HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

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THREE CONVERSATIONS BRIEFING

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Summary

This report provides an update to the 3 Conversations Approach which is being implemented across Adult Social Care.

1. Budget and Policy Framework

1.1 Getting Better Together, the Council's Adult Social Care Strategy 2016 - 2020 articulates our vision for adult social care, and sets out the key themes and priorities for action. The strategy and related improvement programme align with the overall objectives defined within the Council Plan, and the Health and Wellbeing Strategy for Medway.

2. Background

2.1 The primary aim of the Council's Adult Social Care Strategy is to prevent and reduce social need by providing effective support so that citizens maintain their independence. Wherever possible and appropriate we will support citizens with eligible social care needs to remain in or return to their own home, so that they can maintain important relationships with family, friends, and continue to actively be a part of their own community.

2.2 Alongside the development of the Strategy a diagnostic assessment of the opportunities for change was completed by Newton Europe, an organisation with an established track record of working with public and private sector organisations. This diagnostic highlighted a number of areas that were necessary to change to improve the efficiency, quality and best value of services, which in turn improve outcomes for people.

2.3 Feedback from service users and from staff has highlighted that the way we deliver Social Care in Medway needed to change. The existing systems were

often difficult to navigate and bureaucratic, preventing staff from having conversations with people about what really matters to them.

2.4 The Adults Social Care Programme Management Office (PMO) was established to take forward the recommendations of the diagnostic assessment. The work of the PMO has been developed into an Improvement Programme and all of this work has been incorporated into the Getting Better Together strategic delivery plan to ensure that if forms part of a single co-ordinated set of activities.

2.5 The Programme Management Office (PMO) appointed Partners4Change to help implement 3 conversations as a new approach at the start of 2017.

2.6 The "3 conversations" is a strengths based approach which supports frontline staff to have 3 precise, specific conversations with people as a way of discovering a person's needs and finding ways to enable them to be independent and safe.

2.7 The Three Conversations are:

Conversation 1: Listen and Connect	Listen actively – don't assume anything. What really matters to this person? What are their interests and skills? What do they want to do? Consider and discuss all of the resources and supports that you can connect the person to within their community and networks in order to help them get on with their life independently.
Conversation 2: Work intensively with people in crisis	What needs to change urgently to help people regain resilience and stability? Compliment people's own networks by exploring what offers you have at your fingertips, and those of your colleagues – including all of your knowledge of the community to help make these things happen. Pull the most effective things together into an "emergency" plan (that includes the needs of family carers), and stick to people like glue to make sure that the plan in place works. If it doesn't, then change it.
Conversation 3: Build a good life	Listen hard. What does a good life look like for this person (and their family)? What resources, including a fair personal budget, are available? What support, both informal and formal will help people to live a life that is good, according to their definitions? How can we help someone get that support organised so they can live the best life possible.

2.8 The "3 conversations" model is based on the following golden rules:

- Always start conversations with the assets and strengths of people, families and communities;
- Always exhaust conversations one and two before having a conversation three;
- Never ever plan long term in a crisis;
- Listen hard to individuals and their carers – they are the experts on their lives;

- Know the neighbourhoods and communities within which people live;
- Flexibility to use professional judgement and co-design solutions on a case by case basis, treating individuals as individuals.

3. 3 Conversations Test for Change

3.1 It was agreed to set up an initial innovation site to trial and develop a Medway version of the 3 conversations approach, which ran for 13 weeks from April to June 2017.

3.2 The design of the innovation team and how it would operate took place in January 2017, through a number of workshops involving all staff who had expressed an interest in the 3 Conversations approach, together with members of the PMO and representatives of Partners4Change.

3.3 The team was formed of nine members of staff who volunteered and the team was designed to involve many operational roles including social workers, occupational therapists and assistant practitioners with a broad range of skills and experience across adult social care.

3.4 During the test for change the team was tasked with managing all new Adult Social Care contacts for people living in the ME4 & ME5 postcode areas.

3.5 All conversations start as conversation 1's, but can progress to being conversation 2's or 3's. During the 13 weeks of the innovation team period, the team had 388 conversation 1's, of which 29 became conversation 2's and 19 became conversation 3's.

3.6 The data shows that the percentage of contacts needing long-term care packages reduced from 7% in the business as usual environment to 5.15% in the 3 conversations innovation team. Twenty people have gone on to need long-term care from the ME4 team but in the business as usual model it would have been expected that 27 people would require long-term care. This outcome is consistent with feedback from other authorities who have introduced the 3 conversations approach.

3.7 The number of homecare reablement packages being commissioned also reduced significantly. The ME4 team put 22 homecare reablement packages in place (5.6%), but in business as usual 18% of contacts would have received homecare reablement, which works out at 70 packages. The team were able to consider alternative options and solutions to the Council's traditional reablement offer.

3.8 During the 13 weeks a brief telephone survey was conducted with a sample of people with whom the team had had conversations and where the call was now closed. In summary, 100% of the people spoken to responded that they had been listened to by the person they were dealing with, and 100% said they were very satisfied with both the quality and the relevance of support provided.

1. How do you feel about the service?	What difference has this made to you?	Other comments
Very happy	So much of a difference	She lit up the house. Brilliant, so good at her job
Brilliant Service	Helped out following on from hospital discharge	I feel much safer and independent, over the moon
Made a world of difference	Change her life wonderful	Very helpful person
Absolutely unbelievable	Big difference independence back	Made her feel good, did not talk down to her, enjoyed the experience provided

3.9 As well as the above feedback, one of the features of the 3 conversations model is that the team have been encouraged to follow up with people to check that the services that people have been connected with have been able to support them.

3.10 Staff experiences were monitored throughout the time the team was running, with regular opportunities for learning to be shared and reflection on practice. Their feedback was captured at the end of the 13 week period through a workshop.

3.11 Valuable lessons were learned through this small scale test for change:

- Effective support was achieved through telephone contacts, reducing the need for some home visits.
- The need for clear procedures and practice guidance to ensure greater consistency of approach.
- It is vital that members of the team understand what resources are available. It was difficult to free up staff time to make connections with the local community, and staff also reported that capacity of some community services has been limited. Further work needs to be done to identify and develop and strengthen community capacity.
- Significant improvements to ways of working, with reductions in the amount of form filling and unnecessary administration, but there are areas where business processes are not as efficient as they could be.
- The establishment of the team as an “innovation team” encouraged members of the team to think differently and to challenge existing practice. Cultural change has been evidenced in the innovation team as a result.
- The opportunities for staff to provide a more complete solution to meet people's needs

3.12 The innovation site proved the concept and the potential of the approach but has also shown that due to the complexities a significant amount of work is required to roll out the approach at scale.

4. Adult Social Care Restructure

4.1 Our Adult Social Care restructure went live in September 2017. The new structure consists of Early Help & Prevention and Long Term Support teams operating across three localities Rainham & Gillingham, Walderslade & Chatham and Strood, Rochester & Hoo.

4.2 The expected benefits of this new structure lie in locality working which increases the potential for social care to work more closely with and in communities and as part of the Local Care Model with our health colleagues. This aligns with one of the main principles of 3 Conversations of knowing our communities and thereby ensuring that we can look at people's needs in a more holistic way.

4.3 Within the new structure all new contacts are handled by one of three Early Help and Prevention locality teams. Each team is multidisciplinary and handles contacts for a particular area of Medway. This is consistent with the way in which new contacts were managed by the innovation team.

4.4 Two new Community Link Worker posts have been created in order to coordinate the identification of community resources across Medway and to strengthen the links with our voluntary and community sector. The localities also work closely with WALT & wHoo Cares.

4.5 Staff who were involved in the innovation team continue to work to the principles of strength based practice and our focus is now to roll out and embed the 3 conversations approach across the whole service.

4.6 Through significant staff consultation and engagement we have agreed a number of priorities to take this work forward so that by March 2019 we will be working sustainably, with the right tools, and delivering 3 Conversations across the service.

5. Next Steps May 2018 forward

5.1 The roll out and embedding of 3 conversations forms a major part of our ASC Improvement Plan and the PMO is providing additional capacity to achieve this at pace by the end of quarter two.

5.2 To deliver this work the PMO are focussing on three major work streams which have come through the learning from the innovation site. These involve significant engagement from staff initially through a series of workshops.

5.2.1 **Workflows and capacity** – is about working more efficiently through designing the journey a service user follows and what tools, structures, capacity & right resources to are needed to support this. Redesigning our forms and business processes to reduce bureaucracy in order to free up valuable staff time and resource to work differently with people.

5.2.2 **Services & Commissioning** – identify the key services needed from our internal & external partners, developing and strengthening our community resources and designing the means to be able to access these in a timely manner.

5.2.3 **People, Best Practice, Training & Development** – designing how we all want to work such that we continuously deliver the best service. It is vital that staff have the right knowledge, skills and the tools to work in a multi disciplinary and strengths based way. This includes ensuring consistent processes and operational guidance. A Policy, Procedure and Operational Guidance group was formed following the restructure with a remit to review and update current policy and guidance and to ensure they are being applied consistently across the service.

5.3 From these workshops we will identify particular areas to run a number of further 'tests for change' enabling the newly designed processes / workflows to be tested, reviewed and refined.

5.4 The learning will then be used to develop the final plan to roll out 3 conversations at scale across the service to be implemented from August 2018.

5.5 Other enablers which will have a positive impact include the introduction of mobile working. Each frontline staff member will have a tablet which will enable them to work more efficiently, completing paperwork in service user's home, obtaining signatures and being able to access information instantly.

5.6 All of this work will support staff to make the cultural changes needed to work in new ways. Working with individuals and their carers, recognising that they are the experts on their own lives and have strengths to draw upon in coming up with co-designed solutions.

6. Wider Enablers

6.1 The following strategies support and align with the principles of 3 conversations and strength based practice promoting and maximising independence.

6.2 'Getting Better Together: Choices', Accommodation and Commissioning Strategy 2018-2022 for Adult Social Care will set out how Medway Council proposes to shift the balance of care to meet the growing needs of local people within reduced levels of funding by directing resources towards earlier invention and prevention and placing a greater focus on promoting independence.

6.3 The Local Care model supports integrated working with our GPs and other health colleagues with a multidisciplinary approach to maximise the use of community resources including social prescribing to promote and maintain individual well being.

6.4 All the above are underpinned by The Care Act 2014 which sets out a range of statutory duties for Local Authorities, including a number related to the prevention agenda. It is critical to the vision in the Care Act that the care and support system works proactively to promote wellbeing and independence,

rather than waiting until people reach crisis point. The 3 conversations, strengths based approach enables us to fulfil our duties under the Care Act.

7. Risk Management

7.1 This report is an information item. There are, therefore, no risks directly arising from the report.

8. Financial and Legal implications

8.1 This report is an information item previously requested by the Committee. There are, therefore, no financial or legal implications directly arising from the report.

9. Recommendation

9.1 It is requested that the Committee notes and comments on the report.

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Appendices

None.

Background papers

None.