Department of Health & Social Care

Ipsos

Accelerating Reform Fund: case studies

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Contents

Case study 1: Shared Lives expansion

This project aims to expand the existing Shared Lives service in Birmingham and extend it into Solihull. The project is focused on:

- recruiting and retaining new Shared Lives carers
- enhancing training and support
- streamlining processes
- raising awareness among council staff and partners

Consortium

Birmingham and Solihull.

Project summary

Maturity score: Solihull - 3 (project delivery) and Birmingham - 4 (impacts emerging)

3. Project delivery: delivering the service or tools but not yet observing any changes as a result.

4. Impacts emerging during project delivery: changes (such as outputs, outcomes or impacts) have been measured as a result of the project delivery.

ARF priority areas: 1 and 9

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

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

Research conducted

Interviews conducted

Two project leads (December 2024 and May 2025).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope

This project addresses the limited availability of Shared Lives placements and lack of choice for certain residents. The rationale is to offer a more personalised and community-based alternative to residential care, improving outcomes for individuals and potentially generating cost savings.

The target group is individuals requiring long-term care, particularly those transitioning from foster care.

This project involves scaling an existing service already available in Birmingham to Solihull, while expanding the training offer for Shared Lives in Birmingham.

Project delivery

This project is in the delivery phase, and the following progress has been made:

- recruitment to the team managing Shared Lives within the local authority – the team has been expanded to support the safe increase and matching of Shared Lives carers with people
- a targeted Shared Lives carer recruitment campaign has been launched.
- carer incentive payments have been paid to new full-time Shared Lives carers
- bitesize training videos have been produced to raise awareness internally and Shared Lives carers are being granted access to tailored online carer training

Challenges, barriers and unintended consequences

Two main challenges related to the delivery of this project have been:

- IT challenges: delays in IT development and testing, including system upgrades, have slowed the delivery of this project
- recruitment: recruiting for temporary positions within Shared Lives has proved challenging, as candidates often found long-term work elsewhere. Uncertainty around tranche 2 ARF funding also led to a pause in recruitment

Project leads report that these challenges have been mitigated by:

- including targeted recruitment campaigns
- extending ARF-funding post timelines

- clarifying the distinct roles of fostering and Shared Lives

The project is not expected to lead to any unintended consequences at this stage.

Outcomes and impacts

The main outcomes the system is hoping to achieve from this project include:

- increased higher Shared Lives carer recruitment
- improved information sharing
- increased team capacity to ensure safe onboarding of carers and safe matching with people in the community
- enhanced training opportunities

So far, one new carer has been recruited in Solihull and 26 have been recruited in Birmingham. Existing carers in Birmingham now have access to more tailored training.

Increased engagement from and recruitment of Shared Lives carers has already been enhanced by existing foster carers now being given the option to become Shared Lives carers. The project lead said:

> "We've had some early outcomes in terms of positivity around the bringing in an additional choice for our Shared Lives offer. That's meaning that we now have three people that are on our list that are going to be being able to stay long-term with their foster carers, they've got that choice and that's a really positive outcome for them."

In the future, the impacts that the system hopes to achieve include cost savings from delayed residential care placements and increased satisfaction levels with Shared Lives placements. The project lead said:

> "I would anticipate that we will see reduced long-term care costs, higher satisfaction of people being able to use those placements. And giving that increased choice and control to individuals, especially those moving through transition that want to stay in the family environment, we'd expect to see improvements in the scores that we're getting on the social care outcome survey, for example."

There is not yet evidence available for these impacts. Further data collection is planned to assess long-term impacts on carer retention and long-term wellbeing.

Scaling, embedding and sustainability

Sustainability for this project is planned through incorporating team costs into placement fees, effectively making the service self-funding. Scaling beyond Birmingham and Solihull is not currently planned.

The project is aligned with Birmingham and Solihull's wider system mission to modernise and improve unpaid carer assessments and support through digital innovation, ensuring carers receive timely and effective support. Project leads expect that this activity is embedded into day-to-day practices to support these wider missions.

Case study 2: identifying unpaid carers and improving processes for carers

This overarching project involves several sub-projects:

- reviewing and improving carers assessments
- piloting a new carer's break service
- increasing the identification of unpaid carers through a communications strategy across Buckinghamshire, Oxfordshire and Berkshire West

Consortium

Buckinghamshire, Oxfordshire and Berkshire West.

Project summary

Maturity score: 2 (implementation) and 3 (project delivery) for different sub-projects

2. Implementation and set-up: getting projects set up and acquiring necessary resources (such as staff and developing tools).

3. Project delivery: delivering the service or tools but not yet observing any changes as a result.

ARF priority areas: 4 and 7

Priority 4 (focuses on unpaid carers): ways to support unpaid carers to have breaks which are tailored to their needs.

Priority 7 (focuses on unpaid carers): ways to conduct effective carer's assessments with a focus on measuring outcomes and collaboration.

Research conducted

Interviews conducted

Project lead interview (December 2024).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope

Carers' assessment development and review

This project aims to improve the carers assessment process by developing a more comprehensive assessment form and addressing the backlog of 37 carers assessment reviews.

The rationale is to:

- better understand carers' needs
- ensure their involvement in the process
- provide timely support

The scope includes:

- co-production, testing and implementation of the assessment form
- testing recruiting an interim social worker to address the review backlog

Carers' breaks review and pilot

This project aims to review and enhance the existing carers breaks offer and pilot a new service providing both respite care for the cared-for and recreational breaks for the carer. The rationale is to provide carers with more choice and accessible break options, preventing burnout and supporting their wellbeing. The scope includes:

- reviewing current provision
- co-producing a service specification
- procuring a service provider
- delivering the pilot

Joint carers' identification communications campaign

This project aims to increase the identification of unpaid carers through a targeted communications campaign. The rationale is to raise awareness of available support and encourage carers to self-identify. The scope includes:

- developing a communications strategy

- co-creating campaign materials with carers' organisations
- translating resources
- launching a campaign

All these elements are trials of new initiatives rather than scaling existing ones, building upon and improving existing activities in this area. The plan is to implement all these trials across the consortia footprint.

Project delivery

All project activities are in progress, but at different stages. The carers' assessment development has completed testing and is reviewing feedback. Recruitment for the permanent review backlog role is ongoing. An interim social worker has been reducing this backlog in the meantime.

The carers' breaks project is completing the service design and preparing for procurement.

The carers' identification campaign is finalising materials and preparing for launch.

Challenges, barriers and unintended consequences

Project leads identified the following barriers and challenges associated with delivering this project:

- recruitment challenges: delays and difficulties in recruiting for ARF-funded roles across all activities, exacerbated by geographical limitations and the temporary nature of some positions
- funding delays and uncertainty: delayed confirmation of the second tranche of ARF funding created budgeting and planning challenges, impacting project scope and timelines
- integrated funding complexity: co-ordinating funding and project delivery across multiple local authorities within the system proved challenging due to varying needs and priorities
- consortium engagement and commitment: maintaining consistent engagement and commitment from all consortium members, particularly regarding the carers' identification campaign, has been a challenge. Some local authorities have considered withdrawing from the joint project to pursue their own initiatives, creating tension and potential budget implications

Outcomes and impacts

The project activities in this case study are still ongoing, so final outcomes are not yet available. However, the local impact assessment identifies the following achieved outputs and anticipated outcomes for each workstream:

Carers' assessment development and review outcomes and impacts included:

- achieved output: a new, more comprehensive assessment form has been developed and tested with carers, with feedback currently under review. An interim social worker has cleared a backlog of 37 carer assessments, while recruitment for a new role to clear the backlog is ongoing. A comprehensive review of existing assessment processes has been conducted, identifying strengths and areas for improvement

- anticipated outcomes: the new assessment form is expected to better meet carer needs, improve understanding of carer circumstances, and increase carer involvement in the process. Addressing the assessment backlog is expected to lead to faster assessment times for new carers and a better customer experience

Carers' breaks review and pilot outcomes and impacts included:

- achieved output: a carers' breaks service specification has been co-produced with carers. The existing carers' breaks offer has been reviewed, and a commissioning officer has been recruited

- anticipated outcomes: the project aims to improve choice and accessibility of breaks for carers, leading to reduced carer burnout and improved wellbeing. Data on usage and demand from the pilot will inform future service development

Joint carers' identification communications campaign outcomes and impacts included:

- achieved output: a communications strategy has been developed, and campaign materials have been co-created and tested with carers' organisations. Translation of materials is in progress

- anticipated outcomes: the campaign is expected to increase identification of unpaid carers, particularly within hard-to-reach communities. Increased awareness of available support will empower carers to self-identify and access services. The shared toolkit will enable continued use and adaptation of the campaign by local authorities beyond the project's timeframe

Scaling, embedding and sustainability

Project leads anticipate that the new carers' assessment form will be embedded into day-to-day working across the system. They report that the primary focus is on embedding the new assessment form and streamlined processes into business-as-usual practice. This includes training staff and integrating the form into the case management system. Furthermore, it is hoped that learning from the carers breaks pilot will inform future service commissioning the delivery.

Regional scaling of the carers breaks pilots, such as the potential for collaboration with neighbouring local authorities like Wokingham, is planned, subject to the learning generated. Furthermore, the system expects the reusable toolkit generated by the communications campaign to be continued with minimal future investment required.

However, there are concerns around continuing the carers breaks pilot beyond ARF funding. A potential option for continuing the carers break service after the ARF funding ends involves transferring responsibility to the Carers Partnership, a local VCSE organisation. The project lead said:

> "I think one potential way [of continuing the service] is that we ask the Carers Partnership to decide…They are able to identify which carers need it and because its outside the council it might be a quicker way to deliver the service in a more efficient way. It will also take away capacity issues that the council might have as well. We're thinking maybe that could be a way of getting the service embedded post funding."

Case study 3: empowering carers through digital innovation and palliative care training

This initiative focuses on equipping health and social care professionals with the skills and confidence to engage in compassionate conversations with individuals on a disease trajectory and their carers, particularly during hospital discharge. Initially conceived with a focus on adult carers, the project has broadened its scope to consider the transitional needs of child carers as well.

Consortium

Cambridgeshire and Peterborough.

Project summary

Maturity score: 4 (impacts emerging)

4. Impacts emerging during project delivery: changes (outputs, outcomes or impacts) have been measured as a result of the project delivery.

ARF priority area: 8

Priority 8 (focuses on unpaid carers): services that reach out to, and involve, unpaid carers through the discharge process.

Research conducted

Interviews conducted

Three interviews with project leads (August and December 2024, and May 2025).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope

This project addresses a recognised learning gap among professionals who find it challenging to engage effectively with unpaid carers supporting individuals nearing the end of life.

Hospital discharge is identified as a crucial time for early carer identification and involvement. The project aims to empower professionals in facilitating meaningful and

supportive conversations with carers through the development of training materials such as:

- videos
- podcasts
- literature
- training sessions

These resources are designed for integration into council induction programs and refresher training, promoting collaboration between local authorities and health partners to improve end-of-life services. The project draws on good practice and lessons learned from various organisations, including:

- the Alzheimer's Society
- carer network linkages
- the Arthur Rank Hospice
- Sue Ryder

The overarching goal is to foster a cultural shift in attitude and behaviour within the health and social care workforce towards supporting unpaid carers, with a particular emphasis on leveraging learnings to other Association of Directors of Adult Social Services (ADASS) regions.

Project delivery

This project is in the delivery phase with the following progress being made:

- face-to-face training sessions have been completed, reaching a total of 141 attendees across 5 sessions, exceeding initial expectations. Provisional training dates were scheduled early on (7 October and 4 November 2024), demonstrating proactive planning
- e-learning materials, including podcasts, are being developed to broaden access and knowledge retention, with robust plans in place for post-funding dissemination through e-learning platforms and collaboration with hospices
- the project has been presented at various meetings and forums, including:

    - the Cambridgeshire Conversation
    - ADASS Carers Network
    - an ARF hospital discharge workshop
    - an SCIE meeting
    - a provider forum
- an invitation to present at the Palliative and End of Life Conference in May 2025 further indicates the project's growing recognition. SCIE has provided support in developing a case study for the project

Challenges, barriers and unintended consequences

A significant challenge was ensuring internal staff could be released from operational duties to attend face-to-face training. This was mitigated by extending the training invitation to professionals from the integrated care board (ICB), health and voluntary sectors, maximising reach and impact. There is also a concern about potentially identifying a large number of carers without sufficient support systems in place.

Outcomes and impacts

The project has demonstrated increased professional-carer engagement following training, aligning with the intended outcome of more frequent and higher-quality conversations.

Feedback collected during and after training sessions, along with a promotional video and SCIE case study, provide evidence of this impact. Increased contact with the palliative social worker and Arthur Rank Hospice from professionals further suggests improved support networks for carers.

Cost savings in care commissioning have also been observed, although minimal so far, due to more informed decision-making.

Short-term outcomes anticipated include:

- an increase in the number of people recognised in the community who should have been on the care pathway
- improved identification of how best to support them

Scaling, embedding and sustainability

Major lessons learned include the importance of having the right resources and skillsets in place, such as 'end-of-life champions', to effectively deliver and scale the training. Engaging with universities to target social work trainees is also seen as crucial for long-term sustainability.

The project highlights the value of co-production and the importance of incorporating lived experience into training design. The project lead also emphasises the need for ongoing benefit realisation and monitoring to demonstrate cost-effectiveness and secure future funding.

The project team plans to leverage the learnings from the palliative care training and disseminate them to other ADASS regions. There is interest in exploring collaborations with other councils to share challenges and best practices.

Sustainability will rely on securing further funding and potentially integrating the training into university programmes for social workers in training.

Case study 4: supporting carers for people with dementia through combined support and cognitive stimulation therapy

The initiative is a project piloting an innovative program combining carer support training and mentoring with cognitive stimulation therapy (CST) sessions for people with dementia. This model addressed a gap in services by enabling isolated carers, previously unable to leave the person they cared for, to access support and training.

The project aimed to:

- improve carer wellbeing
- reduce isolation
- potentially delay or prevent the escalation of care needs for people with dementia

A significant element of the project was the provision of concurrent CST and memory cafe activities for the cared-for person, to foster carer confidence in accessing respite.

Consortium

Cornwall and the Isles of Scilly.

Project summary

Maturity score: 4 (impacts emerging)

4. Impacts emerging during project delivery: changes (outputs, outcomes, or impacts) have been measured as a result of the project delivery.

ARF priority areas: 3 and 4

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

Priority 4 (focuses on unpaid carers): ways to support unpaid carers to have breaks which are tailored to their needs.

Research conducted

Interviews conducted

Three interviews with project lead (August and December 2024, and May 2025).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope

This project aims use an innovative approach to address a gap in services by supporting isolated carers unable to leave the person they care for. The project's objectives include providing training and support to carers to:

- assist them with the practical and emotional aspects of caring for someone with dementia
- enable them to meet others in a similar situation to reduce carer isolation

To enable those caring for someone with dementia to attend and to provide support to the person they care for, a memory café based on CST was open to the person they cared for with dementia at the same time.

As well as enabling the carer to attend their training, the memory café sessions with CST potentially prevent or delay the onset of dementia symptoms after diagnosis.

The project aligns with existing dementia and carer strategies in Cornwall and addresses the increasing pressure on services due to Cornwall's ageing population and the high number of unpaid carers. The project specifically targets carers of people with dementia who struggle to access support due to their inability to leave the person they care for.

Project delivery

The project has successfully completed its first cohort, delivering combined carer support training and CST sessions in 6 locations across Cornwall.

The pilot was funded with £50,000 from the ARF, with Promas receiving £35,000 and Memory Matters community interest company (CIC) £15,000. Additional funding was secured by the project lead to supplement the Memory Matters CIC portion.

While initial participation was lower than anticipated, the project achieved strong outcomes for those involved. Over 40 carers were supported by the training sessions, with over 20 completing the mentoring sessions.

Pre and post-session questionnaires, 3-month follow-up surveys, and testimonials were collected to evaluate the project's impact. The provider also conducted follow-up support, including telephone check-ins and up to 6 mentoring sessions per carer. Demand for this ongoing support was higher than initially anticipated.

A significant element of the project's success was the ability for carers to bring the person they cared for to the sessions, where they were supported by a memory café in the same building.

Challenges, barriers and unintended consequences

Challenges, barriers and unintended consequences included:

- funding disbursement: delays in getting funding to providers occurred due to NHS and council processes, impacting smaller organizations with limited cash flow
- geographical challenges: reaching carers across a rural area like Cornwall presents logistical difficulties, such as limited public transport, extended travel times and the cost associated with this
- provider capacity: scaling up while maintaining quality is a concern due to the limited capacity of providers
- measuring long-term impact: assessing the long-term effects on care needs is challenging
- partnership and collaboration: the end-of-grant report notes challenges with partnership and engagement, specifically around scheduling and agreements

Outcomes and impacts

A positive outcome has been increased carer confidence in leaving their loved ones in the care of others, enabling them to take breaks. The project revealed greater-than-expected complexity in carers' needs, leading to more intensive follow-up support.

While long-term impacts on care needs are difficult to measure, positive indicators include self-reported information from carers and providers and the emergence of carer self-support groups.

Carers reported positive impacts on their ability to avoid crisis and prevent carer breakdown. Many carers expressed surprise at their ability to leave their loved one with support, and some reported that the cared-for person was more responsive and engaged after the memory café sessions.

The project aims to demonstrate:

- reduced carer isolation
- improved carer health and wellbeing
- increased carer confidence in accessing respite
- delayed or prevented escalation of care needs for people with dementia

Scaling, embedding and sustainability

The project team is actively seeking funding to continue the combined service delivery model. The providers are already contracted for other services, and the goal is to secure additional funding specifically for the joint programme. The project lead believes the model is scalable and replicable in other areas. There is interest in sharing learnings and collaborating with other councils.

Longer-term support needs, identified through the project, are being integrated into ongoing carer support services. The council, public health and the ICB are considering the project's outcomes and outputs as part of their developing prevention strategy.

The project highlights the importance of provider quality and the challenges of scaling up while maintaining high standards. It also emphasises the increasing prevalence of dementia and the need for more support services.

The project has successfully engaged a previously underserved cohort of carers and demonstrated the value of combining carer support with CST for the person they care for.

A major lesson learned was the mismatch between initial expectations (higher participation vs less follow-up) and the reality of carers' needs (lower participation vs more intensive support). The project lead advises others to balance ambition with realism when planning support intensity and duration.

Case study 5: carers and hospital discharge

This project is a new carers support service in hospitals to offer additional support to carers coping with an admission into hospital and subsequent discharge.

Consortium

Coventry and Warwickshire.

Project summary

Maturity score: 4 (impacts emerging)

4. Impacts emerging during project delivery: changes (outputs, outcomes or impacts) have been measured as a result of the project delivery.

ARF priority area: 8

Priority 8 (focuses on unpaid carers): services that reach out to, and involve, unpaid carers through the discharge process.

Research conducted

Interviews conducted

Two interviews with the project lead (December 2024 and May 2025).

Supplementary evidence

End-of-grant report (March 2025).

Project aims, rationale and scope

The ARF funding was used to develop an existing project for hospital social prescribing that was due to come an end because of funding issues.

With the ARF funding, it evolved into the Hospital Carer Support Service, working with people who have been admitted to hospital to support them when they come out of hospital. There is a focus on carers - the patient themselves may be a carer or this may support those who are caring for a patient.

The funding was used to ensure members of staff in hospitals that were offering social prescribing could stay in post to offer this support, with a new focus on carers.

The aim of the project was to see an increase in numbers of carers getting assessments, being signposted and having conversations about support needs. The project lead said:

> "Once they're out of the discharge process, it's being able to say, 'There is some support for you as a carer as well,' or even as simple as, 'You can go onto this website, if you need to, in the future.' Just arming them with it. So, I suppose the success would be that the service is utilised."

Project delivery

In March 2025 (time of end-of-grant report submission), the project was nearing the second quarter of its contract.

Hospital social prescribers, responsible for offering the Hospital Carer Support Service, were in post (they were in post before the start of the funding period) and were attending discharge meetings and ward rounds.

The social prescribers were offering one-to-one information and guidance during the period in hospital and following discharge. They were signposting carers to resources and support, as well as referring some into the Carers Trust.

They were basing themselves within the social care services but spending approximately 50% to 80% of their time in hospitals.

Challenges, barriers and unintended consequences

As the project is scaling an existing initiative, project leads didn't feel there were many significant challenges or barriers to implementation.

Outcomes and impacts

Some impacts of the project are already visible. Nearly twice as many referrals for carers support have been received in the last quarter compared with the previous two. Onward referrals to the Carers Trust have also doubled. Interviewees also said that the number of carers identified has increased but the amount of increase was unspecified.

The project is likely to have broader impacts, with the proactive support offered to carers potentially reducing the need for reactive support further down the line. However, this is not something they are actively measuring as the project leads note this is harder to monitor and capture compared to other impacts. The project lead said:

> "The support that they're giving to carers could prevent a burnout, could prevent a need for more or even any statutory support, but it's one of those

> things that you're potentially never going to know. So, it's hard with some of these preventative services to really be able to say what the impact is, but I do think there's a lot of softer stuff that maybe we won't get through the reporting."

Scaling, embedding and sustainability

At present there is no funding to continue running the service, so it is unlikely to continue. Project leads explained that this would leave a significant gap in the support offer for carers of those in hospital, and were writing a report to outline possible options following the end of the funding period.

Even if funding is secured to continue the projects, there are no plans to extend it to any other geographical areas as it covers all hospitals in the county. Project leads saw more potential for increasing the number of workers to increase the capacity of the service within existing hospitals but that would be dependent on additional resource. The project lead said:

> "With additional funding and a bigger resource, there would be an opportunity to scale up... we are missing out in some of the wards … because … for example we have one hospital social prescriber for 0.7 of a week… working in a hospital that's got thousands of people accessing it ... they don't need to promote the service any further, because they're already at capacity. If we were to have more funding and recruit more people, you know, they could promote the service much harder."

Case study 6: co-production approach to improving support and service access for diverse carers

The Derby Diverse Carers Project is an ARF-funded project led by Community Action Derby, which is Derby's community infrastructure and collaboration organisation. Community Action Derby is working to improve diverse carer access to, experience of and outcomes from carer support and services alongside:

- carers from diverse and under-represented communities
- Universal Services for Carers in Derby
- community organisations
- the city council
- the NHS
- other partners

It is doing this through structured interviews with a cross-section of the community, forming a citywide alliance of carers and community agencies, and using the findings from interviews and the alliance, and collaborative work with commissioning to identify, co-produce and pilot new and improved support.

Consortium

Derby and Derbyshire.

Project summary

Maturity score: 2 (implementation)

2. Implementation and set-up: getting projects set up and acquiring necessary resources (such as staff and developing tools)

ARF priority areas: 3 and 12

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

Priority 12 (focuses on unpaid carers): ways to encourage people to recognise themselves as carers and promote access to carer services.

Research conducted

Interviews conducted

Two interviews with the project lead (December 2024 and May 2025).

Supplementary evidence

Local impact assessment (May 2025), and end-of-grant report (May 2025).

Project aims, rationale and scope

The project aims to develop an inclusive approach to supporting carers in Derby from diverse minority communities who often experience poorer access to, experience of, or outcomes from support services.

Through a programme of semi-structured, in-depth interviews with carers, and ongoing community engagement, the project aims to better understand:

- the experiences of carers from diverse backgrounds
- care-giving roles in these communities
- why carers might not be accessing services
- what diverse carers think needs to be done to reach and support them

The project is broadening the scope of a 2023 pilot, which focused on the experience of carers from black and south Asian ethnic minority communities, to cover different ages, ethnicities and religions, and to include carers with disabilities and those from LGBTQ+ communities.

The local authority, Derby City Council, has contracted Community Action Derby (CAD) to lead the project, including making small grants (up to £2,000) to community groups across Derby to:

- run workshops
- conduct engagement work
- have one-to-one conversations with carers

CAD has also established and is leading a Diverse Carers' Alliance to support this and future listening, engagement and co-production work, with the intention of bringing together partners to actively contribute to improving working systems and ensure carers' needs are better met.

Project delivery

The project is overseen by a strategic steering group and has established the Diverse Carers' Alliance, which includes carers and organisations who are helping identify and consider priorities and barriers for diverse carers accessing support. The strategic steering group involves organisations such as:

- city council local area co-ordination
- Universal Services for Carers
- Derbyshire Carers Association
- Disability Direct

Currently, small grants are being awarded through CAD to 21 'community connector' partners who are carrying out structured, in-depth interviews with carers from diverse communities and groups across Derby City.

The results from this will then be collated, informing the next steps of co-production work between Derby carers, organisations and commissioning, which will identify priorities, develop and pilot options for new and improved support.

Challenges, barriers and unintended consequences

Project interviews cited a number of challenges, barriers and unintended consequences:

- Historically, some partners have worked in silos, which competitive tendering for commissioned services has contributed to. Through the alliance and steering group meetings, statutory and VCSE organisations are now regularly coming together and collaborating for the benefit of carers
- contracting processes delayed procurement, which required continued and effective communication and clear senior level commitment to keep partners on board
- challenges applying action across Derby and Derbyshire integrated care system (ICS) as the offer for carers, including carers assessments, differs across the local authorities Derbyshire County and Derby City

- uncertainty related to levels of NHS investment - for example, the uncertainty around the state of NHS England and the future of ICB and other partners, can make it harder to get commitment and buy-in from statutory partners

Outcomes and impacts

The ARF-funded projects have built on the strong working relationship across Derby and Derbyshire local authorities. The Diverse Carers' Alliance is identifying the broad needs of diverse carers and providing a platform for carers to share their experiences, sharing information and channelling feedback. There has been enhanced community support and greater awareness of the importance of carers generated through the small grants programme.

Currently, the project is beginning the process of listening to the experiences of carers in the community, including the challenges and barriers to services they face. Following this, there are plans to begin co-production with carers, CAD and the local authority to start identifying the priorities and options for improving support for diverse carers.

Scaling, embedding and sustainability

Looking forward, CAD hopes to embed peer support networks into its Diverse Carers' Alliance, and plans to apply for funding to ensure this is financially sustainable beyond the ARF funding life span.

While much of the work has focused on Derby City, which is more ethnically and culturally diverse than Derbyshire County, the plan is to apply learning to the county using working relationships with the county's commissioned carers services Derbyshire system plan to integrate findings from this and other ARF funder projects into their new carers' strategy, which will be published in 2026.

Case study 7: supporting unpaid carers and hospital discharge

This project aims to support unpaid carers when people are discharged from hospital through assistive technology and the voluntary sector, to assist in signposting carers to wider support in the community.

Consortium

Herefordshire and Worcestershire.

Project summary

Maturity score: 4 (impacts emerging)

4. Impacts emerging during project delivery: changes (outputs, outcomes or impacts) have been measured because of the project delivery.

ARF priority areas: 2, 6 and 8

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.

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

Priority 8 (focuses on unpaid carers): services that reach out to, and involve, unpaid carers through the discharge process.

Research conducted

Interviews conducted

Consortia representative (December 2024) and project lead (May 2025).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope.

This project addresses the experience and outcomes of hospital discharge for unpaid carers by providing them with practical support, which is complimented by using assistive technology.

The rationale behind the project stems from the recognition that unpaid carers often face sudden and overwhelming responsibilities when a loved one is discharged from hospital.

The scope of the project is deliberately focused and targeted. Rather than attempting to address all hospital discharges across the county, the project has focused on 2 distinct hospital wards, dealing with stroke patients and those people who are frail (Worcester).

In terms of the type of project, it introduces new elements, such as plug-and-play assistive technology and a more integrated approach to involving carers in discharge planning.

Project delivery

This project is in the delivery phase with progress being made. It has been successfully launched and is now supporting unpaid carers when people are being discharged from hospital. The project is initially focusing on supporting carers of people who have had a stroke.

Some delivery challenges have already emerged in the course of this work, including:

- delays with the technology provider of the digital tool that would enable self-directed support
- slower-than-expected progress on signposting unpaid carers project

However, a recovery plan is in place to address these issues.

Assistive technology has been used to support unpaid carers, with more in the pipeline. The self-directed signposting for carers is less well developed due to issues with the technology provider - however, there is a plan in place to recover some lost time and ensure a longer-term solution.

The project is also linking into the wider volunteering work being supported by other ARF projects in Worcestershire and progress is being made in understanding how volunteers may be able to support the ongoing delivery of the service.

Challenges, barriers, and unintended consequences

Four main challenges, barriers and unintended consequences related to the delivery of this project have been:

- speed and co-ordination of hospital discharges: stroke patients are long-term admissions, allowing more time to plan, albeit mostly around the patient. Frailty settings work with a rapid turnover of patients and discharge. With both cohorts, there are challenges in co-ordinating support. The pace at which the frailty wards must work has impacted the ability to install assistive technology ahead of any discharge and provide adequate preparation for carers at the point of discharge

- technology provider and implementation delays: there have been issues with the technology provider of the digital tool that would enable self-directed support, particularly around the development of the solution. These delays have slowed the rollout of significant components of the project, although a recovery plan is now in place and a new potential supplier identified with an off the shelf solution

- scope management and capacity limitations: initially, the project risked being too broad in scope. To manage this, the team narrowed its focus to specific hospital wards and patient groups. This helped ensure the project remained deliverable but also highlighted the limitations in capacity to scale more widely at this stage

- cultural and relational tensions within the system: as unpaid carers became more informed and empowered through the support provided, unpaid carers began asking more questions and challenging approaches to discharge, which created discomfort among staff under pressure to discharge patients quickly. While this was seen as a positive shift in unpaid carer advocacy, it also revealed the need for even better collaboration and communication across services

Project leads report that these challenges have been mitigated by refining the project's scope, focusing on a specific ward, and strengthening collaboration with health and care partners. A recovery plan is addressing the technology delays, and regular project board meetings are helping to maintain alignment and momentum.

An unintended consequence of the project has been the shift in power dynamics between unpaid carers and health professionals. As unpaid carers have become more confident in advocating for their needs, this has led to increased scrutiny of discharge practices. While this has introduced some friction, it is viewed as a constructive development that enhances the role of unpaid carers in the care process which provides insight to the health and care system as to the requirements of unpaid carers.

Outcomes and impacts

The hospital discharge project has begun to demonstrate a range of emerging outcomes and impacts, both for unpaid carers and the wider health and care system.

One of the most significant outcomes is the enhanced support for unpaid carers at the point of hospital discharge. By providing assistive technology and linking carers with support services from day one, the project has helped carers manage the transition more effectively. This support has enabled carers to sustain their caring roles for longer, potentially delaying or avoiding the need for formal care services or residential placements.

The most significant impact is the empowerment of carers. Through the involvement of carers' organisations, unpaid carers have become more informed and confident in advocating for their needs. This has led to unpaid carers asking more questions and challenging discharge decisions, which, while creating some tension with health professionals, has been viewed positively as it ensures unpaid carers' voices are heard and considered in care planning.

The project has also had a positive effect on system collaboration. For the first time, unpaid carer leads from Worcestershire County Council, the NHS and voluntary sector have come together regularly to co-ordinate support. This has strengthened relationships, improved communication, and fostered a shared commitment to supporting carers more effectively.

In terms of measurable outputs, the project team is collecting both quantitative data (such as the number of discharges supported and technology deployments) and qualitative evidence (including case studies and personal stories). While long-term impacts on outcomes - such as reduced hospital readmissions or sustained home care - are harder to measure within the project's timeframe, early indicators suggest that the intervention is helping people remain at home longer and more safely.

Financially, while exact savings are difficult to quantify at this stage, the project highlights the economic value of unpaid carers. By supporting unpaid carers to continue in their roles, the project helps avoid significant costs that would otherwise fall on the formal care system.

Finally, the project has contributed to a cultural shift within the local system, encouraging more proactive and preventative approaches to care. It has also sparked discussions about how to embed this model into routine practice, despite current funding limitations.

Scaling, embedding and sustainability.

In terms of scaling, the project acknowledges that, while there is interest in expanding the model, doing so would require careful consideration of existing resources. The project team are aware that scaling is not simply a matter of securing more funding, but rather about making better use of the money already in the system.

They suggest that strategic decisions, such as reducing reliance on care home beds and reinvesting in home-based support, could enable broader implementation. However, they also recognise that such decisions would be politically and operationally challenging.

Regarding embedding, the project has already begun to influence practice by fostering stronger relationships and trust across the health and care system. The learning, skills and behaviours developed through the project are expected to remain with those involved, even if the formal project ends. This includes improved collaboration between carers' organisations and health professionals, as well as a more proactive approach to supporting unpaid carers. While the direct capacity to deliver the service may be lost without continued funding, the knowledge and experience gained are seen as valuable assets that can inform future work.

On sustainability, the outlook is more cautious. The project team is clear that the project has a clear end date. There is no secured funding to continue the initiative beyond its current phase, and both the council and the ICB are facing significant financial pressures. Although discussions are ongoing about potentially using the Better Care Fund to support the service, that fund is already fully committed.

The team is exploring opportunities to advocate for national-level funding, emphasising the economic and social value of supporting unpaid carers during hospital discharge.

Case study 8: culture and nature for health and wellbeing

This project aims to support unpaid carers by providing access to co-produced, high-quality arts, heritage and nature-based activities that promote wellbeing, reduce isolation, and help prevent carer burnout through creative engagement and immersive experiences in restorative environments.

Consortium

Lincolnshire.

Project summary

Maturity score: 4 (impacts emerging)

4. Impacts emerging during project delivery: changes (outputs, outcomes, or impacts) have been measured as a result of the project delivery.

ARF priority areas: 4 and 10

Priority 4 (focuses on unpaid carers): ways to support unpaid carers to have breaks which are tailored to their needs.

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

Research conducted

Interviews conducted

Consortia lead (December 2024) and project lead (May 2025).

Supplementary evidence

End-of-grant report and local impact assessment (both May 2025).

Project aims, rationale and scope

This project addresses the wellbeing and resilience of unpaid carers by offering them access to co-produced arts, heritage and nature-based activities.

The rationale stems from the recognition that unpaid carers often experience stress, isolation and emotional fatigue, and that creative, nature-connected experiences can provide meaningful respite and help prevent burnout.

The scope of the project is focused and place-based, centred around Doddington Hall and Gardens in Lincolnshire, with additional sessions planned at a community garden in Lincoln.

It targets unpaid carers across the county and includes training for support workers to extend the reach of the offer. It introduces a new model of preventative support, aiming to test its effectiveness and explore how it can be embedded into existing care systems.

Project delivery

This project is in the delivery phase with significant progress made across its core components. The arts, heritage and nature activities offer has been successfully launched and is now supporting unpaid carers through immersive, creative experiences designed to promote wellbeing and prevent burnout. The project is initially focused on carers attending monthly sessions at Doddington Hall and Gardens, with additional workshops planned at Green Synergy Community Garden in Lincoln.

Co-production workshops have already taken place, shaping the design of the activities in collaboration with carers. A freelance artist was commissioned to lead the sessions, and support workers have received training to help sustain the offer beyond the funded period. Downloadable online resources have also been created to extend the project's reach.

While delivery has been smooth overall, some challenges have emerged, particularly around the short timeframe for recruiting carers. This was mitigated through early planning and strong partnership working. The project is also exploring how to embed its approach into existing care systems and was preparing for a celebration event to mark the completion of the initial phase.

Challenges, barriers and unintended consequences

Two main challenges and barriers related to the delivery of this project have been identified.

The first of these main challenges was ensuring sustainability beyond initial funding:

- a significant challenge has been how to maintain the offer for carers who have already participated and benefited from the activities. While the project has been well received, there is currently no guaranteed funding to continue or expand the programme

- to address this, the project team is actively exploring a range of funding options, including further grant applications (potentially from non-governmental sources), and is working with a local university to generate evaluation feedback to support future bids. The evaluation, conducted independently by the University of Lincoln, combines both process and impact elements. It uses a mixed-methods approach, including qualitative techniques such as letter writing and interviews, as well as quantitative tools like surveys and app-based data collection, to assess both how the project was delivered and the outcomes for unpaid carers

- in parallel, the team is also investigating how the model could be embedded into existing care systems through commissioned services, with the aim of transitioning from short-term funding to a more sustainable delivery model

The second main challenge identified was time constraints for recruitment:

- the short-term nature of the funding created pressure to recruit unpaid carers quickly, which proved difficult

- many carers face barriers to participation, such as limited time, emotional strain or lack of access to respite care. This was particularly challenging given the need to reach carers who may be isolated or face barriers to participation

- the team mitigated this by starting recruitment early and building strong partnerships with local organisations, supported by a targeted communications strategy

Project leads report that these challenges have been addressed through proactive planning, strong collaboration and a focus on co-production.

No unintended negative consequences were formally reported, but the challenges highlight the importance of long-term planning and flexible delivery when working with unpaid carers.

Outcomes and impacts

The arts, heritage and nature activities offer has begun to demonstrate a range of emerging outcomes and impacts, both for unpaid carers and the wider health and care system.

One of the most significant outcomes is the improved wellbeing and emotional resilience of unpaid carers. Through regular participation in immersive, creative sessions at Doddington Hall and Gardens, carers have reported feeling:

- more supported

- less isolated
- better able to cope with the demands of their caring roles

Feedback gathered by the University of Lincoln suggests that the more sessions carers attend, the more sustained and profound the positive impact on their mental health and quality of life.

Another main outcome is the empowerment of support workers. Two cohorts, who received 4 immersive sessions each, have completed training to deliver culture and nature-based activities, and many are already applying these skills in their own settings. This has extended the reach of the project and laid the groundwork for a more sustainable model of delivery, where knowledge and practice can be shared across teams and organisations.

The project has also had a tangible impact through the creation of downloadable resources, including guided meditations and creative activity sheets. These resources are freely available online and provide a lasting legacy that can be accessed by carers and practitioners beyond the life of the project.

In terms of system-level impacts, the project has helped raise awareness of the value of arts, heritage and nature in supporting health and wellbeing. It is being featured in national case studies and research projects, and has sparked interest in how such approaches can be embedded into existing care systems. This has encouraged greater collaboration between cultural organisations, the voluntary sector, and health and care services.

While long-term impacts, such as reduced demand for formal care services, are still being evaluated, early indicators suggest that the intervention is helping carers feel more capable and supported, which may contribute to delaying or avoiding the need for more intensive support.

Finally, the project has contributed to a cultural shift in how unpaid carers are supported. By recognising the importance of creative and nature-based experiences, it has encouraged a more holistic and preventative approach to carer wellbeing and opened up new possibilities for how care and support can be delivered in the future.

Scaling, embedding and sustainability

The arts, heritage and nature activities offer has laid important groundwork for scaling, embedding and sustaining its approach within the wider health and care system.

One of the main ambitions of the project is to scale the model to reach more unpaid carers across Lincolnshire. The project team is currently working with partners, including Every-

One and the Lincolnshire voluntary engagement team, to explore how the offer can be expanded to additional locations and communities. Early-stage research and development is underway to identify suitable sites and consult with carers about their needs, with the aim of preparing a funding bid to support wider delivery.

Embedding the approach into existing care systems is also a central focus. The project has been exploring how culture and nature-based activities can be integrated into services such as Connect to Support, and how they might be commissioned as part of preventative care strategies. The evaluation report, due later in 2025, is expected to provide the evidence base needed to support this integration, including recommendations for how the model can align with health and social care commissioning frameworks.

Sustainability remains a significant challenge, particularly in terms of securing ongoing funding and maintaining momentum beyond the initial pilot phase. However, the project has taken proactive steps to address this by:

- training support workers to deliver the activities independently
- creating downloadable resources for wider use
- building strong partnerships across sectors

The artist involved in the project is also seeking additional funding to continue working with the original group of carers, and there is a clear appetite among participants to keep the programme going.

Overall, the project has demonstrated that arts, heritage and nature-based interventions can be a valuable and scalable component of carer support. While further work is needed to embed the model into routine practice, the foundations have been laid for a sustainable and impactful approach that could benefit many more carers in the future.

Case study 9: short breaks and enhanced wellbeing grants for carers

This case study demonstrates the impact of enhanced wellbeing grants on carer wellbeing and the challenges of implementing a seemingly simple project within a complex social care system.

Consortium

Mid and South Essex.

Project summary

Maturity score: 4 (impacts emerging)

4. Impacts emerging during project delivery: changes (outputs, outcomes, or impacts) have been measured as a result of the project delivery.

ARF priority area: 4

Priority 4 (focuses on unpaid carers): ways to support unpaid carers to have breaks which are tailored to their needs.

Research conducted

Interviews conducted

Project lead (November 2024 and April 2025) and unpaid carer (May 2025).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope

This project addressed the gap in support for carers needing respite care, bridging the gap between smaller grants (up to £500) and statutory support (up to £4,000 to £5,000). The project aimed to reduce demand on statutory services and improve carer wellbeing by providing enhanced grants of up to £2,000 for respite care.

The target group was unpaid carers in Mid and South Essex. This project scaled an existing grant program, increasing the grant amount and expanding the types of respite care accessible.

Project delivery

The project was delivered through 2 community providers with existing carer support contracts. One provider fully expended their allocated funds by 31 March 2025, while the other had a small amount remaining to be carried over.

Some of the main activities included:

- collaboration between the council, providers, and carers
- person-centred conversations to identify carer needs and appropriate grant usage
- an assurance process to ensure appropriate use of grant funding
- ongoing monitoring and support to providers

Challenges, barriers and unintended consequences

Some of the main challenges barriers and unintended consequences included:

- inconsistency in service delivery: differing internal processes and risk aversion between the 2 providers led to inconsistencies in grant distribution and speed of spending. This was mitigated through ongoing monitoring and support to ensure a consistent approach
- sustainability: the time-limited nature of the funding posed a challenge to long-term sustainability. Limited communication about the programme to carers helped manage expectations and mitigate potential reputational damage when the funding ended
- resourcing: the project required more resources than initially anticipated, particularly for staff training and guidance on eligible grant expenditures. Ongoing discussions with providers, legal and policy teams helped address this
- measuring impact on statutory service demand: determining the project's impact on reducing demand for statutory services proved difficult due to a lack of integrated data systems and the challenge of isolating the project's impact from other factors. While direct payments to carers increased during the project period, it is unclear whether this increase would have been even higher without the enhanced grants

Outcomes and impacts

The project demonstrated positive outcomes for carers, including:

- increased access to respite care and other support such as:

    - breaks
    - entertainment
    - personal care
    - hobbies
    - technology
- improved carer wellbeing and mental health, and reduced social isolation (evidenced by carer self-assessed scores using the Carer Staff Framework and qualitative feedback)
- unintended positive outcomes, such as a carer using the grant for driving lessons, leading to sustainable employment that fitted their caring role
- anticipated future impacts (not yet measured) include reduced pressure on statutory services and cost savings. There is a risk that demand for statutory services may increase after the funding ends as carers who were supported by the grants may now require additional support

Scaling, embedding and sustainability

Sustainability is partially addressed through the existing core offer of smaller grants (up to £500) for carers' breaks.

A business case for continued funding was submitted but rejected due to the local authority's financial deficit. Scaling beyond the initial scope is not planned without further funding.

Some of the main lessons learned include the need for:

- consistent service delivery across providers
- realistic timeframes for project implementation
- clear guidance on grant usage

The project has also informed future commissioning decisions, highlighting the challenges of a multiple provider model and the need for stronger partnerships and co-ordination between providers.

Case study 10: scaling digital carer support and fostering innovation

This case study showcases a unique regional approach to scaling digital carer support and fostering innovation within a large and diverse ICS.

Consortium

North East and North Cumbria (NENC).

Project summary

Maturity score: innovation Fund - 3 (project delivery) and Mobilise - 4 (impacts emerging)

3. Project delivery: delivering the service or tools but not yet observing any changes as a result.

4. Impacts emerging during project delivery: changes (outputs, outcomes or impacts) have been measured as a result of the project delivery.

ARF priority area: 2

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.

Research conducted

Interviews conducted

Two interviews with the project lead (December 2024 and April 2025).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope

This project had 2 distinct components:

Mobilise

Scaling up an existing pilot programme called Mobilise. This is a digital platform providing information, advice and support to unpaid carers across all 13 local authorities in the NENC ICS. This aimed to:

- increase carer identification, particularly among underrepresented demographics (such as working-age carers, male carers and marginalised communities)
- improve access to support outside traditional service hours

Innovation fund

Establishing a regional fund to support smaller-scale innovative projects aligned with ARF priorities, fostering collaboration between local authorities and encouraging the development and testing of new approaches to care.

Project delivery

The project delivery went as follows for the 2 components:

Mobilise

The platform was successfully rolled out across all 13 local authorities, with ongoing monitoring of key performance indicators such as:

- website visits
- resource usage
- support interactions

A pilot of digital carer assessments is also underway

Innovation fund

A multidisciplinary expert reference panel, including lived experience representation, was established to review and select projects.

Four rounds of bids have been held, funding 8 projects, including 2 multi-local authority collaborations and one regional project. Activities included:

- developing guidance and criteria
- hosting webinars

- providing support to successful bids

Challenges, barriers and unintended consequences

Some of the main challenges, barriers and unintended consequences for the 2 components included:

Mobilise

Initial challenges with rapid scaling and data reporting across 13 local authorities were resolved through improved contract management and data collection processes.

Innovation fund

The main challenge was maintaining a high bar for innovation, encouraging local authorities to propose truly new approaches rather than simply using technology for 'business as usual'.

Limited project timeframes (18 months) and the difficulty of recruiting specialized staff within that timeframe also posed challenges. Care Quality Commission inspections and heavy workloads within local authorities also caused some project delays.

Outcomes and impacts

Mobilise

Outcomes and impacts for Mobilise included:

- significant increase in carer identification, with 76% of Mobilise users reporting no prior access to carer support
- increased access to support and resources, particularly outside traditional working hours
- improved carer wellbeing and reduced isolation (evidenced by user feedback and case studies)
- positive economic impact through increased access to benefits like Carers' Allowance
- emerging evidence of preventative and delaying effects on the need for statutory services

Innovation fund

Outcomes and impacts for the innovation fund included:

- increased collaboration between local authorities and external partners
- development and implementation of innovative projects, primarily focused on technology solutions (such as AI, large language models, chatbots)
- early stages of implementation for sub-projects, with full regional evaluation planned for spring 2026. Outcomes are anticipated in areas such as:
    - improved service delivery
    - enhanced care quality
    - better understanding of user needs

Scaling, embedding and sustainability

The scaling, embedding and sustainability for the 2 components was as follows:

Mobilise

NENC ADASS plans to step back and support local authorities in developing individual business cases for continued funding, potentially through joint commissioning or partnerships with health and other sectors. The focus will be on demonstrating the value for money and system-wide benefits of Mobilise.

Innovation fund

Longer-term plans include exploring different funding models for the innovation fund and working with Health Innovation Network North East and North Cumbria (the partner organisation) to support the scaling and commercialization of successful sub-projects.

This includes developing a model for protecting intellectual property and ensuring a return on investment for the public sector.

A research and evaluation manager will be recruited to conduct systematic evaluations of funded projects and build a stronger evidence base for innovation in social care.

Some of the main lessons learned include:

- the importance of aligning funding with regional priorities
- leveraging existing networks and relationships
- maintaining a focus on true innovation

The project highlights the potential of regional organisations to drive system-wide change and accelerate the adoption of new approaches to care.

Case study 11: scaling up Shared Lives and developing an app for unpaid carers

This case study outlines 2 interconnected projects undertaken by the South Yorkshire consortium:

- scaling up Shared Lives services
- developing an unpaid carers app

Both projects aim to modernise and expand support for Shared Lives and unpaid carers and individuals receiving care.

Consortium

South Yorkshire.

Project summary

Maturity score: unpaid carers app - 2 (implementation) and Shared Lives expansion - 3 (project delivery)

2. Implementation and set-up: getting projects set up and acquiring necessary resources (such as staff and developing tools).

3. Project delivery: delivering the service or tools but not yet observing any changes as a result.

ARF priority areas: 1, 2 and 9

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

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.

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

Research conducted

Interviews conducted

Project lead (January 2025).

Supplementary evidence

Local impact assessment (May 2025).

Project aims, rationale and scope

Shared Lives expansion

This project aims to expand and enhance existing Shared Lives services across South Yorkshire. The rationale is to:

- increase capacity
- address demand/supply issues
- broaden the scope of Shared Lives to offer placements to individuals with diverse needs, such as:
    - people with mental ill health
    - people with dementia
    - young people transitioning to adulthood

A major element is the development of a digital platform to improve efficiency in recruitment, payroll, and matching Shared Lives carers with individuals who need support.

Unpaid carers app development

This project aims to develop a shared carers app for all 4 regions in South Yorkshire. The rationale is to provide a centralised digital resource for carers to access information, advice and support services, including flexible break options.

The scope includes:

- developing a 'must-do' list of app features
- procuring an AI provider and app developer
- co-designing the app with carers
- integrating it with existing carer support services

A future aspiration is to link the app with the Shared Lives project to enable carers to book Shared Lives services directly.

Project delivery

Both projects are underway. The Shared Lives project:

- has established a consortium board
- has held a regional event
- has developed a carer recruitment strategy
- is exploring new pathways for Shared Lives

The carers app development project has:

- defined initial features
- conducted soft market testing
- identified potential providers
- begun co-production activities

Challenges, barriers and unintended consequences

Shared Lives expansion

Challenges for this project have included:

- varying approaches to Shared Lives delivery across the consortium
- equitable distribution of funding

Doncaster faces a specific challenge related to its outsourced Shared Lives service Recruitment of Shared Lives carers remains a "critical bottleneck". The project lead said:

> "Unless we recruit, we are not going to be able to do anything, so the recruitment is the key thing we're dependent on to deliver any of the other activities meaningfully."

Unpaid carers app development

Challenges and barriers for this project have included:

- managing expectations about app functionality

- ensuring the app meets the diverse needs of each region
- securing long-term funding for app maintenance
- the ambition of integrating the app with existing local authority systems

Outcomes and impacts

The Shared Lives expansion has already achieved increased collaboration and information sharing across the South Yorkshire consortium. Early outcomes include:

- a revised carer recruitment strategy
- localised campaign materials
- the development of a recruitment tracker

Anticipated outcomes include:

- increased Shared Lives carer numbers
- expanded pathways to include diverse needs (such as dementia, mental health and transitions)
- improved referral processes
- increased access to training for social workers and carers

The project also aims to improve matching between carers and individuals. The long-term impact is expected to be greater access to Shared Lives services and better support for carers and individuals receiving care.

While still in development, the unpaid carers app project anticipates several related main outcomes. These include:

- a functional and user-friendly carers app
- improved access to information and advice
- a more streamlined referral process for carer support services

The project lead said:

> "Success would look like having, actually getting an app that works, and that people are using...My success would be if we can link the 2 projects together and have a shared life booking system through the app as well."

The project also aims to increase carer identification and provide a platform for cascading information to carers. The anticipated long-term impacts include:

- improved carer wellbeing
- reduced carer burnout
- increased uptake of assistive technology
- a cultural shift towards greater acceptance of digital support tools

Scaling, embedding and sustainability

Shared Lives expansion

Scaling is primarily focused on increasing the number of Shared Lives carers and expanding the service to new client groups (such as dementia, mental health and transitions).

There are plans to integrate this expansion into local authority service plans and operational processes, including training for social workers and improved referral systems.

Sustainability relies on securing ongoing funding from local authorities and demonstrating the value of Shared Lives to ensure continued investment.

Unpaid carers app development

Scaling will depend on user adoption and the ability to expand app functionality. The project aims to embed the app by integrating it with existing local authority systems and promoting its use among carers.

Sustainability is a major concern, as ongoing costs for hosting and maintaining the app need to be addressed. The project is exploring shared funding models across the consortium and seeking ways to demonstrate the app's value to secure continued investment.

The potential for linking the app with other services, like assistive technology, is also seen as a way to enhance its value and promote wider adoption.

Case study 12: digital technology-enabled services

A programme of 5 projects to support and assess unpaid carers, and recruit and support Shared Lives carers in Sussex through digital technology.

Consortium

Sussex.

Project summary

Maturity score: mainstream technologies - 1 (scoping) and 4 other projects - 2 (implementation)

1. Scoping and design: establishing project aims and objectives.

2. Implementation and set-up: getting projects set up and acquiring necessary resources (such as staff and developing tools).

ARF priority areas: 1, 2, 5, 7 and 9

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

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.

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

Priority 7 (focuses on unpaid carers): ways to conduct effective carer's assessments with a focus on measuring outcomes and collaboration.

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

Research conducted

Interviews conducted

Two interviews with the project lead (December 2024 and April 2025).

Supplementary evidence

Local impact assessment (May 2025) and end-of-grant report (May 2025).

Project aims, rationale and scope

This programme aimed to create a digital pathway for unpaid carers, encompassing 3 projects. The projects sought to address local strategic priorities for unpaid carers across East Sussex, West Sussex, and Brighton and Hove, aligning with each council's carer support strategies and the NHS Sussex Integrated Care Strategy.

A main focus was on:

- improving carer identification
- providing easier access to information and support
- reducing pressure on carers centres

Projects included the following.

Digitised Carers Card

Replacing the physical card with a digital version offering:

- easier application
- wider access to discounts
- improved communication with carers

Self-serve online assessments and systems integrations

Streamlining processes and reducing manual work through system integrations and a self-service online assessment pathway.

Mainstream technologies

Expanding the use of readily available technology (such as Alexa, smartphones) to support carers and the people they care for

Within the programme, 2 projects were designed to recruit and support Shared Lives carers:

Shared Lives pan-Sussex app

Developing an app to connect potential Shared Lives carers with Shared Lives opportunities and support the matching process.

Shared Lives pan-Sussex team

Establishing a dedicated team to drive the project, including talent acquisition and recruitment.

Project delivery

One project is in the scoping and design phase (mainstream technologies) and the others are in the implementation and set-up phases, with a focus on procurement.

Progress has been made in:

- scoping and requirements gathering across the 3 councils and carer centres
- formation of sub-groups based on shared priorities (such as digitised carers card and AI tools) - for instance:
    - West Sussex opted out of the digitised carers card workstream, focusing instead on AI-driven tools for appointment booking, call transcription and online support
    - East Sussex and Brighton and Hove prioritised the digitised carers card, including adaptations for young carers
- scoping of mainstream technologies and their application in carer support
- development of a Shared Lives app in partnership with Shared Lives Plus
- recruitment of a project manager and talent consultant for the Shared Lives team

Challenges, barriers and unintended consequences

Some of the main challenges related to the delivery of these projects have been:

- differing priorities: the consortium faced the challenge of balancing diverse needs and priorities across the 3 councils. This was addressed by splitting the project into smaller workstreams based on shared priorities
- balancing consortium benefits with increased complexity: working across the ICS footprint introduced complexities related to data sharing, differing systems and varying levels of digital maturity

- the project also identified the following risks: rapid technological change, which leads to ongoing maintenance, software updates and compatibility issues (mitigated by focusing on modular design) and limited budget (requiring prioritisation of features). Engagement with NHS and other partners has been challenging, with initial enthusiasm from NHS colleagues waning.

No unintended consequences have been identified at this stage.

Outcomes and impacts

Some of the main outcomes the system is hoping to achieve from this project include:

- earlier identification of carers
- improved access to information and support
- reduced pressure on carer centres
- increased carer engagement
- improved data handling
- increased use of mainstream technology
- expansion of Shared Lives opportunities.

There are no outcomes impacts reported at this stage, reflecting that the projects are not yet in the delivery phase. Impacts are anticipated by November 2026.

Scaling, embedding and sustainability

Sustainability for these projects is planned through:

- developing affordable and maintainable solutions
- prioritising a minimum viable product
- exploring alternative funding models (such as marketing a digital carers card)
- integrating the digital pathway into future commissioning
- building local support

Scaling is anticipated if a successful product is developed, potentially through national adoption.

The project is aligned with each council's wider strategies to improve unpaid carer support. Project leads expect this projects to be embedded into day-to-day practices.