Innovations in Adult Social Care and Social Work Report

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Executive summary

Background: There are many innovations in adult social care and social work across the UK. Therefore, it is necessary to identify top priorities for evaluation.

Aims: The aim of this project was to identify and prioritise a shortlist of top priority innovations to evaluate in adult social care and social work.

Methods: The identification of innovations followed an adapted version of the James Lind Alliance method for priority setting. We followed four steps: 1) Identification of innovations, 2) Development of criteria for shortlisting, 3) Grouping and sifting innovations and 4) Prioritisation of innovations in a workshop setting.

Findings: One hundred and fifty-eight innovations were suggested. Twenty of these were included in the final shortlist. Twenty-three participants attended the prioritisation workshop. They included people who use adult social care services, practitioners, academics/researchers, commissioners/policy makers and carers. The top five priorities, which were agreed during the workshop, are shown in Box 1. The key themes and principles that informed these decisions are described in this report.

Box 1. Top five innovations (in alphabetical order)

- Care coordination for dementia in the community;
- Family group conferencing;
- Greenwich prisons social care;
- Local area coordination;
- MySense.AI

Limitations: Given the short period of time available for the horizon scanning, certain innovations may have been missed from the final shortlist. Similarly, some innovations that were included may have already been, or currently are being evaluated.

Conclusion: This approach was successful in identifying a large number of innovations in a short period of time, developing a shortlist and identifying the top five priorities. The next stage will be to conduct further scoping of the top five innovations (and existing/planned evaluations), in order to identify two innovations that can be evaluated by the two rapid evaluation teams.

Introduction

Why did we do this project?

The National Institute for Health Research (NIHR) Health Services and Delivery Research (HS&DR) team asked its two rapid evaluation centres, BRACE and RSET[1], in July 2019 to jointly identify by early November 2019 a shortlist of adult social care and social work innovations in the UK that might be priority candidates for evaluation. The aim of the exercise was twofold: 1) to identify potential innovations suitable for evaluation by the two rapid evaluation teams; and 2) to inform NIHR HS&DR and other NIHR programmes in relation to their commissioning priorities for adult social care and social work. There are many innovations in adult social care and social work underway across the UK. The emphasis of the project was on rapidity, variety and reliability: i.e. finding relevant innovations in services that warrant evaluation, rather than attempting to identify all such innovations. A (near-) comprehensive list of all innovations in the UK currently in adult social care and social work was not feasible within the required timescale.

The method adopted for this rapid horizon scanning work, and the filtering of innovations to achieve a shortlist, is described and explained in the following paragraphs. The project was undertaken in the context of the NIHR School for Social Care Research "Research priorities in adult social care – scoping review" published in June 2019 (Cyhlarova and Clark, 2019) and the James Lind Alliance's work for the Department of Health and Social Care (DHSC) on "Priorities for Adult Social Work Research" (DHSC, 2018). Those two reports focused on prioritising research questions; the present report focuses on prioritising particular innovations in adult social care and social work that are potentially suitable for evaluation.

The aim of the project reported in the following pages was thus to identify and prioritise a shortlist of top priority innovations to evaluate in adult social care and social work from different perspectives, including: adults who use social care services, carers, practitioners, providers, commissioners, researchers and key national organisations. The scope of the horizon scanning encompasses all types of innovation including new models of care, service innovations, payment and commissioning innovation, person- and community-centred approaches, and technological innovations. The method was designed to draw on all relevant stakeholder groups across the UK in identifying a large number of innovations and then prioritising among those a broadly acceptable shortlist, and to achieve all of that within a timescale of a little over three months from project initiation to delivery of the shortlist to NIHR HS&DR. This approach has advantages in terms of timeliness, breadth and relevance, but nevertheless limitations in terms of comprehensiveness.

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[1] The Birmingham, RAND and Cambridge Centre for Evaluation (BRACE) https://www.birmingham.ac.uk/research/brace/index.aspx and The Rapid Service Evaluation Team (RSET) https://www.nuffieldtrust.org.uk/rset-the-rapid-service-evaluation-team.

Methods - How were the priority innovations identified?

The identification of innovations followed an adapted version of the James Lind Alliance method for priority setting (Crowe et al, 2015; James Lind Alliance 2018). The James Lind Alliance method is a dialogue model for multi-stakeholder involvement. We followed four steps: 1) Identification of innovations, 2) Development of criteria for shortlisting, 3) Grouping and sifting innovations and 4) Prioritisation of innovations in a workshop setting. These steps are described in detail below (see Figure 1).

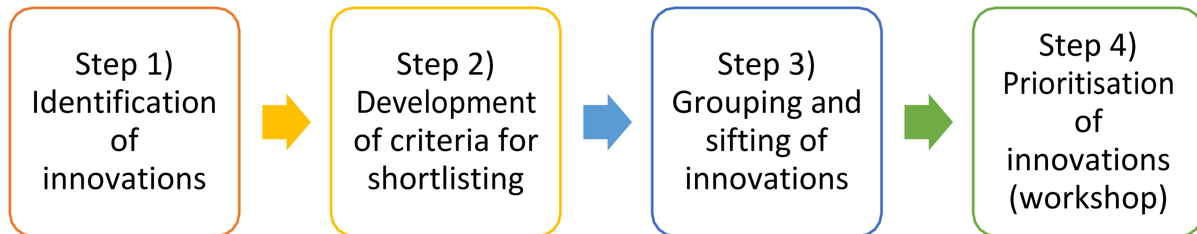

Figure 1. Steps involved in prioritising innovations.

This project was conducted between July and November 2019.

Step 1) Identification of innovations

To identify innovations, emails were sent to 182 individuals or organisations. We contacted a wide range of people with knowledge of social care, including people who use adult social care services, carers, frontline professionals, service providers, commissioners, national organisations, think tanks and researchers. The stakeholder list was created using professional and personal contacts across the full BRACE and RSET teams, contacts of contacts, Google searches and by asking individuals/organisations to forward the email to other interested parties.

To identify innovations, we asked individuals to answer the following question:

> 'What are the most interesting innovations in adult social care and/or social work that you are aware of, which you think would benefitfrom being evaluated?'

Stakeholders were asked to provide, within a four-week deadline: the name of the innovation, a short description, details of areas and providers that are putting the innovation into practice, a brief description of any ongoing evaluations of the innovation (if applicable) and links to further information (if applicable).

To ensure that we had captured as many relevant innovations as possible, further checks were made to ensure that the innovations included in the 'Six Innovations in Social care report' (Think Local Act Personal; 2017) were included in our final list.

Step 2) Development of criteria for shortlisting

To develop criteria that would be used to shortlist the innovations, we amended criteria used in a previous health care innovations prioritisation process by BRACE (BRACE Rapid Evaluation Centre, 2019). These criteria were amended to focus on adult social care and social work. Definitions of adult social care and social work, and corresponding settings and outcomes were identified using the NIHR's School for Social Care Research definitions (SSCR, nd). Criteria were initially discussed during a team meeting. Criteria that were agreed to not be relevant or that were too difficult to judge based on the available information were removed (e.g. we decided that importance would be better evaluated as part of the workshop (see below)). Further relevant criteria were added through team discussions. Criteria were then finalised and agreed across the research team.

Step 3) Grouping and sifting of innovations

All suggested innovations were put into a spreadsheet. When innovations did not have sufficient descriptions, members of the team (PLN/HW/SMT) checked and added further information from web searches into the spreadsheet. To aid the process of narrowing down the list of innovations for evaluation, all innovations were grouped into common themes.

The sifting criteria (see Appendix 1) were applied to each innovation by one of two researchers (HW/SMT). The researchers decided whether innovations should be included or excluded, or whether it was initially unclear from the information provided. A third researcher, who is a social care expert (CN), separately considered each suggested innovation to determine whether it should be included. These decisions were entered into a table and the innovations were divided into:

a) innovations that were included by both a researcher (HW/SMT) and the subject expert (CN);
b) innovations that were excluded by a researcher (HW/SMT) but included by the subject expert (CN);
c) innovations that were excluded by the subject expert (CN) but included by a researcher (HW/SMT); or
d) innovations that both the researcher (HW/SMT) and the subject expert (CN) excluded.

When in doubt, the researchers were as inclusive as possible in this stage.

To further condense the list of innovations, the research team met in September 2019 to discuss and agree innovations that should be included in the final list. The team discussed all of the innovations where there was disagreement between the subject expert and the other researchers (categories b and c). Innovations were excluded at this stage if they were deemed to be out of scope, e.g. if it was known that they had already been evaluated thoroughly, were too health (rather than social care/social work) focussed, focused on improvement not innovation, or were too broad/non-specific. To ensure that innovations retained on the shortlist were consistent with these more stringent criteria, the team also reviewed all of the

innovations that had been initially included by both the researcher and the subject expert (category a). Those innovations that on reflection were considered to be not within remit were then excluded.

Following this meeting, all of the final innovations were checked to ensure that there was scope for further evaluation (i.e. they were not already being thoroughly evaluated). A subject expert (JT) reviewed the final list of innovations. The result was a shortlist of 20 adult social care and social work innovations from across the UK. This list was then taken to a multi-stakeholder workshop to identify the top five priorities for evaluation, and the remaining 15 priorities (listed in no particular order).

Step 4) Prioritisation of innovations (workshop)

Participants

We aimed to recruit around 25 workshop attendees, including: people who use adult social care services, carers, practitioners, providers, commissioners, researchers and key national organisations. In the event, 23 participants (excluding the research team) contributed to the workshop. To identify participants for the workshop, we included an invitation to the workshop in the request for innovations (described in Step 1). Travel costs were covered for those attending the workshops. People who use adult social care services and carer participants were offered payment for preparation and travel time. It was agreed that participants would not be identified in any reporting.

Materials

Workshop materials, including an agenda, participant worksheets and a workshop guide were prepared by a methodology expert (KC). A description of each of the 20 shortlisted innovations was prepared by five researchers (HW, SMT, JS, LH and PS).

Procedure

The format of the workshop was adapted from the James Lind Alliance (JLA) model of consensus development (James Lind Alliance, 2018), which has been used to inform research priorities in many areas of health and social care. Examples of previous work the JLA has engaged in are topics relating to: adult social work (Department of Health and Social Care, 2018), autism (Autistica, nd; Cassidy & Rodgers, 2017), dementia (Kelly et al, 2015) and sight loss and vision (Cable & Pierce, 2013). The JLA model is itself an adaptation of the Nominal Group Technique (Jones & Hunter, 1995; Tuckman, 1965).

Prior to the workshop, participants were sent an approximately 200-word description, plus a web link for further information where available, for each of the 20 innovations. Participants were asked to read through these and rank all 20 innovations in advance of the workshop, in order, from most to least important to evaluate. These initial views would be shared with other participants at the workshop and form the starting point for the workshop process.

At the start of the workshop[2], participants received short presentations which introduced the workshop, outlined the purpose of the workshop, explained how the 20 innovations were identified, and provided the funder's perspective. Participants were given the opportunity to ask questions and seek clarifications.

During the workshop, participants were split into three groups, which were allocated to include a balanced range of stakeholder perspectives. Three facilitators (KC, NJF and JS) guided participants through group activities in which participants discussed and prioritised the list of 20 innovations for evaluations. Facilitators were neutral and did not contribute to discussions or prioritisations.

An initial discussion took place within each small group. Participants took it in turns to describe their top three and bottom three priorities for evaluation and their reasons, from the list of 20. The facilitator of each group then summarised and presented back to the group the aggregate of their initial proposals for the highest and lowest priorities to evaluate.

The first round of prioritisation then took place, within the same small groups. This used a 'diamond nine' approach to priorities development. This approach consists of discussion and negotiation. Drawing on the prior discussion, the facilitators arranged 20 cards (with the individual innovations outlined) to create a 'diamond' shape. The top of the diamond represented the most important innovations expressed in the previous discussion and the lower tip the less important topics. The middle reflected innovations that received divided opinions. The diamond was then developed into a more linear and prioritised list through further discussion, with all 20 innovations ranked one to 20 by each small group. Each group's rankings were then combined in a spreadsheet to create a shared, aggregate ranked list of innovations across all three groups combined.

After lunch, all workshop participants met to review progress. In this session, one facilitator (KC) gave an overview of the combination of all small group rankings, drawing attention to clear areas of agreement or disagreement between the three groups.

In the next prioritisation session, participants were allocated to one of three new small groups. Thus participants were discussing with a largely different group from that with which they had been discussing priorities in the preceding session. This provided an opportunity for participants to hear and understand different views, and to review and, if agreed, revise the shared ranked list. Participants were advised to focus on the top half of the list in order to work towards a final prioritisation. Again, the groups' rankings were entered into a spreadsheet to create a new shared ranked list.

In the final session, all workshop participants met to review the aggregate of the second round of group rankings and completed a final round of prioritisation together. This focused on agreeing the top five priorities. It was agreed that the ranking positions of the remaining 15

[2] Held in central London between 10am and 4pm on 21st October 2019.

innovations were of less importance and that this would be reflected in the publication and dissemination of the results.

Nine observers (from BRACE, RSET and NIHR HS&DR) were also present but did not contribute to any discussions. Three of these observers were also note takers (JE, HW and JN). Notes were taken on how decisions were made, areas of agreement and disagreement, key themes and insights into participants' perceptions of innovations and their importance for evaluation. These notes were used to provide further insight into why decisions were made and why certain innovations were prioritised over others.

Results - What did we find?

Step 1) Identification of innovations

One hundred and fifty-eight different innovations were suggested by 59 individuals from 43 organisations (including: charities, universities, local councils, academic health science networks, health and social care partnerships, government teams, social care enterprises, professional bodies and NHS trusts). Further details on the 43 organisations can be found in Appendix 1.

The innovations covered all four nations of UK: 54.4% of innovations were identified as being implemented in England; 18.4% in Scotland; 1.3% in Northern Irelands; and 2.5% in Wales. Just over a fifth, 20.2%, of the innovations suggested were implemented in two or more of the four countries of the UK. For the remaining 3.2% of the suggested innovations, there was insufficient information to determine the location of the innovation.

Step 2) Development of criteria for shortlisting

Eight criteria were developed. The innovations needed to: 1) fit within our scope, 2) focus on adults rather than children, 3) take place within the four nations of the UK, 4) provide enough detail to understand what the innovation is, 5) focus on social care and social work, 6) be amenable to evaluation, 7) be able to be rapidly evaluated and 8) focus on a relevant outcome. Further details can be found in Appendix 2.

Step 3) Grouping and sifting innovations

In total, 158 innovations were considered. Of these, 82 innovations (51.9%) were excluded upon initial review because they were not clear or did not have enough available information.

Seventy-six innovations (48.1%) were discussed when the research team met to reduce the list of innovations to a number feasible for discussion at the prioritisation workshop. Fifty-six of these innovations (35.4% of total, or 73.7% of discussed) were excluded: 27 innovations were out of scope (17.1% of total), 14 were too health (insufficiently social care/social work) focused (8.9% of total), 11 were known to have already been thoroughly evaluated (7.0% of total), three were judged not to be innovative (1.9% of total), and one was found to be a duplicate of an already included innovation (0.6% of total).

Thus 20 innovations (12.7% of the original total) were included in the final shortlist (see Figure 2 and Appendices 3 and 4).

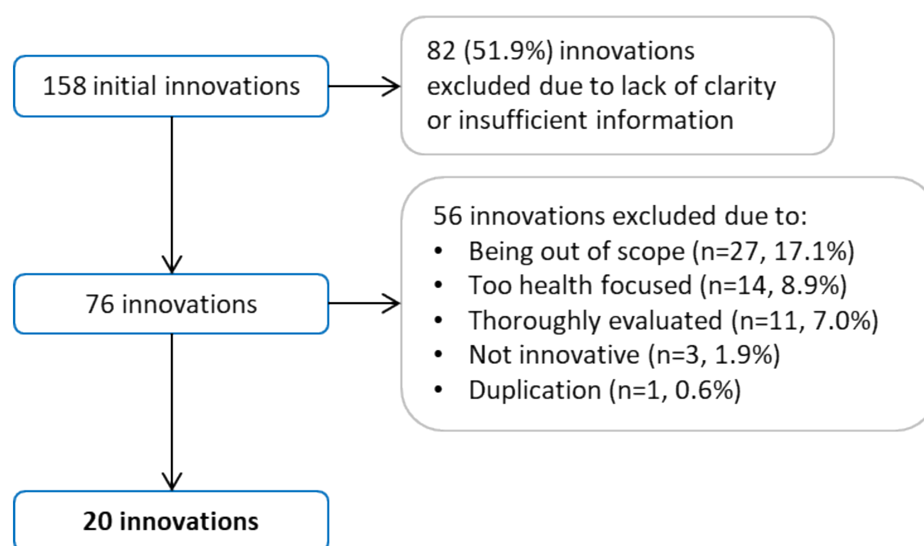

Figure 2. Flow chart demonstrating the inclusion/exclusion of innovations.

Step 4) Prioritisation of innovations (workshop)

Participants

Twenty-three participants attended the workshop: seven people who use adult social care services, six practitioners, four academics/researchers, three commissioners or policy makers, two carers, and one provider (see Table 1). In addition to these roles, several people reported having multiple perspectives (e.g. academic and carer, service user and carer).

Table 1. Description of the types of participants at the workshop and the number of attendees.

Type of participant	Number of attendees
People who use adult social care services	7
Practitioner	6
Academic/researcher	4
Commissioner or policy maker	3
Carer	2
Provider	1
Total	23

Final ranking

Top 5 innovations

The top five innovations agreed at the end of the workshop are shown in Table 2. These are listed in alphabetical order rather than priority order.

Table 2. Top 1-5 innovations (alphabetical order).

Innovation	**Aim**	**Brief description**	**Target group**
Care coordination for dementia in the community	To ensure that people living with dementia and their carers get the right health and social care, at the right time, and in the right setting.	Care Co-ordination in the community approach to supporting people with dementia concentrates on building capacity to enable people with dementia to live well and remain active participants within their own community.	Older adults living with dementia
Family group conferencing	It is an approach whereby key decisions about care and support are made by the person and their family with care professionals present to offer guidance in a conference.	Family, friends and wider community members, come together with the person in question in a conference to draw up a plan as to how they wish that person to be supported and what contributions they each wish to make in order for the plan to be implemented successfully.	Adults with mental health problems
Greenwich Prisons Social Care	To provide a wide range of domestic and personal care to prisoners.	The intervention is delivered by a team of experienced social care staff, assisted by a team of trained Care and Support Orderlies (existing prisoners) to help clients address their wider health and wellbeing need. Key activities: helping with hygiene, mobility and access, cleaning, collecting meals and medication. Receive a support plan and assessment.	Imprisoned adult offenders aged 18+
Local area coordination	It is a community-asset-based approach that facilitates self-supporting communities for social care.	The premise of local area coordination is based on 'what does a good life look like?' Offers two levels of relationship: level one is focused on signposting people to neighbourhood and community based resources; and level two is longer term and focused on forming a relationship to maintain the actions agreed to realise a 'good life'.	People at risk of or needing formal services
MySense.AI	To empower people to live as independently as possible, ensuring that whatever their health, mobility or age, they live to their full potential.	Information from fixed and wearable sensors is used to monitor an individuals' health, wellbeing and behaviour patterns. It establishes what being well looks like and flags subtle changes.	Any adults that need support

Innovations 6-20

The remaining 6-20 innovations are shown in Table 3 in alphabetical order.

Table 3. Innovations ranked 6-20 (alphabetical order)

Innovation	Aim	Brief description	Target group
Age care advice care coordinators	To ensure that the best suited local care options are available to people.	Local care coordination and companion service: Service users are allocated one local coordinator (support and practical issues).	Older adults who require care services
AutonoMe	To develop people's skills with day-to-day tasks and supporting them to live independently.	The app contains videos, accessible 24/7, to encourage adults with learning disabilities to learn how to do day-to-day tasks, such as cooking, cleaning, safety and self-care, by providing simple steps and guidance.	Adults and young people with learning disabilities
Brain in Hand	To improve confidence and independence, enable people to cope with anxiety and reduce demand on carers and support services.	Delivers support services using assistive technology – access to personalised digital self-management tools and human support. Helps people to remember things, make decisions and cope with unexpected events.	People with neurological and mental health difficulties
Community catalysts CIC	To help with catalysing the creation of local social support services.	Community Catalysts CIC designs and manages projects to deliver services like: homecare, day centres, day services, friendship agencies, and meals on wheels programmes.	Older adults and those with disabilities
Community contacts	To help people to design and manage their own support.	Community Contacts offers 'A helping hand with Self-Directed Support'. Provides opportunities for people to make connections with specialist groups who can offer support. Share fact-based information, advice and support.	People of all ages who are eligible for social care and support
Dementia-friendly community	To help people live well with dementia and remain a part of their community.	Encourages everyone to take responsibility for ensuring that people with dementia are able to contribute to the community. Range of support services to help people find the right support, advice and information at the right time. Dementia advisers' and trained volunteers available to offer support by phone or face-to-face.	Older adults living with dementia
Harmonia village	To provide short and long term respite care for people living with dementia which will fully engage with the local community.	A new dementia village opening in Autumn 2019 which is going to be run using sound and motion technology to monitor residents' movements and safety. Also a community hub with café and activity space and guest house.	Older adults living with dementia

Howz	To change the way that we approach ageing and to put freedom and independence first.	Howz sensors are used to monitor activity, movement and use of appliances. Information is sent to company and shared with client via app or website. Analyses data to identify routine, detect changes and monitor for long-term change.	Older adults who are living independently, or their relatives
Link working	To support people to achieve goals by enabling them to identify and access relevant resources and services in their local community.	Link worker and clients co-create action plans and link workers support people to achieve goals (non-clinical) by helping them to identify and access resources and services in community.	People in contact with GP practices
MDTs for brain injury rehabilitation	To support psychosocial community rehabilitation.	A multidisciplinary team (including social work, social care and psychology personnel) jointly develop an individual formulation (consideringbiological, psychological, social and environmental factors).	Adults affected by brain injuries
Nourish care planning systems	To work with care providers across a range of services to deliver a digital care management system tailored to their specific need.	Nourish care planning system is an electronic care management platform that enables care teams to plan, record, report and coordinate care on the go. It empowers the care teams to record more accurate notes, in less time.	Care providers/givers
Shared Lives	To support people to live independently and improve their physical and mental wellbeing by connecting them with accredited carers.	The scheme involves linking up adults in need of social care with a Care Quality Commission-accredited carer who provides care and shares their family and community life with the person.	Young people and adults with social care needs
Social care ECHO	To build workforce capacity in rural and underserved areas through a collaborative medical education model.	Hub-and-spoke knowledge-sharing networks, led by expert teams using multi-point videoconferencing to conduct virtual clinics with community providers. Brings together clinical specialist teams (the hub) and primary care clinicians (the spokes).	Primary care clinicians
Telecare	To employ technology to monitor people's movement, medication and home environment at a distance.	Monitoring of a person's functional status, home environment and health status. Range of telecare devices depending on individual needs. Telecare detects problems, alerts and sends help.	Individuals living with complex health conditions
Three Conversations	To improve care assessment and the planning of people's needs.	The approach involves holding three distinct conversations between the care provider and the person needing care. The first conversation involves exploring the person's needs and connecting them to sources of support. The second conversation is for people who need something to happen urgently. And the final conversation revolves around the long-term outcomes and goals the person wishes to achieve.	People requiring social care

Key themes and principles discussed in the workshop

Throughout the different group discussions, a number of key issues arose when deciding why innovations should or should not be prioritised. Discussion of these themes and principles are discussed below.

Ensuring a mix of different types of innovations to be evaluated

Over the course of the day, workshop participants tended to informally discuss the 20 innovations in relation to three groups of innovations: community-centred innovations, family- or individual-centred innovations and technological innovations. Participants spoke about wanting to ensure that a mix of these different types of innovations were prioritised.

Participants spoke about how they wanted to ensure that some innovations that focused on community- centred support and connecting communities were prioritised. This included innovations that focused on community assets or bringing communities together.

The need to consider individual needs as well as community needs was highlighted. Participants spoke about choosing innovations that supported or worked with individuals and families to maintain independence. For example, innovations that focused on prevention, self-directed support or helping people to do more for themselves. There were some concerns expressed about innovations that may increase dependency.

Technological innovations such as apps and web-based interventions were also perceived as key to include alongside community-centred and individual-centred innovations when prioritising innovations. Technological innovations were slightly more contested as participants acknowledged the value of human interaction. Some negative views towards technological innovations were expressed, including: not liking 'big brother' approaches, having unsuccessful experiences with some innovations, the dated nature of some innovations, potential difficulties using equipment, and concerns over data security and privacy. On the other hand, many benefits of technological innovations were also discussed, including: the potential for professionals to use innovations to objectively monitor clients and the potential to mitigate risks of infringement of civil liberties, as professionals could do assessments remotely and may not need to be in the same location as the care user. Participants spoke about the inevitability of some public funding being spent on technology and hence the need for rapid independent evaluation of such technologies.

Funding

Participants discussed the prioritisation of innovations originating in the private sector as distinct from in the public sector. Some participants proposed that private sector organisations could fund their own evaluations. However, others proposed that privately originated innovations should be treated equally.

Some participants in one group highlighted that they chose innovations based on likely demand, given the occurrence of budget cuts. There were views that accessing and using community resources cannot happen if local authorities cannot afford it. Therefore, it is a balance between savings and helping people. One group queried whether we should be evaluating innovations if we know that local authorities could not afford to implement them.

For example, some innovations may be perceived to be ideal (e.g. case management) but may not be perceived as realistic within the current financial climate. There was also a view that we need to move away from evaluating costs to evaluating impacts.

At points in the workshop, some participants queried whether certain types of innovation should be funded under social care given that they may receive funding from other avenues, e.g. mental health related innovations, innovations that were slightly more health focused, and social prescribing innovations.

Some participants raised concerns that some innovations may replace social care staff such as social workers. Some participants highlighted that prioritisation of innovations may have depended on whether people were interested in innovations relating to social care/work as it is, or social care/work as it should be.

The innovation's target user groups

Throughout the workshop, there were clear discussions around wanting to prioritise and evaluate innovations that focused on underrepresented groups or groups that have been neglected in social work previously and as such have clear unmet needs (such as individuals living with brain injury or prisoners). New topics and responsibilities for social care were also prioritised.

Participants' perceptions on the extent to which innovations could potentially be generalised or rolled out to other groups was one factor that influenced decision-making of priority setting. Some of the innovations are currently being rolled out in numerous areas and were therefore ranked higher. Many participants expressed views that those innovations that were aimed at small groups of the population may have potential to be applied more widely once best practices have been developed. Those that were perceived to be generalizable were often ranked higher.

Participants also discussed how innovations that take place in rural settings may need to be evaluated as there may be less or more of a support infrastructure in these environments.

Potential for impact

An innovation's perceived potential for impact influenced its prioritisation. Those innovations that were perceived to have the potential to make a large positive difference to people's lives and the wider community were ranked highly. Potential positive impacts included: independence, support, staying well and connected, making a difference, empowering people and saving or helping lives. Those innovations that were seen to have less potential for impact were ranked lower. Similarly, innovations that participants felt there was a clear need for (e.g. care coordination) or where people felt there was a genuine commitment to the innovation, were ranked more highly. Participants spoke about the importance of impact over monetary savings.

On a related note, participants felt that innovations that were being implemented by numerous local authorities needed evaluating (e.g. their outcomes).

The role of personal experience

Personal and professional experience and interest influenced decisions about prioritisation. For example, personal family experiences relating to the innovation or having experience, or knowing someone who had experience, working with groups of clients or the specific innovation. For researchers, their areas of interest may also have influenced prioritisation.

In contrast, some participants reflected on how decisions were not only based on personal experience or interest; given that some innovations that participants had little experience of were consistently ranked highly. Many of the participants appeared to have taken time to try and find out more about the innovations that were unfamiliar (e.g. by looking online or watching videos).

Prioritisation of similar innovations

Throughout the day, some participants discussed how they wanted to ensure that at least one, but not more than one, of a group of 'similar' innovations would be prioritised. Participants addressed similar innovations by choosing one innovation that they felt most represented the group of similar innovations. For example, out of all of the technological innovations, one group discussed how they prioritised the technological innovation that was perceived to be the most sophisticated or useful (e.g. helping to identify needs and observe differences). Similarly, the same group prioritised similar community-centred innovations by prioritising a 'general' care coordination innovation or a strengths- and assets-based innovation.

'Innovativeness' of innovation

How 'innovative' an innovation was perceived to be influenced prioritisation. For example, innovations that were seen to be breaking wholly new ground, were very different or shaking up the current social care system were ranked more highly. Innovations that were more nuanced in terms of 'innovativeness' were still sometimes perceived as beneficial, though.

Extent of evidence/research

Innovations that did not currently have much evidence were prioritised over those that were known to have been subject to more research or were currently being evaluated. However, there were varying views on what counted as having enough evidence. For example, the extent to which innovations had been evaluated for use with different target groups in the population. Some participants expressed concerns that innovations had perhaps been evaluated in young people and children but not in adults, or vice versa. Similarly, some participants stated that innovations had been evaluated in one country internationally but not others.

Language used in innovations

Language was discussed by some participants as important when considering innovations. The language used in descriptions of innovations may have influenced decision making. For example, one group discussed the term 'service user' and felt that it prolongs the notion of being a passive recipient. Instead, these individuals expressed preferences that innovations should use rights-based language instead. For example, 'people who use services and care'.

A second consideration about language that was discussed referred to the term innovation and the need to understand what an 'innovation' is. Some participants talked about perceptions that innovation equals cut backs and changes. Within some groups, participants tended to remind each other to distinguish between innovations that seemed like good or bad ideas, and those which merited evaluation. Different perceptions on what an innovation is may therefore have influenced prioritisation.

Conclusions and Next Steps

Conclusions

Overall, the approach undertaking in the horizon scanning and prioritisation was successful in: 1) identifying a large number of suggested innovations from a wide variety of sources across the UK; 2) reducing this to a shortlist of 20 innovations for prioritisation by multiple stakeholders; and 3) identifying with a high degree of consensus the top five innovations they would prioritise for evaluation,.

The top five adult social care and social work innovations recommended at this stage for evaluation are (in alphabetical order):

- Care coordination for dementia in the community;
- Family group conferencing;
- Greenwich prisons social care;
- Local area coordination; and
- MySense.AI

Strengths and limitations

Given the short period of time available and the large number of innovations put forward, we were only able to use the information that was easily available to us to judge appropriateness of innovations for inclusion. However, we acknowledge that as a result, certain innovations may have been missed from the final shortlist. On a related note, the number of individuals or organisations that we contacted may have been larger if given more time. This may have led to an increase in the number and type of innovations suggested.

Similarly, we were unable to establish the full extent to which innovations had been, or were currently being, evaluated. This is a limitation as some of the innovations included in the final shortlist may have already been evaluated, may currently be in the process of evaluation or there may already be well-advanced plans to evaluate them in the near future. The next step of this project will be to conduct scoping research into the top five innovations, part of which will aim to establish to what extent they have already been, are being, or shortly will be, evaluated.

Despite these limitations, we systematically adapted an established method for priority setting (James Lind Alliance, 2018). A strength of our approach is that we used standardised, pre-defined criteria to judge innovations. In addition, all innovations were reviewed by a social care expert and at least one researcher; thus enhancing the reliability of our selection process. We also managed to ensure that innovations were suggested by a wide range of organisations and individuals with varying roles within these organisations and the social care field.

Next steps

The next stage of work is recommended to be further scoping of these five innovations to identify two which could be taken forward for evaluation by the two rapid evaluation teams,

with particular focus on investigating further the extent of any existing or planned evaluations of them.

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Appendices

Appendix 1. Information about the organisations, from which individuals suggested innovations.

No.	Organisation	Description
Charity		
1	Centre for Ageing Better	The Centre for Ageing Better is a charity, funded by an endowment from The National Lottery Community Fund, working to create a society where everyone enjoys a good later life.
2	Health Foundation	The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. The organisation's aim is a healthier population, supported by high quality health care that can be equitably accessed.
3	Community Integrated Care	Community Integrated Care is a national social care charity which provides care and support to thousands of people across England and Scotland. Community Integrated Care is one of the UK's largest health and social care charities, which work in the community, delivering life-enhancing support to people with a diverse range of care needs, including: 1. Learning Disabilities; 2. Mental Health Concerns; 3. Autism; 4. Age-Related Needs; and 5. Dementia.
4	Sense	Sense is an organisation that helps everyone living with complex disabilities, everyone who is deafblind.
5	Carr Gomm	Carr Gomm is a leading Scottish social care and community development charity supporting about 2000 people across Scotland to live safe and fulfilling lives. Specifically, their work focuses on tackling the crippling issues of loneliness and isolation.
6	Forces in Mind Trust (FiMT)	The aim of the FiMT Research Centre is to manage the Trusts' Veterans and Families Research Hub (VFR Hub); to provide advice, support, and various research outputs; and to plan an annual conference and awards event to celebrate and present recent research supporting veterans and their families. FiMT awards grants and commissions research, coordinates the efforts of others, and supports projects that deliver long-term solutions to the challenges faced by the Armed Forces Community.
7	Mind	Mind services include supported housing, crisis helplines, drop-in centres, employment and training schemes, counselling and befriending. The local Minds support over 513,000 people across England and Wales.
8	King's Fund	The King's Fund is an independent charity working to improve health and care in England. The vision is that the best possible health and care is available to all. The King's Fund provides a range of consultancy and advisory services which bring together deep understanding of the health and care system, policy expertise and experience of supporting and developing leaders and organisations.
9	Scottish Autism	Scottish Autism is an organisation dedicated to enabling autistic people to lead happy, healthy and fulfilling lives. Established in 1968 by a group of parents, it is now the largest provider of autism-specific services in Scotland and a leading authority and advocate for good autism practice.

Universities / university partnerships		
10	University of Hertfordshire	The University of Hertfordshire is a public university in Hertfordshire, United Kingdom. The university is based largely in Hatfield, Hertfordshire. Its antecedent institution, Hatfield Technical College, was founded in 1948 and was identified as one of 25 Colleges of Technology in the United Kingdom in 1959.
11	University College London	University College London, which has operated under the official name of UCL since 2005, is a public research university located in London, United Kingdom.
12	Cardiff University	Cardiff University is a public research university in Cardiff, Wales. Founded in 1883 as the University College of South Wales and Monmouthshire, it became a founding college of the University of Wales in 1893.
13	JLA Priority Setting Partnership Steering Group; Joint University Council Social Work Education Committee	The James Lind Alliance (JLA) is a non-profit making initiative established in 2004. It brings patients, carers and clinicians together in Priority Setting Partnerships (PSPs) to identify and prioritise the Top 10 unanswered questions or evidence uncertainties that they agree are the most important.
14	Health Services Management Centre (HSMC), University of Birmingham	The Health Services Management Centre (HSMC) at the University of Birmingham is one of the UK's foremost centres for research, evaluation, teaching and professional development for health and social care organisations. HSMC has established a unique reputation as a 'critical friend' of the healthcare community and strives constantly to bridge the gap between research and practice.
15	University of York	The University of York is a collegiate plate glass research university, located in the city of York, England. Established in 1963, the campus university has expanded to more than thirty departments and centres, covering a wide range of subjects.
16	University of Southampton / Wessex AHSN	The University of Southampton is a research university in Southampton, England. The university's origins date back to the founding of the Hartley Institution in 1862. In 1902, the Institution developed into the Hartley University College, awarding degrees from the University of London.
Councils		
17	Walsall Council	Walsall Council, formerly Walsall Metropolitan Borough Council was created in 1974 to administer the newly formed Metropolitan Borough of Walsall. The Metropolitan Borough of Walsall is based on an amalgamation of two former local government districts, Walsall County Borough and Aldridge-Brownhills Urban District.
18	Kent County Council	Kent County Council is a county council that governs most of the county of Kent in England. It is the upper tier of elected local government, below which are 12 district councils, and around 300 town and parish councils. The county council has 84 elected councillors.
19	Derby City Council / Joined up CAREers	Joined Up CAREers Derbyshire support the current and future health and social care workforce through bringing together local partner organisations. It seeks to find the best candidates for roles within the health and social care sector of Derby and Derbyshire – and support them on their career journey.

20	Gateshead Council	Gateshead Council is the local government authority for the Metropolitan Borough of Gateshead, Tyne and Wear. The council, based at Gateshead Civic Centre, is made up of twenty-two electoral wards, each with three elected councillors. It is currently Labour controlled, and led by Councillor Martin Gannon.
21	Somerset County Council	Somerset County Council (established in 1889) is the county council of Somerset in the South West of England, an elected local government authority responsible for the most significant local government services in most of the county.
22	Nottinghamshire County Council	Nottinghamshire County Council is the upper-tier local authority for the non-metropolitan county of Nottinghamshire in England. It consists of 66 county councillors, elected from 56 electoral divisions every four years.
23	Wolverhampton Council	City of Wolverhampton Council (formally known as Wolverhampton Metropolitan Borough Council, or WMBC) is the governing body of the City of Wolverhampton, England. The Council is still legally called Wolverhampton City Council but uses City of Wolverhampton Council as its corporate brand.
24	South Gloucestershire Council	South Gloucestershire Council is the local authority of South Gloucestershire, a unitary authority in the South West of England region. As a unitary authority it has the powers of a non-metropolitan county and district council combined. It is administratively separate from the rest of Gloucestershire.
25	Birmingham City Council	Birmingham City Council is the local government body responsible for the governance of the City of Birmingham in England, which has been a metropolitan district since 1974. The council is responsible for running nearly all local services, with the exception of those run by joint boards.
Academic health science networks		
26	Wessex AHSN	Academic Health Science Networks (AHSNs) are member led organisations within the NHS. There are 15 AHSNs in England, and they were created in 2013 with the aim of bringing together health services, academia and industry to promote and support innovation to improve patient outcomes and generate economic benefits.
27	Oxford AHSN / National AHSN	The Oxford AHSN (Academic Health Science network) Accelerator programme offers a unique launchpad for entrepreneurs and their ventures at every stage, from idea to market. The Oxford AHSN Accelerator programme is run in collaboration with BioCity and partners from the NHS, industry and research in Berkshire and Oxfordshire who will provide mentors and coaches to help ensure your idea is sustainable.
28	Health Innovation Network (HIN) / National AHSN	The Health Innovation Network is the Academic Health Science Network (AHSN) for south London, one of 15 AHSNs across England.
29	AHSN for the North West Coast / National AHSN	The Academic Health Science Network (AHSN) for the North West Coast is one of England's 15 AHSNs who operate as the key innovation arm of the NHS. Nationally, it is commissioned by NHS England, NHS Improvement and the Office for Life Sciences and work closely with the AHSN Network to deliver national programmes of work to achieve rapid uptake of innovations proved to have an impact, across the country.

30	National AHSN	There are 15 Academic Health Science Networks (AHSNs) across England, established by NHS England in 2013 to spread innovation at pace and scale – improving health and generating economic growth. Each AHSN works across a distinct geography serving a different population in each region. Through Innovation Pathway AHSNs broker access to a range of expert support and services across the health and care sectors that support NHS innovators and companies to realise the commercial and economic potential of their ideas.
31	West of England AHSN / National AHSN	The West of England Academic Health Science Network (AHSN) brings together all the key players innovating health and care in region. In the West of England, AHSN has been work across organisational and geographical boundaries, involving entire network in both development and delivery to drive transformation that is based on genuine needed.
32	East Midlands AHSN	East Midlands Academic Health Science Network is the innovation arm of the NHS in the East Midlands. The aim of East Midlands AHSN is to bring together the NHS, universities, industry, third sector and social care to transform the health of East Midland's residents and stimulate economic growth.
Health and social care partnerships (HSCP)		
33	West Dunbartonshire HSCP	West Dunbartonshire has had the benefit of an integrated health and social care partnership since October 2010. West Dunbartonshire Health and Social Care Partnership aims to improve the health and well-being of West Dunbartonshire residents.
Government teams		
34	Scottish Government Teams	The Scottish Government is the devolved government for Scotland and has a range of responsibilities that include: the economy, education, health, justice, rural affairs, housing, environment, equal opportunities, consumer advocacy and advice, transport and taxation.
School of social care research		
35	Wales School of Social Care Research	The Wales School for Social Care Research is funded by Health and Care Research Wales to support social care research capacity building in ways that make a difference to social care in Wales. The School has members of staff based in Swansea University, Cardiff University and Bangor University and works across Wales.
Social care companies		
36	Founder Age Care Advice	Age Care Advice in 2011 is an independent registered private social worker for older people and adults. They provide care services for older people, adults and their families.
37	Design and Learning Centre, Clinical & Social Innovation. ESTHER Coach Network	The Design & Learning Centre for Clinical & Social Innovation was officially launched in 2016. The vision of the Design and Learning Centre is to make care better for people, by making out-of-hospital care safer for both citizens and professionals.
38	Helen Sanderson Associates	Helen Sanderson Associates are a social enterprise, working to create person-centred change. They work internationally to embed person-centred practices into the heart of organisations and communities – creating better lives together.

Professional body		
39	Royal College of Occupational Therapists	The Royal College of Occupational Therapists (RCOT) Informed Views provide a considered view and direction from RCOT on a contemporary topic.
NHS trust		
40	Torbay and South Devon NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust is an integrated organisation providing acute health care services from Torbay Hospital, community health services and adult social care. The Trust runs Torbay Hospital as well as five community hospitals, stretching from Dawlish to Brixham. We also provide health and social care to the local population.
Council/NHS trust partnership		
41	Health & Social Care Moray	Health and Social Care Moray is an integrated health and social care partnership working under the direction of the Moray Integration Joint Board (MIJB) to improve health and wellbeing outcomes for people who use health and social care and their unpaid carers.
42	Northern Health & Social Care Trust, Northern Ireland	The Northern Health and Social Care Trust is a health organisation in Northern Ireland. The NHSCT provides services at various health facilities including Antrim Area Hospital, Braid Valley Care Complex, the Causeway Hospital and Mid-Ulster Hospital.
Social Care regulatory body		
43	Northern Ireland Social Care Council	The Northern Ireland Social Care Council was founded as the regulatory body for the social care workforce in Northern Ireland under the Health and Personal Social Services Act (Northern Ireland) 2001. The Social Care Council is helping to raise standards in the social care workforce by registering social care workers; setting standards for their conduct and practice and supporting their professional development.

Appendix 2. Inclusion criteria for sifting process.

Inclusion criteria	Description
1. An innovation that fits within our scope	Our scope is: all types of innovation – e.g. new models of care, service innovations, payment and commissioning innovation, innovations in person and community-centred approaches, technological innovations, etc.
2. **Adult** social care and social work only	The innovation must target adult social care and social work. Any innovations targeting children's social care should be excluded. - The innovation should be consistent with the NIHR's School of Social Care research definition of adult social care: *"The term 'adult social care' refers to provision of personal and practical care and support that people may need because of their age, illness, cognition, disability or other circumstances. It also includes support for family members or other unpaid carers." (SSCR website).* - Settings in which adult social care may be delivered are as follows (SSCR website): *"Care and support are provided in a number of settings: in residential and nursing homes, in people's own homes (domiciliary or 'home' care) and in other community settings such as day centres. There are also various accommodation settings, such as sheltered housing, extra-care housing, supported living and Shared Lives schemes. Social workers and other staff carry out assessments, provide information and coordinate activities to back up this service provision."*
3. Taking place within the four nations of the United Kingdom	The innovation must take place within the four nations of the UK. These include: - England - Scotland - Wales - Northern Ireland
4. Provides enough detail to understand what the innovation is	Innovations must provide details on: - What the innovation entails - Who was involved - Evidence-base for the intervention - Desired outcomes - Scale of innovation (e.g. one care home or one care home group or much broader?) - Geographical reach - When the innovation emerged - Potential benefit (small client groups or large client groups)
5. Focuses on social care and social work	Innovations must focus on social care and social work. Innovations that are too clinical or health care focused should be excluded. Innovations that are a combination of health and social care should be included and marked as 'both' (E.g. reviewing medications in care homes). Innovations that integrate health and social care should be included and marked as 'both'.
6. Amenable to evaluation	There must be a sufficient evidence gap that an evaluation of the innovation could fill. To decide this, please consider the following questions: - There is a sufficient evidence gap that an evaluation of the innovation could fill

	- Are there existing evaluations (underway or recently completed)? - If yes, are there significant evidence gaps that an evaluation might fill? - Could the innovation be evaluated in a longer time frame through commissioned research? - Is there potential for broader/national learning, beyond the site(s) involved - Is there a need in social care for learning about this innovation?
7. Amenable to *rapid* evaluation	We include all innovations amenable to innovation but separately note those which are amenable to *rapid* evaluation. To decide this, please consider the following questions: - Is the innovation in operation/being trialled currently? (I.e. is there is something concrete to evaluate?) - Are we confident that we can secure local buy in for an evaluation? - Does the innovation have clear aims? - Is the innovation well defined? - Is it a good time to evaluate (e.g. are there benefits or risks to early evaluation)? - Is a rapid evaluation feasible or appropriate?
8. Focuses on a relevant outcome	The innovation must focus on a relevant outcome for social care. The NIHR's school of social care (SSCR website) research propose that some important aims of adult social care could be: - To help people remain independent - To retain their dignity - To achieve a better quality of life - To safeguard vulnerable individuals from abuse and neglect Other outcomes relevant for social care should also be considered e.g. helping people to deliver social care efficiently.

Appendix 3. Descriptions of innovations used in workshop.

BRACE and RSET
Innovations in Social Care and Social Work Prioritisation Workshop

Guide to Each Innovation

This document provides further information on each of the 20 innovations in social care and social work that will be prioritised for evaluation and research. It accompanies the *Participant Worksheet*, which you have been asked to complete and bring to the workshop.

A: Age Care Advice Care Coordinators

- **What the innovation is for:** The innovation aims to ensure that the best suited local care service options are available to people (local care coordination and companion service).
- **Who it targets:** Older adults who require care services.
- **How it works:** Age Care Advice carries out a comprehensive assessment to identify needs (within 48 hours). Service users are allocated one local coordinator. The coordinator is available to the person and anyone in their network seven days a week, 12 hours a day. The person's case is not closed unless the person wants it to be. The service includes many different things including: care coordination, support and advocacy when attending appointments, capacity assessments, finding the right care home or live-in care, finding tradesmen, personal budget and benefit support, discharge plan from hospital and being the first point of contact on carer's emergency plan. Coordinator provides support for care but also helps with other practical issues that might lead to a crisis.
- **Where it is:** Northamptonshire, Lincolnshire, North Cambridgeshire and Rutland.
- **Website/further reading:** https://agecareadvice.co.uk/

B: Link Working

- **What the innovation is for:** The innovation aims to support people to achieve goals by enabling them to identify and access relevant resources and services in their local community.
- **Who it targets:** People in contact with GP practices.
- **How it works:** Community link working offers non-clinical one-to-one support to people in contact with GP practices. Community link working is based on person-centred values and a human rights based approach. Community Link workers take time to understand concerns impacting on people's health and wellbeing and help them to identify problems and issues that they are experiencing. Community link workers and clients then co-create a bespoke outcomes-focussed action plan which reflects their priorities and concerns. Community link workers then support people to achieve these goals by enabling them to identify and access relevant resources and services in their local community. Some common themes include: attending social activities and connecting with local resources, enjoying education, employment or volunteering, maximising independence in the home (supporting with housing, finances and welfare benefits), building and maintaining relationships with family, friends and other networks and building and maintaining healthy lifestyles.
- **Where it is:** Scotland (Edinburgh).
- **Website/further reading:** https://www.carrgomm.org/community-link-working

C: Community Contacts

- **What the innovation is for:** The innovation aims to help people to design and manage their own support in a confident and informed manner.

- **Who it targets:** Self-directed support is for people of all ages who, after assessment, are eligible for social care and support from their local authority.
- **How it works:** Community Contacts offers advice, information and support about Self-Directed Support. Community Contacts offers 'A helping hand with Self-Directed Support'. Community Contacts aims to help people to design and manage their own support in a confident and informed manner. They work with the local social work department and local community organisations. The project can help to reduce feelings of uncertainty by providing opportunities for people to make connections with specialist organisations or groups who can offer support, e.g. local carers' organisations. Community Contacts facilitate opportunities between people to share experiences and knowledge of Self-Directed Support. Community contacts achieve their aims by sharing information, advice and support and working with others to make connections so that people have more opportunities to participate in their community and wider society to address feelings of isolation and loneliness.
- **Where it is:** Scotland (Argyll & Bute and Highland).
- **Website/further reading:** https://www.carrgomm.org/community-contacts

D: MDTs for brain injury rehabilitation

- **What the innovation is for:** The innovation aims to support psychosocial community rehabilitation.
- **Who it targets:** Adults affected by brain injuries.
- **How it works:** A multidisciplinary team (MDT - consisting of social work, social care and psychology personnel) provides psychosocial community rehabilitation with adults affected by brain injuries. The MDT jointly develops an individual's formulation. Psychology formulations are evidence-based and provide a systematic framework that can be adapted to meet the needs of individual teams. Each formulation considers biological, psychological, social and environmental factors for each section. Sections consist of: the person's background, triggers, presenting and maintaining issues, strengths, hypotheses (explanation and possible solutions), and an individual plan. This asset-based approach is individual and enables a bespoke psychosocial intervention which can be replicated within other multidisciplinary teams.
- **Where it is:** One service in Scotland (West Dunbartonshire).
- **Website/further reading:** N/A

E: Howz

- **What the innovation is for:** The innovation aims to support independent living.
- **Who it targets:** Older people who are living independently and their relatives.
- **How it works:** The innovation uses sensors. Howz sensors detect activity and send this data to a gateway which is connected to the internet. The sensors include a door sensor (monitors doors opening/closing or doors that are open for a long time), a motion sensor (monitors movement within the home or unexpected movement when vacant) and a smart plug (confirming if the person has used certain appliances). The Howz kit can be self-installed (wireless sensors that are attached with adhesive pads). Clients set up an account on the Howz website and choose who they want their alerts sent to. The company receives this information and shares it back with the client directly via the app or website. Howz carries out analysis on the information to identify routine, set the alerts to detect changes, and monitor for long-term change. Used by clients (to learn about their own routine and support conversations with healthcare and care providers) and relatives (for peace of mind).
- **Where it is:** Based in Manchester. East Midlands are currently putting it into practice as part of the Digital Accelerator programme.
- **Website/further reading:** https://howz.com/

F: MySense.ai

- **What the innovation is for:** The innovation aims to empower people to live as independently as possible, whatever their health, mobility or age.
- **Who it targets:** All needing support for self-care.
- **How it works:** MySense is a simple-to-use health analytics platform. It monitors an individual's health, wellbeing and behaviour patterns, establishes what 'being well' looks like and flags subtle changes – providing total peace of mind for them, their family, friends and carers. Information from fixed and wearable sensors is gathered by a secure platform. MySense learns behaviour patterns and quickly identifies declining health or immediate care needs. Sensors include: wristband sensors (measures heart rate for drops or elevations that could indicate stress/illness/abnormalities), door sensors (monitors unusual or a lack of activity), seat sensor (checks physical activity e.g. prolonged periods of sitting), plug sensor (monitors usage of appliances), tap sensor (highlights changes to water consumption), toilet sensor (enables carer to raise issues that individuals may find too sensitive to share), shower sensor (marks decreases in personal hygiene), and a bed sensor (measure prolonged periods in bed).
- **Where it is:** Throughout the UK. London is currently putting it into practice as part of the Accelerator programme.
- **Website/further reading:** https://www.mysense.ai/

G: Brain In Hand

- **What the innovation is for:** Improve confidence and independence. Enable people to cope with anxiety. Reduce demand on carers and support services.
- **Who it targets:** People with neurological and mental health difficulties – who may have to manage challenging environments, transition into independent living, start work or navigate higher education.
- **How it works:** Delivers support services using assistive technology. A professional support system provides access to personalised digital self-management tools and human support. Helps people to remember things, make decisions when anxious or confused and cope with unexpected events. The innovation includes: 1) Personalised user setup with a specialist, including planning (thinking about goals and strengths and identifying solutions) and helping clients to use the technology. 2) Cloud-based, feature-rich software and app which provide access reminders, diary, planned activities, notes and individualised coping strategies and a traffic-light system to monitor wellbeing. 3) A linked responder (non-medical) support team who will contact clients or their personal supporters to help them cope with the situation. 4) Brain in Hand data insights which encourage reflection and enhance communication between individuals and supporters.
- **Where it is:** Currently being trialled in Somerset.
- **Website/further reading:** https://braininhand.co.uk/

H: Telecare

- **What the innovation is for:** The innovation aims to employ technology to monitor people's movement and home environment at a distance.
- **Who it targets:** Individuals living with complex health conditions.
- **How it works:** The ***telecare systems*** include automatic and passive monitoring of a person's functional status as well as their home environment. There are a number of telecare systems, and the best one for any person's needs will depend on their particular requirements. Telecare devices include medication dispensers, pendant alarms, falls detectors, passive infrared sensor (PIR)-based lighting and teleconsultation software to connect the individual with their (formal or

informal) care support network. Telecare detects when there is a problem and sends alerts to a call centre which then organises help. For example, the alert might be sent if the gas on a cooker has been left on by accident, and a personal alarm would enable a call for help following a fall.

- **Where it is:** Countrywide.
- **Website/further reading:** https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/personal-alarms-security-systems-and-keysafes/ https://www.ageuk.org.uk/information-advice/care/housing-options/adapting-home/telecare/

I: Social Care ECHO

- **What the innovation is for:** The innovation aims to build workforce capacity in rural and underserved areas through a collaborative medical education model.
- **Who it targets:** Community based carers needing specialist support.
- **How it works:** ECHO (Extension for Community Healthcare Outcomes) started as a way to meet local healthcare needs. The Social Care ECHO model is organised through hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual 'clinics' with community providers. The ECHO model brings together specialist teams (the hub) and primary care clinicians (the spokes). Through teaching sessions and case presentations, the spokes have the opportunity to discuss any cases which they have found challenging and determine the best course of treatment. The networks foster a spirit of learning from each other in a safe environment.
- **Where it is:** Northern Ireland.
- **Website/further reading**: https://echonorthernireland.co.uk/northern-ireland-social-care-council-2/; https://echonorthernireland.co.uk/about/

J: Dementia-friendly community

- **What the innovation is for:** The innovation aims to help people to live well with dementia and remain a part of their community.
- **Who it targets:** Older adults living with dementia.
- **How it works:** The dementia-friendly communities programme encourages everyone to share responsibility for ensuring that people with dementia feel understood, valued and able to contribute to their community. There is a range of support services to help people affected by dementia find the right support, advice and information, at the right time. The group services involve the improvement of confidence and motivation; provide reassurance; and allow people affected by dementia to get advice and information from our experienced staff. The dementia advisers' experts and trained volunteers are available to speak to by 'phone or face-to-face helping people with dementia take back control of their lives and remain independent for longer.
- **Where it is:** There are now 137 communities across England Wales and Northern Ireland.
- **Website/further reading:** https://www.dementiafriends.org.uk; https://www.alzheimers.org.uk/

K: Harmonia Village

- **What the innovation is for:** The aim of the innovation is to provide short- and long-term respite care for people living with dementia, which will fully engage with the local community.
- **Who it targets:** Older adults living with dementia.
- **How it works:** The Harmonia Village provides an opportunity to do something different to support people living with dementia that compliments and enhances existing services and organisations in Dover. This is a new dementia village opening in Autumn 2019, which is going to be run using sound and motion technology to monitor residents' movements and safety. Harmonia Village, will

have six houses, each with five residents supported by nursing home-type care. There will be a community hub with a café and space for activities, which will also be open to the local community. There will also be a guest house with six bedrooms, fully equipped for people who have dementia, so they and their friends and family can have a break together.

- **Where it is:** Dover.
- **Website/further reading:** https://www.ekhuft.nhs.uk/patients-and-visitors/news-centre/the-harmonia-village-at-dover/

L: Care Co-ordination for dementia in the Community

- **What the innovation is for:** The innovation ensures people living with dementia and their carers get the right health and social care, at the right time, and in the right setting.
- **Who it targets:** Older adults living with dementia.
- **How it works:** The Care Co-ordination in the Community approach to supporting people with dementia in Inverclyde has been to concentrate on building capacity to enable people with dementia to live well and remain active participants within their own community. The aim is to improve access to appropriate support and intervention at every stage in their illness. The work towards a dementia-friendly Inverclyde also aims to improve awareness and knowledge across services and the wider community. Taking a whole pathway approach, the work supports improvements in first diagnosis and post-diagnostic support; secondly in care co-ordination in the community; then in hospital settings, including acute, community hospitals and specialist dementia units; and finally in palliative and end of life care.
- **Where it is:** Inverclyde – Scotland.
- **Website/further reading:** https://ihub.scot/improvement-programmes/focus-on-dementia/integrated-care/

M: Greenwich Prisons Social Care

- **What the innovation is for:** The innovation provides a wide range of domestic and personal care to prisoners.
- **Who it targets:** Imprisoned adult offenders.
- **How it works:** This is a prison social care service for adult offenders aged 18+ at HMP Belmarsh, HMP ISIS and HMP Thameside in the London Borough of Greenwich. The intervention is delivered by a team of experienced social care staff, assisted by a team of trained Care and Support Orderlies (existing prisoners) to help clients address their wider health and wellbeing needs. Prisoners within the Greenwich cluster can self-refer to the service. Key activities will include helping them with personal hygiene, assisting with mobility and access, cell cleaning, collecting meals and prompting them to take medication. Eligible clients will receive an individual care and support plan, designed to improve the quality of life and address their wider health and wellbeing. A full assessment will then be carried out by the Royal Borough of Greenwich (RBG), whowill provide a support plan to any eligible prisoner. The CGL Greenwich Prisons Social Care team also provides resettlement support to trained orderlies as well as patients when transferred or released.
- **Where it is:** London Borough of Greenwich.
- **Website/further reading:** https://www.changegrowlive.org/content/greenwich-prisons-social-care-service

N: Nourish Care Planning System

- **What the innovation is for:** The innovation aims to work with care providers across a range of services to deliver a digital care management system tailored to their specific needs.
- **Who it targets:** Care providers/givers.

- **How it works:** Nourish Care Planning System is an electronic care management platform that enables care teams to plan, record, report and coordinate care 'on the go'. It empowers the care teams to record more accurate notes, in less time. The Nourish Care Planning System enables carers to plan, record, report and co-ordinate care in an electronic environment. It allows carers to record care notes at the point of care, thereby improving accuracy and detail; issues alerts for upcoming tasks and raises health concerns; allows self-calculating assessments and reminders when due; tracks health trends through automated graphs and reports; and allows for instant access to requested information for inspections.
- **Where it is:** Available countrywide in the UK.
- **Website/further reading:** https://nourishcare.co.uk/

O: AutonoMe
- **What the innovation is for:** The innovation aims to help develop people's skills with day-to-day tasks, supporting them to live independently. Progress data from the innovation supports local authorities to make decisions about social care provision.
- **Who it targets:** Adults and young people with learning disabilities.
- **How it works:** The app contains videos, accessible 24/7, to encourage adults with learning disabilities to learn how to do day-to-day tasks, such as cooking, cleaning, safety and self-care, by providing simple steps and guidance. The app also sends reminders to users to encourage them to perform tasks, such as locking the door and eating meals. Users are assessed after watching each video to track their progress. The data on users' progress is accessible to local authorities and care providers to inform decision-making about the services they provide to the local population of adults and young people with learning difficulties and to create achievable outcomes for this population. AutonoMe also provides local authorities with a Local Engagement Officer to help them to embed the app into their practice. For social care providers, AutonoMe offers training on how to embed the use of the app into their work to relieve workload pressures.
- **Where it is:** Seven local authorities in England, including Plymouth, Devon, Surrey, North Somerset and Bristol.
- **Website/further reading:** https://www.autono.me.uk/

P: 3 Conversations
- **What the innovation is:** The innovation aims to improve care assessment and the planning of people's needs.
- **Who it targets:** People requiring social care.
- **How it works:** The approach involves holding three distinct conversations between the care provider and the person needing care. The first conversation involves exploring the person's needs and connecting them to sources of support. This helps the person to develop the relationships and connections they need to start moving towards living independently. The second conversation is for people who need something to happen urgently to help them regain stability and control in their life. The conversation is led by the person needing care and aims to assess the level of risk and identify ways of mitigating the risks through developing an emergency plan. The final conversation revolves around the long-term outcomes and goals the person wishes to achieve and discussing what a good life looks like for them. This final conversation includes discussing practical ways to meet these goals, the resources needed to do so and the support available to help the person meet their aims. The sources of support can include family and friends, but also the wider community and local businesses.
- **Where it is:** Various social and health care organisations in England, including in Wolverhampton, London, Cornwall, Essex, Medway, Reading and Cambridgeshire.
- **Website/further reading:** http://partners4change.co.uk/the-three-conversations/

Q: Shared Lives

- **What the innovation is:** The innovation aims to supports people to live independently and improve their physical and mental wellbeing by connecting them with accredited carers.
- **Who it targets:** Young people and adults with social care needs.
- **How it works:** The scheme involves linking up adults in need of social care with a Care Quality Commission-accredited carer who provides care and shares their family and community life with the person. Those in need of social care can move in with an assigned carer (or vice versa) for a few weeks up to a number of years. Alternatively, a carer can provide daytime or overnight visits to offer respite to an existing family carer. As well as the carer offering support for day-to-day tasks, such as dressing and cooking, they also integrate the person in need into their lives. This helps the individual to develop relationships within their local community with the aim of supporting them to live more independently.
- **Where it is:** Numerous locations scattered around the UK (and in 17 other countries worldwide).
- **Website/further reading:** https://sharedlivesplus.org.uk/

R: Community Catalysts CIC

- **What the innovation is for:** The innovation helps to catalyse the creation of local social support services.
- **Who it targets:** Older adults and those with disabilities (both learning and physical), but incorporates the community as a whole into the project.
- **How it works:** Community Catalysts CIC designs and manages projects to deliver services, delivers programmes of work, facilitates events and workshops, and writes practical guidance and toolkits; while collaborating with community groups, local councils, local NHS organisations (healthcare providers and commissioners), policy makers, and other voluntary and private sector organisations. Services include homecare, day centres, day services, friendship agencies, and meals on wheels programmes. For projects involving community enterprises, it uses a ratio of one coordinator – called a community connector – to 200 enterprises.
- **Where it is:** Based in Harrogate, but works across the UK. Most initiatives are for clients in England (e.g. Leeds, Birmingham, Norfolk).
- **Website/further reading:** https://www.communitycatalysts.co.uk/

S: Local area co-ordination (LAC)

- **What the innovation is for:** The innovation is a preventative, community-asset-based approach that facilitates self-supporting communities for social care.
- **Who it targets:** People at risk of or needing formal services.
- **How it works:** A local area co-ordinator works embedded in a defined neighbourhood of 8,000-12,000 people. There is no formal referral process; the co-ordinator approaches, or is introduced to, people at risk of needing formal services, and there can even be direct approaches by the individuals themselves. The premise of LAC practice is based on 'what does a good life look like?' The co-ordinator asks this question of the person and helps create opportunities for them to begin to progress towards personal goals and ambitions. LACs offer two levels of relationship. Level One is focused on signposting people to neighbourhood and community based resources. Level Two is longer term and focused on forming a relationship to maintain the actions agreed to realise a 'good life'. Co-ordinators draw on family and community resources before considering commissioned or statutory services, where feasible opting for solutions that involve relatively little use of formal care. The aim is to build independence, capacity and resilience, as well as use local resources effectively.
- **Where it is:** 11 areas in England and Wales (e.g. Birmingham, Derby, Wiltshire) and in Scotland.
- **Website/further reading:** https://lacnetwork.org/local-area-coordination/; https://www.enable.org.uk/lac/

T: Family group conferencing

- **What the innovation is for:** Family group conferencing is an approach whereby key decisions about care and support are made by the person and their family with care professionals present to offer guidance in a conference.
- **Who it targets:** Adults with mental health problems.
- **How it works:** All with concern for someone (family, friends, wider community members) come together with the person in question in a conference to draw up a plan as to how they wish that person to be supported and what contributions they each wish to make in order for the plan to be implemented successfully. An independent coordinator undertakes preparatory and follow-up guidance work, but the actual decision making takes place in private 'family time' at the conference. Any proposed involvement of care services as part of the plan is checked with the social worker in order to make sure that it is practicable and acceptable.
- **Where it is:** Camden, Hampshire, Edinburgh, Birmingham and Essex (for mental health), and elsewhere in Europe (mainly The Netherlands and Norway).
- **Website/further reading**: https://eput.nhs.uk/our-services/essex/essex-mental-health-services/adults/family-group-conference/

Appendix 4. All innovations suggested.

#	Name of the innovation	Include or exclude (HW/ST)	CN notes (17 Sept 19)	Pre-meeting excluded	Discussed during the meeting	Short description of the innovation
Group 1: Workforce Capacity Building innovations						
Subgroup 1.1 Training health and social care providers						
1	Help4Carers App	Include	Maybe	Include	Exclude: out of scope	Carers and care workers provide an invaluable role supporting the health and wellbeing of people across Kent and Medway. We are further developing and launching an app which was developed by the Kent and Medway Sustainability and Transformation Partnership (STP) which includes helpful advice, guides and training videos to help support people in these roles. Secured funding through the NHS Digital Pathfinder. From website: Help4Carers is an app developed to support carers, patients and their families with information, education and training, enabling a better coordination of care.
2	Health and care videos (https://demo-paid-carers.healthandcarevideos.com/)	Include	No - just videos	Include	Exclude: out the scope	>1000 health videos, incl. for care workers. Case studies and ROI meant to be good, but I've not checked. From website: help to relay key messages effectively through video (Healthcare).
3	Oomph!	Include	not enough detail	include	exclude: have been evaluated	From website: Wellbeing strategy - community wellbeing and care home wellbeing. Three key services: Exercise classes, creative activities, and engaging days out in care homes and in the community. Care home wellbeing: Training and support to enable care home staff to deliver high quality exercise, activity classes and days out. Community wellbeing: Training and support to enable community services to offer high quality exercise. Hands on training and support for those working in retirement villages, sheltered housing and day care services (Training, equipment, app, report and support, marketing collateral, peer to peer networking.
4	Agylia (Red Ninja)	Exclude	Not enough detail	Included: not discussed	Exclude/not discussed	Training modules.
5	Developing trauma and adversity informed workforce and services	Unsure	Maybe - under a workforce theme	Exclude	Exclude/not discussed	SG is funding a 3 year National Trauma Training Programme (2018/21), led by NES which aims to train over 5000 staff in trauma informed practice. The overall aim is to develop a workforce and services (including those in the social care/social work sector) which respond in ways which minimise distress, overcome barriers and build trust so that ultimately the health and wellbeing of all people affected by trauma is improved.
6	Clinical care delivered by social care staff in care home settings	Exclude	No - too health	Included: not discussed	Exclude/not discussed	Multiple initiatives in care homes focus on how to help social care staff deliver health care e.g. - End of life care - Nutrition - Oral health care - Inappropriate Medication use for people living with dementia

						- Continence care
7	Resilience Revolution	Exclude	Already being evaluated?	Included: not discussed	Exclude/not discussed	There's definitely some interesting innovations happening with social work practice in Blackpool. There isn't really information available online as the Resilience Revolution approach is still being evaluated (led by Headstart and the University of Brighton's Centre of Resilience for Social Justice), but I've attached a two-page summary which might be helpful for context. It doesn't mention social care, but gives a good overview of what the approach is about.
8	Learning Zone	Unclear - wonder if this might cover children social care professionals as well as adults and also not too much info on the innovation	Maybe	Exclude	Exclude/not discussed	The Learning Zone provides Social Workers, Social Care Workers and Early Years Professionals with a range of learning tools and information guides to support learning and development throughout their professional career. We have moved to an Adapt platform (from App) to increase the accessibility and effectiveness of the learning resources. Resources developed include: 1. Induction for SC workers 2. Towards, safe, effective and compassionate care 3. Values Base Recruitment 4. Adult care toolkit: Safeguarding
9	ECHO	Include	Not enough detail	Include	Exclude: too health	A learning model using video conferencing. Using proven adult learning techniques and interactive video technology, the ECHO Model™ connects groups of community providers with specialists at centres of excellence in regular real-time collaborative sessions. The sessions, designed around case-based learning and mentorship, help local workers gain the expertise required to provide needed services. Providers gain skills and confidence; specialists learn new approaches for applying their knowledge across diverse cultural and geographical contexts. As the capacity of the local workforce increases, lives improve.
10	Dare to Learn.	Exclude	No - too much about staff training	Included: not discussed	Exclude/not discussed	A project leveraging a technological solution to provide access to learning and development opportunities at the fingertips of all colleagues, both internally and for the sector. The name of the innovation was selected by the workforce aligning with the Organisational 5-year strategy 'We Dare'. The aim of being a bold and daring organisation, and by redesigning and redefining the learning offering to bring instructor led training back in-house, integrating the leadership offering and qualifications we believe this will truly encourage a learner-led culture where all colleagues Dare to Learn. The primary enabler of this project is the implementation of Cornerstone, a market-leading Learning Management System, enabling and encouraging employees to take control of their learning and development through a personalised learning experience platform. As the organisation is currently undergoing a journey of digital transformation, Dare to Learn will enable to the Learning and Development team to analyse, forecast, plan and

						deliver person-centred learning activities. This will provide a tool to enable front-line leaders to plan required training efficiently, improve controls over time off-rota (relief) and ensure their team members are up to date and compliant on learning and further development activities required in order to fulfil the needs of the service. In addition it will allow us to track performance against performance objectives and appraisals organisationally, and then inform the development offerings in terms of skills gaps and manage our development interventions, whether they be qualifications programmes, formal leadership programmes or more informal modes of learning and self-development.
Subgroup 1.2. Development of new positions						
11	Joined up Careers	Include	Evaluated already?	Include	Exclude: have been evaluated	Health and Social Care Support Worker Pilot Apprenticeship What does the pilot apprenticeship entail? The apprentice is employed on a 15 month contract and will complete rotational placements across a range of different settings including on a hospital ward, in a care home, and in the community. Each placement will last three months. The apprentice will complete the care certificate within the first three month placement, and then will be required to complete mandatory units alongside some optional units throughout their other placements. Due to the ageing population, people have increasing health and support needs and want more control over how they receive the help they need to stay well. Our aim is to show that there are great opportunities for people with the right values to build great careers in health and social care this is a growing sector with an increasing range of roles and skills needed. By working together we want to secure a workforce for the 21st century with the clinical technical and personal skills to make a real difference.
12	Transforming Integrated Care in the Community (TICC) – Ashford South Neighbourhood Care Team / Transforming Integrated Care in the Community (TICC) Buurtzorg (2 suggestions combined)	Include	No - already under evaluation	Include	Exclude: been already evaluated	Using the Buurtzorg model from the Netherlands, Kent County Council are starting a neighbourhood team to give high quality local care to clients delivered by self-managing teams including enablement workers, care staff and occupational therapists. Staff have the flexibility to spend as much time as needed to achieve best possible outcomes with clients. The Design and Learning centre is supporting Kent County Council to implement the Transforming Integrated Care in the Community (TICC), a four-year social innovation project seeking to transform the delivery of community care, guided by the principles of Buurtzorg. The project has been approved and funded by the Interreg 2 Seas Programme 2014 – 2020 (co-funded by the European Regional Development Fund). In total there are 14 partners working on the project across Europe in Belgium, France, Netherlands and here in the United Kingdom. In Kent we have just set up a domiciliary self-managing team in Ashford and now looking to set up new health and social care integrated teams.

13	Rotating health and social care workforce	Unclear - need more info	Maybe	Exclude	Exclude/not discussed	Given the workforce difficulties in social care, some LAs in London and in West Midlands are starting to develop joint contract posts between different care environments so that care assistants/workers are able to move between providers as needed and to promote career/personal development.
14	Resilient Communities	Include	Maybe	Include	Exclude: out of scope	Resilient Communities is testing how do universal and some more targeted services enable people to stay safe, fit and well (i.e. independent) and how this dovetails with more specific criteria based services such as social care, community safety, trading standards, enforcement etc. – in one whole systematic way. The proposition is that personal responsibility that is well informed and supported by public health, then community engagement models and strengths based working are key across the whole system and are enacted before service based responses are enabled. From website: Resilient Communities – Early intervention and prevention to support people and communities to live independently and to have active, prosperous and healthy lives. For example a new a borough wide initiative between health, social care, the voluntary sector and community groups called 'Making Connections Walsall' is being developed by Walsall Council's Public Health team to improve the health and wellbeing of residents by tackling loneliness. It will commission and work with the voluntary sector to utilise social networks and community groups to improve the health and wellbeing of the community (targeted interventions to build social relationships amongst isolated groups). The aim is to utilise existing expertise and knowledge in voluntary sector organisations by taking referrals from health and social care professionals.
15	C&M Health and Care Partnership wellbeing coordination	Unclear	Coordinators - could be compared with the earlier coordinator programme	Exclude	Exclude/not discussed	To introduce wellbeing co-ordinators into discharge planning for 44 different types of discharge and to include social prescribing therein.
16	Community led support (CLS)	Include	Link to other similar things?	Include	Exclude: out of scope	During the last few months of 2018, we commissioned NDTI (National Development Team for Inclusion) to facilitate our journey towards 'Community Led support'; engaging better with our communities and as such aiming to transform the way we offer and deliver social care at a community level. Linked to which we have taken a bold approach in that we are also altering our infrastructures and processes in partnership with communities and our partner agencies to ensure that changes at a community level are reflected through the wider organisational structures. Working with NDTI we have under taken a series of workshops and development days to look at the way we provide services in adult social care, leading to formation of multiple steering groups and corresponding work stream's. This is part of a major Social care transformation within our organisation, which is an integrated Health and social Care (Torbay and South Devon) NHS Foundation trust.

17	Strengths-based approaches	Exclude	Already looked at by the project	Included: not discussed	Exclude/not discussed	A concept that is being promoted across social care but it unclear how this is innovated in practice.
18	Leadership stories: developing effective supervision	Unclear	Could be part of a workforce strand	Exclude	Exclude/not discussed	This leadership and supervision project worked with three organisations from across the social services sector to explore and identify actions to strengthen leadership and supervision approaches across different contexts. From website: This leadership and supervision project worked with three organisations from across the social services sector: Nether Johnstone House, Simon Community Scotland and Dundee City Council. Each organisation formed a project team to work with the Scottish Social Services Council (SSSC) and Iriss, whose role was to facilitate discussion and explore actions with each of the partner organisations. Further support was provided by CCPS and Loretto Care. Iriss and SSSC linked partners in with existing support materials including the leadership logic model, the Supervision Learning Resource (SSSC, 2016), and other resources available through Step into Leadership. This work also contributed to the Leadership Strategy Implementation Plan.
19	(No name)	Include		Exclude	Exclude/not discussed	There would be real value in evaluation of some of the strengths-based/asset-based approaches that are being developed across social care. As an example, I spent some time in South Tyneside recently to look at their programme of embedding social workers on frail elderly wards and using a strengths-based approach to identify and meet needs. I wrote a blog on the subject https://www.kingsfund.org.uk/blog/2019/07/social-care-south-tyneside but I know that South Tyneside are very interested in a formal evaluation, which KF is not in a position to deliver. I'd be happy to provide more information and to put you in touch with the principal social worker there.
20	Setting up a Care Cooperative		Not enough here to evaluate, only at feasibility stage	Exclude	Exclude/not discussed	An R&D project to see if a small community can set up a care cooperative.
Subgroup 1.4 Sharing experience and resources between providers to deliver care						
21	ESTHER	Include	Maybe	Include	Exclude: too broad	ESTHER which is a model from Sweden with an aim to create smoother and safer pathways and use providers' resources more efficiently with a communal goal of always doing what matters to ESTHER. The model strives to improve patients experience and quality of care received. There are 5 levels of continuous improvement, starting with ESTHER with the aim to change culture and strategy for better outcomes. From website: The ESTHER Model in Kent was adopted in 2016 as it was recognised as an excellent way health and social care being able to demonstrate that there is a clear vision and credible strategy to deliver high-quality care and support while promoting a positive culture that is person-centred, open, inclusive and empowering. In Kent weare now asking "What matters to ESTHER?" instead of "What is the matter withESTHER?". To support the roll our ESTHER in Kent we have two training opportunities available the

						ESTHER Coach, which was adopted from Sweden, and the ESTHER Ambassador, which is a unique opportunity we developed here in Kent.
22	S12 Solutions	Exclude	No - not enough detail	Included: not discussed	Exclude/not discussed	S12 Solutions – "uberisation" of Mental health section process by an Advance Practitioner in Mental Health, Amy Manning.
23	Strengths Based Practice Framework	Exclude	I'm sure there has been other evaluation of this - through Jerry PRP project	Included: not discussed	Exclude/not discussed	Development of a practice framework to support professional practice in social work to move from care management approaches to strengths approaches.
24	Breezie	Include	Not enough detail	Include	Exclude: out of scope	From website: Breezie - implemented across residential and community care clients for older adults. Breezie is an open platform that enables senior care providers of deliver care and services through a simple and personalised tablet interface.
25	Team Formulation in multidisciplinary teams working with adults affected by brain injuries.	Include	Maybe	Include	Included	The multidisciplinary team jointly develop an individual's formulation. Each formulation considers biological, psychological, social and environmental factors for each section. Sections consist of: the person's background; triggers; presenting and maintaining issues; strengths; hypotheses (explanation & possible solutions); and an intervention plan. This asset based approach is individual and enables a bespoke psychosocial intervention which can be replicated within other multidisciplinary teams.
26	Adaptations without Delay		Probably enough evaluation of adaptations already	Exclude	Exclude/not discussed	Adaptations play a crucial role in prevention and improving health and wellbeing for older and disabled adults and children and in consequence the sooner they are installed the greater the benefit. The overall aim of the guide is to reduce delays in delivery of adaptations and it does so by providing tools that support a proportionate response. The guide contains a decision-making framework that outlines new ways of working that includes the different levels of complexity of a situation and the most appropriate response. It also helps stakeholders identify the circumstances when an assessment is not required by an occupational therapist. It is intended to be used by practitioners and organisations across the UK who may be contacted by disabled and older people and their families who are seeking advice or support with home adaptations. It will also assist social care and housing managers as to how adaptations can best be provided locally.
27	Best practice network for care home health in-reach teams	Unclear	Not sure what this is	Exclude	Exclude/not discussed	Supporting health teams that in-reach into care homes, helping to provide better care to people living with dementia. The network shares best practice and CPD and spreads innovations.
28	Social Work Function	Include	Not sure what this is	Include	Exclude: out of scope (more improvement	The Social Work function has provided an opportunity for practitioners to work with people who require a comprehensive and intensive intervention that was not easily achievable in a Case Management model of practice. It has ensured that alongside our

					than innovation)	colleagues in other functions we have been able to make a difference to people helping them to maximise independence and to support them to take control of their lives. The Social Work Framework has recently been reviewed and practitioners in all functions have reported that it provides useful guidance supporting relationship based social work and encouraging the use of a range of practice guidance social tools to support practitioners. This function has recently been nominated for Team of the Year and Creative & Innovative Social Work Practice.
29	Gateshead Multi Agency Adult Referral Team (MAART)	Include	Sounds like Local Area Coordination, could be compared with that?	Exclude	Exclude/not discussed	The role of the MAART is to bring together key partners and forge stronger links with other agencies which enables information to be shared quickly and effectively and allows better informed decisions to be made by social care. MAART will provide an early intervention for residents of the Borough of Gateshead who are experiencing chaotic lifestyles, multiple exclusions and negative social outcomes for themselves, families and communities but do not meet eligibility criteria under the Care Act and are not engaging with services.
30	The LPZ Care Home Improvement Project	Include	No - too health	Include	Exclude: too health and improvement (not innovation)	The NHS England long-term plan prioritises roll-out of the Enhanced Health in Care Homes framework. This requires effective mechanisms to build partnerships with care homes and a mechanism to collate data on care quality to demonstrate impact. The LPZ enables homes to benchmark performance, identify care issues and develop improvement plans. It fosters relationships between NHS and care home staff and provides a mechanism to collate data at a regional/national level over time. We have collated case studies showing improvements around nutrition, falls, pressure ulcers and pain. Pressure ulcer prevalence has fallen from 4.5% to 2.1% and falls from 23% to 14% in homes returning between 2015 and 2018. We've learned how to implement LPZ and the improvement workshops in partnership with care homes. We now understand how to present and work with data, how to package improvement methodologies and how to secure and celebrate change with the care home sector. It is ready for adoption at scale and pace.
31	Social prescribing scoping tool	Include (but only for long term evaluation as not ready for rapid yet)	Could be looked at with other social prescribing approaches	Include	Exclude: out of scope	The tool will provide oversight of the social prescribing being delivered in the East midlands and allow for further benchmarking. There have been three stages to the development of the tool which will be based on realist principles (looking at what works best for whom in what context).
32	Coordinate My Care	Include	Maybe too health	Include	Exclude: too health	Electronic urgent care plan which can be shared across care settings. Coordinate My Care is an NHS clinical service that was launched in August 2010 to deliver integrated, coordinated and high quality medical care, built around each patient's personal wishes. At the heart of CMC sits an urgent care plan which is created jointly by the patient and their healthcare professional. It lists the patient's wishes and care preferences, and

						includes practical information (where they keep their medicines, or who to contact in an emergency, for example).
33	The Autism Practice Improvement Framework (APIF), Scottish Autism	Include	Maybe - under a workforce theme	Include	Exclude: out of scope	Scottish Autism's 'Autism Practice Improvement Framework' adapts business quality improvement methodologies to improve autism support practice in social care and education services. Scottish Autism have worked in collaboration with Quality Scotland to create a framework using autism-specific service standards, predicated on a values-based approach to support. The process departs from existing accreditation schemes in that practice teams are supported to work collaboratively and identify their own areas for improvement, Practitioners then take ownership of projects to innovate and improve practice in their services according to identified goals. The process is undertaken with support from dedicated advisers who are themselves experienced autism practitioners. Participating services have access to a bespoke E-tool to facilitate the self-assessment and scoring process. The framework requires participants to evidence project outcomes and identify indicators for progress through the use of Quality Scotland's 'RADAR' methodology. The APIF process systematises reflective practice and provides impetus to practice development through the service projects. Involvement in APIF provides individual practitioners witha pathway to professional development as well as improving the support provided to autistic adults in Scottish Autism's services.
34	Preparation of a toolkit for communities wanting to start similar initiatives to Solva Care	Exclude	Not enough detail	Included: not discussed	Exclude/not discussed	Web based resource developed by members of the Solva Care community.
Group 2: Training & Support innovations for in-need groups						
Subgroup 2.1. Training for patients and carers						
35	Family educational and emotional support pack and group sessions for families affected by brain injuries	Unclear	Maybe - but seems under evaluation	Exclude	Exclude/not discussed	Scotland lacks family supports for people affected by brain injuries. Over 70% of people who survive brain injury lose their informal supports leading to increased carer stress, breakdown of families, increased reliance on formal supports and higher incidences of mental health and addictions issues. The ABI Service are reviewing materials from overseas and are developing a resource pack and group sessions to support families, especially with school age children, of adults affected by brain injury.
36	Supporting younger people with dementia and their carers	Include	Maybe - sounds like an emerging area of need	Include	Exclude: out of scope	The Berkshire service for younger people with dementia ran a course to spread this work to other areas as a means to reduce service variation. New group established in Milton Keynes as a result offering support and activities. This specialist training to provide meaningful age-appropriate activity for young onset dementia, and networking through the post-diagnostic support network, aims to start to address unmet need by increasing staff competency and to promote service provision in areas where there is limited intervention and support.

37	Up-skill unpaid carers in self-care	Exclude	Not enough detail	Included: not discussed	Exclude/not discussed	Project in Calderdale to up-skill unpaid carers in self-care of own health to include mental health and ability to cope.
38	Digital skills training	Exclude	Not enough detail	Included: not discussed	Exclude/not discussed	Delivered to older adults to allow access to support services and opening up new ways to become connected.
Subgroup 2.1. Training for refugees						
39	Dundee Humanitarian Protection Partnership	Include	Sounds too broad	Include	Exclude: too broad	The project supports refugees by working to help build their skills and employment opportunities, to support them to have a voice in improving their health and wellbeing, and to provide opportunities to participate in cultural, heritage and sports activities.
Group 3: Technology innovations to support care						
Group 3.1 Medication						
40	Medication in the community	Include	No - too health	Include	Exclude: too health	Using technology to support Medicines in the Community, with the aim to: - To help promote the safe use of medicines. - To reduce medicines errors. - To provide people with the support that they need to manage their own medicines. - To create safe and effective tools and training to support the care workforce. Medicines issues for people within the community are rapidly increasing across the economy at a county-wide level.
41	YOURmeds (https://www.yourmeds.net/)	Include	No - too health	Include	Exclude: too health	Medication reminder and missed dose alarm / escalation service. YOURmeds pack organises your medication with easy to read colour labels and clearly numbered doses. YOURmeds tag is a mobile device that clips to the pack and alerts you visually and audibly to take your meds. How does it work? :1) setting up your tag is easy and your pharmacist will do this for you, 2) your pharmacist will prepare your weekly pack and deliver it and your tag directly to you, 3) simply clip the tag onto the pack and you are ready to go, 4) if you do forget to take your mediation, don't worry your support network will help you with friendly reminders, 5) at the end of the week simply clip the tag onto your new pack.
42	The Achieving Change Together (ACT) team	Unclear	Already included above	Exclude	Exclude/not discussed	The aim of the team is 'Achieving sustainable outcomes for Gateshead residents by promoting active, health, inclusive, independent lifestyles' As a service, it was identified that we need to change the way we work. This includes looking at the way in which we spend our reducing resources, how we work with providers and how we work with individuals and families. It was also identified that we need to change the way we work and this will include the use of assistive technology, holistic assessments and in depth reviews to consider the whole person, their life story, family, social networks, environment, health and wellbeing, working with our partners internally and externally, to support people live as independently as possible with minimal interference. PAMAN using a specially developed interactive medication administration record (MAR) chart to record all medications taken by the patient and to ensure that the dispensed medication is taken correctly.

43	Docobo	Include	No - too health	Include	Exclude: too health	Telemedicine platform to support remote monitoring of care home residents by the GP practice. Our mission is to improve the quality of life of all we serve through the efficient implementation of digital health solutions. Supporting professional staff to deliver world-class care, and enabling patients to be more aware of their condition and empowered to self-manage themselves at home.
Group 3.2 Assessment/care planning/signposting						
44	Genie	Exclude - need more info	Maybe	Include	Exclude: evaluated already	Genie – Wessex ARC – digital tool to support health/social care workers map individual's social networks (Alison Richardson, Wessex ARC Director ccd).
45	Safe steps	Include	No - too health	Include	Exclude: too health	Digital falls risk assessment and signposting. Safe Steps is easily setup and configured for each individual care organisation. Care home staff use the app to complete a simple, face-to-face assessment once a month for each resident. The assessment looks at 12 key risk factors based on UK NICE guidelines. Completing the assessment creates a personalised action plan tailored to specific needs of each resident. Safe Steps provides care homes with a digital audit trail to satisfy regulatory inspection requirements.
46	S12	Include	Not sure - sounds niche	Include	Exclude: out of scope (app)	Digital solution to improve MHA assessment set-up for service users and professionals. An app and website which makes Mental health act assessment and claim form processes quicker, simpler and more secure. S12 Solutions is a platform that connects AMHPs with available, local s.12 doctors. AMHPs can also search for doctors by other criteria such as specialities and languages spoken.
47	CHC2DST	Include	Not enough detail	Include	Exclude: too health	Digital Continuing Healthcare (CHC) Assessment Process. Continuing Healthcare assessments can result in NHS-funded packages of care being provided to adults to meet both health and social care needs. Clinical Commissioning Groups are responsible for the process. CCG staff work with multiple stakeholders to determine patient eligibility based on a process set out in a well-established national framework. CHC2DST is a cloud-based software solution accessible by different stakeholders involved in the delivery and management of the CHC assessment process. It increases data transparency and speeds up decisions about eligibility whilst reducing administration effort and time wasted on non-value adding activity.
Group 3.3. Independent daily activities						
48	Autonome	Include	No - too niche	Include	Include	Autonome – check out company website – uses QR codes to support people with learning disabilities live independently by accessing appropriate videos re daily living activities. Autonome is a virtual support provider designed to improve the lives of people with learning disabilities. Through step- by- step instructional videos people learn new skills and develop independence. Our data enables Local Authorities to make evidence-based decisions on the support needs and achievable outcomes of their learning disability population.
49	Ownfone (https://ownfone.com/telecare)	Unclear	No - not ambitious enough	Exclude	Exclude/not discussed	Super-simple phone and GPS device; replaces the pendant alarm, with call centre support, and enables users to go beyond their land-line. Also for lone-workers.

						OwnFone Mobile is a cost effective, secure and reliable way of providing telecare which is truly mobile.
50	Unforgettable	Include	Not enough detail	Include	Exclude: out of scope	From website: Live Better with - committed to making everyday living a bit better for millions of people living with dementia. Practical advice, e books and real life stories written by people with dementia. Dementia support group - online community of more than 8000 people. Live better within increases availability, affordability and quality of products that improve everyday life (day clocks, music players, trackers, activity and much more). Work with community to understand how products can better serve the needs of people living with dementia as well as bringing new products.
51	Social Care Digital Innovation Programme	Include	Yes, if not already under evaluation	Include	Exclude: already evaluated	The LGA in collaboration with NHS Digital is grant funding digital innovation in social care, with projects ranging from new assistive technology to data analytics to predict demand. Twelve councils have now be selected for third wave of funding. Find out more about the 43 projects funded across the three years.
52	Howz	Include	Maybe / looks well evaluated already	Include	Include	Uses data from sensors and/or wearables to detect changes in routines and alert families/carers. Howz has been developed with and for older people who are living independently. Some of our customers use Howz for their own use, learning about routine and using the information to support conversations with their health teams and care network. In other cases relatives instigate the installation of the system to give them peace of mind.
53	MySense.ai	Include	Maybe	Include	Included	Uses data from sensors and/or wearables to detect changes in routines and alert families/carers. It monitors an individual's health, wellbeing and behaviour patterns, establishes what 'being well' looks like and flags subtle changes - providing total peace of mind for them, their family, friends and carers. By using non-intrusive devices around the home, we develop a better understanding of an individual's movements and habits. This allows your appointed carer to monitor and respond to your needs.
54	Brain In Hand	Include	Maybe	Include	Included	Piece of Assistive technology that supports individuals with daily living tasks both at home and in the community. Delivering support services using assistive technology. Brain in Hand's professional support system gives people easy access to personalised digital self-management tools and human support. Always available via mobile, it helps with remembering things, making decisions when anxious or confused, and coping with unexpected events. Suitable for people with a range of neurological and mental health difficulties, Brain in Hand improves confidence, enables people to cope with anxiety, and increases independence. It also reduces demand on carers and support services.
55	Use of technology to improve the support of older people and people with physical and cognitive difficulties to live at home	Include	Maybe, but need to avoid overlap in busy space	Include	Included	Introduction of smart homes and surveillance technologies for older people at risk and growth of its use by family members.
Group 3.4. Hydration						

56	Droplet	Include	No - too health	Include	Exclude: too health	Droplet – Digital cup to promote hydration in care homes/among elderly. Droplet is a smart hydration reminder, designed to combat dehydration in community-based and acute environments. For: people with dementia, or those who have had a stroke - for anyone at risk of dehydrations, kidney health. Been endorsed in hospitals and care homes and at home. Droplet has been developed in partnership with over 100 healthcare professionals within the NHS and Social sectors, including Speech and Language Therapists, Occupational Therapists, Dieticians, Geriatric Consultants, Matrons, Dementia Support Managers, Infection Control Nurses, Housekeepers, Stroke Nurses, Catering Managers and many more. We have also carried out user feedback sessions with The Alzheimer's Society, The Stroke Association, care homes in Peterborough and The Hospital Caterers Association. Droplet is suitable for use at home or in care homes and hospitals. Droplet can help people of any age from children to the elderly – to encourage them to drink more.
Group 3.5. Rehabilitation						
57	Researching the effectiveness of using Assistive Technology in the community to prompt rehabilitation tasks with people affected by brain injuries	Include	Maybe - but seems under evaluation	Include	Exclude: been evaluated	Community Acquired Brain Injury team working alongside University Researchers to consider the effectiveness of assistive technology in people's long-term rehabilitation after brain injury. The local service user peer group act as an expert panel to assist researchers to develop their research projects and then act a participants for each project.
58	Enhancement Technologies	Unclear	Not enough detail	Exclude	Exclude/not discussed	Although none of these technologies is particularly relevant to carers, they could be considered to be especially relevant to carers, as, for example, a loved one who is hard of hearing, or very weak, places a particular burden on their carer. Hearing aids – increasingly being referred to as hearables these are set for a dramatic reduction in price and improvement in functionality as they become fashion items and combine vital signs measurement (especially temperature, heart rate, respiration rate, blood oxygen) and personal stereo with the original function. Memory – a wide range of 'brain training' apps exist, to help improve memory though many offer little hard evidence of benefit. Strength and durability – a very wide range of fitness apps now exist both to improve muscle strength and to enhance staying power. Many of these, such as the Seven Minute Workout require just a mobile phone and appropriate apparel and location.
59	Assistive Technology	Exclude	Vague	Included: not discussed	Exclude/not discussed	This is an area that people continue to struggle with - particularly for people with complex disabilities where some of the simple innovations haven't really gained traction in the same way as others. Funding for technology has also been redirected along with support for other preventative approaches.
Group 3.7. Accessibility of home environment						
60	Assisted Living Technology	Exclude	Doesn't sound very innovative	Included: not discussed	Exclude/not discussed	The Assisted Living Technology pilot considered how people can realise their potential through the latest technology to control their home environment. This involved: • Adopting a collaborative approach to ensure that the right technology was matched to the right environment; and

						• Most importantly, to the needs and preferences of the individual. Occupational therapists assessed peoples' activities and levels of participation before and after installation of the technology. 86% of people demonstrated improvements in levels of impairment, activity and participation and carer well-being increased.
Group 3.7. Social interactions						
61	Kraydel	Include	Is this care?	Include	Exclude: out of scope	Uses social media via TV platform to keep in touch with friends and family, share photos, messages etc. Tackle social isolation: Kraydel is a new, easy-to-use service that uses your own TV for video calling - helping people stay connected. The Kraydel hub is specifically designed for those less comfortable with technology. Promote wellbeing: With alerts for everything from carer schedules, to reminders to take medication and go to doctors' appointments, Kraydel can be an effective support for wellbeing. ASsist decision making: Kraydel delivers meaningful insights to a person's wellbeing, helping them make better informed decisions about their care in conjunction with family, friends and caregivers.
62	Sparko TV	Include	Is this care?	Include	Exclude: out of scope	Uses social media via TV platform to keep in touch with friends and family, share photos, messages etc. Sparko's background is deeply rooted in caring for and offering services to seniors and stems from the creation of the pendant panic buttons that you may already be familiar with. The Sparko team has over fifty years combined experience serving the senior community, including previously managing senior housing and retirement communities.
63	Hello Daisy	Include	Is this care?	Include	Exclude: out of scope	Uses social media via TV platform to keep in touch with friends and family, share photos, messages etc. Daisy is a social media device that internet enables any TV. We help create more happiness by connecting everyone, whether you're the person with a Hello Daisy box or if you're using a smart device using our companion app. You can share with a loved one: •messages such as 'Hi Dad, would you like two come over for tea today?' •photos / videos they will treasure forever – 'family snaps, events, a freshly baked cake, holidays •jokes and funny stories •diary reminders •video chats or live feeds, this is especially useful if they cannot attend an important event
64	RemindMe Care	Include	Is this care?	Include	Exclude: out of scope	Uses social media via TV platform to keep in touch with friends and family, share photos, messages etc.
65	Elemental	Include	Could be compared with other sp innovations	Include	Exclude: too health	Social Prescribing platform We're helping NHS and health organisations all over the UK connect patients to non-clinical forms of support through effective social prescribing programmes. We've developed a portfolio of innovative, digital social prescribing products and services designed to empower your communities through social prescriptions that anyone, anywhere, can make, manage, measure and track. Social prescribing platforms: Core Platform.

						Our digital social prescribing platform allows you to make, manage and report on referrals to local social prescribing hubs with ease and confidence. Elemental Core can seamlessly integrate with your internal systems meaning real-time connectivity and synergy with your existing data hubs and processes. Consultancy & Partnerships We pride ourselves in the fact that we've got first-hand experience in community development so we understand the challenges that communities face in reducing health inequalities. It's all about understanding what's already there, what's working well and involving the local community in designing and delivering an approach that matters to them. Self-Refer Focusing on creating a culture of self-care and independence, Elemental Self Refer will empower your community and drive real-time, person centred care in your area. Everyone can avail of social prescribing, but not everyone needs the support of a Link Worker or a referral from a GP.
66	CareFree Family	Unclear	Sounds like Local Area Coordination, could be compared with that?	Exclude	Exclude/not discussed	CareFree Social is a niche social network aimed at people and families who are new to the world of social care and who need somewhere to turn to for information, support and guidance they can trust. Users will have access to expert advice tailored to their specific needs, as well as details about relevant resources and upcoming events in their local area. Crucially, CareFree Social also facilitates peer-to-peer conversations and support. We are creating a supportive online community so that no one going through difficult changes in their own or their family's circumstances has to feel alone.
67	ClickGo	Unclear? - might need more info	Again - it might be good to have something around SDS	Exclude	Exclude/not discussed	ClickGo is Carr Gomm's award-winning digital tool which makes self-directed support a practical reality. It empowers people to have more choice and control over their support by giving them all the information they need at their fingertips. ClickGo enables people to view their real-time support schedule and request which of members of their team they want to support them and when, to manage their personal budget and to track and record progress towards achieving their personal outcomes. ClickGo is an innovative, accessible online tool to empower people to self-direct their social care support.
68	Social Care ECHO	Include	Maybe - I've never heard of ECHO.	Include	Include	We have developed the first Social Care ECHO in Europe. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. Improvement of cohesion and connectivity across employers in the Social Care sector is key to supporting the development of a sustainable and skilled social care workforce. A collaborative approach to identifying and addressing the training, qualification and development needs of the Domiciliary Care workforce will support staff in meeting their registration requirement and will enhance delivery of safe and effective care/support. ECHO will provide for the establishment of a collaborative approach to learning and development that will support the development of a learning culture across the sector. It is hoped that this network and collaborative approach will roll out to other sectors, including day care and residential care.

						Continuing with learning and development opportunities including: Assistive Technology; Outcomes Based Approaches; Values Based Recruitment; Workforce Regulation; and Duty of Candour.
69	(No name)	Unclear - need more info		Exclude	Exclude/not discussed	Assistive Technology NSC successfully awarded £65k from CCG Transformation Project to support AT pilots. Three projects: 1) At Tamar Court Extra Care with Sparks Compass and Alliance, based around voice-activated technology (e.g. Alexa). Skill developed and work underway withGP practise to link skill to Ask My GP app to improve access. 2) Wireless-enabled solutions, focussing on domiciliary care in rural area with CISCO and Notaro. 3) Sycamore House Dementia Care Home with Shaw Care, movement and sound activated sensor monitoring devices to prevent falls and nursing interventions. System live and popular with staff and families, immediate reductions in falls.
Group 4: Housing community innovations						
Group 4.1. Care home innovations						
70	Good Hydration!	Include	No - too health	Include	Exclude: too health	Quality improvement initiative designed by care homes for care homes to reduce urinary tract infections (UTIs) through structured drinks rounds. Keeping care home residents happy and healthy. Good Hydration! is a quality improvement initiative designed by care homes for care homes to reduce urinary tract infections (UTIs) through structured drinks rounds. Developed in partnership with East Berkshire Clinical Commissioning Group, it is now delivering sustained improvements and spreading further afield. Key outcomes to date: •UTI hospital admissions reduced by 36% in the four pilot care homes (150 residents) •UTIs requiring antibiotics reduced by 58% •The gap between UTIs increased from an average of nine days in the baseline period to 80 days in the implementation and sustainability phase •One residential home was UTI-free for 243 consecutive days! •Similar outcomes noted in pilot 2 care homes (215 residents). East Berks CCG logo. This award-winning project has spread beyond east Berkshire and been implemented within Oxfordshire and Luton CCGs. Plans are also underway for adoption through Milton Keynes, Buckinghamshire, Berkshire West, Swindon and Coventry & Rugby CCGs.
71	Vanguard innovation	Include	No - too health	Include	Exclude: too health; too evaluated	NHS England supported care homes to develop and test new methods of NHS services to work with care homes to improve cross sector working. Different sites had different approaches (funding of specialist teams/use of technology). Where there was investment in building relational working this led to improved outcomes in terms of demands on NHS.

72	Development of community based support for people living with dementia and or frailty e.g. dementia villages care homes as community hubs and day care resources	Include	Maybe	Include	Include	Recognition that care homes can be community resources for people living with dementia, to site clinics and to create community focus. US initiatives that extend this to provide access to care where older people return home in the evening.
Group 4.2. Shared living - care/support provided in member of general public's home						
73	Care rooms (https://carerooms.com)	Yes (possibly)	No - too health	Include	Exclude: too health	Providing post-op convalescent services.
74	Home sharing initiative	No	I think evaluated already? Is run by Shared Lives	Included: not discussed	Exclude/not discussed	Younger people getting reduced rent in exchange for providing companionship and low level support to people in their own homes - interesting potential here for those without children/family support.
75	Aberdeenshire Shared Lives Scheme	Unclear	Well evaluated already	Exclude	Exclude/not discussed	The Shared Lives Scheme matches people over 16 years of age who have a disability or older people with someone who shares the same interests. Shared Lives gives the opportunity to have a placement in a person's home. Shared Lives offers the chance to contribute to real friendships and to become active, valued citizens with a sense of belonging.
76	OneHousing's Extra Care Developments	No	Not enough detail	Included: not discussed	Exclude/not discussed	From website: The project offers attractive, self-contained housing that is designed to enable people to retain their independence. Accommodation is designed to Lifetime Home Standards, providing a flexible home for life that enables individuals' to be supported as needs change. 24/7 care is available and support staff are on site. Residents have their own front door, however, there is space for social activities, meal service and amenities such as a hair dresser.
77	Belong Living	Unclear	Not enough detail	Exclude	Exclude/not discussed	Every Belong village offers a number of households for customers that need more advanced support with daily living activities. Moving to a Belong household can offer you the helping hand that you need to exert choice over more areas of life than might otherwise be possible, and enjoy our community in safety. Our village households provide 24-hour support for customers, including specialist nursing and dementia care. With our higher-than-average staffing ratios, no uniforms to create a divide between carers and residents, and a small-scale domestic environment that fosters a warm and responsive atmosphere, Belong households offer safety, security and peace of mind for both you and your family. Each Belong household is grouped into an 'extended family' sized community for 11 or 12 residents, with modern bedrooms that lead directly onto an open-plan, shared communal space. These comfortable, contemporary-styled rooms boast the latest en-suite facilities and access to modern lounge and domestic kitchen areas.
78	Flexicare housing - Hertfordshire	Unclear	Not enough detail	Exclude	Exclude/not discussed	Large scale accommodation programme been running for years. From website: Hertfordshire has embarked on an ambitious programme to accommodate a growing population of older people through an innovative and flexible approach to maintaining

						independent living. The programme is increasing capacity and the range of accommodation for older people by approximately 600 places by 2010/11 in order to keep pace with the growing number of older people and their care needs.
79	Harmonia Village	include	Maybe	Include	Include	This is a new dementia village opening in Autumn 2019 which is going to be run using sound and motion technology to monitor residents' movements and safety. It will also have guest houses and a village hub.
80	Homebridge	include	Could be looked at along with other reablement initiatives in this list	Include	Exclude: no innovative	Homebridge is a short stay rehab and enablement service in Ashford. Clients live in studio apartments with their own bathroom and kitchenette within a sheltered housing scheme where there are communal areas, hairdresser, assisted bathrooms, Age UK day centre etc. Staff are on site for extended periods of time 3 times daily to assist clients. Work is OT led around goal setting and regaining independence and encouraging people to move on to independent living.
81	(No name)	no		Exclude	Exclude/not discussed	We have spent a bit of time scrutinising our work to see if we can provide some useful examples. As you may know, Forces in Mind's work addresses issues within the ex-Armed Forces community and their families with a particular focus on ensuring that they make a successful and sustainable transition to civilian life. The Trust's strategy is to provide an evidence base that will influence and underpin policy making and service delivery. By funding high quality, credible research where there is an identified gap in relevant understanding, and by then exploiting the findings, FiMT effects positive change. With regard to adult social care and social work we have been quite challenged to provide examples that might be of use to you. We have recently funded an awareness and social media campaign run by the veterans' housing lead within the Service charity sector. This campaign will raise awareness of veterans amongst local government and housing associations in order to better identify the veteran seeking housing and to more efficiently direct them toward appropriate solutions. We have also funded several innovative schemes for evaluating new ways of treating veterans' mental health. We are engaged with the other major service charities who, as service deliverers, specifically provide care and case worker support to vulnerable ex Servicemen and their families and could be involved in funding the support of any new schemes that they might suggest – so in this latter case, SSAFA or the Royal British Legion might be useful avenues of exploration for you.
82	Forres transformation of services	Yes	Evaluated already?	Include	Exclude: out of scope	The Forres (Varis Court) HSC pilot project — located in the Hanover Housing Association development — offers an opportunity not only to redesign the social care services within sheltered housing but also an opportunity to test out a new model of in-patient care provision.
83	Woodview	Yes	Not enough detail	Include	Exclude: out of scope	Management of complex behaviour in people with a learning disability in a housing support environment.

84	Founders House, Scottish Autism	No		Exclude	Exclude/not discussed	Founders House is a unique service in Scotland in providing residential care for autistic adults who are ageing or who have physical disabilities requiring specific environmental adaptations. The service opened in 2018. As the first generation to enter Scottish Autism's services as children now reach retirement age services need to innovate to meet increasingly complex care needs. Founders House is the first service in Scotland to combine expertise in the environmental and support needs of autistic adults with adaptations necessary to meet the health impacts of physical and cognitive ageing.
85	Person centred local housing solutions to return people with LD/ Autism from long term residential care out of area to nearer home.	Unclear	Maybe - would fit well into the stalled Transforming Care agenda about getting people out of ATUs	Exclude	Exclude/not discussed	SG LD Policy are seeking to evaluate the person centred outcomes and the financial benefits to Health and Social Care Partnerships (HSCP) of current local to home social care models as an alternative to housing people with complex LD/Autism in larger long stay institutional settings out od area or out of Scotland.
86	Hospital to Home	Yes	Doesn't sound very innovative	Include	Exclude: been evaluated	IRISS worked in Tayside to design a pathway to support the transition from hospital to home for older people. This included work with health and social care practitioners, older people, their families and informal carers to identify and improve care pathways from hospital to home and enable a more positive experience for all.
Group 5: Home adaptation innovations						
Group 5.1. Home aids, equipment and adaptations (non technology)						
87	Adapting for ageing	Yes	Not enough detail	Include	Exclude: no innovation	Since the last call you made we have now completed the report on innovative practice regarding home aids and adaptations some of which span health and housing. These may be fruitful areas to evaluate.
88	Independent Living Centre	not sure	No - ILCs have been around ages	Include: not discussed	Exclude/not discussed	The Independent Living Centre is an occupational therapy equipment specialist service. The occupational therapists train all staff who prescribe equipment in Devon and work closely with manufacturers and suppliers.
89	Address environmental barriers in people's lives	exclude	Doesn't sound very innovative	Include: not discussed	Exclude/not discussed	The housing group introduced: • A priority service for provision of aids and adaptations for tenants and set a dedicated budget. • Direct delivery team for minor works • A simple system for installing medium adaptations (up to £10,000), and • A clear arrangement for agreeing works above £10,000, including use of in-house occupational therapists.
90	Assess for complex housing adaptations	exclude	Doesn't sound very innovative	Included: not discussed	Exclude/not discussed	The Specialist Housing Occupational Therapist covers re-housing for people who need wheelchair adapted accommodation or major adaptations such as ground floor bedroom and bathroom facilities. The occupational therapist writes a re-housing report and views potential properties with the person to confirm suitability and to arrange any further works needed. For new builds the Specialist Housing Occupational

						Therapist liaises with the Development Team on initial designs for wheelchair adapted homes.
91	Single handing	exclude	Doesn't sound very innovative	Included: not discussed	Exclude/not discussed	Specialist equipment solutions, change management of risk adverse health and safety culture.
Group 5.2. Technology aids and adaptations						
92	Howz	include		Include	Exclude - duplicate	Howz is an award-winning smart home care kit created by a physiotherapist to help people live independently for longer. The easy to use system includes smart sensors which once installed learns routines within the home and provides invaluable reassurance to you, your family, and friends at an affordable price of £149 for the Smart home care kit and the Howz Monthly Service Subscription of £9 (Free for the first month).
93	Developing Evidence-Enriched Practice (DEEP) programme, Wales.	Exclude	Maybe	Include	Exclude: not suitable; out of scope	A co-production, narrative and dialogue-based approach to using diverse evidence in learning and development – combining bottom up and top-down through caring conversations.
94	(No name)	Exclude		Exclude	Exclude/not discussed	- There are a number of us implementing relationship based practice approaches in the region (primarily three conversations) – evaluating from a qualitative and quantitative perspective including understanding what factors have potentially increased likelihood of success - Investment in prevention and/or reablement and its impact on longer term spend and use of formal services (exploring success themes and ROI) - Investigating the differences in Investment in supporting carers and impact on demand (financial and use of formal services) - As a region we have shown significant improvement across the board for delayed transfers of care but it would be good to have research that looks at whether this has merely pushed demand to other parts of the system or genuinely improved discharge and benefitted all parts of the system - Market sustainability and impact on wider health and care system - A piece on use of assistive technology (including telehealth) at a regional scale – assessing the benefits and exploring the business case for greater Investment - Exploration of the differences in the flexibility of use of DFG including ROI (capital spend to reduce revenue spend), impact on demand, benefits for carers - Re-visiting Personalisation, impact on outcomes and cost/spend whilst exploring regional differences - Transitions – evaluating differences in approaches and the impact on cost/demand As transition to adult services - There must be a piece around joint funding CHC, S117, joint funding etc, consistency of application – spend per CCG/LA areas
95	Three Conversations	Unclear	Jerry Tew's prevention	Exclude	Exclude/not discussed	It's a new asset-based model of care and support planning implemented in Birmingham and some other counties (e.g. Reading, Gloucestershire, and Cambridgeshire). From

			project has looked at this			website: The ‘3 conversations’ model is an innovative approach to needs assessment and care planning. It focuses primarily on people’s strengths and community assets. It supports frontline professionals to have three distinct and specific conversations. **Solution overview** The first conversation is designed to explore people’s needs and connect them to personal, family and community sources of support that may be available. The second, client-led, conversation seeks to assess levels of risk and any crisis contingencies that may be needed, and how to address these.’ The third and final conversation focuses on long-term outcomes and planning, built around what a good life looks like to the user, and how best to mobilise the resources needed (including personal budgets), and the personal and community assets available.
96	3 Conversations Model in South Gloucestershire Council	Unclear	Already looked at by Tew project	Exclude	Exclude/not discussed	This new approach to adult social care developed by Partners 4 Change aims to: • Enable better experiences & outcomes for those contacting our service. • Create a different way of working that enables practitioners to use their skills to develop more creative solutions & feel more satisfied in their roles. • To better use scarce resources & to reduce waiting times. The Conversational approach to assessments enables us to fulfil our preventative and wellbeing duties under the Care Act 2014 as well as working with people who are eligible for care and support. Conversations are as follows: 1. Listen & Connect- aim to connect people to resources that already exist either in their own networks or within their community to meet their outcomes. 2. Work intensively in a crisis- aim to ‘stick to someone like glue’ while they overcome a change in their lives, and make short term plans, because you never plan long-term in a crisis. 3. Build a good life- aim to support someone to make long-term plans to meet their outcomes, which includes consideration of eligibility. The 3 Conversational approach started with 2 innovation sites in February 2019 it has now grown to 5 sites and has been a successful approach in terms of: • Quicker response times. • 70% of new referrals were concluded with a Conversation 1 or Conversation 2. • Reduction in existing waiting times. • More streamlined processes. • Greater worker satisfaction.
97	3 Conversations	Include	Already looked at by Tew project	Include	Include	3Cs is a social work practice methodology that is based on the strengths and assets of people and communities. It a system disruptor as it changes social works relationship with all internal partners i.e. finance, commissioning, housing etc. as well as relationships with the community sector and the people they work with.
98	The ‘three conversations’ model of assessment	Unclear	Done by Tew	Exclude	Exclude/not discussed	This is slowly being adopted as the preferred model of assessment by LAs and some of the early findings show that it is creating more independence and is more capacity

						based than traditional approaches to assessment. We would be really interested in the evidence base around the model.
Group 7. Innovations - linking patients with health or social care professionals for provision of care						
Group 7.1. Care coordination models						
99	Care Coordination service/model	Exclude	This plus other similar initiatives?	Include	Include: care coordination innovative	After working for 30 years for local authority social services teams all over the UK users/carers/families would tell me what they did not like about the 'system'. I left Lincolnshire County Council in 2011 to roll out a service they would like. The main but significant differences are that 1. The service user gets the one Coordinator 2. Their case is not closed unless the person wants this to happen 3. The Coordinator is available to the person and anyone in their network 7 days a week, 12 hours a day 4. We have little bureaucracy (this is deliberate) allowing for us to be on the road, in people's homes, taking action/proactivity/speed of response- so much more effective 5. Role is not purely focussed on that person's 'care' although this is a huge element but other practical issues that might lead to an eventual crisis so unopened mail, washing machine broken, garden overgrown, debt, pet is unwell……anything that comes up and the person cannot deal with themselves 6. Apart from the 7 days/12 hours a day element the key to this models success is the relationship between the Coordinator and person/network. The consistency and trust. We follow the persons care journey.
100	Red Bag	Unclear	No - too health	Exclude	Exclude/not discussed	Improved 'pathway' for care home residents being admitted to hospital in an emergency. The 'Red Bag' Hospital Transfer Pathway, originally developed in Sutton in 2015, aims to improve communication between care home, ambulance and hospital staff - to improve the quality of care for care home residents conveyed to hospital in an emergency.
Group 7.2. Live in carer models/services						
101	HomeTouch	Unclear	Not enough detail	Exclude	Exclude/not discussed	From website: Live in care - handpicked the finest carers from across the country, ready to help your loved one live happily, safely and with dignity in their own home. Carers for companionship or complex care. (Care hub, care plans, carer library, care journal)
102	Shared Lives	Include		Exclude	Exclude/not discussed	They do a lot in this space in terms of LD provision. From website: Shared lives schemes support adults with learning disabilities, mental health problems or other needs that make it harder for them to live on their own. The schemes match someone who needs care with an approved carer. The carer shares their family and community life, and gives care and support to the person with care needs. Some people move in with their shared lives carer, while others are regular daytime visitors. Some combine daytime and overnight visits. Shared lives schemes are available across the country and are an alternative to traditional kinds of care, such as care homes. The schemes are also known as adult placements.

103	CASA	Exclude	Not enough detail	Include: not discussed	Exclude/not discussed	From website: The UK's largest employee owned social care provider. Provide domiciliary care and a variety of other home care services. Operate in Newcastle, Leeds, Liverpool and Manchester.
104	Outcoming based commissioning - Wiltshire county council	Unclear	No - been abandoned	Exclude	Exclude/not discussed	Lots of challenges and lots of learning. From website: The report describes the process that Wiltshire Council has used to develop its new 'Help to Live at Home Service' for older people and others who require help to remain at home. The approach in Wiltshire is one that has focused on the outcomes that the older people wish to gain from social care. It has involved a complete overhaul of the social care system from the role of the social worker working alongside the customer to determine the required outcomes to the role of the providers of the service who must deliver these outcomes and receive payment based on that delivery. Wiltshire decided to create a single entity which it would call the "Help to Live at Home Project".
105	PAMAN	Unclear	No - too health	Exclude	Exclude/not discussed	Remote monitoring and support of medication administration. Connecting people in their own homes directly with pharmacists / pharmacy technicians. Reducing the need for domiciliary care medication support visits. Ensuring people who need it can get support with their medication at a time which is right for them.
106	Lifted	Unclear	Not enough detail	Exclude	Exclude/not discussed	Home care agency using digital technologies to generate efficiencies, provide better person-centred care, be more responsive etc. From website: A great alternative to a care home, our Live-in Carers stay seven days a week to provide reassurance and hands-on practical support. Whether it be a helping hand with the morning routine, or intensive support for clients with complex needs, our Carers are trained to think of everything.
107	Birdie	Exclude (not a straight forward target group support)	Not enough detail	Include: not discussed	Exclude/not discussed	Home care agency using digital technologies to generate efficiencies, provide better person-centred care, be more responsive etc. From website: Birdie is the digital solution that home care agencies can rely on to deliver safer care. By monitoring your care closely, you know in real-time what's happening during every visit.
108	Cera	Unclear	Not enough detail	Exclude	Exclude/not discussed	Home care agency using digital technologies to generate efficiencies, provide better person-centred care, be more responsive etc. From website: Care at home - each client has a dedicated care manager. Elderly care, palliative care, live in care, post discharge care, respite care, dementia care.
109	Supercarers	Unclear	Think this may be being looked at in the ESRC Sustainable Care programme	Exclude	Exclude/not discussed	Home care agency using digital technologies to generate efficiencies, provide better person-centred care, be more responsive etc. From website: At SuperCarers, we help families to find experienced home carers in their local area, and provide the tools they need to coordinate care directly. We believe your perfect carer is not only someone with the right experience, but also someone you get along well with, and who can understand you. Our system reduces costs versus traditional agencies, so you get a better deal and your carer gets a better reward for their hard work.
110	Lavanya	Unclear	Not enough detail	Exclude	Exclude/not discussed	Home care agency using digital technologies to generate efficiencies, provide better person-centred care, be more responsive etc.

111	The Falls Service	Include	No - too health	Include	Exclude: too health	The Falls Service works as part of the Rapid Response in-house service, responding in a crisis where someone doesn't need urgent medical care, but has fallen and needs help to get back up. Specially trained responders have access to specialist raising equipment and training facilitated by South West Ambulance Service to enable them to respond and assist people in their own homes, preventing ambulance response and potential admission to hospital.
112	Responder Services	Unclear	No - too health	Exclude	Exclude/not discussed	Carr Gomm's responder services support and empower people to live safely and independently in their own home for longer. Furthermore, they significantly reduce ambulance call outs and delayed discharge times, reduce admissions to hospital and long term care, reduce overall health and social care costs.
112	Responder Services	Unclear	No - too health	Exclude	Exclude/not discussed	Carr Gomm's responder services support and empower people to live safely and independently in their own home for longer. Furthermore, they significantly reduce ambulance call outs and delayed discharge times, reduce admissions to hospital and long term care, reduce overall health and social care costs. Responder services reduce overall health and social care costs and improve the health and wellbeing of citizens and unpaid carers.
113	Dementia Community-based care coordination pilot	Yes	Maybe - could be linked to other coordinator type services	Include	Include	This is a pilot funded by the SG in Inverclyde HSCP which began in the summer of 2019 and which will last for two years. Its objective is to pilot intensive, integrated home care for people in mid to advanced stage dementia in order to sustain supported independent living at home, avoid hospital admissions and reduce time spent in residential or nursing care homes and specialist NHS dementia care.
Group 7. 4 Signposting to local services						
114	Reconnections Worcestershire	Yes	Not enough detail	Include	Exclude: lot of evaluations already exit	From website: Service to reduce loneliness and social isolation in Worcestershire run by Age UK. Works with a number of local partners that cater for everyone. Reconnection starts with a call from team to individual to introduce service. Calls are followed by a personal visit to discuss individual needs and co-develop action plan. Support is fully tailored to each person and can range from confidence building to making connections with groups. Designed for over 50s.
Group 7.5. Matching person with appropriate carer						
115	Ways to Wellness	Unclear	Not enough detail	Exclude	Exclude/not discussed	From website: Ways to Wellness Link Workers provide support to people with certain long-term health conditions who are referred by their GP in Newcastle West. A Link Worker works with each person referred, on a one-to-one basis, in the areas they most need support.
116	Link Working	unclear	Maybe, part of social prescribing	Include	Include: social proscribing	Community Link Working offers non-clinical one-to-one support to people in contact with GP practices. Carr Gomm's approach to Link Working is based on our person-centred values and a human rights based approach. Our Community Link Workers take the time to understand the concerns impacting on people's health and wellbeing, supporting people to identify the problems and issues they are experiencing.

						From here, we co-create a bespoke outcomes-focussed action plan that truly reflects each person's priorities and concerns.
Group 7.6. Provision of health services in community						
117	Greenwich community learning disability team	Unclear	Not enough detail	Exclude	Exclude/not discussed	The team provide a range of services to adults with learning disabilities over the age of 18 living in Greenwich.
118	Double-handed care packages	Unclear	Not sure what this is - doesn't sound very innovative	Exclude	Exclude/not discussed	Occupational therapists: • Review double-handed care packages • Review people's priorities and needs • Work with care providers to adjust level of support to meet need • Advise on techniques to ensure safety IMPACT • Annual savings to the council of £472,301 • Plus a saving of £178,500 in avoided care costs • 239 hours of care costs saved
Group 7.7. Reablement/enablement						
119	Offer choice, control and a person-centred approach	Unclear	Not sure what they do	Exclude	Exclude/not discussed	The reablement service was awarded. Outstanding by the Care Quality Commission. In 2016 – 2017 91.7% of people no longer required ongoing support once seen by the Early Intervention Team.
120	Autistic Spectrum Condition (ASC) Enablement	Unclear	Maybe	Exclude	Exclude/not discussed	The service allows individuals with autism without a learning disability to access occupational therapy for up to 12 weeks. Occupational therapy is delivered through one to one support based around a person's goals and focussed on their strengths and assets. ASC Enablement has demonstrated improved levels of independence and quality of life for people, leading to a 64% reduction in the need for care.
121	Reablement	Unclear	Could be looked at along with other reablement initiatives in this list	Exclude	Exclude/not discussed	Nottinghamshire County council have transformed their services to be Occupational therapy led. They are reabling 75% people to maximum ADL potential in 24 days.
122	Enablement services (as a standalone service to 'reablement')	Unclear	Maybe	Exclude	Exclude/not discussed	What is the difference between enablement & reablement? Reablement aims to put people back to how they were prior to an adverse health event or deterioration and is usually modelled on short term home care type services. Enablement moves people forward in areas that matter to them, guided by their strengths & potential, their desires and aspirations. For example, someone with a learning disability who has aspirations for paid work – enablement can help them achieve this goal. This is enablement, not reablement as it is not putting them back to how they were, but moving them forwards. Enablement has multiple benefits for health & wellbeing.
123	Wellbeing Teams	Unclear	Looked to by Jerry Tew's project I think	Exclude	Exclude/not discussed	Self-managing teams delivering home care differently by offering practical support, community connections and basic healthcare/ reablement support - reinventing homecare.

124	(No name)	Unclear		Exclude	Exclude/not discussed	A key issue that has not yet been properly evaluated is the outcome of home care and other hands on services when delivered 'in-house' by LAs vs commissioned from external providers. This was an issue we encountered in the reablement project. No one has ever properly looked at the impact on cost effectiveness.
Group 7.8. Unsure						
125	Education Health and Care Plans (EHCP)	Unclear	Maybe	Exclude	Exclude/not discussed	We know that there continues to be barriers to effective education health and care plans in terms of timeliness; completion; mediation and I think we would be really interested in understanding if more personalised options have come out of the process. The Children and Families Act introduced the power to offer integrated personal budgets arising from the EHCP - it would be good to see if funding streams have been able to come together to provide more creative options and what the outcome has been.
Group 8: Social services in the community innovations:						
Group 8.1. Activity groups						
126	Dementia Day Break Club	Unclear	No - doesn't sounds innovative	Exclude	Exclude/not discussed	Club that is run within Ashford Age UK day centre. This has focussed activities for people with mild to moderate dementia to promote memory and cognition based on cognitive stimulation therapy.
127	Community Growing	Yes	No - too niche	Include	Exclude: out of scope	Carr Gomm's community growing projects use gardening and outdoor activities as the vehicle to actively tackle health and social inequalities in some of Scotland's most deprived communities. We work alongside people of all ages through the provision of inclusive and accessible events and activities, including sow & grow workshops, foraging events and reminiscence walks; we have also previously run cooking workshops, food and blether groups, and craft workshops. Health and social inequalities can heighten stress levels, and stress is a factor in almost all major mental and physical illnesses. Our community growing activities create the space for people to create friendships, develop new skills, and build a renewed sense of purpose in life.
128	Men's Sheds	Yes (possibly)	I'm pretty sure this has been evaluated, GCU were doing work on it	Include	Exclude: too many evaluations	Carr Gomm's Men in Sheds project is a dedicated, friendly and welcoming weekly meeting place where socially isolated and lonely men come together to build self-esteem, develop new skills, and combat isolation and loneliness. Adverse life circumstances can heighten stress levels, and stress is a factor in almost all major mental and physical illnesses. The men who come to our shed identify themselves as socially isolated and living without structure in their lives, so we create the space and deliver activities for men to develop protective factors, including creating community connections, friendships and a renewed sense of purpose in life.
129	Be Active Life Long	Unclear	No - doesn't sounds innovative	Exclude	Exclude/not discussed	22 active ageing groups in Moray, run by and for older people (with support and advice as required), help over 700 people a week stay active and connected to their community.

130	Ensemble	Yes (possibly)	No - too niche	Include	Exclude: too many evaluations	The Ensemble project from Loretto Care, part of the Wheatley Group, has brought together musicians and people who have experienced mental health conditions to give people a new way to express how they are feeling.
131	Highland Migrant and Refugee Advocacy project (HiMRA)	Yes	Might be good to have something with refugees/migrants	Include	Exclude: out of scope	Under Birchwood Highland, the project HiMRA aims to empower and bring together people who identify as migrants and refugees, to strengthen community integration and social inclusion in the Highlands of Scotland.
132	Makers Café, Alloa	Yes (possibly)	Doesn't sound very innovative	Include	Exclude: not innovative	Makers Café is a Scottish Autism community hub delivering day and vocational opportunities for autistic individuals and people with a learning disability aged 16 + who would otherwise lack opportunities to experience a supported working environment. The project houses a community café, shop and gallery, and a kitchen garden. There is also space to host and accommodate events, support groups and workshops for autistic adults and local community groups.
133	Evaluation of a local mosaic art project	Unclear	No - too niche	Exclude	Exclude/not discussed	Intergenerational Mosaic classes attended by members of the community.
Group 8.2. Advice						
134	FISH (Finding Individual Solutions Here)	Yes (possibly)	Maybe	Include	Exclude: out of scope	The model allows people to access a professional directly for advice, signposting, solutions or interventions. • Waiting list reduced • Need for assessment reduced by approximately 70% • 72% of those requiring reablement are independent when leaving the service
135	Community Contacts		Maybe - would be good to have something that links to SDS or personal budgets	Include	Include	Community Contacts is an independent Carr Gomm project offering impartial advice, information and support about Self-Directed Support. We do this by offering 'A Helping Hand with Self-Directed Support (SDS)'. Funded by the Scottish Government's Support in the Right Direction (SiRD) initiative, Community Contacts aims to help people to design and manage their own support in a confident and informed manner; all with the re-assurance of knowing that we are there to help them if they need us. We do this in partnership with others, including the local Social Work Department and local community organisations. The project can help to reduce feelings of uncertainty by providing opportunities for people to make connections with specialist organisations or groups who can offer support; for example, local carers' organisations. We can also facilitate opportunities between people to share experiences and knowledge of SDS.
Group 8.3. Care or support from peers						
136	Provide in-reach support to people in the criminal justice system	Yes (possibly)	Yes	Include	Include	The occupational therapists in PSCAxT review social care provision in the local prisons to address gaps and minimise risk to vulnerable prisoners. The team has been able to evidence the level of support services required; support hours used by the commissioned service, and in the first two years of its implementation, make a cost saving of approximately £80,000 on the social care contract. Other initiatives include

						training Care & Support Orderlies (C&SO) to assist other prisoners with non-personal care tasks. The C&SOs support vulnerable prisoners to participate in communal activities and education, vocation and resettlement programmes.
Group 8.4. Physical activity groups						
137	Keep On Keep Up	Unclear	No - too health	Exclude	Exclude/not discussed	Keep On Keep Up is an application which has been co-produced with older adults living in sheltered accommodation. A feasibility, acceptability and usability study with Jigsaw Housing has seen improvement in a number of outcomes over 6 weeks of use, with those using it more gaining better outcomes. It includes evidence based strength and balance exercises which are progressive and can be matched to ability levels, safety at home, bone health and hydration games – as well as a user-friendly boarding aspect too. It has been in development for several years, with all aspects being co-created with users.
138	Exergaming	Yes (possibly)	No - too health	Include	Exclude: been evaluated	Exergaming is another area where there has been excellent results based on a 2 arm RCT with adults aged 55+ living in assisted living facilities in the UK.
139	(No name)	Unclear		Exclude	Exclude/not discussed	In addition to this, much of the best practice work being carried out across the local areas we worked with all evidence a range of interventions for strength and balance which fulfil both rehabilitation success (Christine/Wigan Model) as well as social integration and prevention models for strength and balance as a measure to reduce social care impact.
140	Sense, Active, Together	Yes (possibly)	Doesn't sound very innovative	Include	Exclude: out of scope	Sport and physical activity play a key role in keeping people fit and healthy, supporting social inclusion and building confidence through learning new skills and making friends. At Sense, we believe everyone, no matter how complex their disabilities, deserves the right to enjoy a physically active life.
Group 8.5. Befriending based on shared interests						
141	Circle Family	Unclear	Maybe	Exclude	Exclude/not discussed	Radical alternative to befriending in addressing loneliness through membership of a monthly events programme to connect people via shared interests.
142	Sense Buddying	Exclude as is for children	Doesn't sound very innovative	Include: not discussed	Exclude/not discussed	Sense Buddying is a pioneering new programme, which enables children and young people with complex sensory and communication needs to 'buddy' up with their non-disabled peers and develop friendships through shared interest and hobby. With its roots entwined in social action, the programme has made a miraculous impact on the lives of the young people, reducing social isolation and building confidence.
Group 8.6. Champions board						
143	East Lothian Champions Board	Exclude as is for children	Not enough detail	Include: not discussed	Exclude/not discussed	Story of care-experienced young people aged 14-25 who gain confidence and influence care services policy through the Champions Board. This reduces isolation and increases engagement to improve outcomes across education, health and employment.
Group 8.7. Short breaks						
144	Short breaks (for both children and adults)	Yes (possibly)	Doesn't sound very innovative	Include	Exclude: out of scope	We know that we are providing innovative models of support to provide short breaks for children, young people and adults that are providing wide reaching outcomes. Commissioners are responding well and there is a move away from overnight building

						based traditional models of respite. However, we know that funding for short breaks has been reduced along with the range of provision. Further evaluation of this to demonstrate impact, and how changing models of provision are meeting the needs of families would be welcome.
Group 10: Innovations relating to provision of funding support						
Group 10.1 Home Adaptation grants						
145	DFG	Yes (possibly)	Not sure what this is	Include	Exclude: out of scope	Service Evaluation of integrated models of DFG required to evidence cost benefits. Info from website: You could get a grant from your council if you're disabled and need to make changes to your home, for example to: • widen doors and install ramps • improve access to rooms and facilities – e.g. stair lifts or a downstairs bathroom • provide a heating system suitable for your needs • adapt heating or lighting controls to make them easier to use A Disabled Facilities Grant won't affect any benefits you get.
Group 10.2 Domestic grants						
146	Asylum and Roma Team Anti-Poverty Initiative	Yes (possibly)	No - too niche	Include	Exclude: out of scope	An initiative to encourage Roma and non-Roma families to claim clothing grants and free school meals, with a positive effect on the school community and beyond.
Without group						
147				Exclude	Exclude/not discussed	We have also been doing work to map the innovation landscape more generally to support UKRI and the Industrial Strategy Challenge Fund on Healthy Ageing.
148	Greensleeves		Not enough detail	Exclude	Exclude/not discussed	
149	Impact of new approach to SW training on, for example: (i) future social work practice; (ii) outcomes for clients; (iii) social work skills and knowledge		Not enough detail	Exclude	Exclude/not discussed	
150	(No name)			Exclude	Exclude/not discussed	It is also an issue in dementia care, where repeated recommissioning of services means considerable discontinuity for a group of people who find change of personnel etc. particularly difficult.
151	PAUSE		No - out of scope	Exclude	Exclude/not discussed	The programme is about taking a 'pause' in one's fertility, to prevent crisis pregnancies and allow women a chance to get their life in order and attend to their own needs. "Pause works with women who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care. We aim to give women the opportunity to pause and take control of their lives breaking a destructive cycle that causes both them and their children deep trauma." (Taken from Pause.org.uk).
152	Nourish Care Planning System	Include	Maybe	Include	Include	To implement Nourish as a best fit care planning system(s) for Community Integrated Care services across England and Scotland, ensuring an effective roll out and embedding of the system to enhance management and leadership while providing a

						ease of use platform to deliver improved outcomes for the people we support and front line staff. Having completed a pilot across 21 sites within the previous financial year where some 110 people supported, and 292 colleagues utilised Nourish for Care delivery this document will outline the case for full roll out to all existing and new services being delivered by Community Integrated Care. Nourish will integrate with our existing core systems and be aligned with our strategic IT direction, taking over the task for accident and incident reporting and action monitoring from Event Tracker and Q-Pulse that are no longer considered fit for purpose. Nourish has been developed in partnership between our own internal team and the provider to ensure a fit for purpose design with the flexibility to build specifics required within differing service models and to date has sat under a thorough project management governance arrangement which will continue into roll out.
153	Transforming Care		No - too health	Exclude	Exclude/not discussed	We would be interested in hearing about the impact and outcomes of the programme; what has been the learning from the commissioning around transforming care; has it really changed practice in relation to care treatment reviews, reduced length of stay in hospital, more community based options; what's next for the programme as the need hasn't reduced. It may seem old hat but is still such a pressing issue that hasn't been addressed.
154	Solva Care		Not enough detail	Exclude	Exclude/not discussed	A community led social health and care initiative centring on prevention and older people
155	Shared Lives				Include	They do a lot in this space in terms of LD provision. From website: Shared lives schemes support adults with learning disabilities, mental health problems or other needs that make it harder for them to live on their own. The schemes match someone who needs care with an approved carer. The carer shares their family and community life, and gives care and support to the person with care needs. Some people move in with their shared lives carer, while others are regular daytime visitors. Some combine daytime and overnight visits. Shared lives schemes are available across the country and are an alternative to traditional kinds of care, such as care homes. The schemes are also known as adult placements.
156	Community catalysts CIC				Include	Community catalysts' established approach is based on releasing local people's capacity to care. The model uses a ratio where 1 coordinator supports c.200 small self-organising enterprises. This results in low cost, flexible and personal care for older people and their families, and appropriately paid, highly satisfying self-employment for local people' From website: Community Catalysts is a Social Enterprise and Community Interest Company working across the UK to try to make sure that people who need care and support to live their lives can get help in ways, times and places that suit them, with real choice of attractive local options. We are a small group of energetic people who believe passionately in the power of people to effect social change. We

						work hard to harness the talents and imaginations of people in communities and organisations to provide imaginative solutions to complex social issues. Headings like 'social care', 'health care', 'community' and 'housing' broadly describe the areas in which we work but labels bring their own limitations. With this in mind we try hard not to limit our thinking to the conventional and are always willing and able to look for radically imaginative solutions that cross sectors and join up dots in unexpected ways. We nurture what works, challenge what doesn't and find practical alternatives. We believe in the power of partnership and work closely with community groups, local councils, health trusts, CCGs, policy makers and other voluntary and private sector organisations.
157	Local area co-ordination				Include	Local Area Co-ordination is an approach to community connection and capacity building that was originally developed in Western Australia. A Local Area Co-ordinator works in a relatively small patch of around 10000 people and (a) connects with the formal and informal networks of support and activity that are already taking place in the community, (b) connects with people who are socially isolated and struggling to have the sort of life they want, and (c) brings people together to develop new opportunities for and with each other. It is an asset-based approach which explores what people have to offer each other as well as what support that they may need and helps people to find solutions to their difficulties that involve relatively little use of formal care services. Its core principles are: 1. The right to citizenship, responsibilities and opportunities 2. The importance of valued relationships and personal networks 3. The importance of access to relevant, timely and accessible information to inform decision making 4. Recognising and nurturing individual, family and community gifts and assets 5. Recognising the natural expertise and leadership of people labelled as vulnerable and their families 6. The right to plan, choose and control supports and resources 7. The value and complementary nature of formal services as a back up to natural supports and practical solutions In the UK it has been developed substantially in Scotland (including Fife) and in a number of local authorities in England and Wales including Thurrock, Derby, Swansea and Wiltshire – and is currently being introduced in Birmingham. There is a national Local Area Co-ordination Network that supports innovation and implementation. Our recent research on prevention would indicate that Local Area Co-ordination can be effective in reducing unplanned use of healthcare service (such as A&E) and local authority wide expenditure on the provision of care services. Other studies have demonstrated a very substantial Social Return on Investment.

158	Family group conferencing				Include	Family Group Conferencing is an increasingly established practice approach in children's services, but is more recently being introduced in adults' and mental health services s. As originally conceived in response to concerns expressed by the Maori community in New Zealand, Family Group Conferencing was developed as a process of shared decision making in which all with a concern for a child (family and wider community members) would come together to draw up a plan as to how they wished that child to be supported, and what contributions they each wished to make in order for the plan to be implemented successfully. This process is facilitated by an independent coordinator who undertakes preparatory (and follow up) work, but the actual decision making takes place in private 'family time'. Any proposed involvement of care services as part of the plan is then checked with the social worker in order to make sure that this is practicable and acceptable. This model translates relatively straightforwardly to the context of arranging appropriate support for an adult. It has been rolled out both in the UK and Europe (mainly Holland and Norway) where more research has been conducted. I studied Family Group Conferencing as part of a wider SSCR study into family inclusive approaches in mental health and our case studies included a number where very impressive results were achieved in terms of building sustainable networks of support and supporting people back into positive roles within the community (Tew et al, 2017). The model has the potential to build capacity through (a) enabling a person and their natural support network to take responsibility and feel empowered, (b) involving and mobilising a wider network of family and non-family with a concern for the person so that all responsibility does not rest on a singular carer, and (c) providing a forum for the family to restore links and to resolve issues and differences that may impair their ability to work together in support of the person for whom they care. Family Group Conferencing is being developed in generic adults services in Camden, Hampshire and Edinburgh, and mental health services in Essex - and is just starting in Birmingham and a number of other local authorities.