An intention to partner, with the goal of *Flourishing*

Photo Credit: People's Trust for Endangered Species

Opening up the "front door"

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Acknowledgements

This piece was authored by Emily Brook, Director of Innovation at Care City.

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The most vibrant spaces on our planet

Earlier this year, my colleague and friend Mags Kalaugher introduced me to the concept of ecotones. Ecotones are the space where two different environments meet - the seashore, forest's edge, riverbank or even a roadside verge. These meeting places on the edge of different things are miraculous. They often have attributes of both of their adjacent environments. As spaces, they provide the conditions for innovation due to the inherent challenge at the interface between different habitats. In these spaces with shared resources and an environment primed for innovation, different species can mix and flourish. They are among the most vibrant spaces on our planet.

What if the point at which people first connect with our public service systems was the human equivalent of such a space? A rich and thriving interface between environments, rather than a barrier. Where resources and skills are shared. Where we meet people with an **intention to partner** with the **goal of flourishing**.

This year at Care City CIC we've been collaboratively reimagining what councils often call the Adults Social Care "front door" with a London council. Here, we share some of the thinking that has brought us to a model that we hope will ultimately feel a bit like an ecotone. As well as practice from our work, we share examples throughout from others who inspire us.

The as-is: A front door for whom, and to what?

> *I'm working with a man at the moment who shouldn't need a care package for many years, but he'll probably end up with one because it's the only option.*
>
> - Staff member in an integrated neighbourhood team

Much earlier in my career, I recall conversations about "front doors" when they were being introduced, and how they were discussed as **a way to help someone easily find something that could assist them**. On the face of it, this makes some sense, but it feels very far from what we've ended up with.

What are adult social care "front doors?" at the moment?

Structurally, these "front doors" typically have a contact centre component, and sometimes linked services such as reablement, elements of community advice, falls prevention, and discharge support, which are intended to help people to avoid, reduce or delay the need for long-term social care support. They sit between people seeking support and services. They attempt, sometimes bravely, to do four broad categories of things as outlined over the next two pages.

Collect information

Connect People to Support

Give advice

Provide early help

Collect information that enables the public service system to work with you. Who are you, what do you need, have you come to the right place, are you eligible for support? Generally the approaches in place are reasonably good at recording information, albeit in a way that often wastes about 50% of working hours through making staff populate siloed organisational case management systems. If the main purpose were to collect this data, this would be a dramatically inefficient model.

Connect people to support is probably the raison d'être that most describe when talking about "front doors". In reality a lot of activity here is about assessing people and "streamlining demand" through processes of giving advice, signposting people out to other places, rejecting people or referring them (most often to a waiting list - more on those later). Often, there are negotiations with one or more services to find someone willing to take the person on. "Front doors" are almost always ineffective at streamlining need in any meaningful sense from a resident, staff, or organisational perspective. Looking at society as a system, we are ill served by spending our limited resources on rejecting people when we first meet them because they're not needy enough yet, or putting them on an endless list, only to work with them once, in the absence of any support, their needs are much greater, and often their strengths are worn down.

Collect information

Connect People to Support

Give advice

Provide early help

Give advice through signposting or providing information to people, increasingly organisations are doing this element digitally - this has been the subject of a recent DHSC discovery project. Where the nature of support needed is transactional, this model can work well.

Provide early help, which is normally time limited and narrow in terms of scope. These services are rarely designed or resourced to get to know a person, to understand and respond to what might be contributing to the 'presenting issue', to identify and prioritise what someone might most want to work towards. They are also often described as 'early help' or 'preventative', but only kick in once someone has already ended up in hospital.

> *‘I think the concept of ‘no wrong front door’ is right - we need to make things easier for people. But what we see most is the services around the front door trying to argue that somebody shouldn’t be their case. [The services] are saying “Do we know that that person has a learning disability? They might not be ours.” We know that things haven’t been working for that person in education, that things are happening in their physical health, we know something is happening that nobody has properly paid attention to so far. Getting someone past the point of being in the front door to something helpful feels really much harder than it should.’*
>
> \- Staff member in a learning disabilities service

For those who meet and cross the threshold of the “door”, they most often end up on a waiting list for another service, or services, that are targeted toward addressing specific needs and are often short-term in nature. These lists are often many months or years long, with nothing significantly beneficial happening in the meantime. The services at the end are often too siloed. In a medical model this approach of diagnosing a need and funnelling someone to a treatment may have some merit, but in the face of human complexity, a “front door” like this will fail consistently. This failure is visible in health elements of the “front door” as well.

We frequently hear of social prescribers who have hundreds of people each on their list to work with. People who went to the GP not with something diagnosable and easily treatable, but because they were tired all the time, were really struggling with things, isolated… If you have hundreds of people on a list it isn’t humanly possible to work with them in an additive way, or understand why they might be living through something difficult - it’s only possible to transact. An assembly line of people that we do things to, not with.

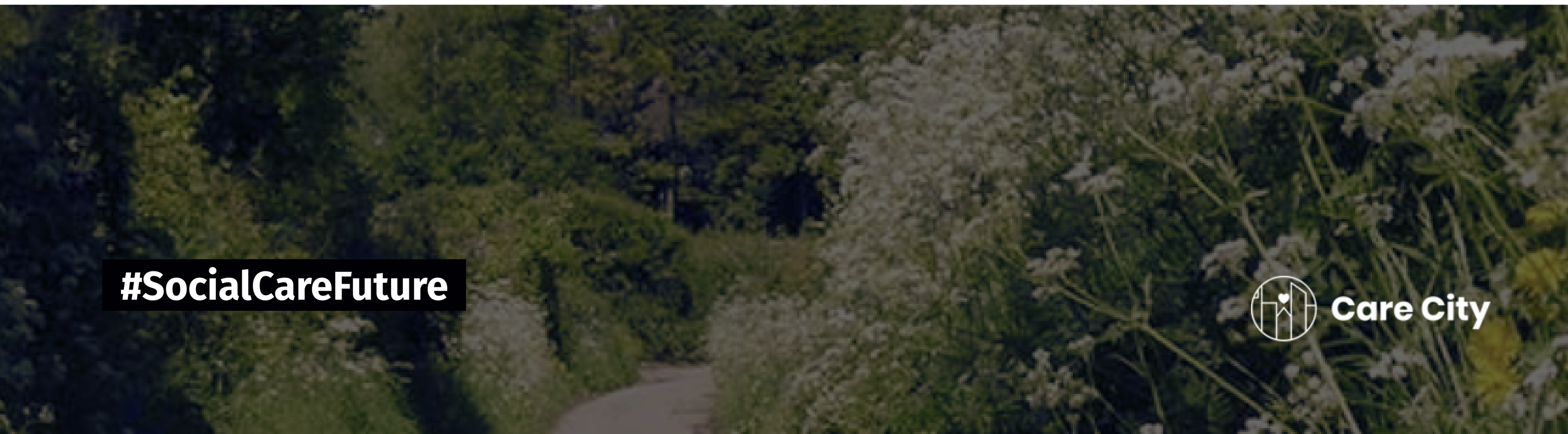
In the event of “front doors” in adults social care failing, we see lengthy waiting lists for single-issue services, people being referred repeatedly between different services, people getting lost in the system for years, a void of genuine early action or personalised support and people eventually ending up with something they don’t want or need. These design flaws are visible in most current “front doors”.

> *If you put support in early that works for that person, that ‘late stage’ is more than likely going to be offset for longer*
>
> - Person living with dementia
> ‘I just want to be able to dance’ Think Local Act Personal

The best interpretation of the system norms here is that we're passing people around because it's become the done thing, and everyone is busy. The worst versions of this I've seen are when there's a 'not wanting something to go wrong on our watch' culture sitting behind it.

Behind this often sits low-impact use of talented staff. A very experienced senior social worker recently told me that the people in their "front door" team are the **best at relational conversations in the whole of the council**. If you're working in a 'front door' role, there's a decent chance that you enjoy and are skilled at interacting with people. The way we've designed the system is the problem, not the people within it. Those staff who are good at relationships in "front door" roles currently have desperately limited power to do anything helpful, and often experience a level of moral injury as a result of not being able to work in the way they want to - imagine if we were making much better use of their time?

> *We have somebody who was dependent on alcohol, what they really needed was to get them into a routine. They worked with our support workers on a plan to get some structure. It built their confidence.*
>
> - REACH, Stockport



The future: An intention to partner, with the goal of flourishing

So, what might it take for our "front doors" to be replaced by an environment where we can flourish?

When I first met Tricia Nicoll at a Social Care Future Gathering she encouraged a reprogramming of our thinking. Less focus on what might go wrong, much more thinking about "what might it take" to meet an aspiration or overcome a challenge, whether the mundane everything days that are often central to our power and self esteem, or the sorts of extraordinary things that make your heart sing. I've asked myself what something might take every day since.

We've been designing a model with one council that we think begins to answer what it might take to replace front doors with a space that stimulates and supports thriving. It has been co-created based on ethnographic research with residents who have previously gone through (or got stuck in) the existing front door, drawing inspiration from models that exist and are working across the world. This new model will shift the lens we work to - seeing people drawing on care and support as active builders in their support ecosystem, with someone from a team in their neighbourhood working alongside them as they do it. Some key attributes relating to the form and function of this model are outlined over the next few pages.

Radical integration

Our new teams will be innovation partnerships between multiple VCSE sector organisations and health and social care staff. The teams will learn and work together, across organisational boundaries. They are being designed to work structurally and culturally in a seamless way alongside integrated neighbourhood health and social work teams and key council teams such as Housing and Revenues and Benefits, helping those services organise around the people they work with when needed.

Learning as core practice

Instead of a performative metric-meeting culture, the teams will constantly test, learn and iterate together, building and exchanging evidence and knowledge. Against a central societal question of 'how might we partner with people drawing on care, to flourish together?' we will prioritise learning and evolving every week - with as much emphasis on what doesn't work as what does.

In neighbourhoods for a reason

A key part of growing VCSE sector capacity within these teams is to 'hardwire' the purpose and benefits of working in neighbourhoods. Our teams will build expertise in their place and the informal networks of support that people want to connect into, draw on and contribute to - this is what will make them sustainable.

Relational working

The team's skills mix has been deliberately designed to provide relational support that helps people grow and sustain their own power. Their focus will be on getting to know people, working in partnership to help them build confidence, overcome barriers, achieve their aspirations, and grow their reciprocal support networks. The VCSE staff at the centre of the team will hold relationships with people - the centre of the team's work.

They will explore with each person what different types of care and support could mean to them, as part of conversations about their life, family and friends, community, hopes and challenges. Where professional advice or support is needed, the people holding 1:1 relationships will be able to tap into advice and support from a team combining occupational therapists, physiotherapists, care technologists, community matrons and pharmacists when needed. Over time, we might add further skills to this team, which will be a key part of learning.

Finding reasons to work with people, rather than reasons not to

The teams in this Council are resourced to work with more than 3,000 people per year. We expect these 3,000 people to include:

- People who currently have a care package
- People entering Adult Social Care at conversation three (where someone might need to draw on longer-term care and support)
- People in hospital who might struggle to stay at home when they leave, or those at risk of ending up in hospital unnecessarily
- People who are proactively identified as being likely to benefit

Rather than exclusion criteria, we will have inclusion criteria, seeking reasons why we can work together.

Stopping things that don't work

At the outset, the council, working closely with health partners, are stopping some existing services that aren't working to free up capacity and finances for these new teams.

Measuring benefits for place and system

We are developing an approach together to understand outcomes across the whole system, measuring and showing the benefits for everyone partnering on this work, including the residents at the centre of that partnership.

Technology helping us be more human
For staff, modern technology and AI are there to support teams in working with people and with each other, whether that involves using new technologies to help digitally record and take notes or to facilitate communication of ideas and ways of working across the team. For the people they work with, a range of proactive digital tools (from sensors to wearables and AI) will be easily accessible, supported by the care technologist roles in the teams, providing a digital “scaffolding” to help them live the life they want.

> *When you come back in your own home at the end of the day, if you've been there, you've suddenly got a silence on your own, yeah? You’re never on your own with that [carephone] right? And that, that goes a long way. Yeah, you know, yeah. I mean, I'm lucky. I've got [another person] there, I mean, but before [they] come along, when you come back at the end of the day, you knew that was there, you know, there for you. That was an unbelievable difference, right?*
>
> - Person explaining the different using technology had made for them

What follows are stories, shared with permission, from five people drawing on different types of care and support. They show how people can build confidence, overcome obstacles and achieve aspirations when viewed as central contributors to their care and support.

What Pat has achieved so far

Alongside Connect

Connect is a VCSE sector partnership in Barking and Dagenham which works alongside people experiencing isolation

A bit about me

"I'm 85. I was born in this area and I've lived in this house over forty years. I love the house - my family have adapted it so it's easier for me to walk.

I worked for social services in the council for 44 years, looking after babies before they were adopted. I got to a hundred and stopped counting! I've got a plaque up at the doctor's down the road, opposite where I lived where I was young, thanking me and my late husband for working in the borough and looking after children. I do a lot of jigsaws in the house to keep my mind occupied."

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Barriers I was experiencing to connection:

“Almost all my friends have died - I lost eight in a year last year. I know a couple of people close by - one on the corner, one up the road - some people pop in and bring some biscuits, but I’ve found it quite lonely. My husband died about a year ago and about two weeks later I had a stroke. Now my brain doesn’t always think right. I haven’t got my balance. I could only move my eyes at first, so I’ve achieved a lot since. I’m not a miserable person, but the first Christmas without my husband was big for me - I was in hospital in a room on my own. It was the first time I thought “I’ve had enough”. But the thought of my girls brought me back again - my girls have been so good that I think “If I give up, I’ve wasted their time”. My daughters are wonderful but they live far away - in Brentwood and Islington - to come it takes them 1.5 to 2 hours, then they have the same journey back… They’re good girls they look after me well. I’ve been to groups, for tea and biscuits. It’s nice and people are friendly. At one though I’m the only one who’s had a stroke, so I struggle - they do it on a long table and you don’t really get to talk to people easily. They play a card game, and a quiz, but it’s hard for me because I can’t write because my hands wont let me. And a lot of the info about stroke support here is out of date.”

My Hopes for Connect:

“Before meeting Abby [who I’m working alongside at Connect], I was housebound. But I’ve always been one to get out. Even when I lost all my mates, I still went to Romford, and to the bingo on my own. I can’t do that now - I can’t go anywhere - so I wanted help getting out and about. Eventually I’d like to be able to get out on my own. I also wanted to know more about what’s happening locally and get myself there. If anyone says we know somewhere, or let’s do something, I’ll do it.“

Some steps we’ve taken together:
“We’ve been going out a lot. It’s wonderful to have someone to help me get out. I got on the bus with Abby for the first time in years, otherwise I have to use taxis for everything. We went out to a shop together to pick out a walker - we went to try them all out. My kids wanted me to have a three wheeler, but apparently you need really good balance for that - so we found another one that suits me. We chat when we’re out and about to people, but you don’t meet many people around here - it’s a bit quiet. Still, this has given me a new life - I couldn't get out before.

I’ve achieved a lot from when I first came out of hospital. I couldn’t even be on my own then. I had to have a person in £100 a day just to have her sleep in the night, because I was too nervous, which linked back to when I was terrified as a child, when I was evacuated [in the war]. I slept with my mum until I got married, and then with my husband. I was afraid of the dark. I still sleep with all the lights on. Now I’m doing better, Abby has helped me to get a better lock now for the door after we got locked out together. This has helped me with sleeping on my own - I feel safer - and it means if something happens to me, people can get in to help, when they couldn’t before.”

How I interact with services and support in the Borough:

Before Connect

“I’ve been in hospital a lot, in and out, in and out - about 10 days each time. After my stroke, I did 6-8 weeks in there. I loved the stroke unit - they was good company the six or seven of us in there. We used to talk and have a laugh. It was good and I learned a lot - it was them that got me this far.”

“I had carers come in, for my husband, but I said I don’t want carers and I stopped them as soon as the 6-weeks [reablement] finished - it’s a lot of money. I thought that “we worked all our life for that, me and him”. When you’re like me, everything you do you have to pay for - I’m not on income support.”

Since Connect

“They rung me the other day from the hospital and asked “How’s your heart?” I said “it’s okay”, so they said “okay we will [discharge you and] put you over to the doctor now”, so I won’t be needing to see them anymore. I used to call the GP all the time, but I don’t do that now - I realise it’s a waste of time - they usually can’t talk to you.”

Things we might work on together next

Finding comfortable limits of mobility and independence

“I’m not sure how much I’ll be able to get out on my own. I think I might have got as far as I can go, with regards walking, after the stroke - I think I’ve lost a lot of my confidence. It’s wonderful to have someone to go out with - that’s important.

I have a lady who comes to the house to teach me yoga, and I know that the day after yoga, I feel good. It’s helping me get more confident. She takes my stick away and says don’t use it when she’s here. I’m alright for the hour until the very last bit where its all legs out. I seem to go blank, I think that’s my brain - it’s had enough.”

Doing what we can in an imperfect world

“I don’t think I’ll ever travel out here now as I don’t think it’s very safe around here - my neighbour parks his van on the drive, to help.”

Exploring environmental adaptations

“My daughters wanted to get a slope, for the front steps. I wouldn’t be able to get the walker out down the steps. I’ve only been going out since I’ve had Abby and I really look forwards to it. Also I can’t shower easily with the bath I have.”

Finding lasting mobility support beyond Connect

“I ring up for a patient transport and tell them I need one for my hospital visits, for my bloods, because I’m on my own. They take me and bring me back, which is how’s it’s been since the stroke.

It’s alright but you wait so long - 2-3 hours for an ambulance, coming back. Sometimes, I refuse to go to hospital. Even when I had three falls in one day - people are in there up to ten hours laying in the corridor - I thought I’m not having that no more.”

Finding the best ways to engage with primary care

“I’ve got a GP booked up for the end of this month, because you can’t get hold of a GP. So, if anything went wrong, I’ve got an appointment, because I take a lot of drugs. To be honest I’ve been like that for years though”

Dee's Story in a Nutshell

Community Catalysts

We cite the story of Dee who lost her leg to cancer. When her mobility scooter broke down, she was left unable to engage in daily activities with her children.

Dee's Story

local area coordination®

Feeling frustrated by a lack of support, Dee voiced her struggles at her children's school leading to an introduction to Local Area Coordinator Sarah. Sarah and Dee explored a simple yet powerful question - what do you want your life to look like? Together, they set a plan in motion.

Within weeks, Dee instigated a community bake sale raising funds for a new scooter. She then launched a community mobility scheme, helping others in similar situations, trained as a Level 2 chair-based exercise instructor and became a Community Health Champion. Through it all, Sarah remained alongside, not as a service provider with a time limit, but as a trusted and connected ally, locally available whenever needed.

More than her mobility, Dee reclaimed her sense of self. She is no longer just navigating life’s challenges, she is shaping her own future, giving back to her community, and, in her own words, feeling like a normal parent once again. Some years on, Dee is utilising her abundant skills as a Lifestyle Manager in a local residential home. As Dee points out “it just proves anything is possible with the right support.”

The Wonderful World of Ryan

who gets support from Possabilities

About Ryan

Ryan is a 34 year old man, with Down's Syndrome. He has a lot of aspirations for what he wants to achieve.

He lives in his own home - a flat in Cherwell - where he can also draw on support from Possabilities. As part of a supportive community, Ryan has been working to achieve some of these big and small goals.

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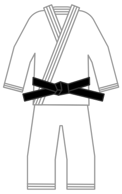
Things Ryan has accomplished:

Ryan completed work experience in food preparation in a café catering for other people who draw on care and support. This built on his passion for cooking and he set up a YouTube channel where he demonstrates how to cook his favourite meals.

He loves being involved in a variety show which we host at the Middleton Arena in front of 1,000 people. One year he wanted to be the doorman, checking tickets, another year he was the star performer, singing ‘This is Me’ from The Greatest Showman. Ryan really enjoys taking part in performing arts, and also featured on our float during Manchester Pride, where he wowed the crowd with his strongman routine, and in the Emmerdale Pride episode.



During a person-centred planning meeting in 2018, Ryan expressed an interest in giving jiu-jitsu a try. He wanted to get fitter and lose a bit of weight. We arranged for him to attend a taster at a local club and buddy-up with a friend. He really took to it, attending three times a week in different locations across the borough and making his own travel arrangements. His progression through the belts is impressive. He’s a valued member of the club and has begun helping the instructors during children’s training nights. He started by setting out the equipment and then after a DBS check was able to help out as a support to the instructor.

Things Ryan has accomplished:

Ryan was struggling to understand his sexuality, and as someone with capacity, had encountered situations which left him feeling confused. Ryan began to attend our LGBTQ+ support club in addition to support through the council's community learning disabilities team. He's been an enthusiastic member of our Manchester Pride float crew, and began a relationship, during which he enjoyed being part of a couple, including a hotel weekend in Manchester, which went well.

It's long been Ryan's dream that he should have a place of his own, and Ryan now lives in his own apartment. He helped to design his home, creating more space to support his cooking and YouTube channel equipment. For his mum, this is a major milestone, recognising that he is very capable. Having his own front door gives him a high degree of independence with just enough support from the Possabilities team and the other networks he has built up. Ryan was also part of the interview panel for the staff who work in the apartments he lives in, helping to shape what is needed from that support network.

Peter – Working with a person, not a ‘condition’

the East Cambridgeshire Neighbourhood Team

We haven’t quite finished working with a man who died recently. We are still involved with some of the details and decisions that follow death, and we talk about him all the time.

We started to work with him soon after our pilot team began. The local GP surgery asked us to support him to access hospital appointments, with a strong possibility that he had cancer. He was someone who had lived his whole life in Soham, but was known more by sight than by name. There were a few diagnoses and theories attached to why he was who he was, but because we work with the whole community, it wasn’t necessary for us to know whether his uniqueness was linked to a mental health issue or a learning disability, or anything else.

When life suddenly got more complicated for him and he needed some support, we were able to get involved.

Maybe it's because our first meetings were discussions about life and death that we felt we needed to stay with him through treatment, rather than looking for an alternative. It felt right that it should be us alongside him to help with navigating his way to and through the hospital, to communicate with a wide range of health professionals, or to comprehend life changing information.

It took a whole team, but we were with him through diagnosis and treatment, and a period of good health, and through follow ups and return of the cancer and discussion after discussion about what it meant when there was no more treatment, about choices in the landscape of end of life plans. We were with him when he talked to the hospice staff about how his death might look, when he talked to the vicar about his funeral, when he talked to the GP about pain relief. We were with him for the last meal he really enjoyed, and for the meals when he realised that eating was becoming something difficult and painful. We were with him as he realised that he was facing something that was eroding his life structuring routines. We were with him when he died.

He was an independent and private and determined man who had spent a lifetime protecting himself from harm with every resource he had. But it felt like, over time, he was able to show us his vulnerability, knowing that we would respect his courage and resourcefulness. We saw him take the steps to reach out to us. To come and find us with letters for us to read, or to join in with events that were put on. He led sing songs at the weekly drop in. He allowed us to see him cry and see him dance, to help him take medication, to start doing some of the tasks around his home that had never been done, or that had become too difficult for him. He showed us his mother's grave, and asked us to visit it for him.

Wonderfully, every member of the team came to have their own relationship with him, and, wonderfully, he recognised and valued our differences. And we each defined our own boundaries. But I know that we were always boundaried with him. We respected his choices, even when that meant a choice not to take certain medications, or to not heat his home, or to wear multiple coats for a long wait in an uncomfortably warm hospital clinic. We always respected his privacy, the limits to which he was willing to share his information or space. We respected his choices and we worked with him to make sure they were respected by others, too.

We are a team established to do things differently. Working with this person, we questioned ourselves every step of the way, checking in with each other that this was still the right thing to do. And we learnt about working as a whole team, about not automatically commissioning support, about not looking at diagnosis or access or eligibility, about planning birthday parties and trips to the coast, about not trying to separate what is health, what is social care, and what is us being human.

We are thankful for being in a team that is professional enough to work together to support people to live and die the way they choose, and open hearted enough to acknowledge each other's loss as we keep on doing the job we want to do.

Andrea on Climbing a Mountain

working with Reviving the Heart of the West End and

Andrea is an outgoing, friendly, warm person who wanted to share her story because she hopes it will inspire others into believing they too can take control of their lives to make a better future.

She is an unemployed single Mum with 3 sons who have severe dyslexia, auto-immune disorders and autism. She described her life as ‘living in a bubble’ in which she struggled to protect and support her sons at the cost of her own physical and mental health.

> *“SIGNAL [a technology that opens up conversations about drivers and goal setting] really helped me. The way it’s structured and the way the indicators are described on the Life Map means that you feel you can do something about them. What I like about it is that it doesn’t point the finger at you. Some surveys I’ve had to complete end up making me feel bad about myself because they seem to highlight all the things I can’t do. SIGNAL does the opposite”*

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uring COVID Sandra, a RHWE Personal Development Lead, invited Andrea to complete a second SIGNAL lifemap, this time via Zoom to comply with lockdown rules. Against expectations at a time where lots of people were struggling, Andrea told the story of a real transformation that she'd achieved.

Previously Andrea had lost her motivation and struggled to feel worthy and now she was smiling, talkative and upbeat. She described a turning point when she read a piece that Sandra had posted on the organisation's EXPLORE Facebook page about how to 'be kind to yourself'. She started exercising for the first time in 17 years.

She graduated from pilates and squats to taking herself off for walks in the country. To do this she had to take a leap of faith and trust her sons to be able to look after themselves. Short walks proved that they could, so she extended the walks - her son was now helping out by cooking for the family. Andrea is fit and healthy, her energy is infectious, and she has inspired other women to join her on the walks. Her sons are much more independent, and their health and wellbeing has improved too. Andrea is applying for jobs but is no longer stressed or depressed at not yet getting one. The most significant green on her SIGNAL follow-up survey is 'self-worth' which she has marked as an Achievement. And, yes, she really did climb a mountain: Ben Nevis, the highest in the United Kingdom.

> *Just to let you know I made it to the top of Ben Nevis. On the coldest wettest day of summer. I did it in under 8hrs. I'm already eyeing up Snowdon.*
>
> *- Andrea*

Reaching for the ‘win win’

The stories above show what happens when care and support is built up around, and in partnership with, people. This is the “right end of the telescope” that Phil Holmes described recently in his excellent article on how we can approach efficiency and productivity in adult social care from the right starting place.

> *I never again wanted to work in a team where we would respond to a person with “it’s not us.”*
>
> **- Charlotte Kirin**
> East Cambridgeshire Neighbourhood Practice Lead

By adopting a model that combines the best of people, communities, and service support, we are creating environments where people (who are drawing on care and support, as well as those working in the teams) are flourishing. We talk a lot about independence in this space, but for all of us our independence and autonomy is derived from the interdependent relationships and support networks in our lives - these are the things that give us purpose, that remind us that we matter, that help us to thrive.

We know that making this change is infinitely possible because through our work at Care City CIC and the efforts of many of our friends and partners, we witness it happening every day. Redesigning “front doors” through this lens is great for people and places, and economically necessary.

> *Adult social care at its best treats people who draw on care and support as active contributors to their families, their communities and their workplaces. It builds on potential (rather than crushing it by stereotyping people as vulnerable). It's not about some of us being dependent and others of us being independent, it's about all of us being interdependent.*

- Phil Holmes
Vice President of ADASS

> *Working in a more 'human' way could save public services £18 billion*

- Manchester Metropolitan University

Ultimately, we are all working to achieve the Social Care Future Vision for ourselves, our friends, our families and our places. Care City CIC and Social Care Future are interested in working with more places to create thriving interfaces between services and communities. We want to hear from people who also want to be part of making this future happen.

We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us.

That's the social care future we seek. #socialcarefuture

#SocialCareFuture

Care City