Appendix 5: Action Plan

1. Communication, information and advice	
Outcomes	**Actions**
• People have the information and support that they need in order to remain as independent as possible. • People have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date. • People will be able to speak to someone who knows something about care and support and can make things happen. • People have help to make informed choices if they need and want it. • People know where to get information about what is going on in their community.	We will develop a bespoke communications strategy to: • help citizens maximise their own well-being • know who they can go to in their own community to seek solutions • change behaviours that cause system challenge such as going to A and E when not in urgent need
	We will provide free information, linked to local and community information sources such as GP surgeries.
	We will ensure that there are skilled and culturally sensitive advisory services available to help people access support, and to think through their options and secure solutions.
	We will make a range of information sources available to meet individual communication needs, including Deaf people and the use of interactive technology which encourage an active dialogue and empower individuals to make their own choices.
	We will work with local user led organisations, disabled people's and carers' organisations, self-advocacy and peer support to provide advice and support locally.
	We will ensure that there is local, consistent information and support that relates to legislation around recruitment, employment and management of personal assistants and other personal staff.
2. Active and supportive communities	
Outcomes	**Actions**
• People have access to a range of support that helps them to live the life they want and remain a contributing member of their community. • People have a network of people who support them – carers, family, friends, community and if needed paid support staff. • People have opportunities to train, study,	We will use local area coordinators to support people to access a range of networks, relationships and activities to maximise independence, health and well-being and community connections.
	We will use asset-based community development (ABCD) to invest in community activity and community based care and support, which involves and is contributed to by people who use services, their families and carers.
	We will make programmes available such as Livewell that maximise people's health and well- being and enable them to recover and stay well.

work or engage in activities that match their interests, skills, abilities. • People feel welcomed and included in their local community and feel valued for the contribution that they can make.	We will shift resources towards supportive community activity. Longer term community support and not just immediate crisis will be considered and planned for.
	We will support both people and carers to achieve and sustain employment if they are able to work.
	We will develop 'Winter Plans', in the first instance, for people aged 85 and over.
3. Flexible integrated care and support	
Outcomes	**Actions**
• People are in control of planning their own care and support. • People have care and support that is directed at them and responsive to their needs. • Peoples support is coordinated, co-operative and works well together and they know who to contact to get things changed. • People have a clear line of communication, action and follow up.	We will enable people who use services and carers to exercise the maximum possible choice over how they are supported and to direct the support delivered.
	We will make support genuinely available across a range of settings – starting with a person's own home or, where people choose, shared living arrangements or residential care.
	We will streamline our processes so that access to support is simple, rapid and proportionate to risk. Assessments will be kept to a minimum, are portable and do not cause difficulty or distress.
	We will ensure that people who access support and their carers, know what they are entitled to and who is responsible for doing what.
	We will continue to build collaborative relationships at all levels so that organisations work together to deliver high quality support.
	We will ensure that support is 'joined-up', so that people and carers do not experience delays in accessing support or fall between the gaps and that there are minimal disruptions when making changes.
	We will pre-plan and manage transition from childhood to adulthood support services so that support is centred on the individual, rather than services and organisational boundaries.
	We will ensure that both commissioners and providers of services enable people who access support to build their personal, social and support networks.
	We will participate fully in the Southern Derbyshire unit of planning system transformation and resilience and the Better Care programmes.
	We will integrate Council assessment, enablement and support planning staff with primary and community health service staff into Community Support Teams.

	We will use risk stratification intelligence to (a) identify and work with people living with long term conditions and (b) people who have a high level of A and E attendance in order to put in place strategies that stabilise their condition and support self-management.
	We will maximise the use of assistive technology.
	We will work with Derbyshire Healthcare Foundation Trust to improve the recovery of people with functional mental health problems.
	Review the number and configuration of beds used for recovery and rehabilitation.
	We will develop strong relationships with housing providers to ensure a supply of appropriate properties. Continue to develop extra care housing and other retirement property choices.
	We will ensure that there is a joined-up approach with the NHS on the monitoring of quality in nursing care, ensure a comprehensive approach to monitoring quality in residential care and develop a Gold Standard for dementia care.
4. Workforce	
Outcomes	**Actions**
• People have good information and advice about the range of options for choosing their support staff. • People have considerate support delivered by competent people. • People have access to a pool of people, advice on how to employ them and the opportunity to get advice from their peers. • People are supported by people who help them to make links in their local community.	We will support people who receive direct payments, self-funders and carers in the recruitment, employment and management of personal assistants and other personal staff including advice about legal issues. We will provide people using council managed personal budgets the maximum possible influence over choice of support staff.
	We will develop a different kind of workforce and ways of working, including new roles for workers who work across health and social care
	We will develop staff to have the values, attitude, motivation, confidence, training, supervision and tools required to facilitate the outcomes that people who use services and carers want for themselves.
	We will develop easy and accessible processes to enhance security and safety in the employment of staff.
	We will develop communities, networks and the workforce to become increasingly focused on and able to help people build and sustain community connections.
5. Risk enablement	
Outcomes	**Actions**
• People can plan ahead and keep control in	We will support people who use services and carers to weigh up risks and benefits,

a crisis. • People feel safe, and can live the life they want and that they are supported to manage any risks. • People feel that their community is a safe place to live and local people look out for them and each other. • People have systems in place so that they can get help at an early stage to avoid a crisis.	including planning for problems which may arise.
	We will manage risk in proportion to individual circumstances. Safeguarding approaches will be proportionate and coordinated so that everyone understands their role.
	Where they want and need it, people will be supported to manage their personal budget – or their own money for care and support (ie 'self-funders) and to maximise their opportunities and manage risk in a positive way.
	We will make good information and advice and easy ways to report concerns widely available, supported by public awareness-raising and accessible literature.
	We will inform people who use services and carers at the outset about what they should expect from services and how to raise any concerns if necessary.
6. Personal budgets and self-funding	
Outcomes	**Actions**
• People can decide the kind of support they need and when, where and how to receive it. • People know the amount of money available to them for care and support needs, and they can determine how this is used (their own money, direct payment, or a council managed personal budget). • People can get access to the money quickly without having to go through over-complicated procedures. • People are able to get skilled advice to plan their care and support, and also be given help to understand costs and make best use of the money involved where they want and need this.	We will give a personal budget to everyone eligible for on-going Council funded support. Direct payments will be the main way of taking a personal budget and good quality information and advice will be available to provide genuine and maximum choice and control.
	We will make sure that Council managed personal budgets offer genuine opportunities for real self- direction.
	We will make sure that people who use social care (whether people who use services or carers) are able to direct the available resource. Processes and restrictions on use of budget will be minimal.
	We will continue to build a market of diverse and culturally appropriate support and services that people who use services and carers can access. We will ensure that people have maximum choice and control over a range of good value, safe and high quality supports.
	We will give people who use services and carers information about options for the management of their personal budgets, including support through a trust, voluntary or other organisation.
	Self-funders will receive the information and advice that they need and be supported to have maximum choice and control.

	We will understand how people are spending their money on care and support, track the outcomes achieved with people using social care and carers and use this information to improve delivery.
7. Coproduction and collaboration	
Outcomes	**Actions**
• Groups of people get together to influence the way that services are designed, commissioned and delivered and are involved as equal partners. • People who use services and carers are valued by organisations as equal partners, can share power and have influence over decisions made. • People who use social care services (and their families) are recognised as having knowledge and experience that can be used to help make services better, not only for themselves but for other people who need social care.	We will involve people who use services, carers and their families in all aspects of a service – the planning, development and delivery.
	We will start small and build up to bigger projects, letting people lead, not professionals.
	We will recruit the right people to support co-production and develop them to be able to take a skilled role in the process.
	We will build on the work completed so far with the coproduction of the Your Life, Your Choice consultation consultations.
	We will work with our NHS partners to ensure that people are involved in coproduction across both health and social care.
	We will involve people in the recruitment of staff.
	We will involve people in auditing the quality and effectiveness of services.