IVAR we listen, and learn together

How we're connecting health communities

in Barnet & Enfield, Birmingham, Leicester & Leicestershire and Somerset

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CONNECTING HEALTH COMMUNITIES with IVAR

Introduction

Four areas are currently taking part in the Connecting Health Communities (CHC) initiative to address health inequalities through cross-sector partnership working that involves local people in the design and delivery of services: *Barnet and Enfield*; *Birmingham*; *Leicester and Leicestershire*; *and Somerset*.

Challenge-Action-Outcome statements

We have developed a series of 'Challenge-Action-Outcome' statements to describe each area's plans as of July 2025. The statements will adapt and change as the local partnerships' work evolves, in conversation with varied stakeholders.

The purpose of these statements is to inform the local areas about the work happening in the other CHC areas. It is also a document that helps shape the focus of the work and actions in each area.

Find more information about Connecting Health Communities on our website.

Barnet and Enfield

Challenge

Barnet and Enfield are two boroughs on the outskirts of North London. They are both part of the North and Central London Integrated Care System (ICS), along with Camden, Haringey and Islington. Barnet has approximately 389,000 residents, of which 13% are disabled under the Equality Act. In Enfield (population 330,000), a similar proportion of residents (14%) reported having a disability or long-term health problem (Census 2021).

Disabled people in Barnet and Enfield are facing barriers in accessing secondary care, in part due to them not receiving the reasonable adjustments they require to get care. The focus of CHC Enfield and Barnet is on:

1. Co-designing and co-producing solutions with disabled people to tackle common barriers they face in accessing secondary care (with a particular focus on reasonable adjustments).
2. Exploring how the solutions identified can then be consistently implemented by secondary care providers across Enfield and Barnet.[1]

Disability and health inequalities in Barnet and Enfield

Within the health system, there is an awareness that disabled people often are not able to access the level of care they need in primary and secondary care, often due to information and services not being made accessible. The additional barriers to accessing healthcare encountered by disabled people are caused by: the way that information is provided; inaccessible venues; reasonable adjustments not being met; and patients not being involved in decisions on their care.

There has been a recent approach in the NHS to tackle these inequalities. For example, the NHS digital reasonable adjustments flag attempts to record people's disabilities and the accommodations they need. However, this isn't linked in with other NHS digital systems, and it can be difficult to deliver reasonable adjustments in a systematic way – particularly as every patient's reasonable adjustments are unique to them.

> *'Often, we tell our patients what is reasonable rather than the other way round.'*
>
> *– Macius Kurowski: Royal Free London NHS Foundation Trust, Group Head of Equality Diversity and Inclusion*

1 This work is concerned with four hospitals in the Royal Free Trust across Barnet and Enfield: Barnet Hospital, Chase Farm Hospital, Royal Free Hospital and North Middlesex University Hospital.

Approach to disability and reasonable adjustments

In the context of this work, we agreed to use the equality act definition of disability : *a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.*

The steering group also decided to use the Equality Act definition of reasonable adjustment: *changes in approach or provision to ensure that services are accessible to disabled people as well as everybody else*.

There was agreement to apply the social model of disability to this work, rather than focusing on certain disabilities or health conditions. This approach has been taken to address the structural issues that cause barriers to accessing care to avoid 'medicalising' the issue.

While we acknowledge that there are some constraints to the Equality Act's definition of disability − because it relies on people recognising their condition as a 'disability' − we agreed that the pros outweighed the cons. Including people in this work who self-identify themselves as disabled means that we can include those who do not have a diagnosis but still face barriers due to their disability. Using the Equality Act definition also means that outcomes from this work will sit alongside other ongoing work in the health system.

Having a shared definition of disability will also help us to measure the success of this work. However, it is important to recognise that each person's understanding of their disability or health condition is unique to them.

Approach to cross-sector collaboration

> *'We have structures in place to make a difference, and this project would give us a good vehicle.'*
> *– Steering group member*

Currently, there are 'pockets of excellent practice' when it comes to cross-sector collaboration and working with the community. However, there is some criticism that when working with the voluntary sector, the NHS tends to be too clinical, too target-driven and too keen to replicate NHS approaches rather than learning from the voluntary sector. As one steering group member told us, when working with the community, the NHS *'expect people to come to us'* rather than going to where the community is and co-producing solutions.

It is important that this work holds collaboration and co-production at its centre. Rather than replicating NHS approaches, we need to start by truly understanding the challenges and barriers that disabled people face, by engaging directly with disabled people and working closely with disabled groups. It is also important to understand what is already happening in community groups and build on this.

Action

The key aspiration of Barnet and Enfield's engagement in the Connecting Health Communities programme is delivering a collaborative approach that avoids repetition and leads to real action. The steering group has decided to focus on urgent care facilities in the hope that some of what is learnt and the actions generated can also be replicated in other care settings. This will be done by working collaboratively with disabled people, carers and healthcare practitioners to understand and co-produce their reasonable adjustment needs.

Some of the potential actions discussed by the steering group can form part of the discussions at the first partnership session once we have heard more about the specific barriers that patients face:

- Informing/educating disabled people and carers on their right to ask for reasonable adjustments and giving some examples on what these could look like.
- Guidance for disabled people and carers on how to ask practitioners for reasonable adjustments (e.g. principles on how to ask questions, similar to the B.R.A.I.N decision-making tool in maternity services).
- Training staff and practitioners on the reasonable adjustments available to people.
- Guidance for healthcare staff on how to respond and adapt to patients' requests for reasonable adjustments.

Desired outcomes

The goal for this work is that disabled people can access secondary care in a way that works for them and have a consistent and positive experience in their engagement with secondary care services.

Potential outcomes mentioned include:

- Disabled people more aware of their right to ask for reasonable adjustments, and what these could look like for them.
- Healthcare practitioners provide more information on reasonable adjustments and how to make these.
- Disabled people and practitioners are able to co-produce their access requirements.

Birmingham

Challenge

The Birmingham Sex Worker Health Needs Analysis (SWHNA) revealed that sex workers are at higher risk of many health problems than the general population, with regards both to sexual health and many other health conditions, with an 87% higher risk of being admitted to hospital for any condition compared to non-sex workers.[2] Health issues range from chronic kidney disease, poor dental health and higher rates of STIs to chronic stress, anxiety and post-traumatic stress disorder (PTSD).

This growing population experiences significant health inequalities. They are more likely to be part of already marginalised groups – including people from diverse ethnic backgrounds; people from LGBT+ communities; people with disabilities, including learning difficulties; and those affected by substance misuse and/or homelessness – which has limited their access to employment.[3] They face a number of issues in accessing services, including sexual health, substance misuse, mental health (often related to trauma and its effects including complex PTSD), screening programmes and other interventions.

2 *Sex Worker Health Needs Analysis*, Birmingham City Council, Public Health, April 2024.
3 Ibid.

Where services are provided, they focus primarily on sexual health needs without consideration of additional physical and mental health needs. A lack of streamlining may lead to further traumatisation due to sex workers having to tell their stories to services repeatedly. The main barriers to accessing services include stigma and fear of judgment, worries about safety, and potential legal discrimination if they disclose their job. These challenges span socioeconomic, safety and societal dynamics, stemming from feeling isolated, experiencing abuse (domestic or sexual), being forced into their situation, or lacking other skills and confidence. However, sex workers want and need the same level of access to services as everyone else.

Why sex workers need to be a priority

After adjusting for age, sex, ethnicity and deprivation, sex work is associated with an increased risk of many health-related outcomes in primary care. Birmingham's SWHNA showed that sex workers were more likely to smoke and use drugs compared to non-sex workers. There is a twenty-fold risk of having a mental health disorder or STI, seven times the risk of self-harm and a five-times greater likelihood of early death. These findings underscore the need to address the stark inequalities in health experienced by sex workers nationally.[4]

> *'People need to be fighting for sex workers, they need stability.'*
>
> *– Steering group member*

While sex workers constitute a relatively small number of people (though this number is likely to be underestimated as sex workers are rarely identifiable within service data), they require a disproportionately high level of access to support services. In addition, current practices keep sex workers in 'crisis mode', contributing to ongoing costs to the system while providing limited support. Due to the multiple, highly complex needs of sex workers, there is an urgent need for specialised, holistic approaches.

Action

A cross-sector partnership led by Public Health and made up of local health and care services, community safety, and the voluntary sector[5] is working collaboratively to transform how health and other services can better support sex workers. The partnership aims to improve the health inequalities for all sex workers in Birmingham but the focus of the work is specifically on those at the highest risk: street-based sex workers or sex workers working through face-to-face engagements.

4 Ibid, page 39.

5 Birmingham City Council: Public Health, Department of Health and Social Care, Housing, Birmingham and Solihull Integrated Care Board, Turnaround, Emerging Futures, Change Grow Live, Embrace, West Midlands Police, University of Birmingham, Umbrella Sexual Health, Birmingham and Solihull Mental Health NHS Foundation Trust.

The partnership is building on a foundation of previous work. The Sex Worker Health Needs Analysis mentioned above was published in April 2024 as an output from the partnership between the Inclusion Health Team, Public Health, Birmingham City Council, and the University of Birmingham. This work to reduce health inequalities for sex workers and other inclusion health populations is driven by the Birmingham and Solihull Inclusion Health Partnership with oversight from the Birmingham Health and Wellbeing Board and links to the BSol Integrated Care System (ICS), supporting the delivery of the ICS ambitions for inclusion health populations.

> *'It can take years for somebody to trust someone that they see every week because of their experiences. You have to look long term in this area. You can't ever look short term.'*
>
> *– Steering group member*

Common priorities

The partnership has identified a number of recommendations and priorities that draw on the SWHNA as well as continued consultation with group members.

Support services

- **Understanding best practice:** Learning where sex workers and other vulnerable groups are already well supported and how to identify the opportunities and areas for improvement.
- **Extending and maintaining outreach:** The ability of organisations to build relationships with sex workers and be trusted is very important and should be fully supported. The evidence demonstrates that assertive outreach is needed to support their health and wellbeing needs.
- **Reducing the risk of the work:** Ensuring that sex workers can work without fear of harm, reporting instances of harassment, assault and/or sexual violence without fear of legal discrimination.
- **Access to drug treatment, STI testing, specialist mental health support and more clinical interventions that will reduce the risks for sex workers.**
- **Connecting services:** Enabling better communication and collaboration between services so that sex workers can be better supported across their diverse needs.
- **Safe places** where women can come and feel safe, protected, and can access the support they need.
- **Support and healthcare for violence:** there is a need to ensure that sex workers can access support and healthcare for violence (including sexual violence) without fear of stigma and judgement.

Training

- **Reducing stigma:** Sex workers need to be supported and able to have conversations that are free from judgement. It requires a system-wide approach to raising awareness of the context and unique experiences and needs of sex workers to enable effective coordinated support. This includes developing/embedding shame competency, cultural humility and trauma-informed approaches in both commissioning policies and front-line practice.
- **Building on previous training:** Turnaround Project CIC was previously commissioned by the West Midlands Office of the Police and Crime Commissioner (OPCC) to deliver across the system. The West Midlands Combined Authority developed a comprehensive Trauma Informed Framework and training resources for trauma aware, informed and responsive commissioning and practice.

Record keeping

- **Improving record keeping and data collection:** There is a need to improve data collection to build a robust evidence base and enable better understanding of this vulnerable group ('If you're not counted, you don't count'), and for effective record sharing to reduce the number of times they have to tell their stories.

Additional priorities for support services

- Better housing options.
- Peer-led services and support.
- Targeted mental and physical health support, including a single wellness appointment.
- Increasing legal and justice options and support (including framing sex work as work and not crime, and increasing access to labour protections to make it safer and fairer).

Including sex workers and their lived experiences

The partnership has established a sub-group to ensure that the lived experiences of sex workers continue to inform the work in a meaningful way. These are the aims for including lived experience:

1. Work with the voluntary sector to engage with sex workers who trust them.
2. Understand what the partnership wants from sex workers in sharing their experiences, and communicate clearly why it's needed.
3. Value and recognise sex workers for their time and expertise advising programmes of work.
4. Ensure a diverse group of sex workers is included.
5. Ensure that feedback and progress is communicated back to those who have shared their experiences.

Desired outcomes

The partnership is keen to develop *'a sustainable model that will work'* for sex workers in Birmingham. This includes changes to the system and mainstreaming sex workers into services, as *'things can't stay the same'*. While recognising the need to address the system and the needs of sex workers holistically, the partnership is also focused on *'practical and possible outcomes'*. There is a *'willingness to be bold'*.

> *'I have more understanding of the barriers and support for sex workers'*
> *– Workshop participant*

Partnership working has already been strengthened through the partnership group and the first multi-sector workshop. Initial steps are being taken but several longer-term goals have been identified:

1. Integrated service models (health, housing, justice, social care).
2. Improve multi-agency communication and data-sharing agreements.
3. Support from those with lived experience to inform service design and delivery.
4. Embed trauma-informed practice across all services.
5. Tackle systemic stigma in society and services through long-term public messaging.
6. Invest in sustainable housing services tailored to vulnerable populations including sex workers.
7. Preventative work in childhood − e.g. ACEs (Adverse Childhood Experiences), instability, early abuse − to break the cycle.

Leicester and Leicestershire

Challenge

Homelessness continues to grow in both scale and complexity, with Leicester City[6] seeing the highest levels, closely followed by Charnwood in Leicestershire[7]. Leicester has seen a 135% rise in rough sleeping from autumn 2023−2024[8] as compared to the national 20% increase, and local drivers like cost-of-living pressures and limited support are some of the challenges. Charnwood has the highest homelessness rate in Leicestershire at one in 496 people, surpassing the county average of one in 509, with a high number of children in temporary accommodation, highlighting hidden homelessness and acute local pressures.[9]

Individuals experiencing homelessness in these areas face persistent and complex health inequalities, with a 30-year gap in life expectancy compared to the general population.[10] People with lived experience emphasise that *'health is rarely a priority when you're overwhelmed'*. Services can be challenging to navigate, especially for individuals living with the trauma, instability and stigma associated with homelessness. While many organisations are doing good work, these efforts can feel disconnected, leaving people to fall through the gaps.

6 Homelessness Services Update Report
7 Leicestershire Joint Strategic Needs Assessment – Housing (2018-2021)
8 Leicester's Homelessness Strategy for 2023-2027
9 Shelter report in Leicestershire
10 Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England

'Services are often fragmented, difficult to access, and shaped more by system constraints than by individual needs.'

– Steering group member

In **Leicester City**, services like the Dawn Centre are long established, but there are challenges in developing and embedding flexible, person-centred approaches that consistently meet people's needs where they are. Meanwhile, in Charnwood and the wider county, rurality and geographical dispersal add layers of complexity along with unreliable transport. Those placed in temporary accommodation are often far from existing services, disconnected from networks of care, and left navigating the system alone.

Structural barriers, like lack of ID and early morning clinics, contribute to missed appointments. These challenges are compounded by judgemental attitudes, and a clear lack of continuity and trust between services, particularly when people are passed from one agency to another without a consistent point of contact. The poorer outcomes resulting from these challenges lead to increased illness, distress, trauma, and earlier death among people experiencing homelessness. They also place additional strain on health and care systems and the people working within them.

'Homelessness is always immediate ... it's always on the spot and often recurrent because they're not getting their health needs met on a regular basis.'

– Steering group member

Action

A cross-sector partnership made of voluntary sector, local authorities and NHS organisations[11] is working collaboratively to transform how health and housing services work for people experiencing homelessness across Leicester and Leicestershire. Their working vision is to establish **accessible and tailored support for individuals experiencing homelessness, based on a multi-agency approach and building on existing work in Leicester and Leicestershire**. This approach commits to addressing health inequalities through practical action, collaboration and proactive prevention, focusing on measurable progress to improve wellbeing.

11 Falcon Support Services, Leicester and Leicestershire Integrated Care Board, Inclusion Healthcare, Leicester City Council Public Health, Leicester's Homelessness Charter, Leicester City Council, Charnwood County Council, Blaby District Council, University Hospitals of Leicester, Leicestershire Partnership NHS Trust and Doncaster Road Dental Practice.

> *'The focus is not on solving homelessness as a whole but on addressing health inequalities faced by people experiencing homelessness.'*
>
> *– Steering group member*

The early focus areas, co-developed through Workshop one and steering group discussions and being taken forward by working groups, are:

1. Designing an integrated and flexible hub model

- **In Leicester City**, partners are working to refurbish and establish the **Dawn Centre** as a multi-agency hub where health, housing, and wellbeing services are offered in a trauma-informed, person-centred way using drop-in services. This is consistent with the steering group's call for tangible progress and consistent, joined-up services, and is a great opportunity to maximise and learn from this renewed vision for the centre, which places co-production, dignity and empowerment at the heart of service delivery.

> *'Appreciate the good work already happening but be bold enough to build something better.'*
>
> *– Workshop participant*

- **In Charnwood**, the aim is to **adapt this model to a rural setting**, using the Falcon Centre as a base for co-designed services. A mapping exercise is planned to understand where gaps lie. Initially, suggestions are to do this through regular multi-agency pop-ups (e.g. on the same day each month) to build routine, trust, and visibility.
- A working group is developing consistent principles and checklists for trauma-informed, person-centred service delivery, addressing quick wins and practical solutions that remove immediate barriers (e.g. access to GPs without having a fixed address).

2. Prioritising oral health

- Across both areas, oral health has emerged as a critical and neglected need and is recognised as a *'hidden inequality'*. Partners are exploring models like mobile dental services, oral health drop-ins, and embedding oral care into wider health checks.
- A working group is exploring mobile clinics and partnerships with dental practices and dental schools to lead this work. A focus could be integrating oral health provision within housing hubs and drop-in services to normalise dental care as part of holistic health support.

3. Embedding health into housing

- Recognising that housing is a wider determinant of health, the group is identifying how temporary accommodation and housing offers can support access to care, especially for those placed far from services.
- Plans include advocating for wraparound support that integrates mental health, substance use and physical healthcare into housing provision.

> *'By improving access, integrating health services and embracing diversity, we create systems where everyone, regardless of their circumstances, can thrive.'*
>
> *– Steering group member*

4. Building trust through relationships, lived experience and peer support

The group is exploring 'trusted person' models and peer-led support approaches to build consistency and reduce disengagement.

- This action responds to the steering group's call to prioritise diverse forms of lived experience across mental and physical health, substance misuse and housing, and to address the challenge of constant staff turnover by developing consistent training and progression pathways. These steps aim to build trust, strengthen engagement, and avoid the frustration of uncoordinated efforts.
- One strand of this is about developing cross-sector training and supervision pathways for peer mentors with diverse lived experiences (e.g. health, substance misuse, housing). Another is collaboratively creating standards for trauma-informed, inclusive support that connects people with lived experience to paid and volunteer opportunities.

5. Commissioning, social value and aligning systems and training

- Another working group is exploring how to embed lived experience and social value into commissioning processes by incorporating co-production, trauma-informed standards, and inclusive training.
- This reflects the steering group's insight that commissioning is key to translating ideas into action, ensuring resourcing and accountability, and avoiding the pitfalls of promising ideas that are not funded or implemented.
- Aligning commissioning with social value causes also creates opportunities for peer mentors and apprenticeships, supporting sustained systemic change.

Workshop one highlighted the need for ethical, secure **information sharing**, consistent messaging, and joint training in trauma-informed practice. There is a need for the continuous involvement of commissioners across all strands to secure funding and align decision-making with lived experience priorities. The steering group is committed to:

- **Developing an evidence base**, beginning with a health audit and service mapping in Charnwood, to inform the following steps and measure future impact.
- Establishing shared protocols for information sharing and case management across health, housing, and voluntary sectors is key. Additionally, this strand will deliver joint trauma-informed training for staff in all sectors, co-designed and co-delivered by people with lived experience.

> *'This is about joint working – bringing money, services, and people together in one place.'*
>
> *– Steering group member*

Desired outcomes

1. **Inclusive, accessible health services**, responsive to the real-world experiences of people facing homelessness. **Services are shaped around people's lives**, not the other way around − delivered where they are or want to be, with warmth and dignity.
2. **A joined-up approach** between housing, health, and voluntary sectors, reducing duplication and fragmentation and offering wraparound support.

> *'The dream is that everybody knows what they are part of and there is nobody trying to outdo somebody else, and all the gaps of provision are dealt with.'*
>
> *– Participant at a partnership workshop*

3. **Trusted, trauma-informed environments** − including hub models in both Leicester City and Charnwood – that feel safe, welcoming, and clear in their offer.
4. **Consistent, well-used oral health provision** – accessible, non-judgmental, and co-located with other services.
5. **Stronger, community-led support** through peer navigators and recovery networks.

6. **Systemic change**, including data-sharing protocols, cross-sector training, and coordinated commissioning, aims to make the *'system more human'*, with trust, consistency and collaboration replacing fragmentation, judgement, and exclusion.
7. **Lived experience at the centre**, not as *'tokenism or an add-on'* but as leadership, guiding design, delivery, and accountability.

Overall, this work is not about solving homelessness outright but improving health and dignity for those experiencing it:

> *'It is a long-term commitment to breaking cycles of exclusion and reshaping how services connect around people.'*
> *– Steering group member*

Somerset

Challenge

Somerset has significant challenges when it comes to transfer of care, or hospital discharge, compared to the rest of the England. Somerset ranks 100 out of 120 trusts when it comes to delays in transferring care from acute hospital or community settings.[12] This means there are a high number of patients in bedded care settings − for example in hospitals − who do not meet the criteria for them to be there.

> *'… discharge is a huge issue. We [Somerset] are an outlier in terms of the number of people we've got in acute hospital beds and in community beds, to an extent where they don't need to be there anymore … from a system point of view, it's causing us all sorts of challenges in terms of patient flow through the system, bed occupancy, and the risks that come with that as well.'*
>
> *– Steering group member*

12 https://oursomerset.org.uk/wp-content/uploads/Somersets-Joint-Forward-Plan-Refresh-FINAL-05.07.24.pdf

The challenge of hospital transfer of care is prominent across sectors – mental health, acute, and intermediate care (community hospitals and care homes). Potential risks of delayed hospital transfer of care have been well reported and include:

- Harm to patients as they are not in an appropriate setting for their needs, which in turn results in deconditioning, increased risk of harm and increased ongoing care needs.
- Too many people in bedded care services, causing inefficiency and increased safety risks.
- Excess costs for all parts of the health and care system over the short and long term.[13]

> *It is important patients are cared for in the right setting once their acute care needs (both physical and mental health) have been met and they no longer need to be in an acute hospital or mental health inpatient setting (including hospital at home). In the majority of cases this will be in the patient's own home, potentially with support. It is, however, recognised that some patients will not be able to return home, either whilst they undergo a period of reablement or permanently.'*
>
> *– Somerset Five Year Joint Forward Plan 2024*

The Connecting Health Communities in Somerset steering group recognised the unique challenges faced by individuals living with dementia during their transition from hospital to home or other care settings.

The types of challenges people living with dementia might face include:

- Limited community awareness of dementia and available services.
- Carers having to repeat patients' stories and not feeling listened to.
- Patients feeling lonely due to lack of family presence.
- Inaccessible or fragmented patient information across systems.
- Failure to involve the right individuals in transfer of care planning.

The focus of this work is to **improve the transfer of care process and the experience of transfer of care** for people with dementia, from the perspective of the person and their family/ caregivers, the teams that support them and the wider system. The hope is that the learning from this work will be used to inform transfer of care processes for other groups.

13 Ibid.

Action

A cross-sector partnership[14] is working collaboratively to transform the hospital transfer of care process for people living with dementia across Somerset. Their working vision for this work is to develop a scalable approach to improve hospital transfer of care experiences for people with dementia, informed by patient, family, caregiver, and health system perspectives. This approach commits to:

- **Building on the energy from the hospital transfer of care side** to think about looking outwards − *'Look at flow (moving people from discharge to different places)'* − and wanting to make sure this space is replicated in pathway zero 1 and 2 for populations that don't have capacity.
- **Developing an approach to transfer of care that is scalable and spreadable** to support other health inequalities currently facing adverse discharge outcomes.

The early focus areas, co-developed through partnership Workshop one and steering group discussions are:

1. **Support for families and carers throughout the different stages of a person's journey between hospital and their home by:** providing time, resources and a space to listen to families and carers; highlighting the importance of Power of Attorney and the dementia passport (outlining the views and wishes of the patient).
2. **Creating more reliable transport:** Looking at how to create shorter time frames and avoid long wait times in discharge lounges; preparing and thinking about timing and communication.
3. **Understanding a person's history to judge the level of care needed:** By having a shared information system to understand the work that has already happened and for stakeholders to be fully educated about how to use this system.
4. **Developing trusted, consistent relationships:** Identify a single point of contact within the system, e.g. who holds the patient's story, shared data, avoiding moving patients around and having safe handovers.
5. **Streamlining and clarifying roles around transfer of care:** Consistent communication coordinated by a single point of access to reduce duplication and confusion of roles/ responsibilities will streamline discharge.
6. **Early planning for transfer of care involving family, carers, community, services:** Education/map of what is available to support transfer of care planning for the multidisciplinary team and an allocated dementia support worker to advocate for this process.
7. **Understanding, awareness, education:** Awareness of the dementia and delirium team and its criteria for healthcare professionals and carers; education in when to admit to emergency department and rapid response and SWAST − the regional ambulance service − to prevent admissions in the first place.
8. **Admission avoidance:** By identifying formal diagnosis and educating the public about dementia through shared experiences.

14 NHS Somerset ICB, Somerset Activity and Sports Partnership (SASP), Dementia Service, Spark Somerset, Community Council for Somerset, The Filo Project Somerset Foundation Trust, Somerset Foundation Trust and Somerset County Council

Desired outcomes

The following were articulated as some of the desired outcomes of Somerset's engagement in the CHC programme:

Building and strengthening cross-sector relationships for ongoing work to tackle health inequalities in Somerset and establish a model of good practice *'to scale this up'* for working together in future. In particular, strengthening trust and communication with the voluntary and community sector to have an equal role in the system.

> *'It's a great time to be able to understand what the problem is, and for me, I guess you know the sort of communication and trust and being able to allow that wider community space to be part of the system.'*
>
> *– Steering group member*

Bringing in the voices of people with lived experience, including both patients and unpaid carers. Creating an environment where the unpaid carers feel listened to and their expertise and experience are equally valued.

> *'Some of the criticism is that our staff aren't listening to them as carers, because they're sort of saying there's a confidentiality issue and they can't talk to the carer about the patient's care. Well, there's some truth in the fact they potentially can't tell the carer certain things without consent, but it doesn't stop them listening to the carer, because the carer will know the individual very well ... The carer has got so much intelligence about how we best care for the patient that we're losing something if we're not having those conversations.'*
>
> *– Steering group member*

Improving the pathway for people living with dementia between hospital and home:

'To create a pathway that is person-centred ... and operational' to ensure individuals have the support they need at home to remain independent and safe, and prevent them from re-entering the system.

The pathway should be tailored for dementia patients and their carers, reducing bureaucracy, shifting funding to the individual and providing a creative, coordinated approach.

> *'This could be a really good way to predict on a larger scale, how much we could save the system supporting people in a different way.'*
>
> *– Steering group member*

More understanding and wider take-up of resources that are already available, including:

- Training on 'This is me' document to become a prominent part of hospital care and encourage families to complete and share.
- Dementia passport.
- Educate health professionals, carers and patients about dementia.
- Awareness of supporting services in community − dementia roadshows worked well.

Reducing admissions and length of stay: including safe transfer of care and carer support and facilitated by informed decisions from better information sharing and a key liaison person, e.g. dementia support worker.

Connecting Health Communities (CHC) in Somerset believes that a collaborative and partnership approach among healthcare providers, caregivers, and community resources is essential to ensure a seamless, supportive and successful transfer of care process.