Halton Borough Council
Communities Directorate

Making a difference:

A strategy for transforming Care Management in Halton

2015 to 2020

Evidence Paper

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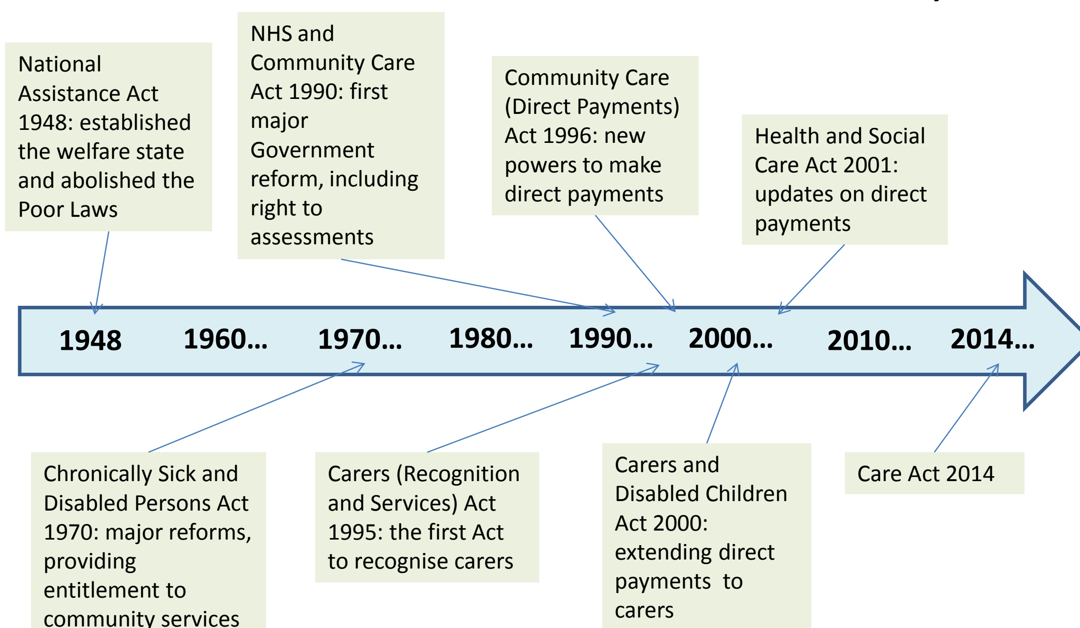
Part 1: National Policy Context

The Care Act 2014 represents the biggest change in Adult Social Care in over 60 years and consolidates numerous previous laws. The Act is reforming legislation and promotes a change in culture and practice through new duties for local authorities and partners and new rights for users and carers.

A brief history of care and support law

Around 30 Acts of Parliament over more than 60 years:



The following is a brief summary of the Care Act in relation to the Care Management Strategy. Building on the white paper Caring for Our Future (DH, July 2012) care and support reforms within the Act come into effect from April 2015. Adult Social Care in Halton and our partners now have a wider focus on the whole population in need of care, rather than just those with eligible needs or who are funded by the state.

The "wellbeing principle" which enshrines people's needs and desired outcomes is now at the heart of the care and support system accompanied by a shift in the local authority's legal duty to the concept of 'meeting needs' recognising that everyone's needs are different and personal to them rather than a one size fits all approach. Further, the Care Act gives carers enforceable rights to their own assessment.

Definition of Wellbeing

Statutory guidance defines wellbeing as relating to the following nine areas:

i. Personal dignity (including treating of the individual with respect)
ii. Physical and mental health and emotional wellbeing
iii. Protection from abuse and neglect
iv. Control by the individual over day-to-day life (including over care and support provided and the way it is provided)
v. Participation in work, education, training or recreation
vi. Social and economic wellbeing
vii. Domestic, family and personal relationships
viii. Suitability of living accommodation
ix. The individual's contribution to society

Through the introduction and further development of personal care budgets and direct payments, users can now look forward to enhanced choice, more involvement, and more say over their particular assessed care needs. The Act includes a statutory requirement for local authorities to collaborate, cooperate and integrate with other public authorities e.g. health and housing.

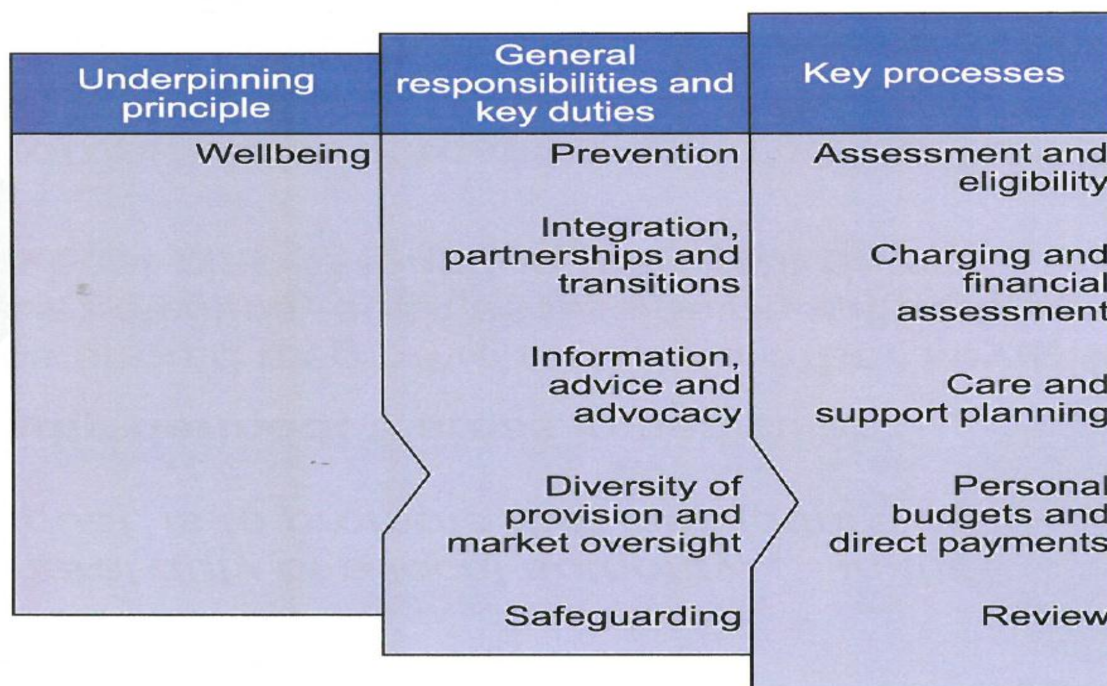
Emphasis is now on **Prevent, Reduce, Delay** the need for formal care and there must be a system in place through the Council or independent sector to provide information and advice on care and support and independent financial advice to all when they need it. Access to independent advocacy to support decision making is also a requirement.

The Act gives the local authority the lead role in co-ordinating local safeguarding activity and for protecting adults with care and support needs from abuse or neglect. This will ensure clear accountability, roles and responsibilities for helping and protecting adults with care and support needs who are experiencing, or at risk of, abuse or neglect as a result of those needs.
If the local authority has a duty to meet a person's needs, it must help them decide how their needs are met through the preparation of a care and support plan or support plan for carers.

A personal budget will from part of the care and support plan or support plan. Where a person, including carers, has a personal budget, they can have a direct payment. Those with eligible needs who are not supported by the authority (e.g. self-funders) will still have an independent personal budget (IPB) to record the notional cost of meeting their eligible needs. Fair Access to Care (FACS) will be replaced by a national eligibility threshold.

Implementation of the Care Act in April 2015 will have significant implications for the way the Council does business and the roles of the adult social care workforce. There will be changes to the way that people access the care and support system and increased demand for assessments and support plans.

The Framework of the Act and its statutory guidance



Mental Capacity Act

The Mental Capacity Act (MCA 2005) created a framework to provide protection for people who cannot make decisions for themselves. The Act contains provision for assessing whether people have the mental capacity to make decisions, and procedures for making decisions on behalf of those people who lack mental capacity, as well as measures to ensure that vulnerable people are safeguarded. It applies to anyone whose mental capacity to make decisions is affected by what the MCA refers to as "an impairment of, or a disturbance in the functioning of, the mind or brain" which may be long or short term. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. The MCA is supported by a Code of Practice and has been further enhanced through the Mental Health Act 2007 to include the duty of access to Independent Mental Health Advocates and Deprivation of Liberty Standards. (DOLS)

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 and aim to make sure that people in care homes and hospitals are cared for in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home or hospital only deprives someone of their

liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

A recent Supreme Court ruling[1] has clarified that there is now a revised test for a deprivation of liberty. This ruling has significant implications for social care practice which are considered further in Part 4 Assessment and Reviews.

Transforming Care: A national response to Winterbourne View Hospital

In December 2012, following its investigation of the failings, the Government published its full response to the criminal abuse uncovered at Winterbourne Hospital and practices observed in other settings. The review exposed concerns regarded as:

i. Inappropriate placements
ii. Inappropriate care models
iii. Poor care standards

A programme of action ensued with stretching timescales across the whole health and social care system to improve care for people with challenging behaviour. The report sets out a revised model based on the work of Mansell[2] along with roles and responsibilities across the health and social care system including regulatory bodies.

National policy has stressed the importance of personalisation and prevention which are now embedded in the Care Act 2014. The findings from Winterbourne support this approach as well as stressing the importance of ensuring that services are available locally that can deliver a high level of support and care to people with complex needs or challenging behaviour.

Francis Inquiry

The Francis Inquiry report was published in February 2013. It examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report makes 290 recommendations, including:

- openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers
- improved support for compassionate caring and committed care and stronger senior leadership across the health and social care sector

[1] Supreme Court ruling P v Cheshire West and Chester and P and Q v Surrey Council

[2] Services for people with learning disabilities and challenging behaviour or mental health needs and challenging behaviour: 'The 'Mansell Report' (revised edition DH, 2007)

Many of the messages are relevant in social care settings. In particular, people who are vulnerable (such as those dependent on care in hospital wards, residential or domiciliary settings) should be treated with dignity and compassion whilst they, their families and staff should be encouraged to raise any concerns they may have.

Information: To Share or not to Share

This document published in September 2013 is the Government Response to the Caldicott Review and accepts all 26 recommendations to improve governance practices for sharing information across health and social care.

People using health and social care services are entitled to expect that their personal information will remain confidential. They must feel able to discuss sensitive matters with a doctor, nurse or social worker without fear that the information may be improperly disclosed. These services cannot work effectively without trust and trust depends on confidentiality. However, people also expect professionals to share information with other members of the care team, who need to co-operate to provide a seamless, integrated service. So good sharing of information, when sharing is appropriate, is as important as maintaining confidentiality. All organisations providing health or social care services must succeed in both respects if they are not to fail the people that they exist to serve.

The term used to describe how organisations and individuals manage the way information is handled within the health and social care system in England is 'information governance'. In 1997 the *Review of the Uses of Patient-Identifiable Information*, chaired by Dame Fiona Caldicott, devised six general principles of information governance that could be used by all NHS organisations with access to patient information giving priority to discouraging the uploading of personal information on to information technology systems outside clinical control. The issue of whether professionals shared information effectively and safely was not regarded as a problem at the time.

NHS organisations responded by appointing 'Caldicott Guardians' to ensure that information governance was effective. The practice spread to other public bodies, including local authorities and social care services, and the remit of the guardians was extended to provide oversight of information sharing among clinicians.

Over recent years, there has been a growing perception that information governance was being cited as an impediment to sharing information, even when sharing would have been in the patient's best interests. In January 2012 the *NHS Future Forum* work stream on information identified this as an issue and recommended a review *"to ensure that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care".* The Government accepted this recommendation and asked Dame Fiona to lead the work, which became known as the Caldicott2 review.

The Health and Social Care Information Centre (HSCIC) has published guidance providing simple rules that complement the revised Caldicott principles to help everyone working in health and care to follow good information governance practice in their daily work. A further document, the Confidentiality Code of Practice also to be published by the HSCIC is awaited.

Integrated Care and Support: Our Shared Commitment (2013).

In May 2013, the Government announced its biggest ever commitment to making co-ordinated health and care a reality through publication of this framework document on integration. Signed by 12 national partners (National Collaboration for Integrated Care and Support) it sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

For health, care and support to be 'integrated', it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered.

I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me.

Definition of integration developed by National Voices

The Collaboration which includes the Department of Health published plans that aim to see them working together nationally and locally and included:

- An ambition to make joined up and co-ordinated health and care the norm by 2018;
- The first ever agreed definition of what people say good integrated care and support looks and feels like;
- New 'pioneer' areas around the country and
- New measures of people's experience of joined up care and support.

In addition ten shared commitments at both national and local level aim to address:-

- Pursuing a common purpose;
- National resources for local ambition;
- Providing practical tools to localities;
- Integrating information; and
- Accelerating learning across the system.

Better Care Fund (formerly Integration Transformation Fund)

Government believes that*:*

> *"to improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs."*[3]

Nationally a £3.8 billion pooled budget for health and social care services has been established to be shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. Access to this funding is based on a plan agreed between the NHS and local authorities that will deliver on national conditions:

- Protecting social care services;
- 7-day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional

Payments will be made based on performance related to:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service-user experience

[3] Spending Review 2013, HMT

Part Two: Professional Standards and Capabilities

Chief Social Worker for adults

The Chief Social Worker for Adults Lyn Romeo works collaboratively with the Chief Social Worker for Children and Families. Together they work from the Office of the Chief Social Worker to:

- support and challenge the profession to ensure that children and adults get the best possible help from social workers
- provide independent expert advice to ministers on social work reform, and the contribution of social work and social workers to policy implementation more generally
- provide leadership and work with key leaders in the profession and wider sector to drive forward the improvement and reform programme for social work
- challenge weak practice to achieve decisive improvements in the quality of social work
- provide leadership to the network of principal social workers

Principal Social worker Role

The role of Principal Social Worker (PSW) is currently held in Halton by the Divisional Manager Assessment and Care Management services. This role remains relatively undefined, within the professional capability framework and there appears to be variations in the role within local authorities. However being involved in the national network, which is supported by the college of social work, the Office of the Chief Social Worker, Skills for Care, ADASS, North West Employers Organisation (NWEO) and partaking in the Cheshire and Merseyside Partnership regional peer group should offer opportunities to be able to influence things nationally. University of Central Lancashire (UCLan) have agreed to provide expert knowledge and experience to support the group on all things related to Social Work education and research and Skills for Care have also identified a lead officer which will be invaluable as the new developments emerge.

Some key aspects of the developing role are as follows:

- Professional leadership role
- Lead, motivate and inspire social workers
- Promote social work role
- Liaise and develop professional networks locally, regionally and nationally
- Influence strategic decision making
- Users and carers and outcomes at the heart of this role
- Monitoring and auditing of quality of the Social Work service
- Undertake organisational health check annually
- Implement and monitor employer standards

The Key focus of practice improvement for the PSW role

- PSWs – 'vital impact on quality of social work in this country'
- Championing good practice – challenge to improve
- Quality assurance role – beyond auditing
- Bring reflective practice into the working environment
- Evidence practice - impact and outcomes
- Importance of CPD
- Courage to work differently/collaborate/ work across boundaries

Standards for employers of Social Workers

The Local Government Association (LGA) has set out "Standards for employers of Social Workers in England"[4] The standards were developed by Stakeholder partners across the sector 2009 and 2012 as part of the Social Work Reform Board, building on existing guidelines for employers of social workers, the Professional Capabilities Framework for social workers held by The College of Social Work, the evolving Career Framework, and the Health and Care Professionals Council regulatory requirements.

The LGA says:

> *"Good social work can transform people's lives and protect them from harm. In order to achieve consistently high quality outcomes for service users and their carers, social workers must have and maintain the skills and knowledge to establish effective relationships with children, adults and families, professionals in a range of agencies and settings, and members of the public. We can use the Standards, along with an appropriate supervision framework to help drive recruitment and retention".*

The eight standards are expectations that are being incorporated within self-regulation and improvement frameworks for public services and used by service regulators (Ofsted, CQC). The Standards apply to all employers of social workers and relate to all registered social workers employed within an organisation, as well as managers and social work students. The purpose of the Standards is to sustain high quality outcomes for service users and their families/ carers/communities.

All employers providing a social work service should establish a monitoring system to assess their organisational performance against this framework, set a process for review and, where necessary, outline their plans for improvement. Employers should ensure their systems, structures and processes promote equality and do not discriminate against any employee.

All aspects of the Standards are equally important, just as the National Professional Capabilities Framework (PCF) is holistic in nature in order to effectively set out the expectations of social workers themselves. The PCF is intrinsic to the implementation of these Standards for Employers.

[4] http://www.local.gov.uk/documents/10180/6188796/The_standards_for_employers_of_social_workers.pdf/fb7cb809-650c-4ccd-8aa7-fecb07271c4a

National Professional Capabilities Framework (PCF)

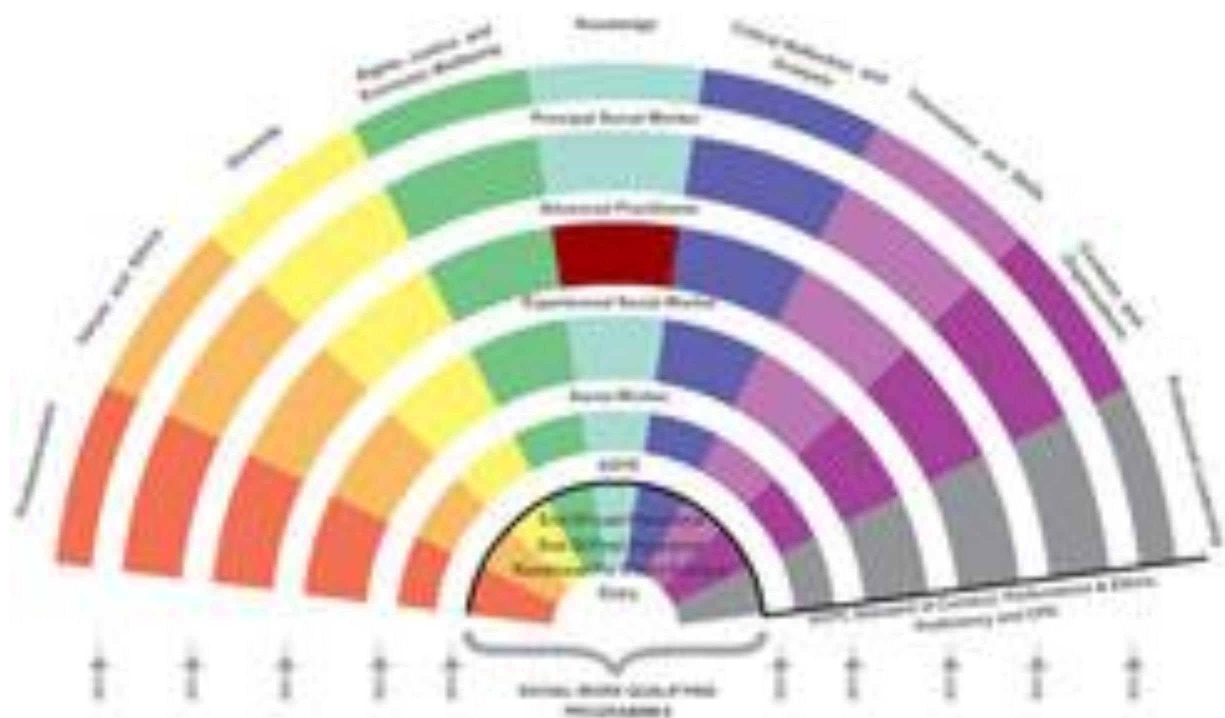
The national "Professional Capabilities Framework" is an overarching professional standards framework, developed by the Social Work Reform Board and now owned by The College of Social Work (TCSW). The PCF applies to all social workers in England - in all roles and settings, including independent social workers which has been developed to help social workers be supported to do the best job they can at all stages of their profession.

The College of Social Work has launched a series of social work toolkits to help support the implementation of a suite of reforms that are galvanising improvements throughout the profession. The six toolkits are designed to direct social workers, social worker employers and education providers through the steps required to implement a series of recent practice developments aimed at strengthening professionalism and improving the public image of social work.

The PCF:

- Sets out consistent expectations of social workers at every stage in their career
- Provides a backdrop to both initial social work education and continuing professional development after qualification
- Informs the design and implementation of the national career structure
- Gives social workers a framework around which to plan their careers and professional development.

Professional Capabilities Framework "PCF"[5]



[5] http://www.tcsw.org.uk/pcf.aspx

Part Three: Integrated Working and Workforce Planning

The principles of workforce integration[6] (Skills for care)

Workforce integration is about working together to meet people's needs and enabling people with care and support needs to live as independently as possible. Its purpose is to improve the quality of care and support by keeping the individual, not the organisation or particular profession, as the driving force behind care and support. Adopting an integrated approach enables workers to understand each other's roles and contributions, and to build support networks around individuals. At a strategic level, integration creates a more seamless experience for individuals.

There are six principles that help in thinking about and discussing integration, these principles address some specific workforce related questions:

- How can workers who are being asked to work in a team with people from different professional backgrounds be supported to deliver real change?
- What is the role of workforce development in developing strategies to steer the path to workforce integration?
- How can workforce development opportunities be shaped to ensure that the goal of integrated care and support with people at its heart is paramount?
- What is the role of workforce development in ensuring that resources are identified, developed and used to their maximum benefit in achieving value for money alongside excellence in care and support?
- How can managers at all levels ensure that workers are involved, engaged and listened to, and create opportunities for learning and sharing across boundaries as well as within teams?
- How can individual workers best be supported to equip themselves to grow as practitioners so that they become confident, knowledgeable and capable of contributing to and delivering high quality integrated services and co-produced care?

Principle 1: Successful workforce integration focuses on better outcomes for people with care and support needs.

Developing a common goal around better outcomes for people with care and support needs creates a single vision to underpin transformation. It is easy to lose direction or get pulled by competing priorities, but continually refocusing on the purpose of the care and support being provided brings everyone back together. Integrating the workforce, including the range of different practitioner skills, around the needs of each individual being supported will result in better use of resources, and support that is tailored to that person's needs. The views and experiences of people with care and support needs, and of family or friends

[6] http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-integration/principles-of-workforce-integration.pdf

carers, are an integral part of developing new ways of working. Creating person-centred provision is not just about workforce reconfiguration. It is about how the team operates around the individual, working together to achieve best outcomes.

Principle 2: Workforce integration involves the whole system.

Bringing together frontline workers without integrating all of the systems that support and enable those workers is not sustainable. It will create conflict and practical difficulties, and make the workers feel unsupported. Integrating resources, responsibilities and control creates a clear message that each organisation is committed to the transformation. Integrating resources will minimise duplication, and help ensure that every part of the system is working effectively. Bringing in new service arrangements will disrupt some long established informal networks; building new ones should be viewed as a priority. The system should be viewed in a non-hierarchical way, each person in the system carries some responsibilities, and all are mutually dependent upon each other for success.

Principle 3: To achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities.

Change and transition can be debilitating if it is perceived to be threatening. Workers need to feel safe, valued and supported. Their anxieties should be freely aired and responded to. Where job roles change, workers can feel de-skilled. Identifying and meeting learning needs should be part of any strategy employed. Safe environments enable people to innovate, take risks, build new models and ways of working, and share learning to enhance practice. A balance needs to be struck so that workers can maintain their sense of professional identity at the same time as working across boundaries that are increasingly blurred. To achieve this, roles, responsibilities and accountability need to be clearly described. Workers, who feel their perspectives and skills are recognised and valued by their colleagues and across organisations are more likely to feel confident, motivated and engaged with the changes. Professional supervision and the opportunity to manage continuing professional development need to be incorporated into any new arrangements.

Principle 4: A confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active and engaged communities is at the heart of workforce integration.

The most valuable resource in any organisation is the workforce. Attending to workforce issues, identifying learning needs, addressing issues of professional identity and recognising infrastructure issues such as employment arrangements, gives a clear message about the value placed upon workers. Successful implementation of integration depends upon workforce issues being addressed from the beginning. Workforce issues cannot be added at the end, they need to influence discussion and decision-making, and need to be included in the process of resource allocation. An environment in which workers feel safe and confident to raise questions, express concerns, talk about their experiences and make suggestions for service improvement based on their experience and relationships with people they support will create trust and help them and colleagues to feel supported. Acknowledging and valuing the expertise that workers bring to their changing workplace environment will make them feel valued and listened to. Creating a

learning environment that draws on the experiences of workers will maximise innovation and appropriate risk-taking, and support the development of new models and ways of working. People learn in different ways and at different paces, and are affected by change to varying degrees. The design and implementation of integrated strategies needs to reflect this, so that things are paced appropriately, with individual workers' needs identified and met in a range of ways. 'Champions' play an important role in the implementation of any transformation and having champions at every level will help in implementation. Motivated and enthusiastic workers should be identified, nurtured and encouraged to take on this role.

Principle 5: Process matters—it gives messages, creates opportunities, and demonstrates the way in which the workforce is valued.

Give attention to the process, it is by getting this right that ownership, commitment and trust will be developed and the likelihood of sustained success will be increased. Good communication, keeping everyone informed and appropriately involved in decision making, is the foundation of an effective strategy. Begin by looking for the resources and experiences that are already there, as building on these demonstrates that individuals' contributions are valued. Create opportunities for people to learn from each other. The ways in which senior workers behave and act should mirror the co-operative, open and motivated approaches that will be expected of frontline workers.

Principle 6: Successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies give each of these attention, creating the circumstances in which all can thrive.

Informal networks are critical to workers, providing them with information, support, ideas and quick responses. Reconfiguring services will interrupt existing networks. Opportunities need to be created to ensure that new relationships can thrive. The ways in which different professional groups and organisations relate to each other will change with integration. This can feel threatening and create insecurity. The needs of each professional group need to be attended to, to enable a continued sense of professional identity and to ensure continuing professional development. At the same time, members of newly created teams and services should have the opportunity to share understandings, perspectives, priorities and limitations so that everyone feels comfortable in their role, and with the roles of others. The new ways of working that emerge with integration may create specific learning needs to enable individuals to work effectively. These need to be identified and attended to. There is richness in the diversity created within integrated teams and organisations; facilitated opportunities should be created to exploit this, so that people can learn together as new approaches evolve.

Skills for Care

The Department of Health has set out the social workers vital role in personalising care and support. This will become more important as part of an integrated response focused on context, possibilities and outcomes, rather than processes and tasks:

- Personalisation reflects social work values: **respect for the individual** and **self determination** are at the heart of social work

- Social workers have a central role in **maximising better outcomes** for people:
- Promoting **independence and choice** – working alongside individuals and their families - independent living, inclusion and well being
- **Empowering people** to shape their own lives and their care and support
- **Putting people at the centre** – working it out together – equal and creative relationship between people who use services and social workers
- **Supporting positive risk-taking** through good assessment and management of risk and information about possibilities
- **Working with other professionals** to ensure responses are appropriate and sensitive to the needs of the individual
- **Strengths-based approaches** – helping to build independence and reduce the risk of more costly interventions
- **Reflection, supervision and Continuous Professional Development** to challenge and improve personalised and quality social work practice

Personalisation of services and the national drive to move to a more integrated approach present a real opportunity to:

- Reposition social work and social workers at the heart of integrated, personalised health and social care
- Refocus on social work interventions that make a difference to the lives of the most vulnerable people in society
- Contribute to shaping the social care market to achieve the best outcomes for people using services

The Professional Capabilities Framework reinforces this approach setting out expectations for social workers to:

- Apply critical thinking, augmented by creativity and curiosity
- Identify, distinguish, evaluate and integrate multiple sources of knowledge and evidence, including:
- Practice evidence and experience
- Service user and carer experience
- Research-based, organisational, policy and legal knowledge
- This will become more important as part of an integrated response focused on context, possibilities and outcomes, rather than processes and tasks.
- Personalisation presents further opportunities for innovative, person-centred approaches in social work practice, using evidence of what works - including:
    - Outcome based approaches to assessment, care planning and review
    - Motivational interviewing
    - Attachment-based strategies for working with adults
    - Making Safeguarding Personal

- Strengths-based approaches
- Micro-providers/ Innovative use of Personal Budgets

The Workforce Capacity Plan

Since 2011 the National Minimum Data Set for Social Care has collated information on all adult social workers employed in the statutory sector. Nationally this tells us that the number of registered social worker jobs over this period has been relatively stable. More than 1 in 3 of these social workers is aged 50 or over which may have implications for continuity planning. The ASYE registrations in 2013-14 was around 1,000 and data suggests that the proportion employed in the non-statutory adult social care sector (i.e. private, voluntary and health) nay be increasing.

'Skills for Care' has been tasked by the Department of Health to support local authorities across the country with workforce capacity planning to help them prepare for the implementation of the Care Act. This model below has been developed to implement workforce reform in the context of the Care Act which will require significant change to workers roles and practice to meet new legal expectations.

The model puts the person at the centre of workforce capacity planning emphasising the role of workforce capacity planning in improving outcomes for people with care and support needs and their carers. Prevention, integration and wellbeing all need to be considered throughout the development of the plan and co-production can be an important part of workforce capacity planning.

The Act sets out the general responsibilities of local authorities describing their broader care and support role towards the local community. In relation to the Act, the workforce needs to have the capacity and capability to work in the context of:

i. **Well-being principle:** a new statutory principle designed to embed individual well-being as the driving force behind care and support.

ii. **Prevention:** the local authority's role in preventing, reducing or delaying the need for care and support. This is a general duty that applies in relation to all local people – including applying equally to carers and those with care needs.

iii. **Integration:** a duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services, such as housing. Improving outcomes for people and communities.

iv. **Information & advice**: broad, high-level requirements for what local authority information and advice services should include to enable people to understand how the care and support system works, what services are available locally, and how to access those services.

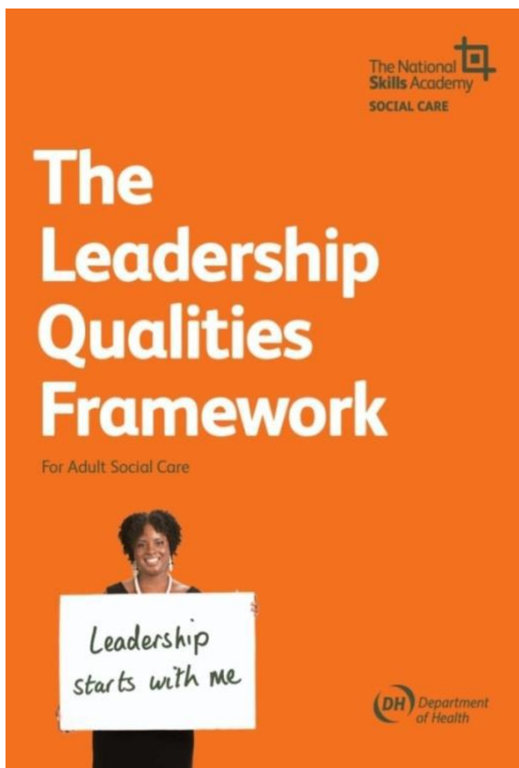
v. **Promote diversity and quality of services:** local authorities will be required to promote the diversity and quality of local services, so that there is a range of high quality providers in all areas. This includes local authorities fostering an effective care and support workforce.

vi. **Co-operation**: local authority and other authorities which have functions relevant to care and support will be required to co-operate. There will be a specific duty to co-operate in relation to individual cases, where the local authority can request co-operation from one of the partners (or vice versa) to help with a specific issue to do with a carer or an adult who uses care and support. These provisions include a duty on the local authority to ensure cooperation between its officers responsible for adult care and support, housing, children's services and public health.

Skills for Care Workforce Reform Model

Social workers as leaders, and leadership from social work:

The 'Social work leadership toolkit'[7] is a refreshed version of the frontline social work managers' framework originally developed by Skills for Care and The National Skills Academy for Social Care. New material and additions to the toolkit have been developed in collaboration with a number of wider stakeholders including The College of Social Work and Learn to Care.



How can it be used?

- Front line social work practitioners (those working at the 'Experienced' PCF level) who aspire to be managers can use it to understand the skills and knowledge required to move into a management role and to support identification of their development needs.

- Front line social work managers (those already working at the 'Advanced' PCF level) who are either new to management or in a new role can use the framework to identify their development needs.

- Established social work managers may use it to maintain and improve their skills and work effectively in a changing context.

- HR, professional development staff and commissioners who want to understand the development needs of social work managers and other professional social work leaders may find it helpful as part of a restructure or workforce re-design process.

- Senior managers, including strategic social work managers (working at the 'Strategic' level of the PCF), who wish to change their service by supporting social work managers and professional leaders to work in different ways or take on different responsibilities.

- Training providers and awarding bodies who are seeking to develop and accredit programmes to meet the needs of social workers.

What is the Structure?

The 'Social work leadership toolkit' works as a coherent whole for those who wish to understand the underlying principles and be guided through the process of developing a social work leadership framework linked to the profession's own 'Professional Capabilities Framework.'

To meet the needs of a range of differing audiences each section of the toolkit are "searchable" allowing users to go directly to specific information using the clickable sections.

[7] http://www.swltoolkit.co.uk/

The 'Introducing the Social work leadership document (2013)' provides a background and overview of the methodology and process used in the development of this toolkit. It contains a number of the models which could be useful to those who are seeking to draw learning from a range of projects.

Each section provides examples of best practice, links to useful tools and research evidence. All the materials are intended to support individuals and organisations plan and implement effective social work leadership development programmes and activities.

Part Four: Assessments and Reviews

Qualified Social Workers

The Audit Commission[8] argued the case for local authorities making significant financial savings by having less qualified staff, rather than experienced social workers to carry out assessments and reviews. By this means, they estimated that local authorities could save £180m annually.

However, to raise the debate, the College of Social Work (TCSW)[9] considered this strategy to be fraught with danger and could even "increase the risk of harm and bring higher costs later". Removing qualified staff from conducting simpler assessments could result in critical elements of risk, vulnerability and need being missed by a less experienced assessor, which would be picked up and acted upon by a qualified Social Worker.

The TCSW further argue that SWs are uniquely prepared by their education, experience and training to foster the social capital that makes active citizenship in thriving communities a genuine possibility. Service users quite often have to have their needs teased out, interpreted and met creatively from the social assets of the family and local community. This asset-based approach requires a deep knowledge of individual, family and community interaction that goes beyond the assessment and the care package, but looks at the inclusion of individuals. Hence as social care theory and legislation continue to develop, social workers will have a central role not only with assessment, planning and review but also with: community development, safeguarding, prevention, early intervention and interpersonal support.

Halton Spend on Assessment and Care Management

Year	£000	% of Total spend on Adult Social Care
2012/13	£4,693	13.5
2013/14	£4,397	12.4

The percentage of Adult Social Care spend on Assessment and Care management is a little higher than the Audit Commissions suggested target of 10% (based on 2010/11 figures) but well below the 17% of high spending authorities. The report recommends that authorities should undertake benchmarking of care management costs with other authorities of a similar size and circumstances.

[8] Reducing the Cost of Assessments and Reviews, Audit Commission August, 2012
[9] The Business Case for Social Work with Adults, December, 2012

Halton assessment and care management capacity (April 2015)

Posts	Complex Care and Initial Assessment Teams	Mental Health Team
Principal Manager	3	1
Practice Manager	5	1
Social Workers	22.5	11
Carers Assessor		1
SW Community Care Workers	21.5	
Occupational Therapists including Accessible Homes	6	
OT Community Care Workers	10	
CHC Nurse Assessors	4	
Vision Rehabilitation Officers	2	
Social Care in practice Community Care Workers (funded by CCG)	3	

It is imperative that assessments and reviews of the needs of vulnerable people are robust as poor assessments increase the risk of harm and bring higher costs later. In making savings in assessments and reviews, each council must monitor service quality and outcomes for people. Some measures of efficiency will provide an indication of quality, such as the time taken to provide for needs and financial assessments.

The Audit Commission's analysis evidenced that low-cost councils achieve broadly the same levels of service quality as high-cost councils. This suggests that councils that spend more on assessments and reviews can make savings without sacrificing service quality, or putting vulnerable people at higher risk. Suggestions on how Councils can reduce their spending on assessments and reviews include:

- redesigning the care pathway to provide information at an early stage to reduce the potential demand for formal assessments;
- reducing overheads, by streamlining the administration supporting assessments and reviews;
- reviewing the grade mix of staff providing assessments and reviews; reviewing pay rates to find savings, but without risking recruitment and retention;
- matching staffing more closely to workload; and
- looking for opportunities to collaborate with other councils to reduce overheads and costs.

Referrals, Assessments and Reviews in Halton

Activity within Assessment and Care Management has increased significantly in 2014/15 compared to 2013/14 and further increases are anticipated with the implementation of the Care Act and recent case law relating to Deprivation of Liberties. Numbers of completed assessments completed are showing a significant increase and includes a 70% increase in the number of Carers Assessments undertaken.

Referrals, Assessments and Reviews

Year	Referrals	Assessments (Including Carers Assessments)	Reviews	Vulnerable Adult Abuse Investigations (including ISU)
1/4/2012 to 31/3/2013*	3,784	2.114	1,476	1,217
1/4/2013 to 31/3/2014	4,930	2,149	1,975	1,473
1/4/2014 to 12/12/14 (extrapolated to 31/3/15)	5,525	3,921	1,916	1,718
Percentage increase 2013/14 to 2014/15	12.1%	82.5%	-3%	16.6%

*Data loaded on Carefirst 5 1/4/12-28/5/12 is incomplete due to structural changes. In view of this 2013/14 has been used as the baseline for comparison

Assessments and reviews completed by Mental Health Team

Team	01/04/2012 - 31/03/2013	01/04/2013 - 31/03/2014	01/04/2014 - 12/12/2014 extrapolated to 31/3/15	% change 13/14 to 14/15
Comprehensive	39	54	81	50
Reassessment/unscheduled review	19	26	34	30.8
Review	328	259	194	-25.1
total	**386**	**339**	**309**	**-8.8**

Worker Average Case Load

01/04/2012 - 31/03/2013	01/04/2013 - 31/03/2014	01/04/2014 - 12/12/2014
43	64	45

The 2014/15 figure is indicative at this stage and will be amended at year end.

The average worker case load is the number of assessments and reviews completed divided by the number of workers. This does not necessarily reflect the type of cases a worker would pick up, e.g. only Social Workers complete safeguarding, whilst a reviewing officer would have a larger case load than a Social Worker or Community Care Worker with more complex cases. Most carers' assessments are completed by IAT and as they offer short term intervention have a quicker throughput of cases.

New responsibilities – Care Act 2014

The new duties under the Care Act will increase demand for assessments and reviews arising from requests by self-funders and carers. The 2011 Census asked whether you provided unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age and for how many hours per week. Overall numbers had changed little from 2001 but the numbers providing more than 20 hours of care each week had increased by 5% and now represents a third of all unpaid carers with 8% providing more than 50 hours per week. As a result of the Act councils must assess carers' needs for support and the duty to promote wellbeing now applies to carers, including parent carers of under 18s, in addition to service users.

This is being considered as part of Workforce Capacity Planning work streams along with the professional development of care managers who will need to incorporate the nine areas of the "wellbeing principle" into assessments of need (outlined in Part 1).

Deprivation of Liberty Safeguards (DoLS)

Recent clarification by the Supreme Court (the Cheshire West ruling) on the test for DoLS has lowered the threshold for DOls assessments resulting in a significant increase in the number of people requiring an assessment for protection under DoLS with serious implications for both social care practice and the wider health and social care system. The Association of Directors of Adult Social Services (ADASS) has predicted that the Cheshire West ruling will see DoLS assessments rise from just fewer than 10,000 last year to a predicted 94,000 by the end of 2014/15 financial year at an extra cost of at least £88 million to Local Authorities.

Estimated maximum number of assessments required in Halton to address new ruling

Setting	Numbers
Residential and Nursing Homes – based on total no of beds in the Borough	837
Hospitals (assuming approx. 30 per week)	1560
Hospice	12
Supported Living	185
Respite (based on figs for shared care vouchers)	79
Estimated no of potential assessments required	**2,673**

In Halton for the year 2012/13, 50 DoLS assessments were undertaken. In the six months April to September 2014, 87 assessments were completed representing a 28% increase. In December 2014 Halton has 19 trained Best Interest Assessors working alongside their current Social Worker role. The increase in assessments has impacted upon the care managers who are also Best Interest Assessors

taking them away from their care management role. These figures represent only the most urgent of cases and do not represent the cases who are in a stable situation in residential and nursing homes who meet the 'acid test' but have yet to be assessed. DoLS authorisations require statutory reviews at least once every 12 months and therefore this demand will be on going.

It has been proposed that the main vehicle for initiating a DoLS assessment for cases within residential and nursing homes will be via the care management review processes. This will provide us with a managed procedure maximising our resources and a stepped approach to future annual DoL reviews. Potentially this will require additional 35 – 40 DoLS assessments per month (based on current reviewing cycles).

Strengths (Asset) Based Approach

Halton as are other local authorities are examining ways of maintaining the same level of service through alternative ways of working. One approach is to commission services in a way that identifies and makes use of the strengths already existing within communities, as a means for sustainable development (Asset Based Commissioning [ABC] and Asset Based Community Development [ABCD]).

Nationally numerous Local Authorities have adopted the ABC/ ABCD approach (Nelson, Cambell and Emanuel, 2011). Locally, various authorities in the North West are making progress using asset based approaches in the widest sense. Liverpool since early 2011 has been using the ABC approach to help involve and engage communities to improve their heart health in a particular neighbourhood, as a means of achieving long-term improvements in local health.

Making It Real

Think Local Act Personal (TLAP) is the sector wide commitment to transform adult social care through personalisation and community-based support. Over 30 national organisations worked together to come up with a way of checking how things are going with changes. The result is 'Making it Real', a framework that highlights the issues most important to the quality of people's lives. It helps the sector take responsibility for change and publicly share the progress being made. It is built around "I" statements, that express what people want to see and experience; and what they would expect to find if personalisation is really working well.

Of note 'Making it Real' framework features prominently in the 'Integrated Care and Support: Our Shared Commitment' May 2013, to coincide with Norman Lamb's announcement around integration. An extract from the document as an example of this is as follows:

> "*We have already started to use the Narrative to inform our national work to support local initiatives. For example, we are developing the "I" statements as indicators for measuring people's experience of integrated care and support and are looking for them to be used at the local level to ensure*

integrated care and support is developed around the needs of the individual. We are looking for Health and Wellbeing Boards with commissioners and providers to come forward to test how the "I" statements can be used in practice to deliver better-coordinated care and support across local health and social care systems.

We expect local and regional organisations to adopt the Narrative and use it to support the planning, commissioning, and delivery of better-coordinated care and support tailored around the individual. The Narrative is intended to be used flexibly at a local level. We therefore encourage localities to develop and adopt "we" statements setting out what you will do in order to make the "I" statements a reality for your patients and service-users.

In implementing the Narrative, we encourage localities to adopt a three-step process, in line with Making it Real, ensuring:

1. Co-production with patients and people who use services

2. Board level commitment

3. Production of an action plan, and sharing this publicly.

In order to ensure coherence, the organisations in our national collaborative and TLAP will work closely together to align the implementation of the Narrative and Making it Real. It is also of note that there will also be significant linkages into the Integration Transformation Fund and this work would be required to be reported back as part of this agenda.

Halton Borough Council and NHS Halton CCG have signed up to Making It Real in 2014

Making Every Contact Count

Making Every Contact Count (MECC) is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change. To do this organisation need to build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals. Doing this will improve health and wellbeing amongst service users, staff and the general public and reduce health inequalities. Enabling and empowering the public requires staff through their interventions to:

- promote the benefits of healthy living across the organisation
- ask individuals about their lifestyle and changes they may wish to make, when there is an appropriate opportunity to do so
- respond appropriately to the lifestyle issue/s once raised
- take the appropriate action to either give information, signpost or refer individuals to the support they need.

There are a range of toolkits and resources to support implementation of these approaches at

http://www.makingeverycontactcount.co.uk/

Part 5: Self Directed Support and Support Brokerage

Self-directed support is about the person having informed choices about the way they are supported. Many people will be able to plan and organise this themselves whilst others may need some help from "support brokers"

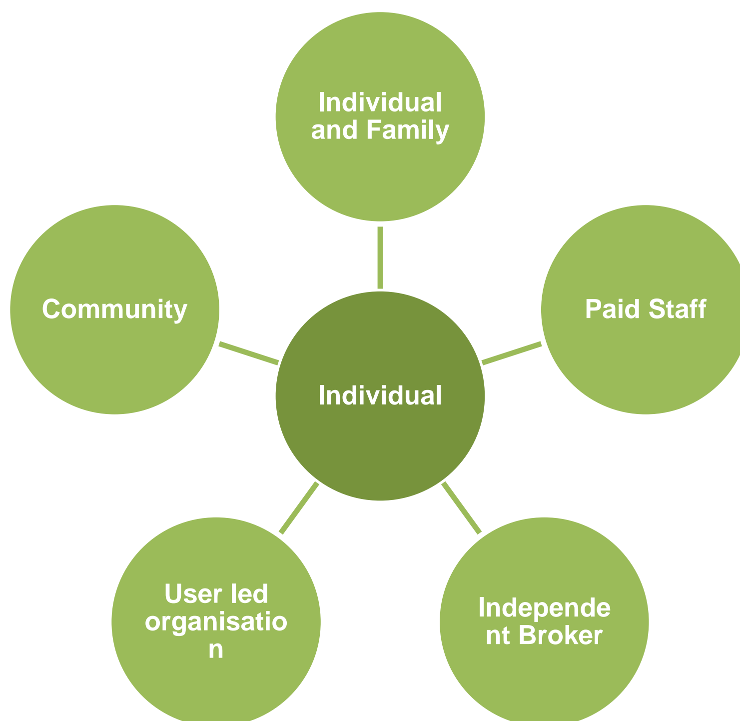
There is growing consensus that support brokerage has a number of functions covering a range of activities or tasks that people may need when directing their own support. The Department of Health provides the following list which offers a framework to understand the range of support encapsulated within the term support brokerage:

Functions of Support Brokerage

1. Information, Advice and Guidance - having the right information and advice to make decisions.
2. Facilitation and Enablement - support to navigate and work through the process of self-directed support.
3. Researching what is available - knowing what's available locally.
4. Technical Advice - drawing on specialist advice where necessary e.g. legal and employment advice
5. Planning - developing Support Plans - exploring how best to organise support that suits the person.
6. Coordinating supports and resources - setting up support systems and longer term management arrangements.
7. Negotiation and mediation - support to resolve conflicts or disputes to ensure the right outcomes for the person.
8. Advocacy - support to be heard and represented if needed.

There are a range of people and agencies that can fulfil the functions of support brokerage represented below. In all cases the starting point should be the individuals brokering their own support before seeking the assistance of others.

Brokerage approaches



There are a number of different models for support brokerage based around either local authority provision or independent/voluntary sector provision. More information on these can be viewed at:

http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/Informationandadvicecasestudies/

In Halton we are continuing with our existing model of brokerage whilst monitoring which models embracing. In Wigan, for example, a model where brokerage is provided by Social care staff working within the Council as a separate function has been implemented. The assessment and resource allocation functions have been separated from the support planning and brokerage functions.

Brokerage is separated from the responsibilities of Social Work staff within the Council. Social Workers continue to assess and agree the resource allocation but do not draw up a support plan or organise the support which is actioned by other social care staff.

This model creates a new service incorporate existing functions i.e. Direct Payments Team, Central Commissioning Team (Care Arrangers) and can be created within existing resources so is cost neutral. The following analysis of this model was completed by Wigan:

Advantages of Brokerage provided by the Local Authority as a separate function

Service User Outcomes

Exercising Choice

- Individuals are able to build a relationship with one organisation.
- Provides an opportunity to match the service user choice of a broker with staff with different expertise, knowledge and skills.

Keeping Safe

- Social Workers could still be accessed quickly to respond to a crisis and unexpected changes in need. Support systems are already in place to protect vulnerable adults.
- Some regulation and accountability, protecting vulnerable people against inefficiency and bad practice and provide a route for complaint.

Organisational

Workforce

- Could create a new team using existing workforce.
- Local Authority Social Care staff are already experienced in some of the brokerage functions
- The skills and expertise of the current workforce are retained and developed.
- There are no TUPE implications for in house but would be TUPE for contracted services.
- May offer opportunities for staff re-deployment from decommissioned service areas.
- This has been an approach that has been done before as it mirrors the current approach around Direct Payments Teams.

Financial

- Could be easier than other options to collate information regarding the market
- Could ensure cost effective approaches in arranging support.
- May reduce costs associated with the possible workforce changes as more people may choose not to use traditional services.

Partnerships

- Information could be more easily collected and shared to inform an emerging area of practice.

Reputational

- Could maintain the regulatory and accountability role, protecting vulnerable adults against inefficiency and potential poor quality provision.
- Social Care workers may have very good trusting relationship with people that are worth building on.

Disadvantages

Service User Outcomes

Exercising Choice

- Council staff providing brokerage may have too much power which is not in keeping with some of the principles of a personalised approach.
- People are unable to choose the organisation that helps them to arrange their support.
- Staff may lack creativity in planning how needs can be met and choose traditional service options.
- Internal brokers may prioritise in-house services or particular providers. A change in practice may not be realised.

Keeping Safe

- The willingness of internal brokers to develop more innovative support packages varies and the duty of care may act as a barrier to the pursuit of independence and control.
-

Organisational

Workforce

- Training and development of workforce required.

- Staff may not want or be able to carry out new roles.
- Significant changes at a time when change agents may not be in place to lead.

Financial

- Some staff working on brokerage type activities may not be required to the same degree. So some staff, in some situations, would be placed at risk.
- May not deliver efficiencies.

Partnerships

- Local Authority staff may be less able to negotiate creative or cost effective solutions due to historical relationships.

Reputational

- May not achieve the strategic shift in thinking and practice.
- Third sector may challenge if they are affected in order to afford this option.

Risk Description	Consequence	Impact	Probabilit	Possible actions to control the risk
1. Lack of available change agents to lead service development.	Challenge to change could delay implementation			- Capacity to take forward changes needs to be fully scoped and resourced.
2. Service users may be dissatisfied with a break in the Personalisation Pathway.	May lead to an increased number of customer care complaints.			- Handover points in the pathway need to be managed effectively to ensure good response times and clarity for all around roles and responsibilities.
3. This option may not realise any efficiency savings as staff re-deployment could be costly.	Increased budget pressures.			- Financial reduction achieved through reduced Social Work resource. - Streamline resources to maximise efficiencies.