CONVERSATION AWARENESS SESSION OVERVIEW AND SCRUTINY COMMITTEE 27TH March 2018

A common approach,
using common sense

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Bracknell Forest Council

AGENDA

- The case for change
- Introduction to the conversations approach
- Implementation in Bracknell
- What is the difference?
- How we change our relationship with the people we support?
- Case studies

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THE CASE FOR CHANGE

- Can no longer do the same things differently. We need to do different things
- Layers and Layers of process
- Disproportionate assessments
- Creating a dependency on the Local Authority

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INTRODUCTION TO THE CONVERSATIONS APPROACH

- Created by Partners for Change
- Adopted by many local authorities
- About starting from a blank page rather than tweaking what we already have
- Locally implemented in Slough, West Berkshire and Reading

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Guiding principles of conversation models

- We are not the experts – people and families are
- People are more resilient that we think
- We must know about the neighbourhoods and communities that people are living in

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IMPLEMETAION IN BRACKNELL

- Met with people who use our services and their carers
- Self-identified group of practitioners who wished to help develop the approach
- Decision to implement across all adult social care groups
- Reconfigured our IT system to reflect the changes

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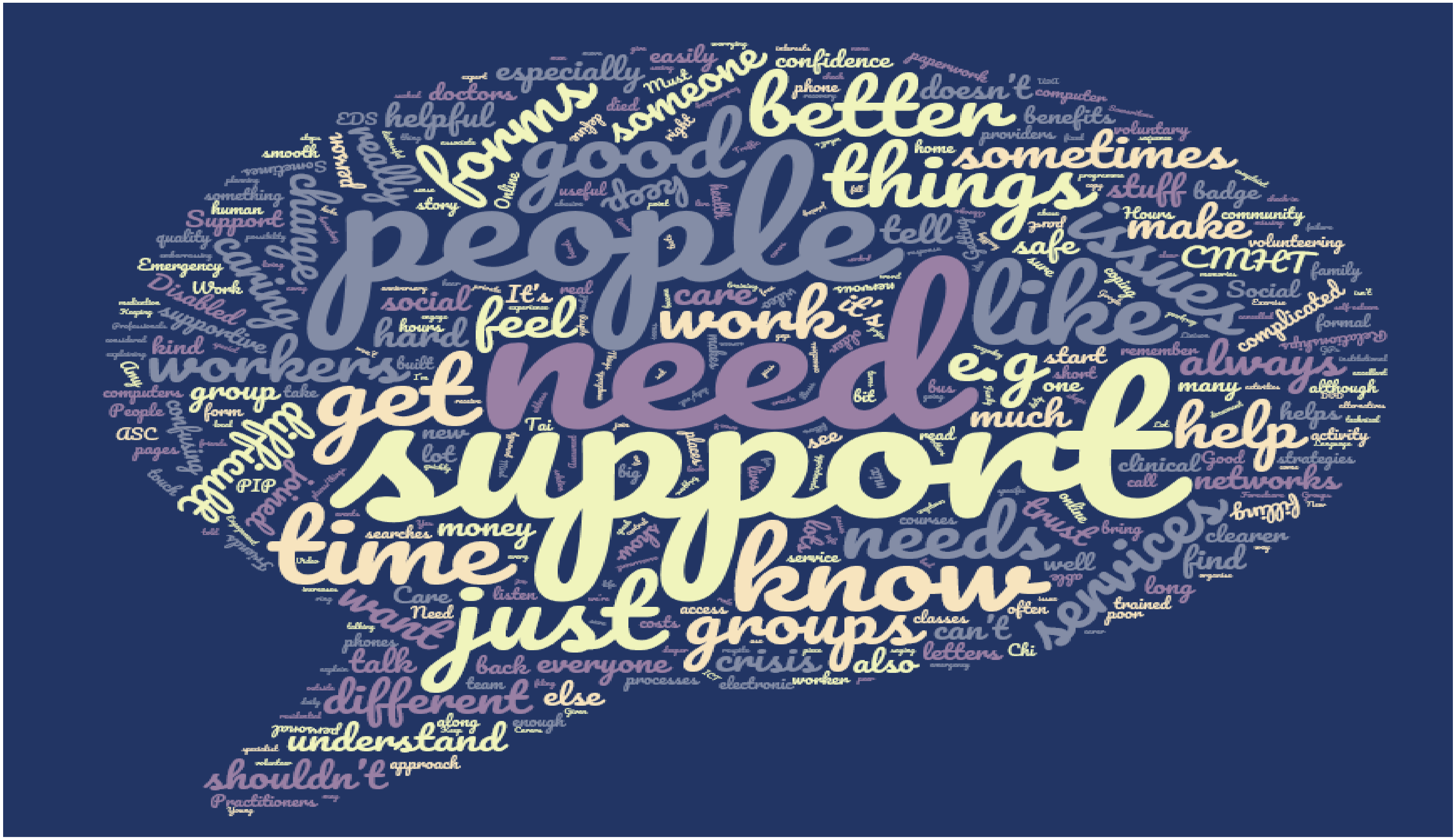
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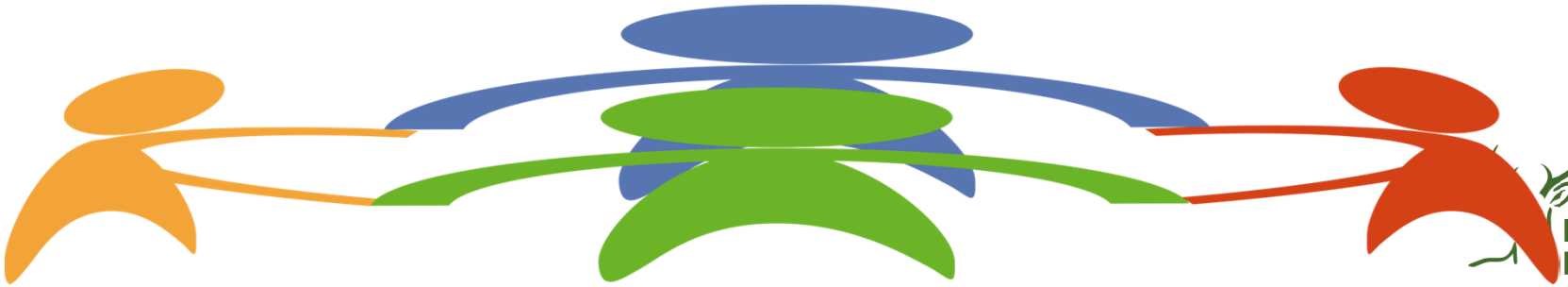
THE INNOVATION TEAM

Lorraine Chapman Older Persons Mental Health	**Melanie O'Rourke** Transformation	**Chris Ray** Transition
Amy Shaw Learning Disabilities	**Steph Bartrop** Autistic Spectrum	**Steph Small** Adult Community Team
Dave Parker Sensory Needs Service	**John Bradshaw** Safeguarding	**Sue White** Brokerage and Direct Payments



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WHAT IS THE DIFFERENCE?

- Less questions more listening
- Don’t make assumptions
- Don’t talk about services
- Don’t make long term decisions in a crisis
- Trial different approaches until we get it right

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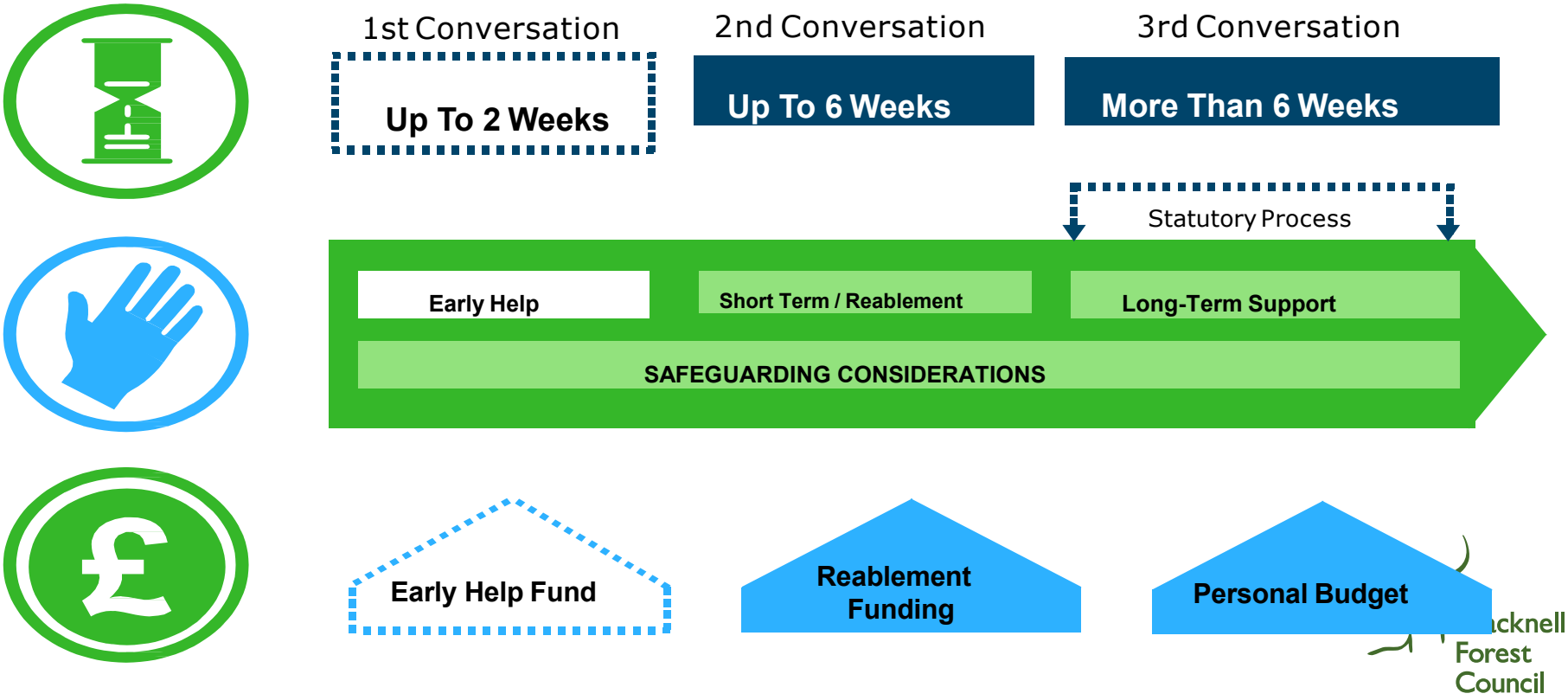
Early Intervention & Prevention



Conversations

Having conversations based on what people want to tell us, not what we want to ask them. We should therefore see them as people within a community, rather than a service user, client or customer. The conversations will allow us to spend more time with the people that ultimately put them at the centre of the work that we do. With the new LAS system, it can cut back the amount of forms that we fill in, again ensuring we can spend more time with the person rather than in the office.

First Conversation

- How can we help you to help yourself?
- Listen actively – don't assume anything.
- Consider and discuss all the different resources in the community and support systems that the person has in place that would help them get on with their life, independently.

Second Conversation

- Working with people intensively in the crisis.
- What needs to change for the person to regain control and to return to managing independently at home.
- What resources do we have as clinicians to pull together an 'emergency plan' to assist this person to regain control e.g. people's own networks, access to a small amount of money, thinking outside the box and other colleagues'
- experiences.

Stick to the person like glue in a crisis and help them through the emergency plan.

Third Conversation

- Building a support plan with the person to ensure they have the best life possible that they want.
- Including a fair personal budget and using formal and information support to achieve the persons goals.

EXERCISE

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Risk & Duty of Care

Risks

- *People were people before they came to social services they took risks and managed situations*

Duty of Care

"We have foreseen the risks and the person has foreseen the risks and a decision was made"

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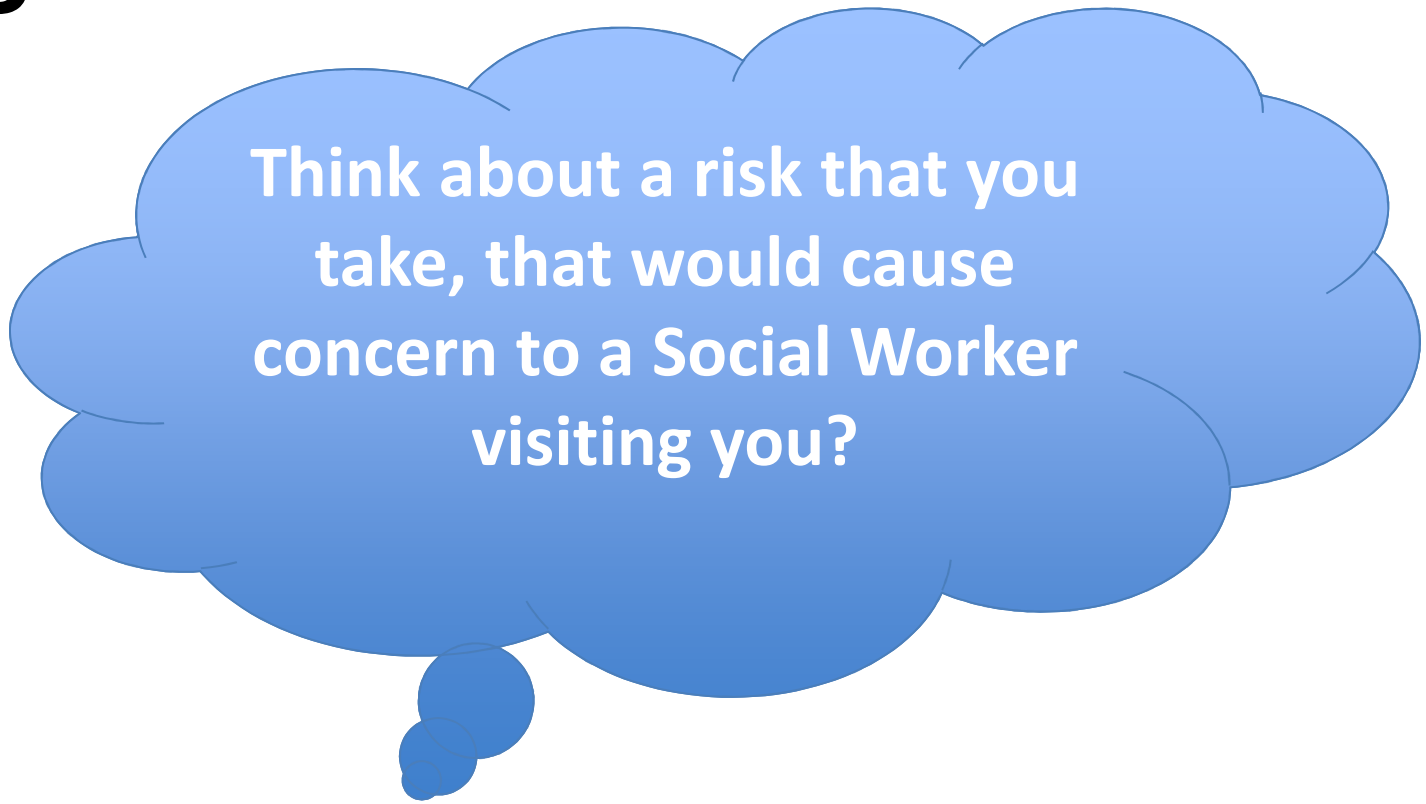
RISKS



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RISK

- People have taken many risks before they came to us
- People are more resilient than we think
- Providing real choice and control means enabling people to take the risks they choose
- Risk can be fluid and change over time

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“We have foreseen the risks and the person has foreseen the risks and a decision was made”

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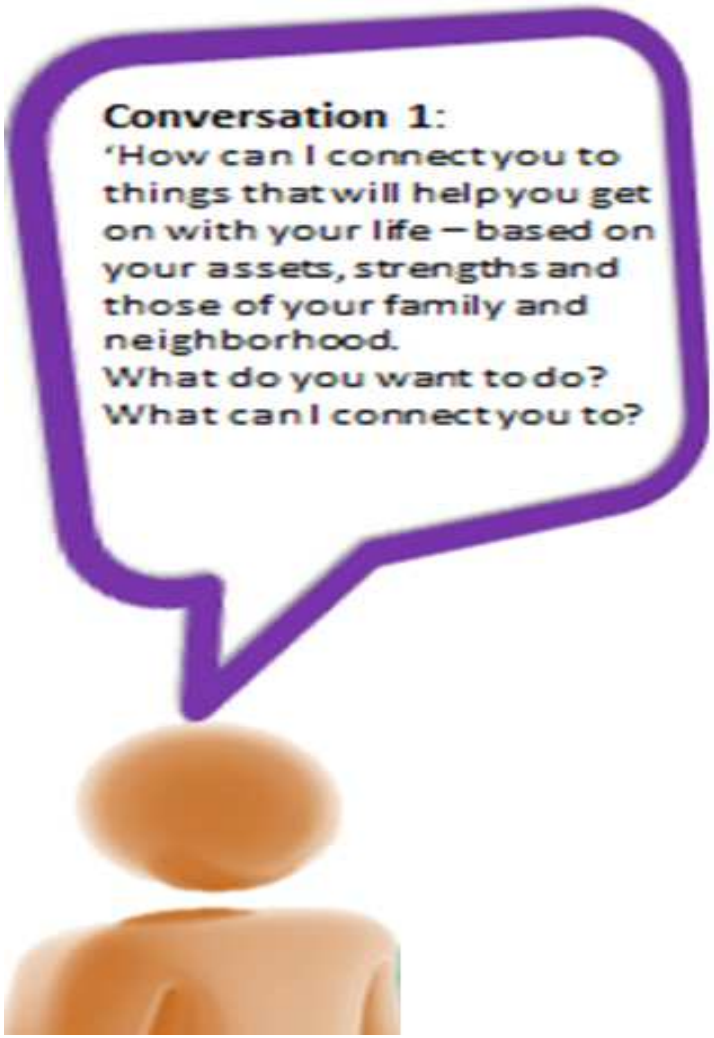
Conversation 1:
'How can I connect you to things that will help you get on with your life – based on your assets, strengths and those of your family and neighborhood.
What do you want to do?
What can I connect you to?

Case Study - Community Connectors

About David

- lives with 18 year old son
- Has multiple sclerosis
- Struggles with daily activities
- Not good at preparing meals
- Main daily meal is pasta with a jar of pasta sauce

1. Community Connector discussed options
2. Vegetable steamer and slow cooker identified to assist
3. Community Connector provided recipes to try
4. Son can help with food prep and David can use cooker
5. Both are able to enjoy nutritious healthy meals together

Conversation 2:

When people are at risk – 'What needs to change to make you safe and regain control?

How do I help make that happen?

What offers do I have at my disposal, including small amounts of money and using my knowledge of the community to support you?

How can I pull them together in an 'emergency plan' and stay with you (like glue!) to make sure it works'?

Case Study - Conversation 2

About James

in late 80's lives alone

Has a number of health issues

Moved to living downstairs

Two falls in 12 months

Admitted to hospital for fall and chest pains

James was discharged with a package of care

ICS provided support with:

Managing with stairs

Personal Care

Meal Preparation

Perching stool provided to support with food preparation in the kitchen

Within 3 weeks of hospital discharge

James was happy to end all support

Able to continue living independently

Third Conversation

- Building a support plan with the person to ensure they have the best life possible that they want.
- Including a fair personal budget and using formal and information support to achieve the persons goals.

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Case Study - Living with Dementia

About Mary

90 Years Old
lives alone, has supportive family

Has Dementia & Alzheimer's

Struggle with daily activities

Assessment is completed

Agreement that they would benefit from paid carers

Assistive technology would also be helpful

Continued support as health declined

At risk of overdosing on medication

Agreement that she can no longer manage living alone

Moves to Residential Home Astbury Manor

Needs are met

She is happy and content

Case Study - Carers and Direct Payments

About John

His wife's health issues affect her energy and mobility

Provides his wife support for all her needs without help

Couple are happy with their arrangement

Carer's assessment is completed

Benefit from assistance keeping the house clean

Received direct payment

Employs PA with direct payment for domestic support

Wife feels comfortable with PA

John can go out whilst PA is with his wife

John can have a break from his caring role and maintain his wellbeing

What we need from O.S.C.

- Help to ensure Members are familiar with the ‘Conversations’ approach so they can support Bracknell residents to understand our new way of working and the fact that traditional services are not always the most effective way to support someone.

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