NAMED SOCIAL WORKER

FINDINGS FROM SIX PILOT SITES

JULY 2017

scie social care institute for excellence

Innovation Unit

The Department of Health initiated the Named Social Worker programme in order to build an understanding of how having a named social worker can contribute to individuals with learning disabilities, autism or mental health needs 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 which we all strive for. This programme is specifically about trying something different, piloting new ideas and generating early and indicative evidence as to their impact.

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INTRODUCTION

This report sets out the findings from the six sites which have been part of the Named Social Work programme during the six months from October 2016 to March 2017.

Each site has developed a locally appropriate model for this pilot which we have explored in two prior reports. In the first we shared the various hypotheses that the sites wanted to test; in the second we looked at what sites were learning about implementing their models. This report details the findings from sites of the early impact of their approach and the themes that are emerging from 6 months of experimenting with a Named Social Worker model.

In this report you will find a summary of the impact that has been achieved in piloting a Named Social Worker approach as well as detailed findings from each of the 6 sites, set in the context of the scope and focus of their pilot; a set of programme level insights, drawn from the sites, about the implications of introducing a Named Social Worker model; and a selection of tools that sites have developed or adapted in order to implement their Named Social Worker model.

The time limited nature of the pilot means that the findings are at an early stage, however we have seen examples of impact on individual's lives, such as greater choice and support; and on the system and mechanisms which support people, such as improved multi-disciplinary working. The programme also provided insight into how a Named Social Worker model can shift outcomes; by providing permission for social workers to work in new ways; by setting expectations around working more closely with individuals; by opening up visibility across the system for named social workers to engage at different stages of an individual's journey; and by being an endeavour of the whole team.

THE 6 SITES IN SUMMARY

Each site determined their own approach based on their local context. This resulted in a range of models being tested.

CALDERDALE

Calderdale have sought to establish relationships where power and control meaningfully shift to the individual, by putting Human Rights at the heart of everything that social workers do to support people to thrive.

CAMDEN

Camden adapted their NSW role from the Independent Reviewing Officer role in children's social care. The NSW aims to hold the system to account, model best practice and identify opportunities to do things differently.

HERTFORDSHIRE

Hertfordshire have built a solid foundation of knowledge and experience to shift the culture in their team, and are shifting perspectives in the broader ecosystem. The intention is that investment in people and knowledge will make the service more robust in the future.

LIVERPOOL

Liverpool have been using the NSW role to develop new practice around assessment of in-patients; experiment and develop best practice in working with colleagues from across agencies; and to build the skills and experience of the wider team to do high quality work with people with learning disabilities of all levels of need.

NOTTINGHAM

Nottingham have used the named social worker pilot to understand gaps in the system (such as the causes of hospital admission) in order to shape and enable better support to individuals prior to crisis point.

SHEFFIELD

Sheffield have focused on building bridges and collaborating, inviting their broader ecosystem of services to key meetings.

They are focusing on doing the right thing for the person and questioning formal processes.

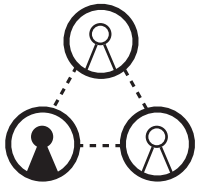
PROGRAMME IMPACT

PROGRAMME IMPACT

Timescales have meant that the the potential to demonstrate serious impact on the lives of many people being supported as part of the pilot has been limited, however we have seen examples of:

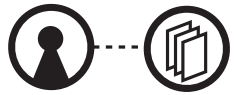
- Discharge or proactive work towards discharge from hospital for people for whom this was not previously on the agenda
- Individuals having greater choice over where they will live with a focus on living independently and in the community
- Individuals feeling more supported by their social worker, with stronger relationships and trust built through having a consistent worker
- Individuals being more involved in their care, for example, through better support planning that is based on people's aspirations or through being involved in decisions and meetings

There are also clear signs of positive changes to the systems and mechanisms that support people, such as:



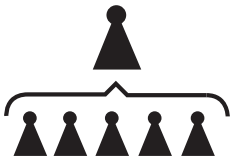
Improved coordination and collaboration between colleagues across professions

Increased visibility and recognition of the social model within multi-disciplinary teams

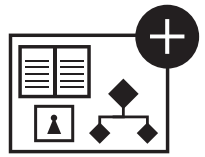


Named social workers building practical knowledge and experience in specific areas such as the Mental Capacity Act, the Care Act and the European Convention on Human Rights

Named social workers developing their confidence to advocate for individuals within multi-disciplinary settings



Named social workers spreading their learning from the pilot across wider social work teams



Embedding new processes aimed to systematise learning from the pilot such as consent forms, transforming care as a fixed agenda item in team meetings and an assessment checklist

A carer's story of nsw

A few months ago Beth wouldn't do anything with anyone but me. Beth takes a long time to recognise and trust people, and after a few months she is just getting to the stage where I can see she understands who Lucy is, that she is not police or hospital staff and trust her. She has had good and bad experiences with social workers in the past, but the fact that they were always changing made things worse. She is supposed to have 1:1's, but with a different person every time she can't move forward.

We have really needed help these past three years, but with social workers chopping and changing they became more of a hindrance than a help. When bruises appear, they don't always get recorded because the social worker doesn't know they are new. Having one person we see all the time makes social workers more accountable, and you can identify the good and bad social workers and make the system work.

As a consistent person, Lucy has been reliable, and on point if anything goes wrong - she's been there. She senses things - alarm bells ring for her when things change, like new people she is interacting with who might have a negative effect, and she can be proactive. Consistency is the key. Lucy has pointed us in the right direction, and been on point when there are bumps in the road. Finding a place for Beth, she has pulled all the stops out - she has explained the housing process as we go, what I can and can't say to Beth. You know where you are and aren't left to pick up the pieces and make sense of them on your own.

I hope Beth can keep her forever - I can't sing her praises enough.

REBECCA IS A CARER FOR BETH, AND HAS BEEN COLLABORATING WITH HER NSW LUCY IN HERTFORDSHIRE.

PROGRAMME INSIGHTS

In addition to the evidence generated by sites on the specific impact of the pilot, programme-wide trends provide further insight into the potential impact of introducing a Named Social Worker model.

It is important to acknowledge the context which the pilots created for some of this to emerge. Sites received a small amount of funding, which was largely used to backfill social worker roles. Sites used the space afforded by the pilot as they saw fit, however it created capacity, in addition to their normal resources, to deploy team members in ways that might not otherwise have been possible.

INSIGHT 1:

THE POWER OF PERMISSION

At the outset of this programme, we asked whether it would be possible for a named social worker, with no structural changes to the system or shift in powers, to be able to make a difference to people's outcomes; effectively, would 'permission' be enough.

This pilot has resoundingly shown that it is. And whilst it is important to acknowledge the time afforded named social workers by a lower caseload, permission has had a significant impact on the way that social workers have operated, both with those that they are supporting and the partners they are working with.

In constructing their identity as a 'named' social worker, we see evidence that social workers:

- Feel supported and empowered to do what they think they need to do as a social worker with their those they support
- Have the confidence in relationships with partners that they bring certain expertise, feel equipped to bring it to bear, and are respected by their colleagues for doing so.

Despite this, most of the sites contended that whilst the permission granted through the pilot was an enabler, they did not see the named social worker as having a distinct professional identity. In fact, the pilot provided the time and space to showcase what good social work looks like; social work as they believe it should be. [See next page for details].

"I feel like I've got permission to "officially" work with people in ways I've had to either fight for or do surreptitiously in the past. If I think it's important to carry on working with someone, my judgement is trusted."

NSW

What is Good Social Work?

Through the course of this pilot, whilst named social workers have been given some different responsibilities to the rest of their team, every site has persistently said that at it's heart this pilot is about 'good social work'.

We wanted to know whether it is possible for sites across the pilot to agree on what that 'good social work' is. It turns out that it is. In the final of the three workshops, we ran a collaborative exercise with the six sites to surface definitions, aspirations and affirmations of just what makes 'good social work'. Here are the results:

Our mission as social workers is to **empower** and **enable** people, with **positive risk taking**, and work within a **human rights framework** in pursuit of **social justice** and **equality**.

The most important skills of a good social worker are **communication** (in its broadest sense, from active listening and empathy to conveying information in an accessible and logical way), **relationship building** and **critical evaluation**.

Social workers use these skills to support people to achieve outcomes like **independence**, **promoting wellbeing** and the experience of **choice and control**.

In order for social workers to be able to apply these skills the system needs to be **responsive to the individuals** they are supporting and **responsive to the social model** which they are advocating.

When working with their **clients**, you will see good social workers **listening** and **advocating**.

When working with their **social worker colleagues**, you will see them being **reflective** and **critical friends**.

When working with **other professionals**, you will see them being **challenging** and **collaborative**.

INSIGHT 2:

WORKING MORE CLOSELY WITH INDIVIDUALS

All sites have identified hearing the user voice more clearly as an enabling factor for named social workers to support individuals better. This is not specific to the named social worker role, but has been facilitated by explicitly designing it into the role.

In Hertfordshire, for example, this has been working at the pace set by the service user, not the system. The team has also invested in co-producing approaches and options with experts by experience, who are key participants in team meetings and reflection sessions.

The impact of this for individuals is apparent as they report improved relationships and trust, having more control over their lives and several people have moved into discharge planning after years and even decades in hospital.

Sites also report that in demonstrating confidence in the individual's decision making, the named social worker is placing value in their aspirations and in doing so empowering them to also believe in their own agency.

Although sites have also found that 'involving people in their care' doesn't just mean asking them to participate in existing processes. One site found: 'Several individuals do not cope well with attending meetings, or engaging with professionals'. Whilst another found that their regular attendance at an individual's residence was a source of anxiety because of negative associations between the regular presence of social workers and points of crisis.

> *"One social worker is working with someone who only trusts people she knows very well; it is not uncommon for professionals to be told a firm 'no' and given a wave out of the door. The named social worker persisted, using the fact that she is a consistent person with time to work at the service user's pace. Rather than rushing the relationship, she made sure that she could be seen talking to people that the service user trusts, being in the background, for example when sat in the courtyard would position herself far away but in her field of vision. This non-invasive presence over time is helping her to become one of the very few trusted people in that person's life."*
>
> TEAM LEADER

What then is the balance between respecting and empowering someone to be in control of their care, and exposing them to the wiring in the system? There is, of course, always further to go in empowering individuals to take appropriate control of their own future, however, the pilot has provided a focus for sites to do so in new and different ways.

> *"Subsequently, alternative ways of working with health colleagues are being developed to ensure their wishes and preferences are included throughout"*
>
> NSW

INSIGHT 3:

OPENING UP VISIBILITY ACROSS THE SYSTEM

The notion of having an 'allocated' worker is not a new one, and many sites across the country allocate cases to team members. However, in defining the scope of their role, named social workers have determined the need to intervene at stages within the care and treatment system which they were not previously exposed to. They have used this to influence upstream planning processes. For example, the team in Camden have attended ward rounds and are attending weekly multi-disciplinary meetings to talk about people on the risk register to ensure that social needs are considered in parallel to medical ones. In Calderdale, engagement with schools and colleges has enabled them to shape care packages for young people in transition to consider a wider range of options than a default residential college setting.

This greater visibility has directly translated into more varied, tailored care plans and crucially enabled discharge both to happen faster, and on occassions where is was not previously under consideration. The energy and focus of named social workers has opened up opportunities to proactively identify more aspirational care packages for individuals who were otherwise being held stationary within a hospital setting.

This suggest that the role could have an important part to play in the Transforming Care agenda.

In addition to involvement upstream in decision making, named social workers have also linked in better to existing multi-disciplinary forums, with most sites considering their presence in these settings as key enablers to influence and inform decision making. In demonstrating to their colleagues that they will be a long term, consistent presence, advocating on behalf of the individual they have got the attention and respect of their colleagues.

As expected, the quality of these relationships are varied, but social workers are reporting changing behaviours from their colleagues in response to their assertion of the social model. Led by the strong advocating of the social model from named social workers, some health practitioners are revising the treatment and care that they are prescribing for people with learning disabilities.

> *"I think it has been helpful to have named social worker presence at [our multidisciplinary team meetings] to contribute to discussions from a social work perspective"*
>
> HEALTH PROFESSIONAL

> *"The nurses at the CCG are clearly gaining the confidence to consider other courses of therapy and are developing more active treatment plans"*
>
> NSW

INSIGHT 4:

A FULL TEAM ENDEAVOUR

As teams, the sites have also worked together differently. Many of the sites refer to the quality of their reflective practice as a tool to support named social workers and strengthen their work towards better outcomes for individuals. For example, alongside self-advocates, Calderdale have developed a tool to support their reflective practice. This embeds the perspective of people with learning disabilities in their consideration of cases.

The amount of leadership time taken to drive forward the pilot has been significant, with some teams drawing on backfill for this purpose. Strong leadership has been important in unlocking persistent blockages, supporting and having confidence in social workers as they develop their practice. But changes in leadership have also been disruptive, and shown the enduring importance of vision and the challenge of aligning with the broader strategic direction of organisations.

Ultimately the environment in which they have worked, and the work that they have been able to do has hugely motivated social workers. They have stated repeatedly how pleased they are to be able to do this work.

> *"We have experienced opportunities which would not normally be afforded in a generic social work role, and received ongoing support from management throughout, which has further encouraged us as social workers and ensured this investment has further enabled positive outcomes for service users"*
>
> NSW

> *"Before this pilot, I didn't feel like the social worker professional voice counted, in this pilot it has."*
>
> NSW

Reflections on the role of Named Social Worker

From Calderdale's blog

Mark totally gets it when it comes to social work for his son Steven. He doesn't want someone who thinks they know Steven and Mark better than Steven and Mark know themselves. He doesn't want an admin officer for a social worker or someone who can broker care (although he does want the awful bureaucracy removing!). Mark doesn't want someone who can interpret other professionals jargon. Mark isn't looking for a mate for him or Steven. Nor is he looking for someone to relay decisions made by the great and good at panels in locked away towers.

Mark wants someone alongside Steven. Someone batting for him. Someone who, when Mark isn't there, is absolutely going to advocate for his son's wishes, feelings values and beliefs in a way Mark knows Steven wants.

Crucially, Mark and others, want someone on behalf of the state (Local Authorities or NHS – it shouldn't matter) who totally get and love the fact that Mark and Steven love each other. The thought of standing in the way of their relationship should be as abhorrent as the feelings generated when you hear Mark talk about those who separated Steven from his dad. Whether it's the principles of the MCA, the Articles in the UNCRPD or the Well Being principle in the Care Act, the overriding ethos is that the state should not interfere with the family life. Our role is to promote it, protect it and if possible to enhance it… And then get out of the way very quickly!

However, it still looks like we are a million miles away. More evidence is coming to light of the routinised institutional nature of human rights abuses which are taking place in the name of so called care and treatment.

There is an ever expanding list which is compelling and which identifies consistent themes including:

- Family members report that they are not listened to, their expertise is not valued and their views are ignored;
- Professionals respond to crisis with the most restrictive options, often admission from an acute general hospital bed into a medium secure unit;
- The care and treatment offered to people is at best unclear, and at worst directly compromises people's dignity; and
- Discharge planning is confused and often involves movement from one unit to another type of unit rather than a genuine plan to get people home.

So, we change the size of our institutions from big asylum to

small group home, and the uniforms are all but gone but the practice is frozen in time. We continue to debate about how it isn't enough to just build new types of institutions – and we agree that a bigger shift is needed in mindsets if learning disabled people are to genuinely experience their full range of their human rights. Medical training still appears to over emphasise that clinical autonomy is the more important in decision making than the views of the person. This has to change. Social Work training is grounded in human rights and individual autonomy. Social Work could potentially be the challenge needed. Since the early 1980s we've been talking about Social Workers becoming a named person providing advice and advocacy for people.

So many people have a named social worker and have done for years. But what's changed?

Whether we are named Social Workers or not we are in the heart of a culture which, families who are brave enough to speak to the press about their experiences are telling us, is immersed in the ways of the old institutions.

We no longer chase the doctors coattails, walk along wards or dormitories in large Victorian buildings but are we still effectively perceived by people and their families as still prowling the corridors, ensuring compliance and often crushing the hope they have of a loving family life.

The Department of Health's vision for adult social work is the most recent attempt to define a role for a Named Social Worker. It is still early days, but from our involvement this feels like something important is being tested.

Social work is at a crossroads. What do we want the Named Social Worker to be? More importantly, what do people with a learning disability and their families and supporters want their Named Social Worker to be?

Self-advocates have told us that they want their Named Social Worker to be there for them. They didn't see the social workers in the heroic role of fighting medics to prevent admission to an ATU. People with a learning disability that we support don't know what an ATU is right up until the point where the options have been exhausted, the 'risks' seemingly too great and the door locks behind them.

The people we spoke to wanted a social worker to be, well, a social worker. The kind of social workers we think social workers want to be; a really good one. One who can speak about love without feeling embarrassed.

For 'Named Social Workers' read 'good Social Workers' or moreover, Social Workers who are legitimised to be exactly what they have trained to be compassionate, kind and on the person's side. Social Work has a unique role and position within the system and it is designed to be the safeguard against people being marginalised. Social work is steeped in an education of social justice, empowerment, human rights and an unequivocal and unashamed approach to helping people to remain as independent as possible and close to the loving support of their families and friends. Ensuring that is our unique role. The only safeguard that is needed is to keep people safe from the system intervening into family life. Whether social workers are 'named' or not, they need to be really good social workers regardless.

THE 6 SITES

SYSTEM STAFF PEOPLE

Key Insight(s):

A named social worker, able to engage earlier with young people in transition, can support them to plan a different future, focused on their independence rather than institutionalisation.

Named social workers are robustly modelling a way of working which is giving confidence to individuals to say what is important to them, and to partners to operate more in line with the social model.

COST BENEFIT ANALYSIS

- There are early indications of significant cost savings arising from greater consideration of appropriate options for young people in transition, rather than a presumed destination of residential college
- It is too early to establish any cost benefit analysis of the named social worker for people in Assessment and Treatment Units

CALDERDALE'S PILOT IN NUMBERS

Team:

4 Social Workers:

2 Advanced Practitioners

2 NQSWs

Cohort:

20 young people in transition (aged 17-18) - living with family (weekly contact with NSW)

10 people living in the community identified as at risk of admission to ATU (aged 20-45) (daily contact with NSW)

6 people in a secure unit (ATU) detailed under the Mental Health Act (aged 20-45) (planned monthly contact with NSW)

NEXT STEPS:

- Continuing to embed the support of Human Rights as the guiding principle across the team through support, supervision and recruitment of team members
- Working out how the lessons learnt from the pilot can be embedded through a period of service change as Calderdale moves to an all age disability service

DESIRED OUTCOME

The idea of 'better social work' to support learning disabled people is embedded within the social work services as a whole

PROGRESS

- Social Workers are making better use of the Mental Capacity Act in assuming, or supporting, an individual's capacity to make their own decisions.
- Case notes also show a more advanced understanding of the right to liberty and security and the right to a family life (as prescribed by the ECHR) than previously demonstrated.
- Reduced numbers of formal assessments are taking place.
- There is a reduced number of safeguarding investigations.

People are supported to uphold their rights and to take informed, positive risks which enable them to live independent lives and to access the full range of rights as citizens

- Through the pilot, and in combination with the development of a '5 day offer' we have seen a greater variety of destinations for young people.
- Involvement of a named social worker at this stage in the young person's journey is leading to more differentiated support plans being agreed with lower numbers of young people on residential support plans, and increased use of local provisions such as the local college, newly introduced internships with hospitals, and services such as gig buddies.
- For people in ATU, progress is slower. The course of the pilot has not been long enough to see anyone released from ATU, but within an ATU setting, named social workers are influencing the support provided ie. changes to the use of therapies to be more appropriate.

SOURCES OF EVIDENCE:

Reflective diaries of 4 NSW's

Health Equalities framework baseline from 36 participants

Infographics collected from self-advocates in three workshops

Reflective analytical piece from Professor Mark Sherry on methodological process; Reflective analytical piece from commissioners

Blog from Principal Social Worker

Interview transcripts from discussion between NSW and principal social worker

Camden

Key Insight(s):

The pilot has improved knowledge and confidence in the transforming care agenda for the named social workers and wider social work teams, as well as growing the visibility of the social model of care within multidisciplinary teams.

The pilot has also surfaced a number of opportunities in the system for example:

- *isolation and lack of meaningful occupation as common unmet needs*
- *the need to ensure all individuals in hospital are assigned an advocate*
- *the importance of having oversight over cases for example to align care plans with care and treatment reviews*

About the model:

Camden adapted their NSW role from the Independent Reviewing Officer role in children's social care. The NSW aimed to hold the system to account, model best practice and identify opportunities to do things differently.

COST BENEFIT ANALYSIS

If the Named Social Worker role was rolled out in its current form, it would need to prevent 6 weeks or more of in-patient care per year to be self funding for the CCG. There is not yet data available to demonstrate the impact the Named Social Worker has had on admissions.

Since the pilot was only 6 months long and only worked with 15 people it was not possible to conclude if the pilot had any impact on length of hospital stay

CAMDEN'S PILOT IN NUMBERS

Team:

2 Named Social Workers (1FTE)

4 Social Workers

2 Senior Managers

Principal Social Worker (adults)

Specialist Commissioning Manager

Commissioning Officer

Learning Disability Nurse

Learning Disability Nurse Manager

Cohort:

15 individuals of all ages (18-68) including 3 people aged 18-25

4 people are living in the community, 6 are in hospital and 5 are in supported living/ residential care

Contact varied in each case and included: an overview at weekly virtual team meetings; 5 CTR's; 2 Blue Light meetings; ad hoc with discharge planning meetings

NEXT STEPS:

- Focusing on individuals in out of area placements and developing new approaches so they can be brought back into community settings where appropriate
- Focus on forensic in-patients and people subject to s117 Aftercare
- Continuing to encourage social work presence in hospital settings and multi-disciplinary teams
- Review TCP commissioner role in light of learning from pilot
- Ensure all TCP cohort have an allocated SW

DESIRED OUTCOME	PROGRESS
 Improved health: An improved understanding of unmet health needs that should lead to improve health outcomes	The Candid-S tool was used to identify unmet needs, highlighting in particular a lack of meaningful occupation and poor social opportunities in both hospital and community settings. Ongoing influence of cases and supporting cases to get on track. Too early to evidence if this has or will lead to improved outcomes.
 Individuals are more involved in their care	The evaluation evidenced that some individuals involved in the pilot had more understanding of the medication they are prescribed, have a better understanding of their own needs and unmet needs, have a better understanding of who to contact in a mental health crisis & when to get help and are more involved in their own support planning. As well as the experience of individuals involved in the pilot, Camden have identified and begun to address barriers in the system to involving individuals in their care. The team have: • Identified that there was a low uptake of the hospital advocate service for people who are unbefriended and have been working with the hospital to address this, for example, ensuring advocacy is on the agenda at all ward rounds, • Developed an easy read consent form to explain the pilot and gain consent for the people to be on the risk register in order to align with Transforming Care Programme policy, Ensured the voice of the individual is represented for example at ward rounds, virtual team meeting and care and treatment reviews (although it was found that the experts at the care and treatment reviews attended were already doing this well).
 Better social work knowledge and skill within the transforming care pathway	A social work audit highlighted the wider SW team had gaps in specific knowledge (4.6/10 confidence score average) and a 22 point action plan was put in place to address these issues, at the end of the pilot the survey demonstrated significantly improved SW knowledge and confidence (6.8/10). The named social workers reported increased confidence in participating in multi-disciplinary conversations and increased specific knowledge about the cohort, the transforming care pathway and legal processes.

SOURCES OF EVIDENCE:

CANDID-S tool: 8 fully or partially completed

Quality Audit tool: 12 cases audited

Reflective diary: One from each NSW, weekly/daily completion

Social Work audit: Interviews at beginning and end of pilot and feedback from social worker team meeting:

Carers Survey: 10 Completed

FOR MORE INFORMATION, CONTACT:

Andrew.Reece@camden.gov.uk

Key Insight(s):

Building the skills of staff and giving them the time, resources and permission to do great social work is improving outcomes, collaboration with other professionals and reducing crises and pressure in the longer term through pro-active and preventative work.

COST BENEFIT ANALYSIS

- Reduced cost from hospital admissions - 0 blue light (crisis) meetings or avoidable hospital admissions thorughout the pilot.
- 1 hospital discharge, 1 move to a more independent setting, and 1 person with a discharge plan in place.
- We believe that the NSW approach in the long term can demonstrate cost benefits for health & social care and better outcomes for individuals that have the need to have a NSW.

HERTFORDSHIRE'S PILOT IN NUMBERS

Team:

8 Named Social Workers

NSWs have minimum of 3yrs experience post-qualified.

Cohort:

A total cohort of 8 adults, all over 25.

2 currently in hospital, 6 in secure living provisions.

Most in weekly contact with NSW and daily if needed.

2 with learning disabilities

2 with learning disabilities & autism

4 with learning disabilities and mental health problems

2 with learning disabilities, autism and mental health problems.

NEXT STEPS:

- Check historical data on key performance indicators (see next page)
- Consider management backfill to continue in another phase of the pilot
- Continuing knowledge dissemination via different channels (surgeries, workshops, collaboration)

DESIRED OUTCOME	PROGRESS
 Lives are more stable, with fewer crises or hospital admissions	Fewer crises, fewer avoidable hospital admissions, fewer blue light meetings. None of these have occurred to the NSW cohort during the pilot. One entrenched service user has moved from being in hospital to discharge planning over the course of the pilot.
 NSWs are skilled and empowered to make a positive change in someone's life, opening up a more positive future.	• NSWs have time and familiarity to build trust with individuals and families, which can have a significant effect on co-designing outcomes and agreeing to participate. • NSWs have the time and space to be more reflective and creative in their work, leading to better outcomes. Sometimes it's surprising how much progress has been made when we present and share it. • Investment in staff resulting in highly-skilled, reflective, creative, effective and knowledgable NSWs. • Staff have the benefit of being coached and mentored and share experiences with Transforming Care Practitioners.
 Our model is effective, sustainable, efficient.	• Strong management lead, support and the can-do attitude surrounding the project. • Increased oversight ("We speak "person being supported" to other professions) and ability to spot gaps and coordinate other professionals, and are increasingly valued by them. • Increased trust, better relationships and satisfaction of staff and service users through favouring consistency over division of labour. (See carer testimonials towards the end of this report).

SOURCES OF EVIDENCE:

Feedback from service users and families

Data collected from peer group sessions

NSW Journals to reflect on progress

Regular Workshops to share information between NSWs and build a knowledge culture

Evaluation Sheets after each training session

Individual experiences, uptake / use of tools

Liverpool City Council

Key Insight(s):

The assessment is a critical intervention in its own right where NSW develop knowledge of the individual and build a trusting relationship.

We have also discovered that we needed to change our assessment process to make it SMARTER.

It has been crucial to drive up the importance of social work role with other professionals and give staff time and capacity to develop care plans which assists providers in achieving outcomes with individuals impacting on improved quality

COST BENEFIT ANALYSIS

- From a cohort of 26 in acute out of area hospital settings, over the course of the pilot, named social worker contact and proactive case management has led to 7 people being discharged, and discharge plans put in place for 5 others.
- A comparison between projected annual costs for new care arrangement in comparison with a hospital shows a 75% reduction in cost.

LIVERPOOL'S PILOT IN NUMBERS

Team:

3 Named Social Workers

Supported by a team manager

Caseload of 7-10: weekly contact

Plus a further 10 cases with lower levels of contact

Cohort:

26 adults (18yrs +) with learning disabilities

Specific focus on individuals in acute out of area long stay hospital setting.

Contact on a fortnightly basis, increased in lead up to discharge.

NEXT STEPS:

- To keep learning from the pilots to provide good social work practice to all adults in Liverpool
- To ensure that the collaborative approach developed with partners becomes 'business as usual'
- To sustain the level of quality achieved in assessment and service specifications

DESIRED OUTCOME	PROGRESS
 What good looks like: improve the lives of vulnerable adults with complex needs via an 'holistic assessment'	Performing assessments that include the nine wellbeing areas of the Care Act and the views of all parties is enabling greater understanding of the individual's circumstances. This has been demonstrated by NSW having time to build a positive relationship, evidenced by the ability to discharge an individual with complex needs and receive feedback such as 'I feel you have actually listened better than anyone else'. An increase in more tailored support packages indicates improvements in the assessment process. An audit will be undertaken of assessments across the locality teams to establish the extent of this.
 Develop and maintain effective relationships with health partners	Both health colleagues and NSW's have reported that their consistent presence and professional interventions of NSW at MDT, CTR, team meetings have increased both the NSW confidence and the level of respect and consideration from health partners evidenced by their responses to NSW input. This has been enhanced by the Team Leader role, who has established regular communication with health partners who have reported that having a named identified person has improved joint working in context of assessment and support planning. This has improved knowledge and understanding from both organisations around each other's roles and responsibilities.
 Lasting legacy: improve standards, knowledge and skills of those staff working with service users with complex needs	4 x training sessions have been provided for Team Leaders, to spread 'what good look like' in context of assessment, support plans and commissioning of individual appropriate services. The NSW have had the capacity and time to develop professionally (research and reading) which has had a positive impact in the confidence and level of skills and knowledge that social workers have. Consequently this has had a positive impact on individual's lives, as social workers are better equipped to assess service users needs, aspirations and promote their independence and inclusion. Team Leaders have reported positive feedback from the training and improved understand of the key ingredients of a 'good assessment and support plan' and have the confidence to support staff. An audit will be undertaken on quality of service specs.

SOURCES OF EVIDENCE:

Joint health and social care patient tracker (date of admissions, personal details, MDT, support plans, estimated date of discharge, etc)

Social Worker reflective practice

Focus groups for health partners

Meeting with health colleagues

Assessments and reviews

Key Insight(s):

By gathering data and stories, Nottingham have built a stronger understanding of the current challenges and opportunities in the system, in particular in relation to hospital admissions. Their findings have highlighted the importance of identifying individuals who might need additional support at an earlier stage (ie before they are put on the risk register), so that the appropriate support can be put in place.

They also identified gaps in social work knowledge around the transforming care pathway and opportunities for providers grow their capabilities working with this cohort.

COST BENEFIT ANALYSIS

Not available

NOTTINGHAM'S PILOT IN NUMBERS

Team:

2 Named Social Workers (AMHPs)

2 Team Managers

Head of Service

Cohort:

4 Social Stories were completed with individuals living in the community

4 individuals were in hospital and work was completed around discharge planning

Intensively working with 1 individual, including weekly visits and meetings with the provider organisation

Nottingham's pilot focused on learning from past cases which meant the two Named Social Worker predominantly focused on qualitative (social stories) and quantitative research.

NEXT STEPS:

- Continuing to meet with the CCG and community health team (ICAT) to develop a collaborative approach to working with individuals at risk of admission, based on data and insights from the pilot
- Enhancing the council's relationships with providers and support providers to deliver higher quality of care and support
- Supporting the wider social work team to build knowledge about the transforming care pathway

DESIRED OUTCOME

PROGRESS

Intensive work with one client

The NSW has worked successfully with one individual and the provider to prevent a further placement breakdown or admission to hospital. They have been on hand to support to the provider, monitor and respond accordingly with the purpose to reduce the risk of any further placement breakdown and prevent hospital admission. This individual remains in the same placement which is working well. The NSW has enabled the individual and their family's voice to be heard by the hospitals and external health agencies by attending meetings with them at the hospital. They have had positive feedback from the family.

Understanding the provider market

Through the social stories, conversations with professional and data analysis, the named social workers identified trends in hospital admissions, for example, where they were living at the time of admission . They found examples of admissions due to placement breakdowns and believe this to be because specialist providers are not always able to manage complex needs.

They also found that spending time intensively with one provider (as part of the intensive work with one client) was fruitful as it allowed the NSW to build a relationship with them and to support them to continue to meet the individual's needs.

The risk register and integrated working

At the start of the pilot, the risk register had been identified as one of the barriers to integrated, preventative working. The named social workers started working more closely with colleagues in the community health team who manage the risk register by convening meetings and gaining consensus around some of the shared challenges and opportunities. Through analysis of historical data, they found:

- 58% of people admitted were not known to the community health team. Out of the total number of admissions prior and post admission only 50% had an allocated worker which increased to 62% when they were admitted.
- the risk register had reduced hospital admissions by 4% since its introduction.
- Only 63% of social work staff felt they had a basic understanding of the risk register and wider transforming care pathway
- That social care are not usually consulted if an individual is being considered being placed on the risk register
- The team now seek to understand more about how the risk register works in order to try and more people er stage before crisis point.

SOURCES OF EVIDENCE:

4 social stories

Data from the ICAT team and Orion Unit for how many people have been placed on the risk register and how many individuals have been admitted to hospital

Questionnaires with social worker colleagues to understand knowledge gaps for transforming care pathway

One questionnaire from a provider

This page highlights insights from specific workstreams in Nottingham as opposed to outcomes due to the nature of the work they undertook for the pilot. The intention is to use these insights as a basis for working differently with social work teams, the CCG and residential provider organisations.

Key Insight(s):

"The NSW can make the system work better for people.

Building relationships allows you to work with people more proactively and effectively. It underpins effective social work practice.

Keeping the individual rather than systems as the focus of social work practice has been key to the success of this pilot."

COST BENEFIT ANALYSIS

As we start out, our first focus is on improving quality of life and experience. In the longer term, we are starting to see indicative data on efficiency.

The pilot has shown success in organising resources around an individual in a timely and relevant way that moves them towards independence. This shift from process-centred to person-centred is improving outcomes.

SHEFFIELD'S PILOT IN NUMBERS

Team:

3 Named Social Workers, each managing a caseload of between 10 and 15 cases plus additional community cases. 1 team leader directly managing NSWs. One Practice Development Coordinator overseeing the project and one commissioning officer linked to the project.

Joint work with the Sheffield Transformation Board (LD) and health colleagues in different areas (including Sheffield Health and Social Care foundation trust who have responsibility for overseeing the "At Risk" Register).

Cohort:

Cohort of 44 adults, with combination of people with learning disabilities and mental health needs. The majority currently live in a hospital/secure setting.

NEXT STEPS:

- Keep this close focus on practice to understand the NSW role in the community after discharges
- Continue to develop tools and invest in training to support the re-introduction of Person Centred Planning
- Continue to build and nurture relationships with other professionals, agencies and institutions

DESIRED OUTCOME

Individuals are empowered, have as much control over their own lives as possible and the right support to achieve their outcomes at the right time

PROGRESS

The feedback from individuals has been extremely positive. They have spoken of how important having a relationship of trust has been. People who receive support and their carers feel empowered and listened to.

Fewer people's lives go into crisis. We are also now moving towards the discharge of at least two people who have each been in hospital for more than a decade. This should be happening in the next 6 months.

NSW's are skilled and knowledgeable practitioners who can use that to support individuals to achieve their outcomes and influence and shape broader social work practice

NSWs believe in the NSW model and report the positive impact it has had on their practice. They have improves social work understanding of the Care Act, and improved knowledge in relation to people detained or at risk of detention under the mental health act.

This has resulted from the increased knowledge sharing within group supervisions, the extra training they've been allowed to access, the positive feedback from the people that they have worked with and a new level of respect they have gained from MDT colleagues.

Health and Social Care systems are efficient, effective and work together well in the best interests of individuals. NSW's support commissioners to know what services are needed and these are put in place

The NSW pilot has led to fewer hand-offs between different social workers, and this consistency has encouraged NSWs to work in a much more holistic way. There is better interdisciplinary working and increased input from service users, which results in smoother discharge from hospital and a reduction in the time it takes.

A range of health colleagues and levels understand NSWs to be about long term support, which has also had a positive impact on how other parts of the health care system have worked with NSWs. The NSW's have also worked closely with commissioners to have the right accommodation and the right support in the right area available to the people of Sheffield.

SOURCES OF EVIDENCE:

Weekly reflective diaries NSW's

Group supervisions: structured minutes, feedback from other social workers and experts by experience

Online surveys of clinicians / other social workers / people who have had a NSW

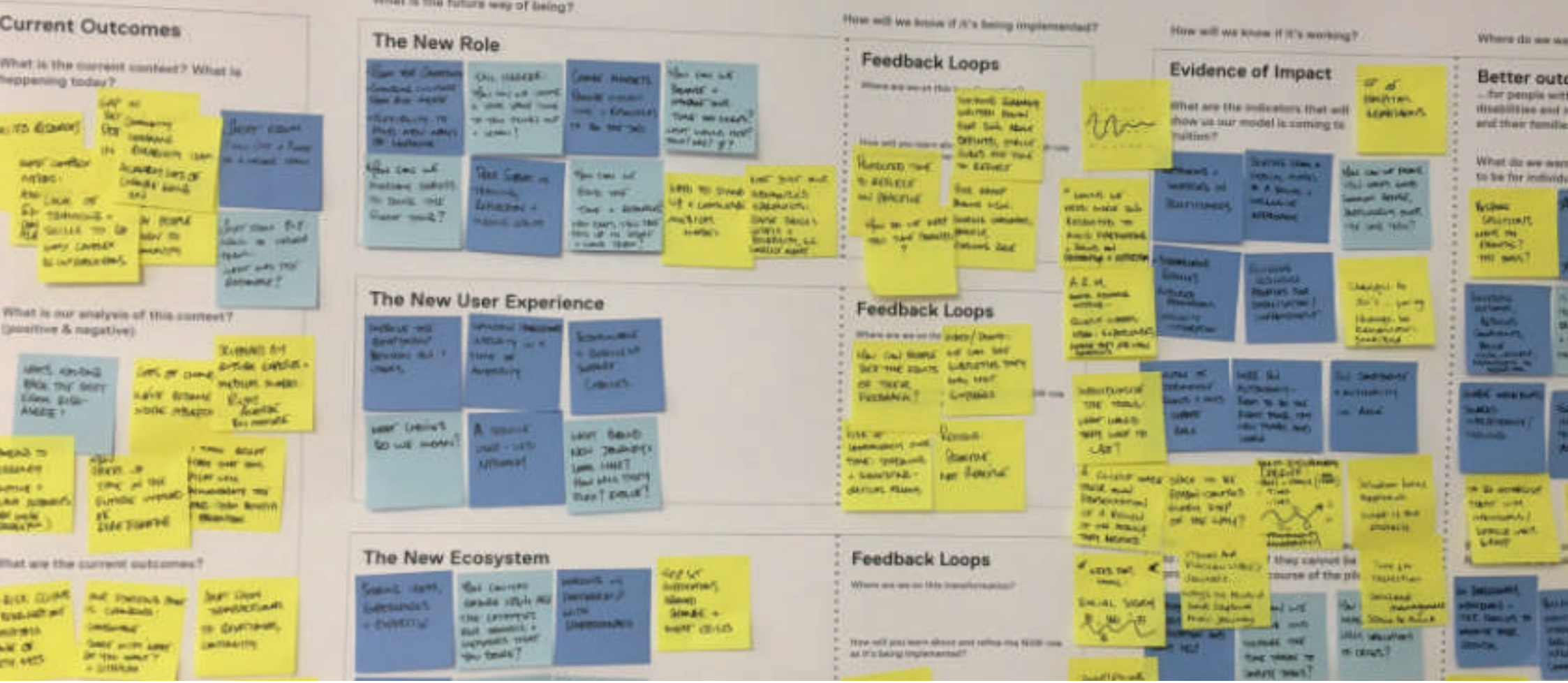
Interview with each of the NSW's at the end of the pilot

Workshop with experts by experience and with the CCG and other clinicians

data on discharges gathered by the CCG

FOR MORE INFORMATION, CONTACT:

Liam.Toner@sheffield.gov.uk or
Adele.Jones@sheffield.gov.uk


Current Outcomes
What is the current context? What is happening today?
What is our analysis of this context? (positive & negative)
What are the current outcomes?
The New Role
The New User Experience
The New Ecosystem
How will we know if it's being implemented?
Feedback Loops
Feedback Loops
Feedback Loops
How will we know if it's working?
Evidence of Impact
What are the indicators that will show us our model is coming to fruition?
Better outc

TOOLS

TOOLS SUMMARY

Each of the sites had specific tools that were key in delivering their work for the pilot. Some of these tools were developed or modified especially, and all were keen to share their approaches. Here is a selection:

If you would like any of the tools mentioned, or the workbooks and activities used to prep each team for the pilot workshops, please contact:

chloe.grahame@innovationunit.org

COMMUNICATION TOOL

Easy Reads

Several sites developed easy reads but applied them in different ways.

Hertfordshire developed an easy read of the pilot to gain consent, and had a slide version (used in-person) and an email version.

Camden developed an easy read explaining the pilot which also doubled as consent to be on the Risk Register.

REFLECTION TOOL

GIBBS Logs & Diaries

Many of the sites used professional reflection as a way to build staff knowledge and confidence amongst staff. Hertfordshire's investment in skilling up staff was integral to their approach. They used the GIBBS model of reflection to encourage sharing and learning amongst their NSW team.

CONVERSATION TOOL

Candid-S as Holistic Conversation

The Candid-S tool is commonly used as a checklist to identify risks and assess status of many different aspects of someone's life, including living situation, family, carer(s), and general wellbeing.

Camden applied the Candid-S tool not just as a checklist to capture data, but as a discussion tool to prompt a more open discussion. The long list of items and topics covered set up a holistic conversation, while the extra time and consistency of contact afforded by the NSW role allowed staff to look beyond immediate issues and assets.

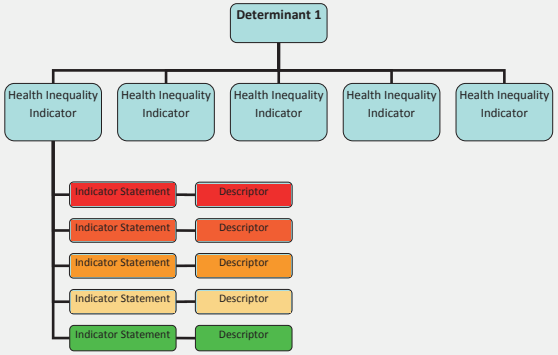
http://www.rcpsych.ac.uk/usefulresources/publications/books/rcpp/1901242994.aspx

REFLECTION TOOL

Health Equalities Framework

In another example of repurposing existing tools, Calderdale used the health inequalities framework as a reflective tool. They have involved self-advocates in reviewing the tool and informing how they use it.

www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf



COMMUNICATION TOOL

Group Supervision & Structured Minutes

Beyond the issue of extra resource providing the time to reflect, each site has found regular reflection sessions to be both beneficial and a time to focus on evolving practice in a changing social care landscape. Sheffield's template asks four simple, human questions to encourage critical reflection, and documents carefully what comes out, including insights, actions and tools.

- Reflect on what your last week as a named social worker was like
- What issues did you encounter and what did you do to resolve them?
- What have you learnt over the last week?
- What could you have done differently?

APPENDIX: PROGRAMME PROCESS

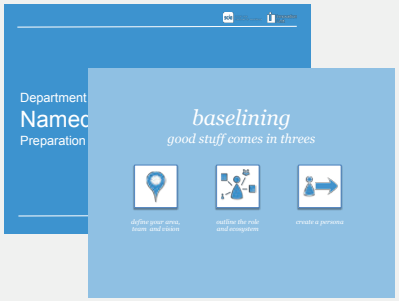
RESOURCES

If you are interested in developing your own approach to a named social worker, we are making the tools used in this programme freely available. To find out more about how to access these, or to understand more about any of the models presented here, please email chloe.grahame@innovationunit.org

PHASE 1 & 2 PREP ACTIVITY BOOKS

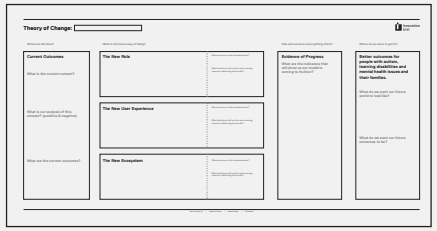
These booklets contain a range of exercises to explore your ideas and assumptions as a team, and develop your readiness, and implement and measure your NSW model, including:

- Define your area, team and vision
- Outline the role and ecosystem
- Create a persona and make observations
- Develop your evaluation practice & plan



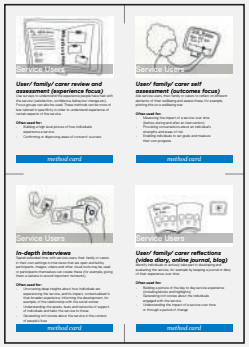
THEORY OF CHANGE POSTER

This Theory of Change poster was used in the first workshop to generate the hypotheses for each of the six sites. It will be revisited in the programme.



METHODOLOGY CARDS

These cards offer some example methodologies for capturing data and helping to measure NSW implementation and effectiveness.

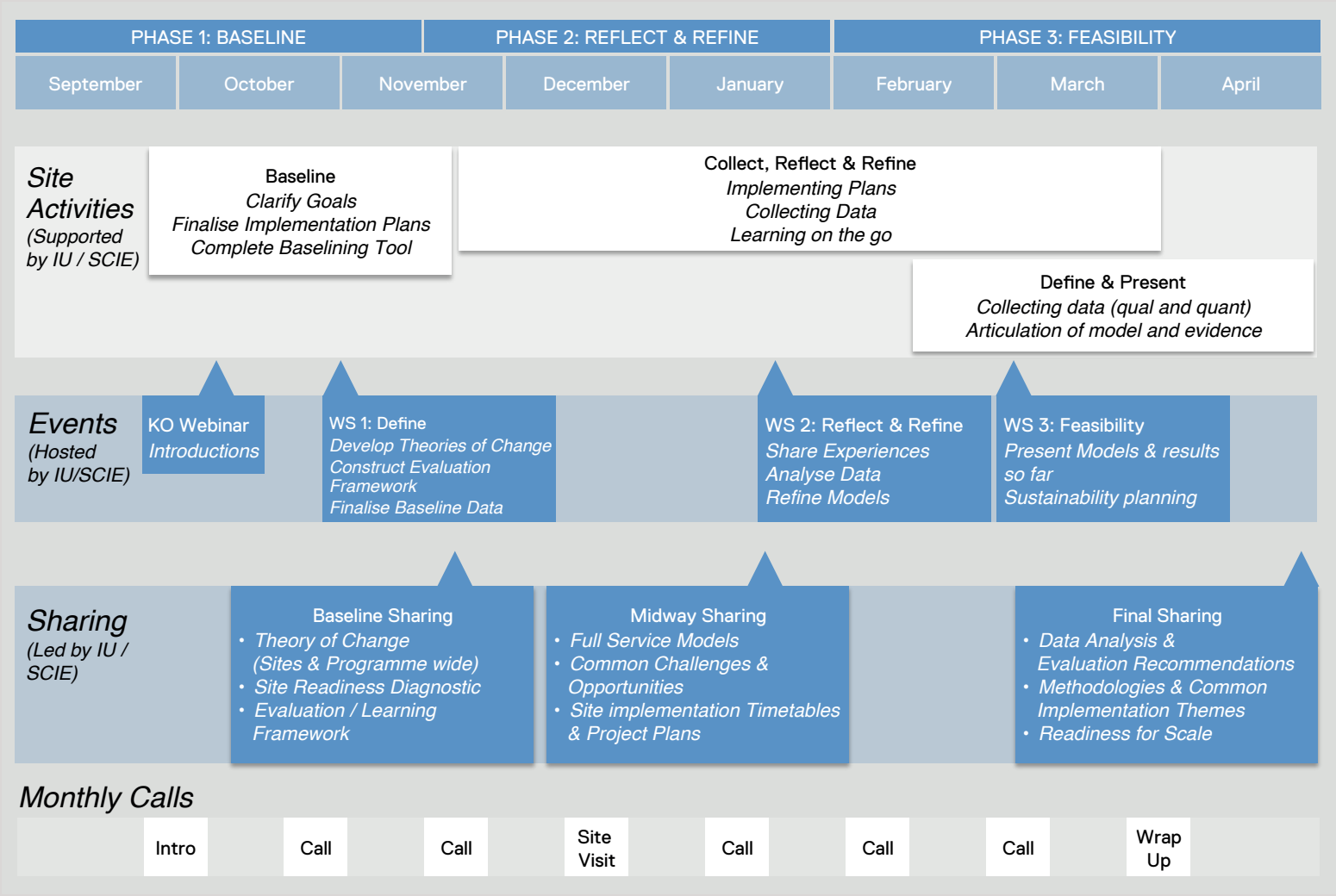


THE PROGRAMME & 3 REPORTS

Sites developing an approach to the Named Social Worker were part of a programme which was structured in three phases. Each has a freely availbale summary report:

- Baseline - articulating the model and planning for implementation.
- Reflect & Refine - gathering data and reflecting on learning.
- Outcomes across 6 Pilot Sites (this report)

In each of these phases there was: ongoing coaching support for sites from Innovation Unit and SCIE, a whole-programme workshop and a report that shares activities, insights and learning.



MORE INFORMATION

The delivery partner for this pilot programme is Innovation Unit, working in partnership with the Social Care Institute for Excellence.

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

Innovation Unit creates new solutions for thriving communities: solutions which build, support and recognise human potential and the critical importance of thriving relationships.