Self Management and Co-Production

Together We Can Make A Difference

The CLARE Community Model.

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CLARE
Creative Local Action, Responses & Engagement

65+ and Living in North Belfast?

CLARE can help you live well at home

Together We Can Make A Difference
CLARE CIC
Community Grown Support Designed by Older People for Older People.

Creative thinking with originality to co-design something new and innovative, thinking outside the box with experts by experience. Co-Production.

Local recognising that the most effective care and support starts within a person’s own home and community; Valuing and respecting the assets of communities and the strengths of people.

Action thinking about change is not enough; by designing CLARE we put our thoughts into action and began to ‘positively disrupt’ to make a difference. Continue to act based on learning.

Responses Asking and listening to what older people and carers tell us and then responding, innovating and evolving to bring about meaningful change.

Engagement Co-producing ideas including giving voice to those people less often heard. Equal partnership with people and communities. Collaborating across boundaries. Empowering individuals to reach their potential through person centred working.
North Belfast

North Belfast Appreciative Inquiry
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• 58 Super Output areas (SOA)-nearly a third are in the top 10% of the most deprived SOAs regionally.
• Life expectancy in 2016 was 3.5 years less for men compared to NI figure and 2.7 years less for women.
• Healthy life expectancy is 50.6 yrs for men living in the most deprived areas of NI compared to 64.3 in the least deprived areas.
• In 2017 112 per 1000 people claiming DLA. 165 per 1000 Housing Benefit. Carers Allowance claims rose by 15.8%. 
North Belfast

CHALLENGES-
• Ageing of the resident population and increased prevalence of complex age-related conditions.
• An increase in suicide rates, increase in infant mortality, rise in cancer incidents, rise in alcohol related deaths.
• Impact of the Troubles on physical and mental health-55% of people surveyed stated they had been affected physically, mentally or both. Research by O’Neill et Al (2015) showed relationship with post conflict events and suicidal behaviour.

POSITIVES-
• 345 assets of direct/ indirect services mapped across North Belfast
• Life expectancy is increasing, decrease in circulatory disease related deaths, decrease in homophobic, racist or sectarian motivated crimes, rise in number of children gaining 5 GCSES grades A*-C.

However despite assets poor health outcomes and inequalities persist:
‘Poverty is an increasingly strong determinant of health and wellbeing.’
The CLARE Model

- **Community grown** response to supporting older people.

- **Asset based approach** encouraging the development of social capital and tapping into the existing neighbourhood support networks;

- **Co-production with clients** to plan how real connections can be made for better health management and social support.

- **Preventative and early intervention focus** to enable people to remain well at home.

- **Skills mix to enable maximum support and engagement.** Community Volunteer Facilitator, Community Social Worker and a Community Wellbeing Worker. A small group of Community Champion volunteers.
CLARE Theory of Change

Exploration with local community to match model of working to local context + Work with individual older people (assessment, tailored support, connecting to local supports) + Building capacity & connections within communities + Influencing formal systems locally and regionally (social workers, policy makers, commissioners) = OP have better quality of life. They remain longer at home, connected to appropriate, high-quality early intervention support delivered at the right time
What We Do

• CLARE works with older people over 65yrs who are very socially isolated with limited or no support networks and who could benefit from a community, personalised approach to enable improved health and wellbeing.

• Referrals can be accepted from any source including self referrals if the person agrees and fits our criteria.

• The service is currently only available in North Belfast but we remain committed to sharing the benefits of and need for a CLARE approach to supporting older people who experience more complex circumstances.
The Diamond Model

A social pedagogy approach.

Eichsteller & Holthoff, 2012
May not be able to afford rent, heating, food.
May not understand benefit entitlements
Living in poverty
Can’t focus on anything else!
Needs immediate action.

May not understand benefit entitlements

Loss of feeling of position.
Loss of self belief
Needs somebody to ‘really’ listen
Consider how confidence to be built
Give recognition
Need treated as someone of value

Social status may have changed
Community can view you differently
Feelings of shame
Maybe less able to get out and about
May need additional support to make and maintain meaningful relationships

New to their situation.
Fearful of professionals, assessments / review.
Needs support with day to day problems

Participate in and contribute to their community
Be active citizens
Getting back to ‘work’
Supporting other people
Need support to build capacity/development, creativity, growth

Needs support to build capacity/development, creativity, growth

Consider how confidence to be built
Give recognition
Need treated as someone of value

Supporting other people

Need support to build capacity/development, creativity, growth

Maslow, (1943)
CLARE Activities

Tailored work with individual OPs

Holistic Social Work Assessment (finance, family, social, housing, interests, past history, physical and mental wellbeing, strengths) and co-production of a personalised Living plan.

Ongoing assessment and review

May include Carer’s assessment and support to carer role

Purposeful support to promote independence and connect with support in the community, including counselling at home if needed

Promote and advocate Self-directed support

Knowledge sharing and capacity building within communities

Support to OPs (one-to-one, in groups or virtually)

Support for OP groups

Clarity Information Management system

Training and capacity building of professionals

Recruitment and capacity building of volunteers to a range of flexible roles

Influencing formal systems locally and regionally (positive disruption)

Knowledge transfer of the CLARE model

Strategic groups regionally

Belfast-wide engagement forums

Local engagement groups

Shorter-term Outcomes

Better understanding of OP strengths and needs (mental, physical and environmental). Any changes picked up and dealt with earlier.

OP more empowered to make day-to-day lifestyle decisions, and can influence decisions/actions that affect them.

OP more active, have better diet and more social contact.

OP receive more appropriate support quicker and is more likely to engage with local support.

OP receive the best quality service from 3rd party providers.

Longer-term Outcomes

OP have better quality of life. They are healthier (less likely to fall, be hospitalized, or move from prefrail to frail). They are better able to self-manage health.

OP remain longer in home, connected to appropriate, high-quality early intervention support delivered at the right time. They are as likely as other groups to access SDS and get personalised support. Carers feel supported in their role.

Community is thriving and connected. People value and see strengths in areas of deprivation as well as understanding needs. Increased employment in community from SDS, carer roles and volunteer opportunities.

Support provided to OP in groups in the community is valued, and adequately funded and supported.

Social workers use community development, early intervention, holistic approaches to value strengths and work preventatively in the community.

Policy makers and commissioners better understand type of change needed in the system, community development, and how to grow volunteers to be active working citizens reaching their potential within their communities. More efficient and effective system for funders.

CLARE seen as trusted, reliable, knowledgeable source of support for OP and organisations, to turn to for support, and for policy makers, commissioners, professionals and service providers to learn from. CLARE is financially viable and sustainable. Scaling of the CLARE model creates a shift to funding for community partnership models of prevention and earlier intervention. This enables more effective and efficient use of the Health and Social Care system and community resources. This will result in a more integrated, sustainable model of providing personalised support to help older people live well at home in their communities.
Self Managing Frailty

CLARE believe should be characterised by;

• Co-production.
• Avoiding labels! Move beyond the label.
• Personalised support planning and strengths based approach- moving from what is wrong to what is strong.
• Seeing the individual, their support networks, their community and the wider societal issues impacting on wellbeing. Working with an individual inexorably tied to thinking about community and society if change is to happen.
• Early intervention and prioritising frailty as a long term condition; AGE NI study-older people believe frailty goes beyond physical wellbeing to include mental wellbeing, social contact and financial security. Requires a ‘more widely encompassing model’
• SWEAT THE SMALL STUFF!
Case Study – Jack.

Jack was referred to CLARE CIC by a re-ablement team due to presenting as socially isolated and not meeting the threshold for support from Social Services. He had a recent confirmed diagnosis of Parkinson’s which had affected his confidence and independence as he is unable to go out alone.

Jack is 81 years old. He is a single man who lives alone; he has a very supportive brother who is older than him and lives a considerably distance away; they try to maintain a weekly visit. Jack has a sister in America. Jack is a very private man who likes routine and order—it took a long time to build his trust but he now has a brilliant relationship with our Wellbeing Worker Amy established through practical tasks and regular contact. Jack’s passion is motorbikes though he can no longer ride one. He loves music and opera.

• Two hospital admissions in April and September due to falls; after the first fall he felt he should move to a Nursing Home but when sent for rehab to a residential home changed his mind!

• Most recently he fell out of bed and broke his collar bone—he didn’t tell the carers but waited for Amy who brought him to A+E.

• Jack wants to stay at home; CLARE staff helped Jack discharge from hospital, getting key safe, and groceries and collecting him from hospital to smooth his transition home; he values the support from CLARE in keeping him connected at home. Despite moving along a frailty trajectory from 4-6 he views his circumstances as improving or being maintained despite increasing challenges- he is ‘self-managing’. 
It Depends-Jacks’ Support

Known for 14 months; 80 hrs of support-*Clarity IMS data.*

- 34 Visits; (16 from the Wellbeing Worker)
- 11 volunteer visits
- 2 onward referrals
- Practical support-personal shopping- 4 times
  - accompany to medical appointments 6 times
  - driving to appointments 9 times
  - social activities 3 times
  - accompany to A+E 1 time
  - visit whilst in hospital 1 time
  - help to discharge from hospital x2 people 1 time
• Staying well  2/10 improved to  5/10
• Keeping in touch  8/10 improved to  8/10
• Looking after yourself  2/10 improved to  5/10
• Feeling positive  2/10 improved to  5/10
• Managing money  8/10 improved to  9/10

Since my Parkinson’s diagnosis CLARE has provided me with excellent company, people who share my sense of humour and treat me like a king with dignity and respect.

In terms of my Parkinson’s diagnosis CLARE has facilitated me with important medical appointments which have allowed me to keep on top of my health conditions and be aware of what is expected to come in the future

I truly benefit from all the support CLARE provide for me and it is reassuring to know that there is always a familiar voice at the end of the phone.
Talking Therapies at Home

Rationale

❖ Older adults make important contributions to our society and communities: Most older people enjoy good mental health and wellbeing but it is important for those who experience mental ill health to be able to access effective and timely support: 22% of men and 28% of women over the age of 65 suffer from depression yet their health problems often go unrecognised and they are much less likely to access psychological help than younger people.

❖ The Journal of General Practice 2017;67 (Pettit et al) highlights that older people are the 'forgotten age group' when it comes to being referred for talking therapies yet they have better outcomes than younger people when they do get referred. Offering timely, appropriate and person centred accessible counselling is therefore a priority.

❖ The need for accessible home-based counselling for older people is now recognised by the BACP-Older Person’s Expert Reference Group. Jeremy Bacon Older Person’s lead supportive of the Talking Therapies at Home pilot and CLARE counsellor part of the group to share learning and explore ideas.
Talking Therapies at Home
Evaluation of One Year Awards for All Big Lottery funded pilot

Developed as a response to identified need and gap in service; Delivered in partnership with CLARE and Cathy Green- former CLARE volunteer and now Bee You Counselling co-founder.

- **10 people accessed after taking part in 10 week counselling at home programme** and then linked with CLARE for onward support.
- **Complex range of issues;** grief and loss, adverse childhood incidents, death of a child, prior unresolved marriage difficulties, guilt, shame, regret, low self-worth, low mood, anger, depression, loss of sense of purpose, loneliness, frailty. Worries about health, dying and death.
- Independently evaluated by Dr Helga Sneddon; most showed meaningful improvement in mental health and emotional wellbeing; the psychometric data shows older people are more content and less depressed following participation in the counselling- qualitative data shows they feel more confident, empowered and better able to cope with their lives and more likely to engage socially. Being home based was a key strength of the service and was much valued. NO current funding—Currently seeking funding to continue and develop.

‘I feel relieved from my past, a weight off my shoulders.’
‘You feel like a million dollars afterwards, you just feel free.’
‘I understand a lot more about myself and my past, it has changed me.’
Talking Therapy is a brilliant idea as I physically can’t go out.’
‘You really listened to me and showed empathy, I didn’t want sympathy

@beeyoucounsell1  @outcomeimps
Ladder of Participation
The New Economic Foundation.

Co-production → Doing with in an equal and reciprocal partnership
Co-design
Engagement → Doing for engaging and involving people
Consultation
Informing
Educating → Doing to trying to fix people who are passive recipients of service
Coercion
THE CLARE SOCIAL ‘COMMITTEE’

A work in progress

“A co-productive approach stands in contrast to traditional approaches which emphasise a person’s deficits, and instead starts with their assets and abilities – what they can or could do, rather than what they cannot do.


• Emerged from the first ever CLARE summer scheme for seniors-no budget, small pilot.

• First meeting of a committee- first gig-an intergenerational project with the Wee Chicks After Schools Group

• Linking with the Boys Model to design newsletter for CLARE community.
The Wee and Wise Intergenerational Group
SDS Pilot with the Chinese Community
USEFUL LINKS

• Link to **Clarity IMS** - CLARE Information Management system designed in partnership with PRECEPT IT. [http://clarityims.org](http://clarityims.org)

• Social Care Institute of Excellence Highlights No 6-May 2019; *Scaling up Community-Based Models of Care in Northern Ireland* [scie.org.uk/transforming-care/innovation/community-based-models](http://scie.org.uk/transforming-care/innovation/community-based-models)

• Campaign to End Loneliness Research Hub- [www.campaigntoendloneliness.org/loneliness-research](http://www.campaigntoendloneliness.org/loneliness-research)

• *You are OK; Strengths-Based Practice Insights From Adult Services* - Dept of Health NI Reflections Series

• *Anti-poverty Practice Framework for Social Work in Northern Ireland* - Dept of Health NI Reflections Series

• *Power to People* - Proposals to Reboot Adult Care in N.I. –Des Kelly and John Kennedy

• *Making Life Better* - A Whole System Strategic Framework for Public Health 2013-2023

• *The Health and Wellbeing of Older People in Belfast* - Black and Minority Ethnic Communities; Belfast Health and Social Care Trust. Jane Turnbull

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