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Care Compass

A simple, plain-language web portal providing clear and accessible information about Adult Social Care options and pathways for residents and carers.

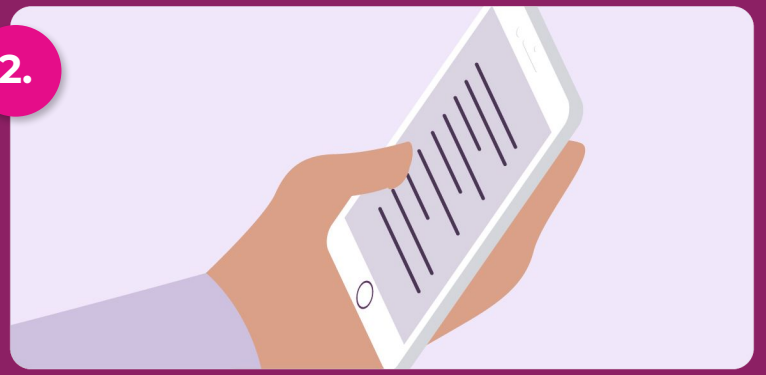
Persona: Aisha

Aisha is the partner of someone who needs social care support

1.

Aisha comes home from work tired, checks on her husband. She knows he needs more support, but she is unsure where to start.

2.

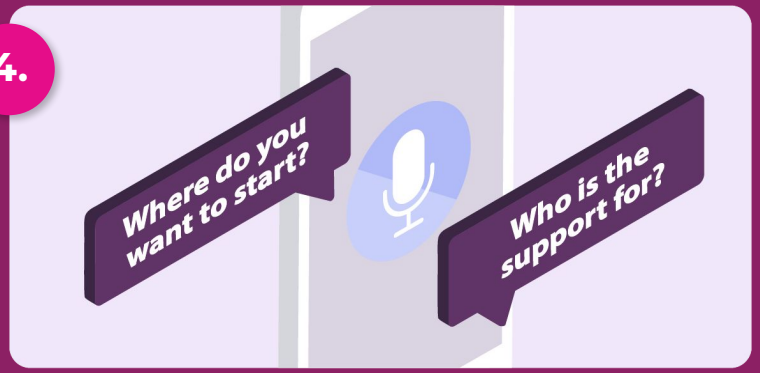


Aisha starts to search online.

3.

Aisha comes across a 24/7 digital assistant on her local council's website, which contains curated and trusted information and advice about care support available from local, national and third sector organisations. She can even ask the digital assistant questions in her own language and voice.

4.



The digital assistant guides Aisha through the process by asking specific questions.

5.

Further, more specific questions are asked to clarify, e.g. Would you like support with daily activities, or to find social support groups.

6.

After a series of questions, there's a suggestion that's appropriate and relevant to what Aisha needs. In this case, a buddy in her local area who can support.

7.

Aisha is now connected with and is in regular communication with a local buddy.

8.

Aisha can check in with the digital assistant to see if any further support is available for her and her situation.

9.

Over the next couple of months, the digital assistant continues to provide ongoing support to Aisha with check-ins at 3 weeks and 6 months later.

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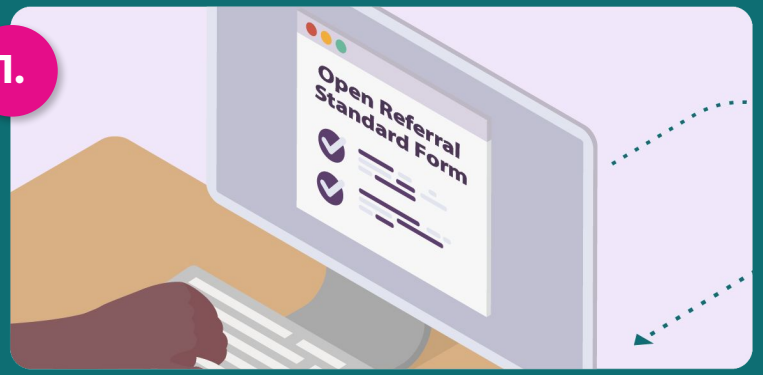
Care Flow

A system that streamlines referrals to social care with behavioural nudges, real-time updates, and AI-powered backend tools for triaging and managing messages efficiently.

Persona: Social Care Manager

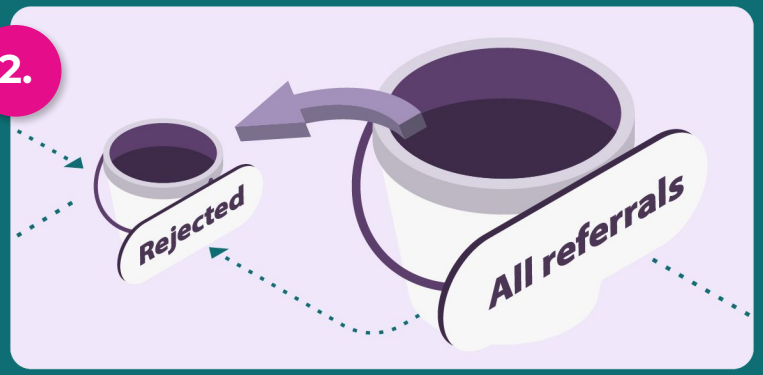
The Social Care Manager is responsible for managing the referrals into the council's adult social care service.

1.



The Open Referral Standard referral form is now used across London, for the following organisations to refer individuals to councils: police, NHS, care, etc.

2.



Referral triage takes place in which referrals that are not eligible for support from the council are automatically rejected with a message and explanation.

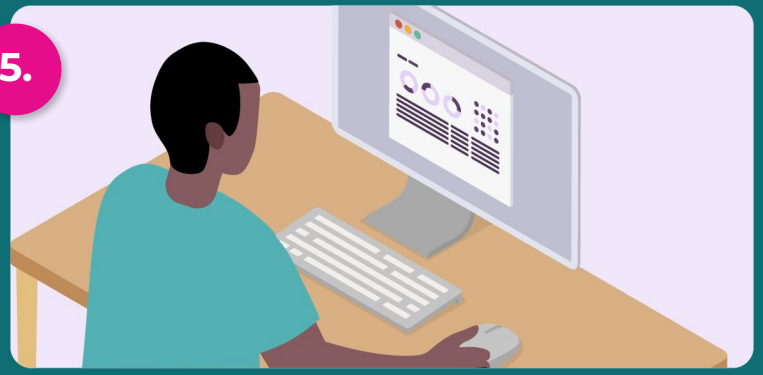
3.

The social care manager has access to a dashboard that shows a breakdown of new and existing referrals. For the latter they can also view their progress.

4.

Based on the insights from the dashboard, the social care manager is able to better manage the service. They're able to assign referrals to specific teams.

5.



The dashboard also helps the social care manager to plan and analyse how the service is doing against internal benchmarks e.g. timescales for dealing with referrals.

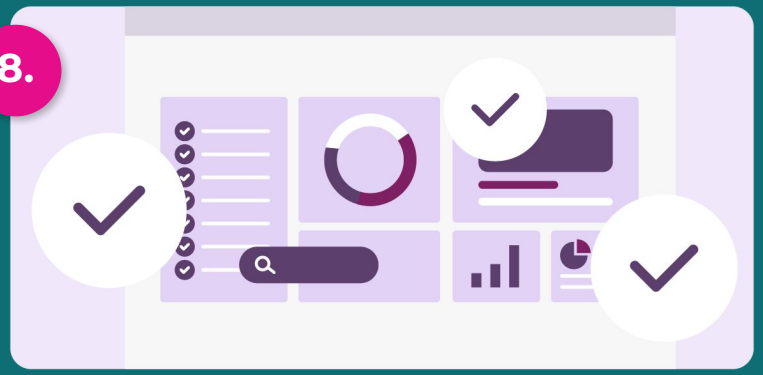
6.

These service performance insights can serve as the evidence base for a business case for change for further investment into the service.

7.

Service transformation is unlocked through better data.

8.



Individuals receive the care they need faster, staff's workload is manageable, referees have better visibility of the outcomes for their referrals.

9.

The social care manager's health and wellbeing improves as well as their job satisfaction.

My-ghty Magnet

A smart fridge magnet with a QR code storing vital health and care information, instantly accessible by paramedics, care workers or family members, in emergencies.

Persona: Paramedic

Paramedics provide emergency medical care while managing patient-specific needs like medications, pets, and handovers to the next point of care.

1.

The information about the individual is collected (e.g. family details, patient name, medications, next of kin, etc.)

2.

Paramedics arrive to find an individual requiring their urgent assistance. They may not have all the information they need about the individual, e.g. What do we do with their pet?

3.

They find The My-ghty Magnet on the fridge.

4.

By scanning the QR code on the magnet they can see the individual's personal details, social care services they receive, and key medical information.

5.

Paramedics are able to provide more personalised care - they can see the medical conditions and medications the individual is taking.

6.

The QR magnet enables paramedics to deliver faster, more holistic care through immediate access to individual's information.

7.

As the paramedic also has information about next of kin, they can promptly contact them, inform them of the situation and make arrangements for any pets at home.

8.

As the individual is taken to hospital, the neighbours are able to take care of the pet, who has been left there as per instructions on the My-ghty Magnet.

9.

At the hospital, the paramedic team is able to provide a detailed handover to the hospital team.

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Plan My Care

A template helping individuals plan their care needs, preferences, and support network before requiring services.

Persona: Mrs S

An elderly woman over 65 with multiple health conditions, that has been identified as 'at risk' by the local authority.

Mrs S receives her Council Tax which also includes information on "Plan My Care" including information about the community drop-in sessions that help individuals set one up. At the same time, her niece, Emily sees the "Plan My Care" initiative on social media.

Emily asks her aunt, Mrs. S, about Plan My Care and together they make plans to go to a community drop-in together to learn more about the initiative and set up Mrs S.

At the community drop-in, a volunteer helps Emily and Mrs. S set up an Plan My Care account. She facilitates a conversation around Mrs. S' views around receiving care, including her priorities, goals and preferences, and existing support network.

4.

A few weeks later, Mrs S feels unwell so she calls Emily to let her know and asks her if she can book a GP appointment for her. Emily does this for her online and an appointment is booked for a few days' time.

5.

Mrs S attends her GP appointment who prescribes a change in medication. The prescription update automatically filters through into her "Plan My Care" record so the information is up to date. She recommends that she completes some of the missing information on her account.

6.

Unfortunately, a few weeks later, the new medication hasn't helped Mrs S feel better. She hasn't gone to the corner shop for several days and so the owner, who is part of her support network, decides to check in on her. He finds her unwell and decides to call an ambulance.

7.

Mrs S is taken to the hospital and the health care workers taking care of her access her online "Plan My Care" record. They are able to deliver her the care she needs without asking her lots of questions whilst she is unwell.

8.

After receiving treatment, as part of planning for discharge, the hospital team reviews her "Plan My Care" record to see her support preferences, which is to remain living independently where possible. They can also see the support network that Mrs S has through the record, and discharge her to her home with some reablement support. They put in a review for three months' time.

9.

After returning home, Mrs S feels very satisfied with the personalised care she received through the "Plan My Care" initiative and decides to return to the community drop-in to complete the rest of her record and promote the initiative to others.

Care Collaborators

A training programme for health and social care staff to develop holistic knowledge and provide personalised advice on navigating care systems.

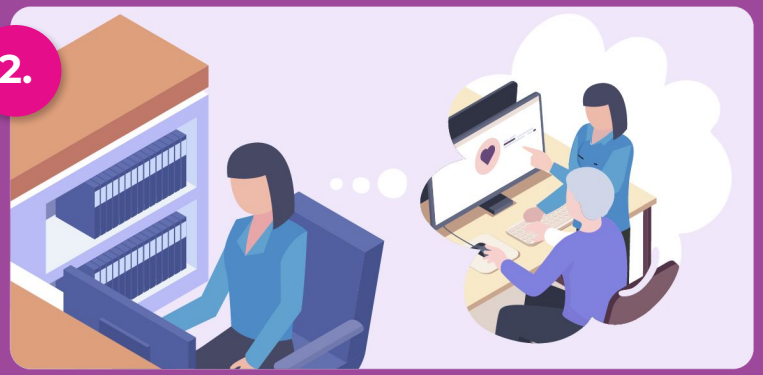
Persona: Mrs S

An elderly woman with multiple health conditions.

1.

Mrs. S calls her GP - the receptionist tells her she needs to book an appointment online.

2.



Following training, the receptionist recognizes that Mrs. S might have difficulty understanding or need assistance with the online booking process.

3.

During the appointment, the GP assesses Mrs. S's health by discussing her lifestyle, support network, and potential risks of living alone.

4.

Mrs. S talks about the closure of the community centre and the GP recommends a few other in person meetups in the area that Mrs. S might like to join.

5.

Mrs. S then heads to the pharmacy to buy the medicines that were prescribed to her by the GP where she is informed that there is a long queue.

6.

Having undergone training, the pharmacist is alert to the fact that waiting 50 minutes might be challenging for Mrs. S. She's able to offer her the option to have her medicine delivered.

Care Buddies

A volunteer programme pairing individuals needing care with local people equipped with the skills and knowledge to help navigate the system and provide support.

Persona: Mr. T

Elderly person with multiple health conditions, who lives at home on his own.

1.

Mr T contacts the GP to make an appointment. After waiting for 12 minutes, they get told by the receptionist that all appointments need to be booked online via the app. The link to register for the app is sent to Mr T's phone.

2.

Mr T clicks the link on his phone but the page doesn't immediately load and he doesn't know what to do beyond this.

3.

Mr T remembers receiving the council magazine at the weekend, with the Care Buddies advert.

4.

Mr T gives the number on the advert a call. After no response they contact his niece / or next of kin. Next of kin then arranges a meeting with Joe, the care buddy.

5.

Joe, the care buddy, meets with Mr T.

6.

Finally, Mr T is getting the support he needs to download the app and book the appointment online with Joe, the care buddy's support.