Public Document Pack

Health and Wellbeing Board *Supplementary Information for Agenda Item 4*

Wednesday, 3 October 2018 2.00 p.m.
Halton Suite - Halton Stadium, Widnes

Chief Executive

COMMITTEE MEMBERSHIP

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 16 January 2019

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

Item No.	Page No.
4. TRANSITIONS IN CARE – TRANSITION TEAM (APPENDICES 1, 2, 3 AND 4)	1 - 249

NHS
Halton Clinical Commissioning Group

Transition Protocol

For children and young people with disabilities and/or complex needs

2017 to 2020

Contents

Information Sheet iii
Section One: Introduction 1
Scope 1
Aims and outcomes 2
Section Two: Local processes and procedures 3
Transition Team 3
Transition timetable 3
Year 9 4
Year 10 to Year 14 4
Age 18-25 5
Out of borough schools 6
Assessment 6
Funding 6
Personal Budgets / Personal Health Budgets 7
Safeguarding 7
Operational and strategic oversight 8
Section Three: Legislation and guidance 9
Children & Families Act 2014 & SEND Code of Practice 9
Care Act 2014 & Care & Support Statutory Guidance 11
Mental Capacity Act 2005 12
NICE guidance 12
Good practice resources 13
Preparing for Adulthood (PfA) 13
Social Care Institute for Excellence (SCIE) 14
Skills for Care 14
Appendix 1: Transition CareFirst Recording Process 15
Appendix 2: Transition Annual Review Process 16
Appendix 3: My Transition Plan 17
Appendix 4: HBC ALD Nursing Team Eligibility Criteria 18
Appendix 5: Eligibility Guidance for 5BP Learning Disability Services 19
Appendix 6: National Framework for Children and Young People's Continuing Care and Adult NHS Continuing Healthcare 20
Glossary 23

Information Sheet

Service area	Health, Education and Social Care Services
Date effective from	March 2017
Responsible officer(s)	Principal Manager, Transition Team, People Directorate (Adult Social Care) Programme Manager (14-19), People Directorate (Education, Inclusion and Provision) Policy Officer, People Directorate (Adult Social Care)
Date of review(s)	March 2018
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	All professionals/agencies in Halton supporting young people with disabilities/complex needs in their transition to adulthood
Date of committee/SMT decision	Adult Social Care Senior Management Team: 1st March 2017 People Directorate Senior Leadership Team: 7th March 2017
Related document(s)	As referenced throughout the protocol
Superseded document(s)	Inter-Agency Transition Agreement 2012
Equality Impact Assessment completed	24th February 2017

Section One: Introduction

Transition is a process or period of change. The term can be applied to all young people to describe the stage in their lives when they move from adolescence to adulthood. However, for the purposes of this protocol it refers to children and young people with disabilities and/or complex needs and their journey from children's to adults' health, education and social care services.

It can be a time of excitement and opportunity with young people perhaps leaving school and considering their plans for the future in terms of employment, training or further education. But it can also be a challenging time with feelings of anxiousness particularly for those who rely on support from health and/or social care services.

This protocol sets out Halton's commitment to supporting those young people who may have a need for care and support in adulthood. It describes how the Council will fulfil its duties and responsibilities under current legislation and guidance relating to transition.

In order for transition to be effective, it is vital that a multi-agency approach is taken rather than being restricted to services provided by the Council. It is equally important that young people and their families/carers are fully informed and involved in the process and enabled to have as much choice and control as possible. It is also essential that transition is seen as an evolving process and not a single event.

This protocol is set within the context of the following vision from the Halton Special Educational Needs and/or Disabilities (SEND) Strategy 2016-2020:

> ***"Our vision is for children and young people with SEND to be included in the planning and development of services; to be provided with information to enable them to participate as fully as possible in decisions so that the personalised support they receive helps them to achieve the best possible aspirational outcomes, preparing them effectively for adulthood, allowing them to be as independent, successful and healthy as possible."***

Scope

This protocol applies to children and young people between the ages of 14 and 25 who have disabilities and/or complex needs, including the following distinct groups:

- Those who have an Education, Health & Care (EHC) Plan (or a Statement of Special Educational Needs);
- Those who are likely to meet the eligibility criteria for adult social care services (in line with the Care Act 2014);
- Those with Continuing Healthcare needs;
- Those with complex needs (e.g. challenging behaviour, learning disabilities, severe autism, acute or chronic medical conditions);
- Those who would benefit from support in planning for adult life but do not have an EHC Plan/SEN (e.g. those with high-functioning autism or social/emotional/mental health difficulties/ill health);
- Carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood.

This protocol ***does not*** *apply to those young people with mental health conditions, i.e. those being supported by the Council's Mental Health Social Work Teams.*

It is intended that this protocol will provide professionals from all agencies involved in supporting young people through the transition process with information about what should happen and when, who has responsibility and how agencies should work together. It is aimed at professionals from across education, health and social care, including the following services/organisations:

- Halton Borough Council – Children's and Adults' Social Care and Education Services;
- NHS Halton Clinical Commissioning Group;
- Bridgewater Community Healthcare NHS Trust;
- 5 Boroughs Partnership NHS Foundation Trust;
- Schools, colleges and other education providers;
- Other partner agencies, e.g. information and advice providers and advocacy services.

Aims and outcomes

Against the backdrop of relevant legislation and guidance outlined in subsequent sections, this protocol aims to ensure that in Halton all young people and their families/carers have a positive transition experience.

Success will be evidenced by the following outcomes of good transition:

- Young people making decisions and taking the lead or being supported by people who can advocate for them;
- Young people being supported to plan what they want to do and achieve;
- Young people with care and support needs being able to access the same opportunities as other young people;
- Young people being able to access services that help them;
- Young people being able to try things out and being free to change their mind;
- Young people and their carers telling their story only once;
- Young people and their carers being listened to and fully involved in planning and decision-making;
- Young people and their carers having one key point of contact through the transition process and receiving consistent messages;
- Young people and their carers feeling supported;
- Young people and their carers having access to understandable information;
- Professionals pursuing agreed plans but being flexible to accommodate change as required.

Section Two: Local processes and procedures

Transition Team

In order to fulfil the obligations placed on local authorities under the legislation and guidance outlined in Section Three, Halton Borough Council has established a dedicated Transition Team comprising 3.5 full-time equivalent Social Workers and a Principal Manager.

The Team will facilitate a joined-up approach to transition from across education, health and social care with increased and targeted co-ordination and communication from all agencies starting from Year 9 (age 13/14) up to the age of 25 years or until appropriate to transfer into generic adult services.

The Team will work closely with a range of professionals from across a range of education, health and social care services.

Referrals into the Transition Team will usually be made by schools in preparation for involvement with the annual review meeting in year 9. Other referral routes will include the SEND Service, children's early intervention services, Complex Needs Panel, Transition Operational Group and family members. Referrals should usually be directed via the Council's Contact Centre. New and unexpected entries to the system may also occur (e.g. as a result of someone moving into the area or a young person acquiring an enduring injury during the transition phase) and would be highlighted via the monthly Transition Operational Group meetings or via a referral through the Contact Centre (either from a professional or the individual themselves/their family).

See Appendix 1 for the CareFirst Transition Recording Process.

Transition timetable

As per the Children & Families Act 2014 (see Section Three for more information), every EHC Plan review from year 9 onwards must have a focus on preparing for adulthood. Transition planning for those young people with SEND takes place as part of the statutory annual review process, which is arranged by both mainstream and special schools and is monitored by the Council's SEND Service.

For those young people at a point of transition, who currently have a Statement of Special Educational Needs, the function of the review meeting will be:

- To discuss progress made by the young person;
- To look at the different options available and discuss the plan for transition;
- To transfer the Statement of Special Educational Needs to an Education, Health and Care Plan.

For those young people who already have an Education, Health and Care Plan, the function of the review meeting will be:

- To discuss progress made by the young person;
- To look at the different options available and discuss the plan for transition;
- To review the Education, Health and Care Plan and the outcomes.

All reviews are to be conducted in a person centred manner. Currently, Halton Speak Out is commissioned by the Council to provide a facilitation role in person centred reviews for those with a learning disability and/or complex needs; their involvement should be arranged by professionals as appropriate.

See Appendix 2 for a flow chart of the Annual Transition Review Process.

Year 9

Year 9 (age 13/14) marks the start of the formal transition to adulthood process and at this point the Transition Team will become involved in planning for the transition to adult services.

The review meeting is called by school and the following must be in attendance:

- The young person and their family/carers or chosen representative;
- School staff;
- A member of the Transition Team (Transition Social Worker);
- SEND Team representative;
- Health professionals as relevant (e.g. school nurse and any therapists involved);
- Careers advisor (provided through school), if relevant;
- Person centred facilitator, if relevant.

In advance of the year 9 review, school will support the young person to complete the **'My Transition Plan'** document (see Appendix 3), which will be discussed during the review meeting and added to and updated as appropriate afterwards. The Transition Social Worker will support school staff with this process. The purpose of My Transition Plan is to capture the young person's aims and aspirations for the future, the options that may be available to them as they move towards adulthood and the care and support they may require.

To assist with transition planning, young people and their families should be referred to the Preparing for Adulthood section of Halton's Local Offer, which provides information, support and advice across education, health and social care covering ages 0-25 years. In addition, the Care and Support for You Portal provides information, advice and signposting with regards to adult social care services (age 18+).

My Transition Plan sits alongside the Education, Health and Care (EHC) Plan and the Health Action Plan, which is initiated by the school nurse at year 9, as necessary. Some young people may also have an 'All About Me' book, which is produced by schools from year 7 onwards (schools are responsible for maintaining this). Each of these documents will be considered within the review and updated by the relevant professional as appropriate following the meeting. The Transition Social Worker, supported by the relevant school, takes responsibility for the My Transition Plan. The SEND Service has responsibility for the EHC Plan. Health staff in attendance at the review will give consideration to whether the young person needs any therapeutic involvement or if any further referrals need to be made.

Year 10 to Year 14

An annual review takes place each year and the process is the same as year 9; schools will arrange the review meeting and ensure that all relevant professionals are invited to attend along with the young person and their family/carers (see full list under year 9). The young person's My Transition Plan, EHC Plan and other documents will be reviewed and updated as appropriate.

There are some additional considerations in **year 11** and **year 14**, as at these times it is possible that the young person may change education provider or finish education. Schools have a statutory responsibility to ensure that young people have access to careers education, information, advice and guidance from year 9 onwards. In years 10 to 14 it is focussed on firming up the options when leaving statutory education. There should be taster sessions offered from the educational setting that the young person is looking to attend post-16 and these will be explored and confirmed by the current setting.

If leaving school or college (year 11/14), the young person's final School Health Review (to incorporate the Health Action Plan) should be completed by the school nurse or paediatrician and a copy given to the young person/their family and shared with their GP (if consent given). It should also be made available to adult services to inform future health needs.

Annual reviews, with involvement from the Transition Team and review/update of My Transition Plan, will continue to take place post-16 whether the young person remains within the same school or moves to another post-16 education provider. Schools/colleges will arrange review meetings and invite all relevant people as per the list provider under year 9.

Financial considerations

When a young person reaches age 16, their financial position may change in a number of ways depending on individual circumstances:

- If Personal Independence Payment (PIP, formerly known as Disability Living Allowance or DLA) is being claimed on a young person's behalf, they will be able to claim it in their own right from age 16;
- Some young people may be able to access Employment and Support Allowance and/or Income Support.

The Transition Team, school or other professional (as appropriate) should make a referral to the Welfare Rights Service in order to ensure that the young person is in receipt of the correct benefits.

It may also be necessary for a referral to be made to Welfare Rights as the young person approaches age 18 given the possible changes in income at this time and the fact that they may be required to make a financial contribution to the services they receive from adult social care.

Referrals for those with learning disabilities

Young people with a learning disability may be eligible for services from the Council's Adult Learning Disability Nursing Team from age 18 (in line with the eligibility criteria at Appendix 4). For those with more complex needs, the ALD Nursing Team may begin their involvement from age 17. The Transition Social Worker should make a referral at the appropriate time; the LD Nurses will then complete an eligibility assessment, Health Action Plan or an alternative piece of work, if required.

The Adult Community Learning Disability Nurse will liaise with child health and paediatric therapy services to establish if there are ongoing interventions that are likely to need to be transferred to adult health services' nursing and therapists. Where necessary, referrals will be made to the appropriate adult health service provider so that any joint working and phased transfer of ongoing intervention required can be facilitated.

Referrals may also be made to the 5 Boroughs Partnership (5BP) Halton Community Learning Disability Team, in line with the eligibility guidance outlined at Appendix 5. The Transition Social Worker should make a referral at the appropriate time.

Equipment considerations

For those young people who use specialist and adaptive equipment to enhance their function, independence or quality of life, child health services will review that equipment in preparation for early adulthood. This is crucial, as some specialist equipment that was funded for their needs as children is not subsequently funded in adult life.

Age 18-25

Some young people with special educational needs remain at a statutory school until they are age 19. As part of the review of their Education, Health and Care Plan, the outcomes under Preparing for Adulthood will be reviewed and if it is considered that they have not yet been achieved and further education is required to meet those outcomes, the young person may transition into a further educational placement. Links will also be made with other services such as Day Services and/or the Community Bridge Building Team to identify opportunities to build independence, maintain and improve health and access employment opportunities, if possible. The most appropriate provision should be identified according to the individual needs of the young person.

All adults in receipt of a service from an adult social care team will have a minimum of an annual review to determine continued eligibility for a service.

If young people aged 18 or over have not been included in the transition process as described above for any reason and professionals/parents/young people feel they may meet the criteria for adults' services, they can refer them for an assessment through the Council's Contact Centre. If the outcome of the assessment is that someone is eligible for services from adult social care, they will be met by the appropriate adult social care team.

Out of borough schools

A number of young people attend schools outside the borough; the procedure outlined above applies in the same way with involvement in annual reviews from the Transition Team and monitoring via the SEND Service.

Assessment

In line with the Care Act, a **transition assessment** will be conducted for young people with care and support needs if they are likely to have needs when they reach age 18. Adult carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood are also entitled to a transition assessment.

The assessment should be carried out when it is of **significant benefit** to the individual, which will differ according to personal circumstances; there is no set time when the assessment should be done and it can be done before the age of 18.

The assessment is separate to the My Transition Plan and looks at levels of need and eligibility for services but, as with transition planning, the assessment must be person-centred and outcome-focussed. It must also be strengths-based and focus on what the individual can do and achieve.

Assessment will be in line with the Care Act and completed as per the adults process through completion of the Supported Assessment Questionnaire (SAQ). Following assessment, application may be made to fund services.

Eligibility for community care services within adult social care will be in accordance with Care Act assessment and eligibility criteria. For more information, consult the Halton Borough Council Adults Assessment and Eligibility Policy and Carers Assessment and Eligibility Policy, which are available on the Intranet (links are provided to the current version of each policy, which are due for review in April 2017; therefore, please ensure that you consult the most up-to-date version).

Adults who are assessed as eligible for services will also have a financial assessment to determine whether the person will need to make a financial contribution to the services they will receive. This assessment will be in accordance with Halton's Charging for Residential Care Services Policy and Fairer Charging for Non-Residential Services Policy (links are provided to the current 2016/17 versions of the policies; please ensure that you consult the most up-to-date versions via the Council's Intranet. Please note that these policies are to be combined into one overall Charging Policy in 2017/18).

Continuing Healthcare assessments will be conducted in accordance with the National Framework outlined in Appendix 6.

Funding

Throughout the transition process, funding applications will need to be submitted to the relevant funding panel according the age of the young person (i.e. under 18 or 18+).

If the young person has complex health needs, consideration should be given to Continuing Healthcare (CHC) funding, which will be in line with the National Framework outlined in Appendix

6. The Transition Social Worker should make a referral to the Adult Continuing Healthcare Team (see Appendix 5).

Decisions on funding of education will be aligned to the Education, Health and Care Plans.

Personal Budgets / Personal Health Budgets

As per the SEND Code of Practice, young people and parents of children who have EHC plans have the right to request a Personal Budget, which may contain elements of education, social care and health funding. A Personal Budget is an amount of money identified by the local authority to deliver provision set out in an Education Health and Care Plan where the parent or young person is involved in securing that provision.

More information is available via the Local Offer using the links below (copy and paste them into your browser):

- Halton Guidance on Personal Budgets for Children with Special Educational Needs and Disability – (September 2014): https://localoffer.haltonchildrenstrust.co.uk/wp-content/uploads/2014/08/Personal-Budgets-.pdf
- Children's & Young People's (0-25) Personalisation & Personal Budgets Policy (*including Personal Health Budgets and Direct Payments*) Special Educational Needs and Disability (SEND): https://localoffer.haltonchildrenstrust.co.uk/wp-content/uploads/2016/06/Personal-budgets-Policy-2016.pdf

Information relating to Personal Budgets for adults is available via the following link:

http://www3.halton.gov.uk/Pages/adultsocialcare/Budgets.aspx

"Personal Budgets are an allocation of funding given to users after an assessment which should be sufficient to meet their assessed needs. Users can either take their personal budget as a direct payment, or – while still choosing how their care needs are met and by whom – leave councils with the responsibility to commission the services. Or they can take have some combination of the two."

Also, the adults Personal Budgets Policy can be found on the Council's Intranet:

- Personal Budgets – Social Care & Health (for Direct Payments) Policy, Procedure & Practice

Safeguarding

Safeguarding is everyone's business. If there are any concerns that a young person is at risk of harm or abuse, a report should be made to Child Safeguarding if the person is under the age of 18 or Adult Safeguarding if they are aged 18 plus. More information on how to report a safeguarding concern is available via the following links:

- Halton Safeguarding Children Board Procedures Manual December 2016
- Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Good Practice Guidance 2015-2018

Operational and strategic oversight

There are a number of meeting groups that focus on transition of young people into adult life.

Operationally, transition is managed through the Transition Operational Group, which meets on a monthly basis to track progress of individuals going through transition in order to identify and plan for the needs of young people who are likely to meet the eligibility criteria for adults' social care/health services. The group facilitates referrals and multi-agency involvement and also helps to highlight any new/unexpected entries to the system in a timely manner.

Also at an operational level there is the Preparing for Adulthood Group and the SEND Commissioning Group; the three operational groups work together to feed through recommendations to the SEND Strategic Partnership, the Children's Trust and the All-Age Disability Partnership Meeting in order to effect changes at a strategic level.

Strategic and decision-making responsibility with regards to the Transition Team/matters arising from the Transition Operational Group sits with the Adults' Senior Management Team (SMT), which meets on a weekly basis.

Section Three: Legislation and guidance

Together, the **Children & Families Act 2014** and the **Care Act 2014** provide a single, comprehensive legislative framework for the transition from children's to adults' services for those with care and support needs.

It is important to note that the Children & Families Act introduced a system of support from birth to 25 years and the Care Act is concerned with those aged 18 or over; therefore, there is a group of young people aged 18-25 who are entitled to support through both pieces of legislation.

The duties from both acts are placed on local authorities, not children's and adults' services separately; therefore, joint working is vital to ensuring smooth transition. Both acts have a shared focus on person-centred and outcome-focussed approaches that involve young people and their carers, recognising that transition is a process experienced as a family rather than an individual. It is also essential that transition is indeed seen as a process evolving gradually from ages 14 to 25, as opposed to a 'cliff-edge' at age 18.

It is also important to note that, with regards to safeguarding, although the Children & Families Act gives rights to young people from the end of compulsory school age, child safeguarding law still applies up to the age of 18. Similarly, the Care Act guidance states that if someone is 18 or over but still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding but with involvement of children's safeguarding and other organisations as appropriate (e.g. NHS, police).

Displayed below is summary information on the legislation and associated guidance plus links to the full information. There is also a range of good practice and guidance resources provided which will be of assistance to professionals in supporting effective transition from children's to adults' services.

Children & Families Act 2014 & SEND Code of Practice

Legislation:

http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

Part 3 of the **Children & Families Act** relates to children and young people with special educational needs or disabilities (SEND); it creates a comprehensive 0 to 25 years SEND system with the aim of joining up education, health and care (through EHC Plans) so that services support the best outcomes for children and young people.

Associated guidance:

https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

The **SEND Code of Practice** provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children & Families Act 2014. It relates to the SEND system for children and young people aged 0 to 25 years. Chapter 8 of the Code of Practice is concerned with 'Preparing for adulthood from the earliest years.'

Key points (consult the legislation/guidance in full for further information):

- Local authorities must publish a 'Local Offer', which should include advice/information on preparing for adulthood;
- Help should be offered at the earliest possible point – good transition planning starts before age 14 and should include raising aspirations and supporting children to make decisions;

- Young people aged 16 or over have the right to make decisions and requests – professionals must ensure they are prepared and that the implications of the Mental Capacity Act 2005 are considered. Parents should still be involved in decision-making, particularly if the young person is aged under 18;
- Education, Health & Care (EHC) Plans (which replace Statements and Learning Difficulty Assessments) must be person-centred and outcome-focussed. Every EHC plan review from Year 9 onwards must have a focus on preparing for adulthood, which includes support to prepare for higher education/employment, independent living, maintaining good health and participating in society;
- Local authorities may continue EHC plans until the end of the academic year during which the young person turns 25;
- There is a right to request a personal budget as part of the EHC process;
- Carers have the right to an assessment and support (similar to the entitlements offered through the Care Act);
- Schools/colleges should raise the career aspirations of SEN students and provide careers guidance;
- All professionals should support young people with SEN to develop the skills, experience and qualifications they need for employment (e.g. arrange work-based learning opportunities);
- All young people with SEN should be supported to make the transition to life after school/college, whether or not they have an EHC plan;
- To prepare the young person for good health in adulthood, support must be provided for their transition to adult health services. Professionals should work with the young person to develop a transition plan, which identifies a lead care co-ordinator (the young person should know who this is and how to contact them). Clinical Commissioning Groups (CCGs) must co-operate with local authorities in supporting transition to adult services and must jointly commission services that will meet EHC plan outcomes. In supporting transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services, CCGs and local authorities should refer to 'The Mental Health Action Plan, Closing the Gap: Priorities for essential change in mental health' (Department of Health, 2014);
- With regards to transition to adult social care, young people with SEN turning 18, or their carers, may become eligible for adult care services, regardless of whether they have an EHC plan or whether they have been receiving care under section 17 of the Children Act 1989. Under the Care Act (see next section), local authorities must carry out a transition assessment where there is significant benefit to a young person/their carer in doing so and they are likely to have needs for care and support from age 18. The transition assessment should be undertaken as part of one of the annual statutory reviews of the EHC Plan and this must be at the right time for the individual (i.e. when it would be of 'significant benefit' – there is no set age);
- Services should work in an integrated manner – co-ordinated, multi-agency support is required if young people are to achieve good life outcomes;
- Under no circumstances should young people find themselves without care and support as they go through transition.

Care Act 2014 & Care & Support Statutory Guidance

Legislation:

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The **Care Act** creates a new modern framework for care and support legislation with the central principle of wellbeing. Sections 58-66 of Part 1 of the Care Act deal with 'Transition for children to adult care and support, etc.'

Associated guidance:

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Chapter 16 of the **Care & Support Statutory Guidance** covers 'Transition to adult care and support' (guidance on sections 58-66 of the Care Act).

Key points (consult the legislation/guidance in full for further information):

- The Care Act introduces an entitlement to a **transition assessment** for the following groups if they are likely to have needs once they or the person they care for turns 18 in order to help them plan for transition:
    - Young people under the age of 18 with care and support needs who are approaching transition to adulthood;
    - Young carers under the age of 18 who are themselves preparing for adulthood; and
    - Adult carers of young people who are preparing for adulthood;
- Local authorities have powers to ensure continuity so that for those receiving children's services, they do not abruptly end when the young person turns 18 but must continue until adults' service have a plan in place;
- The transition assessment must be carried out **when there is significant benefit** to the young person or carer in doing so; the most appropriate timing of the assessment will be different for everyone and will depend on circumstances such as upcoming exams, entering college/work, moving out of the family home, planned medical treatment and so on;
- Transition assessments themselves can help with preventing, reducing or delaying the development of care and support needs;
- The transition assessment must be person-centred and outcome-focussed and guided by the principle of wellbeing. It should support the young person and their family to plan for the future by providing them with information about what they can expect. It should consider current needs and likely needs as an adult, including which are likely to be eligible needs;
- The provisions in the Care Act do not relate only to those young people who are already known to the local authority (i.e. those receiving children's services) but also anyone who is likely to have adult care and support needs once they reach age 18 – local authorities need to consider how they will identify such people;
- Successful transition depends on the young person, their carers/family and professionals working together and local authorities have a legal responsibility to ensure effective internal and external co-operation to ensure transition is smooth. Equally, partners of the local authority have a reciprocal duty of co-operation. There is evidence of the value of having a 'named worker' or 'lead professional' to co-ordinate transition and assessment planning across all agencies and local authorities should consider formalising this.

Mental Capacity Act 2005

Legislation:

http://www.legislation.gov.uk/ukpga/2005/9/contents

The **Mental Capacity Act (MCA)** applies to people aged 16 and over who may lack the mental capacity to make decisions about their care /treatment/ support.

Associated guidance:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

The MCA is supported by practical guidance in the form of the **Code of Practice.**

Key points (consult the legislation/guidance in full for further information):

- A person lacks capacity if they are unable to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken;
- There should always be a presumption of capacity; all adults (aged 16 or over) should be considered to have the capacity to make a decision themselves unless an assessment proves otherwise. In addition, it may be that they have capacity to make some decisions but not others;
- People should be given help and support to make their own decisions or participate in decision-making;
- Any decision or action taken on behalf of someone who lacks capacity must be in their best interests.

Part 3 of the Children & Families Act outlines that the right to make requests and decisions applies directly to disabled young people and those with SEN over compulsory school age (the end of the academic year in which they turn 16) rather than to their parents. The Preparing for Adulthood factsheet (see link in the following PfA section) includes more information on how young people can be prepared and supported to make decisions themselves and/or take part in decision making.

NICE guidance

NICE Guideline (NG43) 'Transition from children's to adults' services for young people using health or social care services'

https://www.nice.org.uk/guidance/ng43

This guideline covers the period before, during and after a young person moves from children's to adults' services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care.

The overarching principles are as follows:

- Young people and their carers should be involved in transition service design, delivery and evaluation;
- Transition support should be developmentally appropriate, strengths-based and person-centred;
- Health and social care service managers in children's and adults' services should work in an integrated manner to ensure that young people experience a smooth transition;
- Service managers in both adults' and children's services across health, social care and education should identify and plan for young people with transition support needs;

- Safeguarding information should be shared as appropriate by all agencies in line with local policy;
- It should be confirmed that the young person has a GP (and consideration should be given to a named GP).

NICE Quality Standard (QS140) 'Transition from children's to adults' services'

https://www.nice.org.uk/guidance/qs140

This standard is based on guideline NG43 and sets out the following quality statements:

- Statement 1: Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9.
- Statement 2: Young people who will move from children's to adults' services have an annual meeting to review transition planning
- Statement 3: Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer.
- Statement 4: Young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer.
- Statement 5: Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage.

Good practice resources

Preparing for Adulthood (PfA)

http://www.preparingforadulthood.org.uk/

The national Preparing for Adulthood (PfA) programme is funded by the Department for Education (DfE) as part of the delivery support for the SEND reforms. PfA's vision is that young people with SEND should have equal life chances as they move into adulthood, which should include paid employment and higher education, housing options and independent living, good health, friends, relationships, community inclusion and choice and control over their lives and support.

There are five key messages from PfA:

- Develop a shared vision of improving life chances with young people, families and all key partners;
- Raise aspirations for a fulfilling adult life by sharing clear information about what has already worked for others;
- Develop a personalised approach to all aspects of support using person-centred practices, personal budgets and building strong communities;
- Develop post-16 options and support that lead to employment, independent living, good health, friends, relationships and community inclusion; and
- Develop outcome-focussed multi-agency commissioning strategies that are informed by the voice of young people and families.

These messages are essential to improving life chances in the four outcome areas – employment, independent living, community inclusion and health.

There are a range of resources on the PfA website, including the following useful factsheets:

- The links between the Children and Families Act 2014 and the Care Act 2014
- The Mental Capacity Act 2005 and Supported Decision Making

Social Care Institute for Excellence (SCIE)

http://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/

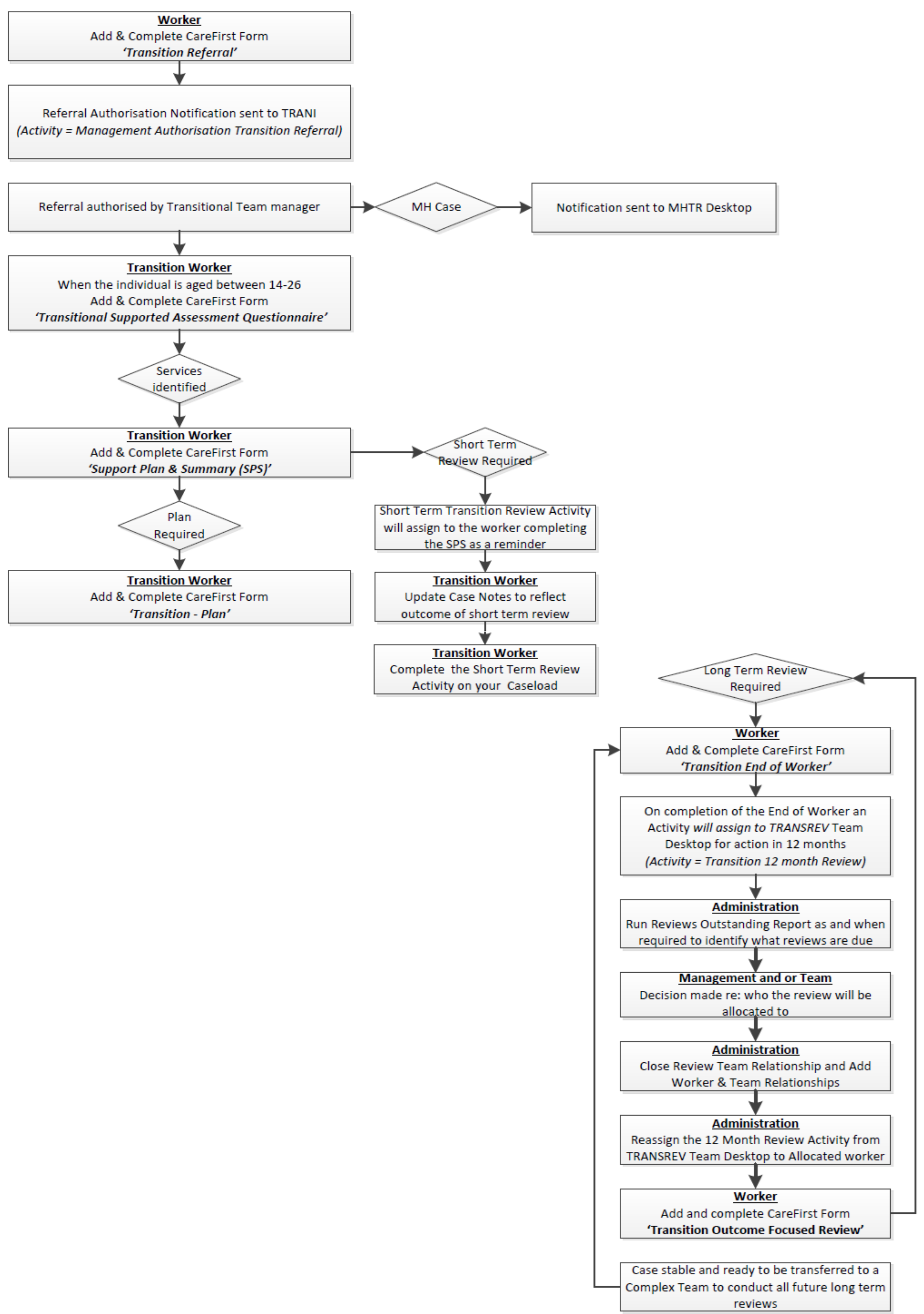
SCIE has developed a range of resources to help local authority staff, social workers, young people and carers to plan for the transition to adult care services.

Skills for Care

http://www.skillsforcare.org.uk/Standards-legislation/Care-Act/Learning-materials/Transition-to-adulthood.aspx

Skills for Care has developed a range of learning and development materials to help with the changes brought about by the Care Act 2014, including a specific set of materials on 'transition to adulthood.'

Appendix 1: Transition CareFirst Recording Process



Appendix 2: Transition Annual Review Process

Preparation for the Transition Review Meeting

The following is to take place at least two weeks before the meeting:

- Young person supported by school to complete 'My Transition Plan'
- School to invite relevant people in consultation with the young person/their family, including representatives from; the Council's Transition Team, health services (CAMHS, Therapists), school nurse (for those on CHC)
- School staff to ensure that the young person/their family are fully prepared in advance of the meeting
- School staff to ensure that all required information (relating to their experience and aspirations plus any previous education/health/social care reviews) is gathered and distributed to those invited to the meeting

Annual Transition Review Meetings:

Year 9 (age 13-14)	Year 10 (age 14-15)	Year 11* (age 15-16)	Year 12 (age 16-17)	Year 13 (age 17-18)	Year 14 (age 18-19)

Consider what assessments and services are required to support adulthood:

- Support with budgets and resources
- Access to leisure and social activities
- Work experience, training, supported employment
- Housing, supported housing, housing advice, adaptations
- Transport, including independent travel training (how will the young person physically get to places?)
- Assistance with personal care and independent living skills
- Short breaks
- Referral to welfare rights (at age 16 for support claiming own benefits)

*At this point (year 11) there needs to be a full assessment of social care needs to determine the appropriate package of support into adulthood – work may need to take place with commissioners to ensure appropriate services are available

At the Transition Review Meeting:

School to facilitate/chair the meeting and ensure completion and sharing of the review

'My Transition Plan' to be reviewed and updated as necessary by Transition Social Worker

A named worker for transition to be agreed at the meeting; this person will act as the contact point for the young person and their family for the forthcoming year

Appendix 3: My Transition Plan

Appendix 4: HBC ALD Nursing Team Eligibility Criteria

The formal criteria for a diagnosis of 'learning disability' are: significant impairments of both intellectual and adaptive/social functioning, which have been acquired before adulthood (Valuing People, 2001; British Psychological Society, 2001; American Psychiatric Association, 1994; American Association on Mental Retardation, 1992; World Health Organisation, 1992).

Indicators that the person *may* have a learning disability	**Indicators that the person *may not* have a learning disability**
• Evidence of delays in reaching developmental milestones e.g. walking/talking. • Previous statements indicating cognitive functioning in the learning disability range (e.g. IQ scores less than 70). ***The onus is on the referrer to locate and send copies of these*.** • Attended special school or attended mainstream school with extra support. • Unable to read, write or tell time, or this is limited. • Requires significant support from others for day to day living e.g. home living, use of community facilities, budgeting, personal care. • Unable to work in paid employment without support. • Previously known to learning disability services. • Educational reports refer to 'severe learning difficulties' (often equivalent to mild or moderate learning disability).	• Reached developmental milestones at appropriate time. • No statement, evidence of qualifications e.g. GCSES. • Has a driving licence. • Attended mainstream school and did not struggle. • Able to read/write well and can tell time using analogue clock. • Able to function independently in most areas of day to day living. • Evidence of working successfully in paid employment without support. • Indicators evident, but these can be explained by other factors e.g. mental health difficulties, physical disabilities, drug/alcohol problems, head injury as an adult. • Educational reports refer to 'mild learning difficulty' (less severe than learning disability).

Appendix 5: Eligibility Guidance for 5BP Learning Disability Services

NHS
5 Boroughs Partnership
NHS Foundation Trust
in Halton

Transition Guidance
Eligibility guidance for learning disability services

For interventions offered by professions in the team, referrals can be made directly. The following information is aimed as a guide when considering whether the LD team is the correct service for someone. It is aimed to support services to consider who could potentially benefit from LD services however; formal eligibility screening will be conducted by the team if the person is not already known to the service. Eligibility screening will also look at whether the person would be able to access mainstream services and what the need is for input from the team.

Definition of a Learning Disability (Health criteria – World Health Organisation, 1992)

There are three factors for determining the criteria: all *three* must be met in order for a person to be considered to have a learning disability:

1. *Significant impairment of intellectual functioning* - A significantly reduced ability to understand new or complex information, or to learn new skills, defined as an IQ of less than 70.
2. *Significant impairment of adaptive/social functioning* - A reduced ability to cope independently.
3. *Age of onset before adulthood* – Significant impairments of the above two criteria must have been acquired before 18 years of age.

Factors which MAY indicate that someone does NOT have a learning disability	Factors which MAY indicate someone DOES have a learning disability
• Successfully attended mainstream education without support • Gained qualifications (GCSE's) • Recorded IQ above 70 • No delays to development of speech or other milestones • Typical development until an accident or head injury post 18 years • Able to manage on work placements with minimal support, particularly those that involve complex skills e.g. use of tills • Able to access the community without support • Able to budget finances to an age appropriate level • Has driving licence or would be capable of completing theory and practical	• Recorded IQ less than 70 before 18 years (N.B there must also be evidence of problems with independent living) • Record of delayed development/ difficulties with social functioning and daily living before 18 years • Requires significant assistance to carry out tasks of daily living (eating/drinking, keeping self- clean, warm and clothed) • Requires significant assistance social/community adaptation (e.g. social problem solving/reasoning) NB need for assistance may be subtle • Evidence of difficulties in a number of areas of function, not explainable by another 'label' e.g. mental health, acquired brain injury, anxiety • Attended special school, or mainstream school with **high levels** of support • Unable to read and write • Unable to tell the time or locate events in time accurately

This table should be used as guidance; it is not exhaustive and other factors may be considered when determining eligibility for learning disability services.

Further support can be sought from Halton Community Learning Disability Team.
Address: Bridges Learning Centre, Crow Wood Lane, Widnes, WA8 3LZ. Tel: 0151 495 5302

Appendix 6: National Framework for Children and Young People’s Continuing Care and Adult NHS Continuing Healthcare

The “National Framework for Children and Young People’s Continuing Care” published by the Department of Health in 2016 sets out a process for assessment and agreement of eligibility for Continuing Care.

Continuing Care for children and young people is needed where a child or young person (under 18) has complex needs which cannot be met from the health services routinely commissioned by NHS Halton Clinical Commissioning Group (HCCG) or NHS England. It has been defined in recent regulations as:

> ‘*a package of care which is arranged and funded by a relevant body for a person aged 17 or under to meet needs which have arisen as a result of disability, accident or illness*.’

The care needed may be resource intensive, and long-term, with a significant element of nursing care. It may be provided in a number of settings and may involve more than one provider.

Children’s Continuing Care differs from adult NHS Continuing Healthcare which applies to anyone from 18 years of age who needs to be considered for a health funded package of care that will be arranged and funded solely by the NHS. Children and Young people’s Continuing Care should be part of a wider package of care, agreed and delivered in collaboration between health, education and social care. The arrangements for children with special educational needs or disability (SEND) in particular provide a framework for outcomes-focused joint assessments involving different partners across education, health and care, and many children and young people who need Continuing Care will have special educational needs or disability. A decision on whether or not Continuing Care is needed must be informed by a clinical understanding of a child or young person’s condition and an understanding of the way in which their needs affect their lives and those of their family. The emphasis should be on understanding the outcomes which would make the biggest difference to the child or young person and their family, and how health services can support delivery of those aims.

HCCG is responsible for leading the process of identifying the Continuing Care needs of a child or young person in Halton; Continuing Care needs should be identified, and the package of care agreed, as part of a holistic assessment of the child or young person’s needs. The subsequent decision about provision of care is made in collaboration with the child or young person’s health professionals, social care professionals, education professionals and the child/young person and their family.

Transition

As far as possible, the aim of providing continuing care should be to support the move from dependence to independence, with children and young people being enabled to manage their condition themselves with a full understanding of the implications of their condition.

Every child or young person with a package of Continuing Care who is approaching adulthood should have an Education, Health and Care (EHC) Plan which reflects an active transition process to adult or universal services or to a more appropriate specialised or NHS Continuing Care pathway.

Once a young person reaches the age of 18, they are no longer eligible for Continuing Care for children, but may be eligible for NHS Continuing Healthcare, which is subject to legislation and specific guidance. It is important that young people and their families are helped to understand this and its implications right from the start of transition planning.

The Children’s Complex Care Nurse should attend Halton’s transition planning meeting, and share information regarding Children with Continuing Care needs with Adults Services, with parental consent.

It is best practice that future entitlement to adult NHS Continuing Healthcare should be clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood.

- At **14** years of age, the young person will be brought to the attention of adult Continuing Care services.
- At **16** years of age, children receiving Continuing Care will be referred to adult services and all screening for NHS Continuing Healthcare will be undertaken using the adult screening tool.
- At **17** years of age, an agreement in principle for adult NHS Continuing Healthcare should have been made so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday (or later, if it is agreed that it is more appropriate for responsibility to be transferred then).
- At **18** years of age, full transition to adult NHS Continuing Healthcare or to universal and specialist services should have been made, except in instances where this is not appropriate.

If a young person who receives children's Continuing Care has been determined NHS Halton CCG as not being eligible for a package of adult NHS Continuing Healthcare in respect of when they reach the age of 18, they should be advised of their non-eligibility and of their right to request an independent review, on the same basis as NHS Continuing Healthcare eligibility decisions regarding adults. HCCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care (for example, to deliver an EHC Plan).

Children and young people eligible for Continuing Care who have a personal health budget may not be eligible for NHS Continuing Healthcare when they reach 18. Although these young people will cease to have a "right to have" a personal health budget, HCCGs can continue to offer services via a personal health budget on a discretionary basis, to support the transition to adult services. Transition should be planned and agreed with the young person and their family or carers in good time to avoid any disruption or delay to implementing a package of care.

Even if a young person is not entitled to adult NHS Continuing Healthcare, they may have certain health needs that are the responsibility of the NHS. In such circumstances, HCCGs should continue to play a full role in transition planning for the young person, and should ensure that appropriate arrangements are in place for services that meet these needs to be commissioned or provided. The focus should always be on the individual's desired outcomes and the support needed to achieve these.

A key aim is to ensure that a consistent package of support is provided during the years before and after the transition to adulthood. The nature of the package may change because the young person's needs or circumstances change. However, it should not change simply because of the move from children's to adult services or because of a change in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person. No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.

The legal responsibilities for child and adult services overlap in certain circumstances. In developing individual transition plans, partners should be clear where such overlaps occur, and the plans should clearly set out who will take responsibility and why.

It should be noted that regulations state that, in certain circumstances, when a young person in receipt of children's Continuing Care reaches adulthood, the care arrangements should be treated as having been made under the adult Continuing Care provisions. Guidance on the regulations sets out that young people approaching their 18th birthday will require a reassessment of their

health and social care needs as part of their transition planning and that, wherever possible, these young people should continue to receive their healthcare on an unchanged basis until they have been reassessed.

The Children's Complex Care Nurse, the LA Lead and the Complex Needs Panel should monitor and actively participate in the reviews of those recipients of Continuing Care who are approaching adulthood.

The regulations and guidance for NHS Continuing Healthcare can be found at: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Glossary

Term	Definition
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
EHC Plan	Education, Health & Care Plan
Local Offer	Published by all local authorities to detail in one place the services available in the area for children and young people up to age 25 with SEND.
NICE	National Institute for Health and Care Excellence
Outcomes	Refers to what someone would like to achieve or happen (e.g. being able to go out and about); individuals have the right to say which outcomes are important to them and be supported to achieve them.
Person centred reviews	Puts the person at the heart of the review and explores what is happening from the person's perspective and from other people's perspectives.
Personal Budget	Money that is allocated by local authorities from adult social to pay for assessed care and support needs. The authority can arrange services or the money can be taken as a direct payment and the individual can arrange their own services.
Personal Health Budget	As above but relates to health care/services and the money is provided by the NHS.
SCIE	Social Care Institute for Excellence
SEN	Special Educational Needs
SEN Statement	Being replaced by EHC Plans
SEND	Special Educational Needs and Disability
Strengths based assessment	An assessment focusing on a person's strengths and what they are able to do, not what they can't do.

My Transition Plan

Name of young person:	
Date of completion:	

Personal information

Name:	
Date of Birth:	
Address:	
Telephone number:	
School/college:	
National Insurance number:	
NHS number:	
Passport number:	
Birth certificate:	
Bank account:	
GP:	
Dentist:	
Next of kin:	
Other relevant information:	

Reference information

Parent/guardian details:	
Lead professional:	
Key education worker:	
EHC Plan Co-ordinator/SEN PA:	
Health professional:	
Social Worker:	
Advocate:	
Personal Advisor:	
Others:	
Friends:	

All about me

Things I like…

Things I don't like…

My aims, goals and ambitions…

Education / training

Your education so far:
Education plan or statement:
Is the plan or statement still correct?
Does anything need to be changed?
Action Plan:
Alternative plan (if required):

Support

What help do you have / what help do you need?
Action Plan:
Personal Budget:
Discussed? Yes / No Actions required?
In place? Yes / No Cost of current PB:
Do you have a Social Worker?
If yes, provide name and contact details:
If no, do you need one / would you like one? Yes / No
Alternative plan (If required):

Health

GP:	
Dentist:	
Speech and Language:	
Other health professional(s):	
Your health needs:	
Physical health:	
Mental health:	
Action Plan:	
Current health funding:	
Joint funding ☐	Full health funding ☐
CHC checklist ☐	DST completed ☐
Considered Personal Health Budget	Yes / No
Alternative plan (if required):	

Accommodation

Where do you live now? Who do you live with?
Are you happy in your current accommodation?
Where do you think you would like to live in the future and when?
What type of accommodation would you like to live in? Are there any access considerations?
Application completed? Yes / No
Date for presentation to Housing Panel:
Action Plan:
Alternative plan (if required):

Independent living skills / development

What help do you feel you need?
What self-care skills do you have?
Do you require equipment to enable you to live independently?
Action Plan:
Travel training? Yes / No
Details / plan:
Alternative plan (if required):

Finance

Welfare / benefits check completed? Yes / No
Action plan:
Individual bank account opened? Yes / No
Date to be opened:
What would you like to spend your money on?
Do you need help to manage your money?
Action Plan:
Alternative plan (if required):

Employment / work-based experience

What kind of job would you like?
What help do you feel you would need to achieve your goal?
Action Plan:
Alternative plan (if required):

Leisure activities / hobbies

What do you really enjoy?
What help do you need to be able to be really involved?
Action Plan:
Alternative plan (if required):

Summary of transition plan

Summary of each area:	Action required (with responsibility and timescale):
Education / training:	
Support:	
Health:	
Accommodation:	
Independent living skills / development:	
Equipment:	
Finance:	
Employment / work-based experience:	
Leisure activities / hobbies:	

Mental Capacity Assessment required? **Yes / No**

Mental Capacity is whether or not it is felt that you are able to make decisions for yourself in important areas of your life.

If yes, in which areas?

Date:		Next review:	

Agreement

Young person's views:			
Signed:			
Parent's/Carer's views:			
Signed:			
All professionals involved in this Plan agree to undertake identified tasks, to achieve the best possible outcome. All participants of this Plan will maintain close contact to monitor progress.			
Name:		**Signed:**	
Name:		**Signed:**	
Name:		**Signed:**	
Name:		**Signed:**	
Name:		**Signed:**	
Review date:			

Named Social Worker pilot

Programme evaluation – final report

July 2018

www.scie.org.uk

The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works.

We are a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

© SCIE

All rights reserved

This report is available online
www.scie.org.uk

Social Care Institute for Excellence
tel 020 7766 7400
www.scie.org.uk

Contents

[SH] Executive summary 4
[SH] Introduction to the NSW pilot 10
  [A] Phase 1 of the pilot 10
  [A] Phase 2 of the pilot 10
[SH] The evaluation approach 13
  [A] The purpose of this report 16
[SH] Pilot profiles 18
[SH] Defining the NSW approach 38
  [A] Piloting new ways of working 38
  [A] Building the NSW team 39
  [A] The knowledge, skills and values of an NSW 40
  [A] Setting up the NSW approach 42
[SH] The impact of the NSW pilot 47
  [A] Impact on the individual and the people around them 47
  [A] Impact on the NSWs 54
  [A] Impact on the wider system 59
[SH] Conclusions and recommendations 65
  [A] Conclusions 65
  [A] Recommendations 66
[SH] Appendix A: Summary of pilot sites 68
[SH] Appendix B: NSW programme theory of change 70
[SH] Appendix C: Findings from the NSW surveys 71

[SH] Executive summary

[A] Introducing the NSW pilot

The Department of Health and Social Care (DHSC) initiated the Named Social Worker (NSW) pilot to build an understanding of how having an NSW can contribute to individuals with learning disabilities, autism and mental health conditions achieving better outcomes. Specifically, that they and their family are in control of decisions about their own future and are supported to live with the dignity and independence for which we all strive.

The pilot sought to change social work practice and wider system conditions to improve outcomes and experiences for individuals in the cohort and for the people around them. This programme was specifically about trying something different, piloting new ideas and generating early and indicative evidence as to their impact.

Phase 1 of the pilot ran from October 2016 to March 2017 and involved six pilot sites – Calderdale, Camden, Hertfordshire, Liverpool, Nottingham and Sheffield. The second phase of the pilot ran from October 2017 to March 2018 and involved Bradford, Halton, Hertfordshire, Liverpool, Sheffield and Shropshire. The overall investment of Phase 1 was £460,000 and Phase 2 was £403,535. This report presents Phase 2 learning. It has been developed by SCIE in partnership with the Innovation Unit.

[A] Summary of NSW pilot Phase 2 activity

There was no defining NSW model adopted by all six sites. Sites were encouraged to structure their social work team and engage their cohort depending on what they wanted to achieve in their local context. Across all sites, the pilot recruited the equivalent of 24.5 full-time equivalent (FTE) named social workers (NSWs) who worked with a cohort of 119 individuals over the course of the pilot. Three pilot areas focused on transition cases while the other three sites worked with individuals who were from learning disability or Transforming Care cohorts.

Sites engaged a wide number of key partners throughout the pilot: children's social care teams, housing providers, health colleagues and advocacy groups, as well as families, carers and the other important people around the individual. A summary of each site's NSW pilot structure is contained in Appendix A.

[A] The evaluation

The evaluation took a capacity-building approach, primarily working with sites to design an evaluation framework that would guide data collection and analysis to draw out learning and impact that could help future decision-making. Sites submitted evaluation packs containing data and analysis to evidence the impact of their NSW pilot. This report draws upon the evaluation packs submitted by sites and is triangulated by findings from two NSW surveys and interviews with site leads.

This report should be read alongside three other reports: the Named Social Worker programme: Cost Benefit Analysis (York Consulting); Putting people back at the heart of social work: learning from the NSW pilot (Innovation Unit); and Peter's story: the perspective of a person supported by a named social worker (Humanly). A short, executive summary evaluation report, The Impact of the Named Social Worker programme, brings together the key messages across all reports.

Commented [JI1]: Hyperlinks to be inserted at next stage.

[A] Meeting the NSW pilot objectives: key findings

Phase 2 pilot sites were highly positive about their experience as part of the NSW pilot. They presented a wealth of evidence and data to demonstrate how the pilot had enabled them to work more intensively with the individuals in their cohorts, and to work in new ways and with different partners, depending on the local issue they were looking to address. Sites reported that the NSW pilot met their wider objectives to pilot new ways of working and that this led to positive impacts on the cohort and the people around them.

Despite the short pilot time frame, the evaluation evidence suggests that the NSW pilot had significant impact at three levels of impact, as presented below.

1. The individuals and the people around them:
   - had increased opportunities to feed into their person-centred plans in ways that met their communication needs and over a time period that helped them build consistent and trusting relationships with their NSW
   - felt that their NSW listened to them and acted on their behalf across the other people involved in their lives and
   - felt that NSW was putting measures in place that met their needs and those of the people around them to live a good life in the future.
2. The NSWs:
   - practised the knowledge, skills and values necessary to do good social work with people with learning disabilities, autism and mental health conditions
   - were protected by the NSW pilot structure, so that good social work happened in practice and
   - reported significant increases in confidence over the pilot and through the elevated status of the role, were more motivated and reported greater job satisfaction.
3. NSW pilot sites:
   - explored and deconstructed specific policy issues or objectives and piloted new ways of working

- engaged a wider body of stakeholders to tackle systemic practice and/or improve processes and
- built up an evidence base of what good social work looks like in the local context.

More detail about these headline messages is presented in the following sections.

[B] Improving outcomes and experiences for individuals with learning disabilities, autism and mental health conditions and the people around them

A relationship-building approach was key to the NSW pilot. It helped NSWs work closely with the individuals and the people around them to explore their needs and build them into their person-centred plans. This was particularly important in the area of transition, when the process of moving from children's to adults' services could feel complex and confusing. Having the time to share and digest information around transition helped young people and their families properly consider their options for the future as they become more independent. The sites that focused on transition generated evidence that linked early intervention to improved outcomes in their local areas.

NSWs reported various examples of ways they built the cohorts' voices into their own person-centred plans to help them live a good life. Individuals were supported into more appropriate living arrangements, including discharge back into the community or moving into a different residential setting with a reduced package of care. There were softer, more qualitative ways the NSW worked with the cohort, for example helping them get the pet they'd always wanted. The evidence also highlighted how NSWs supported family and carers, for example in decisions concerning respite care, in a holistic approach to social work.

Sites submitted examples and photographs of creative means of engaging the cohort in person-centred planning, for example mood boards, pen picture templates and emoji storytelling techniques. NSWs that used these methods were generally positive about using such tools in person-centred planning. However, it wasn't always possible to engage the entire cohort with these methods, just as it wasn't always possible to build a trusting relationship with everyone by the end of the pilot. The evidence suggests that reasons for this variation include:

- the time it took to build up relationships and the short pilot time frame meant that some sites were only ready to use more creative methods of engagement when the pilot came to an end
- the different starting points of the individuals meant there was no 'one size fits all' tool to engagement
- the NSWs had different levels of confidence and skill in designing and engaging the cohort in co-production activities.

Despite some variability in individuals' experiences, there is a wealth of evidence that suggests that the pilot was an opportunity for the NSWs and the people they worked with to begin an important longer-term journey to meaningful engagement, and learn things about each other that helped shape their future plans.

[A] Changing social work practice

Feedback from sites suggests that the knowledge, skills and values of an NSW epitomise 'good social work' – for example, putting the individual at the head of person-centred planning and advocating across the people that surround the individual so that their voices and wishes are heard.

Sites were able to test what it takes to put 'good social work' into practice in complex multidisciplinary settings, working with people who might be united by a learning disability diagnosis but otherwise vary tremendously in terms of their starting points, not to mention how they individually define what a good life looks like to them. This meant NSWs were able to develop their practice, confidence and skills and, in many cases, the practice of others.

The specific components of the NSW approach which allow 'good social work' for people with learning disabilities, autism and mental health conditions to take place in practice include:

- protected time for an NSW caseload, whereby the NSW can spend time to build up trusting relationships with the individual and the people around them, away from a time-and-task model of social work
- protected space and peer supervision structures for NSWs to reflect on their practice, work with colleagues to brainstorm and tackle concerns and share ideas and good practice
- the opportunity to trial and practise creative methods of engagement and approaches to delivering person-centred planning with people with learning disabilities, autism and mental health conditions and the people around them
- a risk-aware permissions framework, underpinned by legislation, to empower NSWs to 'constructively challenge' existing decisions concerning mental capacity and/or packages of care
- the elevated status of the NSW role to be able to work confidently across multidisciplinary teams of professionals and families to ensure the voice and wishes of the individual led the decision-making.

Despite the short pilot time frame, the opportunity to put 'good social work' with the cohort in action had a significant impact on the confidence of NSWs. Being part of the pilot improved social worker morale and motivation in their day-to-day work.

[A] Changing wider system conditions

Sites particularly valued the flexibility of the NSW pilot and the opportunity to try something new and trial new ideas or ways of working. Whether the focus was on the transitions process for young people moving from children's into adults' social services or working with the Transforming Care cohort to move into more appropriate residential settings – or indeed changing the wider systemic approach to taking risk – the NSW pilot allowed sites

to test, tackle and draw out learning around what good social work practice looks like these young people rooted in their local context.

Phase 2 sites used the NSW pilot to explore and tackle wider systemic conditions. This is particularly evident in the ways sites approached the pilot through a particular policy lens. For example, by: investigating the local transition process; streamlining processes for the Transforming Care cohort; or embedding a system-wide overhaul of local social work, underpinned by the Mental Capacity Act (MCA). Sites mapped out the different stakeholders and their touch points in a particular process, trialled a continuing personal development (CPD) training plan for the wider social work teams and built wider strategic relationships (e.g. inviting new partners to attend NSW steering groups or peer supervision sessions). In some areas, NSWs were involved in commissioning activity. For example, being part of the commissioning panel for new services related to learning disabilities and advocacy services, looking to stimulate the market for new forms of care.

[A] Economic impact

Analysis of the economic impact of the NSW pilot conducted by York Consulting used a predictive financial return on investment (FROI) methodology. This model generated an NSW FROI of 5.14. This means that for every £1 invested in the model there was an anticipated return of £5.14. Of the savings, or costs-avoided through the NSW, the primary beneficiary was the local authorities, which attracted 89% of all financial benefits. Full details of the analysis and findings are contained in York Consulting's NSW programme Cost Benefit Analysis report.

Supporting the results of this predictive analysis, sites produced evidence that showed how person-centred plans – taking a strengths-based approach – generated significant savings (or costs avoided) for the local authorities. New care packages, put in place collaboratively with the individual, generated a reduction in costs to the local authority and other partners. For individuals moving back into the community from out-of-borough placements, or for those receiving less intensive forms of respite care, the financial impact was significant, with cases generating savings in the region of £900 per week. Peter's story: the perspective of a person supported by a named social worker (Humanly), explored the financial impact of the pilot upon one individual's package of care in depth.

Commented [JI2]: Hyperlinks to be inserted at next stage.

Sites were confident that these were not just one-off savings but that they also represented cumulative savings in the longer term. As placements and plans were rooted in the preferences of the individual, they were more sustainable and less likely to trigger crises in future. Sites were also confident that these savings were directly attributable to NSW activity. As with the qualitative findings, sites felt that without the NSW approach, positive benefits would either take longer to materialise or would likely not have happened at all. This was especially true of the transition cases where 'business as usual' would not ordinarily have involved an adult social worker at the pre-transition stage of the process.

[A] Building up the evidence base

The NSW pilot gave sites the opportunity to try and test new ways of working and the evaluation process was a mechanism to help capture that impact and learning. Phase 2 sites used the evaluation process to articulate the impact of the pilot on the cohort and the people around them, the NSWs and the wider system. They attributed outcomes directly to the NSW pilot compared to 'business as usual' social work. For example, how an NSW was able to build up relationships before jumping into assessment, or have the knowledge and confidence to challenge a decision rather than accept the view of another

professional. Phase 2 sites added to their evidence base concerning what 'good social work' with people with learning disabilities, autism and mental health conditions looked like locally, as well as the framework required to make it happen in the future.

[A] Challenges to the NSW approach

Protecting time for a specific cohort was more difficult during times of organisational change and NSWs with mixed caseloads could struggle to hold time for their cohort if another case required increased attention. Sites raised questions concerning how the approach could be sustained, particularly in areas which were moving away from specialist social work teams to a more generalist approach. Pilot leads and NSWs agreed that local commitment to an NSW approach has to be in place across a wide range of partners, not to mention funding, for the approach to be sustained in future. Without this wider commitment and investment, there were fears that the NSW would be fighting the system rather than working within it.

Plans for the future

Sites described how they have either secured local funding for future NSW work or are in the process of securing it. As well seeking financial investment to protect the time of an NSW, there are a number of other ways in which sites hope to capitalise on and embed the pilot learning. These include plans to:

- maintain the structure of the peer group sessions, led by reflective practice, and share learning across teams, with the NSWs acting as peer group supervisors
- continue to use and build upon the co-design toolkit and person-centred tools when working with the cohort, and commission NSWs to produce a 'skills and what works guide' to share with other teams
- identify key partners to strategically engage in the system (e.g. mental health teams, housing, health colleagues, schools etc)
- clarify new processes and structures (e.g. the point at which an individual is deemed ready to be handed over to more light-touch community teams).

The ways in which the sites plan to embed NSW pilot learning are as unique to the local area as were the pilots, with sites exploring an approach to engage new cohorts and partners or tackle different issues. In this way, the question for sites is not whether to build a longer-term plan for an NSW approach in future, but how best to do it in practice.

[SH] Introduction to the NSW pilot

The Department of Health and Social Care (DHSC) initiated the Named Social Worker (NSW) pilot to build an understanding of how having an NSW can contribute to individuals with learning disabilities, autism and mental health conditions achieving better outcomes. Specifically, that they and their family are in control of decisions about their own future and are supported to live with the dignity and independence for which we all strive. As Lyn Romeo has summarised, the broader ambition of the pilot was:

> For people with learning disabilities and cognitive conditions to live a good life.
>
> Lyn Romeo, Gov.UK blog

Commented [JI3]: Gov.UK?

The pilot sought to change social work practice and the wider system conditions to improve outcomes and experiences for individuals and for the people around them. The programme was specifically about trying something different, piloting new ideas and generating early and indicative evidence as to their impact.

[A] Phase 1 of the pilot

Six pilot sites (Calderdale, Camden, Hertfordshire, Liverpool, Nottingham and Sheffield) took part in the first phase of the NSW pilot, which ran from October 2016 to March 2017, with investment of £460,000. Despite the short time frame, the pilot generated insights into how providing permission for social workers to practise differently, to work more closely with individuals and to work confidently in multidisciplinary teams throughout an individual's health and care journey, could benefit their work and individuals' lives. These insights are presented in the Phase 1 Findings report.

[A] Phase 2 of the pilot

The second phase of the pilot ran from October 2017 to March 2018 and total investment was £403,535. Each site was responsible for developing and implementing their approach to an NSW pilot, with practical support from the Innovation Unit and SCIE programme team. Three sites from Phase 1 applied for and were awarded Phase 2 funding (the other three Phase 1 sites – Calderdale, Camden and Nottingham – did not apply for Phase 2 funding):

- Hertfordshire County Council
- Liverpool City Council
- Sheffield City Council.

Three new sites were awarded NSW pilot funding:

- City of Bradford Metropolitan District Council (MDC)
- Halton Borough Council

- Shropshire Council.

Table 1 provides a snapshot of each site's activity.

Table 1 Activity in each site

City of Bradford MDC	Halton Borough Council	Hertfordshire County Council
NSWs were starting a process of culture change that made citizens' human rights the focus of social work, including the development of a competency framework for advanced practitioners.	NSWs were building long-term relationships with young people moving towards adulthood and used creative and person-centred approaches. They did whatever it took to support the young people to achieve their goals.	Continuing to implement their approach from Phase 1, Hertfordshire situated NSWs as a lynchpin between the individual and other professionals, with a strong focus on peer support between professionals.
Liverpool City Council	**Sheffield City Council**	**Shropshire Council**
Liverpool's NSWs were working with colleagues in children's social care and other agencies to apply the practice developed as part of Phase 1 to planning for young people moving towards transition who were currently in out-of-area placements. They also continued to work with a small number of cases from Phase 1.	Sheffield applied the NSW approach developed in Phase 1 to its new Future Options Team. That team focused on developing professional and meaningful relationships between NSWs and their families that went beyond support at crisis point.	Shropshire worked with a cohort of young people based at one of its local special education schools. The aims was to work closely with both young people and parents to plan together for better supervision and to inform a better design for transition services in Shropshire more widely.

[B] Phase 2 pilot objectives

Despite tailoring the NSW approach locally to reflect the local situation and needs, the key ambition for all the sites was to use the pilot to:

- provide excellent person-centred support for individuals with learning disabilities, autism and mental health conditions and the people around them
- equip and support social workers to be enablers of high quality, responsive, person-centred and asset-based care

- build more effective and integrated systems that bring together health, care and community support and deliver efficiency savings.

[B] Phase 2 pilot support

As in Phase 1 of the pilot, Phase 2 pilot sites were supported by the Innovation Unit and SCIE. The majority of the support offered through the programme was bespoke to each site to enable them to achieve their ambitions for the pilot. The focus of Phase 2 support was on:

- doing 'good social work' and being ambitious about what this means
- having people with learning disabilities, autism and mental health conditions at the heart of things – from design and delivery, to learning and evaluation
- learning together and on behalf of the wider system
- evidencing the impact an NSW can have.

Specifically, support included:

- a dedicated coach throughout the programme
- design and facilitation of two site visits or local workshops
- specialist input across themes – evaluation, co-design, reflective practice – or other themes as per the specific interest of sites
- a series of webinars involving all sites and the wider sector
- practical tools: frameworks for design and development; implementation; evaluation and learning
- opportunities to share and raise the profile of the work with the wider sector.

Alongside this bespoke coaching support, SCIE offered dedicated evaluation support. The purpose of the evaluation is explored in greater detail in the following section.

[SH] The evaluation approach

The evaluation had two core objectives, at both a site and programme level, as follows.

1. **Site level:** support the six NSW Phase 2 pilot sites to build their own evaluation frameworks to steer their evidence capture and analysis, help articulate their own impact and frame this learning effectively to influence local stakeholders.
2. **Programme level:** design an overarching programme evaluation framework to guide the analysis and reporting of the NSW pilot impact in a robust and systematic way and gather primary data to validate findings presented from sites.

The evaluation approach to both levels is explored in more detail in this section.

[A] Context and considerations

The evaluation was designed to evidence the impact of the NSW pilot on three levels: the individuals and the people around them, the NSWS and the wider system. The methodology was influenced by a number of factors, outlined below.

1. There was a six-month gap between the end of Phase 1 and the beginning of Phase 2 of the pilot. This means that the sites that took part in Phase 1 and who received Phase 2 funding experienced an implementation gap in delivery, making it difficult to attribute longer-term impact directly to the pilot.
2. Only three sites from Phase 1 received funding for Phase 2. This means that sites had different baseline starting points.
3. The pilot was only lasted six months, including the time it took for sites to shape and set up the pilot locally. This implementation period means it is necessary to be realistic about what impact it is possible to measure over that time.
4. Staff capacity was dedicated to delivering the pilot, meaning that evaluation activities had to be light touch, realistic and focused.

Given this context, and the evaluation objective to support sites to build up their own evaluation framework, the evaluation adopted a theory of change approach.

[A] A theory of change approach

The theory of change approach to evaluation was first developed specifically to evaluate complex, community-based interventions[1] and is very well suited to exploring the effects of emergent and heterogeneous interventions such as complex community-based programmes. Additionally, theory of change, with its focus on outcomes, is a helpful planning tool for new initiatives.

Each site was visited in October 2017 and took part in a theory of change workshop attended by the site's NSW pilot lead and other members of the team including NSW team

leaders, the NSWs themselves and other partners such as a local advocacy organisation or a mental health nurse. This session was to support sites to:

- articulate the intended outcomes across three levels of impact (i.e. on the cohort and the people around them, the NSWs and the wider system)
- map back from outcomes, to review the planned pilot activities, and test the logic underpinning the model in terms of why working in a specific way was intended to lead to certain outcomes
- identify what indicators for longer-term change might look like in a six-month period and which could be measured during the evaluation
- identify partners and other stakeholders who needed to be engaged by the pilot in order for it to achieve the desired outcomes
- identify the key people to influence, in order to make the case for longer-term sustainability of the local NSW approach.

Recognising the time pressures facing sites, the evaluation lead used these session to tailor site-specific theory of change models which sites then validated. These models were refreshed and appended to the sites' evaluation packs. The NSW programme theory of change model is presented in Appendix B.

[A] Key evaluation questions

The site's theory of change model was different for each site. To create a programme-level evaluation framework, these models were 'read across' to pull out 10 key evaluation questions for both the sites and programme to explore during the evaluation. The questions mapped across the three levels of impact and are presented below.

Impact on the cohort and the people around them

Commented [JI4]: These are 'micro-headings' designed to accompany lists: they are not weighted. For the PDF, italic would work well. For the online version they could be bold, same point size as body text. (This means that all the weighted headings will need to be at least 1pt larger than the body text.)

1. How has the pilot facilitated consistent and trusting relationships between the NSW, the cohort and the people around them?
2. How has the pilot given the cohort opportunities to tell their stories – and have choice and control – when shaping their own person-centred care and support plans?
3. In what ways has the pilot supported the cohort and their families to live the lives they want?

Impact on NSWs

4. What are the knowledge, skills and values of the NSWs?
5. How have the NSWs been supported to exercise their skills and judgement through the pilot – and what has been most effective in supporting them?
6. To what extent have the NSWs been motivated to work differently, and how satisfied are you that they have been able to do so?

7. Is there any evidence that NSWs have been able to constructively challenge and/or collaborate meaningfully with their partners?

Impact on the wider system

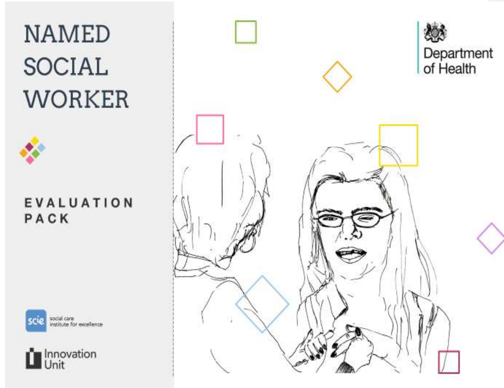
8. In what ways has partnership working improved cohort and family outcomes over the course of the pilot?
9. What is the economic impact of the NSW pilot?
10. To what extent has the NSW pilot influenced practice across the wider system, and what are the barriers and enablers to embedding person-centred practice?

Commented [JI5]: Numbered list needs fixing please (for item 10).

Sites were brought together in January 2018 to review and sense-check the approach and overarching framework in an evaluation workshop. They were asked to map their own objectives against the key evaluation questions and begin to identify the different sources of data they could use to evidence against these key questions.

[A] Site self-evaluation packs

Sites were asked to identify a minimum of six key evaluation questions that they wanted to answer through the evaluation and were encouraged to select those that would best support them to build their own business case to sustain NSW activity and influence their local stakeholders with a case for change. Sites were also asked to reflect on what they felt were the biggest enablers and barriers to NSW activity, as well as outline their hopes for sustaining it in the future.



With some support, sites completed and returned these packs with appendices before the pilot closed in March 2018. Appendices included a range of materials including case studies, NSW reflective logs, new assessment protocols or other information produced throughout the pilot as well as photographs and images taken to build up a picture of day-to-day work with the NSW cohort. Sites submitted their evaluation packs and appendices to the DHSC.

[A] Economic evaluation

In order to understand the financial impact of the NSW pilots, York Consulting conducted a financial return on investment (FROI) assessment. Given the short pilot timescale and the lack of available data over the course of the pilot, York Consulting designed a predictive model, based on a range of assumptions validated by an in-depth study of the Hertfordshire pilot. Sites submitted their own predictive data as part of their evaluation packs which York Consulting used to for a wider pilot-level analysis.

[A] Pilot-level evaluation data collection

This pilot-level evaluation report draws upon the following data sources to summarise the impact of the pilot across the six sites.

Secondary data produced by sites

- **Site evaluation packs** which included: the sites' theory of change models; an overview of their NSW local pilot model (e.g. size of cohort, number of FTE NSWs); an overview of their approach; answers to the key evaluation questions; and plans to sustain the NSW approach in future.
- **Data and evidence submitted as appendices to the site self-evaluation packs** which included: detailed case studies on the cohort; NSW reflective logs; feedback from partners; evaluation data; cost–benefit analysis; examples of new processes and protocols; examples of presentations and training delivered through the pilot; and photographs of work with the NSW cohort.

Primary data gathered during the evaluation

- **Interviews with site leads in April 2018:** site leads were interviewed by SCIE to gather more data on the impact of the programme and by the Innovation Unit to understand their experience of practice elements of the pilot. Data gathered from these interviews was used to validate the key messages coming through the evaluation packs.
- **Interviews with NSWs:** these interviews were conducted by the Innovation Unit in December 2017 and explored the NSW role, experiences of the pilot and hopes for the future.
- **A baseline and follow-up online survey for NSWs:** this received 19 full responses in December 2017 and 17 responses in March 2018. The baseline survey asked the NSWs to reflect on their confidence when they started the programme, and this was repeated in the follow-up survey as the pilot came to a close. The survey also asked NSWs to reflect on whether they had achieved what they'd hoped through the pilot as well as on any barriers and enablers to implementing an NSW approach at a local level.[2] Graphs and additional analysis from the surveys are included in Appendix C.
- **Other data taken from ongoing discussions with sites and coaches:** including during the theory of change planning sessions, at the evaluation workshop in January 2018 and in multiple other conversations with sites when completing their self-evaluation packs.
- **Interview with Phase 1 site**: to complement the learning taken from Phase 2 sites, we invited Phase 1 sites to contribute to the evaluation and conducted one telephone interview with a Phase 1 site lead.

[A] The purpose of this report

This is the programme-level evaluation report. It draws upon a wide range of data sources to summarise the NSW approach and learning at site level as well as present the

emerging impact of the pilot on the cohort and the families around them, the NSWs themselves and the wider system.

[A] Reading this report

This report follows the structure outlined below.

- Pilot profiles: a short summary of the activity at each site, to illustrate the variety and breadth of focus at a local level.
- Scoping out the NSW approach: a thematic review of some the key processes involved in setting up a NSW approach, common to all sites regardless of their individual focus.
- Impact: a thematic review of the NSW pilot's impact on the individual and the people around them, the NSWs and the wider system.
- Conclusions and recommendations: key conclusions from the pilot and recommendations for government and other areas looking to embed an NSW approach.

[A] Other reading

This report should be read alongside other pilot outputs including:

- NSW programme Cost Benefit Analysis report and FROI tool (York Consulting)
- Putting people back at the heart of social work: learning from the NSW pilot (Innovation Unit)
- Peter's Story: The perspective of a person supported by a named social worker (Humanly)
- co-production toolkit (Humanly).
- The Impact of the NSW: a summary of evaluation findings (SCIE, Innovation Unit, York Consulting)

Commented [JI6]: Add links once published.

[SH] Pilot profiles

This section draws on a wide range of data produced by sites over the NSW pilot, including their initial vision statements and final evaluation packs, to produce short pilot profiles that offer a snapshot of site activity. Each pilot profile contains the following.

- **The vision:** the overarching hope for the NSW pilot and what it would achieve locally.
- **The aims:** more specific detail on the pilot core aims and objectives for Phase 2.
- **The approach:** a summary of the approach taken locally, designed to enable sites to achieve their aims.
- **The structure:** a summary of the number of NSWs and the wider NSW team, the size and background of the cohort caseload, the partners they engaged in the pilot and the economic impact of their work.
- **The impact:** a case study or other evidence of how the NSW approach has led to positive outcome for an individual from the NSW cohort.
- **The learning:** from the site's perspective, the key things that have led to positive outcomes, and what they would recommend for other sites.
- **The future:** site's hopes to sustain the NSW in future.

Bradford: embedding a human rights approach in the wider system

Commented [JI7]: I have taken it that each profile will be presented in a panel or box. A panel/box head style will be needed, but the subheadings can I think simply be bold body text, hence not marked up for style here.

The vision

> Our vision is … citizens and social workers being side by side, with citizens having the power to say how they want their lives to be led. A human rights-based approach that supports people to live independently in communities.
>
> Bradford's vision statement

The aims

Bradford as a local authority was new to Phase 2 of the pilot, but the NSW team had been part of Phase 1 in the nearby borough of Calderdale. As such, despite the differences between the two areas, the management team brought their experience and learning – not to mention vision – as a result of Phase 1.

Specifically, the NSW pilot was seen as a catalyst to embedding a wider human rights approach to social work in Bradford as part of significant culture change. This is outlined by the following quote, taken from Bradford's evaluation pack:

> We believe that the endemic low ambition and expectations devalue the lives of learning disabled people.
>
> We were hopeful that social workers educated in the social model of disability, with its theoretical underpinnings in disability studies, held promise to support a different, human rights-based approach to practice, which could challenge deep-held values and assumptions.
>
> Our ambition was that over time this approach may result in learning disabled people experiencing better social work which enables them to access their full range of their rights as citizens.

The approach

Bradford aimed to implement its vision through the following approach and principles:

- have four NSWs starting a process of culture change that made citizens' human rights the focus of social work
- promote independent living and minimise the use of settings that deprive a person of his or her liberty
- work alongside citizens every step of the way
- develop a competency framework for advanced social work practitioners.

The structure

The cohort: The team identified a cohort of 38 individuals across transitions, adults with learning disabilities and transforming care. Of the 38, 6 lived in a hospital or secure unit and 32 in residential care. All members of the cohort had a carer.

The NSW team: The pilot engaged four FTE NSWs. The team was managed by the principal social worker, MCA lead and the programme lead who had been involved with the Phase 1 of the pilot in Calderdale. All social workers were BIA/AMHP qualified advanced practitioners.

Partnership working: Key partners included: the joint learning disabilities commissioner; Bradford talking media editor; director for Centre Disability Research; and specialist commissioning leads. These stakeholders were engaged in various ways, including a monthly planning and review meeting and bi-weekly catch-ups.

The impact

Bradford's case studies are still live and so potentially sensitive and have not been included in this report. However, the Bradford NSW team have worked with colleagues across the social care team and have overturned decisions relating to an individual's mental capacity, leading to new living arrangements informed by that person's needs and preferences.

The learning

For Bradford, the biggest impact was recruiting advanced practitioners into these roles who were experts in human rights and the MCA. The values they feel to be particularly important are as follows.

- People are enabled to choose their place of residence and where and with whom they live on an equal basis with others in keeping with their rights under Article 19 CRPD.
- People are not obliged to live in a particular living arrangement otherwise than in accordance with the MCA or the Mental Health Act (MHA).
- Each person can access a range of in-home and community support services, including the support necessary to ensure inclusion in the community and to prevent isolation or segregation from their community, as is consistent with that person's wishes and feelings.
- People are supported to remain in control, feeling safe and empowered by having a professional who is knowledgeable about their individual needs, and the legal framework for decision-making where the person lacks the capacity to make the specific decision about their place of residence and/or need for care and treatment.
- Where the person lacks capacity to make the specific decision about place of residence for the purposes of care and treatment, all practicable steps shall be taken to enable them to communicate their preferences and to uphold their right to have their previously known wishes, feeling and beliefs taken into account in decision-making.

Bradford's theory was that this pod of passionate advocates working alongside the other social work teams would permeate the wider system. In this way, the NSW pilot was an opportunity to put the building blocks in place to cement this vision.

The future

There are plans to sustain the NSW approach in future, with the hope of building on the positive steps made and expanding the team.

Bradford will continue to deliver CPD events, including training days that focus on legal literacy and human rights. Bradford are underpinning this approach with further work around CPD, including the use of critically reflective supervision, to continue to embed this practice across the whole social work service.

Bradford hope to extend their work in the area of transitions in the future, and would like to explore further options concerning residential colleges for young people with a learning disability and a five-day offer.

Halton: an earlier transitions process to prevent crisis

The vision

> Our vision is … to develop a new transition service that gives young people, from the age of 14, the best chance of a positive journey into adulthood. The named social worker will build long term relationships with these young people using creative and person-centred approaches to help them map their goals, and support to achieve them.
>
> Halton's vision statement

The aims

New to Phase 2 of the programme, Halton Borough Council saw the NSW pilot as an opportunity to explore and test new ways of working around transition. The wider aim was to reduce the number of young people reaching crisis point through an earlier intervention approach. The specific aims were to:

- help young people and families to understand what works already (and what doesn't) in order to develop a new approach to working with the young people who are often seen as the most challenging and who often end up in out-of-area residential placements
- work with young people and those that support them to develop plans that are true to the strengths and needs of individuals and that help them to thrive within their communities
- support social workers to reflect together on their practice and develop a better understanding of the skills and behaviours that enable relational working
- build on a strong foundation of integrated health and social care services in order to ensure that future planning is seamless.

The approach

Previously, adult social care teams in Halton would wait until they received referrals, from various agencies, of young people just prior to their eighteenth birthday. This system wasn't working, and the adult social care team wanted to review their processes. Given the NICE guidelines on transition and wider appetite locally, the NSW pilot was an opportunity to protect time and engage partners around this issue. The NSWs became the core of the new transition team.

The transition team NSWs took a proactive approach to working with young people, by working alongside the children's health nurses and schools to identify the young people who needed support the most, and prioritising them for intense intervention. They also worked closely with a local advocacy agency, Bright Sparks, to understand what 'good transition' looked like from the young people's perspective and to produce tools to help engage them. This enabled young people and their families to develop a positive relationship with their NSW, outside a period of crisis, and so led to better outcomes in the longer term.

The structure

The cohort: Halton has focused on transitions for 16–18-year-olds with learning disabilities and autism. Of the total cohort of 17, 1 lived alone in the community, 14 lived in the community with their family or carer and the remaining 2 lived in residential care.

The NSW team: The team was made up of 2.5 FTE NSWs and a full time social work student. They were supported by one advanced practitioner and one principal manager. Each member of the team was allocated between five and seven NSW cases.

Partnership working: Key partners included a children's nurse and a clinical commissioning group (CCG) commissioner who attended joint assessment meetings. A special educational needs and disabilities (SEND) coordinator supported the review of Education Health Care Plans (EHCPs) and future planning activity with input from schoolteachers, a community matron, a self-advocacy agency and specialist support from the Child and Adolescent Mental Health Service (CAHMS) and an MCA assessor.

The impact

The following case study is taken from Halton's evaluation pack.

Who is this person, what are they like?

C lives at home with his Mum and has a small family network around him. He attends a specialist education placement and enjoys this. C loves the outdoors and enjoys going on his bike, for walks, swimming and horse riding. C has autism and unable to verbally communicate. C requires assistance throughout the day and also support from an MDT to ensure that his health needs are met.

How have you worked with this person during the pilot? Who else was involved?

The Named Social Worker worked closely with C and Mum, visiting him at home and also attending meetings at school. They liaised with the CHC Nurse that is involved with CAD health care as well as the LD Nursing Team. Positive Behaviour Support are involved with C and also had meeting with the Direct Payments Team, commissioning and advocacy. Completion of paperwork.

What was life like for this person before the pilot?

C has Complex Health needs, placement in school that was often disrupted due to challenging behaviour. Mum requested a placement for when C was 18: stressed she did not feel that his support was working. The respite placement not working, as it was making C anxious, his skin condition deteriorated and challenging behaviours increased. Police reports in the community (weekly). To manage his behaviours is was thought that C was in pain and the GP has increased his pain killers. His sleep routine was poor, with him and Mum being sleep deprived. There was only 2 PA supporting at home.

What difference has the pilot made?

- Re-evaluation of the use of Direct Payment monies
- Scrapped respite and increased Direct Payment, support at home
- Reduction in challenging behaviour
- More settled at school
- Medication reduced
- Better sleep routine
- Less anxiety for C and Mum
- Support tailored for C needs
- Reduction to LA of £900 per week.

The learning

For Halton, the biggest impacts were achieved by:

- giving the NSWs the space to invest in young people going through transition at a pace led by the individuals themselves
- putting transition at the forefront of all agencies' minds
- having the opportunity to develop documentation/processes that ensured the approach could continue after the pilot's formal end
- working with the local advocacy agency, Bright Sparks, which supported planning and engagement approaches with young people.

The recommendations for other sites interested in this approach would be to:

- develop an action plan and ensure that all agencies, from senior management to front-line staff, are signed up to the shared approach
- ensure that families and young people are engaged and co-working with the new approach, and have dedicated staff with dedicated time.

The future

Halton has secured funding to continue the NSW pilot for several more months. During this period, the pilot lead plans to take a report to the Halton senior management team, with all the information, feedback and Bright Sparks material, along with financial information. This evidence will seek to demonstrate that this approach has not only improved quality of life for young people, but is less costly and reduces crisis intervention. It will also be used to illustrate that a more planned approach to transition leads to a more enjoyable role for the social workers themselves.

Hertfordshire: building on the learning from Phase 1

The vision

Our vision … is that the NSW pilot:

- situates NSWs as a lynchpin, the connector between the individual and other professionals
- uses a shared collaborative plan (not duplicated in each profession) to create consensus between services
- makes room for creativity in finding person-centred asset-based solutions
- is about being open to input and challenge from professionals, individuals and families, actively seeks feedback and uses it to influence decisions and experience.

Hertfordshire's vision statement

The aims

Hertfordshire was keen to build on the learning of Phase 1, particularly in terms of embedding peer supervision structures for the NSW team as these had been successful in sharing learning, knowledge and best practice. Other aims included:

- spread the NSW approach beyond Phase 1 practitioners and grow the NSW culture across the service
- co-design the NSW service offer and experience with people who use services, carers and front-line staff
- work more closely in partnership with colleagues in health for more integrated delivery
- codify the NSW approach in a 'scrapbook' of practice and develop a deeper understanding of its impact and sustainability.

The approach

Hertfordshire identified two teams on either side of the county, led by social work team managers to lead on the NSW pilot. Each team had four NSWs working on a mixed caseload, including cases deemed to meet the pilot brief. Not all of the NSWs were the most senior or experienced, as one of the objectives of the pilot was to build and share learning across the team and beyond the Transforming Care social workers.

Through the peer supervision structures, teams had protected time and space to creatively engage with the cohort, to be less risk averse and build longer-term, trusting relationships. Hertfordshire also aimed to increase partnership working with providers and health colleagues, by engaging them in pilot meetings and encouraging NSWs to network across teams.

The structure

The cohort: The cohort was made up of 10 adults with learning disabilities who had mental health or behavioural needs requiring specialist assessment and treatment services and who were at risk of experiencing the criminal justice system. Of the cohort,

four lived in supported living, two had their own flats in the community (one with 24-hour support), one was in prison and three were in residential care.

The NSW team: There were eight NSWs who had a mixed caseload (averaging a caseload of 24, with between one and three NSW cases each). They came from two teams within the adult disability teams. Each team had a team manager and deputy team manager who directly supervised them. They had mixed levels of experience: two with under 2 years of post-qualifying experience; four with 5–10 years of post-qualifying experience; and 2 with 10 years of post-qualifying experience.

Partnership working: The Community Assessment and Treatment Service was involved in all cases, attending two formulation meetings and two care and treatment reviews. Other partners included the provider service, advocacy, the commissioned health provider, the general hospital and the wider family of three cases.

The impact

The following case study is taken from Hertfordshire's evaluation pack.

Hertfordshire case study

As part of the Named Social Worker pilot I worked with a 35year old lady who suffers from mental health issues, autism and physical disabilities. I became involved in her case when she was waiting to be discharged from the mental health unit and my role was to support the discharge and make sure that she is appropriately supported in the community.

Ms G has a history of being readmitted to a mental health unit after her placements break down. My priority was to prevent further hospital admission and support Ms G to rebuild her life and integrate back in the community. The Named Social Worker pilot allowed me to use my creativity and try unconventional ways of working to achieve Ms G's goals. Thanks to a protected caseload I was able to meet with her even twice weekly (each time for at least 2 hours) jointly creating her care plan, taking her out, discussing support options, meeting with professionals etc. I was not afraid to try different support options (reducing/increasing care etc) and clearly promoting positive risk taking practice because I felt that being on NSW pilot allows me to do that.

I would often challenge mental health workers' decisions, who based on their previous experience of working with Ms G, would be very risk averse limiting her options and trying to implement the restrictions which in my opinion were unnecessary. I spent hours working closely with the support staff, explaining the relevant legislation to them, supporting them with their recording skills all to make sure that Ms G is supported in a less restrictive and positive way. I would try thing that did not work in the past due to Ms G being too challenging, I would purchases the same items over and over again even though the previous ones were smashed by G- working very closely with her to prevent further damage.

Although the core professionals were not pleased with the idea to purchase a laptop for Ms G due to various reasons including a safeguarding concern raised couple of years ago, risks of damaging it, risk of not engaging in community activities etc, I decided to buy her a laptop which she wanted and there have been no incidents with it.

This is an extract from a Named Social Worker reflective log.

The learning

Hertfordshire describes its approach as similar to a practice development programme which works well for both experienced practitioners and less experienced practitioners alike. For experienced practitioners the pilot was an opportunity to challenge established practice and refresh thinking. By talking about the approaches used, practitioners brought to the fore their knowledge and skills that could be shared with less experienced practitioners. Additionally, the peer group approach brought in expertise in the form of workshops or visiting professionals which kept the learning active and interesting.

Hertfordshire identified some barriers to delivering this type of activity during a period of organisational change, particularly as it could be challenging for practitioners and managers to find the time to attend peer group sessions or write reflective logs. Nonetheless, the peer group approach provided a source of stability and helped people to hold on to good practice during wider flux.

The future

Hertfordshire has plans to continue the NSW approach locally. In particular it plans to identify cases that fit the criteria across the seven adult disability teams and identify the social workers working with those individuals. This is anticipated to be no more than 35 cases.

To share and disseminate the learning, NSWs will be asked to produce a guide to what skills and approaches have been used on the pilot. Hertfordshire also plan to maintain the NSW peer group, continuing with support from Transforming Care professionals, and to bring in the Community Assessment and Treatment Service and a wider cohort of social workers. Hertfordshire intends to continue to use the co-design toolkit and person-centred tools to help support individuals to express themselves. However, Hertfordshire is aware that the NSW approach needs investment if it is to be fully maintained, as outlined below:

> Developing approaches to support co-design and gain feedback on practice needs investment in order to help practitioners to work out how this can be achieved as part of normal practice.
>
> Hertfordshire's evaluation pack

Commented [JI9]: Add link once published.

Liverpool: developing a 'city wide' transition journey

The vision

> Our vision is … to develop a new 'transition journey' from children's to adults' services for a young person, building on their strengths and aspirations, promoting their independence, wellbeing and choice. The principle of the NSW embodies the foundations of best social work practice. Acting as a key 'connector' across multiple agencies and systems, NSWs will build a meaningful assessment to facilitate an effective transition journey to adult life.
>
> Liverpool's vision statement

The aims

As a site which was involved in the first NSW pilot, Liverpool aimed to consolidate the learning and best practice of Phase 1 and embed it into the wider neighbourhood teams. However, for Phase 2 this was to have a specific emphasis on working with young people with complex needs at the point of transition to adults' services. The aim was to work in collaboration with young people, parents/carers, social workers and other professional partner agencies/services to develop effective plans for individuals and a new asset-based assessment tool that was co-produced and designed to facilitate a positive journey to adults' services and adult life.

Commented [JI10]: Add link once published

The approach

Liverpool's overall approach was to deliver the project based on a cycle of analysis, planning, doing and reviewing. The cohort identified as part of the pilot included 27 young people in transition with complex needs, accommodated out-of-area. This group was identified following on from Phase 1 of the programme.

Liverpool proactively engaged a wide range of stakeholders across adults', children's and health services. It initiated a multi-agency project team that met on a fortnightly basis to progress the project and support the work of the NSWs. Liverpool also ran a series of focus groups with wider partners to understand the issues of transition from a strategic perspective and to design the action plan.

In partnership with the children's social workers and independent reviewing officers, the NSW team worked collaboratively over a number of weeks to develop pen picture exercises (mini-biographies) with each individual being supported by the pilot, drawing on information and data from multiple services and professionals. Given the time limited nature of the project, this approach was considered to be the most appropriate route to understanding more about the individuals before being introduced to the NSW. It also provided assurance that these plans would be sustained once initial contact had commenced from adults' services.

The structure

The cohort: The cohort included 27 young people of transition age in out-of-area placements who had either a learning disability and/or autism diagnosis, and also included individuals who had no formal diagnosis but presented with challenging behaviour.

The NSW team: The team consisted of two FTE NSWs who were supported by a team leader and a community, locality and divisional manager. They had between two and eight years of post-qualification experience (one is a practice educator). Each NSW was allocated nine cases.

Partnership working: A wide range of partners were engaged in focus groups, including the adult social care transition team, neighbourhood and mental health teams, children's social care reviewing officers, the leaving care team, the permanence team, the adult community learning disabilities health team, a specialist school pastoral lead, Alder Hey's Children's Hospital transition team and parents and carers. A range of partners were attended NSW fortnightly meetings including service managers, the adult service commissioner, the SEND lead for children's services and the early help information officer. The team scheduled meetings with CAMHS and school nurses to take place at the end of the pilot.

The impact

The following case study is taken from Liverpool's evaluation pack.

Liverpool case study

Who is this person, what are they like?

P is 16 years old and is currently living in a residential children's home he shares with two other boys and attends a specialist education provision. Both his residential home and education provision are out of area.

P loves to play on his computer by finding clips of his favourite movies on you tube and repeatedly playing short sections of them over and over again. P has a diagnosis of autism and displays behaviour that challenges and at times severe self-injurious behaviour when agitated. P does not respond well to demands being placed on him or changes to his routine.
P is largely non-verbal although he can repeat words you say, and has a few words he says without prompting. P uses verbalisation noises to convey how he is feeling. One of the most important things he will say is 'shut door' which means you must leave the room.

How have you worked with this person during the pilot? Who else was involved?

I went to school to complete an observation and he allowed me to stay in the same room as him for 20 minutes and watched a little of what he was doing on his computer. This was positive as I was advised that P often asks new people to leave. Building a relationship will P will take time; I have met his teacher and support staff at school, the manager of his children's home, the Children's social worker and both of Ps parents. A PEN Picture has been completed and a Care Act Assessment commenced.

What was life like for this person before the pilot?

P has been in his current placement for about 18 months and in his current school since September 2016. He had regular visits from his parents but Ps primary focus is engaging with this computer and diverting his attention from this can lead to agitated behaviour. Achieving progress in this area required intensive work. We have now started the transition journey in a meaningful, person centred way engaging with key stakeholders.

What difference has the pilot made?

Early assessment has identified that P has complex needs, which will likely lead to him requiring a specialist service as an adult. Early assessment will inform/frame the commissioning process and assist in his transition to adulthood and adult services.

My conversations with both of his parents have helped alleviate some of their concerns as we all have a clear idea of what outcome we want for P and what a good transition for him would look like and the assessment process has led to a number of recommendations being made, which will be added to the current care plan that is in place from Children's services.

The learning

From the experience and learning to date, Liverpool would certainly recommend this approach to other areas. The response from NSWs, managers and partners was overwhelmingly positive and Liverpool are continuing this work across the city post-pilot.

For Liverpool, the best outcomes have emerged through the relationships built with children's practitioners. It became apparent that they had concerns regarding some young people that they would not have considered referring to transitions, yet after discussion with the NSWs this was deemed to be very appropriate, and a more coordinated approach, embracing person-centred planning, could commence.

Early asset-based assessment provided a platform for a better transition to adulthood and adults' services. A large number of the cohort were in residential care and therefore the primary focus was often around crisis and placement management. This could be a barrier to focusing on preparing for adulthood and ensuring there was appropriate time to develop the necessary skills to be independent within a community setting. By addressing this, the project had a positive impact on the young people themselves as they had an adult self-supported assessment that may not have taken place without the pilot. Their aspirations were recorded, and planning could commence to achieve these.

The focus groups also identified the issues in practice from a multi-agency perspective, which interestingly identified many of the same issues. This allowed practice development to become focused, and meaningful changes in practice to be made. This will be ongoing in combination with workforce development.

The future

Liverpool has been successful in securing additional funding over the next three years to further develop the NSW approach. The additional funding will enable further work to be undertaken to streamline the process of transition, ensuring young people are identified at the earliest opportunity and NSWs are allocated to support the planning of future services through a promoting independence approach.

Sheffield: good social work during organisational change

The vision

> Our vision is ...To develop a professional and meaningful relationship between NSWs and individuals and their families that goes beyond support at crisis point, is proactive, tailored to clients' needs and circumstances and allows for flexibility.
>
> The three key responsibilities of the NSW team are:
>
> - creating meaningful, professional and person-centred relationships with individuals and their families
> - ensuring a multidisciplinary approach and liaising with other professionals to enable it
> - taking accountability and responsibility for professional decisions while advocating for the individual.
>
> Sheffield's vision statement

The aims

Phase 2 of the NSW pilot in Sheffield has focused on embedding the learning from Phase 1 across a bigger team, the Future Options Team, which works with customers who have complex needs and are in restrictive care settings. The aim was to move them to community care settings that promote their independence where possible. Sheffield also wanted to explore how this work could impact across all adult social care teams in the city, which were restructured in September 2017 and moved to locality-based (as opposed to specialist) teams.

For Sheffield, the Future Options Team seemed to be the natural home for Phase 2 of the NSW pilot. It aimed to improve, shape and embed NSW practice, and test the model in a busy social care team faced with competing pressures and priorities. Specifically, some of the issues that the pilot wanted to address were:

- individuals are spending too long in hospitals and out-of-town facilities, away from their communities
- individuals often don't know who to contact when issues arise, meaning initial contact is often during crisis
- processes can be frustrating and intrusive for individuals, with each stage of interaction likely to be with a different person
- carers are frustrated that focusing social worker roles around tasks reduces skills and the chance to build relationships
- interactions are short, specific (narrow) and focused on completing tasks and assessments, rather than building independence.

By the end of the pilot, Sheffield wanted to have a good idea of the added value of the NSW approach and recommendations on how to apply it across other adult social care teams, identifying which service users were likely to benefit from it most. The Future Options Team was also an innovation site for the 'Three Conversations' model (currently

being rolled out across adult social care and referred to as ‘Conversations Count’), and Sheffield wanted to see how the two approaches might complement each other and assess the strengths of each.

The approach

The original ambition was for all 10 of the Future Options social care workers to have a cohort of three NSW cases. However, competing priorities meant that the team was spilt between this pilot and the ‘Conversations Count’ innovation site. While they had many similarities, it was decided to keep the pilot cohorts separate to allow for more robust data collection and benefit-measuring.

One of the Phase 1 NSWs continued into Phase 2 and is an expert practitioner who has helped improve, shape and embed the pilot’s practice. Other members of the Phase 1 team who joined the Phase 2 team included the practice development coordinator, the team manager and the commissioning officer. Sheffield defined three key responsibilities of the NSW pilot as:

1. Creating meaningful, professional and person-centred relationships with individuals and their families.
2. Ensuring a multidisciplinary approach and liaising with other professionals to enable it.
3. Taking accountability and responsibility for professional decisions while advocating for the individual.

The structure

The cohort: The total cohort included 15 individuals, with 7 of those from the Transforming Care cohort. The cohort were people with learning disabilities and mental health needs who were living in a hospital or restrictive setting in the community.

The NSW team: The team included five FTE NSWs who were supported by a Future Options team manager, a practice development officer, a project manager and a commissioning officer. Each received three NSW cases, which were part of an average of 14 cases per person.

Partnership working: a number of key partners were engaged throughout the programme including an independent advocacy group which was used to co-produce pilot documents such as letters and questionnaires. Other partners included residential and nursing care providers, CCG and continuing healthcare (CHC) stakeholders who attended multidisciplinary team meetings, and housing providers and commissioners. Sheffield Health and Social Care Trust was also involved in discussing acute services and multidisciplinary team support, as was NHS England in relation to Transforming Care cases.

The impact

The following case study is taken from Sheffield’s evaluation pack.

Sheffield case study

Who is this person, what are they like?

VM is a young lady who has a very good sense of humour. Due to her PDA she struggles to initiate and progress through daily living tasks. As a result she can be become verbally and physically aggressive.
Long term she would like to live in a flat of her own, and would like a job. This would be in Sheffield.
VM has lots of interests such as; horror films (her favourite is The Nightmare Before Christmas), art activities, anything to do with animals. She is 27 and currently living in a hospital unit.

How have you worked with this person during the pilot?

The pilot has given me the opportunity to visit VM more regularly. I have been able to support her to have pet therapy.
She has a close relationship with me, and will confide information that she is not willing to share with the ward. I am then able to attend MDTs and pass on this concerns, raising Safeguarding where necessary.
A member of her family has become unwell while I have been working with the her, and so I have been able to support the family also.
As I have been visiting VM, and getting to know her I was able to challenge one of her diagnoses and request that she was assessed for PDA. Following this staff were offered specific training linked to this by the ward.

What was life like for this person before the pilot?

VM has had two admissions to ATS in the last two years. On this occasion she has been on the ward for over a year.
VM was living at a specialist residential unit, however following safeguarding concerns this accommodation was closed. VM was physically and verbally aggressive whilst at her home, and police were called on several occasions.
VM is currently medically fit for discharge.

What difference has the pilot made?

Before this admission, the police had been called to VM on several occasions; her placement was not stable and broke down. She requires a high level of support in a specialist accommodation.
VM is now fit for discharge, and by being in the pilot I have had the opportunity to spend more time researching and visiting placements. The hope is that she will be discharged to a more appropriate placement which can meet her needs.

The learning

For Sheffield, the NSW approach fitted with social work values and lead to better long-term outcomes for people who use services, with less crisis management. It focused on individuals and their outcomes and helped to plan for, and manage, crisis situations, leading to fewer formal complaints.

For the cohort

- Consistency is important for providers, partners and families too. It helps families to know who to contact, reduces their anxiety and avoids their call being stuck in the system.
- The pilot allows social workers to undertake a preventative role, focusing on quality of life, to give people a better life.
- The use of PEN pictures is good practice, as it turns someone who may be treated as a customer with a narrow set of needs into a person, and provides an opening for conversation based on their interests, to develop rapport and find out previously unknown information about them.

- An NSW is beneficial for some people to help them navigate the social care system.

For the NSWs

- Time for reflective practice has helped them to develop professionally.
- Peer and reflective discussions have improved staff morale and satisfaction.

For work with partners

- Spending more focused time with Transforming Care cases and the multidisciplinary team has improved quality outcomes for the cohort, including three discharges.
- Improved lines of communication have come from more regular contact with multidisciplinary team partners and have resulted in agreeing roles, responsibilities and ownership with them, leading to better outcomes for people.
- It enables Sheffield to improve its professional standing with other professionals in the multidisciplinary team environment, and clarifies their expectations of social workers.
- It is not one size fits all. The focus is on those with the most presenting risks, for example autism-specific cases in the community, and this helps to prevent escalation.

The future

Sheffield plans to continue to use the NSW approach through the care and treatment review process for Transforming Care cases in the Future Options team, and when working with people in the step-down process. Some of the cases will transfer to locality teams and they expect to recommend that this approach is continued with some individuals.

Sheffield is also planning to explore its links with the ‘Conversations Count’ approach to embed good practice across the wider adult social care teams. Additionally, its final internal evaluation of the pilot will take place at the end of June 2018 and Sheffield is hoping to demonstrate the benefits of this way of working with some people (e.g. complex learning disability cases) to its internal partners in adult social care.

Shropshire: earlier intervention and a system-wide approach to transition

The vision

> Our vision is ... To develop a more transparent and accessible transition process in Shropshire that ensures that young people and their families:
>
> - have consistent and trusting relationships with their social worker and other service professionals at the point of transition
> - have a clearer understanding of the process of transition and who is involved
> - receive transition information earlier and trust the system is going to work
> - are involved in conversations to shape a tailored transition plan so that their needs and aspirations are understood and met.
>
> Shropshire's vision statement

The aims

In Phase 2 of the NSW pilot, Shropshire aimed to deliver the following objectives for the cohort, the NSWs and the wider system.

The cohort and their families

- The aim was for a cohort of 12 young people to have completed person-centred support plans that would allow them to transition from school in a planned way that minimised stress and anxiety. These plans were to be built upon strong and trusting relationships with them and their families which promoted the independence of each young person.

The NSWs

- The aim was for the NSWs to become skilled in working with transition-age young people to promote independence, choice and control over their lives. Each social worker was to gain a thorough understanding of the processes involved and build strong relationships with partner agencies.

The wider system

- Shropshire aimed to have a better understanding of the system for transition, both within adult social care and across the wider system, and to work more effectively with partner agencies to facilitate early intervention and longer-term planning.

The approach

The overall approach was to adopt a 'virtual transition team', with social workers from across Shropshire's localities working together. This aim was to release NSWs from the pressure of a mixed, generic caseload led by crisis intervention, and adopt an earlier intervention model. Shropshire also implemented a peer support model of group supervision to enable the team to gather county-wide resource information.

NSWs were given the freedom to explore what an NSW approach might look like in Shropshire, with a focus on person-centred practice. Through peer supervision, the team developed the concept of 'business as usual' (BAU) and the NSW approach to allow

them to highlight the differences between the two, and articulate how they could implement a new model within transitions in future.

The structure

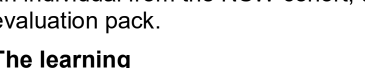
The cohort: The cohort was a group of young people from Shropshire's specialist education academy, involving 12 young people and their families (10 young people from year 14 and 2 from year 13). The young people were from the complex and profound and multiple learning disability (PMLD) groups within the school.

The NSW team: The team comprised three NSW at an FTE of six days per week. Each had four NSW cases and worked two days per week on the pilot. Each social worker covered a different geographical area (north, central and south Shropshire). The team was supported by a principal social worker and a senior social worker (transition lead).

Partnership working: The team's key partner was Severndale Specialist Academy, a local specialist school attended by the cohort. The school helped the team recruit the cohort and communicate with parents, and provided general support in communicating with the young people. Shropshire Joint Training and Taking Part helped develop, deliver and facilitate the parent workshops, with the latter also supporting one-to-one advocacy.

The impact

The case studies submitted by Shropshire are potentially identifiable and therefore cannot be shared in this report. However, this photo illustrates creative approaches to person-centred planning in practice, between an NSW and an individual from the NSW cohort, taken from Shropshire's evaluation pack.



The learning

The biggest impact for Shropshire in the future will be the system change that occurs based on the evidence generated during the pilot. The protected social work time that the pilot financed gave Shropshire the opportunity to identify the challenges in the county to delivering 'good social work' with people with learning disabilities, and to explore ways to make improvements. Key to this is early intervention.

> The intensive work social workers have carried out with each young person and their family highlighted that no level of intensity can compensate for earlier intervention.
>
> Shropshire evaluation pack

Additionally, Shropshire found that partnership working is key, and time spent investing in relationships with partner agencies was successful in terms of both outcomes for young people and value for money. Shropshire believes it now has a good understanding of the knowledge, skills and values that transition social workers need to support young people to plan their 'good life'. Specifically, for the area of transition, Shropshire would recommend:

- working with young people as soon as is practicable within the organisation as planning and early information-sharing with young people and their families is key

- developing a model within the organisation that protects NSW time
- building relationships with, establishing and working towards a shared vision with partner organisations
- introducing advocates for young people before issues arise
- being realistic about what can be achieved in a short timescale
- being very clear to young people and parent carers about timescales, outcomes etc. to avoid unmet expectations.

The future

The Shropshire team feel positive that the NSW pilot has given them a wealth of evidence to inform how the system can change to improve outcomes for young people in transition. They are developing a transition process to support an early intervention model which can be implemented once system change is agreed. They report:

> Without the support we have received during the pilot, both financial and resource, the evidence required to make the necessary changes would have taken years to gather.
>
> Shropshire evaluation pack

As part of this, Shropshire has prepared a benefits and burdens summary for all options to guide how the team is constructed, from social workers remaining generic with an upskilling programme through to a centrally located and managed transition team, with a range of options in between. On completion of the pilot, this will be presented to the senior management team for a decision to be made on the structural changes to the teams.

For this approach to become sustainable, Shropshire will need to ensure it is offering services that offer best value. This will mean working in partnership with both council provisions and provider organisations to ensure the services on offer are able to support young people to develop their independence and maintain their skills.

[SH] Defining the NSW approach

Beyond taking a 'named worker' approach, the NSW pilot was non-prescriptive. The specific cohort, policy angle and overall approach was to be shaped by sites to meet their local needs. As a result, sites devoted the early stage of the pilot to refine their thinking about the pilot's focus and the specific NSW approach that would deliver it. From deciding which cohort to engage, recruiting the NSW team, identifying and engaging key partners and stakeholders to designing pilot materials and processes, each site identified a set of specific activities before the pilot began to deliver in earnest. This section looks across the pilots and presents a thematic review of these key activities.

[A] Piloting new ways of working

[B] Focus on transitions

Three sites – Halton, Liverpool and Shropshire – used the NSW pilot as an opportunity to test approaches to improving practice and processes around transition. These sites were concerned that, as is common nationally, young people in their areas were not adequately supported into adulthood. There was an awareness that adults' services were only picking up these cases as they hit a crisis point or on their eighteenth birthday.

Additionally, sites described how young people and their families had to be supported to understand the different legislation, practice approaches and services that characterise adults' rather than children's services. For example, children's services protect the young person from risk, whereas adults' services give individuals control over their decision-making, as explained in the following quote:

> The focus in children's services is to contain the risk while there is a recognition within adults' services that individuals are able to make what may be considered as unwise decisions.
>
> Liverpool evaluation pack

This change in risk management can be challenging for a young person and their family to understand, and sites described how they wanted to ensure that transition social workers were able to guide young people through this process.

Sites also used the NSW pilot as an opportunity to map out the wide range of stakeholders, from children's and adults' services, through to health and housing partners, local schools and colleagues – not to mention friends and family – who were involved at different points of the process. This helped identify key partners to engage through the pilot so that they could help shape a locality-wide response to improve transition.

[B] Focus on the wider view of social work practice

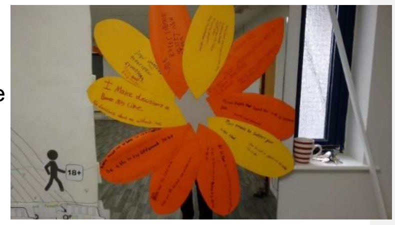
The other three sites focused on adults with learning disabilities, autism and mental health conditions who had higher level of need, particularly those who were considered part of the Transforming Care cohort. Sheffield, Bradford and Hertfordshire worked with individuals from the Transforming Care cohort, as they had done in Phase 1, working with a high number of individuals in residential or out-of-area settings. For Bradford, the NSW approach was synonymous with a human rights approach to social work, whereby social work is a means to uphold a citizen's right to liberty. This meant that the NSWs took a

different approach to other sites, working as a pod that supported the wider social work team to follow the overarching principles of a human rights approach across the wider caseload. As Bradford commented:

> [Our approach is to take] into account a long-term view of developing a workforce with human rights as its base while upholding people's rights during this process.
>
> Bradford evaluation pack appendix

In these ways, the sites used the NSW pilot very flexibly – from exploring a specific local process to being part of a values-based approach to change – depending on the vision and the local needs to be addressed. As such the pilot gave sites the opportunity to protect time to test, trial and embed new ways of working for wider system and practice change.

[B] Using wider partners to shape the approach



For sites focusing on transitions, identifying and working with a wider group of partners such as advocacy organisations and specialist education providers was one way to quickly learn more about the transition process and the specific issues facing different stakeholders. Wider partnership working was also a way to engage the young people in the cohort, as well as their families and carers, and to build in their views of the process. This worked particularly well for Halton, which worked with Bright Sparks to deliver a series of workshops with young people to understand more about how they liked (and disliked) to be engaged. Similarly, Shropshire had the support of a local specialist education provider that helped recruit the cohort and reached out to parents, and Liverpool put on a series of workshops to explore multi-provider perspectives around transitions to help unpick and redefine the process.

Commented [JI11]: Designers/web team: please add acknowledgement line below image in as small a pt size as is readable:

Source: Image taken from Halton and Bright Sparks transition event.

Other sites described the importance of engaging partners to help shape the approach and supporting materials. Bradford worked with a local advocacy organisation, Bradford Talking Media, to test out ideas of what 'good social work' looked like from the perspective of people with learning disabilities and autism, and Sheffield approached a local advocacy agency to help co-produce NSW materials including letters and a questionnaire.

[A] Building the NSW team

[B] Recruiting NSWs

When recruiting for the NSW team, sites often approached individuals with a complementary skills mix, for example those with experience of working in children's services or particular knowledge of the MCA. Others actively looked to build a team of social workers with mixed levels of experience, to transfer knowledge across and upskill individuals across the team. Remaining sites asked for an expression of interest, which served to identify the most keen and passionate applicants to take into the role. In these

ways, sites were able to recruit a high calibre of enthusiastic social workers onto the team despite the short pilot time frame.

Recruitment tended to be quicker for Phase 1 sites who could approach social workers involved in Phase 1, or who might still be working with an NSW caseload. Despite this, building the team of NSWs still required a degree of administration and internal negotiation, which meant that recruitment was often an involved and fairly lengthy process.

[B] Allocating the caseload

Sites had to make a series of decisions concerning the caseload structure for NSWs in the pilot. The sites took very different approaches, often shaped by their overall vision for the role. Bradford operated as a pod, allocating the NSW cohort across the wider team and offering targeted support and training to other social workers around key components of the Human Rights Act, MCA and other legislation. Liverpool similarly offered peer support to other social workers holding the main point of client contact alongside some direct NSW activity. The Shropshire NSW pilot had a smaller team but with dedicated days per week to the pilot, meaning NSWs had protected time to work intensely with their cohort. The remaining sites took a mixed caseload approach, having a larger team working on a reduced number of cases overall, to give them the space to increase their time with the NSW cohort.

The decision concerning how to structure the teams was influenced by various factors including the vision of the overall pilot, the appetite and availability of suitable social workers to recruit to the team and the size of the overall cohort. The shorter pilot time frame, not to mention sites operating in the midst of wider organisational change, meant that initial plans could quickly change depending on these factors. This meant that sites had to be flexible and pragmatic in their approach.

[A] The knowledge, skills and values of an NSW

[B] Doing ‘good social work’

One debate that runs throughout the pilot is the question of whether the NSWs apply a different set of knowledge, skills and values to non-NSWs, or whether the NSW pilot is actually an example of ‘good social work’ in action. This debate continues from Phase 1 of the programme and the overall conclusion from sites is that the core knowledge, skills and values of an NSW fit into a broader definition of ‘good social work’. The pilots have been an opportunity to test what it takes to put this into practice with a cohort that often achieves poor outcomes and for whom complex systems, processes and resource pressures can supersede person-centred and asset-based support. This is well summarised by the following quote taken from the NSW survey:

> [Named social workers have the] same skills that make a good social worker: listening skills; the ability to build trust; honest and open communication; observation skills; multiagency working; consistency and empowering people to make their own decisions.
>
> Follow-up survey respondent

Inevitably, putting 'good social work' into practice isn't easy. Sites describe a range of ways in which they supported their NSWs to develop and deepen the knowledge, skills and values required to do good social work with people with learning disabilities, autism and mental health conditions. This involved training in person-centred planning, legislation and the generation of a wide range of tools to encourage creative forms of meaningful engagement. It also involved reflective practice and team working. This support was designed to build confidence when working with and advocating on behalf of the cohort.

This theme is explored in more detail in the Innovation Unit's practice guide, Putting people at the heart of social work: learning from the named social worker programme.

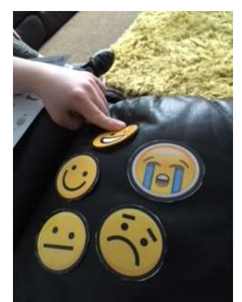
Commented [JI12]: Add link when published.

[B] Training

In order to support NSWs to develop their practice, sites put on a series of additional training sessions for the NSW teams. These ranged from informal workshops to a series of CPD sessions. Training varied across sites. For example, Shropshire's wellbeing through person-centred planning sessions and Bradford's training on the MCA. Sites which focused on transitions also took the opportunity to train NSWs on children's legislation, and Liverpool brought social workers from children's and adults' services together for shared learning focus groups, as outlined below:

> Shared learning included [the] children's social work team being informed about adult legislation including [the] Mental Capacity Act 2005 and adult services staff gaining a greater understanding of the Children and Families Act 2014.
>
> Liverpool evaluation pack

[B] Producing tools for meaningful engagement



The scoping phase was an opportunity to work with self-advocates to produce tools for meaningful engagement, whether that was producing a consent form for being part of the pilot or tools for ongoing person-centred conversations. Halton's work with Bright Sparks shaped 'easy read' feedback forms and materials, as well as smiley face tools which were subsequently used with the young people involved. Halton has since commissioned Bright Sparks to produce a film to help explain what transitions means to young people with learning disabilities and autism. Alongside these tools were a wealth of other materials that sites produced to support NSW delivery, including assessment forms, leaflets and awareness-raising materials, feedback materials etc. Some of these can be found in a separate site profiles and resources document.

Commented [JI13]: Add link when published

As part of Phase 2's programme support, SCIE and the Innovation Unit worked with a specialist agency, Humanly, to support sites to identify tools and approaches to facilitate meaningful engagement including:

- using creative techniques to make involvement more enjoyable and accessible, such as mood boards or smiley faces
- encouraging NSWs to go to different places with their cohort, rather than meeting in less familiar or the same surroundings each time

- involving people that know individuals with learning disabilities, autism and mental health conditions well, for example support workers who may be able to help contextualise or interpret responses
- producing a set of creative tools for meaningfully engaging people with learning disabilities, from planning to evaluation.

Commented [JI15]: Add link when published.

[A] Setting up the NSW approach

What is significant about the pilot is that the NSW approach allows 'good social work' for people with learning disabilities, autism and mental health conditions to happen in practice. It does this in a range of ways, but most notably by protecting the time for NSWs to move away from a time and task model and focus on the details that matter to the person, as explained by the following extract:

> The social workers involved in the pilot feel that the knowledge, values and skills are the same as for other social workers in the Future Options team, but [the NSW pilot means] they are enabled to focus on them. Although the work isn't different to their normal roles, it has allowed time to dig into the details instead of being task focused.
>
> Sheffield evaluation pack

The evaluation revealed a number of other ways in which the NSW approach enabled good social work for the cohort to happen in practice. Many of these themes started to emerge during Phase 1 of the pilot and are explored in more detail below.

[B] Protected time to do 'good social work'

One of the core components of the NSW approach is that it protects time to do 'good social work'. In this way, NSWs are encouraged to tailor their contact with the individual and the people around them, depending on their needs and preferences. It allows them the space to think about and engage differently with the people they work with and the freedom to build up a better understanding of each other. Fundamentally, this time to build relationships is seen to increase the trust between the NSW, their cohort and the people around them, and allows them to build better and more sustainable long-term plans and prevent crises from occurring.

Overall, sites reported that they were able to protect the time of the NSWs to work more intensively with their cohort. Here is an indication of what this might look like, taken from the Hertfordshire evaluation pack:

> A range of between nine and 121 interactions were recorded per NSW between October 2017 and end March 2018, which included direct contact with client, meetings, professional liaison, family liaison. Of these interactions there was a range

> from one to 31 direct contacts with the individual client, either face to face or by phone.
>
> In two individual NSW cases there were over 80 interactions in the time period (one, 81 recorded and the other 121). In the other eight cases there was between nine and 35 recorded interactions in the time period evaluated.

There is a wealth of evidence that describes how the NSWs were given the time to build up trusting relationships with the people they worked with. There are examples where NSWs arranged to meet their cohort in different settings, to build up a more holistic picture of them, rather than always in the same place. There are descriptions of just spending time with the individual, watching them at play, or with other people, to understand what drives them and learn more about their interests. As the following extract from Sheffield's evaluation pack shows, this protected time gave NSWs the flexibility to trial and test different support packages, with relationship-building across partners at the core:

> The NSW approach has differentiated from the normal way of working through having initial interviews, consultation with [the person using services], satisfaction questionnaires, reflective weekly meetings, and we have developed tools and invested in training to support the reintroduction of person-centred planning. There is a focus on building relationships with other professionals, agencies and institutions.

Having protected time and the permission to be led by the cohort's needs and preferences is turning a time and task model of social work on its head. Sites reported that it was sometimes hard for social workers to adapt to this way of working, particularly as it challenges traditional role boundaries and structures that dictate what is and isn't possible. It also requires more emotional engagement, empathy and resilience, which in turn were fostered through creating meaningful reflective spaces. Sites reported that it sometimes felt 'strange' to work in this way given the usual focus on 'output'. This is illustrated by an extract from Liverpool's evaluation pack:

> One of the named social workers reflected on the time it took to visit a young people out of area and that the usual practice would have been to commence the assessment [straight away]. She reported that it felt strange to not have an 'output' from the visit but recognised the importance for the young person to have the time to reflect on her future as she hadn't previously given this much thought.

However, while the NSW pilot protects time for the NSW to work more frequently with their cohort, sites were keen to point out that not everybody would want or require such intense engagement all of the time. Again, this would vary according to the individual and their needs at that particular time. In other words, the NSW approach is not just about increasing contact for the sake of it. It's about really understanding people in order to make sure they have the appropriate support going forwards, where some of that support could

be from family or community organisations, and sometimes would involve a more intensive, ongoing social work intervention. Sites often described an initial engagement-building process which could then become more light touch once trust has been established, as outlined by the following quote from Hertfordshire's evaluation pack:

> Once the NSW has developed trust and demonstrated that they have understood what is important to the individual, the NSW may only need to have occasional direct/indirect contact.

This intensive relationship-building is particularly important for the early contact but doesn't have to be maintained throughout the NSW relationship.

It is also worth noting that while there is a wealth of evidence concerning relationship-building and improved outcomes as a result (as explored in more detail in the impact section of this report), there are examples where this was not always possible. For those individuals in out-of-borough placements, an NSW might only be able to visit once a month, and at the same setting. Additionally, given the different starting points of individuals within the NSW cohort and the people around them, sites reported that for some cases it would take longer to build trusting relationships than the six months of the pilot. Nonetheless, NSWs tended to agree that the protected time gave them the space to work with the individuals at their starting point and to go at their pace.

[B] Resetting the permissions framework

A significant way in which the NSW pilot set up a framework within which 'good social work' could operate was through the way in which it reset the permission for social workers to use their judgement and take positive risks as an integral part of their social work practice. Phase 1 findings of the pilot showed this was central to the NSW approach, and this continued as a key theme into Phase 2.

As already noted, approaches to risk change between children's and adults' services. Additionally, sites described how system-wide partners are also risk averse, for example health colleagues looking to increase packages of care or housing providers who are reluctant to extend tenancies. In this way, social workers are operating in a wider risk adverse environment which, exacerbated by high caseloads and the time and task mentality, can make it difficult to think creatively or build up an argument to back what might be viewed system-wide as an 'unwise' decision.

Perhaps given this system-wide view, all sites talked about the importance of risk-taking as a key component of the NSW approach. This was seen to be a hugely valuable aspect of the pilot by management teams and NSWs alike. For Bradford, risk-taking lies at the heart of the human rights approach to social work and is a core part of the NSW offer. Bradford make the link between risk-taking and the MCA to explain how risk-taking is part of social work practice (rather than a breach of the duty of care by professionals), as outlined below.

> The principles underpinning the Mental Capacity Act 2005 that an individual must be assumed to have mental capacity to make certain decisions unless it is established that they do

> not, [are] core to the way we work. Every effort will be made to support the individual with decisions. If an individual has the mental capacity to make an informed decision and chooses to live with that level of risk they are entitled to do so. The law will treat that person as having consented to the risk and so there will be no breach of the duty of care by professionals.
>
> Bradford, Risk Enablement Panel Framework

To support the wider social work teams, Bradford set up a Risk Enablement Panel. It advises that social workers should always follow the usual positive risk assessment and action planning processes, but when no agreement on risk is reached they can approach the Panel and attend with the individual concerned and/or the people around them. Other sites described how they gave NSWs the permission to take risks, underpinned by the relevant legislation, through training sessions or during workshops and discussions at peer supervision groups.

[B] Weekly practice time and peer supervision

Bringing the NSWs together to reflect on their caseload and work together to identify solutions has continued to be a central plank of the pilot for all sites. Peer supervision has allowed the transfer of learning between social workers, regardless of their levels of experience, and is a useful tool to bring in wider stakeholders or social work teams to build relationships or understand different perspectives. The value placed on peer supervision is explained in more detail in the following extracts.

> Having weekly reflective practice time with each other has benefited the social workers in the pilot hugely. They have been able to talk cases through to unblock problems, support each other and be motivated and supported to work differently.
>
> Sheffield evaluation pack

> The monthly peer/supervision group has provided a safe place to talk through cases and tap into the skills and knowledge of the Transforming Care Team, including aspects of relevant legislation.
>
> Hertfordshire evaluation pack

Peer supervision was also helpful for the structure it brought to team development, particularly for sites undergoing wider organisational change. As part of the pilot, time for peer supervision was protected, meaning that NSWs, management teams and partners would still attend, even if they had busy workloads and competing priorities.

As part of peer supervision, sites valued reflective practice, whereby they could review their own decision-making and share it with the wider team. Peer supervision sessions are not exclusive to the NSW approach, however, they were seen as an essential enabler of putting ‘good social work’ into practice as part of the pilot. The ways in which sites were

overwhelmingly positive about the benefits of peer supervision suggest the NSW pilot was an opportunity to embed such activity into general social work life.

[SH] The impact of the NSW pilot

This section of the report draws on the evidence submitted in and alongside the site evaluation packs, the NSW surveys and the interviews with site leads on the impact of the NSW pilot on:

- the individual and the people around them
- the NSWs themselves
- the wider system.

[A] Impact on the individual and the people around them

The ultimate goal of the NSW pilot was for people with learning disabilities, autism and mental health conditions to lead a good life. The assumption was that having an NSW as a consistent point of contact, with oversight of all aspects of an individual's life, would lead to improved outcomes.

The following section explores the impact of trusting relationships on the cohort. It illustrates how such relationships generate information to help person-centred planning and presents some of the early indicators that the NSW pilot supported the cohort to lead a good life.

[B] The foundation of trust

Sites produced a wealth of evidence to demonstrate that this relationship-building was the foundation on which their NSW activity could build. The following extract from a reflective log shows the importance of a trusting relationship as reported from a cohort's perspective, shared by an NSW in Halton.

Commented [JI16]: Please set the extract in a panel or box if possible.

TB said that because he knows I'm his named social worker he can ask me questions.

TB said he didn't like it when I phoned him directly to arrange to see him. Even though he knows me it made him feel panicky. He has asked that in future I contact his dad or step-mum to arrange to see him and speak to him face to face.

Commented [JI17]: Please fix spacing.

TB is happy now he has been reassured that I will do this in future.

Source: Halton reflective log

Halton also produced evidence from parents to describe the benefits of a trusting relationship from their and their children's perspective:

> [My son] feels it's better he's got a named social worker as he finds it better to work with social services if the social worker stays the same.
>
> Halton feedback, email from A's mum

> Having a named social worker is a great thing as it gives stability and continuity of care for both myself and J. It is great to be able to build up a trusting relationship with a named social worker and has allowed J to be able to trust and rely on social services. This wouldn't have happened if we [had] to keep swapping social workers.
>
> Halton feedback, email from J's mum

Evidence suggested that a consistent point of contact reduced anxiety and increased confidence in the services around the individual. This is illustrated by the following extract, taken from Sheffield's evaluation pack.

> The consistency of having a named social worker is important. It helps [a] family to know who to contact, reduces their anxiety and avoids their call being stuck in the system.

What also emerged from the data is that the building of a consistent and trusting relationship was not necessarily a linear process. In other words, an NSW might have a constructive visit one day and then a difficult visit the next. This might be due to the individual going through a period of being unwell or hitting a point of crisis, or it could be because they decided not to engage on that day. Either way, what was striking from the case studies submitted by sites was the ways in which a trusting relationship was not just a necessary stepping stone or by-product of the wider work, but a significant outcome of the pilot in itself.

[B] Person-centred planning

[C] Finding the individual's voice

Through the pilot, NSWs were led by the individual in terms of where to meet and what to discuss. NSWs reflected on the value of this flexible approach, particularly in terms of the quality and quantity of additional information it generated about the individuals and the people around them. As Shropshire explained in its evaluation pack:

> Named social workers have also been able to observe young people in a range of environments, including at home and in short-break care. This has allowed the young people to communicate to us about their needs, preferences and activities to give us a broader understanding of them.

Shropshire continued to describe how this flexibility varied from general social work practice. They explained how only meeting an individual using a business as usual

approach not only narrowed the information the NSW learned about the cohort but also undermined their voice in the planning process:

> During business as usual, it is common for a young person to only meet their social worker in one environment, leading to an over-reliance on communication about the young person from family and other professionals.

In these ways, the time the NSW had to build up a trusting relationship was a critical means of gathering information about the person. It reduced reliance on direct questioning, which was not always appropriate for the cohort, and allowed time for an indirect process of observation and probing to gather information. The importance of this approach to those who do not like questioning is outlined by the following quote:

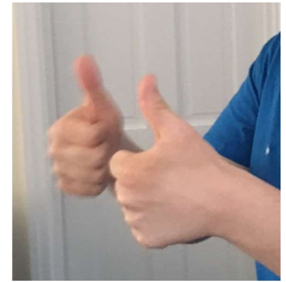
> D cannot cope with demands being put upon him. Asking D questions is demanding and he cannot tolerate it for long so defers to mum. Without an NSW approach it would only be mum's voice that is heard.
>
> Halton, D's case study

Commented [JI18]: Please credit image as follows:

Source: Image taken from Feedback from LF in Halton.

Case studies revealed all the incidental, colourful detail of the individual's life beyond the disability, needs and care package, such as their favourite film and activities, what made them happy and what made them sad. That their NSW learned their likes and dislikes was hugely important to many, as the following extract from a reflective log illustrates:

> It is important that my named social worker visits me and understands what I like and don't like.
>
> Hertfordshire reflective log



Knowing an individual's favourite film or their favourite food was essential information to help build a person-centred plan and gave the NSW the evidence they required to advocate or challenge on the individual's behalf.

[C] Creative methods of engagement

The evidence suggested that NSWs found different ways to work creatively with their cohort. Sites used mood charts to help guide conversations, and emojis and smiley faces to walk through discussions. Pen pictures, an exercise to draw up short, biographical portraits, were used to find out more about the cohort in an indirect, non-invasive way. These methods were tailored to the communication needs of the individuals they worked with and generated quality information to shape tailored person-centred plans. As one site explained, a pen picture exercise revealed something about an individual no one had heard before:

> The use of pen pictures is good practice in giving people the opportunity to tell their own stories and shape a person-centred support plan. For example, we found that one person really wanted a budgie, which is now written into his plan; no one had known that before.
>
> Sheffield evaluation pack

The evidence suggested that the use of creative engagement tools varied across sites, NSWs and the individuals they worked with. Indeed, one site felt that it was just at the point of considering creative methods of engagement when the pilot drew to a close. The reason for this was that the early work had focused on relationship-building and on the immediate priorities (e.g. hospital discharge) rather than wider or longer-term person-centred plans. Other sites reported that taking the time to build up deeper relationships – for example through increased contact points, observations, meeting in different settings etc. – was a creative form of engagement in itself compared to business as usual social work practice.

[C] Time to digest and respond to complex information

Having frequent contact points helped the NSWs convey information to the cohort and help them think through the implications over a longer period. For example, this was particularly helpful for young people at the point of transition between children's and adults' services. Having time to build up a relationship to help the young person think through their options over the next five years was essential to ensure they were clear about this, in order to get the right plan in place for the future. As the Liverpool lead reflected:

> What do you want to do for the next 5 years is a big question. If someone asked me that today I wouldn't know, I'm focusing on what I'm doing tomorrow or next week. How are they expected to know on the spot without thinking about it in advance?

In the context of transitions, it wasn't just the individual who benefited from more time to digest information and consider the options available from adults' services. Family, friends and carers also reported increased understanding of the process of transition and what it involved, as well as having a new appreciation of the fact that they had to allow the young person to begin to make decisions about the key issues that affected them. The overriding reflection for Shropshire, which focused on transitions, was that engaging young people earlier in the process was critical to improving outcomes.

As already suggested, the frequent contact points between the NSW and the people they worked with also helped the transfer of information between them. When the individual was facing a time of monumental change, such as the transition from children's to adults' services, this period of thinking through information was crucial to shaping a quality person-centred plan.

[B] Living a good life

Having choice and control over decision-making is one of the central planks of a person-centred plan – with the ultimate aim of supporting an individual to live the life they want. As a signifier of 'good social work' with people with learning disabilities, autism and mental health conditions one objective of the NSW pilot was to build quality and meaningful engagement into the process, to ensure that subsequent plans were a conduit to a good life.

Commented [JI19]: Please credit image thus:

Source: Bradford NSW presentation for Lancaster Better Social Work conference.

For these individuals, living the life they want to live was just as personal and unique to them as it was for everyone else. Some of the ways the NSW pilot helped people live the life they wanted are presented in more detail below.

[C] Overturning decisions about diagnoses

Bradford's starting point was at a fundamental human rights level. The primary objective was to review the individual's capacity to make their own decisions and, as such, positively reinforce MCA legislation. The NSWs described how they worked with other social workers with complex cases to help them challenge during multidisciplinary team meetings. As a result of this work, Bradford's NSW pilot successfully overturned decisions concerning mental capacity, putting the individual at the heart of new decisions about their package of care.

Another example of a significant impact on an individual resulting from the NSW pilot was an instance where an NSW in Sheffield successfully challenged the mental health diagnosis of an individual in her cohort. The outcome of this changed diagnosis was a more tailored, sustainable support plan for the individual, which would help her to avoid crisis in future. This is described in the extract below:

> [An NSW] observed someone who had an obsessive-compulsive disorder (OCD) diagnosis … She felt this was wrong and it was pathological demand avoidance (PDA) linked to autism; she requested through the multidisciplinary team that the person [be] reassessed, and they were diagnosed with PDA not OCD. This will mean that their future placement will be better able to support [them], increasing stability and avoiding crisis.
>
> Sheffield evaluation pack

[C] New residential settings

Other pilot sites reported how NSWs supported a number of individuals to achieve discharge from hospital or a move from a high-cost residential home into supported living arrangements. This was particularly effective in Liverpool: NSWs worked with young

people living in costly out-of-area placements to help them move them back to their local communities on reduced packages of care.

The following extract, from Halton's evaluation pack, describes how an NSW was able to prevent a young person being admitted to hospital and instead built a support package to enable him to live in his own house in an area close to his family:

> LF was at risk of hospital admission [but as a result of the NSW pilot] has been supported to live in his own home in his home town near to family and familiar places, close to the railway station which he loves and close to open spaces where he can go for walks. He has a trained and dedicated support staff team who are getting to know him really well.

[C] Preventing crisis

There are several examples where NSWs intervened at points of crisis, using their knowledge of the individual to prevent escalation of issues and mediating across providers and other people involved. In at least one instance this meant that an individual was able to stay in their supported living for longer, rather than be admitted to hospital. The vision across sites was to build sustainable, longer-term quality plans that would prevent individuals reaching crisis point in the future.

[C] Defending unwise decisions

Another emerging theme was the way in which an NSW defended 'unwise' decisions. For example, one individual wanted a laptop but, due to previous destructive behaviour had been denied one by the wider multidisciplinary team. The NSW was able to argue a case to overturn that decision and use funding to buy a laptop, which was then well looked after by the individual.

[B] Impact on people and families around the individual

Site evaluation packs indicate that decisions around what a good life looked like took into account the needs not just of the individual but also the families, carers and friends that surrounded them. The case studies reveal examples where the NSW realised that the current living arrangements were not ideal, or worse, actually escalating crisis within families. In one instance, the NSW changed a respite system which was adding to a strained relationship between parent and child. In another situation, an NSW arranged for a carer's assessment for a grandfather and found a confidence-building course for the mother to attend.

Again, these are examples of 'good social work in action' rather than a significantly new model. However, the creativity and flexibility of the NSW, enabled by the time and permissions of the NSW pilot, allowed this holistic approach to happen.

[B] Measuring impact

Given the short pilot time frame, these rich examples of impact are a testament to the NSW approach, which facilitated 'good social work' for people with learning disabilities, autism and mental health conditions to happen in practice. Sites attributed these outcomes

to the work of the NSWs and suggested that without their input either it would have taken much longer to achieve the outcomes or they might not have happened at all.

For example, without Bradford's NSW team, social workers would not have drawn upon their support to challenge decisions concerning an individual's mental capacity. Without permission to build up relationships, NSWs across sites commented on the information they would have missed about an individual if they had jumped immediately to assessment. For sites exploring transitions, the impact of the NSW approach upon the cohort was almost immeasurably different to business as usual social work. For young people and their families, in Halton and Shropshire in particular, having the time to process the meaning of transition and be part of active planning was the difference between a positive, empowering process and crisis. The pilot has generated powerful evidence from these sites which links early intervention to improved outcomes.

However, it is worth exercising some caution, particularly as the evaluation is not able to make statements concerning the extent to which every individual in the NSW cohort experienced trusting relationships or was actively involved with person-centred planning to live a good life. It is clear from the case studies and interviews that the NSWs achieved some incredible successes with individuals from the cohort. But it is equally clear that individuals had different starting points and aspirations, meaning that such 'success' is relative and complex. An NSW reflected on the barriers to delivering the pilot in the follow-up survey:

> The time constraints of the pilot are tight, whereas good social work is about working at the individual's pace. Given the needs of the people we are working with, it may be difficult to achieve outcomes for the pilot with people with whom it necessarily takes time to develop relationships and outcomes.

As such, the evaluation draws together these early indicators of impact to suggest how the NSW approach is part of the journey to a good life and not an end in itself.[3]

[A] Impact on the NSWs

This section explores the impact of the NSW approach on social work practice and on the NSWs who were part of the pilot. It begins by describing the knowledge, skills and values required for 'good social work' with people with learning disabilities, autism and mental health conditions and then reviews the specific elements of the NSW approach which meant that these were deployed in practice. The section ends with reflections on how an NSW approach had a positive impact on NSWs' motivation and morale.

[B] Doing 'good social work' with people with learning disabilities, autism and mental health conditions

The online surveys explored the extent to which the NSWs had confidence concerning some of the principal knowledge, skills and values required to work with this cohort at the beginning and end of their work on the pilot.[4] NSWs reported significant increases in confidence against all indicators over the course of the NSW pilot, as explored below.

[C] Building consistent and trusting relationships

For the NSWs who started the pilot who were more accustomed to an output approach to social work, intense relationship-building the cohort and their families could feel like a daunting task. The online surveys asked NSWs to assess their confidence in their ability to develop consistent and trusting relationships over the course of the pilot. Remarkably, despite the short pilot time frame, NSWs reported a significant increase in confidence – from 49 per cent saying they were confident or very confident in the baseline survey, to 93 per cent saying they were confident or very confident in the follow-up survey.

The evaluation packs presented extensive evidence about the varied ways in which NSWs had the permission and freedom to build up consistent and trusting relationships. There were some instances where this was more difficult. Out-of-area placements could be more difficult to visit regularly and so these members of the cohort sometimes experienced less face-to-face contact. Additionally, those NSWs with a mixed caseload could feel pressured to spend more time on their regular caseload, and so there were instances where their time felt less protected. Nonetheless, the evidence firmly suggests that NSWs enjoyed and valued the opportunities to build consistent and trusting relationships with the people with whom they worked.

[C] Support, assessment and communication

At the beginning of the pilot, 37 per cent of NSWs assessed themselves as confident in their ability to support, assess and communicate with people with significant learning disabilities and autism. Another 37 per cent were quite confident in this area. By the end of the pilot, confidence saw another marked increase, with 43 per cent feeling very confident and another 50 per cent feeling confident.

[C] Understanding legislation

For those sites working to improve the local transition process, which involved new partners and processes, the NSW pilot was an opportunity to increase NSW confidence in specific legislation. The survey asked those involved in the process of transition to reflect

on their confidence in their ability to work with relevant children's legislation and with an education, health and care plan.

Again, despite the short time scales, NSWs reported an increase in confidence across the two points of the survey. In the baseline survey, only 21 per cent of respondents felt quite confident, with 26 per cent reporting themselves to be not confident (42 per cent of respondents felt that this was not relevant to them). By comparison, at the end of the pilot, 42 per cent of respondents felt very confident or confident, with another 36 per cent feeling quite confident. Only 7 per cent felt not confident and, furthermore, there was a significant reduction in NSWs who felt this legislation was not relevant to their practice. This suggests that even sites which didn't focus on transition had the opportunity to generally broaden their understanding of wider social work legislation.

The permission to take risks needed to be underpinned by a solid understanding of the legislation that supports risk-taking in adult social services – the MCA and the European Convention on Human Rights (ECHR). Again, the survey revealed that the pilot had a positive impact on NSWs' confidence about this legislation. In the baseline survey, 42 per cent felt very confident or confident and another 37 per cent felt quite confident. In the follow-up this jumped significantly to 86 per cent reporting that they felt either very confident or confident by the end of the pilot.

[C] Creative approaches to person-centred planning

In Phase 1 of the pilot, a number of sites reflected that they would like to be more creative and ambitious about how to involve the cohort and the people around them, particularly in developing person-centred plans. To enable people to have genuine control of their own life they must be involved in a way that is meaningful to them, in the service design or individual planning and decision-making processes. Indeed, the opportunity to put person-centred planning into action was a key driver for some social workers who applied to take part in the NSW pilot:

> [My hope for the NSW pilot is] to improve [the] quality of person-centred support assessment and planning for people with learning disabilities and autism [and] to have the flexibility to use creative approaches to achieve this.
>
> Baseline survey respondent

NSWs were asked to reflect on their confidence in meaningfully engaging the person they work with (and the people around them) to deliver person-centred plans. As they started the pilot, 45 per cent felt they were confident, and a further 32 per cent reported that they were not confident. By the end of the pilot, 64 per cent felt very confident, with 29 per cent reporting themselves to be confident.

The evidence from evaluation packs suggests that there is more that can be done to support social workers to habitually and confidently utilise co-production techniques in person-centred planning. However, the NSW pilot gave NSWs across the sites the opportunity, confidence and encouragement to trial and test some methods which were new to them, in a short time frame and with a cohort of individuals with different starting points and needs.

[C] Advocating on behalf of the cohort

As the primary point of contact with the individual, and the person with oversight across the individual's life – key people, services, likes and dislikes – the NSW has an important advocacy role. The online surveys asked the NSWs to reflect on their confidence in their ability to advocate on behalf of the people they were working with in multi-agency settings. At the start of the pilot, NSWs were generally confident in this area, with 16 per cent reporting they were very confident and 47 per cent feeling they were confident. This confidence increased by the end of the pilot, with 57 per cent being very confident and 36 per cent being confident.

As the following extract from a Hertfordshire reflective log suggests, this advocacy could involve close work with support staff, to ensure they were working correctly according to legislation in order to improve the experience of the individual:

> I spent hours working closely with the support staff, explaining the relevant legislation to them, supporting them with their recording skills, all to make sure that Ms G is supported in a less restrictive and [more] positive way.

The survey also asked NSWs to reflect on their confidence when advocating with families and the people around them. While slightly less confident here than in multi-agency settings, the broader emphasis is the same, with 11 per cent very confident and 53 per cent confident at the start of the pilot, and 50 per cent confident and 43 per cent very confident at the pilot's end.

[C] Constructive challenge

Linked to advocacy is the notion of 'constructive challenge' where the NSW might have to bring an alternative view to decisions about an individual, to ensure that their views were driving planning. This 'rock the boat without falling out' approach was a particular driver for Bradford, but was a key component of the NSW pilot across all sites.

The survey asked NSWs to reflect on their confidence in their ability to constructively challenge other professionals and services. At the start of the pilot, 7 per cent felt they were very confident and 36 per cent felt confident. At the end of the pilot, 29 per cent felt very confident and 57 per cent felt confident.

[B] The NSW approach in action

The following is taken from a reflective log from Hertfordshire and clearly attributes the change in social care practice directly to the framework of the NSW pilot.

> Ms G has a history of being readmitted to the Mental Health unit after her placements break down. The priority for me was to prevent further hospital admission and support her to rebuild her life and integrate back in the community. The NSW pilot allowed me to use my creativity and try unconventional ways of working to achieve Ms G's goals.
>
> Thanks to a protected caseload I was able to meet with her twice weekly (each time for at least two hours), jointly

> creating her care plan, taking her out, discussing support options, meeting with professionals etc. I was not afraid to try different support options (reducing/increasing care etc.) and clearly promoting positive risk-taking practice because I felt that being on the pilot allows me to do that.
>
> I would often challenge mental health workers' decisions, who based on their previous experience of working with Ms G would be very risk averse, limiting her options and trying to implement the restrictions which in my opinion were unnecessary.
>
> Hertfordshire, reflective Log 2

[B] Working across the system

There is a wealth of qualitative data that describes 'constructive challenge' in action that shows the wider impact of NSWs having the confidence and skills to work across the system. As the following extended extract from a Hertfordshire reflective log illustrates, having the confidence to challenge a decision concerning a hospital recall, based on a detailed understanding of the individual and their triggers, not only led to improved outcomes for the individual but also improved the relationship between the NSW and the service provider.

> L was not a part of the first phase of the NSW project as she had just been discharged at the time and was not yet well settled in the 24-hour 1:1 supported living placement in the community. There had been incidents where she had placed herself, her staff and members of the public at risk. Her consultant as well as the multidisciplinary team was considering recall or the need for additional staff support; 2:1 rather than the 1:1 support she was receiving.
>
> As a named social worker and an approved mental health professional, I was strongly opposed to a hospital recall especially within the first year of discharge. A similar strong view from L's service provider meant that a decision was made not to recall. Furthermore, about six weeks after this crisis, L was discharged from the community treatment order.
>
> The service provider has since fed back that they felt quite reassured and supported by my ability to challenge the medical model as well as my approach in making L's needs and views central in my discussions with all involved in her care. In addition, I also received a 'thank you' card from L expressing her appreciation for 'not giving up' on her.
>
> The service provider has stated that they have found my regular contact, open communication and transparency supportive and reassuring while working with L to ensure that she settles and remains in the community.

[B] Motivated, enthusiastic and values-driven staff

NSWs reported a wide range of reasons why they wanted to be involved in Phase 2 of the pilot. For those involved with Phase 1, the second phase was an opportunity to continue to work with their original NSW cohort or to move into a new area of focus, such as Liverpool which used Phase 2 to look at transitions. For those new to Phase 2, being involved in the pilot was an opportunity to try something new, whether that was work with a different cohort or the chance to apply some of the social work skills which were harder to employ with a busy caseload.

A series of interviews with NSWs in Hertfordshire revealed that there was status and recognition attached to being an NSW. It gave an authority to their work, both in terms of the complexity of the cases but also due to the multidisciplinary approach. This provided an opportunity to increase confidence and broaden experience, and was a huge motivator for NSWs, as illustrated by the following quotes taken from the follow-up survey:

> It was great to be allowed to be a social worker and the pilot showed [that] social work works.
>
> It has been really useful and I have valued the time it has allowed me to take [a] look at my own practice.
>
> I have loved working on this pilot as I feel it has given me permission to work the way I feel I should be working … Having more time to focus on the person and know what works for them as an individual, getting it right for them, gives great worker satisfaction as well as better outcomes for the individual and their family.
>
> It has offered a great opportunity to develop skills and knowledge as a social worker. It has enabled awareness-raising and improvement in transition across our local authority.

As suggested by the surveys, the confidence of NSWs hugely increased as a result of their involvement in the pilot. This is not to say that the NSW pilot was easy or that every individual engaged with it, or that partners always listened. But it does suggest that the pilot was an opportunity to do ‘good social work’ with the cohort, leading to better outcomes for the individuals and for the NSWs themselves.

[A] Impact on the wider system

This section explores the early indicators of the impact of this activity on partners, as well as the ways in which the wider system – processes, structures and budgets – was impacted as a result of the NSW pilot.

[B] Reducing the cost of care

Analysis of the economic impact of the NSW pilot conducted by York Consulting used a predictive financial return on investment (FROI) methodology. This model generated an NSW FROI of 5.14. This means that for every £1 invested in the model there was an anticipated return of £5.14. Of the savings, or costs-avoided through the NSW, the primary beneficiary was the local authorities, which attracted 89% of all financial benefits. Full details of the analysis and findings are contained in York Consulting's NSW programme Cost Benefit Analysis report.

When looking at costs saved for the local authority, sites described rehousing individuals out of expensive out-of-borough settings and into supported care back in the local community. Other individuals had changed respite packages with a reduced number of support ratios. Savings were also anticipated across the system, including benefits for health, police and emergency services, with reduced GP visits, criminal activity and ambulance call-outs.

For Halton, their work with one individual led not only to a vast array of qualitative benefits to the individual and his mother, but also equated to a direct reduction in costs to the local authority of £900 per week. Crucially, these savings had been generated as a direct result of a strengths-based approach to social work and not just as part of a wider drive to save money, as Halton explained:

> Whilst some of the new plans we have put in place have made significant savings to support packages, this is not about saving money. One young person was in a very high cost situation and was deeply unhappy. This is about a longer-term person-plan to make sure it works for everyone.
>
> Halton evaluation pack

As well as the cost savings of individual cases, Bradford calculated how the cost savings generated through the pilot could have a local authority-wide impact of £2.4 million if the approach was rolled wider:

> A 14.7% reduction has been achieved in the number of new people aged 18–65 who are placed in residential care during the period of the pilot. This is a significant rate of improvement. The alternative support plans cost differential is a cashable savings to the council of £200k per annum for the 8 people who were diverted from residential care during the pilot period.

> The gross unit cost of 18–64 placements is £1,519/week, [the] second highest in Yorkshire and Humber (15 councils). The average is £1,279. There were 9,863 weeks paid for in 2016/17 … If unit costs were brought in line with regional average across the whole service due to roll out of the approach, annual gross cost could reduce by £2.4m.
>
> Bradford evaluation pack

Sites were confident that these were not just one-off savings but that they represent cumulative savings in the longer term. As placements and plans were rooted in the preferences of the individual, they were more sustainable and less likely to trigger crises in future. Sites were also confident that these savings were directly attributable to NSW activity. As with the qualitative findings, sites felt that without the NSW approach, positive benefits would either take longer to materialise or would likely not have happened. This was especially true of the transition cases where they would have had no involvement of an adult social worker at this stage.

[B] Shaping a multi-agency response to a systemic issue

As sites scoped out the NSW pilot they engaged various partners in various ways, depending on their particular objectives. All three sites which focused on transitions described bringing a range of partners together across the system (including young people and their families) to explore the issues from a multi-agency perspective, particularly given the wide range of stakeholders involved across children's and adults' services but also beyond into the NHS, education, housing and other charitable or provider services. The aim was to understand how the current transition process operated, what worked well and less well, and identify new ways to create a more integrated, strategic system.

The impact of this strategic engagement, particularly for the transition sites, has been significant, from raising awareness to changing practice, as the following extract from Liverpool's evaluation pack reveals:

> Raising awareness of the transition process amongst various agencies has raised the profile of the team and enabled partners to recognise when the transition process should commence. It has made other professionals aware of the importance of a timely referral from children's to adult[s'] services which has been demonstrated by an increase in referrals from children's social work practitioners.

> A recommendation has also been put forward following the focus group with independent reviewing officers, that a referral is made as part of the Child Looked After Reviews. This supports person-centred planning as an early Care Act assessment can commence, leading to better/more person-centred services implemented at a more timely stage.

Liverpool evaluation pack

Halton, Liverpool and Shropshire all report that the NSW pilot has been an invaluable opportunity to scope out the local transitions processes and build up a body of evidence around what needs to happen locally, and who needs to be involved to improve it.

> The new ways of working during the NSW pilot [have] demonstrated very clearly to us that we are becoming involved with young people far too late. In Shropshire, we already have a commitment to 'different conversations'. In terms of transitions, we have learnt that 'different conversations' means early intervention in order to engage in person-centred planning as opposed to conflict management around funded resources.
>
> Shropshire evaluation pack

> The pilot was a helpful way to get transitions moving. We wanted to learn from our mistakes around transition and it was in the same month that the NSW came up and the NICE guidelines came out around what good transitions looked like. The pilot couldn't have come at a better time and it has helped us get the outcomes we need to sustain this approach.
>
> Halton evaluation pack

In this way, the NSW pilot was a catalyst to testing new approaches which generated local change.

[B] Co-producing strategy with self-advocacy groups

Bringing people with lived experience into planning discussions embedded a degree of co-production into the process. Bradford worked alongside Bradford Talking Media, which gave access to a self-advocacy group of people with learning disabilities to explore what good social care looked like from their perspective. Sheffield worked with an advocacy group to shape information and questionnaires. For Halton, young people were tasked to define what a good transition would look and feel like, via the local advocacy agency, Bright Sparks. This definition of transition is now at the heart of Halton's new transition team. It states:

> Good transition will involve people who listen to me, that let me make my own decisions and don't make them for me. It's about having people that know me well to support and help me to plan ahead. To do this, I need lots of good information in [a] way that I can understand it about the options that I want to do and support to learn the life skills I need.

This engagement of self-advocacy groups is not the same as co-production with the NSW cohort, but there are some examples of direct consultation with the cohort in Hertfordshire, which ran a feedback session with its cohort at the end of the pilot. There were also people from Halton's NSW cohort within their co-design sessions. Engagement with self-advocacy groups is one way the NSW pilot has built the voices of those with lived experience into the process over the short pilot time frame.

[B] Stimulating the market

Sites described a range of ways their work had influenced commissioning decisions or actively stimulated the market around specific areas. For example, in Bradford, any commissioning for new services related to learning disability, advocacy services or mental capacity always involved NSWs on the panel or at the provider events. Bradford has designed case studies for providers to respond to, with a focus on human rights and the MCA, to ensure awareness of the implications for the person if they are served notice to leave their residence.

Commissioning was also important in terms of the process of transition, particularly in light of the arbitrary separation between children's and adults' services. Liverpool has committed to exploring what 'all-age commissioning' looks like, and to embed an integrated approach across its neighbourhood teams.

[B] Sharing learning across the local authority

The findings from Phase 1 suggested that peer supervision was a valuable resource, not just for the NSWs to reflect on their practice with the NSW team, but also because it created a forum in which other social workers could engage. The benefits of bringing in other social workers were that it was a chance to share learning and start to influence practice across the wider local authority. The evidence for Phase 2 echoes this finding and suggests that peer supervision, training sessions and reflective practice were key to disseminating the learning of the NSW more widely, or to keeping the learning interesting:

> A peer group approach that brings in expertise in the form of workshops, or visiting professionals, keeps the learning active and interesting.
>
> Hertfordshire evaluation pack

The extent to which the NSW pilot had an impact on wider practice is, however, difficult to quantify. Sites that were involved in Phase 1 talked about their aim to influence change in social work culture – but at least one site reflected this was not possible in practice given wider organisational change and the competing pressures faced by NSWs. Additionally, as protected time is a significant component of the NSW approach, other social work colleagues might benefit from the training or learning from the approach but not have the protected time to practise it. There are examples, however, of sites that are planning to transfer elements of the practice principles (e.g. asset-based conversations or assessment) to a wider workforce and cohort of people who use services.

The one site which had a more tangible impact across the wider practice of social work teams was Bradford, which put culture change at the heart of its approach. With its hub

model – whereby NSWs supported a wider team to work with the cohort – the Bradford NSW team delivered training and formalised permissions frameworks (most notably around risk), and set up other structures of support including an 'MCA mailbox'. In this way, it was possible to 'rock the boat without tipping ourselves out' as part of a bigger vision of radically changing social work in Bradford.

[B] Widening the ethos of the NSW approach

Pilot sites identified a number of ways in which to engage partners in some of the NSW pilot structures beyond the day-to-day advocacy on behalf of the NSW cohort. Colleagues from different social work teams were invited join NSW peer supervision and training sessions to raise awareness of the NSW approach or to encourage networking. Where office space allowed, nurses or colleagues from mental health teams were invited to 'hot desk' in the NSW office to help share information across cases. This worked effectively in Halton where the transition team was co-located with a children's nurse. There are also examples where strategic stakeholders from health or children's services were invited to join NSW steering groups to encourage a system-wide response to issues.

The evidence suggests that different partners had different priorities and approaches, even when working with the same individual. Cohort case studies and NSW reflective logs contain various examples where they had to challenge partners or support them to understand the legislation in relation to a specific individual. The following extracts from Hertfordshire's evaluation pack describe how this was a signifier of a risk-averse system. Hertfordshire engaged partners into NSW pilot structures to encourage them to think differently about how they planned for individuals, as part of a wider push for culture change:

> The project aimed to continue to focus of developing staff's skills and confidence in challenging the views of others. For example, our NSW staff are often asked by our health colleagues to increase packages of care as a way of eliminating risk. An increase of package isn't always the best way forward for individuals as it demonstrates 'control' and therefore has an undesired outcome. This means that we need to have better links with our health colleagues. This has started to happen and health colleagues have expressed an interest in the pilot and those involved have shared positive feedback.
>
> Hertfordshire evaluation pack

> In general, the project was seen as an innovative and much welcome new initiative aiming to improve person-centred practice, positive risk-taking and partnership working … questions were raised though [about] how that can be achieved.
>
> Hertfordshire, February 2018, meeting with Community Assessment and Treatment Service EP

It is not possible to claim that the NSW pilot achieved system-wide culture change in the six months of Phase 2. Rather, it helped sites identify local issues and the roles of

partners, understand the gaps in services and processes to be addressed and start to build up relationships and networks in order to shape the system in the future.

[SH] Conclusions and recommendations

[A] Conclusions

The NSW was an ambitious pilot with a wide scope over a six-month implementation period. As such, it is necessary to be realistic about what is possible to measure and attribute to the pilot over this time frame. As Shropshire noted:

> A short-term piece of work highlights the gaps in provision, it doesn't solve the problems. Long-term commitment is required to develop a[n] NSW model that is effective.

Despite this, the evidence suggests that sites were able to flex the pilot to suit their needs. It was an opportunity for sites to trial and test different methods and work differently with a caseload compared to a 'business as usual' approach. Through the pilot, NSWs increased their confidence in the knowledge, skills and values required to deliver 'good social work' with people with learning disabilities, autism and mental health conditions. The NSW pilot framework – the protected time, the peer supervision space and the permission to take risks – meant that this good social work took place in practice. Sites have confidently attributed improved outcomes for individuals directly to this pilot. As Halton reflected:

> I don't know how we could go back now, we really can't.
>
> Interview with Halton lead

Sites were encouraged to capture the impact of this work on the individuals, the NSWs and the wider system to build an evidence base of what works locally and to help shape future plans. Sites described how they have either secured funding for future NSW work or are in the process of securing it. The plans for sites' longer-term delivery were as unique to the localities as were the pilots.

Halton planned to continue to pilot the NSW approach for transitions and was considering using 'community connectors' to work with individuals with lower levels of need in the longer term. Bradford planned to continue in an NSW support role to other social workers, particularly with Transforming Care and transition cohorts. Hertfordshire hoped to test how an NSW approach could work in a system that moved away from specialist to more generalist teams. Shropshire and Liverpool were continuing to focus on early intervention to improve outcomes. Again, this suggests the value and flexibility of the NSW approach.

There were concerns from sites about potential barriers to sustaining the NSW approach in future. One question was how to maintain the high level of enthusiasm generated by the NSWs involved in the pilot. These individuals were keen and motivated to engage and so may not be representative of the wider workforce. Similarly, there was the question of how the NSW approach would work for those sites which moved away from specialist to generalist teams.

The bigger question was how to protect the time for an NSW approach in the face of business of usual – the pressures of workload, capacity, pressures on budgets, paperwork, processes in a wider, crowded, risk-averse system. Despite this, with positive feedback from the cohort, a significant impact on the workforce, the opportunity to build genuine relationships with a wider range of partners, and early examples of approaches

that are reducing overall packages of care, the question for sites was not whether to build a longer-term plan for an NSW approach in future, but how best to do it in practice.

[A] Recommendations

[B] Recommendations for government

The following set of recommendations is designed to support the DHSC to build on the learning of the NSW pilot. The recommendations are for government to:

- provide support and develop tools to help local areas bring the existing NSW pilots to scale and to spread to new adopter sites
- establish learning and peer networks to support NSWs to share learning and peer support.
- develop a national guide on NSWs and managing transitions, building on lessons from evaluation and NICE guideline on transitions

[B] Recommendations for training or professional bodies

The following set of recommendations is designed for training or professional bodies to tailor their support in future. The recommendations are for these organisations to:

- ensure findings from pilots are used to advance the knowledge and skills for social work with people with learning disabilities, autism and mental health conditions and their carers
- develop and provide blended training programmes for NSWs on the MCA, transitions, person-centred care planning, strengths-based social work, co-production and working in partnership
- ensure findings about what constitutes good social work within the pilots are fed into development of knowledge and skills statements (KSSs) for supervisors and principal social workers in adult social care

[B] Recommendations for other sites looking to embed an NSW approach

The following set of recommendations is designed to support other local authority areas looking to embed an NSW approach. These recommendations also include thoughts from a Phase 1 pilot site concerning how to sustain the NSW approach once the funded pilot has closed. The recommendations are for sites to:

- co-produce a vision of what good social work looks like for local people with learning disabilities, autism and mental health conditions and rally social workers and other partners around that clear narrative
- take time to plan, identify the cohort, gather relevant data, approach and engage key partners

- structure the model to include protected time for the NSW caseload and peer supervision, to maintain focus and momentum
- focus on what it is possible to achieve and be realistic when managing expectations and relationships if delivering the pilot within a short time frame
- gather data to evidence impact and learning around key impact areas and to clearly illustrate how strengths-based approaches to social work can generate cost efficiencies across the system.

[SH] Appendix A: Summary of pilot sites

Table 2 Summary of site structures

Site	No. NSWs	No. of cohort	Description of cohort	Key partners engaged through the pilot
Bradford	4 FTE NSWs with no direct caseload.	38	Individuals from transitions, adults with learning disabilities and Transforming Care teams; 6 lived in hospital/secure units and 32 in residential care.	Joint learning disabilities commissioner; local advocacy organisation; Centre for Disability Research; specialist commissioning leads.
Halton	2.5 FTE NSWs and a full-time social work student. Each had between 5 and 7 NSW cases.	17	Focus on transitions for 16–18-year-olds with learning disabilities, autism or post-traumatic stress disorder. Of the total cohort of 17, 1 lived alone in the community, 14 lived in the community with their family or carer and the remaining 2 lived in residential care.	Children's nurse; CCG commissioner; SEND coordinator; schoolteachers; community matron; self-advocacy agency; CAHMS; MCA assessor.
Hertfordshire	8 NSWs with a mixed caseload (between 1 and 3 NSW cases each).	10	Adults with learning disabilities with mental health or behavioural needs requiring specialist assessment and treatment services who were at risk of experiencing the criminal justice system. Four lived in supported living, 2 had their own flats in the community, 1 was in prison and 1 in residential care.	Community Assessment and Treatment Service; provider service (including their commissioned health provider); advocacy services; general hospital.
Liverpool	2 FTE NSWs each with 9 NSW cases, each supported by a team leader and a community, locality and divisional manager.	27	Young people of transition age in out-of-area placements who had a learning disability or autism diagnosis or no formal diagnosis but presented with challenging behaviour.	Adult Social Care Transitions Team; neighbourhood and mental health teams; children's social care reviewing officers; Leaving Care Team; Permanence Team; Adult Community Learning Disabilities Health Team; specialist school pastoral lead; Alder Hey's Children's Hospital Transition Team; service managers; adult service commissioner; SEND lead for children's services; early help information officer.
Sheffield	5 FTE NSWs with a mixed caseload (3 NSW cases out of an average of 14 each).	15	7 members of the cohort were specifically part of the Transforming Care cohort. All individuals were people with learning disabilities and mental health needs who were living in hospital or in a restricted setting in the community.	Independent advocacy group; residential and nursing care providers; CCG and CHC stakeholders; housing providers and commissioners; Sheffield Health and Social Care Trust; NHS England.

Shropshire	3 NSWs at an FTE of 6 days per week. Each had 4 NSW cases and worked 2 days per week on the pilot.	12	A group of young people from Shropshire's specialist education academy from the complex and PMLD groups within the school. 10 young people were from year 14 and 2 from year 13.	Local specialist academy school; local advocacy groups.

[SH] Appendix B: NSW programme theory of change

The NSW programme theory of change was initially designed after a review of Phase 1 project documents and Phase 2 material. The first draft was taken to a theory of change mapping session at each site and was revised after all meetings had taken place.

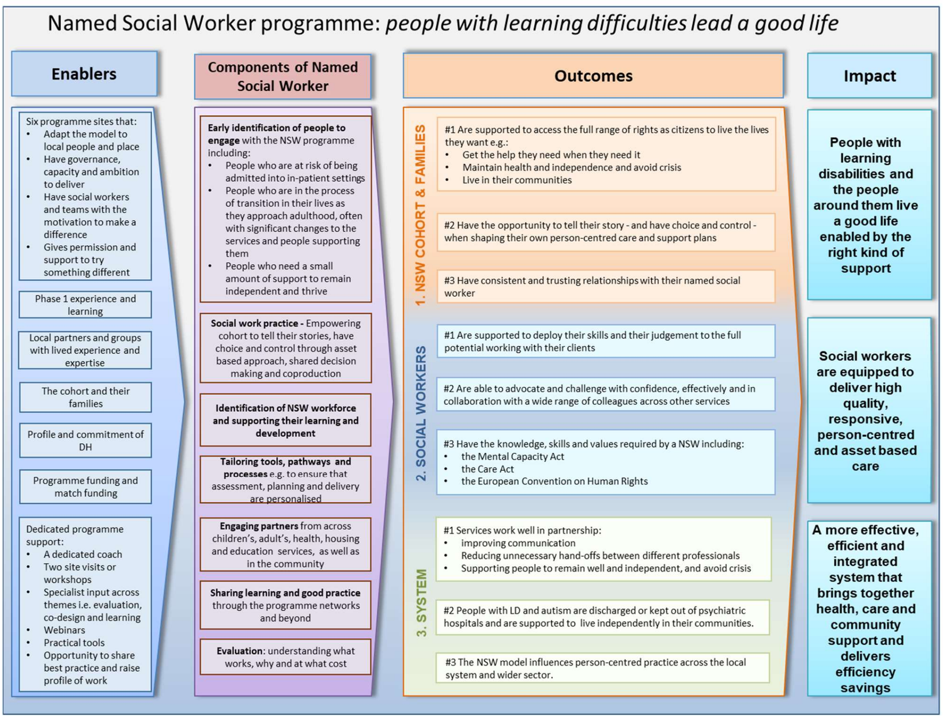


Figure 1 NSW programme theory of change

The evaluation lead used the discussions from each theory of change mapping session to design individual site models which were later validated and signed off by sites.

[SH] Appendix C: Findings from the NSW surveys

This section presents the findings from the two NSW surveys. The first survey ran in December 2017 and asked NSWs to reflect on their confidence in their abilities across various indicators as they first started their role. The second survey ran in March 2018 and asked NSWs to reflect on their confidence in their abilities across the same indicators as their role came to an end.

The survey was completed by 19 individuals for the baseline and 17 for the follow-up. This is a small sample and, as the survey was both voluntary and anonymous, there is no way of tracking that the same NSWs completed both surveys. This introduces a note of caution for analysis as it is possible for the results to be skewed accordingly. Nonetheless, the survey evidence is useful to present broader trends triangualted by all the data presented in site evaluation packs and by the interviews with site leads.

Table 3 presents the percentage confidence reported by NSWs across all knowledge, skills and values indicators. When an indicator sees an increase over over 20 percentage points it is highlighted in green. When it drops by 20 per cent it is highlighted in red.

Table 3 Percentage responses to the NSW pilot surveys

How confident are you in your ability to …	Survey	Very confident	Confident	Quite confident	Not confident	Don't know/ NA
Develop a consistent and trusting relationship with the person you're working with and the people around them?	Baseline	5%	42%	37%	0%	16%
	Follow-up	53%	41%	0%	6%	0%
Meaningfully engage the person you're working with and the person around them to deliver a person-centred plan?	Baseline	0%	47%	32%	5%	16%
	Follow-up	65%	29%	6%	0%	0%
Support, assess and communicate with people with significant learning difficulties and autism?	Baseline	0%	37%	37%	0%	16%
	Follow-up	35%	53%	12%	0%	0%
Work in a strengths-/asset-based way as outlined in the Care Act?	Baseline	0%	42%	42%	0%	16%
	Follow-up	47%	53%	0%	0%	0%
Work with relevant human rights legislation, e.g. MCA, ECHR?	Baseline	5%	37%	37%	5%	16%
	Follow-up	29%	59%	12%	0%	0%
(For those working with transitions) Work with relevant children's legislation and work with an EHCP?	Baseline	0%	0%	21%	26%	53%
	Follow-up	18%	24%	35%	6%	18%
Advocate on behalf of the people you're working with, in multi-agency settings?	Baseline	16%	47%	21%	0%	16%
	Follow-up	59%	35%	6%	0%	0%
Advocate on behalf of people you're working with, with families and people around them?	Baseline	11%	53%	16%	5%	16%
	Follow-up	53%	41%	6%	0%	0%
	Baseline	7%	36%	36%	0%	21%

Constructively challenge other professionals and services?	Follow-up	29%	59%	12%	0%	0%

The following charts present the findings across all indicators in a graph format.

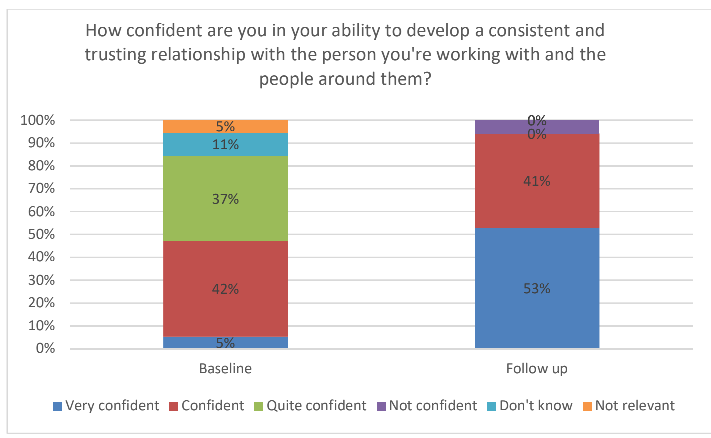


Figure 2 How confident are you in your ability to develop a consistent and trusting relationship with the person you're working with and the people around them?

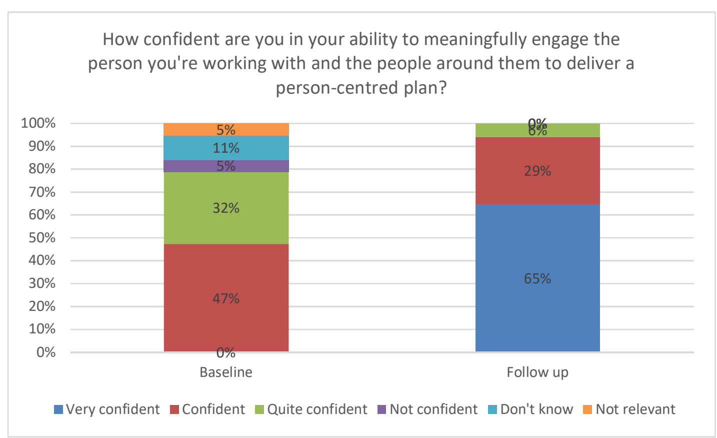


Figure 3 How confident are you in your ability to meaningfully engage the person you're working with and the people around them to deliver a person-centred plan?

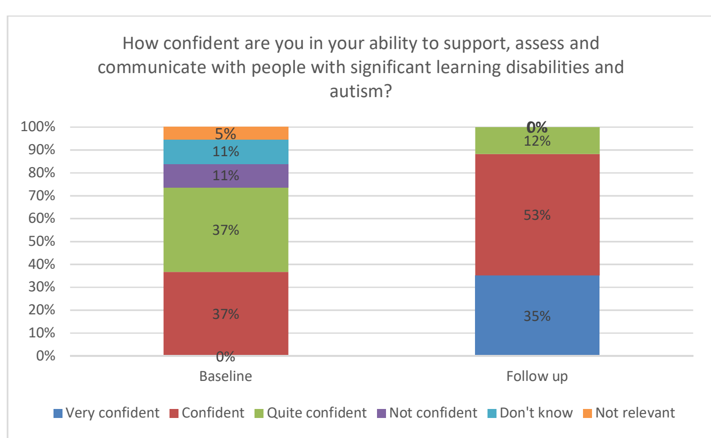


Figure 4 How confident are you you in your ability to support, assess and communicate with people with significant learning disabilities and autism?

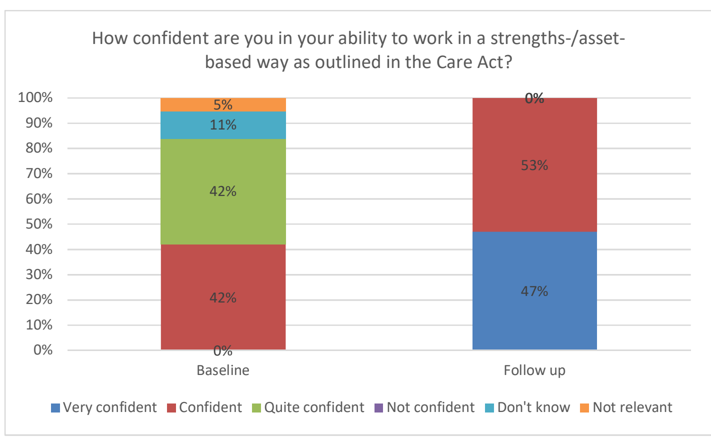


Figure 5 How confident are you in your ability to work in a strenghts-/asset-based way as outlined in the Care Act?

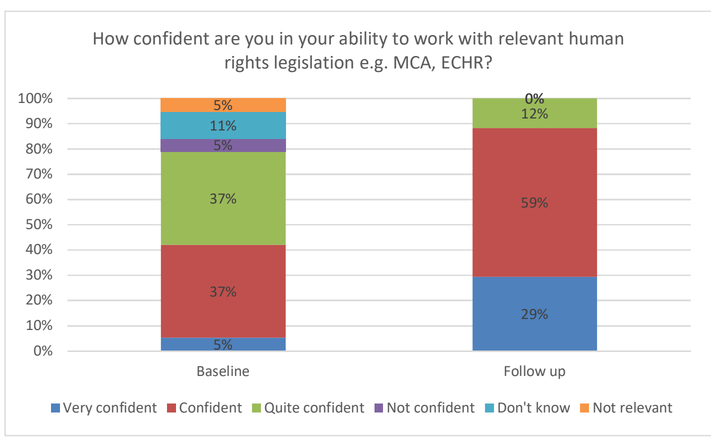


Figure 6 How confident are you in your ability to work with relevant human rights legislation e.g. MCA, EHCR?

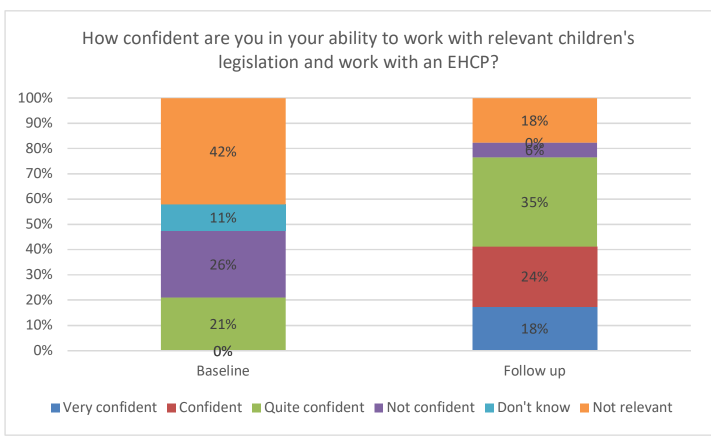


Figure 7 How confident are you in your abiliyt to work with relevant children's legislation and work with a EHCP?

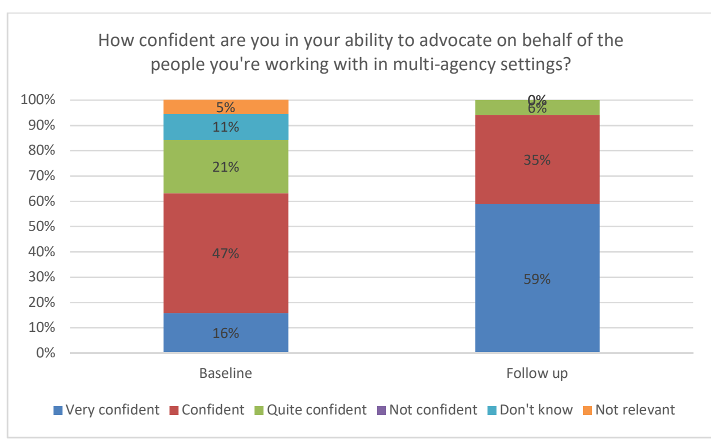


Figure 8 How confident are you in your ability to advocate on behalf of the people you're working with in multi-agency settings?

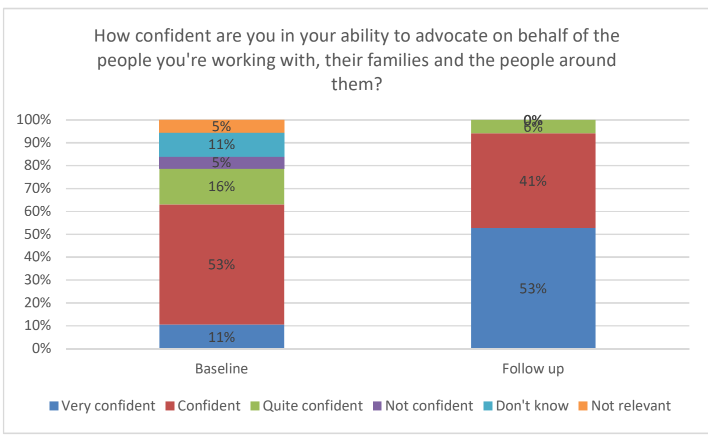


Figure 9 How confident are you in your ability to advocate on behalf of the people you're working with, their families and the people around them?

Social Care Institute for Excellence
tel 020 7766 7400
www.scie.org.uk

Named Social Worker (NSW) Programme: Cost Benefit Analysis (CBA)

June 2018

Author and Contact Details

Date: June 2018

Author: John Rodger and Brian Stewart

Quality Assured by: Brian Stewart

York Consulting LLP
Smithfield House
92 North Street
LEEDS
LS2 7PN

Tel: 0113 2223545
Fax: 0113 2223540

Email: john.rodger@yorkconsulting.co.uk

CONTENTS

Page

1 COST BENEFIT OVERVIEW 1

2 METHODOLOGY 3

3 GENERATING PREDICTIVE DATA 4

4 MONETISING BENEFITS 7

5 RETURN ON INVESTMENT 10

6 CONCLUSIONS 11

ANNEX A: NSW AREA BENEFIT PROFILES 12

ANNEX B: TEN STEPS TO CREATING YOUR OWN COST BENEFIT ANALYSIS 14

1 STEP ONE: UNDERSTANDING COST BENEFIT ANALYSIS 2

2 STEP TWO: ESTABLISHING APPROACH AND ASSESSING LIMITATIONS 4

3 STEP THREE: IDENTIFYING COSTS 5

4 STEP FOUR: BENEFIT MAPPING 7

5 STEP FIVE: MONETISE BENEFITS 9

6 STEP SIX: SPECIFYING COST BENEFIT PROFILES 11

7 STEP SEVEN: ESTIMATE OVERALL FROI 14

8 STEP EIGHT: IDENTIFY BENEFIT BENEFICIARIES 15

9 STEP NINE: OBTAINING ACTUAL DATA 16

10 STEP TEN: CONCLUDING REMARKS 18

1 COST BENEFIT OVERVIEW

Introduction

1.1 This report presents an estimation of the costs and benefits associated with the delivery of the Named Social Worker (NSW) programme using a financial return on investment (FROI) model.

1.2 The FROI approach recognises that NSW teams had limited opportunities, given the short pilot timescale, to collect actual client outcome information. As such, the initial focus was to construct a model of impact based on a range of assumptions. This has provided an illustrative projection which can be checked with actual outcomes data at a later date.

1.3 This report should be read in conjunction with the Cost Benefit Analysis (CBA) Good Practice guide prepared by York Consulting contained in Annex B. This was written to assist NSW teams to conduct their own economic analysis using a predictive CBA methodology. The guide walks through the methodology in detail, using the Hertfordshire NSW pilot as a model of investigation.

The findings

1.4 A 'deep dive' into the costs and anticipated benefits at Hertfordshire NSW pilot calculated a FROI of 2.8. This means that for every £1 invested into the pilot there was an anticipated savings (or costs avoided) of £2.80. Of these savings, 78% were estimated to be of benefit to the local authority.

1.5 Based on the outcome predictions of NSW project staff across the other five pilot sites, the analysis suggests that all six projects would generate a positive return on investment.

1.6 The predicted FROI was highest in Liverpool (9.84) and lowest in Halton (2.17). The variation in the FROI across areas reflects the variation of cohort, benefit profile, pilot approach and local context.

1.7 The assessment indicates that a programme investment of £404,000 would generate an anticipated £1.7 million of benefits on a pro rata basis. This represents a very credible NSW programme FROI of 5.14.

1.8 The primary beneficiaries in all areas and for the programme as a whole was the local authority; attracting 89% of all benefits. Many of the savings made relate to less expensive care packages (as outlined in more detail in Annex A).

1.9 Subject to the assumptions made in developing the CBA model (as outlined in Annex B) this FROI analysis should act as a significant stimulus for all local authorities to continue to support the investment using their own funding.

1.10 Results should however be treated with caution. This is indicative assessment based on predicted benefits. Further analysis should take place when actual data is available to sense check the assumptions in the model.

The assumptions

1.11 It is worth nothing a number of methodological assumptions, set out below:

- The costs of setting up the NSW is estimated to be 20% of the overall initial investment made by the Department of Health and Social Care (DHSC) to sites. The FROI has been calculated against steady state costs (which is therefore 20% less than the total DHSC funding)
- When considering the benefits anticipated by the NSW, sites were asked to be clear which impacts were directly attributable to the pilot as opposed to what would have happened during business as usual
- In these ways, the anticipated FROI is understood as additional to business as usual and excludes the cost of setting up the model. However, as this is an illustrative projection, there is no control group or actual data to directly attribute the benefits directly to the NSW
- The CBA analysis focuses exclusively on the chosen NSW delivery model in each area. No information was available on alternative operational permutations therefore consideration cannot be given to how NSW monies might have been spent differently to achieve better outcomes

1.12 It is also worth noting that as the economic and social dimensions of the cost benefit assessment have been excluded, the benefits generated by the model will almost certainly be an under estimate of actual benefits to the wider economy and society. The chosen approach, however, provides a more realistic estimate from an *invest to save* perspective.

2 METHODOLOGY

2.1 As already outlined, the approach presented recognises that NSW teams have had limited opportunities, given the short time scales, to collect much client outcome information. The initial focus is therefore on constructing a model of impact based on a range of assumptions. This provides an illustrative projection which can be checked with actual outcomes data at a later date.

2.2 It should be emphasised that the results presented here are based on what NSW areas expect to happen and should therefore be treated as provisional estimates. Once the client outcome data becomes available NSW areas will be able to use the guide to recalculate the CBA.

The Predictive CBA approach

2.3 The predictive element follows from the limited actual data to conduct economic analysis over the course of the NSW programme. As such the methodolgy was constructed to project likely client outcomes based on best estimates.

2.4 The CBA model chosen focuses specificially on the fiscal line and is thus referred to as a Financial Return on Investment (FROI). This was selected as it specifically addresses potenitally cashable outcomes, particularly important to *invest to save* project interventions.

2.5 As the economic and social dimensions of the cost benefit assessment have been excluded it has to be recognised that the benefits generated by the model will almost certainly be an under estimate of actual benefits to the wider economy and society. It is however the more realistic estimate from an *invest to save* perspective.

2.6 As the term suggests there are two sides to the cost benefit equation – costs and benefits:

- **Costs** are defined as the costs sustained in delivering the project intervention. In the NSW context this has been calculated 'top down' as the total funding secured from the DHSC for the project
- **Benefits**, on the other hand, are defined as the costs avoided. In an NSW context this might include fewer GP visits and the avoidance of an emergency hospital admission for individuals supported

2.7 The division of benefits by costs, produces a benefit cost ratio which in this specification is the FROI.

3 GENERATING PREDICTIVE DATA

3.1 York Consulting undertook a 'deep dive' exercise with the Hertfordshire NSW project to better understand the costs and likely benefits of NSW delivery. As part of this process we prepared predictive benefit profiles for each of their ten supported clients. This information was then used to construct and illustrate the CBA Good Practice guide and a "benefits template."

Benefits

3.2 The CBA Good Practice Guide and "benefits template" were sent to all NSW sites to help them identify a detailed profile of the predicted benefits for five typical cases in the NSW cohort. This data was returned to York Consulting for analysis. The benefits were then monetised and weighted to reflect this supported cohort as a whole.

3.3 Using this information, it was possible to construct cost benefit profiles for each of the six areas and for the programme as a whole. Details of these profiles are set out in Annex A. The detailed information relating to Hertfordshire's 10 case profiles is also presented in the CBA Good Practice Guide.

3.4 A few notes on additionality:

- It is important to capture the additionality i.e. benefits and costs arising as a direct result of the intervention. This excludes what would have happened in the absence of the programme; otherwise referred to as 'business as usual'
- Ideally an assessment of additionality would be made by comparing the cost and benefit profile before and after the introduction of the NSW intervention. Unfortunately, this information was not available and would have required extensive primary research which was not possible within the timeframes
- For this analysis we asked sites to self-validate the data and asked them to only submit benefit information that they believed occurred purely as a result of the NSW programme and additional to business as usual
- We would recommend that areas formally validate their findings as data becomes available (see Good Practice Guide – section 9)

Costs

3.5 Cost information was provided by DHSC based on the direct funding for each of the projects. As such it is described as 'top down' costs. The alternative would be to generate 'bottom up' costs. This would involve identifying and segmenting delivery costs such as actual staff time and associated resources.

3.6 As the NSW pilot was a six-month programme, costs have been annualised to maintain consistency with benefits which are easier to observe over a 12-month profile. This involved doubling the actual costs of funding.

3.7 Programme costs funded one-off set-up costs as well as steady state operation. One-off set-up costs include the time it took to scope out the intervention, engage initial

partners and recruit named social workers. Steady state operation included ongoing costs to protect the time of named social workers to deliver a NSW caseload.

3.8 Costs have been deflated to reflect steady state operation. Excluded from the analysis are one-off costs associated with the project set-up linked to aspects of design and research and development (see Good Practice Guide – section 4). As this information was not available for all projects we applied a 20% figure calculated from the Hertfordshire investigation.

- As the costs presented relate purely to the NSW intervention they are effectively additional costs and exclude business as usual delivery

3.9 Details of the costs for the six areas and the programme average are set out in Table 1 below.

Table 1: NSW Costs (annual)

	Hertfordshire	Liverpool	Sheffield	Bradford	Halton	Shropshire	Programme
Total cost	£120,000	£232,324	£47,708	£100,000	£185,654	£121,384	£807,070
Steady state cost	£96,000	£185,859	£38,166	£80,000	£148,523	£97,107	£645,656
Cohort size	10	27	15	38	17	12	119
Unit cost	£9,600	£6,884	£2,544	£2,105	£8,737	£8,092	£5,426

3.10 Key points to note are as follows:

- The actual programme cost was £403,535 which in annual terms translates to £807,070.
- Steady state costs averaged at 80% of total costs for all areas.
- Unit costs were higher in Hertfordshire (£9,600) and lowest in Bradford (£2,544). This is strongly influenced by the size of the supported cohort in each area.
- The programme unit cost was £5,246 based on supporting 119 NSW participants on an annual basis.

4 MONETISING BENEFITS

4.1 The calculation of benefits involves monetising the hard outcomes of project interventions. These are effectively the cost avoided from things like police call outs, hospital visits, care packages and less intensive care support etc. The values for each are based on national published research. These benefits can be mapped to specific partners, for example local authorities, NHS, Criminal Justice system, DWP and police.

- This means it is possible to calculate both the total savings or costs avoided anticipated through the programme and the bodies that will directly benefit from the activity.

4.2 As already outlined, the benefits relate to a 12-month period and were validated by sites to be additional to business as usual.

4.3 In the case of Hertfordshire, no weighting of benefits was required as these relate to all ten of their cases analysed as part of deep dive exercise. In the other five NSW areas weighting was conducted by dividing the total cohort by 5 and using this as the multiplier for each monetised benefit, thus achieving a weighted profile average of total benefits.

4.4 Details of the benefits for the supported cohort in each NSW area and for the programme as a whole are set out in Table 2.

Table 2: NSW Benefits

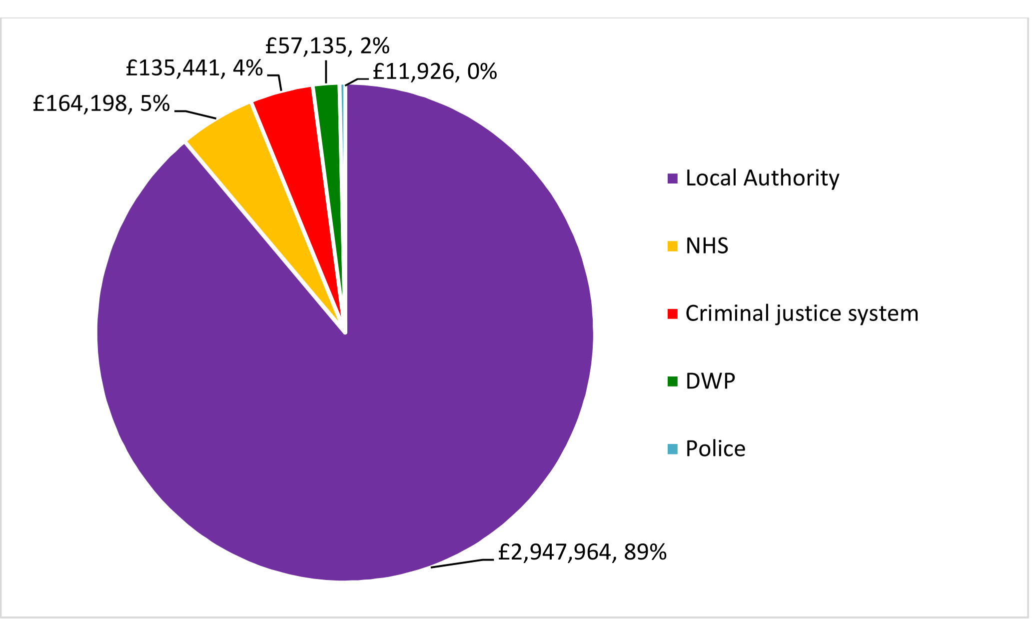
	Hertfordshire	%	Liverpool	%	Sheffield	%	Bradford	%	Halton	%	Shropshire	%	Programme	%
Total benefit	£268,615		£1,828,021		£112,870		£474,240		£322,402		£310,515		£3,316,663	
Cohort size	10		27		15		38		17		12		119	
Unit benefit	£26,862		£67,704		£7,525		£12,480		£18,965		£25,876		£27,871	
Benefit recipients:														
Local Authority	£209,640	78%	£1,632,792	89%	£87,978	78%	£474,240	100%	£262,401	81%	£280,913	90%	£2,947,964	89%
NHS	£46,798	17%	£52,816	3%	£23,070	20%	-	-	£41,514	13%	-	-	£164,198	5%
Criminal justice system	-	-	£127,022	7%	-	-	-	-	£8,419	3%	-	-	£135,441	4%
DWP	£10,410	4%	£12,520	1%	-	-	-	-	£4,602	1%	£29,603	10%	£57,135	2%
Police	£1,767	1%	£2,870	<1%	£1,822	2%	-	-	£5,467	2%	-	-	£11,926	<1%
Total benefit	£268,615	100%	£1,828,021	100%	£112,870	100%	£474,240	100%	£322,402	100%	£310,515	100%	£3,316,663	100%

4.5 Outlined below are key points emerging from the benefit assessment. They highlight the wide variation across the projects of benefit profiles. In many cases these reflect locality specific factors and the nature of the target group. (See Annex A). Points to note are as follows:

- Annual programme benefits were projected to be £3.3million; a unit benefit per supported individual of £27,871
- Unit benefits were projected as highest in Liverpool (£67,704) and lowest in Sheffield (£7,525)
- The high projected unit benefits in Liverpool reflect transitions from specialist care to unsupported living
- At a programme level and in all areas the main beneficiary organisation of benefits sustained was the local authority; attracting 89% of all benefits
- NHS benefits were highest in Sheffield (20%) and Hertfordshire (17%)
- Criminal justice benefits were highest in Liverpool (7%)
- DWP benefits were highest in Hertfordshire (4%)
- Criminal Justice benefits were highest in Liverpool (7%)
- Police benefits were highest in Sheffield and Halton (2%)

4.6 Details of the relative distributions of benefits at a programme level are shown in Figure 3. (see Good Practice Guide – section 8).

Figure 3: NSW Benefit Distribution



5 FINANCIAL RETURN ON INVESTMENT

5.1 The division of benefits by costs, produces a benefit cost ratio which in this specification is the FROI.

5.2 Details of the FROI for each project and for the programme as a whole are shown in Table 4 below.

Table 4: NSW FROI

	Hertfordshire	Liverpool	Sheffield	Bradford	Halton	Shropshire	Programme
Benefit	£268,615	£1,828,021	£112,870	£474,240	£322,402	£310,515	£3,316,663
Cost	£96,000	£185,859	£38,166	£80,000	£148,523	£97,107	£645,656
FROI	2.80	9.84	2.96	5.93	2.17	3.20	5.14

5.3 Key points to note are as follows:

- The overall programme predictive FROI was 5.14 which means a saving of £5.14 for every £1 invested in NSW support. This would consistute a positive return on investment and support a case for continued project funding
- All areas recorded a positive return on investment.
- The FROI was highest in Liverpool (9.84) and lowest in Halton (2.17). The variation in the return on investment across areas reflects the achieved benefit profile and variation of cohort, pilot approach and local context

6 CONCLUSIONS

6.1 The CBA assessment is theoretical based on what areas expect to happen following NSW support. In this sense it is predictive and results should be treated with caution.

6.2 The predictive assessments were provided by each area based on their own expectations. Sites predicted client benefit data as a direct result of the NSW programme (as opposed to what would happen during business as usual). While we asked areas to be realistic regarding their predictions we are unable to comment on the validity of their estimates.

6.3 Based on the FROI model and assumptions generated through the Hertfordshire 'deep dive' and the benefit profile information submitted by sites, the NSW programme suggests a positive FROI. Specifically, the economic assessment indicates that:

- a programme investment of £404,000 would generate an anticipated £1.7 million of benefits on a pro rata basis. These benefits have been annualised in the analysis. This represents a very credible NSW programme FROI of 5.14
- all areas would record a predictive positive FROI. The predicted FROI was highest in Liverpool (9.84) and lowest in Halton (2.17). The variation in the FROI across areas reflects the variation of cohort, benefit profile, pilot approach and local context
- the primary beneficiaries in all areas and for the programme as a whole was the local authority; attracting 89% of all benefits

6.4 This positive assessment should act as a significant stimulus for all local authorities to continue to support the NSW investment using their own funding.

6.5 Finally, it will be important to revisit this analysis once the actual data is available on client outcomes to validate the assessment.

ANNEX A: NSW AREA BENEFIT PROFILES

Liverpool FROI				
Case	Unit cost	Benefit type	Estimated 12-month saving	FROI
1	£6,884	• Placement stability • Reduction in care package • Specialised hospital placement to Supported Living	£152,472	22.15
2	£6,884	• Access to education/training • Residential care to living independently	£76,455	11.11
3	£6,884	• Prevent going to Prison • Reduction in Police call outs • Reduction in Hospital Admissions	£33,835	4.92
4	£6,884	• Hospital setting to Supported Living	£74,435	10.81
5	£6,884	• Reduction in care package	£1,327	0.19
Total	**£34,418**		**£338,522**	**9.84**

Sheffield FROI				
Case	Unit cost	Benefit type	Estimated 12-month saving	FROI
1	£2,544	• Reduction in Police call outs • Hospital discharge • Placement stability	£8,614	3.39
2	£2,544	• Reduction in Police call outs • Hospital discharge • Placement stability	£8,432	3.31
3	£2,544	• Reduction in Police call outs • Hospital discharge • Placement stability	£8,371	3.29
4	£2,544	• Less use of support staff for daily tasks	£3,536	1.39
5	£2,544	• Reduction in Police call outs • Hospital discharge • Placement stability	£8,670	3.41
Total	**£12,722**		**£37,623**	**2.96**

Bradford FROI				
Case	Unit cost	Benefit type	Estimated 12-month saving	FROI
1	£2,105	• Reduction in placement costs	£12,480	5.93
2	£2,105	• Reduction in placement costs	£12,480	5.93
3	£2,105	• Reduction in placement costs	£12,480	5.93
4	£2,105	• Reduction in placement costs	£12,480	5.93
5	£2,105	• Reduction in placement costs	£12,480	5.93
Total	**£10,526**		**£62,400**	**5.93**

Shropshire FROI				
Case	Unit cost	Benefit type	Estimated 12-month saving	FROI
1	£8,092	• Residential college to Community College	£16,478	2.04
2	£8,092	• Supported internship	£6,167	0.76
3	£8,092	• Residential care to Supported Living	£50,285	6.21
4	£8,092	• College Placement	£6,167	0.76
5	£8,092	• Residential care to Supported Living	£50,285	6.21
Total	**£40,461**		**£129,381**	**3.20**

Halton FROI				
Case	Unit cost	Benefit type	Estimated 12-month saving	FROI
1	£8,737	• Reduction on GP home visits • Reduction in Police call outs • Reduction in Criminal Damage • Residential care to living in the community	£151,313	17.32
2	£8,737	• Supported Living to living independently	£52,305	5.99
3	£8,737	• Reduction in Police call outs • Reduction in Ambulance call outs • Reduction in Hospital Admissions • Reduction in Criminal Damage • Agency support	£25,853	2.96
4	£8,737	• Reduction in Police call outs • Reduction in Ambulance call outs • Avoided Mental health hospital admission • Reduction in Fire & Rescue call outs • Avoided eviction from tenancy	£18,052	2.07
5	£8,737	• Avoided Mental health hospital admission • Avoided Youth Court trial • Avoided Court of Protection intervention	£16,739	1.92
6 - 17	£8,737	• Reduction in Police intervention • Change from Night shelter to a tenancy with a support package	£4,845	0.55
Total	**£148,523**		**£322,402**	**2.17**

ANNEX B: TEN STEPS TO CREATING YOUR OWN COST BENEFIT ANALYSIS

Named Social Worker Programme:

Ten steps to creating your own cost benefit analysis

A York Consulting support guide

John Rodger and Brian Stewart

February 2018

CONTENTS

Page

INTRODUCTION 1

1 STEP ONE: UNDERSTANDING COST BENEFIT ANALYSIS 2

2 STEP TWO: ESTABLISHING APPROACH AND ASSESSING LIMITATIONS....................4

3 STEP THREE: IDENTIFYING COSTS 5

4 STEP FOUR: BENEFIT MAPPING 7

5 STEP FIVE: MONETISE BENEFITS 9

6 STEP SIX: SPECIFYING COST BENEFIT PROFILES 11

7 STEP SEVEN: ESTIMATE OVERALL FROI 14

8 STEP EIGHT: IDENTIFY BENEFIT BENEFICIARIES 15

9 STEP NINE: OBTAINING ACTUAL DATA 16

10 STEP TEN: CONCLUDING REMARKS 18

INTRODUCTION

1. This guide, developed by York Consulting, is designed to assist Named Social Worker (NSW) teams to conduct their own economic assessment using a predictive cost benefit analysis (CBA) methodology.

2. The approach presented recognises that NSW teams have had limited opportunities, given the short time scales, to collect much client outcome information. The initial focus is therefore on constructing a model of impact based on a range of assumptions. This provides an illustrative projection which can be checked with actual outcomes data at a later date.

3. Cost and illustrative outcome data was estimated based on a range of consultations with the Hertfordshire NSW team. The method was further market tested with all six second round NSW teams at a NSW evaluation workshop in February 2018.

4. While the methodology presented is not definitive, it should provide NSW teams with sufficient information to get started and specify their own cost benefit models. Teams may require further advice to fine tune their approach and to estimate counterfactual scenarios.

5. Further information relating to this guide can be obtained from Brian Stewart who can be contacted at brian.stewart@yorkconsulting.co.uk.

1 STEP ONE: UNDERSTANDING COST BENEFIT ANALYSIS

What is CBA?

1.1 CBA is a powerful tool which is widely used across government and the private sector to assess the economic case for specific project interventions. CBA aims to quantify in monetary terms as many of the costs and benefits of an intervention as feasible, including items for which the market does not provide a satisfactory measure of economic value.

1.2 Typically, CBA consists of three strands of analysis:

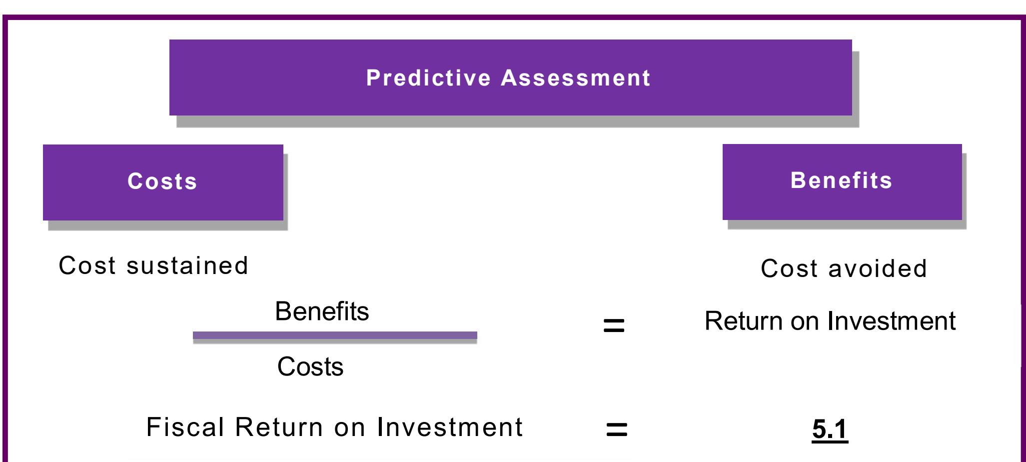
- **Fiscal** – Also referred to as the real money line, it is the most appropriate where the focus is on cash savings or invest-to-save initiatives.
- **Economic** – This is linked to concepts such as the income multiplier e.g. the economic value of an individual gaining employment.
- **Social** – This strand focuses on monetising the value of a wide range of softer outcomes for which there are few financial values e.g. individual well-being.

1.3 Identified benefits are divided by observed costs to generate a benefit cost ratio or return on investment.

Constructing a predictive CBA model

1.4 An overview of the predicitve CBA model is set out in **Figure 1.1**.

Figure 1.1: CBA Overview



1.5 The predicitve element follows from the need to project likely client outcomes based on best estimates. These can be subsequently checked against actual outcomes from client follow up at a point in the future.

1.6 The CBA model we have chosen focuses specificially on the fiscal line and is thus referred to as a Fiscal Return on Investment (FROI). This has been selected as it specifically addresses potentially cashable outcomes which are particularly important in invest to save project interventions. As the economic and social dimensions of the cost benefit assessment have been excluded, it has to be recognised that the benefits generated by the model will almost certainly be an under estimate of actual benefits to the wider economy and society. It is however the more realistic estimate from an invest to save perspective.

1.7 As the term suggests there are two sides to the cost benefit equation – costs and benefits. Costs are defined as the costs sustained in delivering the project intervention. In the NSW context this could be the total funding secured from the Department of Health and Social Care for the project. Benefits, on the other hand, are defined as the costs avoided. In a NSW context this might include fewer GP visits and the avoidance of an emergency hospital admission for individuals supported.

1.8 The division of benefits by costs produces a benefit cost ratio which in this specification is the Fiscal Return on Investment. In the example shown in Figure 1.1, an FROI of 5.1 indicates that for every £1 invested in the project there is a potential saving of £5.10. This would consistute a positive return on investment and support a case for continued project funding.

1.9 It is important to capture the additionality i.e. benefits and costs arising as a result of the intervention. This excludes what would have happened in the absence of the programme; otherwise referred to as 'business as usual'.

1.10 Taking these factors into account, CBA can be used to answer key questions such as:

- Does the project provide value for money?
- Which partners benefit most from the investment?
- How to prioritise investment across a range of projects?

Top Tip 1: Deciding what to include in the CBA should derive from the original aim(s) of the intervention. Is it for an individual, organisation or society as a whole? This should be evident from the theory of change (TOC)/logic model for the initiative. That said, it is not always this simple given the nature of some TOC/logic models. If there are a series of questions, the model may need to be adjusted for each question.

2 STEP TWO: ESTABLISHING APPROACH AND ASSESSING LIMITATIONS

What is the question you want to answer?

2.1 CBA works best when you are clear what you want it to do. Ask yourself – why am I doing this? What do I want to show? What decisions will it influence? What factors will carry greatest weight? What level of evidence might be required? When does it need to be done?

2.2 Answering these questions will help you decide how to specify the model, particularly the benefits to include.

How strong is your theory of change?

2.3 There is a strong correlation between the robustness of your theory of change and the strength of the CBA case that can be made. The tighter your focus on the intervention and the beneficiary group the better. For example, calculating the impact of a more intensive support programme on a clearly defined client group is easier to do than a more general intervention across a wider group. It may therefore be best to concentrate on only one element of your potential TOC.

Hang on to the concept of additionality or value added

2.4 The CBA of a new intervention such as NSW needs to show the impact beyond what was happening before i.e. 'business as usual'. This means you need to identify the additional costs of the programme of support and set them against the additional benefits. While additional costs are relatively easy to observe benefits are trickier!

Beware the magic of modelling: assumed models are illustrative not real

2.5 When conducting a CBA for a project it is rare to have full and complete data at one's disposal. Therefore, the cost benefit model will need to include some assumptions. Assumptions take account of data limitations. For example, if there is no control group (counterfactual) we might assume there is no need to omit any benefits as everything observed is value added.

2.6 This is a very broad assumption. Typically, one constructs a model at the beginning with estimated data which is full of assumptions and then relax them, or remove them altogether, as data becomes available. The construction of an estimated model provides a helpful illustration of the components of the model and its sensitivity to changes in particular costs and benefits.

2.7 Assuming that sufficient data is gathered at a later stage; it will be possible to check the actual data against the predictive approach.

Top Tip 2: Do not get carried away when predicting your projected benefits. This could generate unrealistic expectations or potential ridicule. Concentrate on illustrating the monetisation of potential benefits and the different combinations required to break-even i.e. costs equal benefits. This strategy will be more effective and influential than simply trying to generate a high return on investment.

3 STEP THREE: IDENTIFYING COSTS

Always start with costs

3.1 The cost side of the equation is usually the easiest to estimate and as such should be your starting point in the calculation. As indicated earlier these are the additional costs of delivering your NSW project. They are additional to your business as usual costs. We are effectively ring-fencing these costs from your mainstream business activity to simplify the analysis and focus on the additionality of your project investment.

3.2 Costs are critically important as they set the benchmark for the CBA assessment. A project costing £110,000 needs to generate the same level of benefits to break even. This would correspond to a FROI of 1.0.

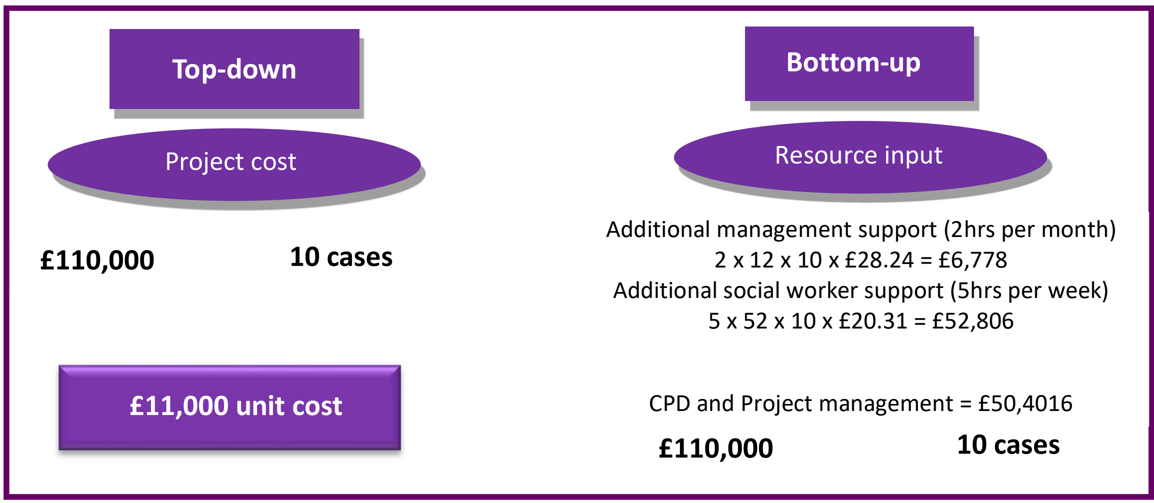
Annualise costs

3.3 It is always best to annualise costs to maintain consistency of comparison and improve the power of illustration. The context then becomes annual costs, annual benefits and an annual return on investment. This allows comparability with potentially other projects of different durations. If your project cost is £55,000 and lasts 6 months the annual cost would be £110,000.

Top-down and bottom-up costing

3.4 **Figure 3.1** illustrates the two methods that can be used to calculate your NSW project costs.

Figure 3.1: Costing Dimensions



3.5 The first, and most straightforward, is the top-down approach. This is the overall delivery cost of the programme. In the case of Hertfordshire this was £110,000. Once you know how many individuals will receive the treatment/support you can calculate the unit cost of supporting one individual throughout the programme. In Hertfordshire's case, there were ten NSW cases which meant that the cost of supporting a NSW case was £11,000.

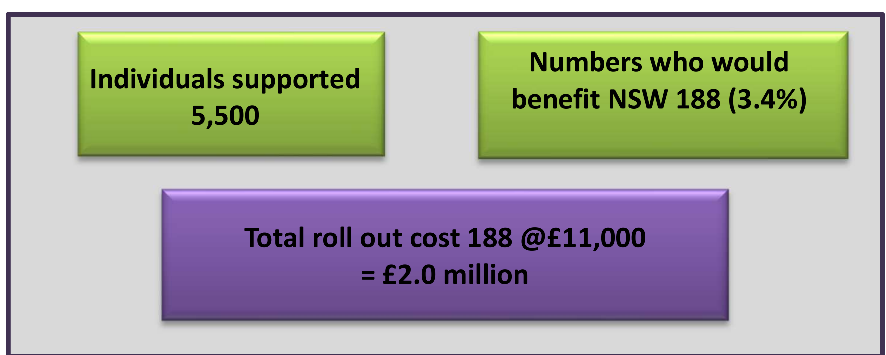
3.6 Alternatively, it is possible to build up the cost profile bottom-up. This involves identifying and segmenting delivery costs. In the illustration we calculate additional staff costs based on duration of support and staff hourly rates. We also identify other costs such as CPD and project management. The finer the granularity resource input assessment, the better the cost intelligence. For example, if costs subsequently prove to be higher than benefits, then the resource input assessment will make it easier to identify where potential savings might be made.

3.7 Figure 3.1 illustrates the top-down and bottom-up costs are the same. This rarely occurs in practice and usually means something has been missed in the resource costing or the project budget has not been fully spent.

Cost simulation

3.8 It is possible to simulate costs and project to a potentially larger target group. An illustration of this is shown in **Figure 3.2**.

Figure 3.2: Cost Projections



3.9 In our Hertfordshire example, 10 clients were supported in the NSW project at a unit cost of £11,000. Hertfordshire have 5,500 individuals supported annually and estimate that 3.4% fit the NSW criteria for additional support. This means that an additional annual cost for a potentially full NSW cohort would be £2 million.

Steady state costs

3.10 Cost estimation, whether top-down or bottom-up, should include only steady state costs. Excluded should be one off costs associated with the pilot project. This might include aspects of research and development.

Top Tip 3: Identifying the costs from a bottom-up approach is a much more time-consuming exercise compared to the top-down method. It is however worthwhile doing if only for a sample of cases. This is the best way of profiling cost inputs and assessing potential variation in support between client cases.

4 STEP FOUR: BENEFIT MAPPING

Map all project outcomes

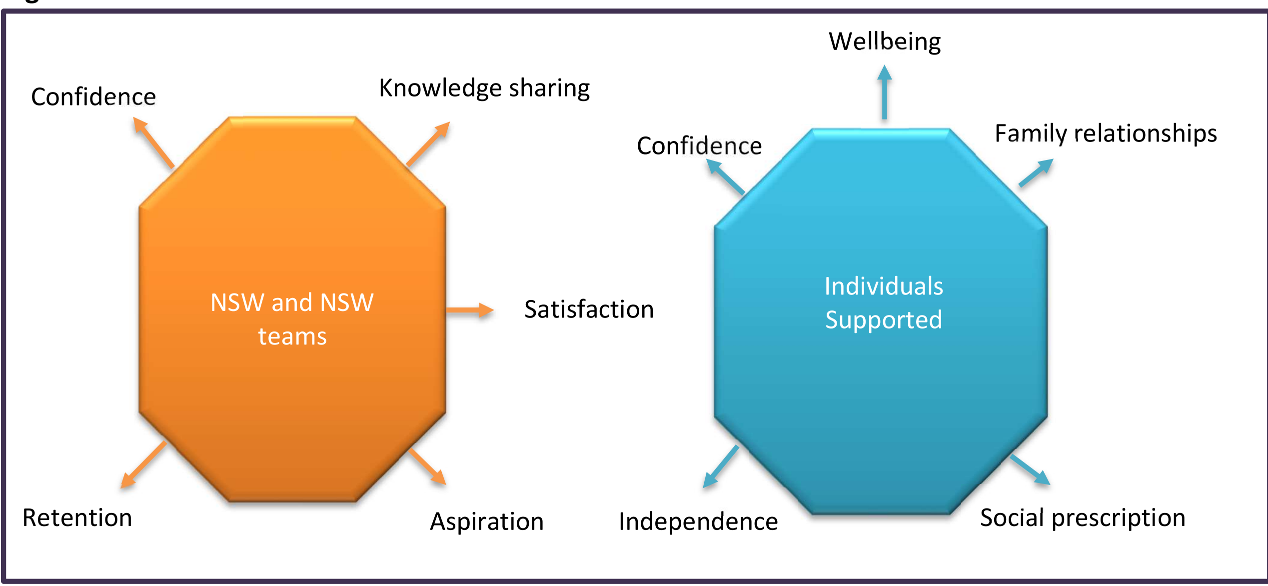
4.1 Within our cost benefit model, we have identified benefits as costs avoided. Prior to identifying what these cost savings might be, it is important first to map key benefit outcomes. These might not yet be evident but can be predicted from the NSW project theory of change or logic model. Construct a full list of the outcomes and the individuals/organisations who benefit from them.

Soft and Hard outcomes

4.2 Translating benefit outcomes to costs avoided takes us into the territory of what might be described as ‘soft’ and ‘hard’ outcomes.

4.3 Examples of soft outcomes linked to NSWs, NSW teams and individual supported are set out in **Figure 4.1**. These relate to aspects such as confidence, wellbeing, satisfaction, independence, aspiration etc. while they are fundamental to most NSW projects they are difficult to translate into cost savings. They also take us into the realms of Social Return on Investment (SROI) which we have excluded from this CBA specification. Although these outcomes will not feature in our cost benefit calculation it is useful to keep them in mind to balance against what will be an underestimation of project benefits. It should also be noted that they may be addressed indirectly through other more easily measurable outcomes.

Figure 4.1: Soft Outcomes



4.4 Hard outcomes are more easily translatable into costs avoided or benefit savings. Examples relating to a range of beneficiary organisations are listed in **Table 4.1**.

Table 4.1: Hard outcomes by beneficiary organisations

Hard Outcomes by beneficiary organisations			
Local authority	**Health**	**Education and employment**	**Criminal justice**
• Care homes placements • Care packages • Placement stability	• GP visits • A&E visits • Crisis situations	• Employment • Qualifications • Volunteering	• Police call outs • Crime • Prison

4.5 The hard outcomes identified relate to outcome savings on care home places, GP visits and police callouts etc. It is important to cluster them by beneficiary organisation as savings can then be deconstructed to specific Local Partners.

Top Tip 4: Focus most of your attention on the hard outcomes and identify as many as is consistent with your theory of change. Be realistic and assess the likelihood and prevalence of outcome manifestation.

5 STEP FIVE: MONETISE BENEFITS

Estimating costs avoided

5.1 Having identified the full range of hard outcomes associated with your NSW project it is necessary to monetise them into costs avoided i.e. benefit savings. In order to do this, you need to identify an appropriate unit cost which is widely regarded as a reliable estimate for each benefit saving.

National estimates

5.2 The best single source of benefit unit costs is 'Unit Costs of Health and Social Care' published by the Personal Social Service Research Unit (PSSRU)[1].

5.3 Established at the University of Kent the PSSRU produce an annual database which brings together data from a range of sources to estimate national unit costs for a wide range of health and social care services including the cost of:

- GP visits;
- Emergency hospital admissions;
- Bed days;
- Day care.

5.4 As an example, see **Table 5.1** which has been taken from the latest (2017) Unit Costs of Health and Social Care report.

Table 5.1: Monetised benefits

NHS reference costs for mental health services	Mean £
Mental health care clusters (per bed day)	£404
Mental health care clusters (initial assessment)	£319
Alcohol services – admitted (per bed day)	£417
Alcohol services – community (per care contact)	£98
Drug services – admitted (per bed day)	£489
Drug services – community (per care contact)	£120
Drug services – outpatient (per attendance	£105
A&E mental health liaison services	£196
Criminal justice liaison services	£176

5.5 An additional useful source from which you can draw financial estimates is the New Economy Unit Cost Database[2]. While this draws on some of the work from PSSRU, it also includes costs covering:

[1] http://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2017/
[2] http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database

- Housing;
- Employment & economy;
- Education & skills;
- Crime;
- Fire.

Local estimates

5.6 As an alternative to national estimates it is possible to use local data to cover local authority variables such as costs of care packages or temporary accommodation etc. If you are doing this check against national estimates to make sure they are in the same ball park. They should be similar. If they are not there is probably a definitional discrepancy. If in doubt use the national estimate. Be very wary of creating your own estimates. This falls outside the 'widely acceptable' sphere of consistency and quality assurance.

Top Tip 5: Check the definition of the unit costs and make sure it fits your situation, you cannot rely on the label. Also note the duration of the unit cost. There are a range of permutations from hours to years.

6 STEP SIX: SPECIFYING COST BENEFIT PROFILES

Micro analysis

6.1 The best way to bring your costs and benefits together is at an individual case level. This allows you to conduct what we describe as a micro analysis. This will essentially generate a unit cost benefit assessment. Examples of ten cost benefit profiles relating to the ten individuals supported on the Hertfordshire NSW project are set out in **Figure 6.1**.

Figure 6.1: CBA Profiles

Case 1
Costs
Total cost = £11,000
Benefits
▪ Bed days (10) £4,040 ▪ GP home visits (7) £1,694 ▪ Learning disability support in long-term residential care (20 weeks) £28,720 ▪ Day care for people requiring learning disability support (30 days) £2,310 Total benefit = £36,764
FROI = 3.34

Case 2
Costs
Total cost = £11,000
Benefits
▪ Ambulance services (6) £714 ▪ NHS community mental health team visit (8) £352 ▪ Elective inpatient stay £3,903 Total benefit = £4,969
FROI = 0.45

Case 3
Costs
Total cost = £11,000
Benefits
▪ Crisis resolution team (12 days) £11,520 ▪ GP visits (5) £185 Total benefit = £11,705
FROI = 1.10

Case 4
Costs
Total cost = £11,000
Benefits
▪ Loss of accommodation £7,348 ▪ Police Officer call out (3) £183 ▪ Alcohol services – admitted (12 days) £5,004 Total benefit = £12,535
FROI = 1.14

Case 5

Costs

Total cost = £11,000

Benefits

- Residential care home £91,370
- Bed days (3) £1,212

Total benefit = £92,582

FROI = 8.42

Case 6

Costs

Total cost = £11,000

Benefits

- Community mental health team (48 hours) £1,920
- Day care (20 hours) £1,540

Total benefit = £3,460

FROI = 0.31

Case 7

Costs

Total cost = £11,000

Benefits

- Detection for psychosis £3,380
- Drug services – admitted (8 days) £3,912
- Ambulance services (5) £595

Total benefit = £7,887

FROI = 0.72

Case 8

Costs

Total cost = £11,000

Benefits

- Criminal offence (2) £1,340
- Police Officer call out (4) £244
- Temporary accommodation (10 weeks) £3,680
- Secure mental health service (14 days) £7,210

Total benefit = £12,474

FROI = 1.13

Case 9
Costs
Total cost = £11,000
Benefits
▪ Long-term residential care £74,672 ▪ Ambulance services (2) £238
Total benefit = £74,910
FROI = 6.81

Case 10
Costs
Total cost = £11,000
Benefits
▪ Employment £10,410 ▪ Bed days (2) £808 ▪ GP visits (3) £111
Total benefit = £11,329
FROI = 1.03

The costs

6.2 On the cost side of the equation we have adopted a top-down method. The total NSW project cost for one year is £110,000. A total of ten individuals will have been supported over a 12-month period creating a total unit cost for every case of £11,000.

6.3 If you had identified your cost bottom-up and observed that the individual cases had different combinations of resource input, then the unit costs would vary by case.

Predictive benefits

6.4 Our starting point for calculating unit benefits is the long list of hard outcome unit costs assembled in the previous step. Now comes the truly predictive element. Based on your best knowledge of each supported case you need to allocate both the type of unit cost and the frequency of occurrence.

6.5 For each service user, there will be a set of benefits based on that individual's profile. Some service users, through NSW support, may have fewer incidents with the police, others may have avoided a placement breakdown. It is key to capture the additionality – the benefits that would not have been observed without the programme. Once the benefits have been identified and financial values attributed to them, you can construct your CBA profile. In our ten examples, unit additional benefits range from £3,460 (Case 6) to £92,582 (Case 5).

Fiscal Return on Investment

6.6 For each case the division of benefits by cost will generate a Fiscal Return on Investment. For example, in case 1 the Fiscal Return on Investment is 3.34. this means that for every £1 invested in the project there will be potential saving of £3.34.

6.7 In Figure 6.1 the returns on investment range from 0.31 to 8.42.

Top Tip 6: Remember that predictive benefits are additional to what would have happened anyway. Avoid the temptation of making total benefits artificially higher than total costs. It is highly unlikely that all cases will have a positive return on investment, although not impossible!

7 STEP SEVEN: ESTIMATE OVERALL FROI

Macro analysis

7.1 The individual cost benefit profiles established at Step Six form the building blocks for the NSW project level assessment or macro analysis. This will reveal the return on investment for the project overall and is therefore the target FROI we are seeking to generate.

7.2 With respect to every NSW case supported their return on investment will be equal to their estimated total benefits divided by their total costs. At an aggregated level this can be expressed as:

$$FROI = \frac{\sum(Benefits_1 + Benefits_2 + \dots Benefits_{10})}{\sum(Costs_1 + Costs_2 + \dots Costs_{10})}$$

7.3 **Table 7.1** shows the overall FROI based on the 10 CBA profiles used in the model. The overall FROI here is 2.44 which means that for every £1 spent, the net additional saving is £2.44. The overall FROI, of 2.44, is regarded as the 'headline' figure. This figure is important as it helps to answer key questions such as:

- Is the programme financially viable?
- How much does it cost/save?

Table 7.1: Macro cost benefit assessment

Case	Total benefit	Total cost	FROI
1	£36,764	£11,000	3.34
2	£4,969	£11,000	0.45
3	£11,705	£11,000	1.10
4	£12,535	£11,000	1.14
5	£92,582	£11,000	8.42
6	£3,460	£11,000	0.31
7	£7,887	£11,000	0.72
8	£12,474	£11,000	1.13
9	£74,910	£11,000	6.81
10	£11,329	£11,000	1.02
Project level	**£268,615**	**£110,000**	**2.44**
Average	**£26,861**	**£11,000**	**2.44**

Top Tip 7: Remember the FROI you have created is predictive rather than actual. Be careful how you couch this finding in any wider analysis or business case.

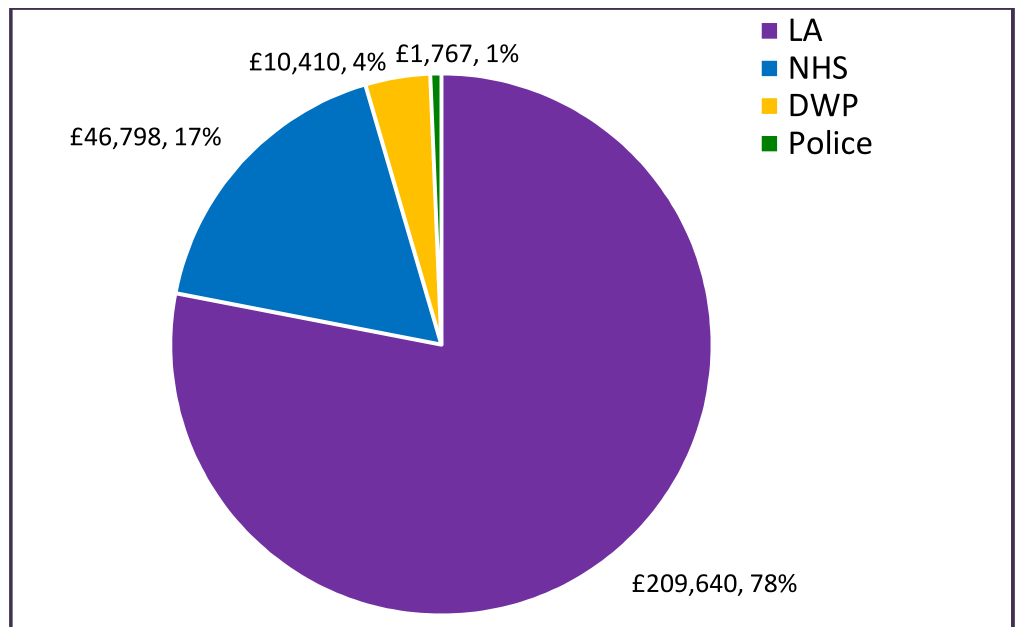
8 STEP EIGHT: IDENTIFY BENEFIT BENEFICIARIES

Who gets the savings?

8.1 We have identified that the NSW project has an overall FROI of 2.44. This is excellent news. However, we need to work out where the savings rest. Who can collect them?

8.2 Attribution of savings is achieved by analysing the overall additional benefit profile. From the previous section we know that the benefit savings from the project were £268,615. We also established from our benefit mapping exercise at Step Four the organisations responsible for delivering each outcome area. These are brought together in **Figure 8.1** which shows the distribution of savings across partner organisations.

Figure 8.1: Benefit beneficiaries



8.3 In this scenario, over 75% of the benefits go to the local authority. One reason behind this is linked to the types of benefits attributed to the local authority. In two CBA profiles, benefits included avoiding placement breakdown or a costlier placement. This totalled a sum of £166,042, 79% of the total local authority benefits.

8.4 Analysis of benefit beneficiaries is a powerful tool to potentially secure partner funding. In this example if we assume that the cost of the project is sustained by the local authority then 22% of the benefits (£59,000) is shared by NHS, DWP and the Police. None of these organisations contributed to the cost but share the benefits. They are probably not aware of this. It is however something that you should bring to their attention.

8.5 In this example the local authority is the main funder and the main beneficiary. This is not always the case. In a number of studies, we have conducted in this area of work the local authority is the main funder, but NHS and Police are the main beneficiaries thus generating a case for urgent dialogue.

Top Tip 8: Seek to find an opportunity to share this analysis with your partners. Avoid a heavy sell for contributions: at least to begin with. Let them work out the potential opportunity for themselves.

9 STEP NINE: OBTAINING ACTUAL DATA

This is an illustration

9.1 Congratulations on completing your predictive cost benefit analysis. You now have some idea of your likely costs, potential benefits and possible return on investment. This must not be the end of the line. Remember the analysis is illustrative. This therefore represents the starting point in the process to generate your own data.

Costs

9.2 You already have a reasonable handle on the top-down costs. You will however need to establish a client monitoring system to identify the resource inputs associated with bottom-up costing.

Benefits

9.3 In order to generate your own benefit information, you need to establish two client datasets:

1. Forward tracking
2. Comparator group

1. Forward tracking

9.4 Forward tracking involves monitoring the individuals supported from the point they enter the project to the point they exit. If a period of support is likely to be prolonged – analyse the results after 12 months. If the number of cases supported is high, monitor a representative sample; maybe 20-30.

9.5 The monitoring system you put in place needs to be capable of identifying the type of outcomes featuring in the predictive analysis and their frequency. Analysis and annualisation of this data will generate your gross benefits. These however need to be adjusted to additional ‘benefits’ before they can be slotted into the CBA.

9.6 Also note that if you are using a sample of cases to estimate your benefits they will need to be weighted upwards. This is done by calculating the average benefit for the sample and multiplying it by the total annual cases supported.

2. Comparator Group

9.7 Comparator analysis is required to deduct the business as usual effect i.e. establishing additionality or a counter factual. If the project had not gone ahead some of the observed benefit outcomes would have happened anyway. These need to be netted off. The only way to establish additionality is to directly compare the outcomes for a similar cohort of individuals who did not receive this support.

9.8 There are three broad methods for establishing a comparator group:

1. Randomise Control Trial (RCT);
2. Quasi Experimental Design (QED);
3. Historical baseline.

1. *RCT*

9.9 This is the most rigorous approach and would involve identifying a client portfolio with similar characteristics and randomly assigning them into two groups. One would receive NSW support and the other would not.

2. *QED*

9.10 This is similar to RCT, but without randomisation. You would seek to match your sample with a similar group not receiving NSW support. This might be with another team within the authority not operating NSW.

3. *Historical baseline*

9.11 This is the least rigorous but often the most practical and would involve comparing outcomes for the same supported cohort before and after NSW support.

9.12 Whichever approach is adopted as the business as usual counterfactual it is necessary to subtract the outcomes achieved for the comparator group from the NSW supported group to establish net benefits. This will then become the benefit profile that will be used in your cost benefit analysis.

Top Tip 9: Design a realistic monitoring system that is fit for purpose and will work for you. Employ a sampling methodology. It is better to have some data than no data.

10 STEP TEN: CONCLUDING REMARKS

10.1 You are now ready to embark on your journey into the world of economic impact and cost benefit analysis. We have provided a framework which you can follow to generate both forward looking predictive cost benefit analysis and a backward facing actual cost benefit assessment. While we provided tips along the way we would like to leave you with some concluding remarks to always bear in mind when conducting your analysis.

i. Not an exact science:

10.2 CBA is not an exact science and as such it is paramount to be realistic when constructing and reflecting on your CBA model. One should always resist the temptation to over claim the benefits of your project when projecting the benefits. Failure to do so could: generate unrealistic expectations of your project; and raise uncertainty around the precision of your model.

ii. An underestimation:

10.3 When reflecting on your CBA model, always remember that the FROI methodology is an approximation and will underestimate the total impact of the programme as it excludes the economic and social benefits.

iii. Clarify assumptions:

10.4 The CBA model is implicitly built on a set of assumptions. Indeed, each step in the guide introduces a new layer. Always clarify these assumptions and make sure it still depicts a close approximation of your project.

iv. Quality data:

10.5 The key to effective CBA is quality data. Rubbish in rubbish out! Make sure the data sources you use, particularly from your monitoring systems are robust.

v. High unit costs:

10.6 Always be wary of high unit costs. Projects with high unit costs are always vulnerable to a negative return on investment. If in this situation check the feasibility of a positive benefit profile.

vi. Cashable savings:

10.7 Savings identified are potential savings. They only become real when the monies are withdrawn. If not withdrawn they have been re-invested.

vii. You are not yet an expert:

10.8 This guide has introduced you to the potential witchcraft of cost benefit analysis. You are not yet an expert. Handle with care! If in doubt seek professional advice.

Named Social Worker Programme:

Ten steps to creating your own cost benefit analysis

A York Consulting support guide

John Rodger and Brian Stewart

February 2018

CONTENTS

		Page
	INTRODUCTION	**1**
1	**STEP ONE: UNDERSTANDING COST BENEFIT ANALYSIS**	**2**
2	**STEP TWO: ESTABLISHING APPROACH AND ASSESSING LIMITATIONS**	**4**
3	**STEP THREE: IDENTIFYING COSTS**	**5**
4	**STEP FOUR: BENEFIT MAPPING**	**7**
5	**STEP FIVE: MONETISE BENEFITS**	**9**
6	**STEP SIX: SPECIFYING COST BENEFIT PROFILES**	**11**
7	**STEP SEVEN: ESTIMATE OVERALL FROI**	**14**
8	**STEP EIGHT: IDENTIFY BENEFIT BENEFICIARIES**	**15**
9	**STEP NINE: OBTAINING ACTUAL DATA**	**16**
10	**STEP TEN: CONCLUDING REMARKS**	**18**

INTRODUCTION

1. This guide, developed by York Consulting, is designed to assist Named Social Worker (NSW) teams to conduct their own economic assessment using a predictive cost benefit analysis (CBA) methodology.

2. The approach presented recognises that NSW teams have had limited opportunities, given the short time scales, to collect much client outcome information. The initial focus is therefore on constructing a model of impact based on a range of assumptions. This provides an illustrative projection which can be checked with actual outcomes data at a later date.

3. Cost and illustrative outcome data was estimated based on a range of consultations with the Hertfordshire NSW team. The method was further market tested with all six second round NSW teams at a NSW evaluation workshop in February 2018.

4. While the methodology presented is not definitive, it should provide NSW teams, and others piloting a similar approach, with sufficient information to get started and specify their own cost benefit models. Teams may require further advice to fine tune their approach and to estimate counterfactual scenarios.

5. Further information relating to this guide can be obtained from Brian Stewart who can be contacted at brian.stewart@yorkconsulting.co.uk.

1 STEP ONE: UNDERSTANDING COST BENEFIT ANALYSIS

What is CBA?

1.1 CBA is a powerful tool which is widely used across government and the private sector to assess the economic case for specific project interventions. CBA aims to quantify in monetary terms as many of the costs and benefits of an intervention as feasible, including items for which the market does not provide a satisfactory measure of economic value.

1.2 Typically, CBA consists of three strands of analysis:

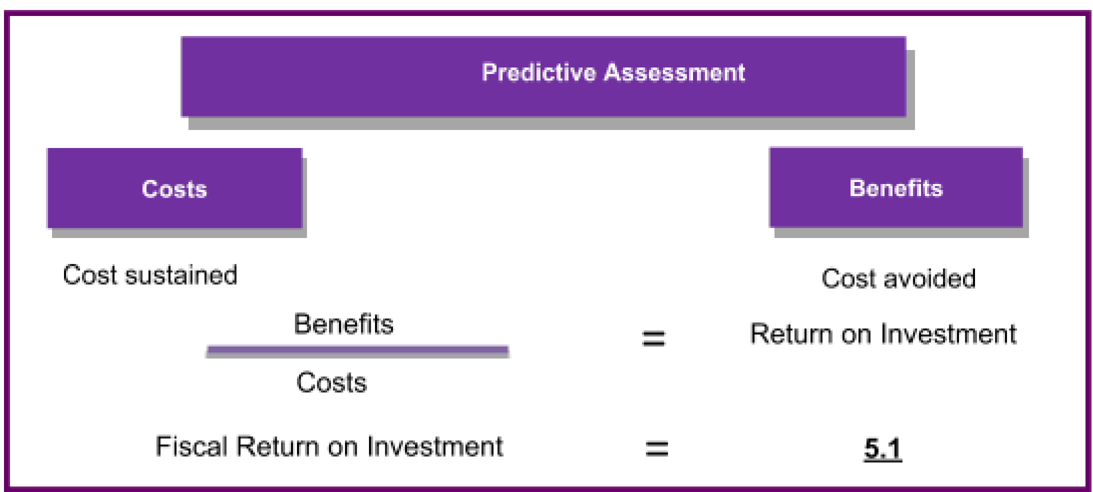
- **Fiscal** – Also referred to as the real money line, it is most appropriate where the focus is on cash savings or invest-to-save initiatives.
- **Economic** – This is linked to concepts such as the income multiplier e.g. the economic value of an individual gaining employment.
- **Social** – This strand focuses on monetising the value of a wide range of softer outcomes for which there are few financial values e.g. individual well-being.

1.3 Identified benefits are divided by observed costs to generate a benefit cost ratio or return on investment.

Constructing a predictive CBA model

1.4 An overview of the predictive CBA model is set out in **Figure 1.1**.

Figure 1.1: CBA Overview



1.5 The predictive element follows from the need to project likely client outcomes based on best estimates. These can be subsequently checked against actual outcomes from client follow up at a point in the future.

1.6 The CBA model we have chosen focuses specifically on the fiscal line and is thus referred to as a Fiscal Return on Investment (FROI). This has been selected as it specifically addresses potentially cashable outcomes, particularly important to invest

to save project interventions. As the economic and social dimensions of the cost benefit assessment have been excluded it has to be recognised that the benefits generated by the model will almost certainly be a under estimate of actual benefits to the wider economy and society. It is however the more realistic estimate from an invest to save perspective.

1.7 As the term suggests there are two sides to the cost benefit equation – costs and benefits. Costs are defined as the costs sustained in delivering the project intervention. In the NSW context this could be the total funding secured from the Department of Health for the project. Benefits, on the other hand, are defined as the costs avoided. In an NSW context this might include fewer GP visits and the avoidance of an emergency hospital admission for individuals supported.

1.8 The division of benefits by costs, produces a benefit cost ratio which in this specification is the Fiscal Return on Investment (FROI). In the example shown in Figure 1.1, an FROI of 5.1 indicates that for every £1 invested in the project there is a potential saving of £5.10. This would constitute a positive return on investment and support a case for continued project funding.

1.9 It is important to capture the additionality i.e. benefits and costs arising as a result of the intervention. This excludes what would have happened in the absence of the programme; otherwise referred to as 'business as usual'.

1.10 Taking these factors into account, CBA can be used to answer key questions such as:

- Does the project provide value for money?
- Which partners benefit most from the investment?
- How to prioritise investment across a range of projects?

Top Tip 1: Deciding what to include in the CBA should derive from the original aim(s) of the intervention. Is it for an individual, organisation or society as a whole? This should be evident from the theory of change (TOC)/logic model for the initiative. That said, it is not always this simple given the nature of some TOC/logic models. If there is a series of questions, the model may need to be adjusted for each question.

2 STEP TWO: ESTABLISHING APPROACH AND ASSESSING LIMITATIONS

What is the question you want to answer?

2.1 CBA works best when you are clear what you want it to do. Ask yourself – why am I doing this? What do I want to show? What decisions will it influence? What factors will carry greatest weight? What level of evidence might be required? When does it need to be done?

2.2 Answering these questions will help you decide how to specify the model, particularly the benefits to include.

How strong is your theory of change?

2.3 There is a strong correlation between the robustness of your theory of change and the strength of the CBA case that can be made. The tighter your focus on the intervention and the beneficiary group the better. For example, calculating the impact of a more intensive support programme on a clearly defined client group is easier to do than a more general intervention across a wider group. It may therefore be best to concentrate on only one element of your potential TOC.

Hang on to the concept of additionality or value added

2.4 The CBA of a new intervention such as NSW needs to show the impact beyond what was happening before i.e. 'business as usual'. This means you need to identify the additional costs of the programme of support and set them against the additional benefits. While additional costs are relatively easy to observe benefits are trickier!

Beware the magic of modelling: assumed models are illustrative not real

2.5 When conducting a CBA for a project it is rare to have full and complete data at one's disposal. Therefore, the cost benefit model will need to include some assumptions. Assumptions take account of data limitations. For example, if there is no control group (counterfactual) we might assume there is no need to omit any benefits as everything observed is value added.

2.6 This is a very broad assumption. Typically, one constructs a model at the beginning with estimated data which is full of assumptions and then relax them, or remove them altogether, as data becomes available. The construction of an estimated model provides a helpful illustration of the components of the model and its sensitivity to changes in particular costs and benefits.

2.7 Assuming that sufficient data is gathered at a later stage; it will be possible to check the actual data against the predictive approach.

Top Tip 2: Do not get carried away when predicting your projected benefits. This could generate unrealistic expectations or potential ridicule. Concentrate on illustrating the monetisation of potential benefits and the different combinations required to break-even i.e. costs equal benefits. This strategy will be more effective and influential than simply trying to generate a high return on investment.

3 STEP THREE: IDENTIFYING COSTS

Always start with costs

3.1 The cost side of the equation is usually the easiest to estimate and as such should be your starting point in the calculation. As indicated earlier these are the additional costs of delivering your NSW project. They are additional to your business as usual costs. We are effectively ring-fencing these costs from your mainstream business activity to simplify the analysis and focus on the additionality of your project investment.

3.2 Costs are critically important as they set the benchmark for the CBA assessment. A project costing £110,000 needs to generate the same level of benefits to break even. This would correspond to a FROI of 1.0.

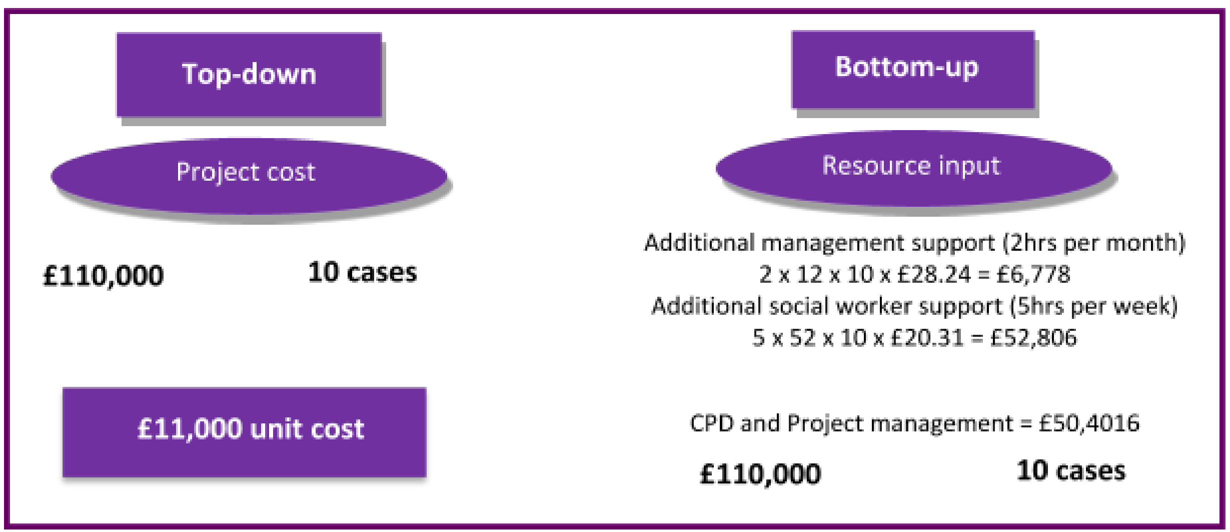
Annualise costs

3.3 It is always best to annualise costs to maintain consistency of comparison and improve the power of illustration. The context then becomes annual costs, annual benefits and an annual return on investment. This allows comparability with other projects of different durations. If your project cost is £55,000 and lasts 6 months the annual cost would be £110,000.

Top-down and bottom-up costing

3.4 **Figure 3.1** illustrates the two methods that can be used to calculate your NSW project costs.

Figure 3.1: Costing Dimensions



3.5 The first, and most straightforward, is the top-down approach. This is the overall delivery cost of the programme. In the case of Hertfordshire this was £110,000. Once you know how many individuals will receive the treatment/support you can calculate the unit cost of supporting one individual throughout the programme. In

Hertfordshire's case, there were ten NSW cases which meant that the cost of supporting a NSW case was £11,000.

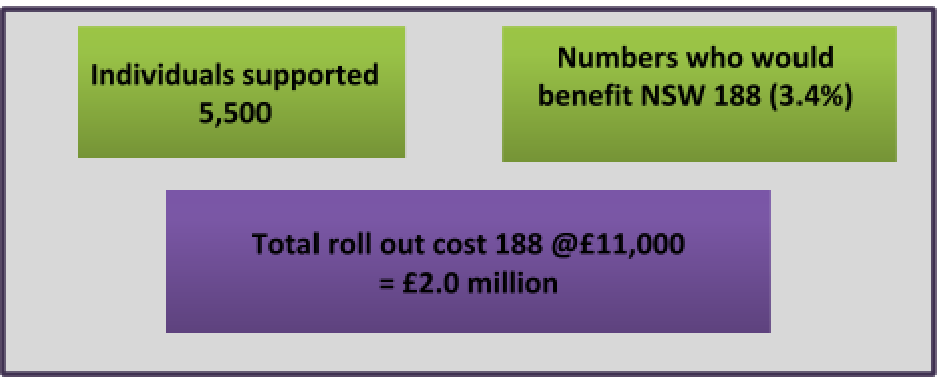
3.6 Alternatively, it is possible to build up the cost profile bottom-up. This involves identifying and segmenting delivery costs. In the illustration we calculate additional staff costs based on duration of support and staff hourly rates. We also identify other costs such as CPD and project management. The finer the granularity resource input assessment, the better the cost intelligence. For example, if costs subsequently prove to be higher than benefits, then the resource input assessment will make it easier to identify where potential savings might be made.

3.7 In Figure 3.1 illustration the top-down and bottom-up costs are the same. This rarely occurs in practice and usually means something has been missed in the resource costing or the project budget has not been fully spent.

Cost simulation

3.8 It is possible to simulate costs and project to a potentially larger target group. An illustration of this is shown in **Figure 3.2**.

Figure 3.2: Cost Projections



3.9 In our Hertfordshire example, 10 clients were supported in the NSW project at a unit cost of £11,000. Hertfordshire have 5,500 individuals supported annually and estimate that 3.4% fit the NSW criteria for additional support. This means that an additional annual cost for a potentially full NSW cohort would be £2 million.

Steady state costs

3.10 Cost estimation, whether top-down or bottom-up, should include only steady state costs. Excluded should be one off costs associated with the pilot project. This might include aspects of research and development.

Top Tip 3: Identifying the costs from a bottom-up approach is a much more time-consuming exercise compared to the top-down method. It is however worthwhile doing if only for a sample of cases. This is the best way of profiling cost inputs and assessing potential variation in support between client cases.

4 STEP FOUR: BENEFIT MAPPING

Map all project outcomes

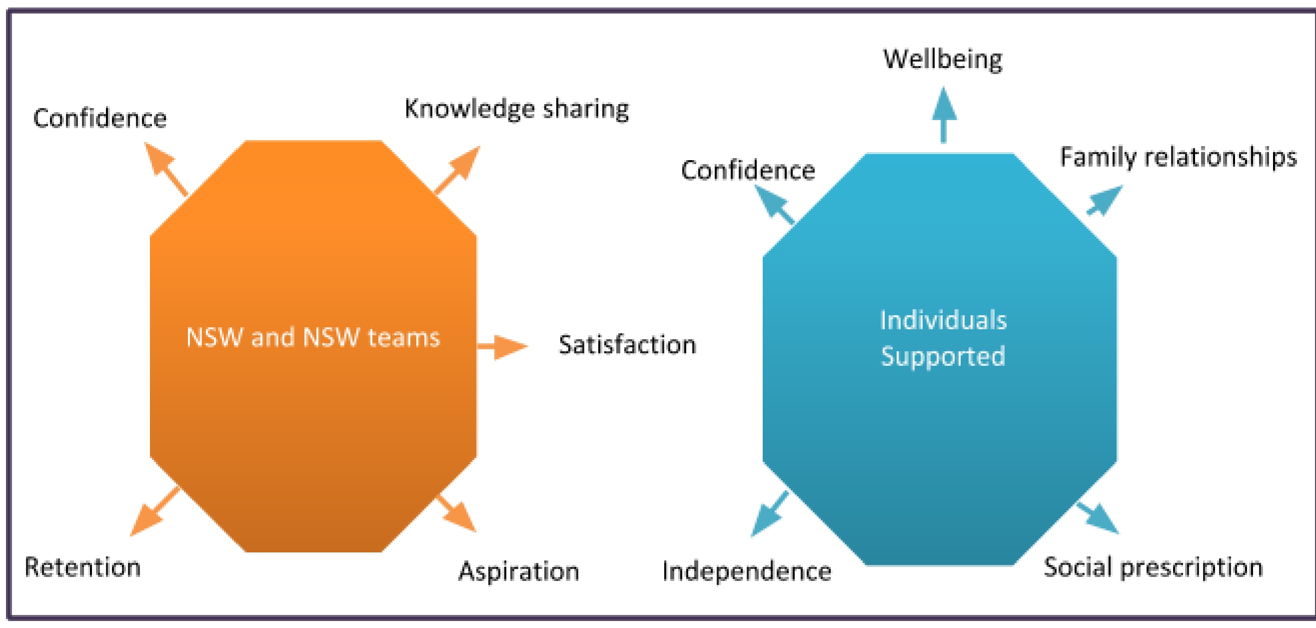
4.1 Within our cost benefit model, we have identified benefits as costs avoided. Prior to identifying what these cost savings might be, it is important first to map key benefit outcomes. These might not yet be evident but can be predicted from the NSW project theory of change or logic model. Construct a full list of the outcomes and the individuals/organisations who benefit from them.

Soft and Hard outcomes

4.2 Translating benefit outcomes to costs avoided takes us into the territory of what might be described as 'soft' and 'hard' outcomes.

4.3 Examples of soft outcomes linked to NSWs, NSW teams and individuals supported are set out in **Figure 4.1**. These relate to aspects such as confidence, wellbeing, satisfaction, independence, aspiration etc. while they are fundamental to most NSW projects they are difficult to translate into cost savings. They also take us into the realms of Social Return on Investment (SROI) which we have excluded from this CBA specification. Although these outcomes will not feature in our cost benefit calculation it is useful to keep them in mind to balance against what will be an underestimation of project benefits. It should also be noted that they may be addressed indirectly through other more easily measurable outcomes.

Figure 4.1: Soft Outcomes



4.4 Hard outcomes are more easily translatable into costs avoided or benefit savings. Examples relating to a range of beneficiary organisations are listed in **Table 4.1**.

Table 4.1: Hard outcomes by beneficiary organisations

Hard outcomes by beneficiary organisations			
Local authority	**Health**	**Education and employment**	**Criminal justice**
• Care homes • Care packages • Placement stability	• GP visits • A&E visits • Crisis situations	• Employment • Qualifications • Volunteering	• Police callouts • Crime • Prison

4.5 The hard outcomes identified relate to outcome savings on care home places, GP visits and police callouts etc. It is important to cluster them by beneficiary organisation as savings can then be deconstructed to specific Local Partners.

Top Tip 4: Focus most of your attention on the hard outcomes and identify as many as is consistent with your theory of change. Be realistic and assess the likelihood and prevalence of outcome manifestation.

5 STEP FIVE: MONETISE BENEFITS

Estimating costs avoided

5.1 Having identified the full range of hard outcomes associated with your NSW project it is necessary to monetise them into costs avoided i.e. benefit savings. In order to do this, you need to identify an appropriate unit cost which is widely regarded as a reliable estimate for each benefit saving.

National estimates

5.2 The best single source of benefit unit costs is 'Unit Costs of Health and Social Care' published by the Personal Social Service Research Unit (PSSRU)[1].

5.3 Established at the University of Kent the PSSRU produce an annual database which brings together data from a range of sources to estimate national unit costs for a wide range of health and social care services including the cost of:

- GP visits;
- Emergency hospital admissions;
- Bed days;
- Day care.

5.4 As an example, see **Table 5.1** which has been taken from the latest (2017) Unit Costs of Health and Social Care report.

Table 5.1: Monetised benefits

NHS reference costs for mental health services	Mean £
Mental health care clusters (per bed day)	£404
Mental health care clusters (initial assessment)	£319
Alcohol services – admitted (per bed day)	£417
Alcohol services – community (per care contact)	£98
Drug services – admitted (per bed day)	£489
Drug services – community (per care contact)	£120
Drug services – outpatient (per attendance)	£105
A&E mental health liaison services	£196
Criminal justice liaison services	£176

[1] http://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2017/

5.5 An additional useful source from which you can draw financial estimates is the New Economy Unit Cost Database[2]. While this draws on some of the work from PSSRU, it also includes costs covering:

- Housing;
- Employment & economy;
- Education & skills;
- Crime;
- Fire.

Local estimates

5.6 As an alternative to national estimates it is possible to use local data to cover local authority variables such as costs of care packages or temporary accommodation etc. If you are doing this check against national estimates to make sure they are in the same ballpark. They should be similar. If they are not there is probably a definitional discrepancy. If in doubt use the national estimate. Be very wary of creating your own estimates. This falls outside the 'widely acceptable' sphere of consistency and quality assurance.

Top Tip 5: Check the definition of the unit costs and make sure it fits your situation, you cannot rely on the label. Also note the duration of the unit cost. There are a range of permutations from hours to years.

[2] http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database

6 STEP SIX: SPECIFYING COST BENEFIT PROFILES

Micro analysis

6.1 The best way to bring your costs and benefits together is at an individual case level. This allows you to conduct what we call micro analysis. This will essentially generate a unit cost benefit assessment. Examples of ten cost benefit profiles relating to the ten individuals supported on the Hertfordshire NSW project are set out in **Figure 6.1**.

Figure 6.1: CBA Profiles

Case 1

Costs

Total cost = £11,000

Benefits

- Bed days (10) £4,040
- GP home visits (7) £1,694
- Learning disability support in long-term residential care (20 weeks) £28,720
- Day care for people requiring learning disability support (30 days) £2,310

Total benefit = £36,764

FROI = 3.34

Case 2

Costs

Total cost = £11,000

Benefits

- Ambulance services (6) £714
- NHS community mental health team visit (8) £352
- Elective inpatient stay £3,903

Total benefit = £4,969

FROI = 0.45

Case 3

Costs

Total cost = £11,000

Benefits

- Crisis resolution team (12 days) £11,520
- GP visits (5) £185

Total benefit = £11,705

FROI = 1.10

Case 4

Costs

Total cost = £11,000

Benefits

- Loss of accommodation £7,348
- Police Officer call out (3) £183
- Alcohol services – admitted (12 days) £5,004

Total benefit = £12,535

FROI = 1.14

Case 5

Costs

Total cost = £11,000

Benefits

- Residential care home £91,370
- Bed days (3) £1,212

Total benefit = £92,582

FROI = 8.42

Case 6

Costs

Total cost = £11,000

Benefits

- Community mental health team (48 hours) £1,920
- Day care (20 hours) £1,540

Total benefit = £3,460

FROI = 0.31

Case 7

Costs

Total cost = £11,000

Benefits

- Detection for psychosis £3,380
- Drug services – admitted (8 days) £3,912
- Ambulance services (5) £595

Total benefit = £7,887

FROI = 0.72

Case 8

Costs

Total cost = £11,000

Benefits

- Criminal offence (2) £1,340
- Police Officer call out (4) £244
- Temporary accommodation (10 weeks) £3,680
- Secure mental health service (14 days) £7,210

Total benefit = £12,474

FROI = 1.13

Case 9
Costs
Total cost = £11,000
Benefits
▪ Long-term residential care £74,672 ▪ Ambulance services (2) £238 Total benefit = £74,910
FROI = 6.81

Case 10
Costs
Total cost = £11,000
Benefits
▪ Employment £10,410 ▪ Bed days (2) £808 ▪ GP visits (3) £111 Total benefit = £11,329
FROI = 1.03

The costs

6.2 On the cost side of the equation we have adopted a top-down method. The total NSW project cost for one year is £110,000. A total of ten individuals will have been supported over a 12-month period creating a total unit cost for every case of £11,000.

6.3 If you had identified your cost bottom-up and observed that the individual cases had different combinations of resource input, then the unit costs would vary by case.

Predictive benefits

6.4 Our starting point for calculating unit benefits is the long list of hard outcome unit costs assembled in the previous step. Now comes the truly predictive element. Based on your best knowledge of each supported case you need to allocate both the type of unit cost and the frequency of occurrence.

6.5 For each service user, there will be a set of benefits based on that individual's profile. Some service users, through NSW support, may have fewer incidents with the police, others may have avoided a placement breakdown. It is key to capture the additionality – the benefits that would not have been observed without the programme. Once the benefits have been identified and financial values attributed to them, you can construct your CBA profile. In our ten examples, unit additional benefits range from £3,460 (Case 6) to £92,582 (Case 5).

Fiscal Return on Investment

6.6 For each case the division of benefits by cost will generate a Fiscal Return on Investment. For example, in case 1 the Fiscal Return on Investment is 3.34. this means that for every £1 invested in the project there will be potential saving of £3.34.

6.7 In Figure 6.1 the returns on investment range from 0.31 to 8.42.

Top Tip 6: Remember that predictive benefits are additional to what would have happened anyway. Avoid the temptation of making total benefits artificially higher than total costs. It is highly unlikely that all cases will have a positive return on investment, although not impossible!

7 STEP SEVEN: ESTIMATE OVERALL FROI

Macro analysis

7.1 The individual cost benefit profiles established at Step Six form the building blocks for the NSW project level assessment or macro analysis. This will reveal the return on investment for the project overall and is therefore the target FROI we are seeking to generate.

7.2 With respect to every NSW case supported, their return on investment will be equal to their estimated total benefits divided by their total costs. At an aggregated level this can be expressed as:

$$FROI = \frac{\sum(Benefits_1 + Benefits_2 + \ldots Benefits_{10})}{\sum(Costs_1 + Costs_2 + \ldots Costs_{10})}$$

7.3 **Table 7.1** shows the overall FROI based on the 10 CBA profiles used in the model. The overall FROI here is 2.44 which means that for every £1 spent, the net additional saving is £2.44. The overall FROI, of 2.44, is regarded as the 'headline' figure. This figure is important as it helps to answer key questions such as:

- Is the programme financially viable?
- How much does it cost/save?

Table 7.1: Macro cost benefit assessment

Case	Total benefit	Total cost	FROI
1	£36,764	£11,000	3.34
2	£4,969	£11,000	0.45
3	£11,705	£11,000	1.10
4	£12,535	£11,000	1.14
5	£92,582	£11,000	8.42
6	£3,460	£11,000	0.31
7	£7,887	£11,000	0.72
8	£12,474	£11,000	1.13
9	£74,910	£11,000	6.81
10	£11,329	£11,000	1.02
Project level	**£268,615**	**£110,000**	**2.44**
Average	**£26,861**	**£11,000**	**2.44**

Top Tip 7: Remember the FROI you have created is predictive rather than actual. Be careful how you couch this finding in any wider analysis or business case.

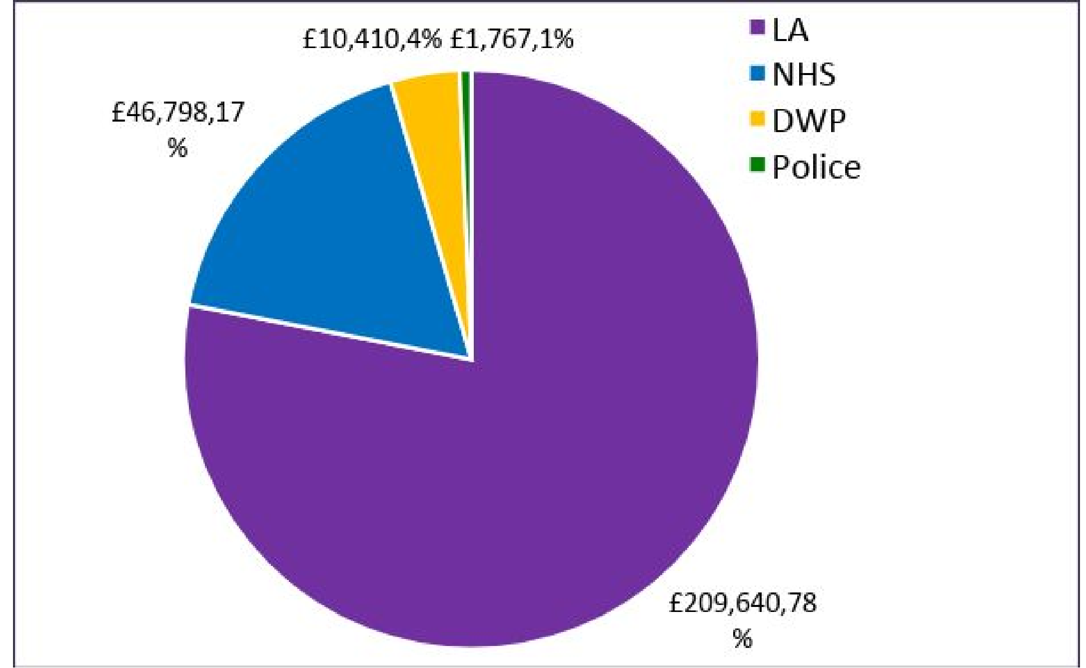
8 STEP EIGHT: IDENTIFY BENEFIT BENEFICIARIES

Who gets the savings?

8.1 We have identified that the NSW project has an overall FROI of 2.44. This is excellent news. However, we need to work out where the savings rest. Who can collect them?

8.2 Attribution of savings is achieved by analysing the overall additional benefit profile. From the previous section we know that the benefit savings from the project were £268,615. We also established from our benefit mapping exercise at Step Four the organisations responsible for delivering each outcome area. These are brought together in **Figure 8.1** which shows the distribution of savings across partner organisations.

Figure 8.1: Benefit beneficiaries



8.3 In this scenario, over 75% of the benefits go to the local authority. One reason behind this is linked to the types of benefits attributed to the local authority. In two CBA profiles, benefits included avoiding placement breakdown or a costlier placement. This totalled a sum of £166,042, 79% of the total local authority benefits.

8.4 Analysis of benefit beneficiaries is a powerful tool to potentially secure partner funding. In this example if we assume that the cost of the project is sustained by the local authority then 22% of the benefits (£59,000) are shared by NHS, DWP and the Police. None of these organisations contributed to the cost but share the benefits. They are probably not aware of this. It is however something that you should bring to their attention.

8.5 In this example the local authority is the main funder and the main beneficiary. This is not always the case. In a number of studies we have conducted in this area of work

the local authority is the main funder, butthe NHS and Police are the main beneficiaries thus generating a case for urgent dialogue.

Top Tip 8: Seek to find an opportunity to share this analysis with your partners. Avoid a heavy sell for contributions, at least to begin with. Let them work out the potential opportunity for themselves.

9 STEP NINE: OBTAINING ACTUAL DATA

This is an illustration

9.1 Congratulations on completing your predictive cost benefit analysis. You now have some idea of your likely costs, potential benefits and possible return on investment. This must not be the end of the line. Remember the analysis is illustrative. This therefore represents the starting point in the process to generate your own data.

Costs

9.2 You already have a reasonable handle on the top-down costs. You will however need to establish a client monitoring system to identify the resource inputs associated with bottom-up costing.

Benefits

9.3 In order to generate your own benefit information, you need to establish two client datasets:

1. Forward tracking
2. Comparator group

1. Forward tracking

9.4 Forward tracking involves monitoring the individuals supported from the point they enter the project to the point they exit. If a period of support is likely to be prolonged, analyse the results after 12 months. If the number of cases supported is high, monitor a representative sample, maybe 20-30.

9.5 The monitoring system you put in place needs to be capable of identifying the type of outcomes featured in the predictive analysis and their frequency. Analysis and annualisation of this data will generate your gross benefits. These however need to be adjusted to additional 'benefits' before they can be slotted into the CBA.

9.6 Also note that if you are using a sample of cases to estimate your benefits they will need to be weighted upwards. This is done by calculating the average benefit for the sample and multiplying it by the total annual cases supported.

2. Comparator Group

9.7 Comparator analysis is required to deduct the business as usual effect i.e. establishing additionality or a counterfactual. If the project had not gone ahead some of the observed benefit outcomes would have happened anyway. These need to be netted off. The only way to establish additionality is to directly compare the outcomes for a similar cohort of individuals who did not receive this support.

9.8 There are three broad methods for establishing a comparator group:

1. Randomised Control Trial (RCT);
2. Quasi Experimental Design (QED);
3. Historical baseline.

1. *RCT*

9.9 This is the most rigorous approach and would involve identifying a client portfolio with similar characteristics and randomly assigning them into two groups. One would receive NSW support and the other would not.

2. *QED*

9.10 This is similar to RCT, but without randomisation. You would seek to match your sample with a similar group not receiving NSW support. This might be with another team within the authority not operating NSW.

3. *Historical baseline*

9.11 This is the least rigorous but often the most practical and would involve comparing outcomes for the same supported cohort before and after NSW support.

9.12 Whichever approach is adopted as the business as usual counterfactual it is necessary to subtract the outcomes achieved for the comparator group from the NSW supported group to establish net benefits. This will then become the benefit profile that will be used in your cost benefit analysis.

Top Tip 9: Design a realistic monitoring system that is fit for purpose and will work for you. Employ a sampling methodology. It is better to have some data than no data.

10 STEP TEN: CONCLUDING REMARKS

10.1 You are now ready to embark on your journey into the world of economic impact and cost benefit analysis. We have provided a framework which you can follow to generate both forward looking predictive cost benefit analysis and a backward facing actual cost benefit assessment. While we provided tips along the way we would like to leave you with some concluding remarks to always bear in mind when conducting your analysis.

i. Not an exact science:

10.2 CBA is not an exact science and as such it is paramount to be realistic when constructing and reflecting on your CBA model. One should always resist the temptation to over claim the benefits of your project when projecting the benefits. Failure to do so could generate unrealistic expectations of your project and raise uncertainty around the precision of your model.

ii. An underestimation:

10.3 When reflecting on your CBA model, always remember that the FROI methodology is an approximation and will underestimate the total impact of the programme as it excludes the economic and social benefits.

iii. Clarify assumptions:

10.4 The CBA model is implicitly built on a set of assumptions. Indeed, each step in the guide introduces a new layer. Always clarify these assumptions and make sure it still depicts a close approximation of your project.

iv. Quality data:

10.5 The key to effective CBA is quality data. Rubbish in rubbish out! Make sure the data sources you use, particularly from your monitoring systems are robust.

v. High unit costs:

10.6 Always be wary of high unit costs. Projects with high unit costs are always vulnerable to a negative return on investment. If in this situation check the feasibility of a positive benefit profile.

vi. Cashable savings:

10.7 Savings identified are potential savings. They only become real when the monies are withdrawn. If not withdrawn they have been re-invested.

vii. You are not yet an expert:

10.8 This guide has introduced you to the potential witchcraft of cost benefit analysis. You are not yet an expert. Handle with care! If in doubt seek professional advice.

The impact of the Named Social Worker pilot

Summary of evaluation findings

July 2018

Executive summary

The impact of the Named Social Worker pilot

The Department of Health and Social Care (DHSC) initiated the Named Social Worker (NSW) pilot to build an understanding of how a named social worker can help to improve outcomes for individuals with learning disabilities, autism and mental health conditions. Phase 1 ran from October 2016 to March 2017 and Phase ran 2 from October 2017 to March 2018.

The Social Care Institute for Excellence (SCIE) and the Innovation Unit, worked with the six Phase 2 sites to assess the impact of the pilot on the individuals engaged in the pilot, the named social workers and the wider system. Three sites focused on transition cases while the other three worked with individuals who were from learning disability or Transforming Care cohorts.

This report draws from and summarises findings from the *NSW Phase 2 programme evaluation report* (SCIE) and *NSW Cost Benefit Analysis* (York Consulting). It is aimed at other local authorities or commissioners interested in learning how a NSW approach can improve outcomes, have a positive impact on social worker's skills, confidence and motivation and reduce costs.

The report should be read alongside *Putting People at the Heart of Social Work* (Innovation Unit) and *Peter's Story: the perspective of a person supported by a named social worker* (Humanly).

Summary of key findings

Despite the short pilot timeframe, the evaluation evidence suggests that the NSW pilot had impact across three levels: on the individuals engaged in the pilot, on the named social workers themselves and on the wider system, as outlined below:

1. Impact on the individuals and the people around them

- trusted relationships with people supported by services and those around them
- increased and meaningful opportunities for people to shape their plans that respond to individual communication needs and preferences
- new packages of support that better meet their strengths, aspirations and needs and those of the people around them
- high levels of satisfaction reported including that people felt that the named social worker listened to them and acted on their behalf
- evidence that people have been better able to live the lives they want including faster and smoother discharges, restrictive decisions overturned and greater stability of placements.

2. Impact on the named social workers

- increased levels of skills, knowledge and confidence to do good social work e.g. the NSW survey found that confidence to meaningfully engage the person they are working with and those round them to deliver a person-centred plan increased from 47% to 94%
- confidence to advocate for the people they work with and bring their voices to the fore e.g. the NSW survey found that confidence to constructively challenge other professionals/ services increased from 43% to 88%
- higher levels of satisfaction with quality of work.

3. Impact on the wider system

- evidence base of good social work in the local context and what it takes to put it into practice
- evidence of reduced costs for packages of care
- better cross-service coordination
- supporting and complementing other strategic developments and policy areas locally
- positive return on investment - a predictive financial return on investment (FROI) exercise suggested that the **FROI of the NSW pilot was positive for all sites and generated a NSW FROI of 5.14**, meaning that every £1 invested would anticipate a saving or costs avoided of £5.14. Of these costs avoided, 89% were anticipated to benefit the local authorities

Index

Introduction 1

The six Named Social Worker pilot areas 2

The evaluation 3

What is a Named Social Worker model? 4

Improving outcomes for individuals with learning disabilities and the people around them 5

Growing social work practice 7

Changing the wider system 9

The economic impact 10

Sustaining the Named Social Worker model 12

Further reading 13

Introduction

The Named Social Worker pilot

The Department of Health and Social Care (DHSC) initiated the Named Social Worker (NSW) pilot to build an understanding of how a named social worker can help to improve outcomes for individuals with learning disabilities, autism and mental health conditions. It aimed to put them and their family in control of decisions about their own future and support them to live with dignity and independence.

Lyn Romeo, England's Chief Social Worker for Adults, summarised the broader aim of the pilot:

'For people with learning disabilities and cognitive conditions to live a good life.'

The NSW pilot sought to change social work practice and wider system conditions to improve outcomes and experiences for individuals with learning disabilities, autism and mental health conditions and for the people around them. It was specifically about trying something different, piloting new ideas and generating early and indicative evidence as to their impact.

Phase 1 of the pilot ran from October 2016 to March 2017 and involved Calderdale, Camden, Hertfordshire, Liverpool, Nottingham and Sheffield. The second phase ran from October 2017 to March 2018 and involved Bradford, Halton, Hertfordshire, Liverpool, Sheffield and Shropshire. Sites worked with transition cases and Transforming Care cohorts, including individuals with learning disabilities, autism and mental health conditions.

This report presents learning from Phase 2 of the pilot.

Phase 2 pilot objectives

Phase 2 pilot objectives were to:

- provide excellent person-centred support for individuals with learning disabilities, autism and mental health conditions and the people around them
- equip and support social workers to be enablers of high-quality, responsive, person-centred and asset-based care
- build more effective and integrated systems that bring together health, care and community support and delivers efficiency savings.

How to read this report

This report is a summary of findings from the *NSW programme evaluation report* (SCIE) and *NSW programme Cost Benefit Analysis* (York Consulting).

It should be read alongside *Putting People at the Heart of Social Work:* (Innovation Unit) and *Peter's Story: the perspective of a person supported by a named social worker* (Humanly).

Six Pilot Sites

Named Social Workers led a process of culture change that aimed to make citizens' human rights the focus of social work, including the development of a competency framework for advanced practitioners.

Cohort of 38, 4 FTE named social workers

Named social workers built long-term relationships with young people moving towards adulthood, using creative and person-centered approaches; doing whatever it took to support the young people to achieve their goals.

Cohort of 17, 2.5 FTE named social workers

Continuing to implement its approach from Phase 1, Hertfordshire situated the NSW as a connector between the individual and other professionals with a strong focus on peer support between professionals.

Cohort of 10, 8 named social workers with a mixed caseload

Liverpool's NSWs worked with colleagues in children's social care and other agencies to apply the practice developed as part of Phase 1 to planning for young people moving towards transition who are currently in out-of-area placements. They also continued to work with a small number of cases from Phase 1.

Cohort of 27, 2 FTE named social workers

Sheffield applied the NSW approach developed in Phase 1 to its new Future Options Team. It focused on developing professional and meaningful relationships between named social workers and their families that go beyond support at crisis point.

Cohort of 15, 5 FTE named social workers

Shropshire identified a cohort of young people based at one of its local Special Education schools who volunteered to be part of the pilot. It worked closely with both young people and parents to plan together for a better journey towards adulthood and to inform a better design for transition services in Shropshire more widely.

Cohort of 12, 3 named social workers

The evaluation

Evaluation objectives

The evaluation had two core objectives:

1. **Site level:** support the six NSW pilot sites to build their own evaluation frameworks, steer data collection and analysis, articulate their impact and frame this learning to influence local stakeholders.
2. **Programme level:** design an overarching evaluation framework to guide the analysis and reporting of the NSW pilot impact in a robust and systematic way.

The evaluation had to be robust *and* realistic, given the pilot timeframe. It took a hand-holding approach to capacity building to encourage site's ownership of evaluation at a busy time of delivery.

The three high-level impact areas

The three, high-level impact areas identified by sites through the planning process:

- People with learning disabilities, autism and mental health conditions and the people around them live a good life enabled by the right kind of support
- Social workers are equipped to deliver high-quality, responsive person-centred and asset-based care
- A more effective and integrated system that brings together health, care and community support and delivers efficiency savings.

To help sites guide their data collection, these broad impact areas were broken down into 10 *key evaluation questions*.

Programme-level evaluation

The programme level evaluation drew on the evidence submitted by sites and was triangulated with primary data collection including:

- two named social worker online surveys that measured their confidence across specific indicators before and after the pilot began
- interviews with NSW site leads
- multiple and ongoing conversations and work with sites including an Evaluation Workshop in January 2018 attended by site leads and named social workers

York Consulting conducted a financial return on investment (FROI) of the NSW presented in more detail on page 13.

A theory of change approach

SCIE supported NSW sites to develop a theory of change model to underpin their approach and to make a plan for tracking progress against their intended outcomes during the life of the NSW and beyond. Pilot sites co-designed a set of high-level impact areas that guided the design, delivery and evaluation of the pilots.

These impact areas were broad enough to apply to all pilot sites, whilst allowing sites to develop their own theory of change that reflected their local goals, contexts and interpretation of he NSW approach.

Site level evaluation

Sites took a mixed methods approach to evaluation. They collected data to evidence the process they had undertaken and the impact they had on people who use services and their families and carers, the named social workers and the wider system. They also made predictions of an annualised cost and benefit of the NSW approach on five individual cases. This information was submitted in evaluation packs and then analysed for the programme evaluation.

Image taken from site's evaluation packs

Understanding the Named Social Worker model

Sites were not prescribed a NSW model or dictated how to implement the pilot. Rather, they were encouraged to trial new ideas or ways of working locally. The NSW pilot allowed sites to test, tackle and draw out learning around what good social work practice looks like for people with learning disabilities, autism and mental health conditions rooted in their local context. The focus was either on the transitions process for young people whose support was moving from children's to adult social services, working with people in restrictive hospital settings to move back into their communities, or indeed changing the wider systemic approach to taking risk.

The evidence suggests that across the six pilot sites the NSW model provided the framework by which 'good social work' with people with learning disabilities, autism and mental health conditions happened in practice. It did this in the following five ways:

1. Protected time for a NSW caseload, where the named social worker spent time to build up trusting relationships with the individual and the people around them, away from a time and task model of social work

2. Protected space and peer supervision structures, where named social workers reflected on their practice, brainstormed with colleagues to tackle concerns and shared ideas and good practice

3. Provided the opportunity for named social workers to trial and practice creative methods of engagement and approaches to deliver person-centred planning with people with learning disabilities and the people around them

4. Provided a risk-aware permissions framework, underpinned by legislation, which empowered named social workers to 'constructively challenge' existing decisions around mental capacity and/or packages of care

5. Elevated the status of the named social worker role which meant that named social workers worked confidently across multi-disciplinary teams of professionals and families to ensure the voice and wishes of the individual led decision-making

Improving outcomes for people with learning disabilities

The ultimate goal of the NSW pilot was for people with learning disabilities, autism and mental health conditions to lead *a good life*. This was based on the hypothesis that having a named social worker, who acted as a consistent point of contact and worked according to the principles of asset-based and person-centred practice, would lead to improved outcomes for individuals and the people around them. The evidence suggested that the NSW approach, built on a relationship-based model of social care, helped put the individual at the centre of their plans. As one young person commented:

'It is important that my named social worker visits me and understands what I like and don't like.' Taken from Hertfordshire reflection log

This approach meant that the individual's voice was clearly heard as part of the care planning process:

*'David cannot cope with demands being put upon him. Asking David questions is demanding and he cannot tolerate it for long so defers to mum. Without a NSW approach it would only be mum's voice that is heard.' Taken from David's case study, Halton**

Named social workers achieved some significant successes with individuals from across the cohorts, reporting instances of moving people back into their communities from out of borough placements, changing patterns of respite care to improve the family situation as well as building relationships with individuals who had been previously hard to engage. It is worth noting, however that individuals had different starting points and aspirations, meaning that 'success' was relative and complex to define, particularly over a relatively short six-month period.

In these ways, the evaluation drew together these early indicators of impact to suggest how the NSW approach was **part of the journey to *a good life* and not the end in itself.**

Image taken from Bradford evaluation pack

**The name of the young person in Halton's case study has been changed.*

Improving outcomes for people with learning disabilities

Many of the local pilot sites stated that their goal was to help people live *a good life*. As described, definitions of *a good life* was highly qualitative and personal. However, the evaluation suggests that the individuals engaged in the pilot:

- **Shaped and meaningfully contributed to their person-centred plans in a way that they wouldn't previously have been able to, and built consistent and trusting relationships with their named social worker:** Moving away from a time and task approach helped individuals and their families digest complex information and make informed decisions about what they wanted in future, particularly for those moving into adulthood and about to transition between children's and adult services.

- **Felt that their named social worker listened to them and acted on their behalf:** Having the opportunity to form trusting and consistent relationships helped individuals have greater trust in the system and increased confidence that the named social workers would advocate on their behalf.

- **Felt that their named social worker was putting measures in place that met their needs and those of the people around them to live *a good life* in the future:** Individuals had decisions about their mental capacity overturned, moved from out of out-of-area placements back into the community, and had reduced packages of care. Families and carers also benefited as named social workers implemented respite care and other interventions to improve the quality of life across the individual and the people around them.

See also *Peter's story: the perspective of a person supported by a named social worker* (Humanly).

'[An NSW] observed someone who had an obsessive-compulsive disorder (OCD) diagnosis … She felt this was wrong and it was pathological demand avoidance (PDA) linked to autism; she requested through the multidisciplinary team that the person [be] reassessed, and they were diagnosed with PDA not OCD. This will mean that their future placement will be better able to support [them], increasing stability and avoiding crisis'.

Sheffield evaluation pack

Changing social work practice

Despite the short pilot timeframe, named social workers had the opportunity to test what it means to put into practice 'good social work' with people with learning disabilities. This had a **significant impact on their confidence** to work with this cohort in future.

The following knowledge, skills and values saw a significant increase from 'very confident or confident' in baseline survey compared to 'very confident or confident' in the follow-up survey.

How confident are you in your ability to:

- Meaningfully engage the person you're working with and the person around them to deliver a person-centred plan (from 47 per cent to 94 per cent)
- Support, assess and communicate with people with significant learning disabilities and autism (from 37 per cent to 88 per cent)
- Work with relevant Human Right's legislation e.g. Mental Capacity Act, European Convention of Human Right's (from 42 per cent to 88 per cent per cent)
- 'Constructively challenge' other professionals and services (43 per cent to 88 per cent)

Sites also suggested that being part of the pilot improved named social workers' **morale** and **motivation.** Putting good social work for people with learning disabilities, autism and mental health conditions in action helped named social workers feel more confident in their abilities and it also led to greater job satisfaction.

'It was great to be allowed to be a social worker and the pilot showed [that] social work works'. Survey respondent

'I have loved working on this pilot as I feel it has given me permission to work the way I feel I should be working… Having more time to focus on the person and know what works for them as an individual, getting it right for them, gives great worker satisfaction as well as better outcomes for the individual and their family.' Survey respondent

'It has offered a great opportunity to develop skills and knowledge as a social worker.' Survey respondent

A note about the online surveys: In order to encourage frank feedback the surveys were anonymised. The baseline survey was completed by 19 and the follow-up survey completed by 17 named social workers. This means that the sample is not the same in each survey and it is not possible to track the specific impact upon individual named social workers.

Nonetheless, the increased confidence reported in the surveys is strongly supported by other evidence produced by sites and described in interviews with site leads.

Reflections from practice

The following extract, taken from a named social worker Reflective Log, illustrates how the named social worker was able to draw on the NSW pilot to change her approach with one person she worked with, presented here as Ms G.

This extract illustrates how a NSW approach allowed the named social worker to work closely with Ms G to identify and plan towards her goals, and take positive risks and challenge other professional opinions based on these plans.

'Ms. G has a history of being readmitted to a mental health unit after her placements break down. The priority for me was to prevent further hospital admission and support her to rebuild her life and integrate back in the community. The NSW pilot allowed me to use my creativity and try unconventional ways of working to achieve Ms. G's goals.

Thanks to a protected caseload I was able to meet with her even twice weekly (each time for at least two hours) jointly creating her care plan, taking her out, discussing support options, meeting with professionals etc. I was not afraid to try different support options (reducing/increasing care etc) and clearly promoting positive risk-taking practice, because I felt that being on the pilot allows me to do that.

I would often challenge mental health workers' decisions, who based on their previous experience of working with Ms. G, would be very risk averse limiting her options and trying to implement restrictions which, in my opinion, were unnecessary.'

Hertfordshire, taken from Reflective Log 2

Image taken from Halton evaluation pack

Impact on the wider system

Phase 2 pilot sites reported a range of ways in which they used the NSW to explore and tackle wider systemic conditions.

This is particularly evident in the ways sites:

- **Explored and deconstructed specific policy issues and piloted new ways of working:** Sites approached the pilot through a particular policy lens, for example by: investigating the local transition process; streamlining processes for the Transforming Care cohort; or in embedding a system-wide overhaul of local social work underpinned by the Mental Capacity Act (MCA). This meant that the NSW pilot was used flexibly, so that sites could focus on specific local issues or areas of concern.

- **Identified and engaged a wider body of stakeholders to tackle systemic practice and/or improve processes:** Sites mapped out different stakeholders and their touch-points in a particular process and invited new partners to attend NSW steering groups or to attend peer supervision sessions

In some areas, named social workers were involved in commissioning activity, for example by being part of the commissioning panels for new learning disabilities and advocacy services, to actively stimulate the market for new forms of care.

- **Built up an evidence base of what good social work looks like in the local context:** Phase 2 sites used the evaluation process to articulate the impact of the pilot on the cohort and the people around them, the named social workers and on the wider system, attributing outcomes directly to the NSW pilot compared to 'business as usual' social work. This process helped sites determine what worked and why about the local NSW approach. This helped them shape decisions about sustaining it in future.

'Raising awareness of the transition process amongst various agencies has raised the profile of the team and enabled partners to recognise when the transition process should commence. It has made other professionals aware of the importance of a timely referral from children's to adult services which has been demonstrated by an increase in referrals from children's social work practitioners.'

Quote and image taken from Liverpool evaluation pack

Predictive analysis of economic impact

York Consulting conducted a 'deep dive' analysis to better understand costs and likely benefits of the NSW model in Hertfordshire. It worked with the NSW leads and named social workers to identify the top-down cost of the pilot and mapped out likely benefits to 10 individuals engaged in their cohort. These benefit types – or costs avoided – ranged from changes in care packages to reduced use of other services such as ambulance or police call-outs. The monetised value of each benefit type was based on national published research. This process helped build a robust predictive financial return on investment (FROI) model.

Hertfordshire's FROI was calculated at 2.8. This meant that for every £1 invested in the model there was a potential saving or costs avoided of £2.80. Benefit beneficiaries were anticipated to be:

- Local authority – 78 per cent
- NHS – 17 per cent
- DWP – 4 per cent
- Police – 1 per cent

Using the Hertfordshire model, other sites were invited to break down the costs and benefits for five individuals in their NSW cohort. Sites were asked to be realistic and focus on what would have happened over a 12-month period as a direct result of their NSW activity.

The analysis suggests that **all sites would generate a positive FROI regardless of their NSW approach**. Sites which reported the highest FROI were those that focused on supporting people to move from specialist care to their communities, putting in place a bespoke and meaningful support package to ensure longer-term success.

At a programme level, the analysis indicates that the DHSC investment of £404,000 would generate an anticipated £1.7m benefits pro rata. This represents a **NSW programme FROI of 5.1.** The primary beneficiary of costs avoided was the local authorities, attracting 89 per cent of all benefits. This suggests that the NSW approach generated a positive financial impact on all areas that took part in the pilot.

A note about the methodology:
This approach recognised that NSW teams had limited opportunities, given the short time scales, to collect detailed outcome information. The initial focus was therefore on constructing a model of impact based on a range of assumptions. This model was validated at the Hertfordshire site.

These FROI figures exclude one-off set-up costs (estimated by Hertfordshire to be 20 per cent). Sites attributed benefits directly to the NSW pilot and therefore the analysis represents additional savings beyond what would have happened in 'business as usual'.

This analysis provides an illustrative projection which can be checked with actual outcomes data at a later date

The economic benefits of a Named Social Worker approach

The pilot sites reported other ways in which the NSW approach had a positive economic impact for the local authority. Sites produced case studies to illustrate the financial implications of specific cases, for example where an individual had moved from an expensive out-of-borough placement into a supported care arrangement.

Halton suggested that one individual's changed package of respite care equated to a direct reduction in cost to the local authority of £900 per week:

'Whilst some of the new plans we have put in place have made significant savings to support packages, this is not about saving money. One young person was in a very high-cost situation and was deeply unhappy. This is about a longer-term person plan to make sure it works for everyone.' Halton evaluation pack

This evidence suggested that **a relationship-building model of social care which built on the strengths of individuals** not only led to improved qualitative outcomes but also generated more sustainable, less expensive packages of care which helped mitigate against crisis, both now and in the future.

Peter's story: a perspective of a person with a named social worker (Humanly) shows how his person-centred plan led to a reduced (and therefore less expensive) package of care.

Sustaining the Named Social Worker approach

All sites planned to secure local funding to sustain the NSW approach in future. As well as seeking financial investment to protect the time of a named social worker caseload, there were a number of other ways in which sites hoped to capitalise on and embed the pilot learning. These include plans to:

- maintain the structure of the peer group sessions, led by reflective practice
- share learning across teams with the NSW acting as peer group supervisors
- continue to use and build on co-design and person-centred tools when working with the cohort
- commission named social workers to produce a 'skills and what works guide' to share with other teams
- identify key partners to strategically engage in the system e.g. mental health teams, housing, health colleagues, schools etc
- clarify new processes and structures e.g. the way in which individuals and families are engaged in conversation about young people moving into adulthood.

In these ways, the pilot acted as **a catalyst for change**, both in terms of sites having the opportunity to trial and test new approaches, but also in building up a body of learning around *what works* and *what needs to change*.

The NSW pilot has also given us the opportunity to develop documentation/processes that will ensure that at the end of the project, this way of working doesn't end'. Interview with Halton lead

'Without the support we have received during the pilot, both financial and resource, the evidence required to make the necessary changes would have taken years to gather'. Shropshire evaluation pack

The ways in which the sites planned to embed NSW pilot learning were as unique to the local area as were the pilots, with sites exploring an approach to engage new cohorts and partners or tackle different issues. In this way, the question for sites is not *whether* to build a longer-term plan for a NSW approach in future but *how* best to do it in practice.

Further reading

NSW Phase 2 full evaluation report (SCIE)

NSW Cost Benefit Analysis (York Consulting)

Putting people back at the heart of social work: learning from the NSW pilot (Innovation Unit).

Peter's story: The perspective of a person supported by a named social worker (Humanly)

Co-production toolkit (Humanly)

THE IMPACT OF THE NAMED SOCIAL WORKER PILOT

Summary of evaluation findings

This report was developed by the Social Care Institute of Excellence to summarise the impact of the Named Social Worker programme. It draws on findings from economic assessment of the pilot conducted by York Consulting.

The Named Social Worker programme was funded by the Department of Health and Social Care and run in partnership by Innovation Unit and the Social Care Institute for Excellence.

PUTTING PEOPLE AT THE HEART OF SOCIAL WORK

LESSONS FROM THE NAMED SOCIAL WORKER PROGRAMME

JULY 2018

FOREWORD

Between 2016 and 2018 the Department of Health and Social Care has supported the Named Social Worker (NSW) programme, which was led by Innovation Unit and SCIE, and involved nine local authorities from across England over its two phases.

Through this initiative, people with learning disabilities, mental health conditions and autism were assigned a named social worker – a social worker who could build a trusting relationship with them, advocate on their behalf and coordinate their care and support in a more holistic and person-centred way.

The ambition is that people with learning disabilities and other cognitive impairments lead a good life. Indeed, that is what we wish for all the people we seek to help. But we know that too often the support that we offer to this group and the people around them is not as good as it could be. It can feel like box-ticking and hoop-jumping and lack the personal connection and continuity that is necessary to build trust.

This is why this programme has focused on testing ways to give people who use services and the people who care for them a stronger voice, designating a social worker to be their key point of contact and building the skills and confidence of social workers to serve people in the most holistic, tailored and, ultimately, the most helpful way possible.

We did not prescribe a set NSW model through the programme. Instead, we invited sites to shape their approaches building on local practice and initiatives. This resulted in different foci - for example, three out of six sites in phase 2 focused specifically on transitions - and it surfaced some common themes across the pilot sites about what it takes to achieve success.

For example:

- The importance of creating spaces dedicated to reflection and learning for named social workers, in supervision and peer groups;
- The power of engaging people who use services and the people around them in conversations that start from their own perspective, objectives and capabilities (rather than from a limited definition of options, dictated by rigid processes and restrictive approaches to risk taking);
- The empowering effect of giving permission - and some extra time - to social workers to really get to know people and to use their judgement and creativity in how they work with people to achieve their goals;
- The importance of communication and collaboration with colleagues in other services, and of the key role that social workers can play as advocates for the people they support within a multidisciplinary team of professionals.

Most of these will sound familiar to many of us. So, aren't we all named social workers? It's a very fair question to ask. In many ways we are. We know that many areas already use an allocated worker model in supporting people over the longer term, especially those who are moving in and out of crisis and appearing on risk registers. However, we also know that there can be challenges to delivering social work practice in the most effective ways.

Over two phases and a diversity of pilot approaches, we have been exploring the common features of a NSW model. We converged towards the notion of putting 'good social work' into practice and being ambitious about what this means when working with people with higher levels of need and vulnerability. We have been surfacing the common principles that underpin good social work, the difference it can make and how we make it possible in practice. This guide aims to share the insights that have emerged.

It takes time before shifts in practice are embedded and bear fruit in terms of sizeable, measurable outcomes. However, site evaluations so far suggest that named social workers are able to invest more time building a relationship with the people they support, and to draw on the support and skills they need to work in a more asset-based and person-centred way. As a result, people are more satisfied with their experience of the service and evidence from the sites suggests that discharges from institutional settings happen faster and placements and arrangements are more sustainable as a result.

Moreover, and crucially, social workers express high levels of satisfaction, reporting both that they are happier with the way they are able to work with people and that they feel that their role and credibility as social work professionals is better recognised by colleagues in other services. These social workers are raising the ambition for 'good social work' and helping to increase its profile, both with people who use services and with other professionals.

At the practice level there are many transferable lessons emerging from the sites, which I sincerely hope will support and enhance practice across the country. For example, creating opportunities for reflective peer learning; building communication skills and liberating creativity to engage people who use services in different conversations; working collaboratively across the system between health and care services, commissioners and providers to deliver more integrated and preventative services.

At the policy level, too, there are a number of lessons from the NSW programme that are highly relevant to other crucial integrated care questions, such as how we are going to work collaboratively to ensure that transitions into adulthood for young people with learning disabilities are as seamless and empowering as they can be; or how we will come together to deliver on the imperatives of the Transforming Care agenda.

I believe that social workers and 'good social work practice' have a fundamental role to play in putting person-centred care at the very heart of these important initiatives, by modelling and championing it in multidisciplinary professional contexts and by living it in their everyday interactions with the people they support.

This is my ambition. I hope that the lessons from the NSW programme will resonate with and support further the great work that lots of dedicated social workers, service and system leaders are doing across the country, with resilience, passion and creativity, in the face of all the challenges that our public services face.

Lyn Romeo
Chief Social Worker

INTRODUCTION TO THIS GUIDE: WHAT IT IS, WHAT IT ISN'T AND WHO IT IS FOR

Now that the Named Social Worker (NSW) programme has drawn to a close, we want to share the lessons that we have learnt along the way, so that they may benefit other social work teams and services across the country. We are doing so through two publications: this guide and a programme evaluation report. While the programme evaluation provides a narrative and evidence about impact and processes, this guide focuses more closely on practice and on the lessons emerging from implementation across the sites.

What this guide aims to achieve

We hope that this publication will help to:

- make the case for 'better social work practice', drawing on the learning and emerging evidence from NSW programme sites;
- identify common principles and enablers of 'good social work' and what this means for people with learning disabilities;
- provide inspiration, tools and practical tips to other localities across the country that are committed to maximising the impact that social workers have as they help the people they support to lead the lives they want.

What is isn't

This guide is not a blueprint for a new service model or a new school of social work practice. It also isn't a comprehensive training package on how to implement a Named Social Worker approach, since applications varied across sites. It is instead a collection of lessons, reflections, examples and provocations intended to support others to change and improve social work practice and processes in their local areas.

Who it is for

This guide has been created with an audience of practice and strategy leaders in mind. We hope that it will provide directors of Adult and Children services, heads of service, service managers and team leaders with food for thought and an argument for developing, leading and nurturing person and asset-based services. It also aims to provide inspiration, reassurance and practical ideas to support social work teams to stretch and develop their practice.

We believe that Transforming Care leads will also find valuable transferable learning in these pages.

How to navigate it

There are four key sections in this guide and an additional Appendix.

Executive Summary 'Putting 'good social work' into practice' sets out the case for change and key principles and enablers underpinning the NSW models developed through the programme;

Chapter 1 'Lessons from Practice' includes a series of 'spotlights' on different aspects of the NSW approach. This aims to share key learning around the 'pillars' of the approach, namely: identifying who to work with; defining the skills, values and behaviours of a named social worker; nurturing skills and confidence in the social work team; key elements of practice for person-centred interactions; and partnership working with other agencies and taking a systemic view;

Chapter 2 'Measuring the difference we make' offers some pointers on developing an evaluation approach that captures the qualitative and quantitative impact of different ways of working;

Chapter 3 'The way ahead' closes this guide by offering some reflections and provocations for social work practice, inspired by the learning emerging from the programme;

The **Appendix** includes useful tools, case studies and artefacts from pilot sites.

A note about language

The Darlington Learning Impairment Network rightly points out that:

If we are to change the current system of social care to a model that is genuinely empowering, then the impact and power of language needs to be taken into account.

Mark Humble, A Report on the Language of Personalisation

In this publication we have endeavoured to keep jargon and acronyms in check and tried our best to use language that puts people before labels and does not get stuck in 'service land'.

EXECUTIVE SUMMARY: PUTTING 'GOOD SOCIAL WORK' INTO PRACTICE

The Named Social Worker programme unfolded over two six-month phases between October 2016 and March 2018. It supported nine local authority pilots to test what a NSW model could look like in practice in different places; explored culture, practice and operational implications and mapped the emerging impact that working in this way with particular groups of people could have.

The case for change

The case for change - both locally and nationally - is clear. Social workers tell us that the current way of working doesn't help as well as it could. Sometimes, the system focus on risk minimisation and poor understanding of the individual means that people aren't helped to realise their right to a good and 'normal' life. Without a better understanding of the person, more empowering (and often also cheaper) care options aren't achievable. So we still see too many people spend a long time in restrictive settings, away from their families and communities and too many young people miss the opportunity of growing into adulthood developing independence with the right choice and support.

In the current operating model, time and resources are often focused on servicing processes and minimising risks, leaving less time to focus on enabling people to live the life they want to live. Social workers, who came into the profession to deploy the best of their humanity, empathy and resourcefulness to help people flourish, can find themselves managing large caseloads and focusing on tasks and protocols to meet service throughput targets. People in need of support too often go through multiple hand-offs, don't know who to turn to when issues arise and often don't get help until things get to crisis.

The very real pressures that services operate within can make the default mode reactive, rather than proactive. Resources are often spent on gatekeeping - protecting access to services, when a lower level of help earlier on could help keep people stable and reduce the need for more intensive interventions. Social worker teams so often have to deal with crises that it can be challenging to find the time and headspace to imagine what a radically different way of doing things might look like - and achieve. The Named Social Worker programme aimed to afford pilot sites just such an opportunity.

The 'Named Social Worker' way: key principles

Pilot sites have taken different approaches to the NSW model. Some have embedded the approach in their localities teams, others in teams dealing with complex cases or with young people preparing for adulthood. All have used the programme as an opportunity to support wider changes to practice and culture, aimed at optimising the contribution that social workers make to delivering the best outcomes for people.

Across the diversity of contexts and approaches to implementation, similar core features have emerged from the NSW sites:

1. **Being person-centred, asset-based and ambition focused** - this includes taking time to get to know people, focussing on the things that are most important to them and being creative in finding ways to achieve them. Crucially, this means having high aspirations for what people can achieve and how the system can help;

1.

2. **Nurturing the skills and confidence of social workers -** group learning sets and reflective supervision, combined with the 'permission to think outside the box' that comes with the NSW 'label' grow social worker confidence in working differently with people and advocating for the people they are supporting in multi-disciplinary settings;

3. **Better partnership working -** named social workers have been reaffirming the important role that social workers can play in multi-disciplinary settings, ensuring that services join up, providing a trusted point of contact for people who use services and using the knowledge of people and their lives to ground and direct the contribution of other services;

4. **Taking a systemic approach -** creating the conditions for this way of working to become mainstream by establishing feedback loops with commissioning, working with providers to create a market with the right options of support and tapping into local assets in a way that goes beyond collaboration between statutory services. *

Making it possible

Over the course of the programme, sites converged towards the idea that the named social worker role was about reconnecting to the values of 'good social work', and, crucially, putting them into practice.

The principles set out in the previous section are neither new nor radical. Their application in practice, however, is much more challenging as sites on the NSW programme found. Project leads shared learning about what it takes to turn these principles into practice.

1. **Protected time -** Time is a rare commodity and social workers are often acutely aware of their duty to account for it. Learning from the sites suggests that protecting time to work in a more intensive way with some of the people they are supporting, and for reflective learning to maximise their impact, is a wise investment rather than an unaffordable luxury;

2. **Peer/ action learning -** Interactions between social workers in a team can become task oriented, driven by the necessity to deal with high numbers of referrals. Social workers in the programme talked about the importance of learning and reflective spaces where teams can come together, talk about the people they are supporting and learn from each other and from other colleagues;

* Interestingly, and not surprisingly, these principles and the lessons emerging from the programme bear similarities with the 'Seven features of practice and seven outcomes' set out by the Children's Social Care Innovation Programme.

3. **Reflective supervision -** Supervision is a space that is meant to be nurturing and reflective and can risk becoming transactional. Great social work is enabled by managers that hold a safe space for their staff to deploy the best of their judgement and human skills;

4. **Explicit permission -** Although there are relatively few actual red lines limiting the things that social workers could try when working with people, there can be many perceived constraints, stemming from limited resources, lack of confidence and the need to manage risk. Practitioners on the programme reported that being identified as a named social worker brought with it a sense of permission to use their judgement more and a recognised 'status'. This enabled them to challenge colleagues in other services that they would not normally feel able to do and to be more creative and ambitious in the support they provided.

5. **Clear measures -** Working differently will often require some form of investment, even if it means frontloading resource to get savings further down the line. A clear plan to identify costs and benefits, combined with patience to track impact over time - required especially when working with people whose needs are more complex - provide valuable ammunition for leaders and managers advocating for change;

6. **High levels of ambition for what good social work looks like -** At the heart of every site's approach has been the recognition that 'we can do better' and the commitment to try something different and learn from it. And, crucially, **social workers on the programme had a high level of ambition for what the people they support can achieve** and for how 'good social work' can help them get there.

The difference it makes

Although the duration of the programme did not allow for monitoring longer term impact, site evaluations suggest that social work practice that is led by the principles and practices set out above has a positive impact on people who use services, the workforce and the wider system.

Individual stories and direct feedback from programme participants suggest that named social workers have had the opportunity to build **strong and trusting relationships** with the people they are supporting in a way that does not tend to be possible within 'business as usual' and that people who use services, their carers and families express high levels of satisfaction with the service they received. Case studies suggest that the NSW approach has sped up discharges, improved collaborative working supporting young people preparing for adulthood and resulted in more stable placements. In a number of cases there have also already been **reductions in the cost of individual packages of care**.

Moreover, social workers reported significantly higher levels of confidence, skills and knowledge around working in a person-centred way, engaging with and supporting people with different communication needs and preferences, working with relevant human rights legislation and advocating on behalf of the people they are supporting in multi-agency settings. They are also happier with the quality of their interactions with people and feel that they are liberated to work as they would like to.

Finally, at a system level, partner agencies have reported improved collaboration and coordination in how people are supported as a result of the role played by named social workers in multi-disciplinary teams. NSW pilots have also complemented wider strategic developments within sites, such as changes in commissioning and integrated delivery.

For more detailed information about impact and process learning you can read the programme Evaluation Summary Report or full suite of evaluation materials.

Having a named social worker is a great thing as it gives stability and continuity of care for both myself and Jake*. It is great to be able to build up a trusting relationship with a named social worker. This has allowed Jake to be able to trust and rely on social services, this wouldn't have happened if we had to keep swapping social workers

Mum, Halton

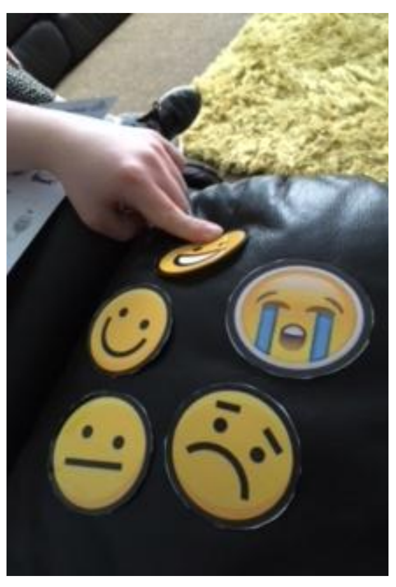
I have loved working on this pilot as I feel it has given me permission to work the way I feel I should be working… Having more time to focus on the person and knowing what works for them as an individual, getting it right for them, gives great work satisfaction as well as better outcomes for the individual and their family

Named social worker, survey response

*All names have been changed

Throughout and after Andy's* transition, the social worker has been a significant point of contact for all professionals involved in the case; should any information be needed during the assessment stage, she was quick to respond and accommodate to ensure an effective transition and to promote the individual's wellbeing.

Feedback from health partner, Hertfordshire



*All names have been changed

01

LESSONS FROM PRACTICE

1.1 Identifying who to work with

As we have just described, one of the key differentiating features in the NSW way of working is the permission to spend the time it takes to get to know the people the named social worker is supporting, and to really understand their needs, so that the support offer may be tailored to meet these in the most effective way.

Ideally, we would want to work in this way with everyone, and whilst the principles and values of asset-based and person-centred practice can be brought into even the smallest interactions, we need to think carefully about who would most benefit from additional time invested. Resource constraints and rising demand mean that the rate of throughput can be a more important criterion of success for services than the quality of interactions with the people who use services.

However, in the case of people whose needs and life circumstances are more complex, closing down cases quickly can be a false economy. When these people continue to require support from services, they will often have a different social worker for each interaction, and the social worker will need to start from scratch in understanding what is going on in their lives and making choices about the best way to support them. Here there is, then, a clear efficiency rationale for the continuity of relationship that underpins the NSW model, as well as for front-loading investment of social worker time in getting to know people and working with them to ensure their support offer is the right one.

The 6 NSW pilots have been working with two main groups of people:

- **Transforming care -** people with learning disabilities and/or autism who display behaviour that challenges (including behaviour that is attributable to a mental health condition), who are currently living or at risk of being admitted to hospital settings.
- **Transitions -** young people who are preparing for adulthood.

The criteria for NSW **casework allocation** varied in the programme due to both the nature of the different approaches being tested and the range of local teams and structures. For example, Sheffield implemented the approach within their Future Options Team, set up to manage more complex cases, while in Liverpool, Shropshire and Halton named social workers worked with young people going through transition. Hertfordshire placed named social workers in two of their locality teams.

The NSW approach to case management lends itself well to implementation into teams that have a specialist focus, such as Transforming Care or Transitions teams, and therefore, generally, smaller and more complex caseloads. However, it has also been used alongside traditional caseworking, with social workers having a combined caseload of 'generalist' and named social worker cases. In this scenario, cases were chosen because they could benefit from intensive support due to more complex and enduring needs. This latter approach offers the opportunity to spread the NSW way of working across a wider base of social workers.

When allocating NSW cases alongside 'generalist' cases, managers must however be mindful of how they will **protect time for NSW case working and meaningful reflective learning** (although the latter may be offered to a broader cohort of workers). For example, this may be reflected in a lower overall caseload and/or involve removing named social workers from rota duty. Moreover, offering the continuity of relationships that underpins the NSW model means maintaining cases open for longer, albeit without requirement for high levels of ongoing involvement. This translates into a larger 'virtual' caseload to whom 'the door is open', which needs to be reflected in the modelling of individual and team caseloads.

One of the key questions that the programme has explored is: *what is the impact of the Named Social Worker approaches on the financial **sustainability** of services?* The limited duration of the pilots and the nature of the caseload mean that it will still take some time before we have a conclusive answer to this question. However, evaluation findings point not only to improved satisfaction for people who use services, social workers and partner agencies, but also to savings in terms of greater stability of placements, lower care packages and reduced incidents involving health, police and emergency services. Taking a system-wide view on sustainability, the pilots' experience suggests that the NSW model creates efficiencies through improved collaboration, as well as better support solutions and improved outcomes for people. Moreover, some sites have already started to explore how to draw more on the wider community assets in ways that, while increasing the local service offer available, reduce the direct demand on statutory services.

Transforming Care

For the sites that chose to focus the implementation of their NSW approach on the Transforming Care group, the programme afforded an opportunity to work more creatively with people who use services and more collaboratively with partners.

Working with people who use services has meant connecting with people and getting to know them in different ways ways, visiting them regularly and **building trust** in ways that would rarely be possible in 'business as usual'. This was enabled by the additional time afforded by the pilot models.

The NSW project allowed me to use my creativity and try unconventional ways of working to achieve Tracey's goals. Thanks to a protected caseload I was able to meet with her even twice weekly, jointly creating her care plan, taking her out, discussing support options, meeting with professionals etc. I was not afraid to try different support options and clearly promoting positive risk taking practice because I felt that being on the NSW pilot allows me to do that.

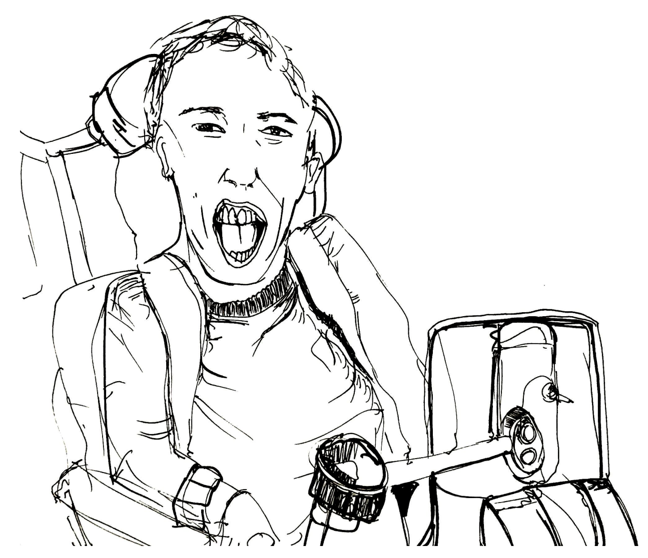
Named social worker, Hertfordshire

The placement took me over two and a half hours each way on the train. It felt very strange to spend the whole day doing one visit and not to have a completed assessment to show for it. I'm glad that I had the 'all about me' to give a more concrete/clear 'purpose' to my visit, so it still felt as though I had accomplished something tangible from the visit. I think that this was more important to me than it was to Michelle.
I could understand from Michelle's point of view that it was important to take things a little slower and to give her time to work out her skills and to get her thinking more about the future. This was particularly necessary as she had not really got a very clear idea of what she wanted from her life.

Named social worker, Liverpool

We received feedback from parents that the named social worker was helpful, took the time to get to know their son and to visit them, and the placement felt right because of this. It meant they visited fewer placement options as the social worker had done more background research and the options were more appropriate.

NSW evaluation report, Sheffield



Named social workers have tried different ways of **exploring with people their preferences and aspirations** for their future. This ensured that longer term plans were designed and put in place. For example, Sheffield used pen portraits as a tool to have different conversations with people. Named social workers have also been able to carry out more direct observations with people who do not use verbal communication, rather than relying on information from other professionals.

The use of the pen pictures really helped - giving the person the social workers' pen picture and talking with them to develop their own uncovered lots of previously unknown personal information. It provides a personalised approach for the individual to have a conversation based on their interests and helps to develop a rapport.

NSW evaluation report, Sheffield

I don't usually do observations as I don't feel as though I always have time and there isn't a clear purpose to these visits – instead I would usually speak to people who knew Paul best and have more limited direct contact with the young person. This was however a really positive experience and I got a lot of new information about Paul, but more importantly I got a real sense of who he is.

Named social worker, Liverpool

The pilots also enabled named social workers to play a more significant role **advocating on behalf of the people they support within the MDT teams** that were making decisions about them. Several workers reported that the authority and recognition that came with the 'named social worker' label made them feel more like equal parties in MDT meetings and it gave them the confidence to challenge colleagues and make suggestions that were grounded in their knowledge of the people they are supporting and resulted in better coordination between agencies and better communication with the people who use services.

One of the steps taken by the MDT to facilitate Helen's effective participation in less daunting meetings was to have two parts to her care planning meeting. The first part was Helen meeting with 2 -3 professionals of her choice at a venue of her choice (her home). The professionals would then feedback the outcome of the first meeting to the wider second part of the meeting. Feedback from Helen and all involved is that this format has been very productive for all. Helen was very relaxed, she engaged in the discussions, freely and confidently expressing her views, wishes and goals for the future.

Named social worker, Hertfordshire

Julia has a close relationship with me, and will confide information that she is not willing to share with professionals on the ward. I am then able to attend MDTs and pass on these concerns, raising safeguarding concerns where necessary. A member of her family has become unwell while I have been working with the her, and so I have been able to support the family also.

Named social worker, Sheffield

I would often challenge mental health workers' decisions. They would often be very risk averse, limiting her options and trying to implement the restrictions which in my opinion were unnecessary.

Named social worker, Hertfordshire

Named social workers have also been **supporting providers** to work with the people who are using the service in a different way to ensure placements remain stable and successful.

I spent hours working closely with the support staff, explaining the relevant legislation to them, supporting them with their recording skills, all to make sure that Tracey is supported in a less restrictive and more positive way.

NSW evaluation report, Hertfordshire

My multiple visits at the scheme helped me to build the relationship with the care workers and the scheme manager, so that they are very forthcoming about any issues they identify. They are not afraid to call me and just say:
"We think we messed up, what we shall do?". Thanks to that I am able to advise them and speak to Tom quickly enough to prevent problems escalating.

Named Social Worker, Hertfordshire

Transitions

Three sites chose to focus on young people preparing for adulthood as they developed their NSW model into phase 2. The case for change was clear and common to all of them: packages of care were being put together without the appropriate knowledge of the individual and their circumstances, often in ways that caused considerable stress to young people, families, carers and workers. Adult services were often getting involved too late, and children's services were focusing on managing short term risk rather than longer term outcomes.

There are a number of factors at play in determining this sub-optimal state of affairs: firstly, due to resource constraints, forward planning is de-prioritised over crisis led interventions, so that time to plan transition progressively with young people and their families and carers is seen as an unaffordable luxury. Secondly, and consequently, adult practitioners often lack experience and knowledge of working with young people, including of their role within Education Health and Care Plans, and they are not familiar with the local offer and service options open to young people. Thirdly, the legislation, practice and principles that underpin children and adult social care can at times feel at odds with each other - one being geared towards protection and safeguarding and the other towards building and supporting independence - and this can get in the way of effective collaboration at transition point. In all this, those who pay the price of the system's shortfalls are young people and their families and carers, who are left anxious, confused and often angry by the lack of long-term planning and support in place.

NSW sites therefore aimed to **get to know young people and their families and carers earlier on**, understand their aspirations for the future and build trust, with the expectation that this will not only improve the experience of preparing for adulthood, but also lead to packages of care that enable independence where possible, improve outcomes and reduce reliance on services going forward.

The intensive work social workers have carried out with each young person and their family highlighted that no level of intensity of support can compensate for earlier intervention.

NSW evaluation report, Shropshire

Shropshire partnered with a specialist academy to recruit young people and families for their NSW pilot. Out of 20 year 14 families, 12 took up the offer to become involved in the pilot and have the support of a named social worker to work with their child to plan their transition. In parallel, parents were invited to a series of workshops to explore what transition meant for them (including from a rights, process and family perspective). Halton established a dedicated Transition Team working with 16- 18 year olds and Liverpool named social workers focused on 14-17 year olds in out of area placements, working closely with the child social workers and other key professionals.

Asset-based and creative ways of engaging young people in conversations about their future were at the heart of the approach that Halton and Shropshire took and they worked in close partnership with local self advocacy organisations.

Named social workers in Shropshire used visual communication tools to explore with young people their aspirations for the future.

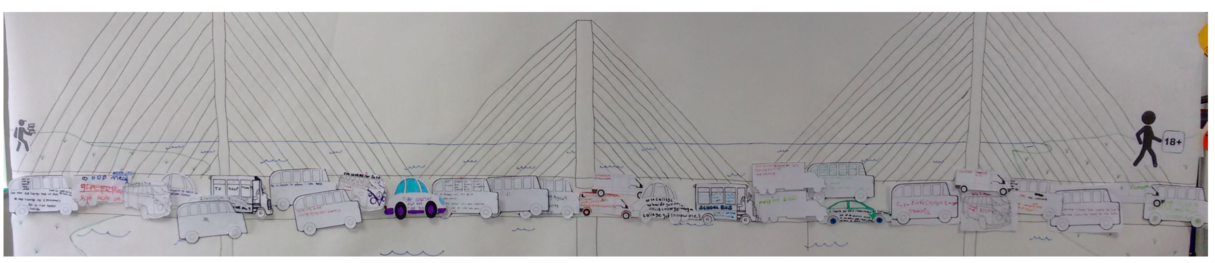
Halton held co-design workshops with young people set up by local self advocacy group Bright Sparks. The workshops focused on what is most important to young people as they prepare for adulthood, and how services could better engage and communicate with them. As a result, Halton are now developing an informational video on transition for young people.

NSW pilots have been working to develop clear **Transition protocols** (Halton published theirs in March 2018) and make the available offer more visible to families, carers and workers.

NSW pilots focusing on transition have also invested in fostering **dialogue and collaboration between agencies**.

In Halton the Transition team has been co-located with a children's nurse and works in close partnership with the positive behaviour support service. They also seconded a children's social worker into their team which they describe as hugely impactful as she was able to act as a bridge across the different process, practice and legislative frameworks. Moreover, the head of Halton's Transition team chairs the meetings of the cross-agency Transitions Operation Managers Group.

Liverpool's named social workers have used the pilot to work with professionals supporting children with high levels of need and vulnerability who are currently in out of area residential placements. They have been providing both support and challenge to these workers and building a deep understanding of the young people themselves in order to ensure these young people have asset-based and long term plans developed and in place.



Commissioning is a crucial piece in the Transitions puzzle. Early engagement with young people and their families and carers provides greater visibility over demand in the pipeline and can inform better strategic choices in relation to wider provision, including making better use of the support capacity that exists at the community level within partner agencies and the voluntary sector. Ultimately, sites agree that the separation between ‘children’ and ‘adult’ services is artificial and unhelpful, as in life there is no ‘transition’ from one state to the next: one just grows older.

Liverpool are committed to exploring what all-age commissioning looks like and to embedding an integrated approach across children and adult offers in their neighbourhood teams. They are restructuring their social worker workforce into neighbourhood teams, whose skills and composition is determined on the basis of the neighbourhood’s demographics. Every person with a package of care will have a nominated point of contact within their neighbourhood team. The plan is for neighbourhood teams to be delivery partnerships between social care and other agencies, including the voluntary sector.

1.1 What's in a Named Social Worker

Skills, Values and Behaviours

We have outlined the key attributes of a named social worker based on contributions from the named social workers who took part in the programme.

A named social worker is…

- **Truly ambitious** for the people they support, believing in what they can do not what they can't;
- An **empathetic listener**;
- An **open-minded problem solver**;
- A **team player,** always ready to share and learn with and from colleagues;
- **Literate of key legislation** (i.e. Care Act, Mental Health Act..);
- A **strong communicator**, able to connect and communicate with people with different communication needs and preferences and to advocate for the people they are supporting with colleagues across disciplines;
- Confident and able to **use their judgement** in tricky situations;
- Able to take **risks and be flexible**;
- Knowledgeable about the **local service offer** and about local communities;
- **Well connected** with colleagues in partner agencies.

.

Social workers on the programme included people at different levels of experience. While more experienced workers brought great depth of insight and maturity of practice to NSW teams, less experienced workers, including social work students, brought fresh and imaginative approaches to person-centred working, so that everyone in the mixed NSW teams benefited from sharing practice and learning.

For many social workers the NSW approach was liberating and enthusing. But it's important to note that not all social workers found it easy to work in this way - a small number found specific skills such as creative communication approaches with this cohort to be challenging to learn and adapt to, others found it hard to move away from more structured transactional approaches and feel confident being more responsive and flexible.

The best bits

We asked social workers on the programme about the best aspects of being a named social worker. Here is what they told us:

You can take a longer view, and not just 'stick a plaster on' the issues. You have time to think through their aspirations, how best to support them to be independent in the long term, not just for the next year or so.

Named social worker, Shropshire

You're there solely to support someone and ensure their voice is heard. You get fulfillment in this. When you have that time to help people. I might be the only person who they talk to and ask for help.
[...]
One woman I had been working with in hospital was discharged into the community. She told me: 'Thank you for not giving up on me', and that says it all really.

Named Social Worker, Hertfordshire

I really like the problem solving aspect of social work, and I think this is important. You need to be able to think outside the box to help someone, because everyone is different, so you always need to work in different ways. This way you can make sure that they are the core reason for doing everything, not because of assessment processes.

Named Social Worker, Sheffield

The thing I hadn't expected or thought about was working with the rest of the team - it's been a really positive dynamic.

Named Social Worker, Shropshire

People have more support around them, and social workers can build relationships with the wards and, in turn, they build confidence in you. There is more collaborative working with health teams too.

Named Social Worker, Sheffield

I feel confident in challenging other professionals, and enjoy this. Saying: 'Can you explain to me why?', And giving advice like 'We need to be looking at it like this, from the individual's point of view'.

Named Social Worker, Bradford

What gets in the way

Acknowledging that it can be challenging to apply the NSW principles in practice, we asked named social workers to reflect on what gets in the way. They highlighted:

- Difficulties **communicating** with people with significant communication impairments;
- The need to constantly reaffirm and uphold the unique value and **legitimacy of the social work profession** when working within multidisciplinary settings;
- Working with young people going through transition, the challenge of knowing how to act in the **best interest** of a young person when a social worker's opinion differs from that of a parent;
- Driving **culture change** across busy teams, when progress can be slow;
- '**Culture clash**' between services - for example when health services push for options that social workers consider over medicalised and restrictive or when the children social care duty to 'maintain stability' is at odds with adult social care efforts to build independence;

They also reflected on barriers to applying the NSW principles without changing wider system conditions:

- **Large caseloads**, and the need to account for and justify the use of time;
- The pressure to **close cases as quickly as possible**;
- Sustaining the focus on quality interactions in the midst of **competing pressures** on resources.
- How operating in **crisis mode** does not allow time and headspace to plan forward and invest in prevention;
- **Bureaucracy** and paperwork.

What helps

Finally, we asked the named social workers what, from their perspective, were the key enablers of 'good social work' practice in line with NSW principles. They identified:

- The **freedom to 'do what it takes'**, for example freedom to spend as much time as needed with the people they are supporting and access to small flexible budgets;
- **Earlier involvement** with young people preparing for adulthood;
- **Strong leadership** and managerial support, including permission to take risks and allow people to make 'unwise decisions';
- Team working and **peer learning**;
- A team with **diverse backgrounds;**
- **Lower caseloads;**
- The ability to do **preventative work** with people before needs escalate;
- **Colocation** with other services;
- **Integrated** health and social care budgets;
- Being **linked into the local service and community offer**.

Permission was important. My manager was encouraging. For example, he encouraged me to go and spend time with a service user who lived out of county.

Named Social Worker, Hertfordshire

The social workers involved in the pilot feel that the knowledge, values and skills are the same as for other social workers in the Future Options team, but [the NSW pilot means that] they are enabled to focus on them.

Sheffield Evaluation report

If it’s an open/close case approach, just dealing with the presenting problem then going away, then you haven’t got the whole picture.

Named Social Worker, Hertfordshire

It’s about me helping them not because I need to do paperwork every 6 weeks, but because I can and want to. Because I really know them.

Named Social Worker, Halton

The following quote offers an interesting practitioner perspective on the question 'are we not all Named Social Workers?'

My initial thought about the NSW project was: why do we need it and what difference will it make to my practice? I believe that in my everyday work I use skills and knowledge that are in line with the NSW principles and I would expect every single social worker to do the same. Promoting person centered practice, positive risk taking, being the first point of contact for the service user's and people involved in their support, in my opinion, is a core element of a good social worker practice. I could not think how anyone can not work in a same way?!

However, after a while I understood what difference I can make by being part of the NSW project. Thanks to a protected caseload I had a chance to attend a meeting I would probably never attend (Community Mental Health Team meeting).

I could meet with Gayle whenever I needed to and did not have to rush through the meeting, I could support the care staff making sure that they are well aware of Gayle's needs and we are consistent in the way we support her.

Being on the NSW project gave me the confidence that I can make autonomous decisions, take risks to try new ways of support without worrying that I will be criticized for unreasonable practice. I was able to make all decisions according to the individual's best interest and within the legislation.

Named Social Worker, Hertfordshire

1.3 Nurturing great social work practice: building skills and confidence

All the team leaders and managers involved in the programme put a great deal of thought and effort into nurturing the skills, confidence and wellbeing of their teams, so workforce development was probably the most consistently strong area of work across programme sites.

As a result of the pilot, Sheffield developed a practice framework for their Future Options team, Bradford created a Statement of knowledge and skills for named social workers supporting adults with learning disabilities and a Framework for Reflective Supervision and Liverpool are developing a new Workforce Development Strategy. All these can be found in the Site Profiles and Resources publication.

According to both managers and social workers, the most helpful things in building confidence and improving practice have been:

- **Peer learning sessions** - Named social workers said that regular reflection and information sharing with their team made them feel like they had a 'shared brain'. They also talked about the strength in team diversity, particularly in NSW teams that included or were co-located with colleagues from health, children's services, transforming care and commissioning;

- **Reflective supervision** - Sites put an explicit emphasis on reflection over transaction in supervision sessions and developed or adopted tools to support this. Reflective supervision happened one to one and in groups, with managers and with peers. These spaces were used to develop and stretch individual practice, and enable 'good social work' to be applied for the cohort.

- **More active involvement in multi-disciplinary meetings** - Named social workers attended MDT meetings more regularly and played a more active role in decisions being made. They found these meetings very helpful, both to advocate on behalf of the people they are supporting from a social work perspective and to start learning about people they would soon work with;

- **Managerial support and involvement** - The direct involvement of managers and heads of service in the pilots has given social workers a clear sense of support and 'permission' to work in different ways and it has provided the management team with direct insight into opportunities and enablers from the practitioners' perspective;

- **Training** - Named social workers benefited from training focused on, for example: legislation, creative tools for communication and how to work with individuals whose diagnosis includes a forensic background. Managers were resourceful in creating opportunities for named social workers to join training sessions run by other services, for example Transforming Care teams. In some sites, colleagues from other services joined peer group sessions to share their knowledge and perspective and to learn more about the practice approach taken within the pilots. Bradford have collaborated with Lancaster University to offer their social work teams opportunities to engage with human rights theory from an academic perspective, complementing practice based learning, and they are planning to use this to develop a Continuing Professional Development programme;

- **Advanced practitioner advisory roles** - Bradford established a Mental Capacity Act team of senior practitioners, who are driving a wide and ambitious programme of culture and system change. As part of their role, they are providing support and guidance to social workers around mental health legislation and asset-based practice. They work as Best Interest Assessors, support social workers on request, hold clinics and manage an advice inbox open to all social workers in Bradford. Liverpool's named social workers worked across neighbourhood teams and provided advice and support to a wide range of colleagues on specific cases.

Overall, the impact of the programme on social workers has been overwhelmingly positive, with people consistently reporting higher levels of knowledge and confidence, feeling more satisfied with their work and feeding back that the NSW label brought greater visibility, authority and respect to their role as a social workers. All of which contributes to the aspirations and needs of those supported by the social workers being brought to the fore.

We have been working very closely together as a team. To us, it feels like we have a 'shared brain'.

Team manager, Halton

You can't do it without the backing of your team. You need to be able to have discussions to ensure you're doing the right thing - share the anxiety and get different viewpoints. You need peer support and access to people who are working in other areas if you need it - psychology or psychiatry for example.

Named Social Worker, Hertfordshire

The monthly peer group has provided a safe place to talk through cases and tap into the skills and knowledge of the Transforming Care team, including aspects of relevant legislation.

Hertfordshire Evaluation report

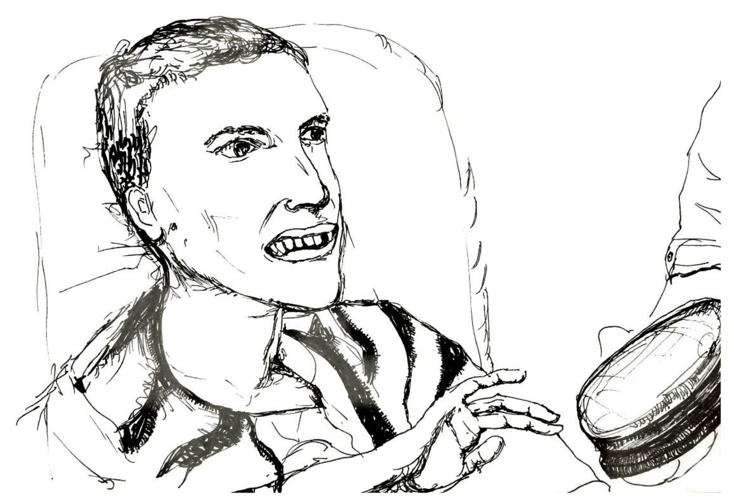
Our manager has made it easier. She is probably coming across more barriers than us, and she has discussions with higher up managers. She shoulders some of these challenges so from our perspectives as social workers it's not too bad.

Named Social Worker, Halton

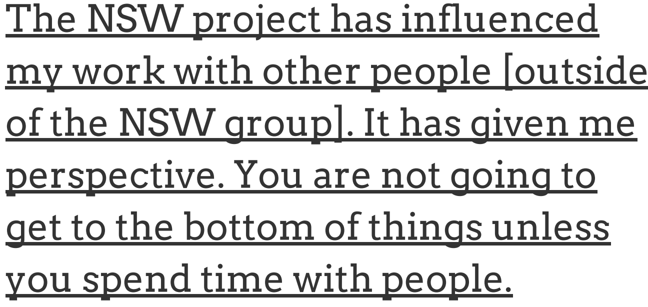
As a manager, the quality of the conversation [with social workers] was so different. Because I wasn't necessarily line managing them, I was exploring with them what they were doing, how they were feeling. In supervision there is a clear power dynamic going on: the manager is there to answer questions, offer advice. But there is also real value in paying close attention to the perspective of the social worker, finding answers together. It blows your mind to see the skills that the social workers are using, how creative people are.

Team manager, Hertfordshire

Something that I'm learning to do is listening, really listening. And also to what people aren't saying. This is about parents too because they have dealt with professionals for a long time and there is a tension between our job within a legal framework, and the parent knowing their children best. So listening is really important to navigate this.



Named Social Worker, Shropshire



The NSW project has influenced my work with other people [outside of the NSW group]. It has given me perspective. You are not going to get to the bottom of things unless you spend time with people.

Named Social Worker, Hertfordshire

1.4 Key elements of practice for person-centred interactions

Lots of excellent guidance, inspiring examples and helpful principles exist about how to work in a person-centred way. Some of this is explored in the guide to meaningful engagement developed as part of the programme- 'Big Plans'. In this section we are focusing on elements of practice which have emerged as significant through the NSW programme.

These are:

- Continuity of relationships: 'open door' instead of 'case closed'
- Creative approaches to help build relationships and co-produce plans
- Putting the relational over the transactional
- Supporting appropriate risk taking

Continuity of relationships: 'open door' instead of 'case closed'

From the perspective of people who use services, a lot of confusion, distress and sometimes poor decisions can occur when social workers and other professionals do not know them well or understand them; they want to know who to call when they need help (and to get a prompt answer) and they don't want to retell their story many times to different people. From the service perspective, delivering on these expectations can be superseded by a pressure to close cases.

NSW pilots have taken different approaches to securing continuity of relationships. Halton are experimenting with keeping cases open and **distinguishing between active and non-active cases** within caseloads. Sheffield and Liverpool invest in completing comprehensive handovers when people are transferred from the specialist team to a locality team, thus assisting in the transfer of care.

In Halton, **all team members are up to speed with different cases**, so that, if a social worker is unavailable, their colleagues can help the people she is supporting as well as she would. Halton and Liverpool are also exploring how they can **work with practitioners in different roles** (for example community connectors) to offer helpful relationships at a lower level of intensity for people who do not require regular contact but will benefit from a constant support presence.

We asked families what they wanted from social workers. It was consistent that they wanted to see social workers more often, having a consistent person that knows them.

Named Social Worker, Sheffield

When we talked to service users, they said they wanted someone on the phone who knows them and knows where they're at. They get frustrated about repeating themselves, getting conflicting information, or talking to someone who doesn't understand what they need.

Named Social Worker, Bradford

Continuity is really important in named social work. On my caseload there are people who have been detained under the Mental Health Act for years and years and have now come out of hospital and out in the community under the transforming care agenda. Working with them is really important to make sure they don't end up back in hospital.

Named Social Worker, Hertfordshire

If you don't know someone, the amount of time you spend solving the small issues is really big, but if you know them, you already have a good starting point and it means you can do things quicker and better for them when there is a problem.

Named Social Worker, Sheffield

My son feels it's better he's got a named social worker as he finds it better to work with social services if the social worker stays the same.

Mum, Halton

Creative approaches to help relationships and co-produce person-centred plans with people who use services

Recognising that the fundamental starting point for delivering person-centred care is how we engage with people who use services and their carers, one of the key foci for the NSW programme has been supporting the use of creative approaches that enable more meaningful engagement with people, including those who have different communication needs and preferences.

Liverpool and Sheffield used **pen pictures** to prompt conversations with people about their lives, preferences and ambitions.

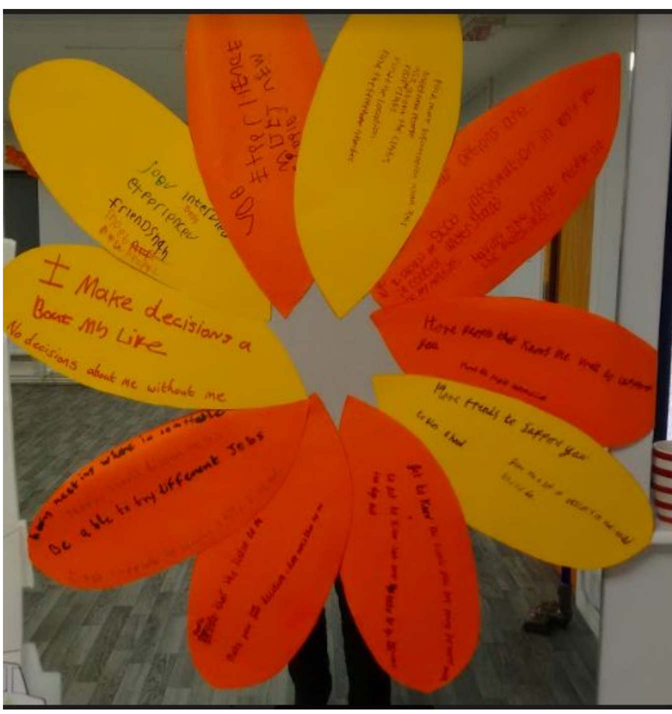
Even if you've got more time, if you don't scratch beneath the surface, then you won't be able to help that person and especially not in the long run. Even if they're not engaging, you can be more creative. For example, there have been a couple of times when I've thought 'well they're part of the NSW group, so what else can we do?' We need to be supporting them and trying something else.

Named social worker, Hertfordshire

What and who is important to me?	My One Page Profile VM	I like my support to...
My family - mum (K), Dad (V), sister (K) and 2yr old nephew (J). I like animals That people listen to me and support me properly. I want to live in my own flat in Sheffield and be like my sister. I want to have a job I am vegetarian		To listen to me, and support me properly. They need to understand why I struggle because of my autism and OCD. I like people who are nice and want to watch films with me. I don't like it when people talk about me not to me.

I like...	I do not like...	People who know me well say I am...	Other important info:
Animals, any Art and activities Shopping at Meadowhall Visiting places, such as the butterfly farm. Films, and going to the cinema especially horror films. Painting my nails	People talking about me Rude people Bad manners.	I am very funny, and have great sense of humour	

Halton worked closely with young people in the Bright Sparks self-advocacy group to run a series of **co-design workshops** focused on young people's aspirations as they grow up.



The young people in the Bright Sparks group told us that they felt they talked and talked all the time about what transition is like for them and that we haven't really listened in a way that has made a difference. So they decided to make a film about what transition means to them.

Team Manager, Halton

Bradford worked with the local **self advocacy group**, Bradford Talking Media, to create training materials for social workers.

It's not about us and what we think, or our professional opinion. Bradford Talking Media have been teaching us through videos, and from their point of view. We can think we're following legislation but if they don't understand or feel listened to, and are not living the life they want, then we haven't succeeded. Working with self advocacy groups is really useful. It stops the 'I am a professional, so I know what to do' attitude.

Named social worker, Bradford

Shropshire used **creative and visual communication techniques** to engage young people in conversations about their aspirations for the future in order to create their transition plans. Humanly, one of the delivery partners in the Named Social Worker programme, worked in partnership with Shropshire to create '[Big Plans](#)', a guide for meaningfully engaging people with learning disabilities in the development of their plans.

Putting the relational over the transactional

For all sites, the NSW pilot either contributed to new, or complemented existing, person-centred approaches to assessment. Practice varied slightly from place to place, but there was significant convergence around **changing the nature of interactions** with people. Moving away from being driven by checklists, processes and thresholds towards starting consistently with what is important to people; building resilience and independence by connecting people with networks of support in the community and outside of statutory services wherever possible; intervening only when necessary, and following a plan that is created by the individual and social worker together.

These approaches to assessment usually create better opportunities for the worker to use their **judgement and initiative**, and can offer a small **flexible budget** to be used at the social worker's discretion to make things happen quickly where a little help can stop the need for more intensive interventions.

Can we look at doing that assessment in a different way? How can we make it a conversation and less of an assessment, and get more useful information for us as well, and properly listen.

Named Social Worker, Shropshire

We ran the Named Social Worker pilot in parallel to a pilot to implement the Conversations Count model across our service. We found that the two approaches complement each other really well.

Service Manager, Sheffield

In 'business as usual' it is common for a young person to only meet their social worker in one environment, leading to an over reliance on communication about the young person from family and other professionals.

Shropshire Evaluation Report

Supporting appropriate risk taking

Prevalent attitudes to risk can get in the way of social workers' efforts to support people in ways that are consistent with the person-centred and human rights-led principles that underpin the NSW approach. Social workers in the programme reported that the managerial support and permission that have come with the NSW 'label' have given them confidence to explore options that they would not have otherwise tried - and which turned out to be successful.

Bradford are creating an internal process designed to officially hold a space for supported risk taking by social workers. It is called the **Risk Enablement Panel** and was adopted from Calderdale, where members of the team who were part of phase 1 had implemented it before. The panel can be convened by social workers who want to discuss support options considered to be more risky. People who use services and their family members can attend it too. It is run by the Mental Capacity Act Team - the specialist team driving Bradford's social work culture and practice change initiative and taking part in the NSW programme - and supported by senior managers. Through these meetings the group takes shared responsibility with social workers for decisions made. The idea is that, once the panel is up and running, social workers can use it not just to make decisions in times of crisis, but also for forward planning.

The Risk Enablement Panel is a different way of exploring case work from the perspective of: "Why can't we try this?"

Mental Capacity Act Team Lead, Bradford

1.5 Better interagency working

Cross service collaboration is key to delivering person-centred care in the most efficient and effective way possible. At its best, interagency working should occur at all levels:

- Collaboration between frontline professionals
- Collocation and integration of teams and services
- Interagency management fora and integrated budgets

Collaboration between frontline professionals - Named social workers in the programme attended MDT meetings on a more regular basis than in 'business as usual'. Partner agencies in Hertfordshire noted that service coordination was significantly improved thanks to the role that the social worker played. Social workers, in turn, felt like equal partners in the MDT and were able to challenge colleagues as they had not done before.

Members of the Transforming Care team in Hertfordshire and Sheffield attended NSW peer sessions and offered training, part of this was to identify training needs and action appropriately.

The Shropshire Transitions team worked closely with a local special school to engage with young people preparing for adulthood and their families.

The Halton Transitions team have been developing their connections with local agencies and community organisations, as collaboration with them is key to their service strategy. As part of their outreach efforts, they organised a Transitions event in November, which included a young person sharing his experience of transition supported by the named social worker, and a number of different agencies showcasing their offers to families and carers.

Colocation and integration of teams and services - Social workers and a nurse work together in the Halton Transitions team which (alongside budget integration) has had a big impact on collaboration, where before relationships were often tense and resource focused. Social workers are co-located with health professionals in Liverpool's neighbourhood teams, delivering place based integrated services in the community, in collaboration with primary care and voluntary sector organisations.

Since I moved to this team I've found out so many different services and agencies - you learn this through families and from each other. That's a key skill in this kind of social work.

Named social worker, Halton

Interagency management fora and integrated budgets - Thanks to integrated health and care budgets, cross-agency collaboration in Halton is strong. The Transitions team manager chairs three-monthly meetings of the Transitions Operations Managers Group, which discusses priority cases and operational issues. The team includes: the lead nurse for children with complex needs, the manager of the adult learning disability health service, the manager of the learning disabilities nursing team based within social care, head teachers from three special schools, CAMHS and adult mental health, the positive behaviour team, SEND and transport.

The management team involved in Sheffield's pilot includes managers, practice leads and team leaders from social services and community and secondary services. Liverpool are also developing a Provider Alliance, linking agencies together into governance and contractual agreements that will bring service integration to a new level.

The reason it's working is that there is signup from all agencies. Particularly health and education. We all want this to work. We can say hard stuff to them. They trust us.

Team manager, Halton

The pilot improved relationships in the transforming care MDT. In the past social workers would have attended an MDT meeting when they needed to discuss a particular issue. The NSW pilot afforded the social workers time to attend each MDT meeting. As a result, the social worker had a better understanding of the individual and felt an 'equal partner' in offering their perspective to health colleagues.

Team Manager, Sheffield

A named social worker worked with someone who had an obsessive-compulsive disorder (OCD) diagnosis. She felt this was wrong and requested a reassessment. The service user was then diagnosed with Pathological Demand Avoidance not OCD which means that their future placement will be better able to tailor support, increasing stability and avoiding crisis.

Sheffield Evaluation report

1.6 Beyond social work teams: changing culture and changing the system

Learning from the programme points to some crucial systemic connections which create the pre-conditions for 'good social work' for the cohorts supported as part of the pilot. Namely, the importance of:

- Closing the loop with **commissioning**;
- Working with providers to **create a marketplace of appropriate support options**;
- Upholding the **importance of the social work perspective** within increasingly integrated and place-based health and care services;
- **Tapping into all local resources** for more effective prevention;
- And driving **culture change** across social work teams and beyond, into the wider system.

Most NSW teams have been **working closely with commissioning teams**, feeding back learning about need, highlighting gaps in provision, creating better forward visibility over the pipeline of demand and, in Bradford, supporting retendering of key contracts and strategic reviews of provision. This also involves working more and better with **personal budgets** to enable people to choose their support for themselves.

Bradford and Halton NSW teams are engaging with providers to **stimulate a market of provision** that offers more flexible and customisable solutions, better choice and greater opportunities to build independence. This involves, for example, offering input from experienced named social workers into new residential plans and supporting the creation of small and locally based social enterprises, some of which are run by people with disabilities.

Liverpool are using the learning from the NSW pilot to **design social worker roles** in new neighbourhood teams delivering **integrated place-based health and care services**. They are tailoring the team skill mix to neighbourhood demographics. They are committed to allocating a named social worker to anyone who is in receipt of a package of care. They are also working closely with health and voluntary sector colleagues to improve the quality of prevention and creating Advanced Children Practitioner roles based in neighbourhood teams and available to provide specialist support to social workers across areas.

To ensure the sustainability of the NSW way of working, Halton and Shropshire have invested in developing connections with the wider local offer, **collaborating more closely with VCS organisations** to work with young people outside of formal support networks. The aim is to offer continuity of support for people when their intensity of need reduces, and to be able to provide **preventative support** that will reduce crisis escalations.

As well as examples of sites explicitly continuing to test and deliver their NSW model, all pilot sites are committed to transferring learning and features from the NSW pilots to wider social work teams - and beyond as part of ongoing **culture change initiatives**. For Bradford, this is part of a significant programme of change in adult social work culture and practice, which has wide strategic ramifications. Halton are hoping to ‘cascade’ the approach across other support organisations. Liverpool are embedding key NSW principles into their new integrated models of provision. Shropshire will use the learning from the project to inform the design of a permanent Transitions team. Hertfordshire and Sheffield want the learning from the programme to influence mainstream practice in the wider locality teams, in alignment with other initiatives around asset-based interactions.

We know we have 294 young people coming through our door over the next couple of years. We cannot offer this approach to everyone. We can sustain this approach for people who need it - and offer some short term support to others at a lower level of need to prevent escalation of need later. We need to work cleverly with local resources. For example, people with lower level needs could have a community connector.

Team manager, Halton

The idea is that Bradford’s Mental Capacity Act team [who were leading their NSW pilot]will eventually make themselves out of a job and that, in time, as a result of our work, people will not need social workers as much in their lives.

Mental Capacity Act Team Lead, Bradford

We are embedding learning from the pilot in the implementation of our neighbourhood model of support - it is not just about a named social worker but also about transferring the principles to the rest of the system. [...] We aim to have an all-age commissioning strategy, associated with public health and covering the preventative angle, excluded groups and complex needs.

Assistant Director, Liverpool

Part of the remit of the Mental Capacity Act team in Bradford is to shift commissioning and procurement across the board. We were involved in events with providers organised by NHS England, which explored how we can move away from traditional models of support towards more flexible options, including separate provision of accommodation and support and helping people to buy their own homes. We have also been involved in commissioning reviews across the Yorkshire region.

Mental Capacity Act Team Lead, Bradford

02

MEASURING THE DIFFERENCE WE MAKE

2.0 Measuring the difference we make

The approaches tested by the sites, although different, all share a rationale of upfront investment of time to support reflective practice and quality interactions, with a view to reducing the overall cost of interventions through more tailored and preventative work.

Operating as we do within significant resource constraints, it is now more imperative than ever to support the case for different ways of working with clear data and solid evidence. Although it is still early days to see the full impact of this different way of working, sites are already recording case studies of people who were supported by a named social worker whose packages of care have reduced in cost, while at the same time delivering good outcomes.

The Social Care Institute of Excellence (SCIE) supported NSW sites to develop a Theory of Change underpinning their approach and to make a plan for tracking progress against their intended outcomes during the life of the programme and beyond. Working with York Consulting, the programme also developed a guide to calculating return on investment.

More detail on the programme level evaluation can be found in the Summary Evaluation Report or full suite of evaluation publications. In this section we share some of the tools and learning from the evaluation approach taken.

The theory of change and enquiry framework for the programme

The Named Social Worker programme took a theory of change approach to evaluation.

A theory of change approach has a strong focus on outcomes and impact, and can be a helpful planning tool for new initiatives. It can also be used to bring a wider group of stakeholders into the process. As a methodology, it was originally developed to evaluate complex, community-based interventions and is well suited to explore the effects of emergent and wide-ranging interventions through an overarching narrative.

Along with the programme team, pilot sites codesigned a set of high level impact areas that would guide the design, delivery and evaluation of the pilots. These impact areas were broad enough to apply to all pilot sites, whilst allowing sites to develop their own theory of change that reflected their local goals, contexts and interpretation of the Named Social Worker approach.

These impact areas are:

1. **People with learning disabilities and the people around them live a good life** enabled by the right kind of support;
2. **Social workers are equipped** to deliver high quality, responsive, person-centred and asset-based care;
3. A more **effective and integrated system** that brings together health, care and community support and delivers efficiency savings.

These three impact areas lent themselves to a series of ten programme evaluation questions that framed the data collected. These were:

1. How has the pilot facilitated consistent and trusting relationships between the named social worker, people and their families and carers?
2. How has the pilot given people the opportunity to tell their stories - and have choice and control - when shaping their own person-centred care and support plans?
3. In what ways has the pilot supported people and their families and carers to live the lives they want?
4. What are the knowledge, skills and values of a named social worker?
5. How have named social workers been supported to exercise their skills and judgement through the pilot?
6. To what extent have named social workers been motivated to work differently and how satisfied are they that they are able to do so?
7. Is there any evidence that named social workers have been able to constructively challenge and or collaborate with their partners?
8. In what ways has partnership working improved outcomes for people and their families over the course of the pilot?
9. What is the economic impact of the pilot?
10. To what extent has the NSW pilot influenced practice across the wider system and what are the barriers/ enablers to person-centred practice?

Useful measures

In order to answer these evaluation questions, sites were supported to take a mixed methods approach to evaluation. They were able to collect a wealth of evidence about the process they had undertaken and the impact they had on people who use services and their families and carers, the named social workers and the wider system.

To track the impact of the NSW approach on **people who use services** and the people around them, sites collected evidence including:

- Individual case studies
- Social workers' reflective logs
- Reviews of case files
- Interviews with people who use services (See 'Big plans - a guide to meaningfully engaging people with learning disabilities' for a set of helpful tools for evaluating people's experiences)

To track the impact that the NSW approach had on **individual and team social work practice** sites collected evidence including:

- The number and nature of group practice and supervision
- Social worker reflective logs
- 'Before and after' survey of social workers experience and reflective logs

To track the impact on the **wider system,** sites collected evidence including:

- Feedback from partner agencies
- Assessment of costs and benefits accruing outside of social services budgets

A guide to cost benefit analysis

As part of the economic evaluation, York Consulting developed a '10 steps to creating your own Cost Benefit Analysis' guide that can be used by authorities outside the programme to carry out their own similar analysis.

The approach taken recognises that often financial impacts are longer term and therefore provides a framework for a predictive analysis that can be validated with real data when it becomes available over time. This approach takes into account feasible outcomes, expectations and early progress.

The guide outlines how to:

- Map potential benefits and identify those that will have a cost benefit (including to people who use services and their families and carers, social workers, the local authority, health services, criminal justice);
- Access average unit costs of, for example, hospital admissions or criminal justice services using the PSSRU database;
- Take a 'top-down approach' to understand your delivery and unit cost of supporting an individual through the programme, based on the total cost of the programme and number of people supported;
- Develop cost benefit profiles at an individual case level;
- Calculate an estimated FROI.

03

THE WAY FORWARD

We would like to conclude this collection of lessons and reflections on what makes 'good social work' possible by offering some provocations around the key question: **given that we have been clear for a long time about what the outcomes and principles of support for people with learning disabilities should look like, why is it that we are still so far from achieving them?**

Sites that are seriously addressing this question grapple with a series of tensions:

1. 'More and better social work' vs 'No social work at all'

Often, when we talk about improving social work, we are looking for ways to deliver more and better services. The NSW team in Bradford argue that at least part of the question to explore should be: *How do social workers do themselves out of a job?* In their view, if social work practice was to systematically be driven by the commitment to maximise independence and minimise interventions, social workers (and professionals) should feature *less* rather than *more* in private elements of an individual's life.

2. 'Managing risk' vs 'Building Independence'

One thing is to talk about co-production with people who use services. Another is to do it in practice. NSW sites have highlighted how the practice of co-production may involve supporting people to enact what social workers may consider to be 'unwise decisions'. Of course, proportionality and sensibility are key in determining safe practice and fora for sharing ideas and accountability with peers and managers have helped to make decisions about risk with greater confidence.

One of the key challenges that NSWs across sites have posed to themselves and colleagues has been: *Why couldn't we do that?*

3. 'Living the life I want' vs 'At the taxpayer's expense'

This tension has to do with the meaning of 'choice and control' in practice. Over the course of the programme we have heard about work currently being done in West Sussex, where they have set up an Intensive Planning Team to reduce the numbers of young people being placed in out of area 38 and 52 week education provision. The team are using a radical approach, supported by senior managers, to 'do what it takes' to keep young people supported in education locally and with a good family life. Here, using budgets to pay for a vacation, for play equipment in a family's garden, or to lay a floor in a family's home has resulted not only in significantly better outcomes and experiences for families and carers, but also in net savings. Especially in the current financial climate, the media and public opinion can easily portray these choices as unwonted luxuries on the taxpayer's tab. The experience of West Sussex, however, prompts a more interesting way of looking at this issue by asking: *If the cost is the same, is it fairer to deploy public money on restrictive options that keep people 'surviving' or to purchase solutions that allow people to live the way they want?* Of course, a significant part of the answer also lies in creating more diverse and flexible markets of provision, as Bradford, Halton and Liverpool are doing.

4. 'Gatekeeping' vs 'Open Door'
Financial constraints and high demand mean that services need to spend resource turning away people who don't meet thresholds for support. At the same time, we know that often too much money is spent on packages of care that are neither efficient nor effective. Practitioners in the NSW programme tell us that they feel services are reaching people too late and that being more proactive would save not only distress but also significant amounts of money. By adopting more asset-based approaches, most NSW sites are shifting the core assessment questions towards: *Who or what can best help you lead the life you want and how?* And finding that the answer can often be connections with informal networks of support.

5. 'Process driven' vs 'Humanity Unleashed'
Finally, and most crucially, there is the question of finding the right balance between processes that ensure accountability and proportionate use of resources and conditions that enable the best of social workers' judgement, creativity and humanity to come into play in their interactions with the people they support. Learning from the programme suggests that protecting time for peer learning and reflection goes a long way to grow individual confidence and raise quality of practice. Encouraging appropriate risk taking by offering managerial backing and spaces to share ideas and feedback between peers also leads to more truly person-centred support solutions.

One of the key aims of the Named Social Worker programme has been to create the conditions so that the driving question determining social worker practice may more systematically be: *What do your knowledge and judgement suggest that you do?*

Programme learning suggests that the space for great social work can be found in the balance between these tensions, among others. In our experience, this holds true across other services as well.

Read the Site Profiles and Resources, Planning Guide for People with Learning Disabilities, Service User Story and Evaluation Reports for more useful tools and information.

With thanks to the Named Social Worker teams across the sites and to the social workers and individuals who have shared their stories and experiences with us.

This guide was developed by Innovation Unit in partnership with the Social Care Institute for Excellence.

Innovation Unit is a not for profit social enterprise. We grow new solutions to complex social challenges and are committed to taking solutions that work to scale.

The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works.

PUTTING PEOPLE AT THE HEART OF SOCIAL WORK

Lessons from the Named Social Worker Programme

APPENDIX 4

Getting your feedback – Named Social Worker Project

Your social care worker will fill out this section:

Service User Name:____CareFirst6 No.:________________________

Your named social worker:____

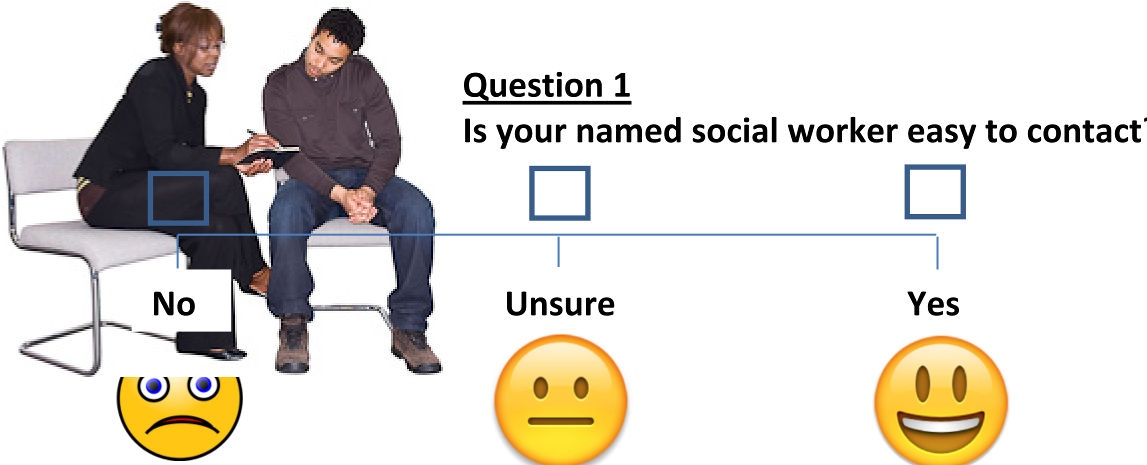
Your named social worker has been supporting you through your transition process.

In the past this process might have involved you working with a few different social workers – depending on who was available when you contacted us.

We would like to find out if having a particular, named social worker is helpful.

We would like you to ask you a few questions

Please tick one box to answer each question ☑



Question 1

Is your named social worker easy to contact?

☐ **No** ☐ **Unsure** ☐ **Yes**

Question 2

Do you understand the information given to you by your named social worker?

No information

Some information

All information

Question 3

Do you feel listened to by your named social worker?

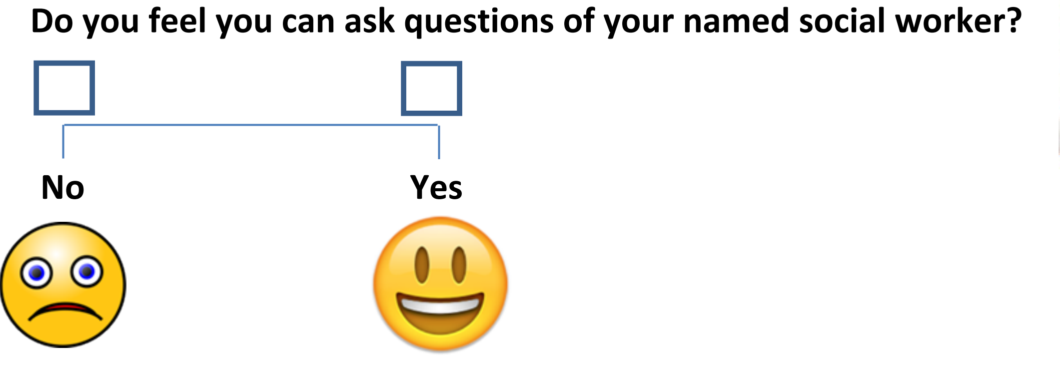
No

Unsure

Yes

Question 4

Do you feel you can ask questions of your named social worker?

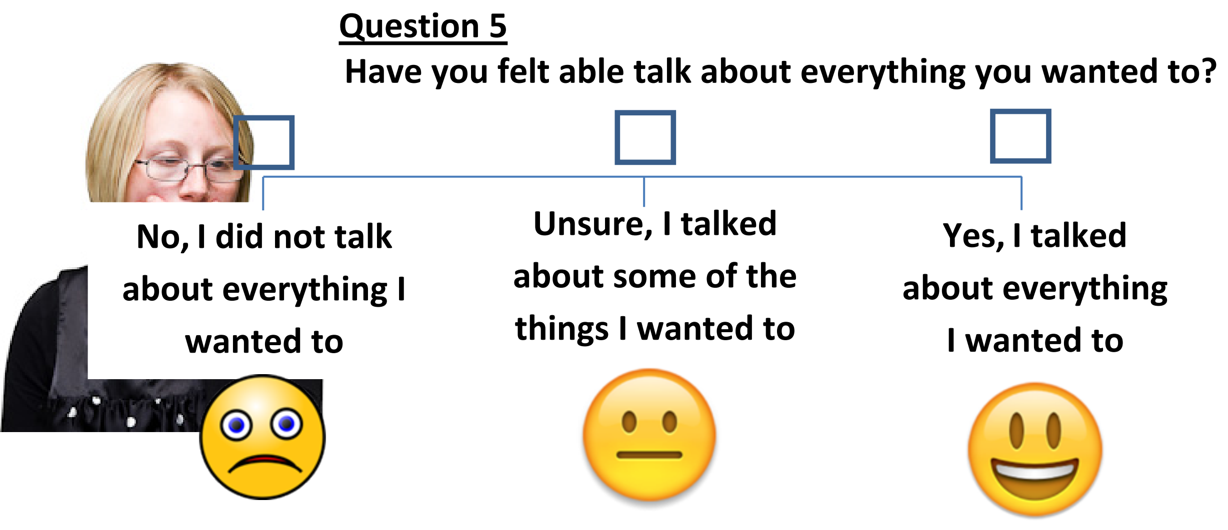


No

Yes

Question 5

Have you felt able talk about everything you wanted to?



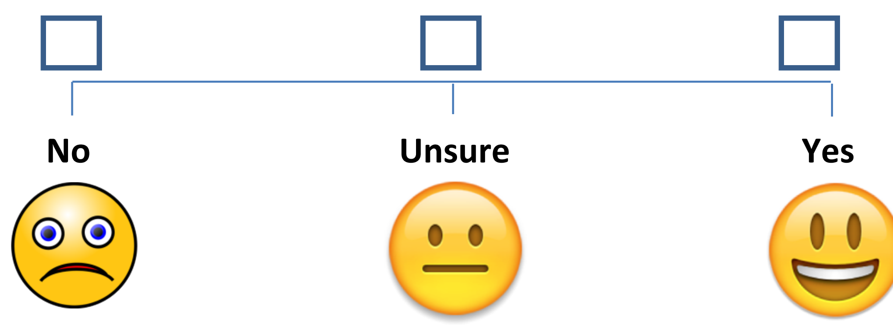
No, I did not talk about everything I wanted to

Unsure, I talked about some of the things I wanted to

Yes, I talked about everything I wanted to

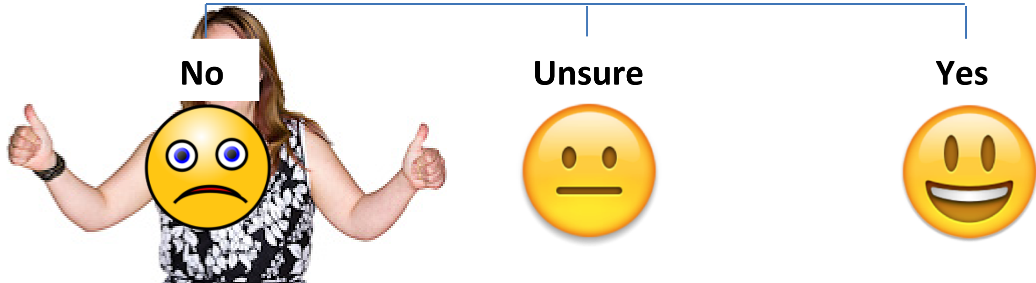
Question 6

Do you feel that having a named social worker gives you more control over your transition process?



Question 7

Has your social worker done what they said they were going to?



Question 8

Is there anything else you want to say about having a named social worker?

Please write you answer in this box, you can ask for help to write your comments:

Thank you. Your completed questionnaire can be returned to: Transition Team, Halton Borough Council, Ground Floor, Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD.

If you would like to give more detailed feedback, in the form of a compliment or complaint, please contact the Adult Social Services Customer Care Team Tel: 0151 511 6941 Email: ssd.complaints@halton.gov.uk

For information about data protection please go to www.halton.gov.uk/privacy