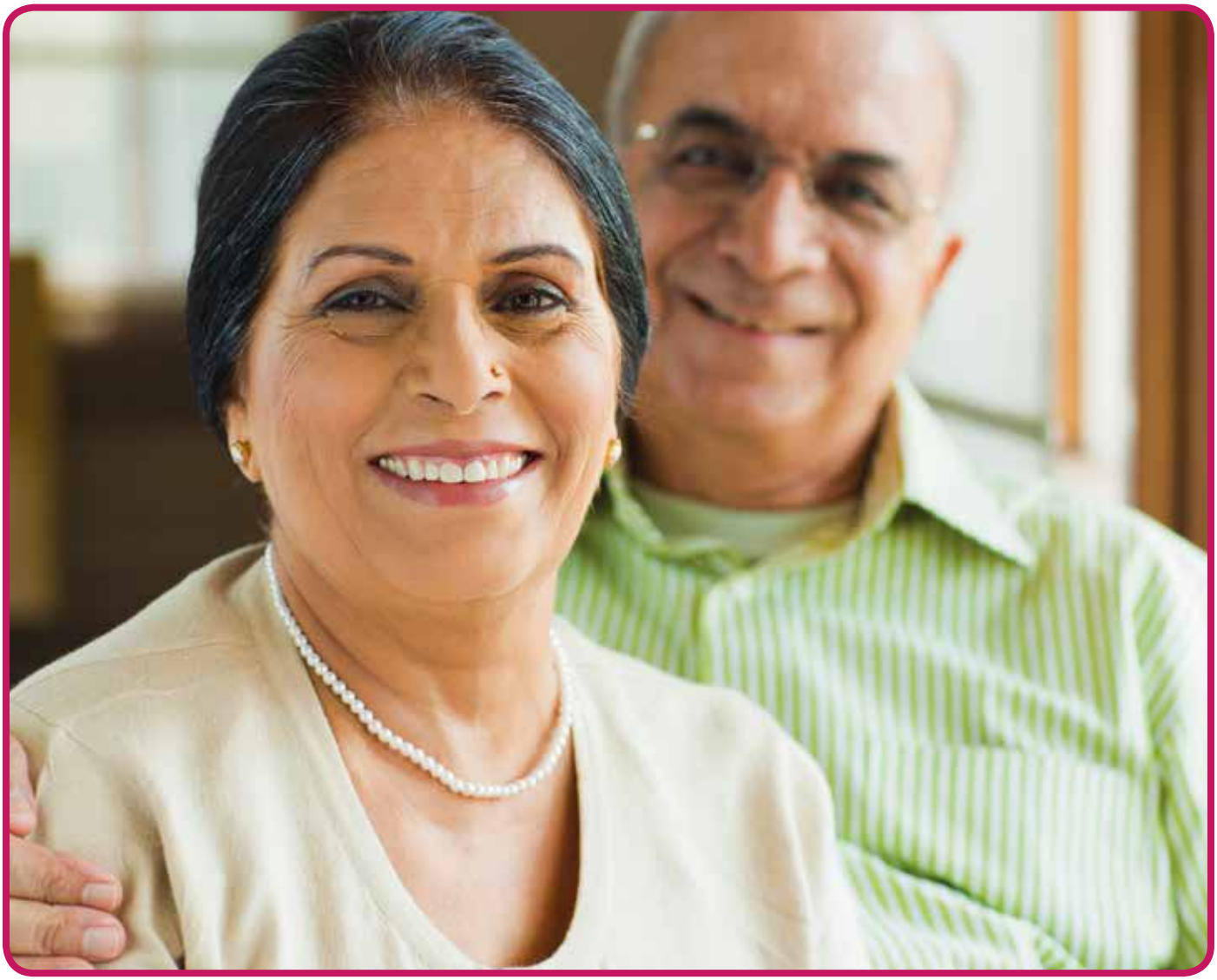


Your Life, Your Choice

Building the care and support we need in Derby

April 2015

Derby City Council

Adult social care is at cross-roads. With increasing need and less money we could, if we are not careful, resort to making it harder and harder for people to get the support they need. This would deny support to people who need it to live their lives feeling safe and with dignity. If we carry on doing things in the same way, we are worried we may fail people.

This paper shows how we will stop adult social care from becoming an emergency service and moves it closer to, and working with, individuals, families and communities in collaboration with our partners. We want to fundamentally change the current model of care and support to something that really works for Derby people.

The strategy seeks to focus our energy on what matters to people and acting swiftly to achieve it. We seek to build the systems, relationships and resources to support people to live lives that are meaningful and uphold their dignity. We want to ensure that support is provided as close to home and family as possible.

Our journey: what we are trying to achieve

The Council is delivering essential public services within less and less money. It is really important that we are clear about what we are trying to achieve for local people and where we are heading. As part of our work on personalisation we have been talking to Derby people to better understand what their experience of our service is like and whether we are focusing on the right things.

People told us that:

- It is sometimes difficult to get good advice and information in order to make informed decisions.
- When we make changes we do not always explain them very clearly.
- People can find it difficult to speak promptly to the person who can help them with their issue and waiting times at the "front door" are growing.
- They can sometimes feel passed around and have to tell their story again.
- The assessment process tends to focus on the things people can't do and misses out the strengths and things that they can do for themselves or they can do with help from family or friends.
- Our processes are over-bureaucratic and reduce the time staff can spend focusing on solutions.
- We are sometimes too quick to offer the usual menu of services rather than think through more creative, more personalised and often simpler solutions.
- We can get involved too late in a situation which makes it so much harder to find a good solution.

Having thought about what people have said to us, we have identified what we think we need to do to make things better. This can be summarised as:

- Our starting point is focusing on people's strengths, skills and assets – as individuals, within their families and as part of their community.
- Having different conversations with individuals around "what does a good life look like to you" and "how can we work together to find solutions"?
- Redesigning our "front end" so people can speak to someone who can assist them straightaway.
- Thinking about how we can help earlier on and who is the best person or partner to do this.
- Making the focus of social work assessment and review not support planning as people can do this with their family and friends.
- Building much stronger partnerships with primary and community health services.
- Making every part of our system work well to support people's independence, recovery and rehabilitation.
- Working with partners to ensure no one goes unnecessarily to hospital or into long term care.
- Building a culture that supports creativity and innovation - removing the barriers that hold citizens and our staff back.
- Finding new ways to engage with individuals, families and communities to deliver services differently.

The failure to find new solutions is potentially a high one. We need to do things differently so that we can give people the support they need within the money we have to spend.

We will now set out our purpose, principles and three year strategy.

Our purpose, principles and approach

"Our vision for people in Derby is that they have the right support so they can live happy, fulfilling and independent lives"

This is under-pinned by the following principles:

1. Self determination – each person should be in control of their own life and, if they need help with decisions, those decisions are kept as close as possible to them.
2. Direction – each person should have their own goals and aspirations and a sense of purpose to help give their life meaning and significance.
3. Money – each person should have enough money to live an independent life and are not unduly dependent upon others.
4. Home – each person should have a home that is their own, living with people that they really want to live with.
5. Support – each person should get support that helps them to live their own life and which is under their control.
6. Community Life – each person should be able to fully participate in their community.
7. We will maximise the opportunities for people to learn or re-gain the skills to be as independent as possible.
8. Everyone should be able to contribute to family and community life.
9. Rights – each person should have their legal and civil rights respected and be able to take action if they are not.
10. Responsibilities – each person should exercise responsibility in their own lives and be able to make a contribution to their community.
11. Assurance – people can have confidence in the quality of the services the Council commissions or provides directly itself.

Our promise to people is:

- We will listen carefully to understand what makes a good life for you.
- We will communicate clearly and in a way that works best for you.
- We will listen to, and value, what you, your family, your friends and your community say.
- The focus of our help will be to find solutions.
- We will work with you at a pace that is right for you.
- We will actively engage with our local communities, support networks and partners to develop alternative solutions for people.
- You will only have to tell your story once and we will make sure our systems and procedures support that.
- We will ask your permission upfront to share information to help keep you safe and well.
- We will empower our front-line staff to design different solutions with you.
- Only by exception will you go into long term care from an acute hospital bed.
- Keeping you safe is really important and we will work together with you and other people and organisations to keep you safe in a way that works for you.
- We will work fairly within our resources.
- We will actively work with our partners to take away the things that get in the way of helping people.

Our approach will operate at four levels:

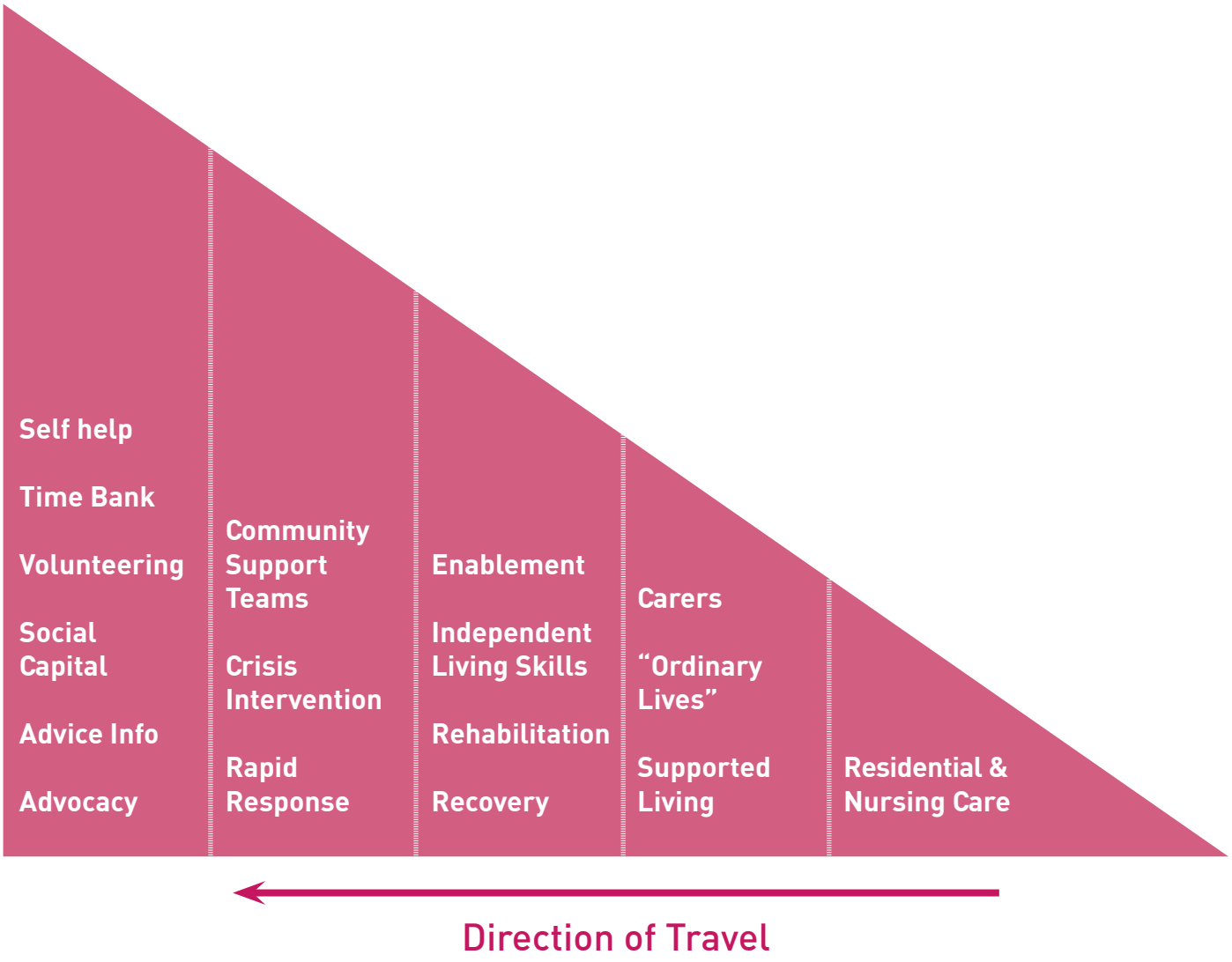
(i) At the community level: building resilient individuals, families and communities.

(ii) At individual practice level: working in a different way to help individuals and their families find solutions that build on their strengths, skills and assets.

(iii) At the service level: building flexible, empowering and responsive services that are delivered in new and innovative ways.

(iv) At whole systems level: recognising that part of the solution to our challenge rests in working in partnership with our colleagues in the wider public and private sectors. We need to all work together to create local solutions across health and social care to manage demand pressures and to keep people safe and well.

The Council has worked with local partners to set this out in picture form, represented by the "Care and Support wedge".



Our hope is that, as much as possible, people find the support they need on the left hand side of the "wedge" and the money and people shift from the right to the left side of the system to make this happen. However, there is much to do in order to achieve this.

So what do we think Derby would look like in five years time – Better Care Together

Health and social care services have worked together to look at how we can transform care to better meet people's needs. We wrote this up in a plan as part of the national Better Care Fund initiative. Set out below is what we think a better health and social care system will look like in three years' time:

In three years' time we will have empowered Derby citizens to be able to get information on a range of subjects that promote their independence and that helps them to manage their long term condition/ risk to independence. They will be supported in this through a good network of family, friends and people in the community. Increased volunteering will make a valuable contribution to tackling social isolation and increasing informal forms of support.

The number of local people willing to help each other will have increased through the work of the Local Area Co-ordinators and our voluntary, community and faith sector. The involvement of local businesses and workers will have increased and people wanting to offer help to others will be able to make informed decisions about donating through the Vital Signs charitable giving guide.

Every older person aged 85+ will be offered the opportunity to have an individualised "winter plan". This means that if they get snowed in, or become poorly and need someone to fetch their prescription or get them some bread and milk, we will link them up with someone who will do that for them. Every person with a serious mental illness will have a Wellness Recovery Action Plan (WRAP) that sets out how they can help themselves, or get help when more unwell. Getting help will be easy and dynamic, increasing and decreasing in response to a person's changing needs.

Carers will be more involved in planning services to help us get it right first time. Informal carers will be supported to continue their caring role for as long as they feel able or wish to. They will receive a carers' assessment and from this they will get the support they need to prevent carer breakdown. Spending more money on carer emergency plans will reduce the number of 'cared for' people being admitted to hospital or a care home following a carer crisis. Clear pathways of support for the carer will reduce carer stress and the need for even more funded support from the NHS or local authority. There will be continued support to carers who support people with dementia and other mental health conditions.

The Community Support Teams (created by putting together social work, primary and community health services) will be at the heart of how we support people in the community and will cover both physical and mental ill-health. They will work closely with the Local Area Co-ordinators. They will help more people to remain living at home. They will especially work with people who have to go to hospital a lot. The Community Support teams will work with people who have lots of things that affect their health and that won't get better - we call these "long term conditions".

Some people have other things happening in their lives such a loved one dying that makes it hard for them to stay independent. We want to work much earlier on with people at risk of losing their independence to help them have the best possible quality of life under the circumstances. Working with peer educators and citizen leaders will be a key part of this work as will making the most of health and social care personal budgets. There will be close working between Community Support Teams and Care Homes for any person who does need a short stay in a care home or community hospital.

Doctors/ GPs will be an integral part of Community Support Teams and provide clinical leadership. Practices will be working together to provide a wider range of services within each geographical area than is currently the case.

These teams will be complemented by a rapid response service which doctors can get by making one phone call. GPs will have confidence in this because it guarantees it will see someone within two hours of referral and will have a wide range of services available to support people at risk of going to hospital or a care home. The work of the service will be supported by doctors specialising in the care of older people who will spend a lot of their time working in the community rather than at the hospital. Health and social care support staff will work together to provide a single source of care for patients.

There will be more staff and support to help people recover from whatever is getting in the way of having a good life. This will be true for people who are physically unwell as well as people who need support to have good mental health. Rather than go to day centres, people with a mental health problem will tap into Recovery and Well-being Networks to gain the skills and confidence they need to overcome their illness. Rather than people be assessed in hospital before they can go home, we will help people get home with the support they need to be safe and work out with them what is the best thing to do in the longer term. Some people might need intensive support and night sitting in the first few days to make this happen safely. Far more use will be made of care home beds and people's own beds as the best places to recover and convalesce with staff travelling to provide therapy support where it is needed. This will be backed up by care workers acting as agents of therapy. It is likely that we will need fewer buildings as services will be delivered in people's own homes.

Derby Royal Hospital will be free to focus on its core purpose. It will no longer need to keep getting bigger because there will be less people needing to go to hospital and when they do they are helped home quickly. Services that help people will move out into the community closer to people's own homes. Community staff will reach in to hospital to provide continuity of care and help with discharge. The doctors who work in Derby Royal Hospital will provide expert advice and support to the Community Support Teams and primary care. There will be regular circulation of staff between acute and community settings.

Local Area Co-ordination: Connecting people to their community

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Mrs Shardlow is a 72 year old widow. Following the death of her husband two years ago there were numerous referrals and requests made to Adult Social Care for Mrs Shardlow, resulting in assessments and equipment provision.

Whilst on a visit, one agency worker raised concern about Mrs Shardlow's lifestyle and proceeded to refer her to a number of different services. This experience had a significant impact on Mrs Shardlow's confidence and resulted in her becoming increasingly dependent on the original worker, more withdrawn from her natural community networks, and less confident about making decisions for herself often deferring to the worker for support.

The Local Area Co-ordinator (LAC) was one of the services Mrs Shardlow was referred to. The LAC met Mrs Shardlow and again spent time getting to know her and started to talk about the things she wanted from life, they talked about the things that worried Mrs Shardlow, but the majority of the conversations focused on her gifts, skills and interests. Mrs Shardlow talked about the fact that she felt very lonely and so together they drew up a plan of action to address this.

This asset based approach meant that alongside the LAC, Mrs Shardlow was able to connect in to local activities and develop relationships with neighbours, therefore reducing her reliance on workers to meet her social contact needs.

Mrs Shardlow now attends a 'knit and natter' session in the local library and has been introduced to a neighbour who shares her passion for antiques. Mrs Shardlow then worked with the LAC to think about her house and together they planned out what she wanted to do to make her home more secure and comfortable, Mrs Shardlow was able to call on her friends and neighbours to make some of this happen. The LAC still calls in on Mrs Shardlow every month for a cup of tea and a chat and Mrs Shardlow is happy to know that the LAC is still around. She also reports feeling more able to cope, knowing that the LAC is on hand should she need support.

Community Support Teams and assistive technology

Mrs Khan has Chronic Obstructive Pulmonary Disease (COPD) and Emphysema which leaves her short of breath and prone to lots of chest infections. She was going to the doctor or A&E 4-5 days a week for oxygen or a nebuliser. She lives on her own.

The district nurse in the Community Support Team suggested she tried a POD. The POD is a gadget that measures Mrs Khan's oxygen levels and asks her a few simple questions every morning. The results are transmitted straight to the district nurse who phones her within minutes if they see anything that concerns them. They help her get an appointment at the GPs or if she needs a prescription they pick it up and drop the medicine to her.

At the weekly multi-disciplinary team meeting the district nurse mentioned that Mrs Khan was lonely. The social worker suggested Mrs Khan be buddied by Mrs Hussain, also a COPD sufferer and POD user who was keen to help other people manage their condition as she had.

Mrs Khan rarely goes to the GP or A&E anymore. She no longer panics if she is short of breath and her incidence of chest infections has dropped. She feels in control of her COPD, is reassured by the nurse being on the end of a phone and has made a new friend in Mrs Hussain.

"Home First" services help people to remain at home

Mr Walker is 85 and has dementia. He is cared for by his wife Iris who is 81. Iris is getting very tired because Mr Walker's dementia means he is up a lot in the night.

Mrs Walker wakes up one morning with a high temperature and feels fluey. She calls the GP but is more worried about who will look after Mr Walker as she feels too ill to get out of bed.

The GP talks to the social worker who he knows well as she is part of the Community Support team aligned to his practice. She gets on the phone to the Council's integrated recovery service "Home First". They are able to schedule carers to go in that evening and the following five days to provide support to Mr and Mrs Walker until she recovers. This is better for Mr Walker as he is being cared for in his own home – in the past he probably would have gone into respite care, an unfamiliar environment, while his wife recovered.

They also suggest Mr Walker has a bed sensor fitted so Mrs Walker can go to sleep reassured the sensor will wake her up on the occasions her husband wanders in the night. They put her in touch with a local dementia support group where Mr and Mrs Walker can meet up with people in similar circumstances to make friends and gain support.

We can give you this information in any other way, style or language that will help you access it. Please contact us on: 01332 642797 Minicom: 01332 640666

Polish

Aby ułatwić Państwu dostęp do tych informacji, możemy je Państwu przekazać w innym formacie, stylu lub języku.
Prosimy o kontakt: 01332 642797 Tel. tekstowy: 01332 640666

Punjabi

ਇਹ ਜਾਣਕਾਰੀ ਅਸੀਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਵੀ ਹੋਰ ਤਰੀਕੇ ਨਾਲ, ਕਿਸੇ ਵੀ ਹੋਰ ਰੂਪ ਜਾਂ ਬੋਲੀ ਵਿੱਚ ਦੇ ਸਕਦੇ ਹਾਂ, ਜਿਹੜੀ ਇਸ ਤੱਕ ਪਹੁੰਚ ਕਰਨ ਵਿੱਚ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦੀ ਹੋਵੇ। ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ ਟੈਲੀਫ਼ੋਨ **01332** 642797 ਮਿਨੀਕਮ **01332** 640666 ਤੇ ਸੰਪਰਕ ਕਰੋ।

Urdu

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yourlifeyourchoice@derby.gov.uk

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Derby City Council

Derby City Council The Council House Corporation Street Derby DE1 2FS
www.derby.gov.uk