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Growing innovative models of health, care and support for adults

Introduction

There are some really good examples of innovative models of health, social care and support for adults. The challenge now is to scale up these primarily small-scale successes so that as many people benefit from them as possible. Like Andrew, who became isolated and was drinking too much. Andrew was supported in the community by local volunteers and a micro-enterprise providing home care. This meant that he avoided having to stay for longer than necessary in hospital. Can we scale up small success stories like this?

The Government aims to publish a green paper on care and support in 2018, promising to look beyond the issue of funding to encompass broader questions about how we develop high-quality, community-orientated and sustainable social care. This is encouraging. The green paper offers a fresh opportunity to consider how we can foster an environment in which innovative, cost-effective and impactful models of care can be shared more effectively, adopted more widely and implemented more rapidly. The goal? To improve health and wellbeing for all of us with health, care and support needs.

The development of Accountable Care Systems (ACSs), along with the planned expansion of Integrated Personal Commissioning (IPC), will promote a strong focus on integration, community-based models of care and prevention. As a result, the opportunities for testing, sharing and bringing to scale innovative models of care are arguably greater than ever before. By 'bringing to scale' we mean increasing the number of people who benefit from a social innovation.

Key messages

- Innovation is needed more than ever as our challenges grow. Innovation does not only mean technological breakthroughs or large restructures. New and better ways of delivering relationship-based care are needed, and already exist, but are inconsistently implemented or poorly scaled.
- For innovation to flourish, we need to find better ways to help people bring good ideas from the margins into core business. The keys to success are:
  - a shared ambition to 'embed person- and community-centred ways of working across the system, using the best available tools and evidence'
  - co-production: planning with the people who have the greatest stake in our services from the beginning
  - a new model of leadership which is collaborative and convening
  - investment and commissioning approaches which transfer resources from low quality, low outcomes into approaches which work effectively
  - effective outcomes monitoring and use of data to drive change
  - a willingness to learn from experience.

In pilots across England ACSs have shown early potential to make better use of resources to drive transformative change. Additionally, as we are beginning to learn more about what works from the models of care in the NHS Vanguards, it will be vital to ensure that opportunities are not missed to bring these to scale.

Our reports 'Realising the value', 'Six Innovations in Social Care', and 'Total transformation of care and support' have highlighted a number of the innovative care models within the sector which are transforming outcomes in a cost-effective way. We argue that while encouraging new innovations remains important, the greater problem facing the sector is finding ways to bring to scale new models of care which have been proven to work. This is at the core of driving transformational change, not just in pockets and for the few, but across the whole of England and beyond. Other papers look at how new innovations can be identified and started. Here, we articulate how we can help innovations in the health and care sector grow to scale.

The briefing is based on research conducted during the spring of 2017 by Nesta, SCIE, Shared Lives Plus and PPL. The intention is to inform the work carried out by the Cabinet Office and the Department of Health on emerging plans for the care and support green paper. The research involved:

- desk research of the latest evidence of innovative models of care and the science of innovation in public services
- interviews with stakeholders in policy, commissioning and delivery roles, as well as with people who use care and support and carers
- a seminar involving over 40 stakeholders drawn from across health and care.

Imagining a transformed health and care landscape

In our paper 'Total transformation of care and support' we identified five areas where transformation is needed in health and care systems:

1. Helping people and families to stay well, connected to others and resilient when facing health or care needs
2. Supporting people and families who need help to carry on living well at home
3. Enabling people with support needs to do enjoyable and meaningful things during the day, or look for work
4. Developing new models of care for those who need accommodation as well as support in their community
5. Equipping people to regain independence following hospital or other forms of health care.

For each area, we also identified promising models of care, such as Shared Lives, Local Area Coordination and Age UK's Living Well approach, and modelled the potential savings to the care system if we scaled them up. Based on financial modelling of cost savings from implementing the changes elsewhere, we concluded that implementing these models in Birmingham would generate cashable savings of £7.5 million per year within adult social care.

In 'Realising the value', Nesta and partners, including the Health Foundation, National Voices and PPL, looked at what it means to put people, families and communities at the heart of health and wellbeing, and the actions that national bodies and local areas can take to make this a reality.

In 'The asset-based area' (TLAP, 2017) and 'Asset-based places' (SCIE, 2017), we described how statutory services, working with communities, can develop asset-based areas which create the right conditions in which innovation can be fostered.

The question which follows is: what would a local health and care system look like were we able to create asset-based areas and scale up the most promising innovations? Such a system, in our view, would have the following features.

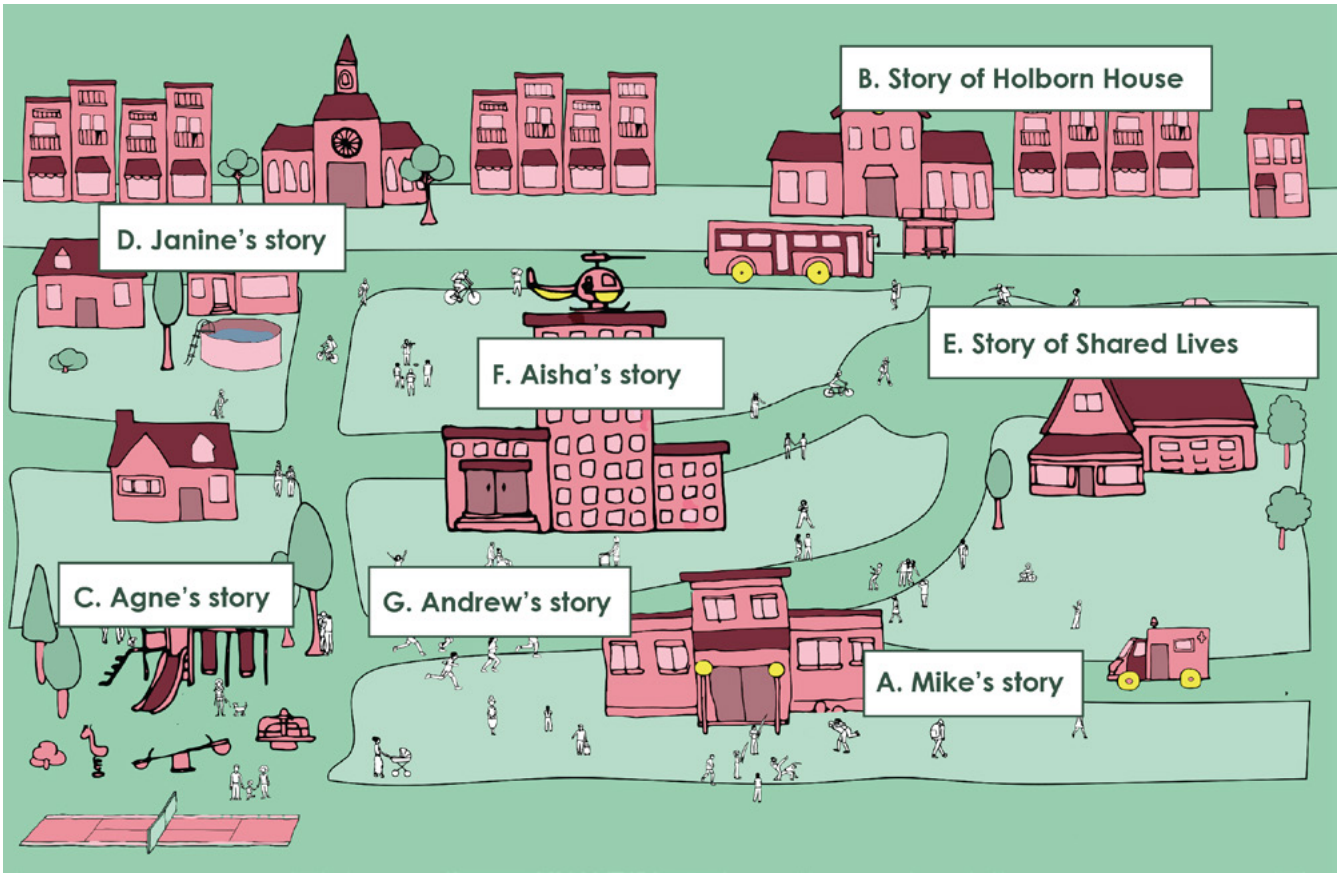
- People's health, care and support shaped through **strength-based conversations** that seek to address a whole person's life, rather just assessing a narrow set of needs
- **Services are co-produced** with the people whose lives they touch. This means that everyone involved identifies priorities, co-designs services and systems and works together wherever possible to co-deliver the work that takes place
- A flourishing range of **community assets and peer networks** focused on building the knowledge, skills and confidence of people to self-manage their care
- **Neighbourhood-based multidisciplinary and integrated teams**, working with communities and volunteers and focusing on what is important to each person. This can be done through personalised planning which aims to include all aspects of family and community life
- **Budgets are devolved** as far as possible down to neighbourhoods, families and individuals, maximising choice and control over how money is spent on people's care
- Community buildings, including care homes and primary care centres, are reassigned as **multi-use community resources**
- Services are funded and measured on the basis that they **make positive changes in people's lives**, in terms of wellbeing, resilience, independence, connections to others and the ability to self-care
- **A thriving and sustainable voluntary, community and social enterprise sector**, working alongside people, families, communities and the health and care system

These features of a transformed system are represented in the following map and stories.

Real life stories from our research

What would a transformed system of health, care and support be like for people who use services and carers?

The map below depicts a place in the future where promising innovative models have been scaled up across all five total transformation areas. It also indicates where individuals or groups of people receive excellent, joined up, health, care and support, which link to stories describing the experiences of these people.



1. Helping people and families to stay well, connected to others and resilient when facing health or care needs

A. Mike's story

Mike, 73, spent most of his working life in the petroleum industry, surrounded by petrol fumes. He has chronic obstructive pulmonary disease (COPD), the most common lung condition among older people, and also has high blood pressure. Mike used to feel as if he was the only one suffering from COPD, but everything changed about five years ago, when his GP mentioned a local Breathe Easy peer support group for people living with lung conditions. Mike was initially hesitant about joining the group but he took a flyer home that day and decided that he would give it a go. He was really surprised at how much he liked being in a group environment – it made him feel that he wasn't 'on his own'. He also found the information and support from the health professionals helpful. In a matter of months, Mike's symptoms improved dramatically – particularly as he really enjoyed joining the weekly walking group and choir. Fast forward to today, and he is now the lead volunteer for the local Breathe Easy group. He really enjoys encouraging new people to join and takes it upon himself to search for new 'recruits' when he's out and about in the neighbourhood.

2. Supporting people and families who need help to carry on living well at home

B. Holborn House

Holborn House is a complex of 68 flats, with a mix of older and younger residents, which attracts a lot of students because of the nearby college. On the first Thursday of every month, the housing association puts on a social event at which everyone can gather, meet and chat over tea. Every other month, the association opens the gathering to others in the neighbourhood and hosts a cultural event so that people feel connected to each other, within and beyond the walls of the complex. As the residents have got to know each other, they have started to help each other more and more.

Each week Anne, 68, helps her neighbour, Clare. At 47, Clare is a full-time carer for her disabled son and needs help with her shopping. Andrew has lived in the complex for nearly 45 years, and has recently retired at 69. He regularly helps Anne and Clare with their DIY. John – Andrew's older brother – lives in the same building and has recently lost his wife to cancer. After his wife died, John wanted to stay at home but knew he would need some extra support. With some nudging from Andrew, a daily visit was arranged from a 'supercarer', who helps John with his personal care.

Rina – another neighbour – at 60, has diabetes. A health and wellbeing coordinator who works for the complex visits Rina every week, and has helped her set up Connected Care – an online portal that enables her to access all her health and care information in one place. This helps Rina keep on top of her appointments and has made it easier for her to manage her care needs.

Sergei, 62, has been the local postal worker for many years and recently trained as a 'call and check' support worker. He regularly pops in to see local residents, including Anne, Clare, Andrew, John and Rina, to discuss their health and wellbeing. He then flags any concerns to the health and wellbeing coordinator.

3. Enabling people with support needs to do enjoyable and meaningful things during the day, or look for work

C. Agne's Story

Agne, 43, is living with a mental health condition and had a head injury five years ago. She had to stop working as a result of her injury and this led to her becoming increasingly depressed and more socially isolated. After being referred to MySupportBroker by the local authority, Agne met her peer broker, Sohan. Sohan is a peer with direct lived experience of living with a mental health condition. He was trained to be a peer broker by MySupportBroker two years ago after benefiting greatly from the service himself. Sohan helped Agne source, plan, negotiate, budget and manage her support and care needs within the overall context of improving her wellbeing. He helped her maintain the social connections she wanted and to stay living at home. He also worked with Agne to use her personal budget to pay for a personal tennis coach, reviving her childhood love for tennis. Agne's tennis coach accompanies her to the tennis courts every week and helps her maintain her fitness. Agne is feeling a lot more positive and is even considering being trained as a peer broker herself, so that she can help others in the future.

D. Janine's Story

Janine, 46, is a mum of three boys, the eldest of whom, Freddie, is 22 and has a learning disability. He attends a day centre during the week and needs a lot of support at home. Janine's marriage broke down a few years ago and since then she has had to give up her job to look after her family full time. Although the day centre is close by, Freddie seemed disengaged when he was there. Janine was feeling increasingly isolated and depressed. A member of staff at the day centre suggests that Janine meet Amir, a local 'circle connector'. Amir supports a number of local Community Circles which bring family, friends and community members together to support individuals. Amir works with Janine to build a circle of support around her, and also helps her connect with a service which could provide her with advice about her entitlements and how to access a personal budget. This would give her greater control over what services were purchased for her son. Worried about her weight gain and shortness of breath, Janine is also referred to a health coach who has worked with her to lose weight and cook healthier food for her and her family.

She has also stopped taking Freddie to the day centre and has used his personal budget to pay for gym membership and swimming classes for Freddie, which he really enjoys. These positive activities and extra money have greatly improved Janine's mental health and made the whole family much happier and under less pressure.

4. Developing new models of care for adults and older people who need support and a home in their community

E. Shared Lives

Ling and Harry are 52 and 55 respectively. When their children left home, they decided to become Shared Lives carers. Doris, who lives nearby, is a single mother who was working as a waitress at the local diner. She has a teenage son, Russell, who has a learning disability. Doris worked about 45 hours a week, and cared for her son when she was not at the diner. She also visited her mum – who is living with dementia – once a month in a neighbouring village. She wanted to see her mum more often but it's quite a long drive and Doris often felt too stretched and too tired to make the journey safely. It made her feels anxious that she couldn't see her mum very often and this made her less patient with Russell, and with colleagues at the diner. Doris found out about the local Shared Lives scheme after a having a breakdown at work. She told a colleague that she wouldn't be able to manage it all without support because she was exhausted. Her colleague told her about Shared Lives and said that she used a wonderful Shared Lives carer to help her care for her husband, who was also living with dementia. After finding out more, and signing up for the scheme, Doris and Russell were matched with Ling and Harry and they all met shortly thereafter. After a successful first meeting, Russell started staying with Ling and Harry every other week for a short break (consisting of two nights). With this caring respite for Russell, Doris was able to visit her mother more often and even began to think about evening college classes – something she had wanted to do for years. Russell and Doris have become like family to Ling and Harry.

5. Equipping people to regain independence following hospital or other forms of health care

F. Aisha's story

When Aisha, 81, fractured her hip, she was relieved that her home care coordinator, Betty, had encouraged her to prepare a Red Bag with her personal possessions. The Red Bag keeps important information about Aisha's health in one place, easily accessible to ambulance and hospital staff. This meant that when Aisha was picked up by the ambulance, the staff knew immediately that she had a severe allergy to a common painkiller.

Whilst in the hospital, Aisha had a daily visit from Sheila, a 'movement buddy' volunteer on the hospital ward. With guidance from the hospital physiotherapist, Sheila took time to help Aisha with some simple chair-based exercises after lunch every day. Along with the rehabilitation work with the physio in the morning, Aisha felt that the chair exercises really helped her regain her mobility quickly. This meant that Aisha was able to leave the hospital within five days. However, it was clear that she was apprehensive about going home. Lynda, the social care discharge worker in the hospital, recognised this and took the time to understand her concerns. It turned out that Aisha was worried that, without being fully recovered, she was not going to be able to attend her regular knitting classes at the local community centre, and she was fearful of feeling isolated. Lynda quickly suggested the British Red Cross local First Call – support at home scheme. First Call is a 12-week service where a friendly volunteer regularly visits people in their homes, and provides them with support.

Aisha really appreciated the British Red Cross volunteers, not only did they give her assurance and walked with her to her knitting class, but they were also very friendly and accommodating. For example, if it was too wet to go out, they would stay at home with Aisha and have a cup of tea and a chat.

G. Andrew's story

Andrew is 66 and recently retired. Since his wife died two years ago, he has lost contact with his friends and has started to drink excessively.

Andrew was seeing his GP about his back pain, who used a social prescription to refer him to John, a local area coordinator. The GP also referred Andrew to a volunteer-led older men's peer support network to help him reduce his alcohol use.

John built a relationship with Andrew, getting to know him and learning about his vision of a good life and how that might connect with others. This led to him being introduced to Scott, a disabled person who shares Andrew's passions for the local football team and who wants someone to go with to the matches. Andrew started going out more and helping local people he was meeting through his new networks with DIY. He also started drinking less.

On a cold winter's day, Andrew slipped on some ice and broke his hip. He had a successful operation but was worried that he would struggle to get going again. His friends through his new networks visited him though and offered to help out where they could.

Well in advance of being discharged from hospital, Andrew met a social care discharge coordinator to discuss his mobility, social and care needs, on returning home. This provided him with reassurance that he would be able to get around his flat safely. He also met up with John to revisit his goals and how he was working with others to find support, which included getting a little bit of help each day from a small micro enterprise proving home care, supported by Community Catalysts. Scott was also in touch and met him on the day he got home.

During the six weeks after Andrew left hospital, Scott visited Andrew once a week. Andrew was having problems getting fresh food as he couldn't walk to the shops so John showed him how to shop for groceries online. A few weeks later Andrew admitted to not having any visitors as he was embarrassed about having a messy flat, so Scott helped out with some cleaning and tidying to encourage him to invite round his friends.

After six weeks Andrew felt much recovered but he still hadn't been able to do much walking and was worried about becoming isolated from his friends at the local football club. Encouraged by John, he also registered for a buddy walking group, who met him at his front door twice a week and then walked him to the local community café for tea and biscuits which really helped him build up his strength and was a chance to meet new people or re-connect with friends.

Routes to scale – lessons from experience

For this research, we interviewed a range of stakeholders involved in trying to build and grow successful and sustainable innovations in health, care and support. We also spoke to commissioners and funders with experience of enabling, shaping and supporting new innovations. We learned about:

- different routes to scale
- the challenges people encountered
- the factors that have enabled them to bring new models to scale.

This research has identified several routes to scale although these are not necessarily mutually exclusive and can happen at the same time in more than one place.

Spreading across boundaries

Several innovations have sought to spread their models to other areas, with varying degrees of success. 'Lifting and shifting' innovations can follow different routes, though these are not mutually exclusive.

- **Organisational growth**: this enables innovators to maintain control and influence on the delivery and impact of their model
- **Licensing and affiliation:** this can enable innovators to retain some quality control, while harnessing local expertise and resources to adapt to local context, where appropriate
- **Partnerships:** these can enable innovators to access skills and resources, and reach people, volunteers and markets that may not otherwise be accessible. Although more complex, partnerships can be a good approach where people are also likely to be using some mainstream services and where integration and coordination will create demand and improve people's experiences
- **Replication through delivery networks:** this can scale a new way of working which can be delivered by, or incorporated into, practices of existing organisations and networks.

In choosing the right approach, it is important to consider the right balance between local co-production and being faithful to an emerging model. Enabling people to design and adapt local programmes, based on the core features of an external innovation, is likely to increase the degree to which they value those programmes and engage personally with them. Focusing on outcomes and goals, core values and essential practices, with room for local creativity and ownership can get the balance right.

Case study: North London Cares

North London Cares is a community network of young professionals and older neighbours helping one another in a rapidly changing city. Founded in 2011, its objectives are to:

- **reduce isolation and loneliness** among older people and young professionals alike
- **improve the connection,** confidence, skills, resilience and power of all participants so that neighbours can feel part of a changing city rather than left behind by it
- **bring people together** to reduce the gaps across social, generational, digital, cultural and attitudinal divides.

Independent evaluations have shown that North London Cares has reduced loneliness and increased the wellbeing of those involved, with 73 per cent of older neighbours reporting feeling less isolated as a result of participating in its activities.

In 2014, South London Cares was founded. In 2017 the model expanded into Manchester and there are plans for branches elsewhere.

Key factors supporting scaling up

- Provision of advice from experts in business growth and finance, e.g. in managing risk and developing effective governance arrangements
- Co-production – always listening to the people involved, responding to their needs and drawing into their ideas
- When moving your model into a new area, understanding it will be very different, and will need a unique approach which reflects local circumstances
- Recruiting, developing and retaining people with strong values, ideas and energy.

> *When we started to build South London Cares, after the success of North London Cares, we couldn't just take the model and plant it across the river. We needed a whole new set of people with local community experience and local community ties, who were excited to do this kind of work, and with new ideas on what would make it successful.*
>
> **Alex Smith,** North London Cares

Case study: Age UK's Personalised Integrated Care programme

Age UK's personalised Integrated Care programme operates across England and brings together voluntary organisations and health and care services in local areas; providing an innovative combination of medical and non-medical personalised support for older people living with multiple long-term conditions who are at risk of recurring hospital admissions. The programme was originally piloted in Cornwall, and has grown significantly, operating across several local areas.

The process begins with a conversation between the person and the voluntary sector coordinator, who helps them to identify their goals and coordinate a management plan. Trained volunteers provide support to help the individual become better connected to their community, be more physically and socially active and subsequently have better health outcomes. Practical support, navigation and coordination are provided to boost self-confidence and self-reliance, reducing adult social care spend and primary/community health benefits.

Scaling up

The programme was first trailled in Cornwall in 2013. In 2015, it was extended to eight new sites, each aiming to support a further 500 to 1,000 older people a year. These sites are Portsmouth, North Tyneside, Ashford and Canterbury, East Lancashire, Blackburn with Darwen, Redbridge, Barking and Havering, Sheffield, Guildford and Waverley.

In 2017, South Gloucestershire, North Kent, South Kent, Croydon and Northamptonshire were added.

Key factors supporting scaling up

- Undertake robust evaluations of the impact of the programme, and utilise this evidence to convince other commissioners and funders
- Ensure that the initiative is aligned to current and emerging policy drives, such as the development of integrated person-centred care
- Select areas for adopting the model that have strong existing partnerships

Embedding a local innovation

This happens when a local innovation is successful beyond pilot funding to become core funded. Some providers have made this transition, but the challenges for many innovations are considerable. It is important for emerging networks to be able to continue to co-produce and refine core values and practices, as has happened with the UK-wide Shared Lives and Homeshare networks and is beginning to happen with the Local Area Coordination Network.

> *I frequently meet visionary senior leaders who assume that key systems such as referral, care pathways and procurement processes will align around the goals they articulate. This only happens when those leaders are willing to follow through on the detail: this is a willingness to step outside of being "strategic" at times.*
>
> **Alex Fox,** Chief Executive, Shared Lives Plus

Case study: Shared Lives

Shared Lives is a model in which adults either live with or regularly visit their chosen carer, who is trained and managed by a local Shared Lives scheme. Shared Lives has grown slowly and organically over 40 years, from an association formed from local initiatives which coalesced around a set of values and core practices, to a regulated care and health model used by 14,000 people from an increasing range of groups. These include adults with learning disabilities, people leaving hospital and women fleeing domestic abuse.

The model exists in nearly every area, but some have small, local schemes, while the biggest schemes support hundreds of people. The Greater Manchester devolved region is now taking a Greater Manchester-wide approach to developing its 10 local schemes. NHS England and seven clinical commissioning groups are investing in taking the model from social care into the NHS.

Key factors supporting scaling up

- It is regulated but flexible enough to allow different local authorities to adapt it to particular groups, and to enable individuals to define what family life looks like for them.
- The CQC inspection regime and national membership network (Shared Lives Plus) mean that all participants can join communities of practice and benefit from research programmes, alongside a single quality framework, outcome measuring tool and tax regime.
- Shared Lives has an evidence base which clearly demonstrates the economic benefits of the model versus other forms of care. The Care Quality Commission consistently highlights Shared Lives as the most consistently high performing of all kinds of regulated care. This in turn gives local authorities the incentive to grow the model.

Case study: North Yorkshire Innovation Fund

Funded by North Yorkshire County Council's Health and Adult Services Directorate, the Innovation Fund aimed to support voluntary and community organisations in innovative approaches to provide early intervention or prevention measures. The overall goal was to transform adult social care in the county and help to prevent, reduce or delay the need for statutory social care services.

The Innovation Fund awarded grants against these three themes:

- Reducing loneliness and isolation
- Prevention and falls
- Supporting people to remain in their own homes.

Over four funding rounds, 28 projects received funding worth a total of £1.13 million. The last round of funding occurred in January 2017 and future innovation is to be supported as part of the Stronger Communities programme.

Key factors supporting scaling up

In a Year 3 impact report, Innovation Fund projects reported tangible outcomes for the people who used their services, including improved mental health, reduced social isolation and enhanced independence. However, providers also reported ways in which being an Innovation Fund beneficiary helped them to scale up their activity, beyond the initial impact of the funding itself. Most notably this included the following.

- The funding helped providers to trial and pilot new models of delivery and to evaluate what worked and its impact. This experience – and evidence – enabled several providers to secure investment from other funding schemes after the innovation funding finished.
- Providers also reported increased opportunities to collaborate and work in partnership with other local services. This helped build up networks and resilience.

Whole-area innovation

Whole-area innovation takes place when there is a system-wide vision and strategy for scaling and embedding the best models of care. This involves a concerted, whole-system approach to identifying, developing and scaling innovations.

> *"The "Deal" is our plan of plans. It is our budget strategy. It is a single unifying philosophy that holds everything we and our partners do to make families and communities self-reliant while taking out systemic waste. As we shrink as a council, we have invested £7.5 million into the community to grow our brilliant social enterprises and community projects that reach the parts we can't reach."*
>
> **Donna Hall,** Chief Executive, Wigan Council

Case study: Wigan's place-based approach

'The Deal' is an informal agreement between the council and everyone who lives or works in Wigan, to work together to create a better borough. It is driving new relationships between citizens and services, and between staff and management across the council.

The Deal has encouraged a different type of conversation between council and citizens. Instead of looking at residents as a collection of needs and problems, the borough views everyone as individuals who have strengths, assets, gifts and talents. This asset-based approach has:

- driven awareness of a richer range of local assets
- generated a new approach to investing in those community assets
- empowered staff with the training and tools to connect individuals to resources
- concentrated resources at key stages, for example around reablement.

This approach has led to a reduced demand for formal care, removed capacity that doesn't address demand (e.g. the borough has reduced the number of day centres from 15 to 5), reduced the number of permanent admissions to residential/nursing care and increased staff satisfaction.

Key factors supporting scaling up

The Deal has been implemented and embraced across the local authority. This has been enabled through:

- a clear vision, which has been driven by political and executive leadership
- funding from NESTA and a Local Government Association innovation programme
- workforce development and capacity-building for the entire workforce around asset- or strengths-based approaches.

Challenges and facilitators to scale

The people we interviewed told us about four key challenges.

- **Financial pressures,** which make it difficult for organisations and commissioners to fund new, innovative services at the same time as maintaining delivery and running down (decommissioning) low quality services. Although innovators may be able to access early stage investment or grant funding to develop and test their early ideas, it can be difficult to secure funding to grow and sustain impact.
- Lack of innovation and growth of **skills and capability** – such as strategic planning, marketing and market analysis, organisation and business case development – can mean that opportunities to address need and create demand are missed. Without understanding what is 'core' to success and what is negotiable, fidelity to the original values and intended ways of working can be lost and/or innovations can fail to adapt to local context.
- **Inward looking organisational leadership teams,** focused on short-term goals and local evidence and solutions, prevent organisations working together as partners to develop shared goals and learn about 'what works' from other places.
- **Performance management and contracting systems.** Our performance management systems are designed to manage the old models of care, not to incentivise new ones. They are institutionally-based, rather than focusing on people, pathways or localities. They reinforce silos and they are inherently conservative. The current contracting arrangements across health and social care promote perverse incentives, prioritising treatment over prevention, and rewarding activity rather than outcomes.

Facilitators

- **Sustained engagement and co-production with stakeholders, including citizens, people who use care and support and carers.** Stakeholders told us that when they engaged actively with local stakeholders and fully embraced the ideas, lived experience and expertise of people who use care, service changes were more readily accepted, and services were better tailored and more sustainable. Previous research by Nesta has found that innovators that have successfully scaled have been relentless in their ambition to improve outcomes for people and put strong emphasis on engaging their stakeholder communities.

> *"The innovators who have been able to achieve the most change are disabled people. But they needed innovative people to work with, they couldn't do it alone. It is about alliances, forging alliances. Need to formalise that."*
>
> **Sue Bott,** Deputy Chief Executive, Disability Rights UK

- **Ability to undertake high quality impact evaluations.** Many of the most successful innovations have an ambition to 'go big' from the beginning. They value and act on feedback and intelligence to improve what they do and increase the number of people who benefit. Producing high quality evidence of impact, meeting the highest standards possible (Nesta Standards of Evidence), is increasingly seen as vital to convincing commissioners and other funders to invest in a new innovation. Commissioners and funders can help by being clear about their expectations and being willing to engage with evidence of impact from other areas.

> *It is important to make sure when you are testing new innovation that you are collecting high quality evaluation evidence and data, thinking ahead about how you will use this to make the case for further investment.*
>
> **Jane Townson,** Chief Executive, Somerset Care

- **A clear vision of the change being sought and the core features of the innovation that will achieve it.** Stakeholders told us that when an innovation is easy to describe – its vision, how it works, and the difference it makes – it is easier to raise awareness, gain support and engage stakeholders in practical considerations of how to scale. Taking time to define and codify the 'core features and benefits' of the innovation can also reassure those interested in adopting it that the intended benefits are likely to be realised. By working together to develop clear referral routes through public services and community resources, innovators and commissioners can create demand for their innovation and a clearer pathway to scale and sustainability.
- **Leadership.** A 'tight and loose' leadership approach can help to create and maintain a clear shared vision and values, while enabling local teams to develop an approach that is adapted to local context and the needs of local people. For innovators, this can mean being open to different routes to scale and creating multiple pathways to reach new users. For commissioners and other providers, it can mean being open to new ideas and enabling teams to take the steps needed to make them a success, including where this requires developing new relationships, decommissioning or changing existing services, or giving up resources and control.
- **Innovation funding.** In some areas money has been diverted away from traditional services to nurture and develop innovations, especially in the voluntary sector. Stakeholders see this as essential to support emerging, and often small, local initiatives. However, it was only seen to be useful if local innovations were given a clear route map and support to move from innovation funding to core, longer-term, funding. By taking a more system-wide approach, it can be possible to use non-recurrent innovation funding to create additional capacity to 'double run' services. This demonstrates 'proof of concept' and shifts demand, before other services can be safely decommissioned.

New approaches for scaling innovations

> *The question you need to ask is, how do you create an environment and permissions framework, so that people can think and feel differently and try things out without bureaucracy, but so that there is some structure and safety?*
>
> **Kathy Clarke,** North Yorkshire Council

The biggest innovation challenge we now face is how to move new ideas to core business in ways that improve people's lives and support a more sustainable health and care system for the future. This was the whole-system change articulated by 'Realising the value' and 'Total transformation of care and support'. If we are to realise this vision, it is time to take a step change in our approach. There are number of system-wide change methodologies that have the potential to help break this innovation glass ceiling. We wish to draw on four of the approaches that show the most promise, to develop, test, compare and share the very best ways to bring new person- and community-centred approaches to scale.

1. **People powered results and other design-led approaches.** These approaches bring innovation and scaling which have been successfully used by other sectors into public services. Nesta has developed a 100-day approach to change with the Rapid Results Institute. It supports professionals across the local health and care system – including the local voluntary and community sector – to connect and create shared purpose around key goals, such as reducing unnecessary hospital admissions for people who are frail. These connections build shared motivation across individual institutions and give permission to frontline staff to solve problems with people who use services. They enable the whole system to act as more than the sum of its parts and create momentum for change in ways that may otherwise never happen. This approach could be used in combination with any of the others to catalyse more rapid action.
2. **The co-production approach.** Co-production involves people who use services and their families being an equal part of change conversations from the start. It aims to achieve system and culture change through involving different perspectives to those usually asked to lead change and by being open to different sets of priorities. We have outlined a structured approach to considering five key kinds of council and NHS activity which need reform. Leaders are often nervous about having open conversations with local people concerning difficult decisions, but in the small number of areas that have taken this risk, they have often been surprised by local citizens' pragmatism and appetite for radical change.
3. **The asset-based area approach.** This starts from the premise that radical change will always be limited within deficit-based systems. Piloting innovations without realigning the system around new goals and values can lead to repeated promising experiments which survive only as long as their temporary funding. Asset-based approaches take a different starting point ('What does a good life look like?' rather than 'What changes shall we make to our services?') in order to redefine local relationships ('What are we all willing to do to make this a good place to live?') and different solutions. The chief executive of Wigan, Donna Hall, argues that the Wigan Deal is an existing example of doing this. Thurrock is working on the Six (plus) innovations model, led by Martin Routledge of Community Circles and Helen Sanderson of Helen Sanderson Associates.
4. **Trial new outcomes-based payment mechanisms and integrator models to bring together and align a range of community-based approaches.** Effective social prescribing programmes invest in the infrastructure to support and work with a range of community groups and resources. Accountable care organisations can align both statutory and voluntary provider organisations around shared goals and outcomes, using 'alliance contracting' and other approaches. The organisation Social Finance has developed a model in which an 'integrator' organisation acts as bridge and broker between state and community providers.

Conclusions and recommendations

For the Government's vision of a sustainable, high-quality and person-centred health and care system to be realised, we need to grow what we know works. Many of the models of effective care exist already, but to a degree they are reliant on short-term, often charitable, funding, rather than core statutory funding. To get to the point where these models become part of the mainstream, there will need to be braver decisions about how local resources are spent, with money being transferred over time from low-quality, low-outcome services to impactful innovative models of care.

The Government and national partners should do the following.

- Bridge the gap between the Care Act's vision for wellbeing and the reality of current procurement, by developing new ways to pay providers which create wellbeing and resilience
- Create an innovation scaling fund to test new approaches to scaling across local areas, incorporating the best of the approaches outlined in this paper, and fund, where necessary, the double running costs sometimes required to support promising models of care to scale. Funding must be contingent on a plan to transfer core resources into the new models, but allow time and resources to support local stakeholders to adopt, adapt and test models so that they meet local need
- Work with user-led organisations to ensure that personal budget and personal health budget holders in every area can access and make real choices with their budgets
- Support capacity building and practise exchange and coaching for social entrepreneurs and change-makers, including disabled entrepreneurs and frontline workers
- Develop an action-based learning network, with resources, coaching and facilitation support, to enable innovative local authorities and local partners to test new ideas and share learning and support with others
- Develop national measures and measuring tools for wellbeing and social connection, creating and collating datasets which can be generated by providers and used by commissioners
- Bring together the evidence base on innovative models of health, care and support, into a single 'what works' repository.

Local areas should do the following.

- Seize opportunities to learn from others, to adopt, adapt and scale person- and community-centred approaches, including drawing on the approaches to scaling set out in this paper (e.g. people powered results, asset-based areas and co-production)
- Establish a local innovation fund to test new ideas, with a confirmed route to long-term funding to scale. Sustain innovative community and voluntary enterprises
- Ensure that all commissioning strategies, plans and specifications are co-produced with people who use services and citizens, as well as local statutory, community and voluntary organisations
- Ensure that evidence generation is embedded within implementation, including outcome measures and evaluations to compare the social and financial impact of new and existing services and support evidence-based funding decisions
- Pay providers on the basis that they improve resilience, independence, self-care and social connections.

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Contact us
If you would like to discuss any aspect of this paper or how SCIE, Nesta, PPL and Shared Lives Plus can support you, please contact ewan.king@scie.org.uk. Further blogs and information will be made available at www.scie.org.uk/future-of-care.

Useful links
Total transformation of care and support (SCIE, 2016)

Asset-based places. A model for development (SCIE, 2017)

Prevention resources (SCIE)

Improving outcomes for children and young people by spreading innovation (SCIE, 2017)

Making It Big: Strategies for scaling social innovations (Nesta, 2014)

Realising the value (Nesta, 2017)

Six innovations in social care (Community Catalysts and other organisations, 2017)

The state of care 2016–2017 (Care Quality Commission, 2017)

Innovation and tech can create social care services for the future (The Guardian, 2017)

Engaging and empowering communities: a shared commitment and call to action (Think Local Act Personal, 2016)

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The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works. We are a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. We also work closely with related services such as health care and housing.
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Shared Lives Plus
Shared Lives Plus is the UK network for family-based and small-scale ways of supporting adults. Our members are Shared Lives carers and workers, and Homeshare programmes. Shared Lives used to be known as Adult Placement.
sharedlivesplus.org.uk

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The SCIE Future of Care series aims to stimulate discussion among policy-makers and planners about the future of care and support, based on analysis of developing evidence and projections for the future.

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