3 Conversations Approach

Janne Solpark, Practice Lead

Janne.Solpark@edinburgh.gov.uk

Edinburgh **Health and Social Care** Partnership

Partners 4 Change

Where had social care got to?

- Operate central contact function.
- Keep people ‘out’ of the system. Divert!
- Only get involved if eligibility thresholds are met.
- Then ‘triage’ people, label them, make them wait, move them around our system, push down a ‘pathway’. Place on a waiting list. Run a ‘sorting office’.
- Eventually - people receive ‘an assessment for services’ – this is our core business. Output is often ‘time and task’ plan.
- Usually very little in between – % of people get a re-ablement service?
- Pressures to avoid delayed discharges
- “It’s become all about KPI’s and feeding the system with data”
- Try to eliminate all risks – at the expense of innovation
- Does this sound familiar?

Can you think of an example of when you felt frustrated by “the system”?

We're changing our DNA

- we aspire to support people to develop their full potential and enrich their lives
- we connect to our people, our partners and our communities
- we are expert listeners
- we free and empower our colleagues to be the best they can be
- we have a clear Partnership identity that embodies our values and includes our partners in all sectors.

The Three Conversations Approach

1 Conversation 1 : Listen & Connect

Listen hard. Understand what really matters. Connect to resources and supports that help someone get on with their chosen life, independently.

2 Conversation 2 : Work intensively with people in crisis

What needs to change urgently to help someone regain control of their life? Put these into an emergency plan and, with colleagues, stick like glue to help make the most important things happen.

3 Conversation 3 : Build a good life

For some people, support in building a good life will be required.

What does 'a good life' look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organized?

Partners 4 Change

How it makes a difference

- improves the experience of people and families who need support
- significantly improves workers' job satisfaction and productivity – by liberating them to do the role they aspired to
- supports independence and connectedness with community
- reduces the bureaucracy that threatens to drown us all
- has been successfully implemented and evaluated across the UK.

In practice…

- The Three Conversations replace what we do at the moment – not add to it.
- We learn how to be so good at conversation 1 and 2 that we reduce significantly the number of conversation 3s we have.
- Developing a good eye for strengths and assets and being creative in how to use these.
- Trying new approaches, reflecting on success and learning from what works.
- We have to learn a new way of recording our work – not adapting what we have.
- Lots more autonomy/accountability, seeing things through to the finish.
- This represents a significant cultural and behavioural change for everyone involved.

- ❑ Abandon assessment for services as our ‘offer of value’ for ever
- ❑ Always start conversation with the assets and strengths of people, families and communities
- ❑ Our focus is on wellbeing and not eligibility
- ❑ Don’t use jargon or complex words. Plain English will do!
- ❑ Always exhaust conversations 1 and 2 before having conversation 3 and test this out with colleague
- ❑ Never plan long term in a crisis
- ❑ Stick to people like glue during conversation 2 – there is nothing more important that supporting someone to regain control of their life
- ❑ We actively aspire to no hand-offs, no referrals, no triage, no waiting lists
- ❑ We are not the experts – people and families are
- ❑ Know about the neighbourhoods and communities that people are living in.
- ❑ Always work collaboratively with other members of the community support system.

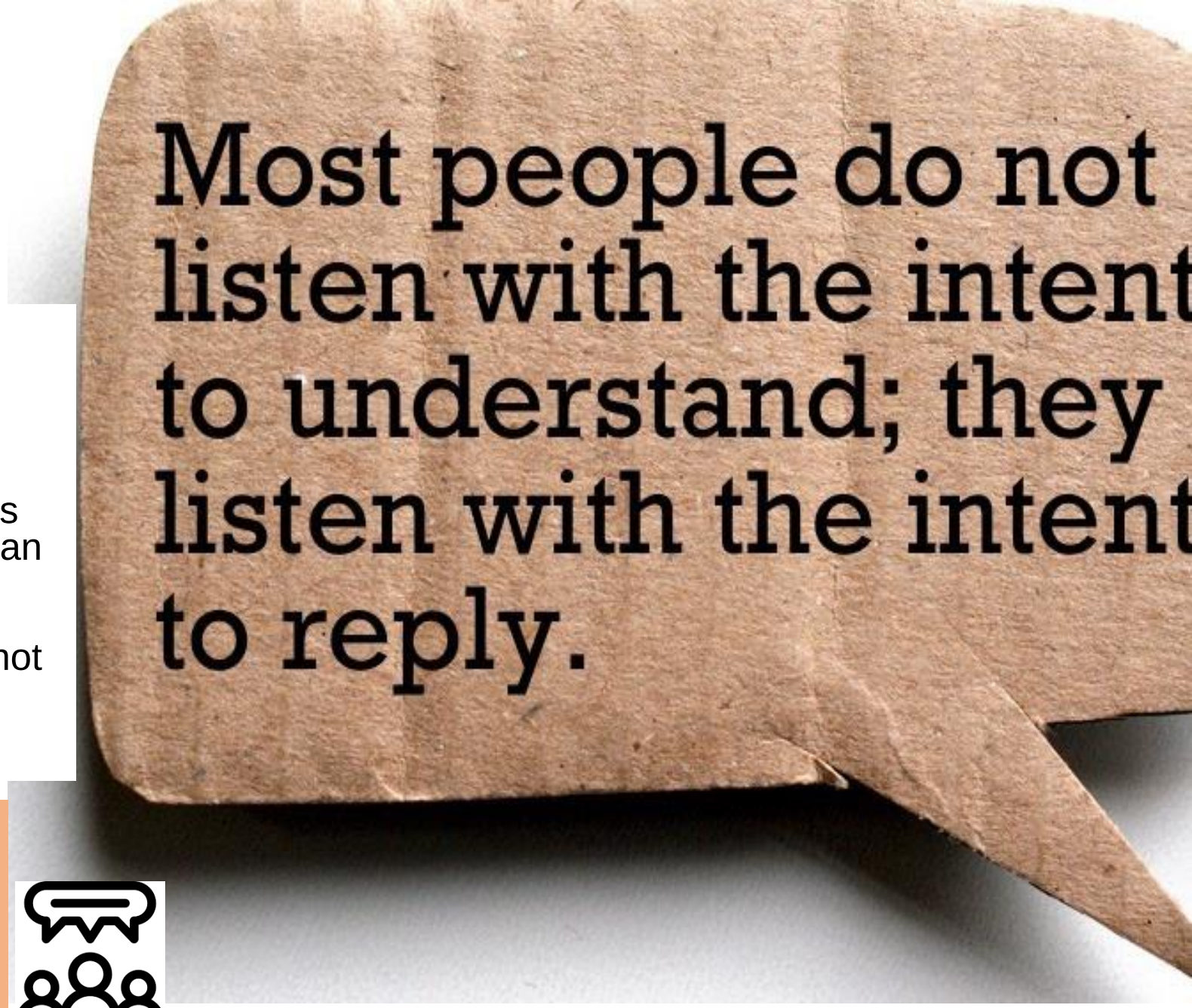
What freedom or support would you need to put these rules into practice?

Conversation One

- Not just for people we've not met before!
- Developing a rapport/relationship – quickly
- Understanding what really matters
- Connecting people to local resources and opportunities - not the same as an 'information and advice'
- Helping people's life work better
- Can be phone or face to face – but not just at home – maybe library, community centre, café, GP surgery

What might you hear yourself saying differently if you were part of one of these conversations?

How would you open a conversation?



Conversation Two

- We use it immediately we detect instability, crisis, risk of people losing control of their life, their quality of life, becoming dependent on formal care.

or…

- Where people need more of our time to support their situation and help move them on towards independence

Can you think of a situation where being allowed to spend more time with a person might have made a big difference to what happened?

Conversation Three

Open, honest conversations about the informal and formal support options available

Work with the person and anyone else they'd like to be involved to develop their Care and Support

Plan, and organise the support.

Agree with the person when you'll contact them to check how things are going.

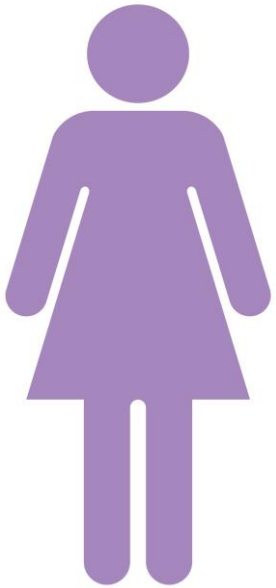
If everything is working with their plan, and they are getting on with their lives, that's great.

Be prepared to have further conversations to either tweak the plan or make more significant changes to help them get on better with their lives

3Cs and the Assistive Living Team, Assistive Technology Enabled Care 24 (ATEC24)

- ❑ Created in 2020 within existing telecare and assessment functions
- ❑Early intervention and prevention remit
- ❑ Workstreams applied to;
  - Recurrent callers and fallers
  - Fallen and Uninjured Person Pathway (FUPP) follow up conversation
  - Planned reviews
  - Proactive Outbound Calling test of change (phase 1 and 2)
  - Assessments for equipment and minor adaptations

A story of difference



Background

- Citizen living alone in a flat following a stroke resulting in left hemiparesis and reduced safety awareness. Also high anxiety levels evident. History of falls.
- Mobilises using wheelchair full time and transfers using hoist.
- In receipt of a care package and CAS alarm with pendant
- Chinese origin

The issues

- Citizen identified as a “frequent caller” reaching 165 weekly alarm activations with a high number of calls being unconfirmed and triggering responder visits to check safety / assist when fallen
- Lack of communication with call handlers causing frustration and uncertainty if there was a technical fault or alarm used inappropriately
- High number of falls during both day and night time
- Citizen unclear of purpose of CAS alarm / role of alarm service
- High levels of anxiety around when the next carer would visit and would attempt to access toilet in between planned visits
- Uncomfortable lying in one position during night

A story of difference

Challenges

- Anxiety plays a big role in citizen's life and puts him at risk i.e. unsure of how to contact carers, attempts to access toilet independently. During first part of visit he pressed his alarm 3 times and appeared unaware of this when pointed out.
- High level of reassurance is required by carers and alarm service call handlers, but they were often rushing
- Communication barriers were explored and it was identified he has capacity, speaks English and falls alarm not faulty
- Citizen engagement was achieved when allowing sufficient time for processing and responding.
- **He expressed he felt powerless and not in control of his life**

What's different

- Citizen is actively communicating and engaging with alarm service and carers.
- Ongoing need for re-assurance, but reduced dependency
- Less frequent falls
- Number of alarm activations has reduced significantly to average 36 per week

By informing and re-designing services around his unique needs, **citizen feels empowered to be actively involved in his own care management and takes responsibility for communicating his needs**

Outcomes

- Review visit with citizen, GP, carers and Social Worker in his home environment to make him feel at ease, and to identify his preferred communication, strengths, fears and goals
- Discussion around telecare and alarm service role, and response protocol identified highlighting call handler time is essential to facilitate conversation. Record updated including detailed care plan
- Re-assurance around carer role / times of visits informing both citizen and carers. Written time table designed for citizen
- Overnight service arranged for re-positioning in bed for discomfort
- Review of transfer equipment by Occupational Therapistj
- Telecare review - falls trigger button de-activated but sensor still alerting of suspected falls. Bed monitor relocated to floor immediately next to bed

Working together for a **caring, healthier, safer** Edinburgh

NHS Lothian

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL