

A graphic consisting of five blue, tapered, brush-stroke-like shapes radiating upwards from the top of the word "Pilotlight".

Pilotlight

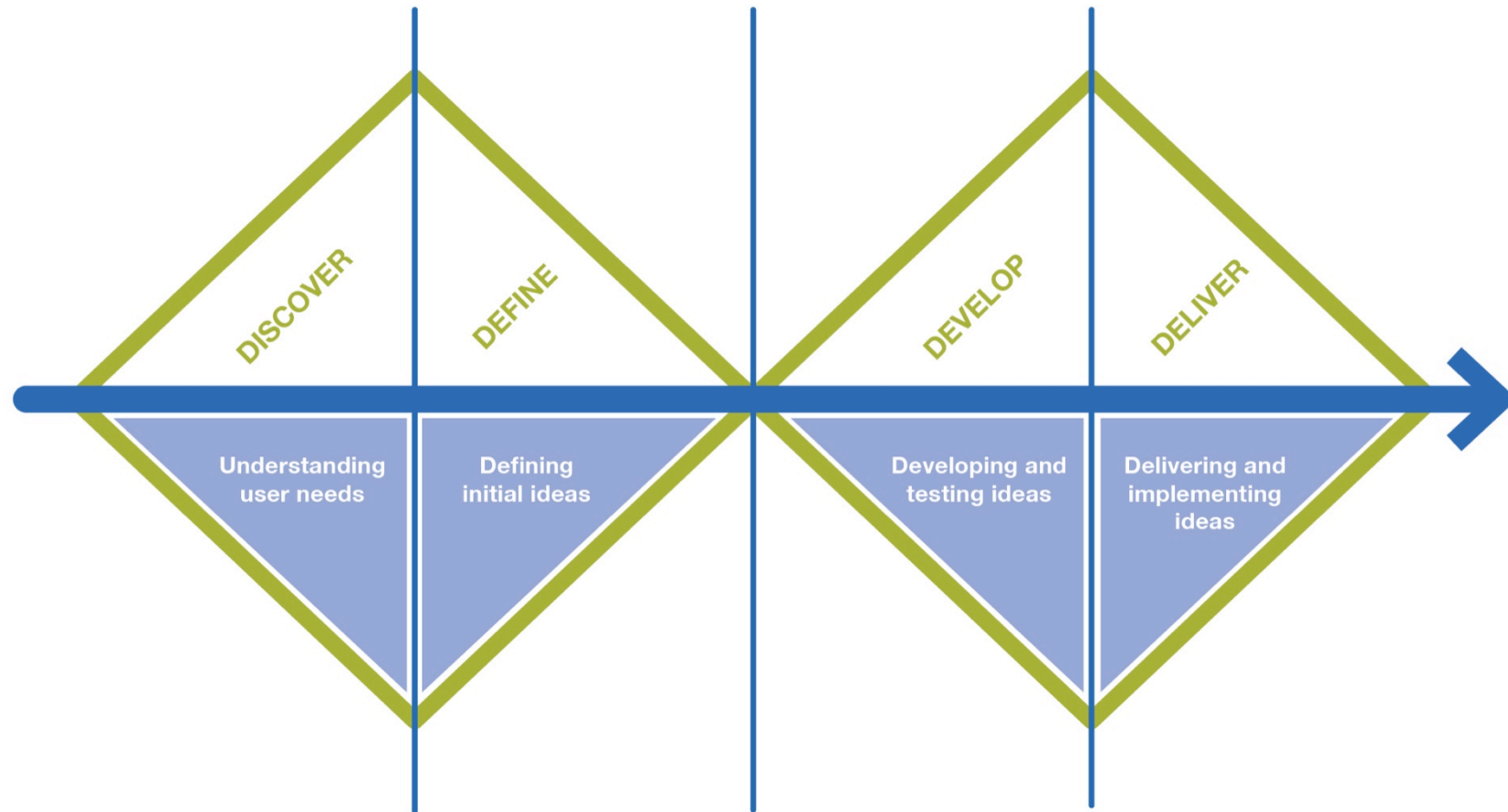
www.pilotlight.iriss.org.uk

AGEING WELL



**EAST RENFREWSHIRE
COMMUNITY HEALTH AND CARE
PARTNERSHIP**

Design process



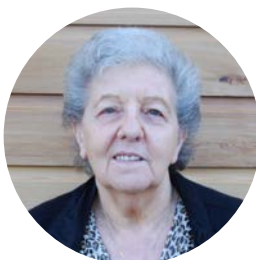
Ageing Well co-design team



Alison



Angela



Bernice



Derek



Antoinette



Rosalina



Dorothy



Flora



Gayle



Hameeda



Morag



Rosaleen



June



Lorraine



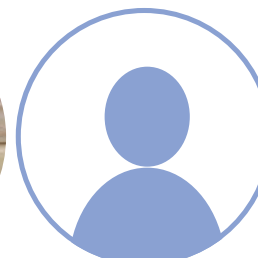
Maureen



Mechelle



Marion



Mary

Co-production matters!



The parable of the Blobs and Squares shows that there is more to people than their problems, that the solutions to the problems lies in the problem in itself, not in an imposed solution, and that co-production really matters!


<http://s.iriss.org.uk/1WtSECD>

Working together










AGEING WELL


Ways we want to work

			
Respect	Encourage others	Be positive	Have fun
			
Listen to others	Use 'stop' and 'I want to speak' cards	Share experiences	Share information
			
Get to know each other	One person speaking at a time	Everyone contributing and being heard	Confidentiality if personal sharing
			
Challenge ideas / thinking!	Good discussions	Good timekeeping	Clear goals

AGEING WELL


Ways we don't want to work

			
Rubbishing others contributions	Aggression / noisy people	People dominating / taking over	Talking over one another
			
Interrupting others	Recapping for late comers	Competitiveness	Excluding people
			
Negativity about other people's ideas	Time wasting		

I agree to working in this way throughout Pilotlight

Pilotlight characters

Character: Betsy

Name: Betsy

Age: 85

Who do they live with?
Newton Mearns, lives alone

Who are their family and friends?

A single niece who lives in south of England, two sisters who have passed away. Lost contact with friends, retired early as a result of deteriorating health and mobility.

Why are they in need of care and support now?

Previous hip replacements as a result of osteoarthritis however mobility now very poor, history of falls, has severe pain most of the time - osteoarthritis affects all joints. Struggling to walk any distance, bend, raise arms above shoulders, very fatigued, struggles with many daily living activities - washing, showering, dressing, undressing, making meals, housework, garden, accessing items she needs, low mood as a result of being lonely, inability to get out in the local community every day to do the things she enjoyed.

What do they do during the day now?

Struggles to get washed, dressed, make meals, takes a lot of time which is exhausting her, will go online to do some shopping, crosswords in German, jigsaw puzzles to try to keep brain active.

What would they like to be doing during the day?

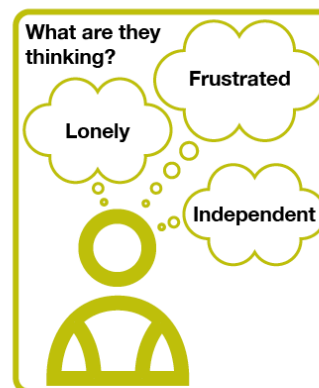
Would like to go out shopping, have a coffee, go to the coast, theatre, out for a meal, bake again, visit her niece.

What are their most important memories?

Parents + family + friends, time at university, teaching career - seeing pupils doing well, holidays abroad.

What are their skills and talents?

Articulate, good financial and management skills, speaks German and Spanish, baking, knitting, good organiser, independent, sense of humour.



Research we did...

- Information and awareness sessions
- 1 : 1 Interviews with co-design team members
- Co-design team action research
- Other East Renfrewshire projects
- Co-design team discussions
- Desk research
 - Outside the Box
 - CCPS (Option 2, Direct your own budget)
 - Scottish Care (Option 2, Direct your own budget)
 - Alzheimer Scotland

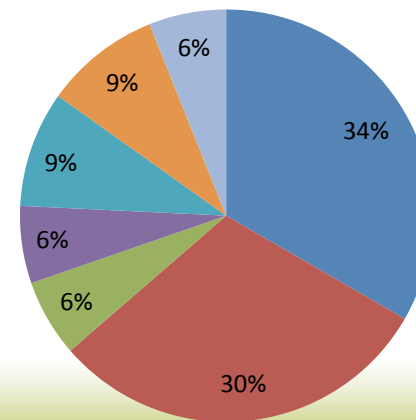


Research Insights

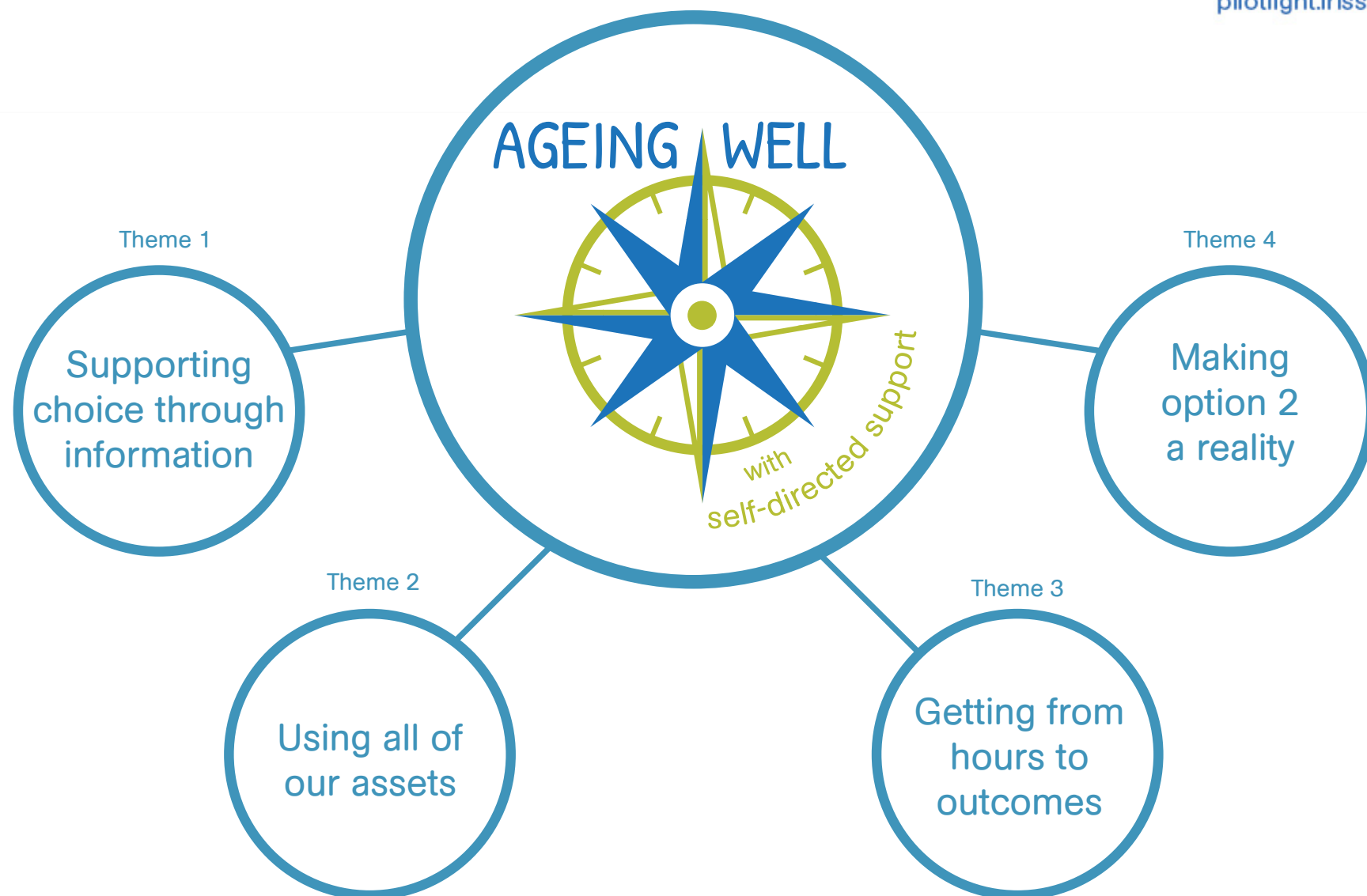
- **Health/Active**
- **Financial security**
- **Identity/
independence /
Control**
- **Friends**

What's important to you?

- Choice
- All about me
- Being a part of my community
- Being able to think 'outside the box'
- Having control
- Feeling safe
- Money



Project themes



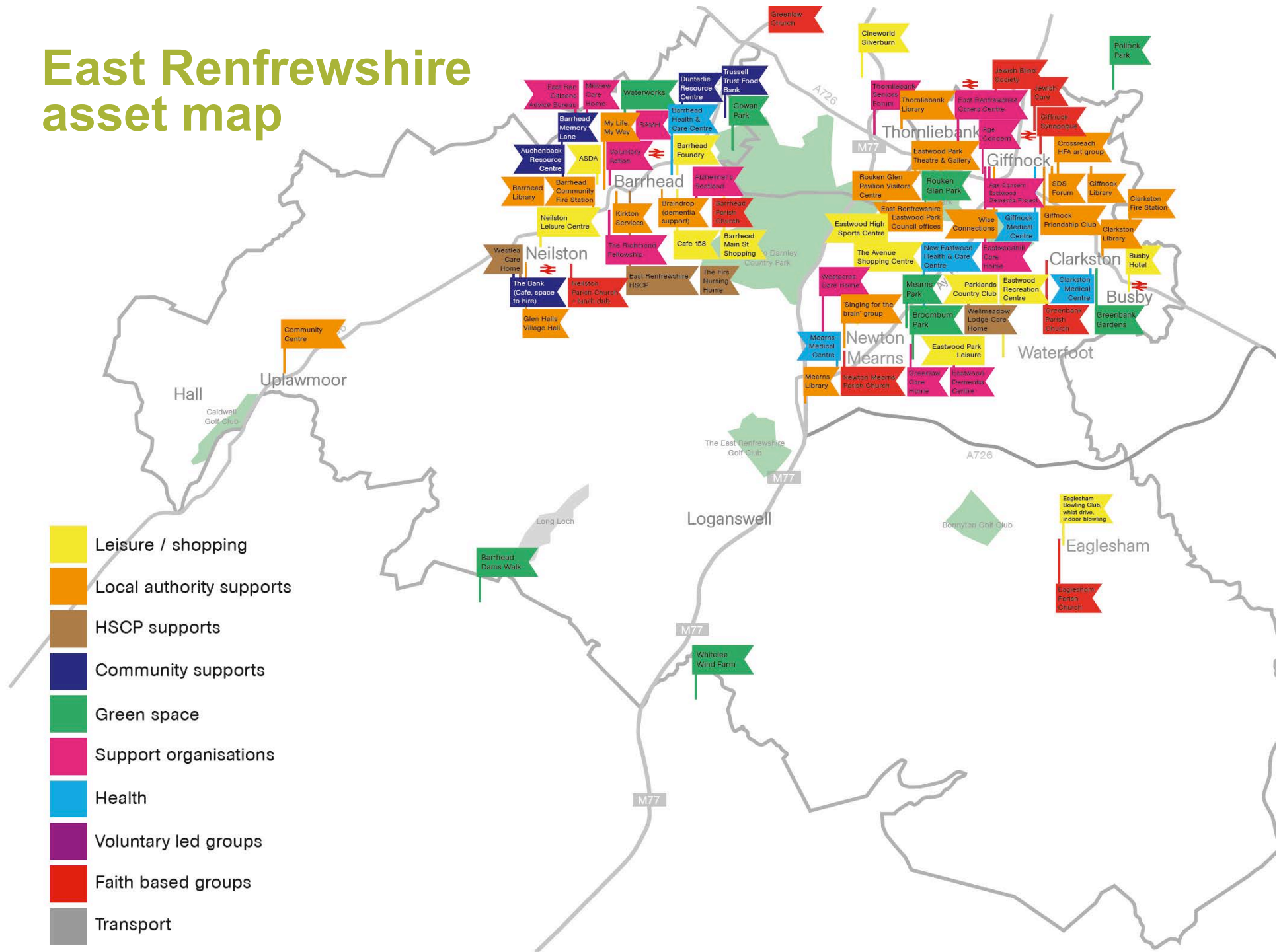
Using all of our assets

Key insights

- Older people are contributors to society
- Mapping and sharing community assets
- Skilling up practitioners to be community connectors
- Transport barriers in East Renfrewshire



East Renfrewshire asset map



Community Connecting ABCD

COMMUNITY CONNECTING **ABCD** FOR ALL HEALTH AND SOCIAL CARE WORKERS

Inspired by John McKnight and the Asset-Based Community Development movement (ABCD)

COMMUNITY CONNECTORS

- **Assets** are your starting point. Focus on identifying the assets of the people you support (gifts, family, friends) and get to know the community assets (groups/facilities/people) to which people can be signposted.
- **Building** a person's connections and relationships within the local community is the outcome of your support.
- **Communication** is your number one tool. Know how to have positive conversations with people that identify who and what is important to them and what they want in their lives.
- **Developing** and growing your own local knowledge and connections over time is the key to becoming a skilled and effective community connector.

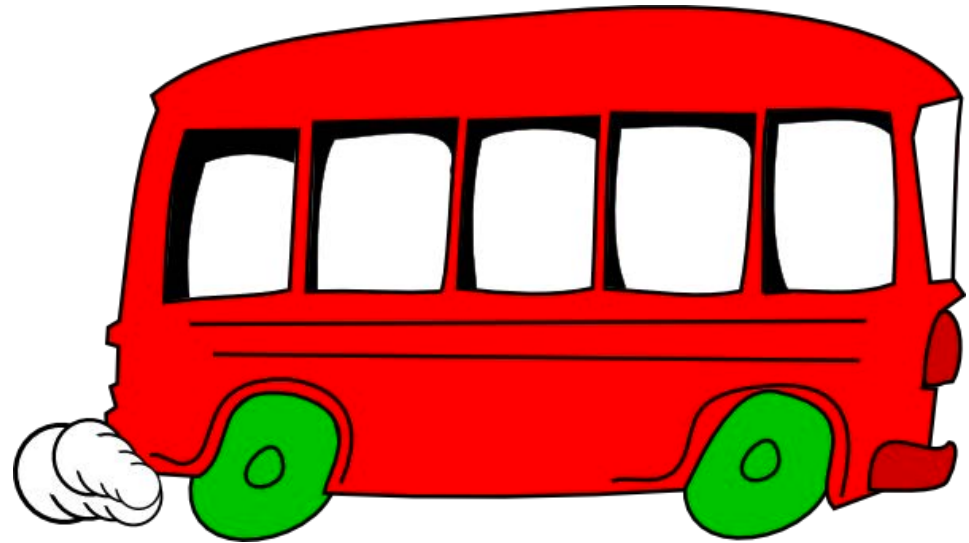
COMMUNITY CONNECTOR EMPLOYERS **PART I**

- Employers should recognise their **people** as **assets**, and reward them by paying at least the Scottish Living Wage.
- Employers should provide **resources** to draw on, including relevant training and information on local groups/facilities/people to which people can be signposted.
- Employers should provide **time** for employees to get to know local groups/facilities/people and to have good conversations with people to build relationships and to work together to identify what is important to them.
- Employers should ensure the ABCD of Community Connection is **integral** to job designs and training plans.



Transport brief

- **The challenge:** lack of accessible transport to enable people to engage in community activities to combat isolation
- **Solution proposed:** maximising use of community, staff and private vehicles to support older people to access community activities through up skilling and supporting volunteer drivers and health and social services workers.



Supporting choice through information

Key insights

- Equipping health professionals and social workers to provide SDS information
- Synchronisation between info providers
- Equitable access to all 4 options
- Personalised, face to face
- Rights based approaches



Self-directed support checklist

SELF-DIRECTED SUPPORT CHECKLIST

- ☐ 1. Know about the self-directed support values, principles and options
- ☐ 2. Understand the East Renfrewshire process
- ☐ 3. Know how to have positive conversations with people that identify who and what is important to them and what they want from care and support
- ☐ 4. Signpost to people that can help

1. Know about the self-directed support values, principles and options

Quick reference guides for basic knowledge Social Care Statement of Values and Principles:
<http://s.iriss.org.uk/1RfVA3A>

Pilotlight accessible information:
<http://s.iriss.org.uk/21GOqXC>
<http://s.iriss.org.uk/22EPwpc>

More advanced information:
<http://s.iriss.org.uk/21GOEy3>

2. Understand the East Renfrewshire process

East Renfrewshire Guide to Self-Directed Support:
<http://s.iriss.org.uk/1pym3hX>

These are the steps that a person will be guided through:

- The steps in the process
- How to apply
- Eligibility and assessment
- Who authorises the decision
- Timeframe

For more information please contact:
June Findlater
june.findlater@eastrenfrewshire.gov.uk

3. Know how to have positive conversations with people that identify who and what is important to them and what they want in their lives

Helen Sanderson Associates 'Sorting Important to/for' and 'Relationship Circles':
<http://s.iriss.org.uk/1o62dtA>

East Renfrewshire Talking Points, A Personal Outcomes Approach:
<http://s.iriss.org.uk/22vyhdm>

Community Connecting ABCD for all health and social care workers:
([add link here](#))

4. Signpost to people that can help

East Renfrewshire Customer First (0141 577 3001) to ask to have a social work assessment or to ask the person's social worker for a review.

East Renfrewshire Self-directed Support Forum (0141 638 2525)
<http://s.iriss.org.uk/1RxQ8F5> provides advice and information to people directing, or thinking about directing, their own support and care.

Advocacy Project (0141 420 0961)
<http://s.iriss.org.uk/1pHPjnl> provides free, independent advocacy to older people (65 or over) and younger adults (16-64) affected by disability, resident in East Renfrewshire when the referral is made.

East Renfrewshire Carers' Centre (0141 638 4888)
<http://s.iriss.org.uk/1Sw82LG> provides a full programme of support for carers.

East Renfrewshire asset map
([add link here](#))

**Any
questions?**



Getting from hours to outcomes

Key insights

- Assessment being about having good conversations
- Starting from outcomes not services
- Shifting commissioning from time and task to outcomes given adequate resources
- Sharing and embedding innovative approaches e.g. Outcomes Star / Wellbeing Wheel



Learning materials



Getting from hours to outcomes

Learning Materials



Instructions

- Divide the group into two smaller groups of equal numbers.
- Give each group 45 minutes to complete the tasks below.

Group 1

1. Read Betsy's character
2. Allocate roles - character, commissioner/social worker, support provider
3. Betsy has a budget of 7 hours home support per week at £15 ph = £105 per week
4. Design Betsy's support to meet her outcomes and answer the 'getting from hours to outcomes' questions on page 4

Group 2

1. Read Betsy's character
 2. Allocate roles - character, commissioner/social worker, support provide
 3. Betsy has a £5,460 budget to spend over the year
 4. Design Betsy's support to meet her outcomes and answer the 'getting from hours to outcomes' questions on page 4
- After 45 minutes, bring the two groups back together.
 - Spend 30 minutes discussing each of their approaches, differences in how they designed the support and reflecting on the barriers and opportunities they saw in each.

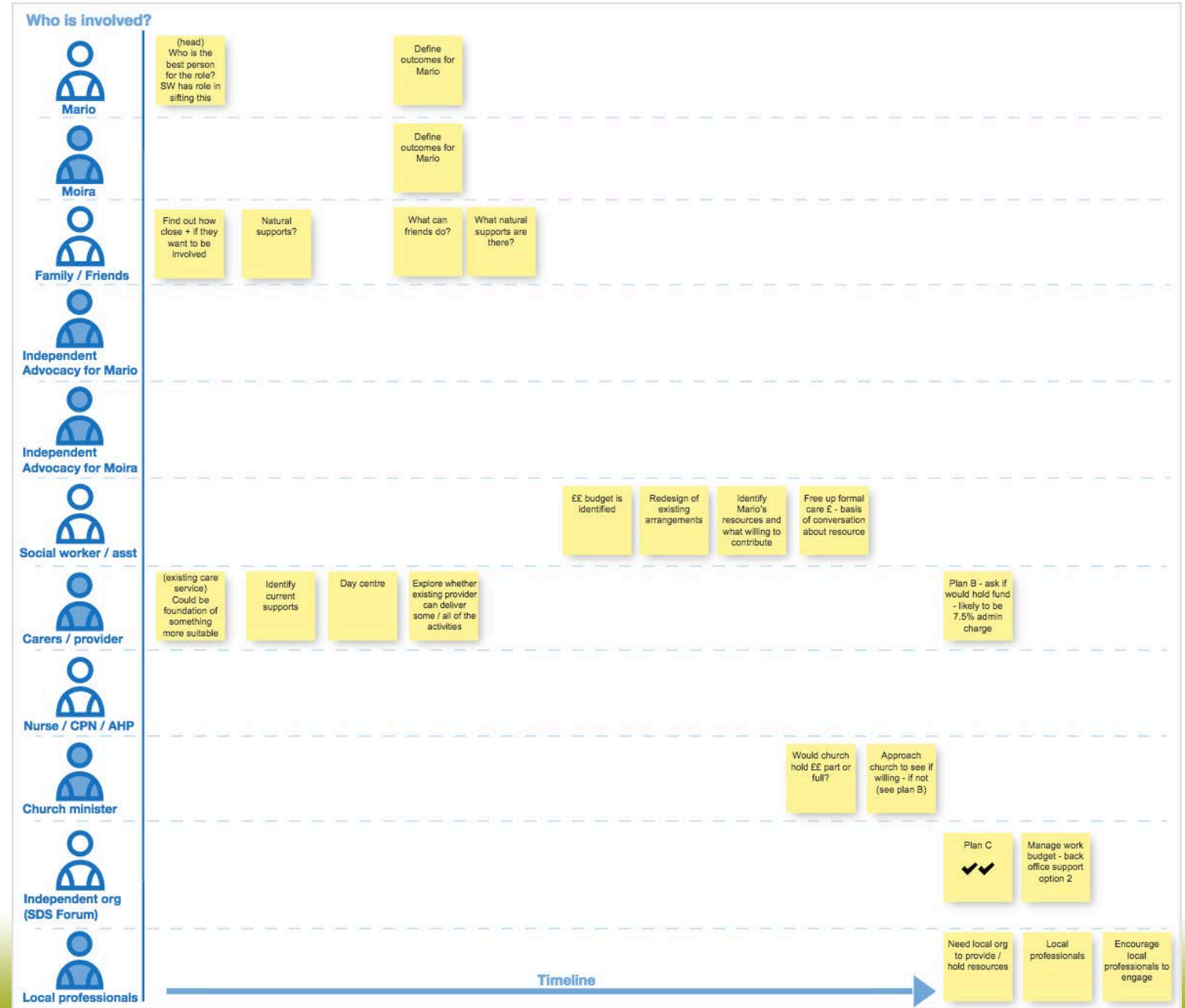
Making option 2 a reality

Key insights

- Clearly defining what it looks like
- Working in partnership with providers to design and develop option 2
- Equipping practitioners with knowledge and confidence to inform and offer
- Piloting use by older people
- Promotion of choice and control without money management and employer role



Mario's journey



Easy steps to SDS



step 1

YOU COME TO US WITH
A PLAN FOR YOUR
SUPPORT AND A BUDGET
AGREED WITH THE
HEALTH AND SOCIAL
CARE PARTNERSHIP.

WE WILL HAVE A
CONVERSATION WITH
YOU ABOUT HOW TO
PUT YOUR PLAN INTO
PLACE AND PAY FOR
YOUR SUPPORT.

step 2

step 3

WE RECORD HOW MUCH MONEY
YOU HAVE AND HOW YOU WANT
TO SPEND IT IN AGREEMENT.

WE WILL CHARGE YOU £ FOR
MANAGING YOUR BUDGET
EACH YEAR. THIS MEANS WE
ARE ACCOUNTABLE TO YOU.

WE WILL PAY FOR THE
SUPPORT AND ACTIVITIES
IN YOUR PLAN.

EVERY 4 WEEKS WE WILL
GIVE YOU A STATEMENT
SHOWING HOW YOUR
MONEY HAS BEEN SPENT.

step 4

step 5

WE WILL TELL THE FINANCE
DEPARTMENT AT THE
HEALTH AND SOCIAL CARE
PARTNERSHIP WHAT WE HAVE
SPENT ON YOUR BEHALF ON A
REGULAR BASIS.

WE WILL MEET WITH YOU
AND THE HEALTH AND SOCIAL
CARE PARTNERSHIP TO
REVIEW YOUR PLAN EVERY
YEAR, OR SOONER IF YOU
WANT TO CHANGE IT.

step 6

**Any
questions?**



Feedback

