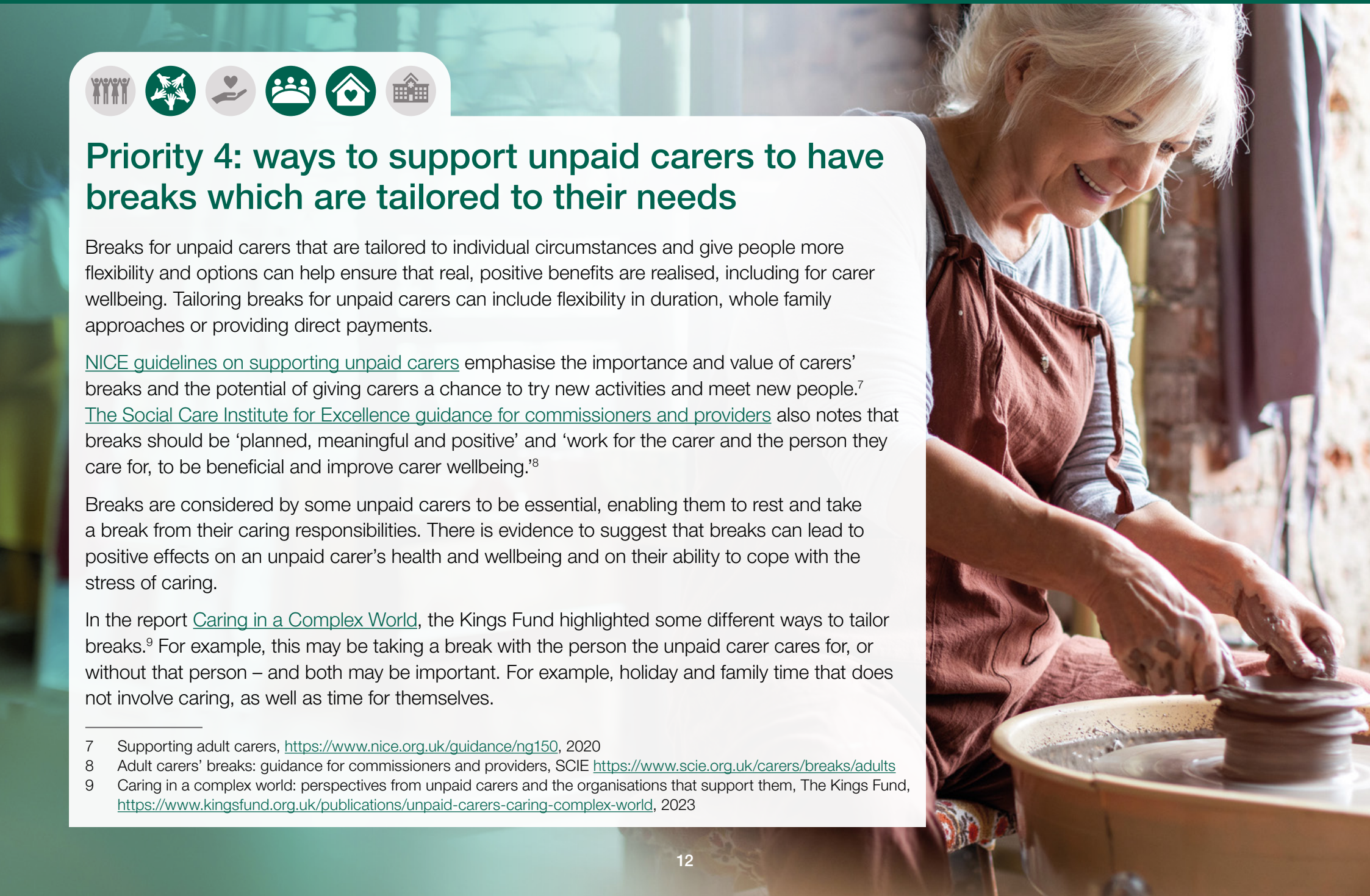
One of the networks, Holbeck Together was established in 1992 to support older people living in Holbeck, Leeds. Their key focus includes making improvements to the environment, helping people feel safer and providing opportunities for learning new skills leading to employment, as part of a longer-term strategy for the area of Holbeck to make it one of the best places to thrive, work and play. They have now expanded their objectives to become a cohesive community presence for all ages – as well as continuing to offer community outreach support for older members of the community. The Holbeck Together team work closely with public health, adult social care and communities' colleagues in Leeds City Council to bring relevant people together in support of a safer, supportive and empowering environment for the whole community.

Being a part of the Leeds neighbourhood networks and the wider partnerships that Holbeck Together is part of, has been key in providing services and enables them to act as a voice for the local community.

Leeds City Council's Executive Member for Adult Social Care, Public Health and Active Lifestyles said:

> *" Leeds City Council has long recognised the benefits of working with a strong and diverse third sector, underpinned by core investment and an outcomes-based model of delivery. The neighbourhood networks are a key part of our work to make Leeds the best city to grow old in, providing opportunities within communities and helping to improve health and reduce the risk of loneliness. Looking forward, there are so many more opportunities to continue to build on this great work, helping to deliver more seamless services and helping to strengthen communities."*

6 How community organisations contribute to healthy ageing, Sheffield Hallam University, https://www.shu.ac.uk/centre-regional-economic-social-research/publications/how-community-organisations-contribute-to-healthy-ageing, 2022



Priority 4: ways to support unpaid carers to have breaks which are tailored to their needs

Breaks for unpaid carers that are tailored to individual circumstances and give people more flexibility and options can help ensure that real, positive benefits are realised, including for carer wellbeing. Tailoring breaks for unpaid carers can include flexibility in duration, whole family approaches or providing direct payments.

NICE guidelines on supporting unpaid carers emphasise the importance and value of carers' breaks and the potential of giving carers a chance to try new activities and meet new people.[7] The Social Care Institute for Excellence guidance for commissioners and providers also notes that breaks should be 'planned, meaningful and positive' and 'work for the carer and the person they care for, to be beneficial and improve carer wellbeing.'[8]

Breaks are considered by some unpaid carers to be essential, enabling them to rest and take a break from their caring responsibilities. There is evidence to suggest that breaks can lead to positive effects on an unpaid carer's health and wellbeing and on their ability to cope with the stress of caring.

In the report Caring in a Complex World, the Kings Fund highlighted some different ways to tailor breaks.[9] For example, this may be taking a break with the person the unpaid carer cares for, or without that person – and both may be important. For example, holiday and family time that does not involve caring, as well as time for themselves.

7 Supporting adult carers, https://www.nice.org.uk/guidance/ng150, 2020
8 Adult carers' breaks: guidance for commissioners and providers, SCIE https://www.scie.org.uk/carers/breaks/adults
9 Caring in a complex world: perspectives from unpaid carers and the organisations that support them, The Kings Fund, https://www.kingsfund.org.uk/publications/unpaid-carers-caring-complex-world, 2023

Case study: Kirklees Council

Kirklees Council funds all its carer support services through the Better Care Fund, meaning it draws from both NHS and social care budgets. Kirklees Council has commissioned Carers Trust Mid Yorkshire to provide breaks, a service which has been developed to reflect and meet the needs of local carers.

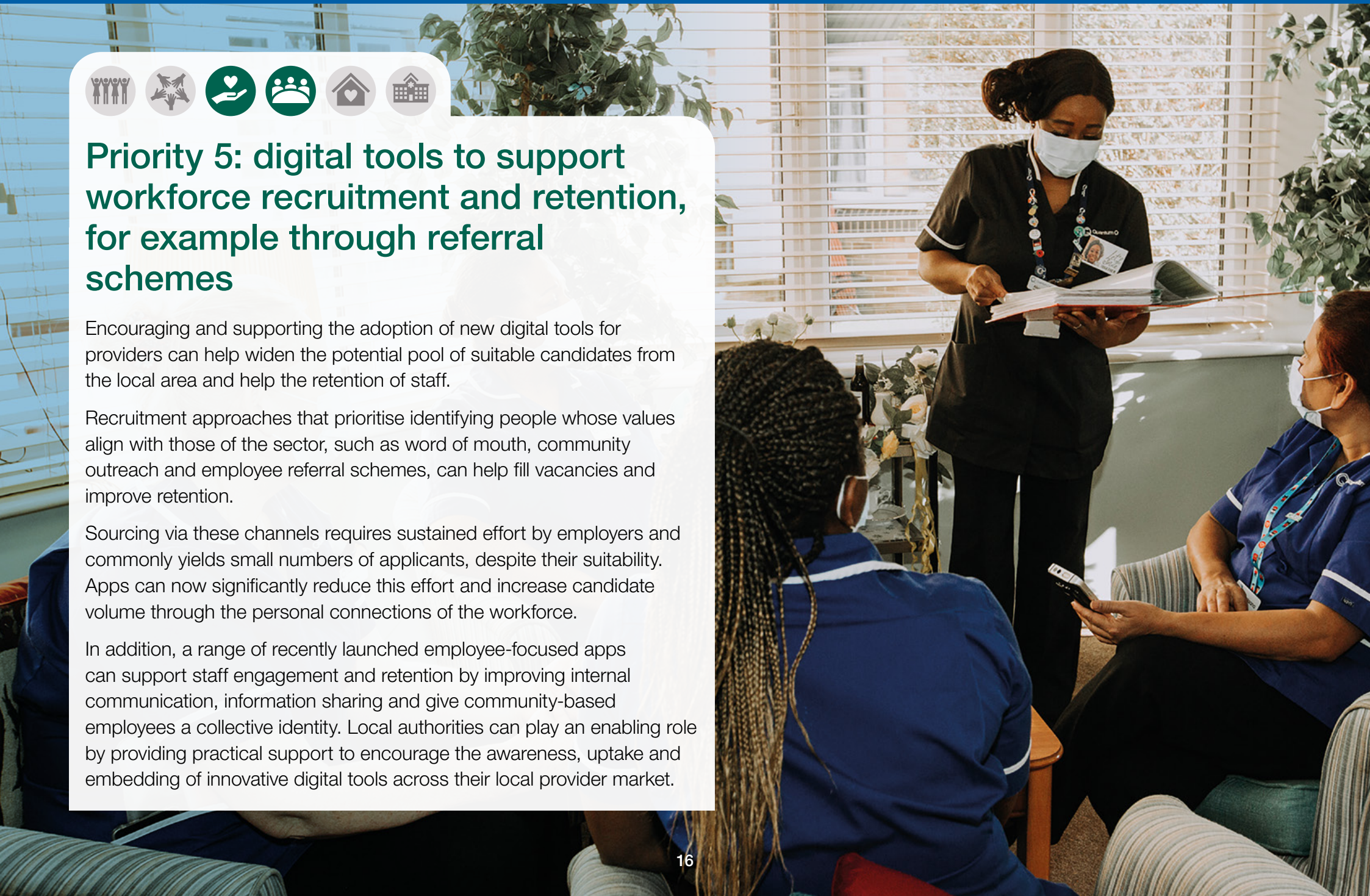
Carers can access breaks after having a statutory carers' assessment undertaken by a council social care assessor. If the assessment concludes the carer would benefit from a break, they are then referred to access support through the Carers Trust Mid Yorkshire breaks service.

Crucially, the assessment does not set out the length of break that the carers need – only that the carers need regular breaks. Carers Trust Mid Yorkshire then meet the carer and the carer support workers have the autonomy to decide the length of break based on direct conversations with the carer. Generally, breaks are a few hours a week or a few hours every couple of weeks and Carers Trust Mid Yorkshire manage this within the overall framework of the contract.

By giving the autonomy and freedom to Carers Trust Mid Yorkshire to discuss and respond to carers needs, this means the breaks are tailored to the needs of the carer. This has created a positive impact on carers' wellbeing, reducing stress, and giving carers time for themselves in a way which suits them and the person they care for.

Objective 2: people can access outstanding quality and tailored care and support

We want care and support to be of outstanding quality, such that it is bespoke to individuals, safe and responsive to people's needs. Care should be co-ordinated so that people experience a seamless care journey where services are brought together to support improved outcomes. This includes ensuring that unpaid carers are identified early and consistently so they can access the right information and support. Central to this is making sure that the social care workforce feels recognised, rewarded and are equipped with the right skills and knowledge to develop and progress.



Priority 5: digital tools to support workforce recruitment and retention, for example through referral schemes

Encouraging and supporting the adoption of new digital tools for providers can help widen the potential pool of suitable candidates from the local area and help the retention of staff.

Recruitment approaches that prioritise identifying people whose values align with those of the sector, such as word of mouth, community outreach and employee referral schemes, can help fill vacancies and improve retention.

Sourcing via these channels requires sustained effort by employers and commonly yields small numbers of applicants, despite their suitability. Apps can now significantly reduce this effort and increase candidate volume through the personal connections of the workforce.

In addition, a range of recently launched employee-focused apps can support staff engagement and retention by improving internal communication, information sharing and give community-based employees a collective identity. Local authorities can play an enabling role by providing practical support to encourage the awareness, uptake and embedding of innovative digital tools across their local provider market.

Case study: Care Friends and Essex County Council

In 2022, Essex County Council partnered with Care Friends, an employee referral app operated in partnership with Skills for Care, which fills social care vacancies by encouraging more of the workforce to become regular recruiters of their friends for their employer.[10] The app rewards care workers with bonus points for bringing in people from outside the sector, in addition to recognition for good work or achievements. Each point earned converts to £1 when cashed in.

Essex County Council offered fully funded software licences to care providers, focused on the county's hardest to recruit services such as homecare, supported living and learning disability residential settings. In addition, Essex Care Association supported this pilot by promoting the service to its members. Over 1,800 candidates across Essex have been sourced via the app to date from 962 app users across 24 participating employers, with a conversion rate to employment over 7 times more than that typically reported from internet job boards.

One of the participating employers, Zero Three Care, a learning disability provider based in Colchester, has hired 168 people via the app so far.[11] For 57% of Zero Three Care's app-generated new starters, it is their first paid care role. This is an almost 50% improvement on the county average of just 39% of recruits coming from outside the sector and an important contribution to growing local workforce capacity, a key focus for Essex County Council.

Moira McGrath, Director of Commissioning Adult Social Care said:

> *"Our partnership with Care Friends has shown digital innovation has a place in social care recruitment. The app is reaching people that wouldn't have considered a career in care without the encouragement of a friend already working in the role. It also benefits care workers who can earn meaningful extra cash rewards. We are committed to supporting innovative digital solutions to social care issues and systems like Care Friends play an important part in developing a local recruitment infrastructure for providers."*

10 Care Friends, https://carefriends.co.uk
11 Zero Three Care Homes, https://zerothreecarehomes.co.uk/

Priority 6: develop and expand the impact of local volunteer-supported pathways for people drawing on care and support

Encouraging and supporting the development of volunteer roles can contribute towards improving outcomes and supporting services.

Volunteers can enable people to leave hospital faster and settle in at home safely. This can alleviate pressures on social care services and assist in the flow of people between hospital and care settings. By carrying out certain functions, volunteers can also enable health and social care staff to focus on other priorities: a recent report by the Royal Voluntary Service found that volunteers in care homes play a vital role in improving both the working and living environment for staff and residents.[12]

Local authorities can play an enabling and convening role in developing sustainable volunteer strategies through:

- building on and managing existing volunteer-led support to develop more resilient, flexible and sustainable volunteer programmes
- developing and investing in relationships with local voluntary, community and social enterprise (VCSE) organisations and mapping health need in relation to local voluntary sector provision
- co-developing flexible and impactful volunteer roles in collaboration with local VCSE organisations to meet individual service needs
- planning and delivering volunteer-supported patient and care-user pathways to improve outcomes

12 Reimagining social care – the role of active citizenship – Royal Voluntary Service https://www.royalvoluntaryservice.org.uk/about-us/our-impact/our-research-policy-work/reimagining-social-care, 2022

Case study: Cheshire East Partnership – an integrated health and care volunteer-led discharge-focussed pathway

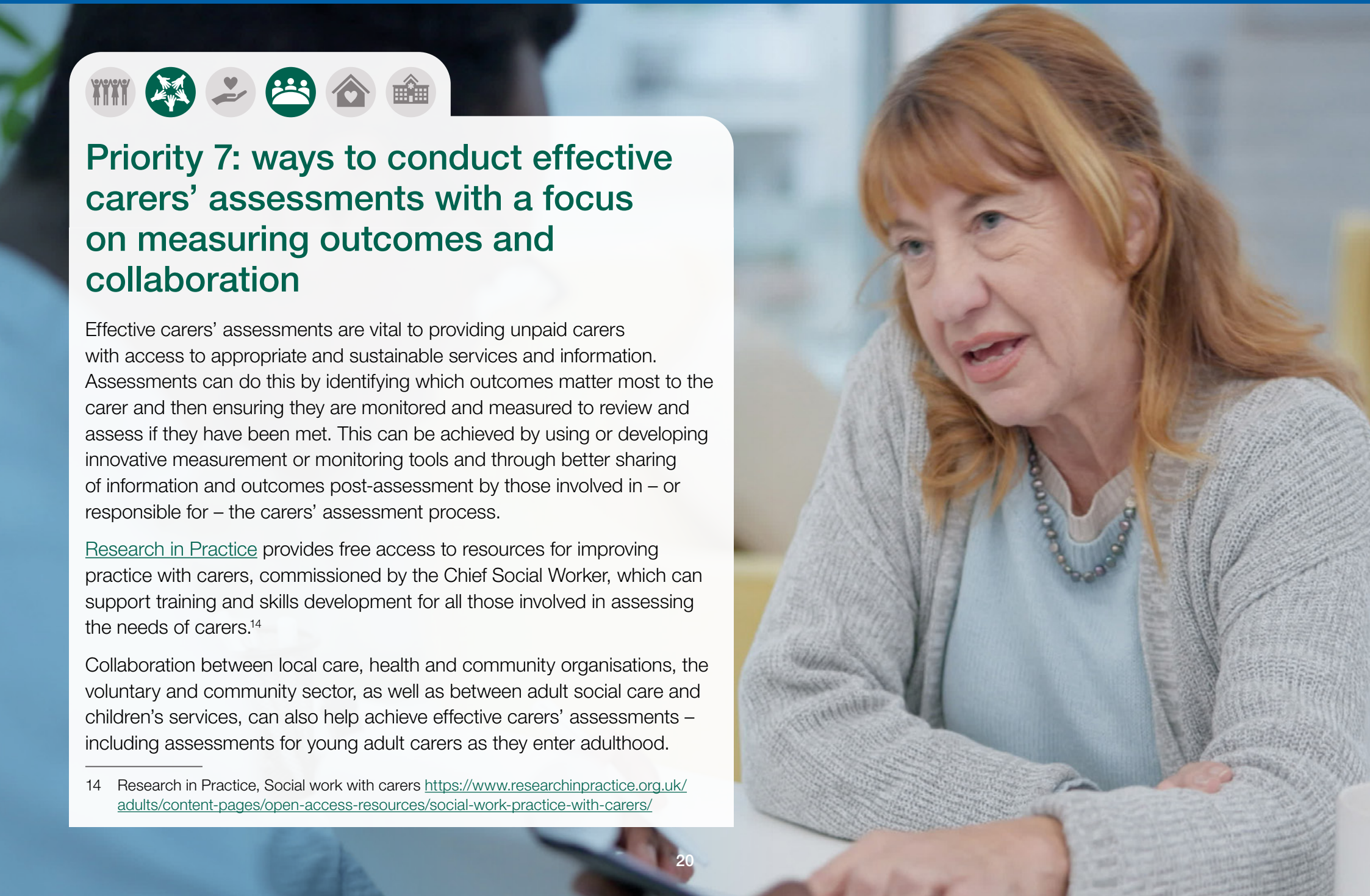
Cheshire East Partnership has developed an integrated 'back to health' volunteer-led pathway focused on 'getting well in hospital' and 'living and/or recovering well in the community'.[13] The programme included 2 bespoke volunteer roles to support patients to prepare for discharge, to settle in at home and to provide bridging support and further re-enablement support out in the community.

The 'discharge volunteer' role, under the supervision of local authority community connectors involves meeting patients on wards or in discharge lounges to establish a relationship that can be further developed upon discharge and identify areas where the person may need support when they return home, such as with shopping, food parcels, or gas and electricity meter credit.

Once discharged and settled, the 're-enablement' volunteer role, under the supervision of the local authority re-enablement team (such as occupational therapists, physiotherapists, care workers), includes supporting the re- enablement team with home visits and assisting with environment checks and domestic tasks.

This volunteer discharge-focussed pathway provides people who draw on care and support, with continuous support throughout their discharge journey. Once in the community, it helps them reduce pressure on the workforce, contributing towards improved service-user experiences and outcomes.

13 Cheshire East Partnership, https://www.cheshireeast.gov.uk/livewell/care-and-support-for-adults/working-in-partnership/cheshire-east-partnership.aspx



Priority 7: ways to conduct effective carers' assessments with a focus on measuring outcomes and collaboration

Effective carers' assessments are vital to providing unpaid carers with access to appropriate and sustainable services and information. Assessments can do this by identifying which outcomes matter most to the carer and then ensuring they are monitored and measured to review and assess if they have been met. This can be achieved by using or developing innovative measurement or monitoring tools and through better sharing of information and outcomes post-assessment by those involved in – or responsible for – the carers' assessment process.

Research in Practice provides free access to resources for improving practice with carers, commissioned by the Chief Social Worker, which can support training and skills development for all those involved in assessing the needs of carers.[14]

Collaboration between local care, health and community organisations, the voluntary and community sector, as well as between adult social care and children's services, can also help achieve effective carers' assessments – including assessments for young adult carers as they enter adulthood.

14 Research in Practice, Social work with carers https://www.researchinpractice.org.uk/adults/content-pages/open-access-resources/social-work-practice-with-carers/

Case study: n-compass

From 2022 to 2023 n-compass (who operate services supporting carers in Lancashire, Rochdale, Bury, Staffordshire and Warrington) completed 5,170 statutory carers' assessments and 10,319 statutory carers' assessment reviews.[15] n-compass has a robust approach to monitoring outcomes of carers' assessments and utilises several tools for carers, one of these being 'I' statements and recording whether they have been met.

Other tools used by n-compass include 'getting the most out of life' (GTMOOL) ratings to see how the carer feels about different areas of their life and the 'Short Warwick-Edinburgh Mental wellbeing scales' (SWEMWBS), in which carers score from a scale of 1 to 5 ('1' being 'none of the time' and '5' being 'all of the time') on the statements about their thoughts and feelings over the past 2 weeks.

Joanna Solanki, CEO n-compass, commented:

> *"n-compass undertake thousands of statutory carers assessments and reviews year on year alongside outcome tools to measure the impact of interventions and we have witnessed first-hand the transformative power of these assessments and tools. Using tools such as 'I' statements, GTMOOL and SWEMWBS allows us to provide*
>
> *a conversation that gives carers the opportunity to reflect how caregiving affects their day-to-day life.*
>
> *"For example, using tools such as GTMOOL, we identified that a carer needed time away from caring to attend their own health appointments and regular reflexology, and to spend time with other people. Consequently, we were able to arrange a volunteering 'sitting in service' for the carer which meant they could leave the person they care for safely to attend appointments and to meet friends and other carers at 'coffee and chats', maintaining a social life alongside their caring role. These approaches enable carers to receive the support they need to continue caring, while maintaining their own health and wellbeing."*

In the following testimony (provided by n-compass), a carer wrote:

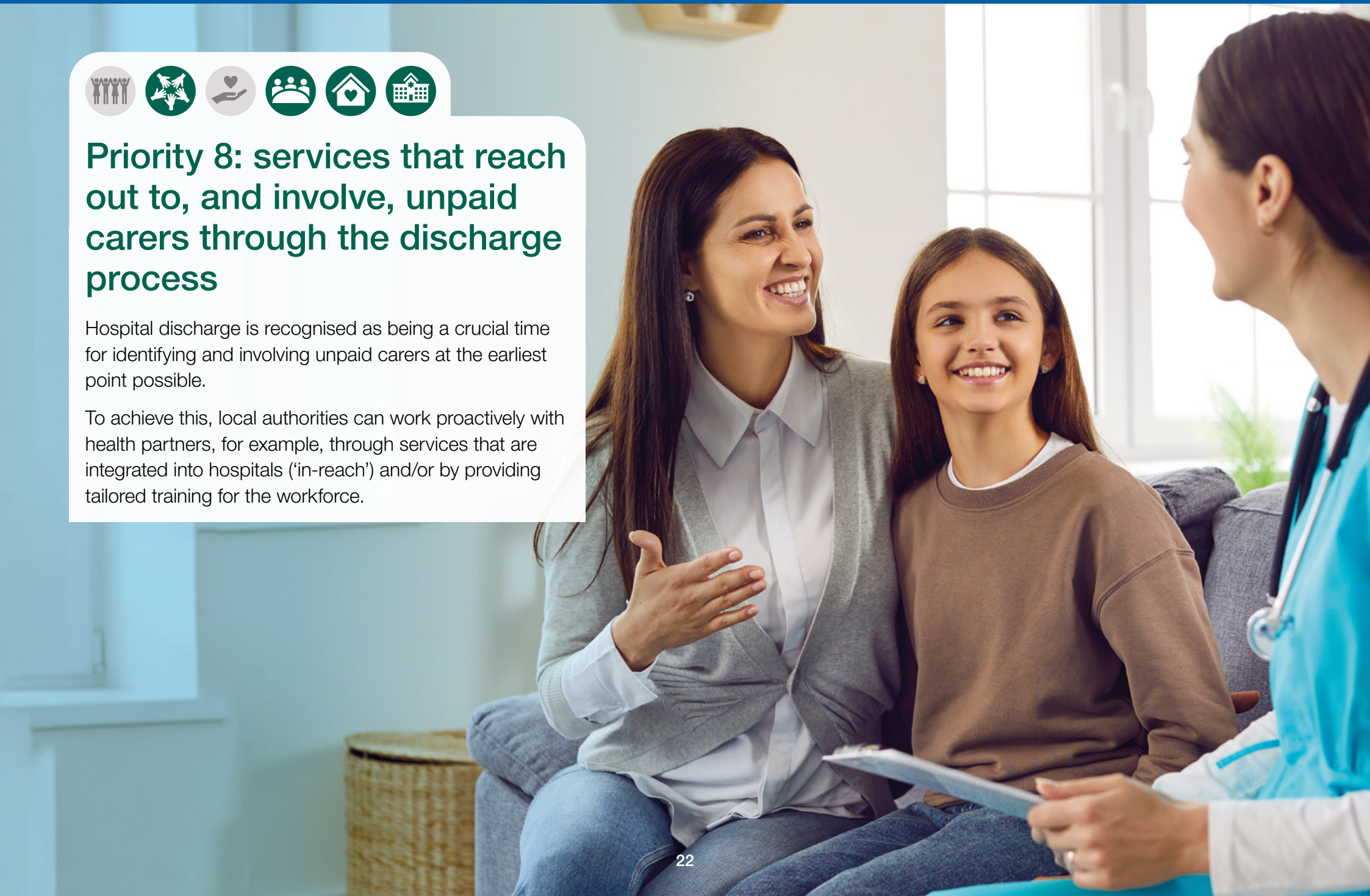
> *"Talking to you was a real tonic for me, as you facilitated my exploration of needs in a person-centred way – it was great. I felt heard and that you were really interested in me personally; the whole interview did not just feel like a professional doing an assessment.*
>
> *The unconditional positive regard made all the difference."*

15 n-compass: Advocacy, Carers, Well Being and Young People, https://www.n-compass.org.uk/

Priority 8: services that reach out to, and involve, unpaid carers through the discharge process

Hospital discharge is recognised as being a crucial time for identifying and involving unpaid carers at the earliest point possible.

To achieve this, local authorities can work proactively with health partners, for example, through services that are integrated into hospitals ('in-reach') and/or by providing tailored training for the workforce.



Case study: Carers Support West Sussex in-reach service

Carers Support West Sussex provides an in-reach service within their local NHS trust to support carers at the point of hospital discharge. These services involve carrying out a 'light touch' assessment of the carer, with a focus on immediate support needs and a forward look to the longer term and a more comprehensive assessment, to be completed at a later point when the person being cared for has left hospital. This has the added benefit of ensuring that there are sufficient support services in the short and longer term.

Carers Support have seen a benefit for carers through directly providing an in-reach hospital service in this way because, for example, carers can be too uncertain at the point of admission to, or discharge from, hospital to be able to make future plans and discuss their needs in a comprehensive way.

The Carers Support in-reach team undertake the light touch assessment using the 'carers star', providing a quick, proportionate and practical service. Once the future prognosis is clearer and the carer understands the impact their caring role will have, they are offered and can request a carer's assessment. This enables a smoother transition to the carer's assessment team and feels more joined up for the carer.

A carer provided by Carers Support, said:

> *" It was helpful speaking to the hospital service before attending a meeting on the ward. I wouldn't have known to ask about the Elderly Patient Mental Health Team and how they planned to move my sister successfully to a suitable home. I was also able to get information on how to access the information I wanted from the NHS teams."*

Objective 3: people find adult social care fair and accessible

Everyone – whether that be people who already, or may need to, draw on care and support, their families or unpaid carers – should be able to access the right care and support, with the right information and advice, at the right time. This includes growing local capacity so that people can have their care needs met, including the needs of unpaid carers. We want people to be able to navigate the adult social care system with ease, recognising that people in receipt of care and support and people who provide unpaid care are diverse and varied and that different services and interventions are likely to be effective for different groups of people.

Priority 9: digital workforce development and market shaping tools with capability to map, strengthen and grow local workforce capacity relative to system demand

Established digital tools, including artificial intelligence (AI), can help local statutory agencies to map existing and future patterns of need, and to connect, grow and diversify local assets to meet them. By connecting people with existing community support providers and volunteers, offering a wide range of support and opportunities, digital tools and technology can offer people the means to identify, personalise and draw on blended support. Support can include checking in and helping with shopping, to local groups and activities, home maintenance, gardening and personalised formal care.

Digital tools can also help to generate new local system capacity, supporting local people to set up and trade as micro-providers, while offering local voluntary and community groups a new way to target support where it is needed most.

Case study: The Tribe Project

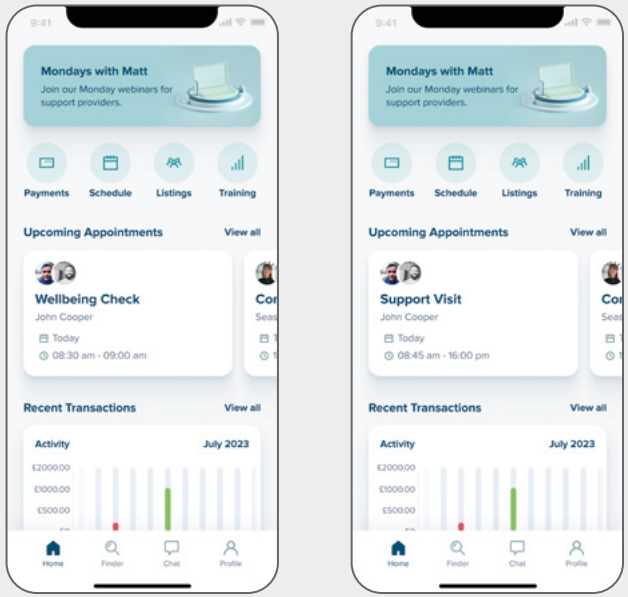
The Tribe Project is a digitally led AI innovation for market shaping which aims to improve the wellbeing of people who require care and support to live in the place they call home. The platform maps and predicts future patterns in demand for care and support and helps to generate new capacity, connecting and growing diverse community provision to meet projected demand. This takes the form of paid micro support providers, volunteers and community groups, cultivating a blended model of community support. People looking for care or support are then offered a tool to easily find trusted, personalised support or opportunities that work for them.

Tribe supports local people into high quality flexible employment, developing skills through access to necessary resources (including training, Disclosure and Barring Service checks, insurance) to trade safely, sustainably and legally as a community support provider. The interoperable platform also offers a vehicle through which voluntary and community groups can scale their reach and impact while quantifying and securing recognition for their contribution to system capacity. Having done so, Tribe offers people seeking support with the means to find and secure the care or support that works for them from trusted, local providers.

An independent evaluation of Tribe (PDF, 666KB) has shown it can close gaps in community-based care and support, restoring choice and control to people while offering an economically sustainable model for commissioners.[16]

Stephen Watt, Adult Social Care Commissioner, Essex County Council said:

> *"The Tribe platform has created an opportunity to offer real and genuine choice to people who are purchasing care and support. It has reduced the barriers to entry for people who want to offer support to their community. This has supported increased capacity within the market and created an ecosystem of support that has improved access to good quality, personalised care and support."*



16 The Tribe Project, Tribe Evaluation – Year 2 tribeproject.org/static/evaluation/tribe-year-2-review-report-140423.pdf, 2023

Priority 10: social prescribing to connect people with information, advice, activities and services in the community

Social prescribing is an approach that connects people to activities, groups and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. Not knowing where to go for the right help can often prevent someone from accessing the support they need. Use of social prescribing tools and approaches can significantly reduce these barriers and help people find the support they need in their local community, based on their unique situation, background or needs.

It is useful to see social prescribing in the context of a system, or whole community approach. Through co-design and collaboration with community leaders and effective use of community assets, local health and social care systems can adapt to local need, drive down inequalities and improve the health of people and places. This is key in creating a well-functioning and connected system which can provide a rich, cross-sectoral and sustainable social prescribing offer that is locally driven to meet local needs.

Local authorities can invest in this community-based infrastructure in a variety of ways by looking at the current landscape and where they can add value. By working with the social prescribing system in a local area, they could focus on improving referral pathways and data collection, strengthening the social prescribing offer through activity provision, or increasing the social prescribing workforce to provide a co-ordinated approach to information and advice.

Case study: community navigation, Involve Kent and Kent County Council

Involve Kent, a local charity, have been working with Kent County Council to deliver a social prescribing service which provides complementary support in the community alongside social care and enables people to remain independent. This includes supporting people to complete assessments for adaptations such as grab rails and fall censors, access support services such as dementia cafes, and support to enable people to claim appropriate benefits and entitlements.

This has been shown to reduce the demand for residential care and social care packages, as well as reducing the likelihood of attendance at A&E. Monitoring of A&E attendance for those who use the service showed a 23.64% reduction over a 12-month period.

Case study: Waltham Forest – 12 new social prescribing initiatives

Waltham Forest Borough ran a community chest grant programme to fund small to medium-sized charities, organisations and VCSE groups to run services and activities supporting the health and wellbeing of Waltham Forest residents. This programme is one of the 7 community chests in north-east London initiated by the Transformation Partners in Health and Care and organisations had the opportunity to apply for up to £9,999 of the total £70,000 council funding.[17] The applications were reviewed by a panel of health, local authority, voluntary sector and local residents and the project was co-ordinated by working closely with Waltham Forest place-based partnership.

Examples of funded work includes the Waltham Forest Disability Resource Centre, who are running a project called 'Belonging', an art and creative writing project for disabled adults and adults with learning disabilities.

Additionally, there is the Forest Churches Emergency Night Shelter who currently run a drop-in centre for homeless people in Waltham Forest and will launch a summer project which will involve staff and some service users getting training in co-production.[18]

17 Transformation Partners in Health and Care, https://www.transformationpartners.nhs.uk/
18 Forest Churches Emergency Night Shelter, https://www.forestnightshelter.org.uk/

Priority 11: ways to better identify unpaid carers in local areas

Effective identification of unpaid carers can be an important pre-requisite for the carers themselves being able to access the support they might need or find beneficial. Working together with a wide range of organisations and partners can be an important way to help achieve this, combined potentially with staff training to encourage the better identification of carers.

There are, for example, several touchpoints through which an unpaid carer could be identified and/or encouraged to come forward, such as through GPs, as part of hospital discharge, through adult social care services, or through other local community organisations and services, including local carer organisations.

Case study: 'Carers in Hertfordshire'

With funding received from Hertfordshire County Council, Carers in Hertfordshire use a carer passport to encourage carers to come forward because it provides local discounts, as well as serving as unofficial identification.[19]

When the carer goes to sign up for the service, they are asked questions which serve as a triage point for the carer, including to help them identify their own needs. Early triaging of the carer also helps the charity to put resources where they are most needed.

If triaging identifies that more intensive support is needed, Carers in Hertfordshire will have a more in-depth conversation about the carers' needs and support that can be offered. Conversations can also explain local authority carers' assessments and if the carer or Carers in Hertfordshire feel it would be beneficial, the carer can be referred to the local authority for a carers' assessment.

For all carers who encounter Carers in Hertfordshire, demographic data is requested with the consent of the person and outcomes of support tracked. This allows them to understand which services carers are using and to evaluate the impact of those services. This allows Carers in Hertfordshire to consider issues and outcomes and develop plans, for example, to address inequalities.

19 Carers in Hertfordshire, https://www.carersinherts.org.uk/

Priority 12: ways to encourage people to recognise themselves as carers and promote access to carer services

Unpaid carers are a diverse group of people and not all carers readily identify as such.

Projects such as community programmes that focus on unpaid carers who are less likely to have a carers' assessment (for example, some carers from a minority ethnic background) can be good ways of building trust and promoting access to carer services.

Programmes might include the development of 'carer champions' within communities who work as a key contact to support and help carers access information and services, or investment in tailored training for the workforce to better identify and work with different groups of unpaid carers. This might be to ensure that the workforce is able to identify and understand the varied needs, barriers, challenges and experiences of unpaid carers.

Case study: Tower Hamlets

People from minority ethnic backgrounds may be less likely to recognise themselves as a 'carer' and that caring may not be regarded as distinct from other familial relationships. According to the recent State of Caring 2022 report by Carers UK, programmes are key gateways for many carers that would otherwise not have considered undertaking an assessment.[20]

In Tower Hamlets, one of the most diverse boroughs in London, the majority of assessments are done face-to-face in the carers centre. One of the biggest challenges Tower Hamlets has faced however, is communicating what an assessment is to a multitude of diverse communities and letting these carers know how they are eligible for this support.

The number of assessments undertaken since the centre was commissioned to carry out assessments in 2019 has nevertheless gone up, thanks to, in large part, the promotion of assessments in the community with a dedicated team of advocates who have steadily built relationships with key figures in Bengali, Somali and other community languages over the years. Such figures, who carry a lot of influence in their communities, effectively spread the word as a result of this outreach and in turn encourage more carers to come forward.

20 State of Caring Report, Carers UK https://www.carersuk.org/reports/state-of-caring-2022-report/, 2022

This publication is available at https://www.gov.uk/government/publications/accelerating-reform-in- adult-social-care-in-england/accelerating-reform-in-adult-social-care-in-england-priorities-for-innovation-and-scaling