directors of adass
adult social services
YORKSHIRE AND HUMBER

Posters

CARE WE WANT

Reimagining care and support at home in Yorkshire and Humber

Barnsley Older People Physical Activity Alliance (BOPPAA)

BOPPAA
Barnsley Older People Physical Activity Alliance

Learn more

What did you do?

BOPPAA was developed in response to the decline in older people's physical and mental health following the Covid-19 lockdown and periods of self-isolation.

BOPPAA physical activity providers offer a wide range of activities to improve strength and balance, preventing falls in our communities.

We utilise local resources, groups and volunteers to deliver activities across Barnsley. We take a strengths-based, personalised approach by working with people to ensure they attend the right activities for their needs.

80+ organisations making up BOPPAA.

210+ activities on offer for older people.

360+ people have attended falls exercise classes.

Love to Move delivered in **29** care homes.

Equity, diversity and inclusion

By designing inclusive programmes and ensuring equitable access to activities, BOPPAA creates a welcoming, supportive environment for all participants.

This approach enhances the wellbeing of older adults and strengthens the fabric of the communities we serve.

How have we done this?

- Customised activities, catering to diverse interests and needs.
- Offering afforable, accessible services at little to no cost to residents.
- Targeted outreach to engage with under-represented groups.
- Training local providers to build inclusivity into their activities.

"The strength training classes have helped me regain my confidence. I can now do things I thought were no longer possible."

"Joining the walking club has been a gamechanger for me. I've made new friends and feel healthier and happier than ever."

Difference made

- BOPPAA now has over 80 organisations united in the common aim of increasing physical activity opportunties for older people and improving strength and balance.
- 43 members of staff and volunteers have now completed Functional Fitness MOT training.
- Older people are telling us how our activities have helped improve their physical health and mental health.

Wider impact

- Strengthening community bonds.
- Reducing social isolation.
- Encouraging volunteering.
- Building a culture of active ageing, rooted in physical activity and healthy living.

Claire Barnes, clairebarnes@barnsley.gov.uk

With thanks to Age UK Barnsley, NHS South Yorkshire ICB, the Better Care Fund and our BOPPAA partner organisations.

2030 Barnsley – the place of possibilities.

BARNSLEY Metropolitan Borough Council

Assistive Living Technologies (ALT) and Yorkshire Ambulance Service initiative

The issue

Yorkshire Ambulance Service (YAS) were experiencing delays responding to 999 calls for people who fell but weren't injured in Barnsley.

What are we doing

- On receiving a 999 call, YAS assess people who have fallen at home and are either uninjured or only have a minor injury.
- Referrals are then sent to ALT by phone call, text or push notification.
- Our ALT responders then visit their home and help them up safely, referring them to other services if needed.
- Ambulances and paramedics can then prioritise more urgent, life-threatenng calls and visits.

Difference made

People:

- Improved response times, quality of life and wellbeing for older people who fall.
- Promoting early intervention and prevention, supporting independent living.
- Avoiding 'long lays'.

Health and social care:

- Reducing pressure on YAS, creating efficiencies in their service and budgets.
- Better integrated working.
- Increasing awareness between health and social care services.
- Reducing potential hospital admissions or readmissions for A&E and hospital visits.

We have responded to 270 YAS falls since December 2021!

Representing a saving of **over £87,000!**

In addition to the 4,800 urgent response visits ALT makes annually, which save YAS and the NHS at least £1.5 million per year

Next steps

- Regular review meetings between ALT and YAS.
- Further integration with Barnsley Urgent Community Response

Bevan White, Service Manager for ALT and Disabled Facilities Grants, bevanwhite@barnsley.gov.uk

2030 Barnsley – the place of possibilities.

BARNSLEY Metropolitan Borough Council

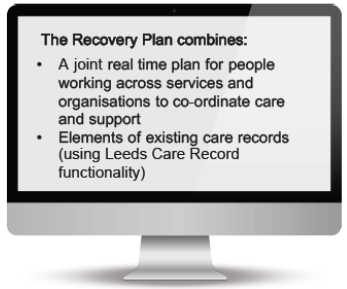
Recovery Care Plan - A shared digital platform

Recovery Care Plan First Version -
Supporting the case management process

WHAT IS IT FOR?
- Creating a shared, live, document that staff involved in a patient's discharge can read from and write onto.
- Starting with Pilot Wards Available to staff in the case management function from LCC, LTHT and LCH.

WHAT ARE THE BENEFITS?
- Improving patient experience by reducing the need for different staff to ask the patient the same questions.
- Putting an understanding of what is 'normal' for the patient and what their goals are at the centre of discharge decisions.
- Providing richer, and more structured data that is easy to understand 'at a glance' so that everyone is sighted on the plan for discharge
- Improved reporting and service improvement with more reliable and integrated data capture

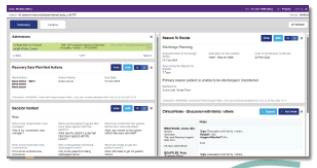
WHAT WILL IT REPLACE?
- Replacing the Discharge Plan and Tracker.
- Removing duplication from information that is already stored in PPM+ by other colleagues by pulling existing information together

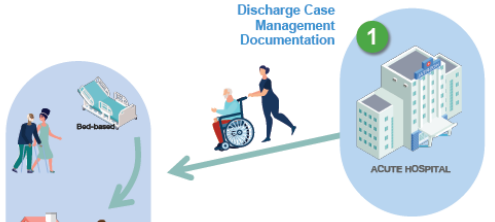


HomeFirst Vision: Part 2

Recovery Care Plan - A shared digital platform

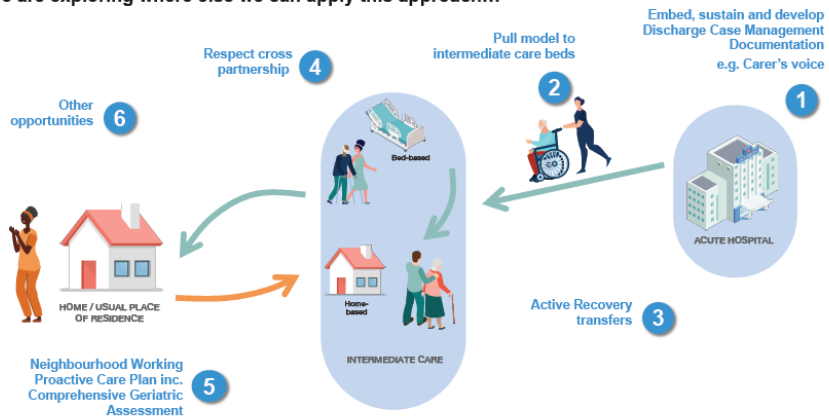
The first version of the Recovery Plan supports joint case management of patients leaving hospital





RCP Version 1
- Built in PPM+ and accessible through LCR, making the most of existing functionality.
- Enables an efficient proof-of-concept with staff from LCH, LCC and LTHT all using it within the hospital environment.
- Extensive testing has been completed with a final live-patient trial prior to rollout
- Links into the System Visibility reporting are being built to capitalise on the data being captured

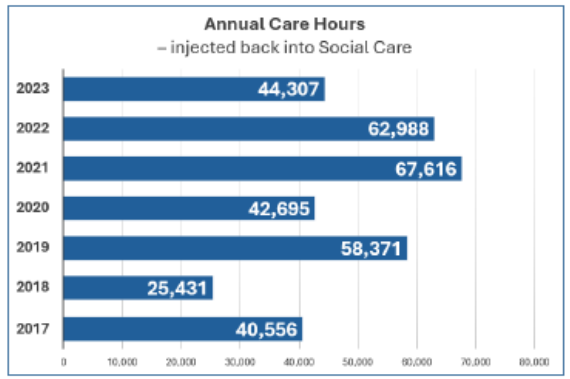
We are exploring where else we can apply this approach...



Note - partner involvement will vary dependent on scope e.g. primary care, third sector, hospital, council, community health and social care

Optimising Moving and Handling Practice

Moving & Handling Ergonomics Team | Kirklees Council



What did you do?

We implemented single-handed care as normal moving and handling practice within social care, fundamentally reshaping service delivery to enhance person-centred support, promote independence, and efficiency. This initiative focused on:

- Reducing reliance on double-handed care where unnecessary, optimising resource allocation.
- Providing system level training and education to equip all stakeholders with appropriate competencies.
- Collaborating with healthcare professionals to ensure a seamless transfer of care.
- Embedding best ergonomic practices into policy and operational frameworks to ensure long-term sustainability.

How were people who draw on care and support involved in doing this?

Participation was at the heart of this initiative:

- Co-production with service users and their families, sharing insights into their needs and experiences, allowing individuals to contribute to decision-making and shape their care.
- Regular feedback ensured ongoing adjustments to improve care quality and service user satisfaction.
- Testimonials and case studies from participants reinforced best practices and informed continuous improvement.

How you addressed issues of equity, diversity and inclusion?

We prioritised fair and inclusive care by:

- Ensuring diverse representation in consultation and planning processes.
- Recognising and accommodating individual needs in care planning.
- Removing systemic barriers to ensure equitable access to optimised handling practices.
- Providing tailored training to staff on inclusive care practices and unconscious bias awareness.

What were the resource implications?

Our initiative demonstrated both efficiency and financial responsibility:

- **Financial Savings:** Cost avoidance, contributing to overall budget efficiency.
- **Workforce Optimisation:** Care hours were reallocated back into the social care system.
- **Training and Education:** Comprehensive training and education programmes equipped carers with essential skills.
- **Technology and Equipment:** Investment in assistive devices enabled a wider range of ergonomic solutions

What went right & what went wrong?

What Went Right?

- Enhanced **person-centred care** with tailored solutions.
- Improved **service user independence** and wellbeing.

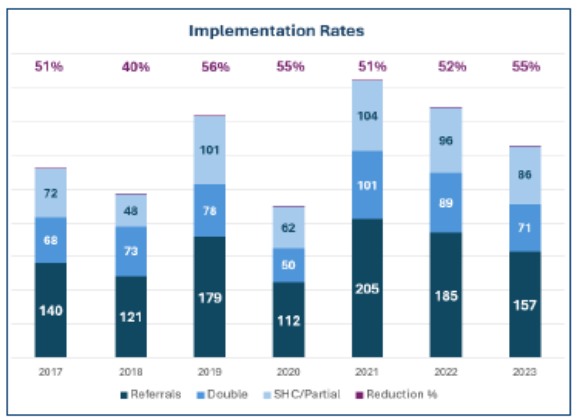
Increased workforce capacity, allowing for better allocation of care hours.

What Were the Challenges?

- Initial resistance from staff and stakeholders, requiring targeted engagement efforts.
- Need for ongoing training and education.
- Ensuring consistency across different care settings.

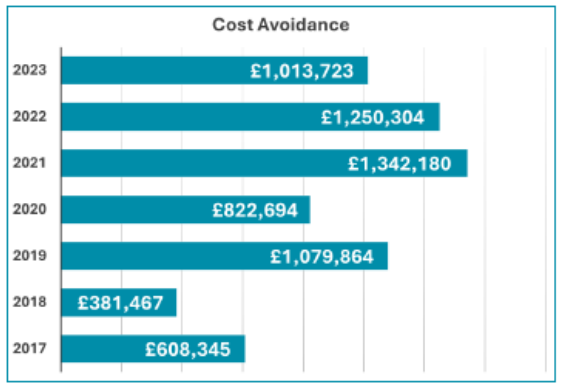
What are people saying about it?

- *"They help me to do more things on my own now"* – Service User
- *"I can see how much my mum has improved; she does more things for herself now."* – Family member
- *"At first, I was a bit worried about being on my own, but now I can see the benefit, I can actually talk to my service user and get to know them"* Support Worker
- *"We can provide more care to more people."* – Care Provider Supervisor
- *"We appreciate the support given by the Moving & Handling Ergonomics Team"* Care Provider Manager



How do you know it's worked?

- Demonstrated alignment with initial goal of reduction in care costs, improved work-force efficiency, and better service user outcomes.
- Positive testimonials from both service users and care providers.



How can its impact be sustained and how might others replicate it?

- Having a dedicated Moving & Handling Ergonomics Team to set guidance and drive the initiative forward.
- Embedding single-handler care as a risk assessment baseline into policy and training frameworks.
- Developing a knowledge-sharing network to support continuous improvement.
- Encouraging wider adoption through training, education, case studies, and strategic partnerships.

How this helps wider public life?

- Reducing strain on social care services, allowing better resource distribution.
- Contributing to a **more sustainable, person-centred** care model across the sector.
- Promoting independence, wellbeing and dignity for individuals receiving care.
- Creating a replicable model for system-wide transformation in social care.

This initiative represents a significant step toward a more efficient, equitable, and person-centred approach to care that not only saves costs but also enhances the lives of those who rely on care and support.

Kirklees - Home First Recovery beds

adult social care

What did you do?

- During Covid both acute trusts within the Kirklees system required the use of Discharge to Assess (D2A) beds to move people out of hospital into a safe place to continue their recovery and maintain hospital flow.
- Our spot purchase model for Discharge to Assess beds scattered patients across Kirklees in a large number of care home settings.
- It was recognised that the outcomes for our D2A bed patients were not consistent with the outcomes we wanted to pursue as a system. **78%** of people remained as 'short stay' residents at 28 days with on average an additional 3 weeks length of stay.
- As a result of these findings, we agreed as a system to move to a Home First model which made 'home first' the priority for all discharges and increased our Reablement capacity to support this.
- We also agreed to move away from using D2A beds and renamed our new bed base as 'Recovery beds' to further promote the home first principle.

How were people were involved.

- This was a system-wide change led jointly by the ICB, Independent Sector Providers and the Local Authority.
- Several engagement workshops took place with system partners and stakeholders to develop the Home First model.
- Comms and engagement sessions were developed to explain the new model to teams across both health and social care.

What it took to implement.

- Embedding change is slow and needs continued effort with all partners bought into the change.
- Challenges for this work were around recruitment timescales.

Gathering feedback.

Patient experience is gathered as part of the Recovery Bed stay, changes have been made based on this which now include the opportunity join in activities and a family visiting transport scheme has been developed jointly with NHS Volunteers.

Kirklees COUNCIL

How our approach was inclusive.

Challenged ourselves on our approach inclusion through public feedback featured in Healthwatch Kirklees and research from the Social Care Institute for Excellence (SCIE) which recommended communications should be inclusive and accessible as much as possible for service users and their families. This research was factored into the rationale for identifying a new service philosophy and identity that would immediately resonate with those who came across it.

A Discharge Dashboard was developed to pull reporting from both health and social care system to monitor the protected characteristic profiles of service users and understand the impact of the changes.

A flexible approach to discharging patients has been adopted by the teams to support the Home First model.

We have started to review the look, feel and offer through the Recovery beds to align more closely with the wider Kirklees demographic, e.g. we are holding a halal food tasting event on the 17th of Feb for professionals, partners and service users to help inform a more inclusive menu of dietary options.

More information

Email: saf.bhuta@kirklees.gov.uk

How we know it has worked.

- We stopped using spot purchase D2A care home beds and instead allocated one of our Local Authority owned homes to become our Recovery Hub (x 40 beds), which is now viewed as a centre of excellence promoting a home first approach
- Patients from both Acute Trusts are now discharged directly to our Recovery Hub and are supported by: the Local Authority Care Team who manage patient needs on a daily basis and promote independence; the ITOC team who assess for therapy/care needs; the medical/pharmacy team who provide weekly home rounds (both in-reach teams) and District Nurse team for any nursing needs.
- The whole staff ethos is to support people to go home after their 4-6 week stay or move onto Intermediate Care/Reablement.
- Two-thirds of patients now go home or onto Intermediate Care after their Recover Bed stay with **33%** going onto short/long term care home placements.
- There has been a recognised need for a higher-level sub-acute bed base (patients too complex for Recovery Beds but considered medically optimised for discharge).

What went right and what went wrong?

- Embedding change is slow and needs continued effort with all partners bought into the change.
- Recommendations to others aiming to undertake a similar change would be to engage with stakeholders at all levels to ensure everyone is bought into the change and have channels for feedback so that tweaks can be made as needed. Ensure that BI colleagues have the work on their radar to support demonstrating the impact of the change.
- Challenges for this work were around recruitment timescales.

How can its impact be sustained?

Recommendations to others aiming to undertake a similar change would be to engage with stakeholders at all levels to ensure everyone is bought into the change and have channels for feedback so that tweaks can be made as needed. Ensure that BI colleagues have the work on their radar to support demonstrating the impact of the change.

How this helps wider public life?

More people with complex needs can be supported through the new model therefore reducing the need for bed-based provision. Flexible and responsive night support is available for those people where there is uncertainty of needs or risks throughout the night. This supports a hospital discharge or avoidance of 24 hr bed-based provision and ultimately reduces pressure on the wider system.

The Recovery Plan principles and ambition

WHAT IS IT FOR?

1. Personalised Journey
2. Continuity and Collaboration
3. Empowerment and Ownership
4. Efficient Information Sharing
5. Strengths-Based Approach

RECOVERY CARE PLAN

WHAT WILL IT REPLACE?

1. Discontinuity and inconsistency during handovers
2. Incomplete or fragmented information
3. Lack of real-time tracking

WHAT ARE THE BENEFITS?

1. Efficiency for Staff
2. Patient-Centred Collaboration
3. Better outcomes for patients
4. System Benefits and Tracking

The Recovery Plan combines:

- A joint real time plan for people working across services and organisations to co-ordinate care and support
- Elements of existing care records (using Leeds Care Record functionality)

Adult Social Care Practice Framework

WHY?

We want every person in Doncaster to live in the place they call home with the people and things that they love, in communities where they look out for one another, doing things that matter to them.

WHO?

Everybody	People who require urgent support	People who require longer-term support
We listen to people to understand what matters to them. We make connections and build relationships to improve people's wellbeing and independence.	We don't make long term plans in a crisis. We work with people until we're sure there is no immediate risk to their safety, health or wellbeing, and they have regained stability and control in their life.	If people need longer-term care and support, we work with them to understand what a good life looks like for them. We make sure they have resources and support to live the life they choose and do the things that matter to them as independently as possible.

HOW?

Hope	Connection	Relationships	Inclusion	Flexibility	Rights
We focus on possibilities, dreams and aspirations. We don't limit people's choices.	We explore ways to involve people in their communities. We make and maintain meaningful connections.	We support people to keep existing relationships and make sure they have opportunities to build new ones.	We don't judge people or make assumptions. We involve people as equal partners in conversations and decisions about them, their families and their communities.	We are willing and able to adapt. Our approach is responsive and proportionate.	We make sure people know their rights. We promote autonomy, choice and self-determination.

We're kind	We behave	We're trusting	We're transparent	We're present	We're honest
We respect and understand people as individuals. We don't make snap judgements.	We know and follow the law, ethics and best practice. We are always open to improvement.	We know people tend to be honest and know what's right for them. We listen and we keep an open mind.	We're open about our rules, making them clear so people know what they can and cannot expect.	We connect and engage well with people. We respond in a timely manner.	We are honest about what we're going to do. When we say we are going to do something, we do it.

We know the language we use matters. We use plain, respectful and kind language.

WHAT?

Wellbeing and independence	Information and advice	Active and supportive communities	Flexible and integrated care and support	When things need to change	Workforce
Living the life I want, keeping safe and well	Having the information I need, when I need it	Keeping family, friends and connections	My support, my own way	Staying in control	The people who support me

SO?

Better experiences and better lives for Doncaster people	Improved morale and satisfaction for Doncaster's workforce	More sustainable use of resources

Your Life Doncaster

Doncaster adult social care: our commitment to cultural competence

What cultural competence isn't:

- Just being tolerant
- Something to think about that is separate or distinct from day-to-day practice in adult social care
- Having to know everything about age, disability, race, religion, sex, sexual orientation, gender reassignment, being pregnant or on maternity leave, being married or in a civil partnership
- Getting everything right first time when you meet someone
- Assuming that a single, polite conversation will establish all the facts in a calm and objective way
- Something that's only important for "front-line" workers who directly interact with Doncaster people who need information, advice and support about adult social care

What cultural competence is:

- Actively addressing discrimination
- Central to the way adult social care makes connections and builds relationships to improve wellbeing
- An individual conversation that starts with asking what is important to that person, then actively listening and looking for ways to improve understanding and shared learning
- Being able to admit ignorance and open to exploring unconscious biases
- Recognising individual boundaries, emotions and traumas that may require trust to be built over time
- Something that's important for everybody, including managers who also need to provide culturally competent support to the individual staff and the teams they manage

How will we get there?

- By always focusing on human rights to ensure everybody can live in the place they call home with the people and things that they love, in communities where they look out for one another, doing things that matter to them
- By using plain, respectful and kind language, planning ahead to think about the first impression we want to make and enabling a conversation that is based on curiosity and mutual respect
- By feeling safe and supported enough to be able to admit limits to our knowledge
- By understanding how previous trauma informs the way people feel and react and being able to respond to this
- By creating different spaces for people to connect with each other and, whether they are receiving support from adult social care or work within it, feel seen, understood and respected

MANUAL HANDLING WITH DIGNITY & RESPECT

Rotherham Metropolitan Borough Council

What did you do?

Completed Manual handling assessments and support plan reviews for people with multiple carer packages with an outstanding Care Act review.

The aim of the project was to 'right size' care to ensure that people receive support that builds on their strengths , is least restrictive focussing on positive risk taking and is monitored and reviewed to ensure it is achieving the best outcomes.

How were people who draw on care and support involved in doing this?

- A project mid-way evaluation was completed and feedback from people who draw on care and support was reviewed.
- We will continue to engage with people who receive support by consulting with the co-production board on embedding practice by looking at 'what good looks like'.

What were the resource implications?

- 2 temporary OT roles and social work assessor
- 6 month pilot project to complete 180 reviews
- Oversight via Principal OT; Social Work manager; OT team leader; Commissioning
- Effectiveness tracked through regular meetings
- Cost savings and efficiencies reported into an assurance board

What went right & what went wrong?

- Communication with key stakeholders was key to ensure that the homecare provider networks and health leaders were aware of the work going on.
- Process could have been streamlined by an OT trusted assessor role.
- Need to shift the culture to ensure that optimised handling is embedded.

What are people saying about it?

- On the whole people who draw on care and support found this experience was positive.
- Our homecare provider networks welcomed the refreshed way of working and were proactive in drawing on OT support for if a care package review was needed.
- Social care practitioners see the need to shift the focus to more positive risk taking and are helping leadership on a change journey and embracing changes..

"Thank you for making me feel like my needs have been put first"

"The equipment given has made such a difference"

How you addressed issues of equity, diversity and inclusion?

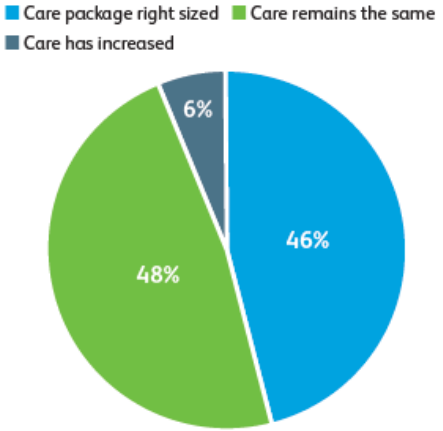
- This personalised approach ensures that everyone has the opportunity to have support which is non-restrictive and helps them achieve their full potential.
- A reduction in the number of carers will support choice by enabling 'same gender' male carer calls to be more feasible as there is a shortage of male carers.
- Staff reflect the diverse population of the community and work in line with the council's EDI strategy.
- Working within the region to develop a consistent approach to practice and equity of service.

How can its impact be sustained and how might others replicate it?

- Create a therapy led pathway to support new care assessments and reviews through ongoing OT staffing resource.
- Support key stakeholders in understanding the benefits of Optimised handling to maintain positive change.
- Strengthen assurance ensuring therapy is considered for homecare authorisations.
- Working with regional networks to share best practice through the developed Community of Practice.

How do you know it's worked?

Mid-way evaluation shows £334K savings on homecare; 157 care hours able to be recycled for people who need them.



How this helps wider public life?

- System level accountability through integrated working between health and social care.
- People will live healthier lives connected to the communities who matter to them.
- Less people will be admitted to long term care or hospital with a reduced length of stay.
- This will contribute to suitability as carers would be travelling by car.

Carers Wakefield & District: Discharge Support to Unpaid Carers

Carers Wakefield & District

Did you know?

There are an estimated 5.7 million unpaid carers in the UK (Census 2021), whose economic contribution equates to £119 billion per year.

In the Wakefield District. We expect there to be 35,000 unpaid carers, and we have just over 9000 Carers Registered.

59% of unpaid carers are women (Census 2021) and one in seven people in the workplace in the UK are juggling work and care (1 in 3 NHS staff provide unpaid care).

Carer's Allowance is the main carer's benefit and is £76.75 per week (2023/24) for a minimum of 35 hours. It is the lowest benefit of its kind.

Caring can have a significant impact on health and wellbeing. 60% of carers report a long-term health condition or disability compared to 50% of non-carers.

What we do

Wrap around service. Community, Care Home Support and Hospital including Discharge Support.

Advice and Information; Navigate the system, liaise with other professional/organisations, benefits/grants, legal (POA, wills/trusts).

Group and Peer Support. 11 groups across the District.

Events and Activities.

Training and Awareness; Carers and Professionals/Public.

Contingency Planning Emergency Alert Plans.

Hospital Discharge Support

In Wakefield, we have identified the critical need to support unpaid carers when their cared for person is admitted to hospital. We want to be there to support them to navigate the hospital system and support through the discharge planning process.

Our dedicated support workers liaise with nurses/doctors, social workers, finance teams, ward admin, Occupational Therapists, other VCSE organisations, Integrated Transfer Of Care (ITOC) hub.

We check-in and follow-up following discharge (48hrs-1week-4weeks min) and signpost and connect people to others.

We believe our support increases family resilience and reduces readmission.

Case Study

Joan is a carer for her husband Eddie, who has Parkinson's Disease with Dementia. Joan herself has arthritis, but they are an independent couple who don't want carers in their home.

Carers Wakefield have been supporting Joan and Eddie with advice since 2020. In the spring Eddie was admitted to hospital and Joan was told that he was dying, and they had withdrawn medication. A day or so later he was sat up alert in bed.

Our Hospital Carer Support Worker, NAME, met with Joan on the ward. Joan was anxious and understandably confused about what was happening.
NAME liaised with the discharge co-ordinator and hospital social work team to help Joan understand what was happening and to seek information about how Joan could safely get Eddie home.

Eddie would need care at home, so NAME helped Joan to consider this, to identify the care provider and understand the financial implications of receiving care, building the relationships with the Finance Team and Hospital Social Worker. NAME liaised with the Discharge Lounge, and helped with communicating discharge plans with Joan and Eddie's wider family and with the care provider so that everything was in place.

NAME also supported Joan and Eddie to plan for the end of Eddie's life, having important conversations about planning Eddie's funeral.

Joan became very unwell just after discharge - she was diagnosed with Pneumonia. There was confusion over when the Care Company should be attending and NAME helped to reengage with the social work team and increase the care calls for Eddie as well as provide temporary meal support while Joan was unwell.

Our hospital carer support workers are important connectors to other support. in Eddie and Joan's situation, NAME was able to connect them to support from the Age UK for sitting service, and to Occupational Therapy who supported with aids and adaptations to maintain as much independence as they could.

Joan states that without our support she thinks that they both would have been in a much worse place possibly with Eddie dying in hospital which is not what he wanted, and Joan potentially admitted due to her own ill health and the strains of caring.

Our Performance

This service has supported 179 carer (1151 contacts), 63 of these being newly identified. On discharge the carer is contacted periodically to ensure that any care package is fit for purpose and issues that arise can be dealt with in a timely manner (discharge contacts total 342) with a view to preventing further admissions and decline.

For every contact with a Carer there is around 6 calls or conversations with "others" on their behalf.

More importantly the vast majority require no further support at this time (but know where to find us).

Our Impact

- 63 New Carers known to adult social care and registered with their GP Practice.
- Supported the development of the Carer Lanyard (allowing Carers some benefits whilst their loved one is in hospital).
- Supporting the development of a Trust wide Discharge Support Tool.
- Supporting a single referral process for the voluntary sector in WY&H Trusts.
- Supports the Trust's Working Carers Group.
- Honorary Contracts, so that patients can be located quickly etc.

Keys to Success

- 'Can do attitude'
- Shared purpose with like partners in ITOC hub.
- Identifying key individuals with the ability to make things happen.
- Dedicated individuals with a flexible approach.

More information: info@carerswakefield.org.uk

Working to become Dementia Friendly

MINDFUL EMPLOYER

Healthy Wakefield Charter Mark Workplace Wellbeing

An NIHR Doctoral Fellowship: evaluating the new online 'Support Needs Self-Assessment' within adult social care at North Yorkshire Council

Thousands of people are waiting for a needs assessment

Why is this important?

- Increasing numbers requesting adult social care support
- Approx 250,000 people are waiting for an assessment of needs in England
- Unmet needs are catastrophic for the individual, family and services

Digital health and social care
Using technology, applications, websites or online services to help people live safely and independently at home.

The **COVID-19 pandemic** had a huge impact on adult social care practice, with staff having to find new ways to work, within budgetary constraints. One of these ways is to carry out assessments of need online.

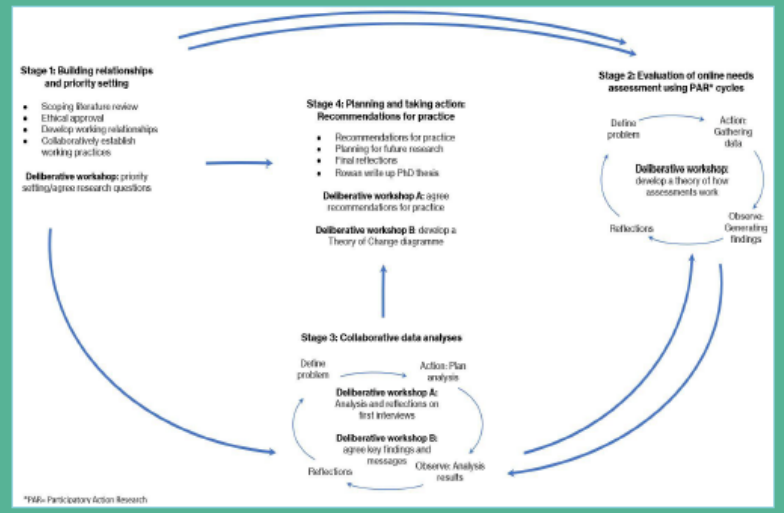
There is **limited research** on how local authorities have done this and little is known about the advantages and disadvantages for staff and people using these services.

Curious Minds
Members of this public involvement group are people with lived experience of adult social care, either for themselves or a family member. They will be contributing to each stage of my three-year research study.

Curious Minds
Public Involvement Group

Aim
To evaluate the design and implementation of an online 'Support Needs Self-Assessment process in one regional local authority in England.

Methods
A four-stage project plan will be followed, using a participatory action research (PAR) approach where I work together with staff in North Yorkshire Council. Mixed methods will be used to collect data, both from staff and people using the online service. Recommendations to improve practice will be developed and shared locally and nationally.



Knowledge sharing and Impacts

- Publishing articles in influential journals, ensuring these are open to access for everyone
- Distributing plain English summaries of publications
- Presenting at national and international conferences
- Writing articles for local authority bulletins and attending meetings
- Providing information through social media
- Speaking at community groups
- Running public and sector engagement events

Who am I?

Rowan Jasper, an applied social care researcher at the University of York. I have over 18 years research experience and a special interest in research to improve social care support for older people

My next career step is a PhD qualification. This will increase my specialist knowledge in an area so I can 'lead' my own research studies in the future.

University of York

Supervisory Team

Professor Yvonne Birks
Dr Phillip Whitehead

FUNDED BY
NIHR | National Institute for Health and Care Research
School for Business and Society
NORTH YORKSHIRE COUNCIL

Rotherham Metropolitan Borough Council

SUPPORTING INDEPENDENCE TEAM

COMMUNITY CONNECTORS

The community connectors support health and wellbeing by using community assets and linking in in with appropriate services to promote independence. Community connectors.

Support with:

- **Health and wellbeing**
- **Financial hardship**
- **Housing issues**
- **Employment solutions**
- **Assistive technology**

"Helpful, polite and a caring nature"

"Someone actually listened after 18 years in the system"

"I didn't know this service existed"

SENSORY OFFICERS

Dedicated specialist sensory workers will support individuals who have experienced sight and/or hearing loss that affects their daily life, including access to services, information, advice and support.

The sensory officers support individuals with becoming more independent, this may include provision of specialist equipment or advice to help with daily living tasks and communication.

"I felt like I was let out of prison"

CARER LINK OFFICERS

Dedicated Carer Link Officers are responsible for providing information, advice and guidance for anyone who is an unpaid carer.

The Carers Link officers support Carers to maintain their caring role through access to community resources, providing equipment and assistive technology and supporting with housing issues and financial wellbeing

"I feel like I've had elephants legs lifted off of my shoulders"

"Couldn't have got out of the hole without you"

"You offer a right good service"

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Care we want

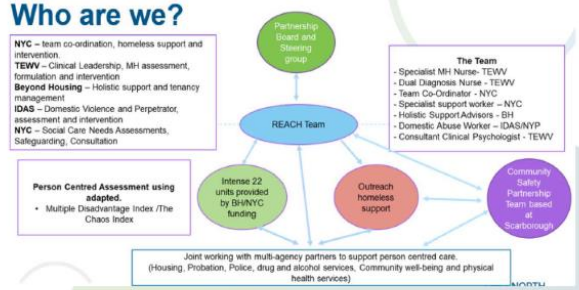
14th March

NORTH YORKSHIRE COUNCIL | IDAS | Beyond Housing | NHS Tees, Esk and Wear Valleys NHS Foundation Trust | REACH Housing First

REACH: Housing First

Multi-agency team response for supporting complex needs

Who are we?



REACH is a Housing First model, initially funded for 3 years in 2021, that has been extended due to the positive outcomes of the clients. REACH seeks to accommodate homeless individuals first, then work with the client to create a settled and functioning lifestyle. Accommodation is offered without conditions, i.e., clients do not have to accept the support of the team or be 'tenancy ready' to be given a property. REACH has 18 dedicated units of accommodation supplied and maintained by Beyond Housing. The accommodation is dispersed throughout the Scarborough locality. NYC utilised NSAP funding to ring-fence 8 properties from Beyond Housing stock and then RSAP funding to acquired 10 additional properties for the project.

The support team is comprised of officers from TEWV NHS trust, IDAS, NYC Housing Needs, Beyond Housing and we are supported by NY Police, Horizons, Adult Social Care, Probation, and local charities to deliver person centred care and support. The team are based in a shared office at Scarborough Town Hall, and we see ourselves as joint team members, not co-located colleagues.

The team offer intensive and community support to people over the age of 18 who are currently homeless or likely to be made homeless due to a range of social and long-term health needs including mental health/substance misuse, physical health needs or because of their criminal activity or anti-social behaviour.

Reducing

Exclusion for

Adults with

Complex

Housing needs

Principles of the team

Shared team stance of working

Psychological and Trauma informed

Principles of engagement and relational focused interventions.

Strength based focus for person and team.

Donaldson S., Sweeting, B., Croall, R., & Loveless, E. (2023)

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Proud to Care North Lincolnshire

Care Sector Recruitment and Retention Support

LGC Awards 2023 WINNER

We know that people want to be supported within their own homes, families, jobs and communities

Proud to care North Lincolnshire

To enable the care sector to continue to meet the needs of individuals and support them to remain independent in their own homes, We developed the Proud to Care North Lincolnshire initiative to enhance local recruitment, retention, and capacity in the care sector. This campaign aims to elevate the profile of care workers, celebrate their impact on daily lives, and promote employment in the sector.

Some of the initiatives that sit under Proud to Care North Lincolnshire include;

Promotional Activity
To encourage employment into the sector and direct potential employees to the website, including branded promotional material, leaflets, public banner, local advertisements a radio advert and two sky adverts

Proud to Care North Lincolnshire Website
Where all local care jobs can be advertised, as well as the development of the employer hub

Agency Hub
To support the sector facing staffing challenges by enabling retired workers, NHS bank staff, and health and social care students to undertake paid work that fits their availability

Funded Childcare

Offering additional funded childcare beyond individual entitlements for care sector workers to help working parents join the sector and support existing employees in working extra hours.

Wheels to Work

Facilitated the recruitment of non-drivers and supported our Green Futures agenda through a subsidised pay-as-you-go hire scheme for electric mopeds and bicycles.

Health and Wellbeing Incentives

To support the sectors wellbeing, annual Normanby Hall passes and 3-month NL Active gym/swim memberships were offered.

By expanding the care sector workforce, including individuals with protected characteristics, we aim to create a diverse sector that better meets the needs of those who rely on care and support.
The scheme has elevated the profile of care roles, making them a viable career option for many.
It has also strengthened our partnerships with care providers and improved workforce retention by valuing our employees.

Provider quote
"Receiving staff from PTC has been very beneficial. It has helped to increase capacity and fill staff vacancies. Staff retention has been good and new staff have referred their friends and family to us which has been fantastic. Proud to Care have been very committed to filling our vacancies which has been a huge help during difficult recruiting times."

Care Worker Quotes
'The scheme allowed me to work more hours, this has had a positive impact on my income and quality of life'

"We've worked really hard to support people all throughout the pandemic and it's really great to be recognised for our work."

The initiative has increased the delivery of care at home services, boosting capacity and enabling more people to receive support at home. Health and wellbeing incentives have led to greater use of local leisure facilities and helped families engage with community attractions, fostering community connections.

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Care we want

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North Lincolnshire Council Digital Initiatives

Within North Lincolnshire, we are currently piloting a range of technologies to support people to develop life skills and remain living independently at home.

The aim of the technology initiatives are to:

Promote people's independence

Improve dexterity and cognitive ability

Enable a routine through reminders or prompts

Improve overall quality of life, skills progression and achievement of outcomes

Increase aspirations, confidence and sense of control

Increase social connection

Virtual Homecare Monitoring

Genie Connect is a digital companion developed to support adults in maintaining their independence, wellbeing and social connections through video calls with friends and family to help reduce feelings of isolation, reminders for daily activities to help manage routines and cognitive actives to keep users engaged and mentally active

social-ability

Happiness Programme

Designed to enhance the wellbeing of individuals using interactive light technology to create engaging games that improve cognitive, social and physical wellbeing

AutonoMe

Unlocking Independence

Mobile Technology

A suite of assistive technology devices designed to help individuals regain their independence through environmental controls such as lights, fans, beds and televisions and communication tools for non verbal individuals with word prediction and pre-stored messages

Impact

Learners have a self-assessment rate of **97%.**

54 skills have been developed across **7** individuals.

Surveys show **29** positive outcomes for improved quality of life, including increased aspirations, reduced depression/anxiety, increased confidence, motivation/resilience, and sense of control.

100% of learners report an increased sense of control and independence.

1 learner assisted to write the script for 2 x videos that are now active on the App around cooking and cleaning.

4 pilot learners have shown significant improvement in independence and are ready to integrate AutonoMe into their care assessments.

Genie Connect has helped users establish routines with reminders for medication and fluids, promoting greater independence across various settings. It has also **reduced social isolation** by enabling connections with family members and other users who serve as Genie Buddies.

10 users with lower-level support needs were identified within Ashby Meadows who were then supported to utilise the Genie within their own flats for lower level prompts/reminders and social support.

Interactive projection activities via the **Happiness Programme** have proven effective for residents, including those in wheelchairs, and have successfully engaged staff and families. These activities, which include music, games, and personalised content, have enhanced cognitive and physical engagement, bringing joy and interaction to residents.

Feedback

Genie Connect

Learners appreciate how Genie Connect prompts them to complete AutonoMe tasks and reminds them of upcoming appointments.

One user, who previously missed medication, reported that Genie helped establish a routine and provided reminders, preventing missed doses.

Two users at Ashby Meadows enjoyed using the Genie Buddies system to have drinks together while in their own flats, enhancing their social involvement.

AutonoMe

Learners are pleased with the independence they are achieving.

One learner shared that with AutonoMe, they do the cooking while the app assists them. When support staff are present, the staff cook, and the learner assists, highlighting the independence gained through AutonoMe.

Happiness Programme

Learners enjoy the interactive elements to the technology that enable them to continue with the activities they used to enjoy.

One Welsh learner with dementia who is unable to speak, enjoys singing along to songs in his native Welsh language via the technology. One learner who used to enjoy golf but has been unable to continue due to deterioration in his dexterity is able to utilise a gold programme that is accessible via his wheelchair.

Involve users, providers, families/representatives, and support staff in initiatives from the planning stage

Develop comprehensive training materials and sessions to address technological literacy challenges among older adults

Customise communication strategies to address resistance to change, highlighting the positive impact of technology on users' lives and the gradual integration into their routines.

Share success stories and positive user experiences to inspire confidence in potential users and their families.

Consider creating a dedicated team to manage technology offers, ensuring efficient monitoring and support, and providing timely assistance and troubleshooting.

Keeping people in their own homes, families, jobs and communities

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HULL ADULT SOCIAL CARE
SENSORY TEAM
... and the things we do

1 WHAT DO WE DO?

- We provide specialist assessments for aids and adaptations for everyone with a hearing impairment and long term eye conditions within Hull.
- We have Specialist Sensory Social workers who complete Care Act Needs Assessments for everyone who's primary need is Sight and or Hearing impairment.
- We have Rehabilitation officers who complete community mobility training and assessments.
- We hold the register for all sight and hearing registration.
- We offer Specialist deaf blind assessments.

2 HOW WE INVOLVE PEOPLE

We offer clinics and drop-ins across Hull for information, advice, and referrals, including hearing aid clinics and services at local hospitals. Our team is trained in BSL and DeafBlind communication. We collaborate with local charities and welcome feedback to improve our service.

3 THE RESOURCE IMPLICATIONS

We assess under the Care Act 2014, providing free equipment and adaptations, which we repair and replace as needed. We also maintain vibrating smoke alarms annually. We work hard to triage all referrals with a robust duty process, prioritising them as needed. We focus on staff well-being through weekly peer meetings and regular case discussions, which has significantly reduced waiting lists

4 HOW WE KNOW IT WORKS

We have strong ties with the sight impaired, deaf, and hearing impaired community, getting regular feedback. Our referral pathways and outreach make it easy to contact us for information, advice, repairs, and referrals. We take pride in our work and often get compliments from users and partners

5 WHAT WENT RIGHT AND WRONG

We've cut waiting lists. We raise awareness about sight and hearing impairment, offering advice and joint visits to support communication. We're now fully staffed, reducing wait times. We work with housing associations and Humberside Fire Service to improve adaptation requests for tenants.

Hull City Council

6 WHAT PEOPLE ARE SAYING

Julie Sensory Social Worker
I support individuals with sensory loss, advocating for their rights and independence. It's rewarding and humbling to make a meaningful difference in their lives.

Mr C (92) *"Thank you for the great service, I'm very happy with my new phone. I can finally ring my grandchildren and hear them"!*

7 HOW WE SUSTAIN IT

Due to the specialist skillset of the Sensory team it's really important that we have a good succession plan in place for the current work force, and so we also support rehabilitation apprenticeships as a 'grow our own approach'. we also promote and educate the wider adult social care work force of our area and what support is available.

By ensuring that our current budgets remain in place so we can continue to offer the same great service.

Mrs M (75) "Mrs M told me she is so grateful for the equipment that has been provided and said "it has changed my life".

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Bradford Autism & ADHD Resource Centre

Autism & ADHD support, assessment and diagnosis to meet needs in Bradford

What problem are we trying to solve?

Waiting times for diagnostic assessment for under 18s are currently standing over 4 years and this position increases by 3 months every month due to demand. Previous attempts to mitigate through waiting list initiatives, non-recurrent investment to purchase additional capacity through the independent sector have not yielded sustainable impacts on the waiting list or more importantly, the experience and outcomes for children and young people (CYP).

The trend for demand on assessment has been increasing over the past 10 years, this is likely due to the changing climate of providers, social media, awareness and understanding of neurodiversity. Diagnosis is sought to gain support with support at school being the main theme for CYP.

What did we do?

Reviewed other transformation models and services who had innovated; Portsmouth, North East London Foundation Trust; along with those in our own system: Bradford, Leeds, Wakefield, Kirklees & Calderdale, along with other evidence and research (child of the north, learning from SUCCESS programme) to innovate a model for Bradford.

Our Proposed Model

Bradford's model will bring all three NHS providers of assessment together, under one provider. There are several benefits to this:

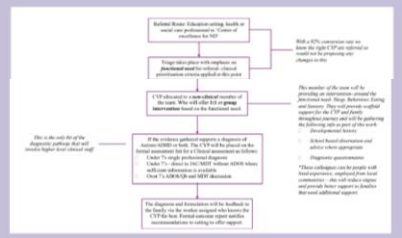
Transition: CYP will no longer need to transition between provider when they turn 7 years of age

Efficiency savings: Reduction in corporate and operational needs as this will relate to one provider and not three.

Could and should work as a system offer: Although the model outlines are health focused, we should seek to 'act as one' with other providers across the system and include Local Authority services including Children's Complex Support Team (CCST), Signet sleep service, Joint funded service– Together trust sleep service, and VCS – AWARE – Bradford Early Advice Team (BEAT). This would significantly improve the offer to families and improve work between services.

Consistency: One service– one pathway for parents and professionals to navigate

Having the offer independent from CAMHS- Mental health this will support to change culture around neuro diversity to ensure a holistic and systemic approach.



Pathway for the new "needs-led" model.

The benefits of the new model

The emphasis of the model is CYP functioning and getting support for the functional difficulty, regardless if the CYP goes on to receive a diagnosis. Support and assessment will run in tandem with each other. With clinical assessment and MDT diagnostic panel only being required if wanted or indicated. Each CYP and family will receive a orked to take them through the intervention and gather the information required to inform some of the assessment process, this person will know the family the best and will be able to offer holistic support and feedback. There are significant benefits to working this way:

- CYP are not waiting for support
- Settings and schools will have greater links with ND professionals as part of work
- Clinicians can be assured prior to diagnosis a thorough and quality assessment has taken place; this will ensure quick diagnostic decisions are made
- Prescribing clinicians can be assured CYP have accessed a non-pharmaceutical intervention prior (this may also reduce the rates of CYP needing ADHD prescribing)
- CYP and families will feel supported through the process and parents that require additional support (average reading age in UK is 9 years) or where English may be a second language are not disadvantaged
- Some CYP may not go on to the clinical assessment stage as parent and carers may feel reassured needs have been met – reducing the diagnostic rates
- Change the culture of provision by making the service support driven – not assessment driven. CYP come in to receive support for the identified challenge (behaviour, sleep, communication and sensory) with assessment a bi product of this. This new model, takes this from being a medical diagnostic medical model by putting emphasis on a holistic and systemic approach across all our organisations with model being delivered predominantly by non-clinical staff (this will substantially improve the experience of CYP and families, and provide efficiencies around triage, address workforce challenges, and provide more varied and community driven recruitment)
- There is opportunity due to the expertise and training for staff to widen offer to other ND conditions that require a multi-agency workforce, examples include Dyspraxia, Tics and Tourette's, Learning disability and Foetal alcohol syndrome should the system want to commission this in the future.
- There is opportunity to provide training and gain insight and input from GP's with a specials interest and trainee doctor and other healthcare professions.
- The staffing structure provides opportunity for variance in workload and staff progression, thus improving retention for the workforce - The model has been aligned to learning from the Alternative Provision work taking place, and the outreach team will be able to align with other AP's in BDC to build on evidence and good practice gathered.

What impact are we expecting to see for the investment?

- Reduction in wait times
- Increase satisfaction in patient experience- gathered by outcome measures
- Reduction in prescribing rates - Increase in shared care rates -
- Increase in staff retention
- Increase in conversion rates for girls and CYP from ethnic minority backgrounds
- Decrease in patient choice requests (and associated costs for this)

Care we want

14th March

Care we want

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PA workforce Campaign

The Adult Social Care workforce campaign includes promoting and raising awareness about the Personal Assistant (PA) role.

What is a Personal Assistant?
Personal Assistants (PAs) support individuals with various aspects of their daily lives, helping them live as they choose. This could be by supporting them to do their own shopping; getting dressed for the day or for a night out; playing computer games with a mate; going to work or college; baking that cake off the telly; or getting out to the football.

PAs are usually employed directly by individuals who need care and support, managing and paying for this through a personal budget or their own money. These individuals are known as 'individual employers.'

In Sheffield, people reported difficulties in recruiting PAs. Our mission is to raise awareness of this rewarding profession and highlight the opportunities and benefits it offers to job seekers. We also aim to dispel myths about working in the care sector and the experience required.

Many people feel their PA is the "missing piece" that helps them live their best life, providing essential support and companionship.

What we did

- PA rates tool: Sheffield co-developed a decision-making tool to help Individual Employers set pay rates based on the skills, knowledge, and competence of PAs.
- PA Register: The Direct Payment service commissioned a free-to-use website with Disability Sheffield to help Individual Employers and PAs advertise their needs and services. It includes useful resources such as PA training.
- PA champions: Sheffield's Direct Payment service worked with Embrace - Wigan and Leigh, to recruit two PA champions with lived experience to raise awareness of the PA role, create peer support networks, and build relationships with local education providers.
- PA and Proud campaign: Artwork designed by people who employ PAs and PAs themselves alongside local artist, Luke Horton, who brought their ideas to life. This fantastic artwork was part of a week-long exhibition in Sheffield city centre. Percy Street Collective, a local provider offering learning and training for young adults with Autism, built the exhibition display boards with the people they support.
- Stories for the PA and Proud exhibition: Interviewed individual employers and PAs to gather stories highlighting the enriching experiences of being a PA and the positive impact on those they support.
- ILG-PA memberships: Purchased 12-month memberships for Individual Employers to gift to their PAs, providing valuable resources and support services for them.
- PA Summit: Sheffield hosted the second PA Summit in November, in partnership with ADASSYH, to promote the PA role. The event, attended by over 65 delegates, served as a space to share success stories, hear from guest speakers, and agree on key topics of development in 2025.
- Direct Payment Support Service: The creation of a new in-house Direct Payment Support Service which includes assistance in finding and recruiting suitable PAs and provides advice and support for carrying out the role of an Individual Employer.

The Results

Since the PA Champions were recruited they have been attending job fairs, speaking at colleges and universities events to promote the PA role. As a result the Sheffield PA Register has seen a...
98% increase in website visitors.
200% increase in registered users
200% increase in users posting adverts
625% increase in introductory links between individual employers and PAs!

PA CHAMPION SHEFFIELD

The PA Champions have launched the Sheffield PA Network.
"A space to connect with PAs within Sheffield, find community & support, share experiences, discover training opportunities, wellbeing resources, events and workshops to help you grow as a PA."
AND
Joined forces with Sheffield based Social Care Heroes to provide PA Wellbeing Sessions.
"Workshops, techniques to help tackle isolation and support wellbeing at work. Guest speakers, and time to chat over a cuppa with other PAs facing similar challenges"

The 2024 PA Workforce Summit in Sheffield for the Yorkshire and Humber Region was a fantastic celebration of PAs. It brought together passionate individuals to connect, collaborate, and make things happen. The key topics were, communicating the PA role, developing a PA Charter, and discussing the Local Authority's responsibility in providing support and helping people understand the PA role. The summit was a huge success and the momentum to journey forward to a more visible, promoted, and responsive PA workforce is stronger than ever, inspiring everyone involved to continue their efforts with renewed enthusiasm and dedication. Plans for PA Summit 2025 are well underway!

#PAandProud

- Pay that reflects experience
- Training that offers career progression
- Employee recognition with incentives
- Improved support and resources for both PAs and individual employers
- More PAs in Sheffield!

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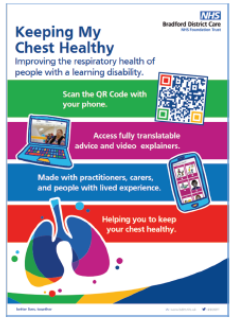
Care we want

14th March

Keeping My Chest Healthy

https://keepingmychesthealthy.bdct.nhs.uk/



Respiratory disease is one of the biggest causes of death for people with a learning disability but many of these deaths are avoidable. Chest infections, pneumonia and aspiration pneumonia are more common for people with learning disabilities.

We were concerned about the avoidable deaths of people with a learning disability with respiratory health issues and wanted to find a way to co-ordinate our MDT to work in an efficient, clinically effective way to improve the health of people with a learning disabilities.

Keeping my chest healthy has provided an innovative way to develop and share a personalised care plan, with support resources that are accessible to the person, their family, carers and professionals involved. A person's care plan is the tool that helps keep the person happy healthy and at home and can help save a person's life.

Keeping my chest healthy is providing people and their families with the knowledge and tools to better manage their care at home. It's helping to build confidence and independence in managing their own care and is reducing the number of times a person may be experiencing a worsening of their condition. It means they're able to be at home and not need hospital care and support by having more effective ways to record store and share information. We are releasing time to care for our clinical teams. Time that would have been spent on administration of tasks can be spent alongside people and their families.

How were people who draw on care and support involved?

Co production is at the heart of what we do in Bradford. The plan was developed in partnership with people with lived experience, via groups such as the Healthy Lives group and other advocacy and community organisations. Keeping My Chest Healthy is a Bradford District Care Trust project. The team includes people with learning disabilities and their families, carers, and people who work in daycare and respite.

What are people saying about it?

We have devised an evidence-based solution with compelling outcome measures, being recognised as Learning Disabilities Initiative of the Year in the 2024 HSJ Patient Safety Awards.

"The judges were particularly impressed by the simplicity and impact of this initiative which addresses one of the leading causes of avoidable deaths for people with a learning disability, the leadership and dedication to improving care pathways and creating broader societal and environmental benefits were noted. The coproduction approach with individuals with learning disabilities demonstrated a strong commitment to patient involvement, this initiative's scalability and potential for even greater impact, make it a truly stand out project."

HSJ Patient Safety Awards 2024

We are proud winners

Learning disabilities initiative of the year

What were the resource implications

In addition to the core project team the following staff groups have been part of creating the solution.

- Dieticians
- Speech and Language Therapists
- Nurses
- Physiotherapists
- Dental and Oral Health professionals
- Pharmacists
- Occupational Therapists

How you addressed issues of equity, diversity and inclusion?

The site uses VirtTuri Avatars to enable information to be shared in different languages. VirtTuri is a next-generation, patented, AI digital assistant that combines market-leading response speed and accuracy with a hyper-realistic avatar interface. This combination is scientifically proven to elevate user engagement and recall of complex information. VirtTuri's avatars can reflect any ethnicity, age, or gender, and speak over 120 languages. By addressing crucial challenges such as reducing inequality and improving user adherence, VirtTuri strives to make a meaningful impact on people's lives.

EasyRead and accessible images are used through out the plan and the site.

How might others replicate this?

We have created a detailed website with resources for people and their families, professionals and a space to share learning with other areas wishing to embark on a similar journey.

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Our Co-production Journey

Community Voice

The Community Voice co-production group was set up because we believe people are experts by experience and should shape the services they use. The purpose is to empower people and design services with them rather than for them.

Co-production in Adult Services and Wellbeing (ASW) has shaped the Co-production Strategy, the Better Lives hubs, a new carers assessment and recruitment via the lived experience People's Panel.

Co-production Strategy

Our co-production strategy event was open to the public and the focus of the session was around the questions: what does good support look like, how can adult social care be better in Calderdale and how can we work together? A theme from these sessions was people wanting a physical social care presence in the community that was accessible, friendly and adaptable to the communities' needs.

The result of this was the Better Lives hubs which were co-produced with Community Voice and are now thriving across the borough.

Care we want

14th March

Feedback

Feedback from the People's Panel interviewers:
"I feel valued and listened to and that my points are valid. Others can see my potential and I feel in the future, I will not only gain more skills but feel confident enough to look for more opportunities in working."

Feedback from the People's Panel interviewees:
"I think it keeps us honest, and, especially at Management Level reminds us of keeping people we support at the forefront of our thoughts in doing that."

Feedback from Co-production Strategy event:
"There were great ideas and people were really thinking outside the box. I loved it, it was very relaxed but also structured so it flowed really well. Loved the art, it was very inclusive and easy to reflect on."

Feedback from Community Voice:
"I think it is great, lots of discussions, lots of different, diverse people."

Next steps

- Community Voice will be designing a co-production training package that they will deliver to staff in Adult Services and Wellbeing (ASW) to ensure that true co-production is embedded across the directorate.
- We will work to grow Community Voice membership and ensure that it reflects the diversity of the population.
- Co-producing a Rewards and Recognition policy to acknowledge the contributions of people with lived experience.

Calderdale Council

Calderdale Adult Services & Wellbeing – 8Ps Strengths Based Practice Model

The 8Ps Strengths Based Model launched early 2024. There was already a strong commitment from the workforce to work in a strengths based way, however it didn't have its own identity, and we had no tangible way of saying how we did this in practice. This is where the 8Ps were born.

The 8Ps are now at the heart of our wider Consistent Practice Framework, focusing on truly putting the person at the centre of everything. They reflect the local Calderdale context, including our initiatives such as Active Calderdale.

Our assessments are also aligned with the 8Ps. They have been mapped onto both the Initial Discussions template and the Living Well Assessment to ensure that it is the golden thread through our practice. This means that any time someone comes into contact with Adult Services, they are met with a holistic, person-centred approach to their care.

Person	Always start with the person's strengths and what matters most to them; how they want their life to be; how they contribute to others and to their community, - now and in the past; what they want to achieve, what they can contribute again; what they want to happen and how they can help make that happen.
Potential	What have you helped them to identify as their potential? What can they do to achieve that; What support could help? Would equipment or technological solutions could help them achieve their outcomes?
People	Who is important in their life and why? What do they already do? What else could they do? Have you spoken to them? Who else could get involved? How does what you are proposing help to support those relationships and networks to flourish?
Places	What are they already connected to? What else can you connect them to? Include ordinary local activities and places, clubs and groups, community and voluntary sector.
Prevention	What might help deterioration in the situation and avoid crises or emergencies? What planning for the future might help? What support may be available from Inclusion Matters or other preventative options.
Physical	How can physical activity help? How might it connect to and support what's most important to them? How can you help them think about making changes:- moving more / active habits (no matter how small). What support do they need and who can help – family, friends, communities, community programmes/services?
PRIDE (promoting inclusion, diversity and equality)	What are the persons' religious and cultural wishes? Have you discussed and included all protected characteristics? What does the person want to happen and what can they, the people around them and we do to support?
Paid	Paid support should consider all of the above; the whole person, the people around them, what matters to them. How does the paid support you are proposing support this? What gaps is paid support meeting?

Feedback

Staff were consulted on the early version of the 8Ps and had the chance to shape the language and suggest the addition of 'PrIDE'. This ensured that it resonated with them and was not tokenistic.

Feedback from Peer Challenge Team - October 2024:

"There is a strong focus on the 8Ps (Strengths based practice framework) with colleagues demonstrating a good understanding of the model and a recognition that 'this is what we do'. This understanding also extends to partner colleagues. Physical activity is embedded in the 8Ps and in support planning with commitment to further embed this across adult social care."

"There is palpable enthusiasm for change and commitment to the ideals (8Ps), and even when it's tough to implement - colleagues know it's the right thing to do."

Feedback from the workforce:

"This is very holistic and very akin to Occupational Therapy and core principles… this model is fabulous"

"I like how it focusses more on the assessment (what is important to the person) and not all about eligibility outcomes"

"The 8Ps promote the ethos of professional curiosity by encouraging practitioners to view and value the person in their entirety."

"I think the 8Ps are useful because they force people to consider the person's life history and culture, the people around them and the resources they already have which means people are more likely to work in a preventative and strengths-based way rather than make assumptions about what people need."

Calderdale Council

directors of adass adult social services
YORKSHIRE AND HUMBER

Care we want

14th March

HULL ADULT SOCIAL CARE

Digital Deep Dive

1 THE PROBLEM

Hull Adult Social Care recognises that the implementation of technology can contribute to service priorities. As the 4th most deprived local authority in England Hull is more deprived than 99% of other local authorities. 54% of Hull's population live within the most 20% most deprived areas in England.

Digital technologies have opened up a wider range of options to help people stay healthy and to live independently for longer. To maximise opportunities, we need to understand how the local population connects to and engages with technology.

2 STARTING POINT & BARRIERS

Our aim is to Co-Produce a Digital Strategy, which has clear priorities that are meaningful to ASC/HCC/Partners/Providers and the people we work with (now and in the future).

We recognise that understanding the local position provides Hull ASC with solid foundations to design and deliver services to the people of Hull.

We needed RESEARCH!

3 RESEARCH PARTNERSHIP

We reached out to the Curiosity Partnership who linked us with the researchers at the University of York.

They've helped us shape a survey so we could maximise responses to gather meaningful data and provided help and support around engagement and collection methods.

4 ENGAGEMENT ACTIVITY

Using HCC Customer Insight information, we devised a Communication and Engagement Plan. This plan uses customer segmentation to profile the population of Hull.

Understanding the population demographics helped us to design and shape our engagement techniques.

5 EVALUATION AND NEXT STEPS

Customer Insight tells us that a large proportion of the Hull population are unlikely to engage through direct methods, which meant we had to adjust our collection methods in order to hear from this cohort of people. Using the data gathered we identified the population groups which required focussed attention. Through existing partnership networks, we carried out a range of focus groups. Data gathering is ongoing and we are on target to meet the desired number of responses.

The survey closes at the end of October, when with the support of the Curiosity Partnership we will evaluate our findings to inform the Hull ASC Digital Strategy and underpinning work plans.

The Curiosity Partnership

University of York

Hull City Council

directors of adass adult social services

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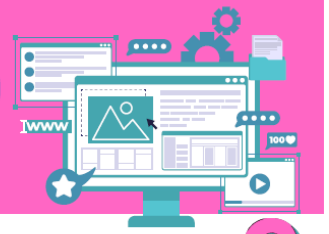
14th March

DIGITAL DEEP DIVE (PART 2)

Hull Adult Social Care



BACKGROUND

1

Technology has the potential to revolutionise the way we work and deliver services. We want to embrace technology and innovation; to empower staff and support those we work with to live the best life they can and remain independent, resilient, and well for as long as possible.

We recognise that understanding the local digital position provides Hull ASC with solid foundations to design and deliver a strong Digital Strategy

COLLECTION

2

We launched a survey in July 2024 using a range of engagement methods to hear more about local digital habits. The survey was open for four months, gathering feedback from **493** people. We have a **95%** confidence rate in our results.

REFLECTION

Initial analysis would indicate that the people ASC works with are more likely to be digitally excluded and have less confidence in accessing services and resources online.

4

Analysis of Hull Customer Insight groups indicates that those furthest away from digital inclusion are the elderly and those with poor health. Younger people from global majority backgrounds have more confidence, but find language a barrier to accessing services.

There was a reluctance amongst some groups not to engage with us as they had little trust or confidence in the LA.

SOME SURVEY FACTS

3

Device Ownership and Access

- People who use ASC are significantly less likely to own or have regular access to a device compared to those that don't.
- **54.5%** of people who us ASC have no interest in owning or using a device compared to **28.6%** of the wider public.

Trust in Technology

- **36.4%** of those who use ASC do not trust technology, compared to **7.1%** of the wider public.

Internet Connectivity

- **63.2%** of those who use ASC have home broadband, compared to **85.5%** of the wider public.
- **46%** of those who use ASC have a mobile internet connection, compared to **79%** of the wider public.
- People who use ASC are significantly less likely to regularly connect to the internet compared to the wider public.

Access to HCC Services

- **58.6%** of people who use ASC prefer to call rather than access HCC services online, compared to **24.6%** of the wider public.

Digital Confidence

- **30.6%** of people who use ASC have no confidence in their ability to connect to the internet using a device, compared to **7.9%** of the wider public.

NEXT STEPS

5

The data and analysis of this survey will be used as the foundations for the ASC Digital Strategy and Action Plan.

As we develop and coproduce the ASC Digital Strategy we will seek the opinions of local people to explore the findings and to delve further into areas of reflection.

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"IT'S ABOUT US, IT'S NOT ABOUT WHAT YOU THINK WE NEED."

"IT NEEDS TO BE LOCAL WITH LOCAL PEOPLE THAT UNDERSTAND"

"NAVIGATE MY CARE USING MY UNDERSTANDING OF THE WORLD"

"COMMISSIONING SHOULD PRIORITISE THE COMMUNITY RESPONSE"

CARE WE WANT

RECOGNISE CARERS

INVEST IN COMMUNITIES

CULTURALLY SENSITIVE SUPPORT

GENUINE COPRODUCTION

RELATIONSHIP-BASED PRACTISE

PERSON FIRST DIGITAL APPROACH

"START WITH US"

"ITS A RELATIONSHIP BUILT ON TRUST"

"WE NEED TO TALK TO OTHERS WHO UNDERSTAND"

"WE'RE SAVING THE SYSTEM BILLIONS"

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