i Reflect

January 2019 • Edition 18

Putting learning, development and good practice into the heart of Camden Adult Social Care

Learning opportunities to note

Read and Reflect hour

The Social Work Teaching Partnership is offering the chance to try out a 'read and reflect hour'. This is how it works: a journal article is sent out a few weeks in advance giving you time to read it. You then have an opportunity to critique and discuss the article and its application to practice with colleagues and a facilitator from the university. There is a session on **5 March 2019 from 12-1pm:** please book via the L+D Hub. This is a chance to get together with colleagues to discuss and critque some new ideas or research.

Lunch and learns sessions

We continue to put on short informal learning sessions which give staff across ASC the opportunity to learn from a speaker from another service or outside organisation; the aim is to help us to work together to improve our service to Camden residents. You can bring your lunch or take a break for lunch before or after. The next session on **31 January 2019** is being led by Paul Faddy on the I**mportance of Sleep.** There is also a session planned for **27 February 2019** on **tenancies,** which is being led by housing and the personal finance team.

BIA qualifying training

You should have seen a recent email inviting you to send an expression of interest to train as a Best Interest Assessor. The deadline is 25 January 2019: if you missed the information sent out, then please get in touch with Tony Anyaegbu, the DoLS team manager (Tony.Anyaegbu@camden.gov.uk).

In this edition

A week in the life of...

Marilyn Douglin has worked as an Administration Officer for Careline, Camden's assistive technology service for 9 years.

MONDAY

On Monday morning I come in and check all the referrals that have come in from the weekend social workers and other referrers such as OTs and doctors.
The admin team check all the information in the referral form to help determine what equipment is suitable; there is a range of equipment that can be installed depending on the person's specific needs. Examples of equipment we use to manage risks and achieve a variety of outcomes include pendants, GPS trackers and epilepsy sensors.

Once I have put all the relevant data from these onto Careline's systems, I schedule an appointment for the installation of the equipment. Given how long the appointments take, there is a limit to how many installation appointments can be made in a day and we always prioritise the absolute emergencies.
On average we do around 6-8 installations a day but this depends on what equipment is being installed as the more complex equipment takes longer. We do our best to ensure appointments are made as soon as possible following a referral.

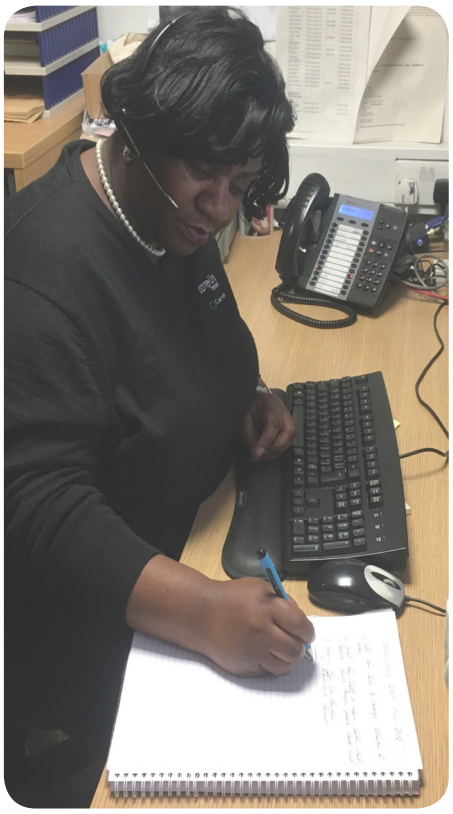
I contact the client to arrange the appointment and if the situation requires a joint visit, I contact the practitioner as well. Once the visit is arranged, I print out the paper work and a check is done to see if the person is eligible for a subsidised service or if they are self-funding. The referral is then passed on to the installation officer to do the assessment and installation of the relevant equipment for the person's needs.

TUESDAY

On Tuesdays, Charlotte the admin apprentice, does the key audit. This involves checking all the keys that Careline holds securely for our clients are there and that they are up to date. Careline requires a set of keys for the Gold service, which is the physical response service. The Silver service requires at least three contacts to sign up, they are then contacted if the alarm is raised to respond if necessary.

We keep all keys in the safe and they are identified by a number so that they are not linked to any address. It's really important that we hold keys for our clients so that we can get to them quickly in an emergency, or we risk delays in getting to the person and the possibility of having to call the emergency services to break down the door.

On Tuesday afternoon I was answering the phone dealing



with enquiries about the service. We get a variety of calls; I had a call from the monitoring service as they couldn't get hold of a responder to go out to somebody who had fallen. The responder was on another visit but after a few more attempts we managed to get hold of them and they were able to respond to the person who had fallen. Later on I had a call from a client who just wanted to tell us how happy she had been with the service, which she had used for her husband who she had cared for at home. She was unable to lift him if he fell but could rely on Careline to respond and get him up off the floor if needed.

WEDNESDAY

Every Wednesday we have our Careline team meeting where we discuss everything to do with the service. I took the minutes for this to capture the discussion points and actions.

Today we were discussing one client who had continuously refused the service so we had to keep cancelling and rearranging their appointments.

Unfortunately they then had a fall and an ambulance was called and police had to attend to force entry to the property. This made the person realise the value of the service and they are now grateful that they have it. In these situations we can only advise but we were pleased that we eventually managed to find a solution to help this person.

In the afternoon I checked the auto low battery report. This tells us all the equipment which has sent an alert saying that the battery is low. I then contact the relevant client and arrange an appointment for one of the team to go out and change the battery or the equipment.

THURSDAY

This morning I received a list from the data team of clients who have passed away. I arranged appointments for the equipment to be collected so that this can be refurbished and used to support someone else.

In the afternoon I was processing the applications for carers cards. This is a free service that we offer for people who are the main carer for someone such as an elderly relative or young person with a disability. They can carry a card in their wallet with a phone number that people can call to alert if something happens to the person. Arrangements will then be made for the person that they care for.

FRIDAY

Like Mondays, Fridays are one of our busiest days as the weekend is coming up and lots of people want to make referrals and have equipment installed as soon as possible. We do our best to accommodate this but we have to go based on how many available appointments we have in the calendar and prioritise the most urgent cases.

We have our admin team meeting on Fridays. We all get together to discuss just about everything and come up with ideas on how we can improve our service.

I have worked at Careline for 9 years. From the start, I realised what a wonderful service Careline is. I did not realise that there are so many people who live alone with no family members or friends. I've seen it change over the years as more people are using assistive technology to live more independently and improve their lives. It's a busy service which never stops as we're there for people 24 hours a day, 365 days a year, including Christmas and Bank Holidays, when people are more likely to feel isolated. It's a valid service because people know they are never alone. The team are great, we work together to help find the right solutions for people and ensure that issues are resolved quickly so that people feel safe and happy with the service they receive.

So what do OTs do?

by Angela Vazquez

OCCUPATIONAL THERAPY

I am an occupational therapist (OT) in Adult Social Care (ASC) and I have been working for Camden for the past three years. My days working as an OT are varied. When I am not out and about, in all weathers, visiting people in their homes, I'm here at 5PS doing paperwork, making referrals, attending meetings and enjoying the view from the 7th floor…

I get to know people from all backgrounds and in different situations. One day I might work with someone who needs help getting into their bathtub, another day with someone recently diagnosed with Parkinson's disease who is finding it hard to mobilise and to participate in self-care tasks, or with someone who is becoming forgetful at home or with someone who cannot keep an upright seating position due to a spinal condition.

occupational therapy

Reach your pOTential

I often get to know people quite well. Firstly, I spend time talking with clients and their relatives about their medical condition and their difficulties, asking specific questions. This way I get to know how disability affects their lives, but also about their strengths, their social support, their memory, how they feel emotionally and what they would like to achieve. Everyone experiences challenges differently and people have different values and priorities that influence how they feel about their situation.

I also spend time observing clients in their everyday life in their homes, assessing how safely and independently they perform daily tasks; for instance, how they get off the bed, walk to the bathroom, wash and dress, manage their medication, prepare their meals, manage their domestics, go to the shops, manage their money…

Sometimes I need to take measurements of people's bodies, like their legs or their back: for instance, someone with spinal issues who requires specialist seating. I also measure furniture height (sofa, chair, bed) or door widths: for example, for someone who is a new wheelchair user.

What I really try to do as an OT, is to "breakdown" the activity in order to get to the heart of the problem - what is the cause of the challenge, what are the risks. Once I know what the issue is, then the client and I can work together towards a solution. At least we try! I try to offer practical advice, simple solutions I have learnt over the years, through sharing experiences with colleagues and clients. I guess us OTs have to be quite creative at times! However, no one solution fits all.

As an example, I recently met Mrs M, who is 85 years old and lives alone in a council house that she has lived in for the past 40 years. She brought up her daughter in this house. The house is split in two levels, with bedrooms and toilet upstairs. Mrs M is very independent and goes out in the community several times per week. Her daughter lives nearby and visits often. Mrs M finds it hard to negotiate her stairs to access her bathroom; the stair case has a banister on one side only, she has limited range of movement and pain in her legs due to arthritis and she needs extra time to climb the stairs and can only do so one step at a time. This means that at times she cannot make it to the toilet on time during the day, which is causing her much distress.

We discussed some practical advice (perhaps planning to make her way to the toilet at specific times such as after meals / tea to allow extra time, as well as strategies to negotiate the stairs). I suggested a commode to use downstairs as / when needed and recommended an additional banister on the stairs. We also discussed that she might benefit from one-level accommodation and consider applying for sheltered housing. Mrs M felt very strongly that a commode downstairs was something she would NOT want but she wanted an extra banister installed on the stairs and to explore sheltered housing options. Of course, a different person in a similar situation might prefer a commode downstairs or to be set up on one level downstairs, rather than moving and leaving the house where they have lived for many years. It really varies; everyone is unique and so are his or her needs, goals, strengths and home environments.

Often my clients need a more far-reaching intervention: manual handling equipment (like hoists) when they cannot get from bed to chair on their own or specialist seating or major adaptations within their property. In these cases, I try out equipment, visit multiple times or visit jointly with a surveyor/other colleagues. At other times, for instance, in safeguarding cases, I work closely with social workers, GPs and district nurses to contribute to the risk assessment.

As an OT, I try to promote well-being and independence, so people are able to participate in meaningful activities. I attempt to make the complex lives of people with disabilities easier and safer. It is not only a rewarding job; it keeps me grateful and right on my toes.

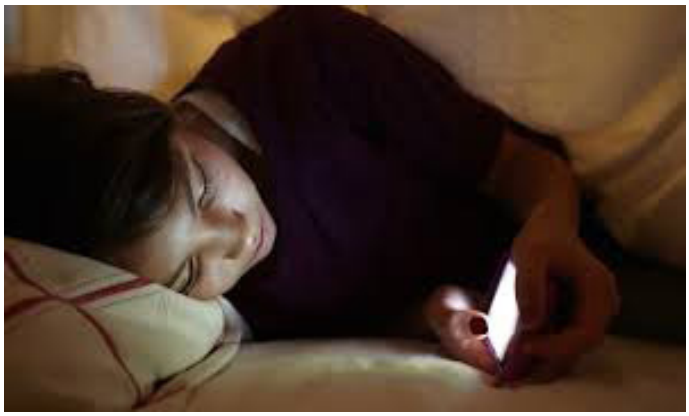
Social Care and Sleep

by Paul Faddy

At the Social Work Conference held in October 2018, I conducted a workshop on sleep. We started the workshop late so I didn't get a chance to have a discussion on how sleep relates to our work in social care working with both children and adults. I felt guilty about this, the day was a work jolly afterall, so here are a few ideas on the topic.

Adolescents are generally the most sleep deprived age group.

During puberty, the timing of the suprachiasmatic nucleus (the body clock, which controls the Circadian rhythm) shifts back, so sleepiness does not occur until later at night, often later than their parents. This can be exacerbated by teenagers' use of devices with blue light emitting screens, which tricks the suprachiasmatic nucleus to think the time is earlier than it is. A teenager's busy after school schedule of homework, sport, extracurricular activities, part-time work and social commitments all cut into their sleeping time.



The developing brain of a teenager is recommended to have between 8 to 10 hours of sleep per night. The many effects of sleep deprivation on teenagers include:

* concentration difficulties/shortened attention span
* memory impairment
* reduced academic performance
* poor decision making
* lack of enthusiasm
* depression
* suicidal thoughts and suicide attempts
* risk-taking behaviour, sensation seeking/ addiction
* moodiness, aggressio, other behavioural problems
* increased likelihood of exclusion.

Children diagnosed with attention deficit hyperactivity disorder (ADHD) have symptoms nearly identical to those caused by sleep deprivation.

If a sleep deprived child is assessed by a doctor and those symptoms are outlined without discussing the lack of sleep, it is possible a doctor would diagnose and subsequently medicate a child for ADHD.
The rise in diagnoses of ADHD is possibly due to a rise in sleep deprivation. The problem with this incorrect diagnosis is the common types of drugs prescribed for ADHD are Adderall[1] (amphetamine) and Ritalin (a stimulant also used in the treatment of narcolepsy), which are two of the most powerful drugs to prevent sleep.This is obviously the last thing a sleep deprived child needs.

[1]Trump's alleged drug of choice.

Older peoples' sleep is often fragmented.

As people age, the more frequently they wake through the night. The primary reason for this is a weakened bladder. When people wake at night they are often groggy, when standing blood is drawn from the head by gravity, resulting in feeling light headed and unsteady, especially for people who have blood pressure issues. Nocturnal bathroom visits are associated with an increased risk of falls, which can lead to fracture, hospital admission, loss of confidence, need for care cycle. Falls and fractures significantly increase morbidity and decrease life expectancy.

Tips for safe sleep for the elderly:

1) have a lamp within reach

2) use dim lights in the bathroom and hallways to illuminate path

3) remove trip hazards

4) keep a telephone next to the bed or a Careline alarm

5) consider Telecare such as falls or bed sensor

6) consider using a commode/urinal in the bedroom.

Nursing and residential homes are often poorly lit.

Some common rooms may only have 20 lux light levels. By way of comparison, office lighting is 320-500 lux and direct sunlight is 32k-100k lux. One of the more depressing sights in the job is visiting a nursing home in the morning and seeing residents (and sometimes staff) asleep in the common room with Jeremy Kyle goading on the TV. Neuroscientists in the Netherlands looked at the sleep / wake patterns of nursing home residents with early stage dementia. Initially the patterns varied wildly, out of sync with the Earth's day / night cycle (the suprachiasmatic nucleus needs to be reset by sunlight). The neuroscientists then installed bright lights throughout the home, which produced lux levels close to environmental light levels. The residents' sleep / wake pattern consolidated to the Circadian cycle, improving the resident's sleep patterns. An added benefit was the residents' cognition levels significantly improved. I need to speak to the care home commissioner about this research.

Paul will be leading a lunch and learn session on 31 January 2019 from 12-1pm on the importance of sleep and will discuss some of the ideas in the article and the importance of thinking about the impact of sleep for the people with whom we work as well as for ourselves and our families. It is currently fully subscribed, but he will consider repeating it if there is enough demand. Sleep is universal so it is a topic that seems to be of interest to us all. In the meantime, a few references to follow up if your intetested in finding out more:

** Action for happiness. Sleep your way to happiness - with Professor Russell Foster. You Tube, 2018 https://www.youtube.com/watch?v=3mvFd2KU57E&t=1228s

**Walker, M., Why We Sleep. London: Penguin, 2017

** BBC One. The Truth About Sleep [online]. London: BBC, 2017. https://www.bbc.co.uk/programmes/b08q8p13

** Martin, P. Counting Sheep. London: Flamingo, 2003

The house that Camden built...

Andrew Reece writes about developing the Camden Model of Strengths Based Practice

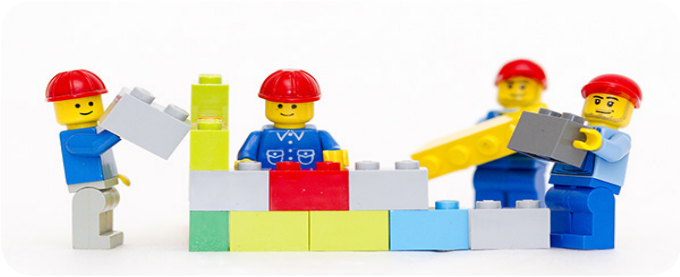
As the first anniversary of the 3 Conversations approach in Camden's adult social care teams passes, I thought it might be helpful to take stock of the approach while reconsidering how 3 Conversations fits with and complements other practice developments that are happening across the department, such as

* neighbourhood based teams in Support and Safeguarding
* the Supported Living project in CLDS
* the new s75 arrangements for Social Work in Mental Health

Seen in isolation, it may seem that these projects are separate from and different to the 3 Conversations work: perhaps as a senior leadership team we could have been better at linking them all together to help people understand how this work all fits together as part of a coherent whole. To try and help you visualise these projects as a coherent whole (excuse the slightly shaky metaphor), I am going to compare the development of a strengths based model of social work and social care to the building a new 'strengths based' house.

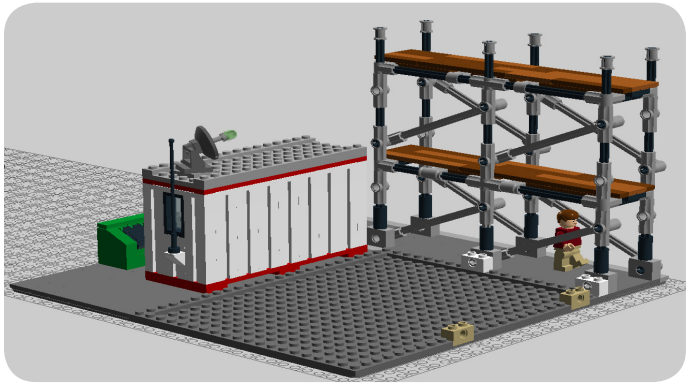
A house with many rooms

This 'strengths based' house has lots of different rooms, and each room (for 'room' read innovation site, project or team) will be used by different people for slightly different purposes. The house could even end up with more than one front door (£1 into the 3 Conversations swear box).



Foundations and Bedrock

When building a house you need solid foundations: in this case the foundations are the requirements of the Care Act, to deliver strengths based practice, and our local articulation of the Camden approach to this, *Supporting People, Connecting Communities*. To have a better chance of success, foundations need to be built on solid bedrock. This bedrock is our values, our commitment to people, our compassion, our belief that lives matter.



Scaffolding

Once the foundations are in place, you need scaffolding to support the workforce to build the new house: in this metaphor, our scaffolders are Partners4Change and 3 Conversations is the scaffolding that is helping us all to build the new 'strengths based practice' house.

During the building phase, the scaffolding enables us to build these new models, but once the walls and roof of the 'strengths based house' is finished the 3 Conversations scaffolding will be removed while we finish the final stages of construction. The principles of 3 Conversations will have been built into the fabric of the building, or built into the new care and support system we have built together.

Co-production as our Architect

One criticism that some people lay at the door of the 3 Conversations model is that it is too focused on staff and improving their experience and does not pay enough attention to the requirements of older and disabled people, their families and carers, in developing the new system. In this metaphor, I would suggest that the architect for the 'strengths based house' has to be 'co-production' with the people we support, developing the new model through Camden's 'shared endeavour'. The 3 Conversations scaffolding is only one of the essential components for a successful build, but it can't build the 'strengths based' house on its own if we haven't co-produced proper plans for the teams to follow.

For example the CLDS supported living project, which has been part of the CLDS Innovation site work, was developed from the CLDS Promise, a co-produced vision of what a good service would look like to people with learning disabilities and their families living in Camden. People with learning disabilities and their families told us that they want consistency in who they work with: they don't want to have to keep repeating their story or keep getting to know a new worker (or worse, not have the chance to get to know a worker at all). The supported living project is therefore based around the principle that everyone will have an allocated worker. This principle, core to the Named Social Worker pilot in which CLDS was a phase 1 participant, helped shape the thinking in CLDS about how to approach our innovation site.

Alongside that principle, we are adapting our face to face practice, using the principles of conversations 1 and 2 in particular to deliver more responsive and personalised support, without having to place people on a duty waiting list.

First Fit, second fit and completion

When the walls and roof are on, the next phases of a build involve finishing off the inside: plastering, electrics, plumbing, decorating etc. This involves people from a variety of trades pulling together and coordinating effort to deliver the completed house, room by room.

The next phase of 3 Conversations involves a similar coordination of effort from people across Adult Social Care: MOSAIC, performance and finance teams, working with locality and other social work and health and social care teams, all working alongside the voluntary sector and disabled and older people to finish the house together room by room. Like a building project we have a project manager to help us coordinate effort, ensure we do things in the right order and make sure that the needs of one room are consistent with the needs of the whole project.

Moving in?

So when do we expect to be able to 'move in' to our lovely new 'strengths based house?' The Partners4Change theory of change, has always envisaged a progression from innovation to scaling up to business as usual for the new model of working. Equating 'moving in', as per the building a house metaphor, to the new way of working becoming business as usual, would mean that CLDS and Support and Safeguarding expect to be 'moving in' sometime in the spring.

Like any new house, there will still be a 'snagging' phase and the building activity will continue, as the Social Work teams from the Mental Health trust finish off their rooms and while we continue to work with our care and support providers to add the finishing touches.

Slow shopping by Katherine Vero

Slow Shopping is for anyone with visible, invisible or intellectual disabilities who may find shopping stressful or challenging. It provides a safe space and time to think for all who need it, and their carers and families. I was inspired to create Slow Shopping by the experience of shopping with my mum who lived with dementia. She was an independent minded person and shopping was an activity that we could do together. As the dementia progressed our shopping trips became increasingly challenging. Mum might get confused, or need the toilet, or want to go home. I was trying to care for my mum, manage my own emotions, as well as to mediate between the store staff and other customers' expectations. Sometimes it was a very isolating and upsetting experience. I reflected on this and after mum passed away I wrote-up a small project and took it to my local supermarket.

Slow Shopping advocates a designated time in the week when there are enhanced services available to customers. Having a designated time enables stores to manage their resources and plan their provision. Staff are trained so that they have knowledge and skills to support customers and the customers know that this is a time that they can visit the store and understand that they can get assistance if they need it. During Slow Shopping no one has to identify themselves as having particular needs, unless they wish to. Slow Shopping is designed so that it is a no fuss, straightforward and manageable way of working for shops and supermarkets. There is a guide available as well as a short video to support staff.

Shopping tends to be an undervalued activity yet it involves social interaction, making choices, financial skills, moving around as well as being part of the ordinary everyday life of a community. It can be part of a therapeutic intervention. It can be done by anyone, rich or poor, well or living with ill health, an individual can wear more or less what they want to and the protocols of shopping are universal and have been part of our ordinary lives since the little play shop in the nursery. Shops are usually warm and safe places to be.

It was over two years ago that I took my project to my local supermarket and they are still offering Slow Shopping to their customers. I am now working with Sainsbury's, ASDA, Waitrose, Tesco and have two shopping centres interested. I am advocating Slow Shopping as an opportunity for people who may feel isolated or disenfranchised through visible, invisible, intellectual or cognitive disability to be able to engage in ordinary community life at whatever level they wish to.

The experience of slow shopping:
For the customer: they are able to come shopping alone or with someone and know that there are chairs to sit on and support if they need it. They are not judged and are given the time they need to do what they want to. Customers report that they like the experience very much and choose this time to shop because they feel empowered to ask for help.

For the store: they are able to plan their time and what they offer during Slow Shopping. Many stores quieten the music, stop using the tannoy, provide extra seating and do not stack shelves. This means that more staff can be available during the Slow Shopping and everyone has an awareness that a customer may need extra assistance. Stores have reported increased footfall during Slow Shopping as well as a 'halo' effect as customers like what they are offering even if they don't use it themselves.

For the staff: they enjoy this time and report how calm the store is and how they are able to really spend time with customers and help them. They like offering the service and they feel better about their work.

This article was a Ripfa blog and is reproduced with permision from the author. Katherine Vero is the founder of Slow Shopping. You can also access other blogs and a wealth of resources at Ripfa at www.ripfa.org.uk.

He Kotuku Rerwnga Tahi (a white heron flies once) by Shabnam Ahmed

The title is a Maori proverb often used when something very special and unusual takes place. This captures the essence of what I was fortunate enough to witness recently in Camden. If you were among the 100 people who attended the Family Group Conferening (FGC) event recently, you will know what I mean about a gathering with a difference. There was singing, there was dancing, there were beautiful Maori proverbs, but most of all, there was an energy which can only be described as magical. It was indeed special.

He kai kei aku ringa (there is food at the end of my hands)
Said by a person who can use his basic abilities and resources to create success

Tim Fisher, FGC Service Manager, successfully bought together Camden citizens, academics, social workers, FGC coordinators and several others committed to the values of this strengths based approach, to have honest conversations about what works and what we need to do to drive this forward. With guest speakers from New Zealand, America and the Netherlands we understood from them the positive and lasting effect of a whole family based approach and the strength in communities.

Kaore te kumara e kokero tona ake reka (the sweet potato does not say how sweey he is)
A proverb accentuating the value of humbleness

The tone of humility was set by the opening speakers, who included Clarissa, a Camden resident who asked us to leave our titles and qualifications behind us today and just come together as citizens.

The day unfolded through conversation circles and in the morning we heard from Paul Nixon and his experience of FGC in New Zealand. He urged us to think radically to bring about the change that is required through a rights and social justice lens. He emphasised the importance of relational practice and the act of bringing connected groups of family and community together; to strengthen the collective impact so people can have the leadership over the things that matter to them the most. We also heard from David Tobis who shared with us how parents and their allies changed New York City's Child Welfare System and the important role that parent advocates were able to play.

In the afternoon we were, as usual, blown away by our very own humble Martin Hampton, social worker, alongside Alice, an older Camden resident who has been connected to her community and neighbours with the help of the FGC process. If you have not yet seen Alice's story then do take time to watch the short brilliant film. Her story is an excellent example of the strength in her own community which enabled Alice to achieve the outcomes that were significant in improving her wellbeing.

Naku ten au te rourou ka ora ait e iwi (with your basket and my basket the people will live)
Referring to co-operation and the combination of resources to get ahead

Family group conferencing began in New Zealand and is hugely successful in connecting communities and keeping families together. There is an excellent vlog by Tim in which he explains simply what it is and its purpose.

In Camden our colleagues in children services use this approach in the early intervention services as well as child protection situations. I was both surprised and pleased to hear from Jamie Spencer that in Adult Social Care we have also now facilitated 60 FGCs.

By the end of the day we had even learnt how to sing Happy Birthday in Maori and all that was left for me to do was pack a bag and book a flight to New Zealand! When I tweeted exactly that, I immediately received a link to book my ticket! Did I do it? Not yet and instead wrote this...

Thank you very much Tim and all that were there for bringing a version of yourself that made the day a day to remember.

Chief social worker's visit to CLDS

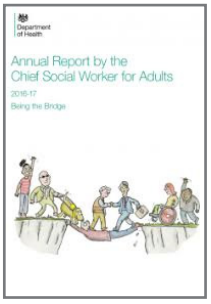
The Chief Social Worker for Adults with the Department of Health and Social Care, Lyn Romeo, and Stephen Airey, Policy Lead for the Government's Social Care Green Paper, visited 5 Pancras Square in October to learn about our good and innovative practice.

They met social workers and access and support officers from the Camden's Learning Disabilities Service, and heard about our innovative supported living work, strengths-based practice and the named social worker programme.

Lyn (pictured, third from left) and Stephen spent two hours with the team, exploring the challenges and opportunities of being the allocated social worker for whole schemes and of relationship-based social work, as well as the impact of these on our wider service and practice. They also discussed a range of other issues affecting services for people with learning disabilities, practice development and scope for future research.

The visit was reported on Essentials with the following quote from Catherine Schreiber, the social work team's service manager:

"The important and groundbreaking work we are doing is being recognised at the highest level, and will support Lyn's business cases and policy work for the forthcoming Social Care Green paper. We have also been asked to contribute to the Chief Social Worker's Annual Report, and our project and evaluation will be included in this. It is rewarding to know that all our hard work and efforts could make a real difference to the future development of social care policy and the profession."



Qualitative outcome measures: What is a good life? by Rosie Clewlow

In November 2018 Camden adult social care, with support from Strategy and Change, organised three focus groups which brought together around 50 citizens to discuss the topic 'what is a good life?'. The aim of these focus groups was to develop qualitative outcome measures for adult social care, so we can measure our performance against the ambitions set out in the Council's strategic plan 'Supporting people, connecting communities.'

The attendees at the focus groups were involved with adult social care in a variety of ways, enabling Camden to hear opinions from varied points of view. This included people with sensory impairments, physical and learning disabilities, mental health issues, older people, carers and colleagues from the VCS. Some of the citizens who attended had been part of engagement events with Camden before, including the focus groups held in summer 2017 when we asked for their thoughts on the strengths based approach. Some attendees had never engaged with Camden in this way before.

The focus groups were organised to find out from residents what matters to them in regards to living and ageing well in the borough, to ensure Camden is measuring the right things. We discussed what was important to citizens and how people could be supported to feel safe, well and connected. We encouraged people to talk about what a good life is and how we might measure adult social care's contribution to this.

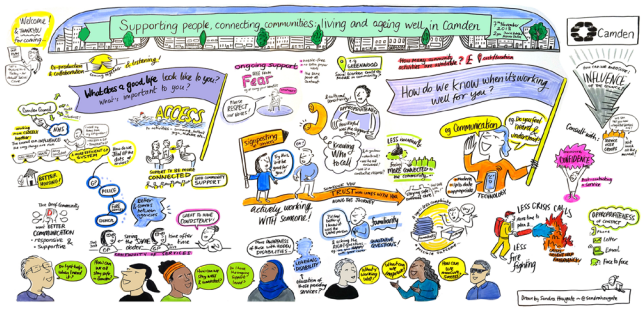
The focus groups were really constructive and rich; citizens spoke openly and creatively about adult social care's role in their life and a wide range of other things that matter too. It was brilliant to hear ideas we had not thought of, as well as hear confirmation about some things we have been doing recently and how they resonate with what matters to Camden citizens and with strengths based practice.

Some of the main themes to emerge were:

* Residents need accessible, useful and up to date information at the right time
* Citizens wanted to access the things in the community that they need and feel like they can participate – to be connected, not just signposted.
* Communication should be easy, appropriate and accessible for the person
* Their relationship with Camden staff should be trusting, honest and consistent
* The focus of care should be person centred, recognising the outcomes the person identifies, what support and networks they have, what is important to them and build on their strengths
* People wanted to know who to contact in a crisis and have a crisis plan
* People wanted to feel safe at home and in the community and have a place to raise safety concerns
* Residents wanted choice and control, to be recognised as experts in their own lives; they should, for example, write their own support plans
* People told us they have something to give and wanted that to be recognised

Citizens also discussed how we should measure our performance and potential ways to collect the data. These included telephone interviews/surveys, citizen casefile audits and a whole range of other activity. They thought external oversight of the work was important, as well as reflecting internally on whether we are getting it right. These focus groups reaffirmed the importance of listening to citizens and taking a collaborative approach to coproduction. It was interesting to hear their feedback, both positive and where there is room for improvement; we could not have developed these measures without them.

The next steps are to agree proposals on how we measure the outcomes and collect the data – we will be speaking to colleagues across the department, sharing the proposed measures and discussing the



methods of collection, roles and responsibilities in that collection and exploring how we will use the data gathered over the coming months.

There will be an opportunity to learn more about the outcome measures at ASC breakfast Drop-ins where you can also see the graphic illustrations drawn live at the focus groups and through future communications as they develop. We can also share the illustrations with you electronically if you wish to use them. We have found they are an excellent tool for bringing the residents voice into the room when discussing a whole range of issues.

Contact Jodi Pilling (Jodi.pilling@camden.gov.uk) or Rosie Clewlow (rosie.clewlow@camden.gov.uk) with any questions.

ASC required and core learning by Deborah Gordon

My name is Deborah Gordon and I have recently started at Camden as the OD & L&D Lead Officer for Supporting People. I look forward to meeting and working with many of you over the coming weeks and months. You should have received an email around 20 December 2018 informing you of the required learning and core subjects that are available from January 2019. Please make every effort to make sure that you sign up for places as soon as you can so that we are able to maximise our resources effectively.

Strengths based practice underpins Camden's strategic plan: "Supporting people: connecting communities" and is key to the transformation programme. This practice approach supports people, carers, families and communities to find the solutions that are right for them. It is about working with people to identify 'what matters' not 'what's the matter' and focuses on strengths rather than on deficits. Through collaboration there is partnership and connection to local communities and resources and a creative outlook, to make the best use of what we have available, and also to innovate to improve and maximise the best possible outcomes.

In Camden we believe learning happens everywhere and we do our best to find ways to support your learning opportunities in a variety of ways. The courses we are running are one element of the foundation needed to take a strength based approach when working with residents. All the courses are listed on the L + D Hub, so please check out what is there. Things worth noting:

* The frequency for attending refreshers is indicated and tends to be every 3 years.
* All experienced staff must attend the required learning as these sessions underpin our new ways of working. Experience can be considered against Core and Service/Role specific learning.
* You can check the courses you have been on.

To check courses you have attended: go to the L&D Hub (using the desktop icon) and choose 'My Learning', then 'Record of Learning'. You will be able to see what you have attended and the dates you attended. Historic information has been pulled in from the old TDSOnline system on these required subjects only.

During 2019 you will receive further notification of the up and coming Assistive Technology programme of learning during March and April, as well as other learning linked to our ways of working. Further communications will be issued nearer the time.

We are planning some drop in sessions and skype calls for managers as support. If you have any queries regarding the learning programme you can contact: patricia.cox@camden.gov.uk or learning@camden.gov.uk.