

Design in Social Care Programme

London Borough of Barking and Dagenham Project Summary

Giving people greater involvement in their care and support planning

Context

Barking and Dagenham applied to the Design in Social Care programme in 2018 as part of work across the borough to move towards a more person-centred and asset based approach in social care.

In 2018 the borough published its Joint Health and Wellbeing Strategy which puts an emphasis on delivering person-centred and place based care where partners from across the borough work together to improve the health and wellbeing of the local population.

For Barking and Dagenham, the Design in Social Care programme was about looking at opportunities to encourage greater joint working and collaboration between local partners.

The challenge

Barking and Dagenham wanted to understand how people could be more involved in their care and support planning.

At any one time around 2457 people in Barking and Dagenham are being supported by social care. This is providing care and support both to working age adults and to older people.

One area that became a specific area of focus on the project was understanding people's experience of leaving hospital and opportunities to strengthen this. Across a year, around 290 people leave hospital and go on to receive some form of reablement support to assist them as they go back home and to move them towards independence.

The work in Barking and Dagenham through the Design in Social Care programme was intended to help them understand how this worked and to look for opportunities to improve involvement such that people were more involved in their carer and support planning when leaving hospital.

What they did

The council already had links with an external evaluation organisation who they worked alongside to carry out semi-structured interviews with people who were in receipt of care as well as carers.

The in-depth discussions with people helped the team better understand the views and experiences of people. These were used to develop a set of personas and for the team to consider (both for service users as well as professionals), opportunities to support them in their different roles.

What do they look like? (Show them) 	Tell us about this person Albert grew up in the borough and used to work for Ford. He has seen his local area change significantly over the years and most of his friends and family have either died or moved away. He doesn't know any of his neighbours and says that they seem to change every few months. Albert used to play football but developed a number of mobility issues and most recently had a fall which resulted in a hospital admission. Tell us about their day-to-day life. Albert has a carer visit twice a day to assist him with washing and dressing, as well as preparing food. Spends most of the day watching television and doesn't go out much due to his mobility issues. Only visits are from the care professionals. Occasionally receives a phone call from his niece every month and gets sent a card on special occasions such as his birthday and Christmas.	What are their challenges? Albert is isolated and is reliant on the carers for support. He finds it difficult to adapt to his new life following his recent hospital admission, particularly the loss of independence. He is worried about the financial side of his care, and is a private person so sometimes finds the care somewhat intrusive.
Name Albert	Tell us about their support network. Very limited support network – just the care professionals that visit. His best friend is old Jack Russell Terrier, but he too is experiencing mobility issues due to lack of exercise.	What do they need? Support to keep safe and reassurance about finances and care options. His home may also require some adaptations and equipment to enable him to continue to make full use of his property despite his mobility issues. Support with his dog who is a very important source of companionship.
Age 85	What would this person say? “ I'm fine, we all get old eventually. I don't know what all the fuss is about! ”	
Job Resident – care recipient. Retired mechanic.		

What they found

There were a number of themes which came through from the discovery research. Some of these themes re-confirmed for the council existing knowledge but the programme also gave the opportunity to review these and to consider how they may be able to work together to make improvements to the service.

Financial concerns was one area where people weren't always clear that they may need to pay for their care. This was particularly the case for people leaving hospital whereby they may initially receive a period of reablement support but there may be a charge for ongoing care needs.

The team heard about confusion from people on **what should, or would happen when they left hospital**. There were opportunities to strengthen the provision of information and bring clarity over where people could go for advice and support.

The **cross-over between different organisations** was also a key theme which was raised a number of times and how best to engage with the service user as well as wider family unit. Coordination between organisations was seen as essential – particularly between the council, hospital and social care provider agencies.

Prototyping solutions and next steps

Based on what they heard the Barking and Dagenham team looked at opportunities to make improvements for people when leaving hospital. The team mapped through customer journeys to look at what information people receive and when – and how this relates to information flows between different organisations (which often happens in the background).

The work found opportunities to improve the information people receive when leaving hospital – particularly in relation to what home care / reablement care is being arranged for people when they return home.

As a short-term improvement the team have designed a **personalised guide for people** that can be used to inform people about what care will be provided and by whom after they have left hospital. The information is also intended to be used to help people understand what happens when they are discharged (including making them aware that they may need to contribute to the cost of their care) and where they can go for support.

The next steps are to further develop and test the guide with patients and carers and also with healthcare professionals who are the first point of contact in the hospital.

In the longer-term Barking and Dagenham are keen to be exploring opportunities to strengthen communication between local partners and continue to involve people in their care and support planning.

Although still at early stages of prototyping, the Design in Social Care programme has given Barking and Dagenham a range of tools and techniques that they can use in applying service design in other areas – both of social care but across the council.