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Shaping *our* Future:

Transforming Lives

A new strategic approach for Social Work and Social Care for Adults in Cambridgeshire

Proactive, Preventative, Personalised

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SUMMARY

This model presents an opportunity to develop a model of adult social care which is markedly different from the current model of social work and social care in Cambridgeshire. It is increasingly proactive, preventative and personalised and aims to enable the people of Cambridgeshire to exert choice and control and ultimately to live healthy, fulfilled, socially engaged and independent lives.

The priorities for this new way of working are:

- A comprehensive, universal and accessible information and advice function, connecting people to their communities.
- Strong, integrated community capacity which is based on a clear prevention strategy and support for carers and families.
- Early identification and intervention, including working with people with sensory impairments, to prevent people from reaching points of crisis
- Assistive technology
- Safeguarding
- Ongoing support for those who need it, based on a personalised, holistic assessment, facilitating care and support which is built on a sustainable budget
- Integrated service delivery with partners, including the voluntary and community sector, NHS and wider public services

This model will require a significant shift in the way that services to adults are delivered and will enable services to meet their statutory, financial and professional objectives. This model underpins the Older People's Strategy and is integral to the achievement of the Council's business plan savings and demand management plans for Adult Social Care and Older People's Services for 2014-15 and beyond. It will also underpin the delivery of Mental Health Social Care. Moreover, this model is a key facet of the Council's joint proposals with the NHS for the Better Care Fund. This is an exceptional opportunity to gain significant funds to support the transformation of the health and social care system in Cambridgeshire with the aim of managing and reducing demand for acute health services and social care services.

Proposal of a new strategic approach for Social Work and Social Care for Adults in Cambridgeshire

Proactive, Preventative, Personalised

1.0 PURPOSE

1.1 To propose a new strategic model for social work and social care in Cambridgeshire, in response to a number of key drivers, as part of the thematic review work and provide outline next steps in taking this proposal forward.

1.2 To outline the integral links between this model and the other internal reviews, strategies and other key pieces of work, including the thematic review areas on prevention and early intervention, triggers of entry to social care, carers and assistive technology; and also the Older People's Strategy and the Alder progression work in the Learning Disability Partnership, and the delivery of Mental Health Social Care within Health Services under a section 75 agreement with Cambridgeshire and Peterborough Foundation Trust (CPFT) to deliver social care for Mental Health.

1.3 To outline the fundamental links between this model and other external processes including the Clinical Commissioning Group (CCG) procurement exercise for Older People, and the Better Care Fund proposal that Cambridgeshire County Council is developing in partnership with the NHS.

1.4 To develop "*a practice method that is designed to engage people's strengths and the forces pushing towards growth, and to influence organisational structures, other social systems and physical settings so they will be more responsive to people's needs" (*German and Gitterman 1980).

2.0 BACKGROUND

2.1 The thematic review on Social Work and Social Care was commissioned in June 2013 in response to a series of national drivers (which can be found in Appendix two), the need to make savings within the adult social care budget and the challenge of whether Adult Social Care services could be delivered differently in Cambridgeshire.

2.2 The review was commissioned by the Children, Families and Adults Service (CFA) management team with a view to looking at Social work

and Social Care in Cambridgeshire and proposing a sustainable model that meets both the key national and local drivers and, significantly, meets the needs of Cambridgeshire communities.

2.3 Adult social care is operating in the context of great change at national level. There is an urgent national agenda, being driven by a number of influential bodies who are strongly advocating the need for change. Coupled with new legislation and the need to reduce budgets at a local level, there is a strong case for change to our current approach and structure of social work and social care in Cambridgeshire.

2.4 During the development of this model, research was undertaken into models of social work and social care in other counties. The work that Suffolk County Council is currently undertaking to reform their adult social care services has been of particular interest and has provided a platform from which the proposed model has been developed.

3.0 TRANSFORMING LIVES: A PROPOSED STRATEGIC MODEL FOR SOCIAL WORK AND SOCIAL CARE IN CAMBRIDGESHIRE

3.1 The model outlined within this paper provides a clear strategic direction which would enable adult social care to meet national drivers, including legislative and policy changes and emerging best practice within the field of Social Work and promote a joined-up approach. The model is based on building upon people's strengths (a strengths based model - see appendix three for definition) that would ensure that we are able to meet the needs of individuals and communities in Cambridgeshire. It intends to deliver improved choice, control, well-being and independence for the residents of Cambridgeshire.

3.2 The model updates and encompasses Cambridgeshire's local commitment to 'Shaping our Future: Transforming Adult Social Care', based upon 'The vision for a modern system of adult social', which is built upon six principles. The six principles[1]of personalisation, partnership, plurality of markets, protection, productivity and people continue to be championed within the proposed model.

3.3 Furthermore, the proposed model would enable CCC to make the most effective use of money, based upon preventing the escalation of crisis, and therefore preventing or delaying longer term needs for adult social care services. This would see a reduction in the number of people receiving ongoing support as these services become a last resort, rather than a first offer. Given the context of increasing demographic pressures on services, this work provides an excellent opportunity to

[1] From 'A Vision for Adult Social Care: Capable Communities and Active Citizens', Department of Health, published November 2010

create a sustainable model of demand management that will be able to meet the needs of our communities, both now and in the future.

3.4 This model is predicated on a person-centred, strengths based approach, with carers, the community, the voluntary and community sector and partnerships at its core. It would require health, social care and housing, as well as other public service partners to work effectively together to meet the needs of our communities. It focuses upon positive action and effective social work rather than process.

3.5 This model of social work and social care is customer focused, focusing on what people really want and providing individuals with increased opportunities to personalise their solutions to issues they are facing, exercising higher levels of choice and control. It is a strengths based model which has a focus upon recognising individual assets and utilising existing networks and community initiatives. It encourages individuals to seek solutions from within wider networks and communities, before requiring the provision of adult social care services. This model requires staff from across adult social care services to operate in a way which supports this approach.

3.6 The proposed model, based on integrated working with the voluntary sector, NHS, Adult Social Care, together with other partners, can be found in Appendix one. It should be noted that this model is intended to cover all client groups within adult social care services, but clearly has particular benefits for the older population, who we are seeking to prevent or delay using social care services in future.

4.0 INFORMATION AND ADVICE

4.1 The proposed model is predicated upon an effective, universal accessible and well-publicised information and advice offer which is quick and easy to access, clear, friendly and has the ability to be personalised to meet the needs of the customer. Information and advice will be available online, in easy-read written form and through face-to-face interactions.

4.2 At a primary level, the universal advice and information could be based on the CCC Website, but would also act as a ‘one-stop-shop’ which would be accessed by professionals, carers, voluntary and community sector organisations or anyone within the community. This would ensure that everyone has access to the same, transparent information.

4.3 Cambridgeshire has good provision of information and advice. This could be strengthened by:

- Improving signposting and sharing of information on prevention and support services.

- Improving or developing the information and advice offer around key triggers of entry to social care and unplanned hospital episodes e.g. frailty, mobility issues
- Continuing to raise awareness of the 'Your Life, Your Choice' website (Cambridgeshire's adult social care portal) and the 'Ask Sara' website (self assessment tool relating to community equipment)
- Ensuring that all information is as accessible as possible for all client groups and sectors of the community

4.4 The prevention review recognises the importance of a strong information and advice offer and proposes the development of preventative programmes:

- Promoting the benefits of being in work or other purposeful activities
- Encouraging people to plan for older age

4.5 The Community Navigators are a key facet of very local information and advice functions. It is recommended that the capacity of the Community Navigators programme is increased to provide further support to older people and vulnerable adults. Appendix four provides further information about Cambridgeshire's Community Navigator programme.

4.6 Alongside the Community Navigators function, there would be an expectation that professionals all take on a signposting duty, ensuring that they have a knowledge and understanding of local information, allowing them to provide friendly local information and advice.

4.7 It is recognised that individuals may be aware of opportunities within their local area, but may not feel confident to attend or get involved. This model proposes that professionals, volunteers and members of the community when providing information and advice would facilitate or provide a 'supported introduction' between the individual and the community activity, for example attending a lunch club with them and facilitating introductions, to encourage them to attend and to provide emotional and possibly practical support.

5.0 PREVENTION, EARLY IDENTIFICATION AND EARLY INTERVENTION

5.1 Information, advice, prevention, early identification and early intervention are inextricably linked. Information and advice would help people to find out about local voluntary and community activities and as illustrated above, the model will have particular benefits whereby a 'supported introduction' has taken place.

5.2 Strong, independent communities are fundamental to this model, in providing activities, support and friendship that will contribute to individuals' wellbeing and ability to live happy, healthy, fulfilled,

independent lives within their local communities.

5.3 Alongside communities, supportive families and carers are crucial to the success of this model. Families and carers are often best placed to support individuals to achieve their aspirations.

5.4 There are some excellent examples within Cambridgeshire of community engagement programmes, including Timebanks and Community Navigators which aim to build community capacity. We will need to work with communities (and their District and Parish Councils) to build and develop their resources to support people, through organised activities, for example a Timebank or a lunch club, but also by encouraging people to be 'good neighbours' and considering the needs of those around you, for example driving a neighbour who has mobility issues to the shops and assisting with their shopping.

5.5 This model aims to increase the capacity of the community to provide support to vulnerable adults by:

- Expanding the Community Navigator Model
- Developing a deep outreach/ community mentoring programme
- Increasing support to carers
- Expanding and encouraging the creation of Timebanks within Cambridgeshire and other capacity building mechanisms
- Further developing the role of Community Hubs (further information can be found in appendix five).

5.6 The development and investment in information and advice and community capacity has the ability to prevent people from entering a crisis situation. Residents will be able to access a wealth of information on local activities, health care, housing, transport and much more, that will help them to maintain their independence, improve their well-being and live more healthy, active lives.

5.7 For individuals with learning disabilities, physical disabilities, sensory impairment or mental health issues the prevention activities described support a strong progression offer. Community based activities will encourage participation from all individuals and offer the opportunity for all to contribute their skills. Progression is a key element of this model, and it is strongly underpinned by opportunities within the community and those led by our voluntary and community sector partners.

5.8 A focus on prevention and supporting individuals to maintain and maximise their independence has the potential to reduce long term care costs. If action can be taken early and this helps people at risk of reaching a crisis, more serious situations might be avoided, so that people can live independently for longer. This approach will provide support for people when they need it, allow them to maintain their independence and avoid or delay a proportion of longer term costs. For some client groups including those with a learning disability, a physical disability and vulnerable adults, this early identification and intervention

needs to start as children particularly ahead of transition planning and the need at that point in their journey to focus on progression and life skills alongside educational attainment.

5.9 Early identification and intervention is key to the success of this model and to preventing people from entering longer term adult social care. Prevention work ensures that professionals are aware of the individuals living within a community, understand their circumstances and aims to maintain individuals' wellbeing independence; early intervention is about professionals being proactive in identifying need and putting things in place to avoid the escalation into crisis, rather than waiting for it to be presented as a formal referral. Adult social care professionals based in communities will lead on early intervention and will work with NHS colleagues within Multi-disciplinary Teams (MDTs) to identify those people within communities who are more vulnerable and may be at risk of crisis in the future. The work undertaken on triggers of need for adult social care will help us to shape further opportunities for early intervention within communities. A key aspect of this will involve information sharing between partners to enable the early identification of individuals who are vulnerable to a health and/or social care crisis or at risk of hospital admission.

5.10 Evidence-based preventative initiatives can help to support adults and carers to maintain their independence and support self-care for those with long-term conditions or risk factors for ill health. These include falls prevention programmes, sensory rehabilitation, physical activity, encouraging a healthy diet and preventing malnutrition, and promoting smoking cessation (Cambridgeshire Joint Strategic Needs Assessment on the Prevention of Ill Health in Older People, 2013). There are opportunities to build these initiatives into integrated pathways and identify those who would most benefit from them through partnership working, recognising the contributions of all public sector services to prevention and early identification of need.

5.11 This model acknowledges that not all crises are preventable, however, with high quality information and advice, and a strong community offer, together with support to individuals, families and carers, when a crisis does take place it is more likely that the individual feels better supported to deal with the crisis. When a crisis has taken place very often the family or carer will be able to help to assist the individual through the crisis and clear information and advice will help the individual to make well-informed choices.

5.12 In order to realise the benefits listed above strong partnerships will need to be established with voluntary and community sector (VCS) organisations who are fundamental to the success of the model. CCC, partners and the VCS have valuable learning and skills that must be shared as this work is developed.

6.0 CRISIS RESOLUTION AND RECOVERY

6.1 Crisis resolution provides a local, rapid response immediately following a crisis, at which the individual is put at the centre of this intensive work. It focuses on the needs of the individual at that point in time, and very short term planning will take place with support needs designed around the needs and circumstances of the individual. The adult social care professional would then provide support to the individual for the duration of the crisis, checking with them regularly to ensure that they are coping and feel well supported.

6.2 An example of this might be of an older couple who live together, independently but supporting each other, within the community. If the wife went into hospital, the rapid response would be out within a few hours and would ask the husband what he needed at this point in time to help him to maintain his independence. This could be transport to hospital to visit his wife, and he would be asked if he had any support networks he could utilise, e.g. if he had anyone (family/friends) that could help him and assist with this. It could be that he needs assistance to get to the local community centre so he can maintain his life and can continue to independently socialise with his friends, preventing loneliness and isolation. It might be that he wishes maintain his routine and he needs some help with shopping, so he is able to remain independent. This would increase his wellbeing, a concept which underpins the draft Care and Support Bill; "*The overarching policy objective of these measures is to support people who use care and support, and their carers, to maintain their health, wellbeing and independence for as long as possible"* (Draft Care and Support Bill, July 2012 p137). A definition of wellbeing from the Draft Care and Support Bill can be found in Appendix six.

6.3 The aim of the rapid response is to support individuals through crisis to help individuals to maintain their independence and to prevent further deterioration and the need for longer term adult social care. One of the key aims of crisis resolution is therefore to support people to remain independent of statutory services.

6.4 Crisis response will be friendly, personalised and goal focused and will require the adult social care professional to quickly establish what the individual needs most urgently at that point in time and work with them to establish how this will be achieved within their circumstances through the use of strengths-based conversations, building upon people's strengths, example questions can be found in appendix seven. At the heart of this approach is getting underneath the issues that cause problems for an individual, and giving them tailored support to help them when they need it. There will be a wide range of support available, from the community, voluntary and community sector organisations, public services, carers and family and friends.

6.5 It will require adult social care professionals to think differently and creatively about the support that the individual needs, and will require a different type of conversation with our service users. It will feel different to the way in which we manage crisis situations currently, and will enable social care professionals to utilise their local knowledge, work with local partners and find creative solutions to meet the needs of the individual. The visit from a professional may begin with them sitting down with the individual in their home and having an informal conversation about the things that are important to them and the issues they feel they have as a result of the crisis (examples can be found in appendix seven).

6.6 Alongside crisis response is reablement, visual impairment and occupational therapy rehabilitation, assistive technology and deaf services equipment, which play a fundamental role in supporting, encouraging and enabling individuals to regain their independence and where possible to continue to live active, fulfilled lives independently in their own homes and maintain their role within the local community. This model suggests that an increased investment in professionals to assess for Assistive Technology and the technology itself which could prevent or delay access to more costly and longer term social care packages.

6.7 When a crisis has been resolved, the individual will be signposted by the professional to local appropriate information, advice and community activities, which will support them in the continuation of their recovery and encourage their independence.

6.8 The work that has been undertaken within adult social care on the triggers for individuals accessing health and social care services will be integral to the development of the crisis response approach. In looking at the most common and frequent triggers of social care need by area within Cambridgeshire, it will help us to understand the likely crises, informing our outline approach to them. Conclusions are beginning to be formed which will help to further shape the preventative work as we will seek to prevent people experiencing the crisis. One of the conclusions emerging from this work is the importance of the role that other agencies, for example community health or GP, play in who accesses social care. The importance of partnership working to the success of this model cannot be overstated. Further detail about the work on triggers can be found in appendix eight.

6.9 Establishing a time-limited, local crisis response will often prevent the need for long-term support. By providing short-term goal focused support, it will prevent long-term costly care packages being allocated at the point of crisis which may not be required after the point of crisis.

6.10 This approach meets the needs of the customer better by providing a fast and responsive service that is focused on helping them to recover,

so that wherever possible, they are able to live independently or with minimum support in their own home.

7.0 ON-GOING SUPPORT FROM CORE ADULT SOCIAL CARE SERVICES

7.1 The model proposes that on-going support from core adult social care services for those who need it is based on a requirement of effective integrated longer-term planning and support, with our multi-agency partners. The premise of the model is to prevent people from entering this area through the enhancement of our information and advice offer and preventative activity and through the creation of a crisis management approach. The model is predicated on the clear separation of longer-term social care from the other more mainstream elements of this model, and it will therefore enable adult social care to focus its statutory resources on those who quite properly require it.

7.2 The longer term support for individuals would be planned through the use of holistic, integrated assessments, and would be self-directed, based upon personal budgets and the principle of choice and control. The nature of the strengths based conversations that professionals will have with the individual would change, and planning would take place with the individual to ensure that we are continually building upon their strengths, families, networks and resources to achieve their aims. At this level, it is anticipated that deeper conversations, for example into individual's personal financial circumstances, may be required. It will be acknowledged that the individual, their carers and their families are the experts on their own lives.

7.3 Individuals in receipt of on-going support from adult social care services would be encouraged to utilise assistive technology and rehabilitation services and encouraged to be active participants within their local community. When any additional issues might be raised, the individual would be signposted to information and advice, enabling them to find a local solution that meets their needs.

7.4 Ultimately, the aim is to reduce the numbers of people accessing ongoing adult social care and health services and increase the numbers of people who are able to maintain independence within their communities, with little or no input from statutory services. This demand management will produce financial savings, and prevent reliance on adult social care core services.

8.0 CULTURE CHANGE

8.1 This model is different to our current approach and would require a

significant culture change, both internal and externally with our partners for it to be successful. It is a strong vision which would provide a clear focus with all professionals and partners, enabling us to tie up a plethora of policy changes within a clear strategic model.

8.2 It is predicated upon changing the nature of the conversations that professionals have with their customers. Professionals would put the individual and their opinions and feelings first and ensure that we are taking into account and building upon their strengths, networks and resources as well as upon their needs. In addition, there is an emphasis upon self-help and resilience of service users. Professionals will have knowledge and understanding of the local area and will consider the full picture, away from the traditional notion of services and packages. Flexible budgets and resource management which allows professionals from different partners to combine their resources and work across organisational boundaries will be encouraged to ensure that professionals find the most cost effective solutions.

8.3 This model requires strong partnership working between health, social care, housing and the voluntary and community sector and wider public services. It will involve all professionals in these sectors and beyond to be well informed and able to provide customers with information or to signpost them to further information. It will require strong and proactive multi-agency work to intervene early to keep people from entering a crisis situation or longer-term social care. When people enter social care, it will require clear integrated assessments, pathways and processes to ensure that collectively, professionals are able to meet the needs of the individual in the most efficient way.

8.4 As well as utilising the strengths of the individual, the model recognises the much wider roles and contributions that individuals, families, communities and services make to the wellbeing of adults.

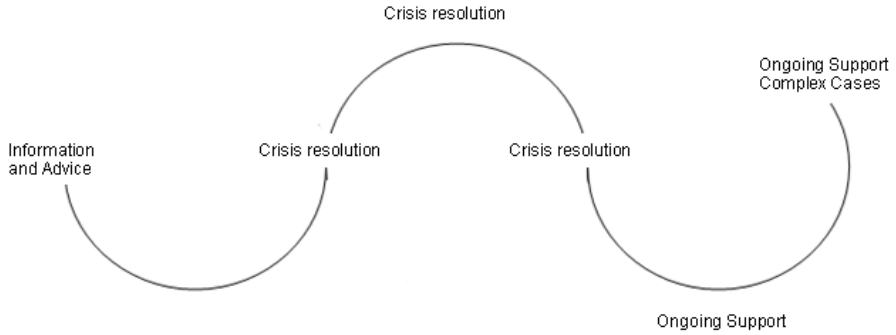
8.5 This provides a ‘Cambridgeshire’ solution to the complex issues facing adult social care services nationally, as it will involve local and community focused commissioning and delivery of the provision of prevention, care and support for adults in Cambridgeshire.

9.0 STAFFING AND PROFESSIONAL STRUCTURE: A NEW WAY OF WORK

Prevention and Early Intervention

9.1 The model is predicated on a ‘mixed economy’ of contributions from across the public services, voluntary and community sector and the community.

9.2 This model requires staff to have diverse and mixed skills to utilise public sector staff appropriately and prevent duplication. The diagram above illustrates the key provision as described within this paper, with



peaks where more intensive working with complex cases would be required. This may indicate where to deploy qualified social workers within this strategic model, based on experience elsewhere.

9.3 Changing current practice, never long-term planning within a crisis and changing the nature of the conversations that the workforce have with our communities are fundamental to the success of this model. Culture change and workforce development is crucial to the success of this model and must play a key role in its design and implementation.

9.4 The aim of the model is to ensure that social workers are able to spend more time with less people: those who really need their help and support. This is a positive change, in favour of authentic social work and ensures that our social work and social care staff are valued as professionals and will help them to feel that they are making a positive, more specific contribution.

9.5 The model will recognise social work as a profession and ensure that all staff, qualified social workers and alternatively qualified staff, have the opportunity to progress within this integrated system. As part of a new workforce development offer, clear progression pathways will be available, based on the Professional Capabilities Framework (see Appendix 11), application of which will improve practice and support continuing progression and professional development.

10.0 KEY STRENGTHS

10.1 The key strengths of this staged model are that it gives a coherent strategic framework and direction of travel for adult social care which:

- Is preventative and pro-active, aiming to identify and support individuals, carers and families who are at risk before they may require intensive support or care
- Is personalised and promotes greater independence, choice and control
- Meets the needs of the customer better by providing a fast and responsive service that is focused on helping them to recover from crisis
- Has a strong community focus, based on local knowledge
- Is based on proportionate assessment
- Is a strengths based model which utilises and values the contributions and strengths of our communities and carers
- Has a truly person focused approach, looking at the needs, networks and resources of the individual and building a long term plan where necessary based on this holistic assessment
- Utilises and values the skills, experience and contributions of our current workforce
- Moves away from the traditional notion of social care services and packages as a primary solution to crisis.
- Reduces or delays the demands for acute and long term health and care services
- Is based on integrated working with partners to facilitate a quick, joined-up response.
- Utilises and builds upon our current good relationships with the voluntary and community sector
- Intends to reduce the number of people who need on-going and long-term support from adult social care and therefore has the potential to reduce waiting times for customers as well as reducing expenditure
- Is strengthened by the concept of multi-disciplinary teams
- Values and supports carers, recognising that they are fundamental to the successful working of this model.
- Promotes the use of assistive technology and occupational therapy and sensory rehabilitation to aid independence which in some cases may prevent the need for costly services e.g. a waking night service.

11.0 ALTERNATIVE MODELS

11.1 As part of the thematic review work, research is being undertaken into alternative models of social work and social care in the UK. As summarised within the business case, this is a new area of policy development and councils are in the process of developing their responses. Nationally, a pilot project is underway which is exploring various options for innovative organisational arrangements for social care.

11.2 Irrespective of the model that Cambridgeshire adopts for its adult social work and social care, it will need to make significant changes to

enable it to meet the demographic and budget pressures which the service is already facing and which will intensify over the coming years.

12.0 FINANCE

12.1 Further work will need to be done to begin to identify the potential savings and costs of this model. It is anticipated at this stage that this will be an 'invest to save' model.

12.2 This model intends to reduce or delay the demands for acute and long term health and care services, and therefore there is the potential for significant savings to be achieved across the public services.

12.3 Furthermore, it will allow us to strip out any unnecessary, repetitive or non-value added parts of the system, and instead focus upon the needs of the customer, increasing the savings potential. Process and system redesign to build in more flexible ways of working with partners will make the model more efficient and cost-effective.

12.4 Suffolk, who have adopted a very similar model, anticipate that the change is estimated to save the county council £3.7million by 2013/14.[2]

13.0 A CHANGE MANAGEMENT PROGRAMME

13.1 A change management programme will be required to design, deliver, implement and evaluate this work.

13.2 A project board has been established to govern this work, membership of which can be found in appendix ten.

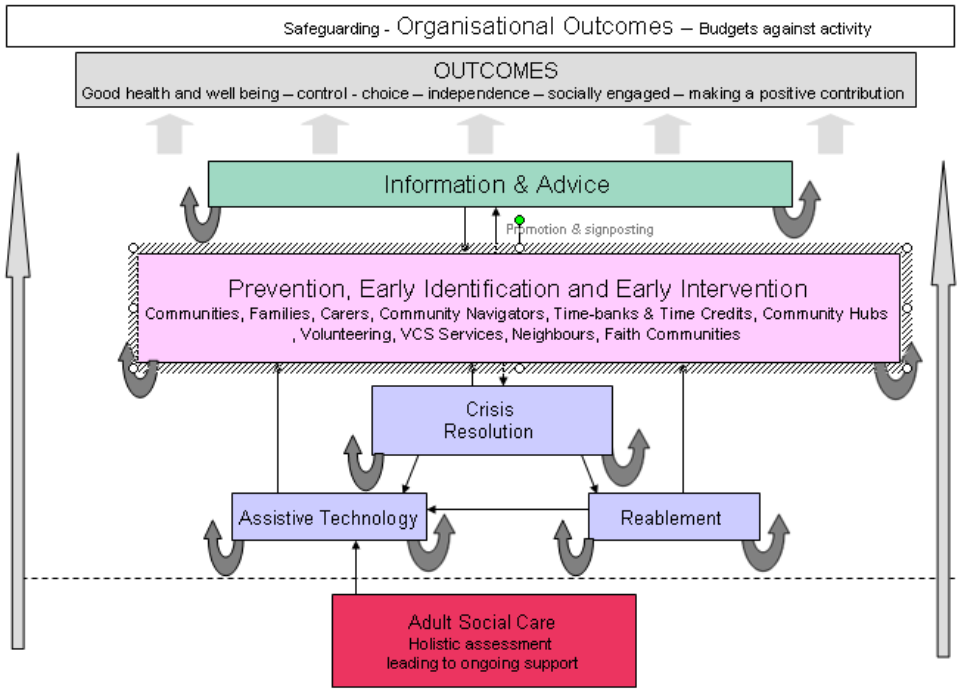
13.3 Three workstreams have been set up to deliver this work, details of which can be found in appendix ten.

13.4 The model described within this paper will be discussed with staff through a series of area-based roadshows. The roadshows will provide staff with the opportunity to help to shape and develop this model.

13.5 When developing this work, we will need to take the same strengths based, solution focused approach to the adoption and implementation of this strategic model as for working alongside individuals, families and their communities.

[2] Sufffolk County Council Cabinet Paper from 21st February 2012 .

Appendix One



Appendix Two

National Drivers

There are a number of national drivers for this project, including:

- The Social Work Reform Board which has made a series of recommendations to reform of social work in order to ensure that outcomes are more effective and the need for social care to modernise. These recommendations have begun to be broadly adopted nationally as a model of good practice. It is likely that Authorities will be inspected against implementation in future.
  The recommendations are summarised within five key areas of reform:
    - The Professional Capabilities Framework for Social Workers in England (an overarching professional standards framework)
    - Standards for employers of Social Workers and Supervision Framework
    - Principles that should underpin a Continuing Professional Development Framework
    - Proposed requirements for Social Work Education
    - Proposals for effective Partnership working.

- The College of Social Work strongly advocates social work reform. In December 2012 they published a Business Case for Social Work with Adults which argues that reducing the numbers of Social Work practitioners may offer short term savings but will fail to realise the potential of social and community capital which will offer the long-term sustainable savings which are required.
  Furthermore, in May 2013 The College of Social Work published a consultation document on the 'Roles and Tasks Requiring Social Workers' which closes on 28th June 2013. This document provides advice for the circumstances under which a social worker must be used and an extensive list of reserved tasks and other tasks that social workers should complete.

- The Care and Support White Paper, Caring for our Future also acknowledges the importance of the role of the social worker, arguing that *"Social workers have a crucial role to play in the reformed care and support system"*.
- The Draft Care and Support Bill (July 2012) emphasises a number of key 'General responsibilities of Local Authorities' which include:
    - Promoting individual well-being
    - Providing information and advice
    - Promoting diversity and quality in provision of services
    - Co-operating generally
    - Co-operating in specific cases
    - Promoting integration of care and support with health services etc
    - Preventing needs for care and support

- Valuing People Now: a new three-year strategy for people with learning disabilities (2009) is a strategy to improve the lives of people with learning disabilities and their families.

Appendix Three

Strengths Based Approach

At the very least, the strengths perspective obligates workers to understand that, however downtrodden or sick, individuals have taken steps, summoned up resources, and coped. We need to know what they have done, how they have done it, what they have learned from doing it, what resources (inner and outer) were available in their struggle to surmount their troubles. People are always working on their situations, even if just deciding to be resigned to them; as helpers we must tap into that work, elucidate it, find and build on its possibilities.

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Appendix Four

Community Navigators

Cambridgeshire Community Navigators project is a three year project running from October 2012 to October 2015, which is funded by CCC adult social care.

Care Network Cambridgeshire has been commissioned to be the delivery partner.

The Community Navigators project was commissioned by adult social care as part of its strategic whole-system shift toward preventative approaches.

Context for the service:

1. A reoccurring central theme that emerged from the Ageing Well workshops was the need for access to accurate and comprehensive information about services, such as finding support and care, and wider community issues, such as transport and benefits and the range of activities available locally.
2. Cambridgeshire County Council's website, 'Your Life, Your Choice' sets out and links to much of this type of information and is being increasingly used by many people across the county. However, many older people have limited access to the Internet, and/or require explanation and support to understand the more complex topics.
3. The model has been adapted from the Dorset Wayfinder Project which was developed as part of the Dorset Partnerships for Older People Programme (POPPs).

Project aims:

To maintain and improve the health and wellbeing of older people in Cambridgeshire by:

- Informing people about and referring them to relevant activities and services.
- Helping people overcome barriers to make use of relevant activities and services.
- Identifying where more activities and services are needed and working with local people to provide these.
- Targeting people at risk of poor health and wellbeing.
- Reaching out to communities to engage with hard to reach and isolated older people.

The service provides:

- A countywide Community Navigator Manager.
- Five District/City level Community Navigator co-ordinators and Project Support Worker.
- A network of Community Navigator volunteers (both community and organisational) who will then act as a local key point of contact, identifying and assisting isolated older people in accessing appropriate services and activities at an early stage and so delaying or preventing crisis.

Appendix Five

Community Hubs

In September 2011 the County Council adopted a strategy to create a 21st Century Library Service, following an extensive review of the Service. This established that "Library services are at the heart of the Council's development of Community Hubs, building on the service's unique network of quality, well located buildings offering a safe, neutral and non-commercial space for communities to meet and find information, resources and assistance, as well as a highly valued and trusted 'brand'.

A set of Guiding Principles for Community Hubs were identified in the Cabinet report of 27 September 2011:

- Services shaped by the community.
- A modern and accessible approach to local public services.
- Sustainable public services, which provide long-term value for money.
- A gateway to learning, knowledge and information, contributing to the local economy.
- Create savings for CCC and wider public services.

Crucially, it has been agreed that Community Hubs will be the 'face to face channel' for information about all Council services, just as the Contact Centre and the Council's web site are the telephone and online channels. This will be increasingly important as more and more services go online as part of the Government's "Digital By Default" strategy, to support people who don't have the skills or equipment needed to transact online, with face to face assistance.

Cambridgeshire's vision is that a Community Hub is a place in a local area where residents can go to access information, advice, and guidance about Council services. Community Hubs will be an enabler to help communities to help themselves.

There are clear benefits to developing libraries as Community Hubs, both for customers and for the Council.

For customers these include: being able to access a wider range of information and services under one roof in a more integrated way; being able to make use of the generic facilities on offer for a wider range of individual and community activities; and being able to receive face to face support for a wider range of transactions in order to become independent digital citizens and participate fully in society.

For the Council the benefits include maximizing the use of its property assets and those of other public sector partners according to "Making Assets Count" principles; efficiencies through reducing duplication and better joining up between services.

Appendix Six

Definition of Wellbeing from the Draft Care and Support Bill (July 2012)

"The general duty of a local authority, in exercising a function under this Part in the case of an adult, is to promote that adult's well-being.

"Well-being", in relation to an adult, means that adult's well-being so far as relating to any of the following –

(a) Physical and mental health and emotional well-being;
(b) Protection from abuse and neglect;
(c) Control by the adult over day-to-day life (including over the care and support provided to the adult and the way in which it is provided)
(d) Participation in work, education, training or recreation
(e) Social and economic well-being
(f) Domestic, family and personal relationships
(g) The adult's contribution to society "

From:
http://careandsupportbill.dh.gov.uk/general-responsibilities-of-localauthorities/clause1/

Appendix Seven

Strengths Based Approach Example Questions

There are many different questions that can be used to discover internal and external strengths. For a more complete reference, see Saleebey (2006) and De Jong and Miller (1995). Nevertheless, strength-discovery questions are endless.

1. Survival questions: How have you managed to overcome/survive the challenges that you have faced? “What have you learned about yourself and your world during those struggles?” (Saleebey, 2006, p. 87)

2. Support questions: Who are the people that you can rely on? Who has made you feel understood, supported, or encouraged?

3. Exception questions: “When things were going well in life, what was different?” (Saleebey, 2006, p.87)

4. Possibility questions: What do you want to accomplish in your life? What are your hopes for your future, or the future of your family?

5. Esteem questions: What makes you proud about yourself? What positive things do people say about you?

6. Perspective questions: “What are your ideas about your current situation?” (Saleebey, 2006, p.87)

7. Change questions: What do you think is necessary for things to change? What could you do to make that happen?

A word of caution is necessary here. Any strengths-based assessment must proceed from the belief in the client and it should not become a verdict or sentence for the client.

Repeating these questions or filling out a strengths-based form does not mean that you are working from the Strengths Perspective.

A profound belief in the client’s potential is intrinsic to any strengths-based assessment.

Thinking about strengths begins with the understanding what goals and dreams the person has; reflecting on the possibilities and hope in their lives.

In this process, they can discover or develop new possibilities for themselves and change toward a better quality of life.

References: *Saleebey, D. (Ed.). (2006). The Strengths Perspective in social work practice (4th ed.). Boston: Allyn & Bacon.*

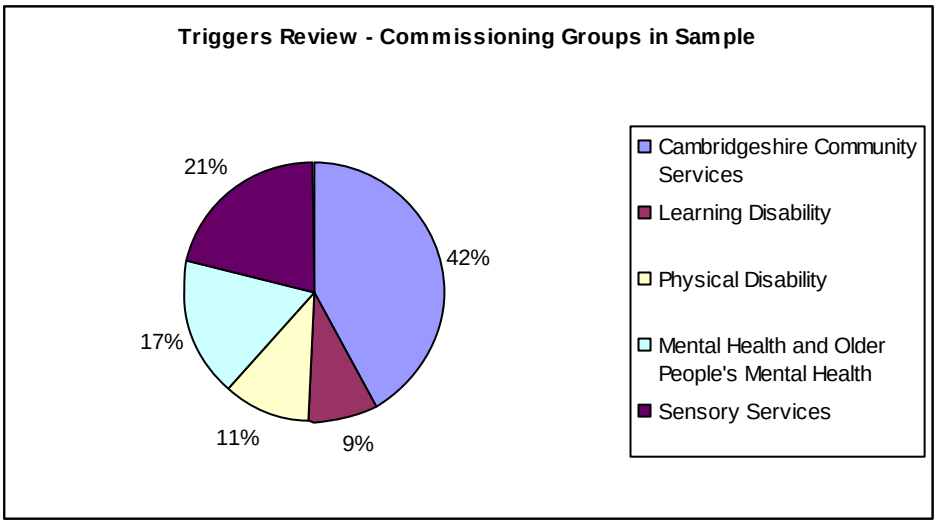
Appendix Eight

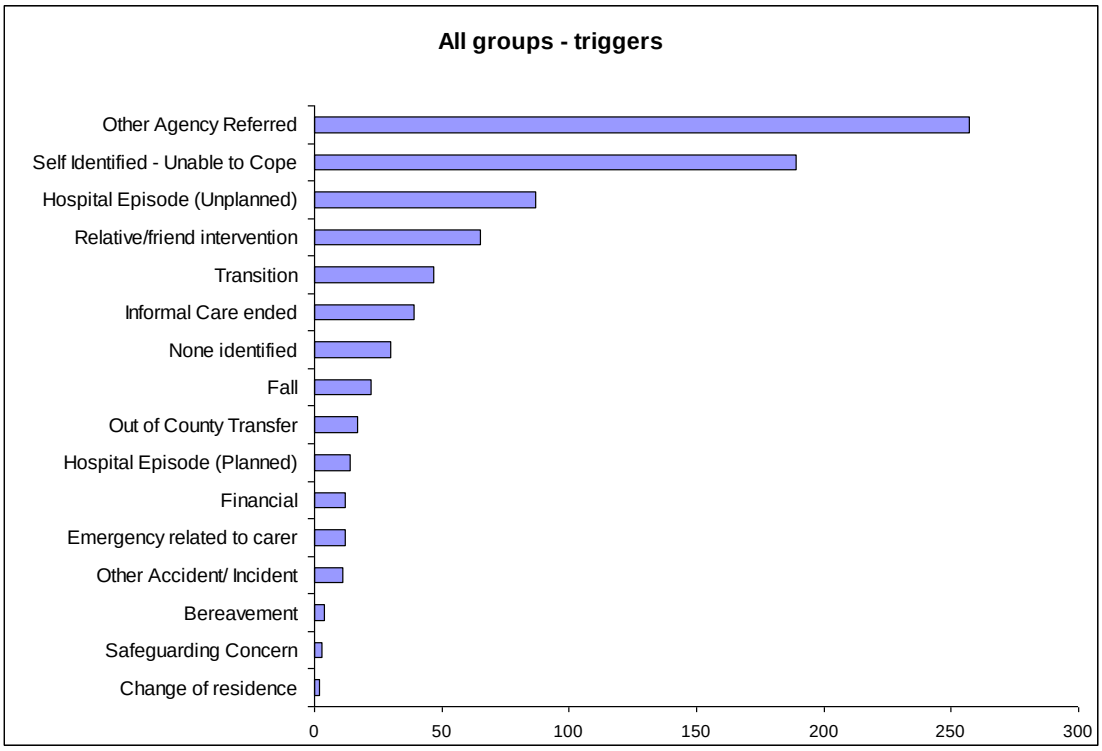
Triggers

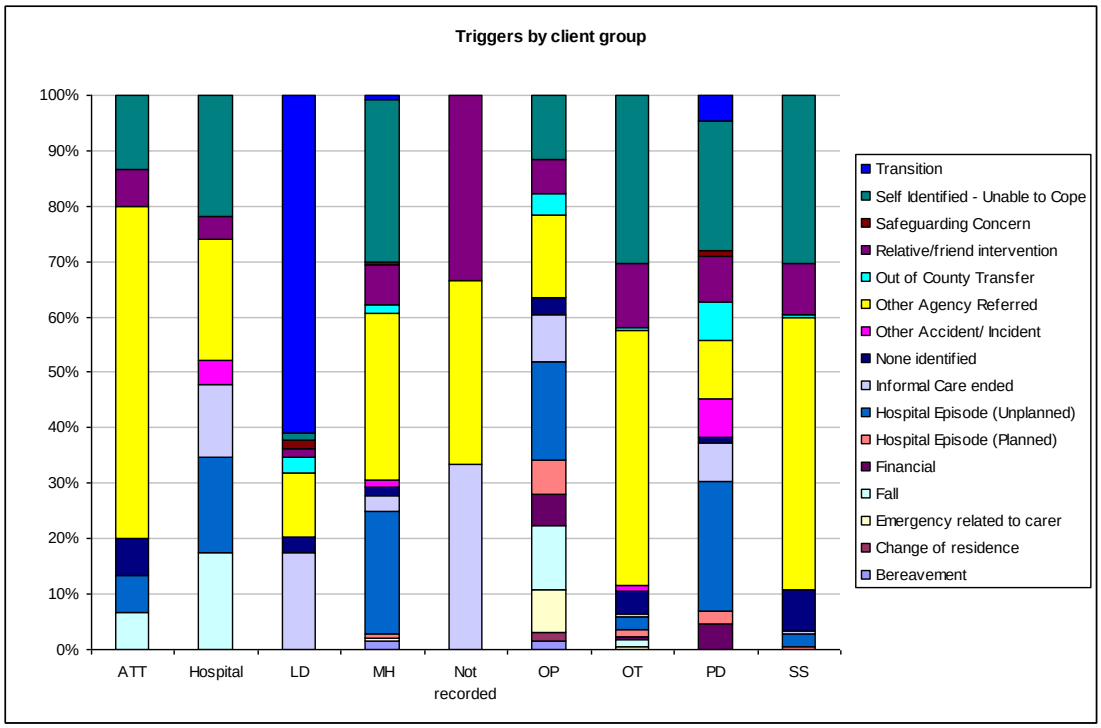
Work has been recently undertaken in adult social care to look at the 'triggers' of need for adult social care.

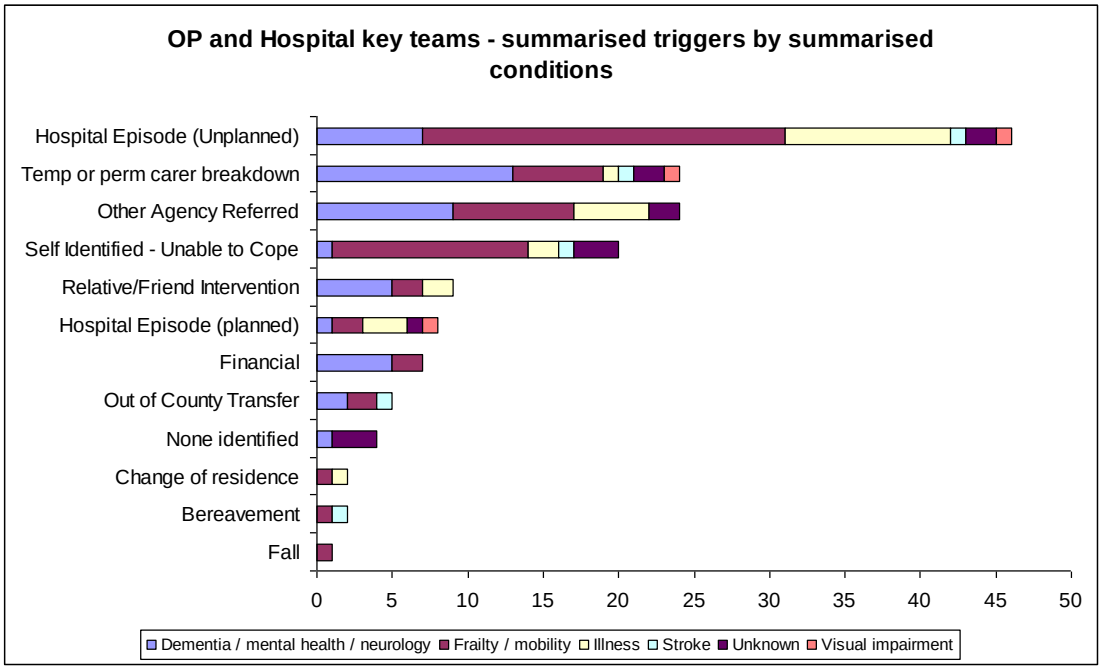
Triggers Methodology:

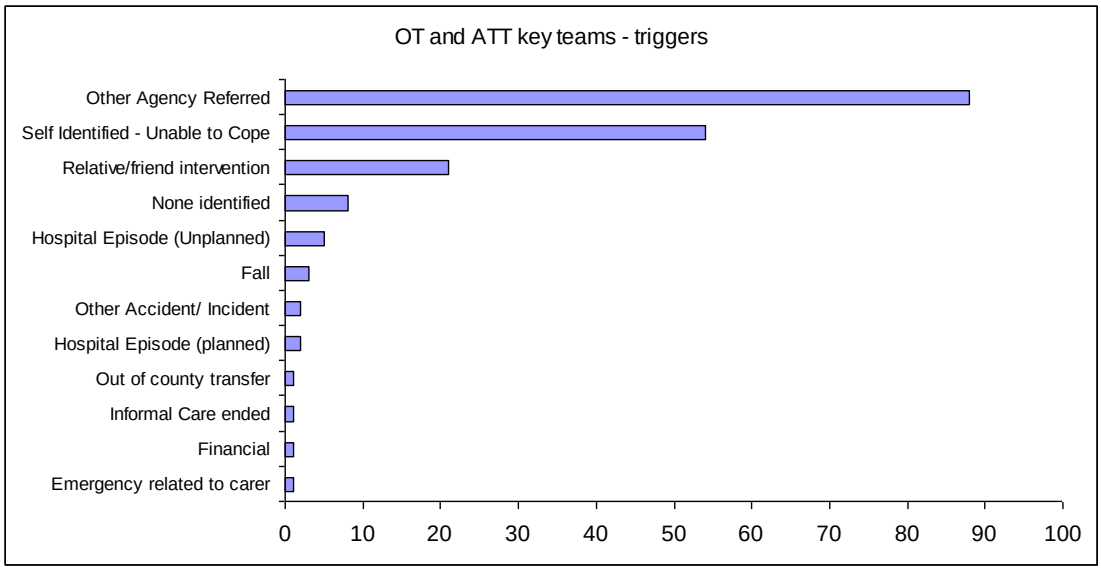
- Asks 'what event happened that meant an assessment was undertaken?'
- Looks at Assessments undertaken in 2012-13
- Divide by client group
- Samples are random and representative and will give 95% confidence level

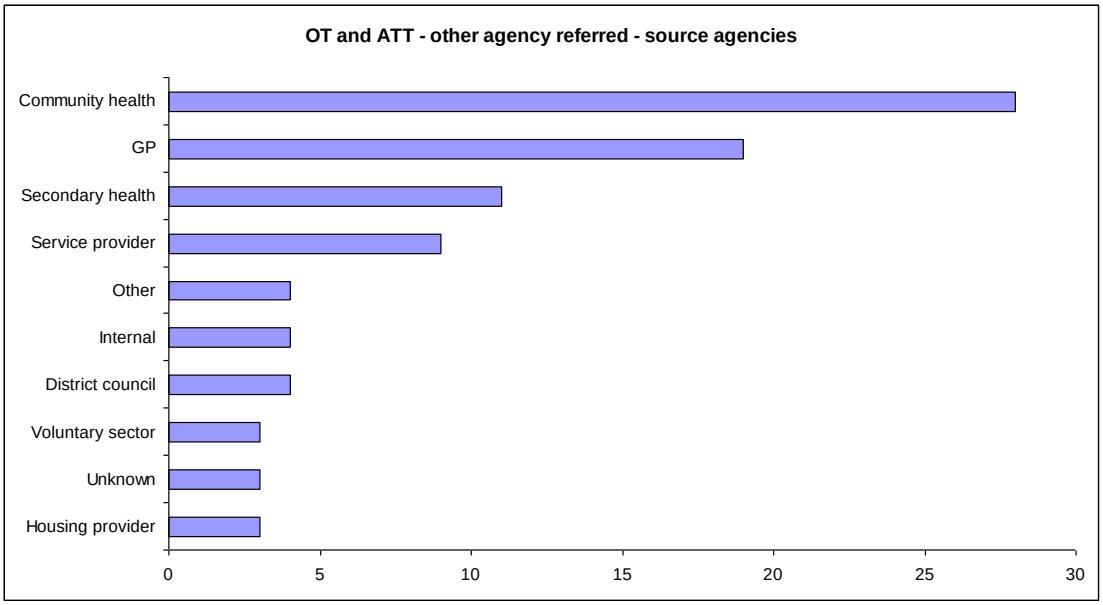





Triggers by client group
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ATT
Hospital
LD
MH
Not recorded
OP
OT
PD
SS
Transition
Self Identified - Unable to Cope
Safeguarding Concern
Relative/friend intervention
Out of County Transfer
Other Agency Referred
Other Accident/ Incident
None identified
Informal Care ended
Hospital Episode (Unplanned)
Hospital Episode (Planned)
Financial
Fall
Emergency related to carer
Change of residence
Bereavement


OP and Hospital key teams - summarised triggers by summarised conditions
Hospital Episode (Unplanned)
Temp or perm carer breakdown
Other Agency Referred
Self Identified - Unable to Cope
Relative/Friend Intervention
Hospital Episode (planned)
Financial
Out of County Transfer
None identified
Change of residence
Bereavement
Fall
0
5
10
15
20
25
30
35
40
45
50
Dementia / mental health / neurology
Frailty / mobility
Illness
Stroke
Unknown
Visual impairment





Conclusions:

- Other agencies play a very important role in who accesses adult social care
- The pattern of triggers is different for people with a key team of OP, PD or MH compared to key teams of OT, ATT, LD, all of which have a pre-dominant trigger
- Unplanned hospital episodes (falls or illness) are the most common trigger for people in key teams of OP and Hospital (mostly over 65s)
- Community / primary health services are the most common trigger for people who use less intense occupational therapy or assistive technology care packages (also sensory services), so the relationship between these services is likely to be key to preventing situations deteriorating
- There is not likely to be a single intervention that could prevent people from using complex more intense services like those used by people in OP key team

Appendix Nine

Definition of Social Work

Definition

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

Commentary:

Social work in its various forms addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction. Professional social work is focused on problem solving and change. As such, social workers are change agents in society and in the lives of the individuals, families and communities they serve. Social work is an interrelated system of values, theory and practice.

Values

Social work grew out of humanitarian and democratic ideals, and its values are based on respect for the equality, worth, and dignity of all people. Since its beginnings over a century ago, social work practice has focused on meeting human needs and developing human potential. Human rights and social justice serve as the motivation and justification for social work action. In solidarity with those who are dis-advantaged, the profession strives to alleviate poverty and to liberate vulnerable and oppressed people in order to promote social inclusion. Social work values are embodied in the profession's national and international codes of ethics.

Theory

Social work bases its methodology on a systematic body of evidence-based knowledge derived from research and practice evaluation, including local and indigenous knowledge specific to its context. It recognises the complexity of interactions between human beings and their environment, and the capacity of people both to be affected by and to alter the multiple influences upon them including bio-psychosocial factors. The social work profession draws on theories of human development and behaviour and social systems to analyse complex situations and to facilitate individual, organisational, social and cultural changes.

Practice

Social work addresses the barriers, inequities and injustices that exist in society. It responds to crises and emergencies as well as to everyday personal and social problems. Social work utilises a variety of skills, techniques, and activities consistent with its holistic focus on persons and their environments. Social work interventions range from primarily person-focused psychosocial processes to involvement in social policy, planning and development. These include counselling, clinical social work, group work, social pedagogical work, and family treatment and therapy as well as

efforts to help people obtain services and resources in the community. Interventions also include agency administration, community organisation and engaging in social and political action to impact social policy and economic development. The holistic focus of social work is universal, but the priorities of social work practice will vary from country to country and from time to time depending on cultural, historical, and socio-economic conditions.

Adopted by the IFSW General Meeting in Montréal, Canada, July 2000.

*This international definition of the social work profession replaces the IFSW definition adopted in 1982. **It is understood that social work in the 21st century is dynamic and evolving, and therefore no definition should be regarded as exhaustive.**

Appendix Ten

Project Governance

Project Board:

Project Sponsor: Claire Bruin – Service Director: Adult Social Care
Charlotte Black -Service Director: Older People's and Mental Health Services
Mike Hay - Head of Practice and Safeguarding
Paul Evans – Head of Workforce Development
Ken Fairbairn – Head of Procurement / Supporting People
Jackie Galwey – Head of Operations: Older People's Services
Kim Dodd – Head of Mental Health Services
Lynda Mynott – Head of Disability Services
Richard O'Driscoll – Head of Service Development: Older People's Services
David Tebbutt – Service Finance Manager
Caroline Adu Bonsra – HR Business Partner
Lynsey Barron – Business Improvement and Development Manager
Tammy Liu - Business Improvement and Development Manager
Representative(s) from user/carer reference group

Proposed Workstreams:

- Developing the Model : Mike Hay to lead
    - Learning Disability Partnership
    - Older People's Services
    - Mental Health Services
    - Physical Disability Services

- Supporting Systems – to cover: Finance, data, I.T., Practice Guidelines and Monitoring and evaluation. Lead TBC

- Change Management, Workforce Development and Project Communications – Paul Evans to lead

Appendix Eleven

The Professional Capabilities Framework

The Professional Capabilities Framework (PCF) is an overarching professional standards framework, developed by the Social Work Reform Board and is now owned by The College 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.

Domains within the PCF.

The Professional Capabilities Framework has nine domains (or areas) within it. For each one, there is a main statement and an elaboration. Then at each level within the PCF, detailed capabilities have been developed explaining how social workers should expect to evidence that area in practice.

The nine capabilities should be seen as interdependent, not separate. As they interact in professional practice, so there are overlaps between the capabilities within the domains, and many issues will be relevant to more than one domain. Understanding of what a social worker does will only be complete by taking into account all nine capabilities.

Professionals and their practice will be assessed 'holistically', by which we mean that throughout their careers, social work students and practitioners need to demonstrate integration of all aspects of learning, and provide a sufficiency of evidence across all nine domains.

1. **PROFESSIONALISM** - Identify and behave as a professional social worker, committed to professional development
2. **VALUES AND ETHICS** - Apply social work ethical principles and values to guide professional practice
3. **DIVERSITY** - Recognise diversity and apply anti-discriminatory and anti-oppressive principles in practice
4. **RIGHTS, JUSTICE AND ECONOMIC WELLBEING** - Advance human rights and promote social justice and economic wellbeing
5. **KNOWLEDGE** - Apply knowledge of social sciences, law and social work practice theory
6. **CRITICAL REFLECTION AND ANALYSIS** - Apply critical reflection and analysis to inform and provide a rationale for professional decision-making
7. **INTERVENTION AND SKILLS** - Use judgement and authority to intervene with individuals, families and communities to promote independence, provide support and prevent harm, neglect and abuse
8. **CONTEXTS AND ORGANISATIONS** - Engage with, inform, and adapt to changing contexts that shape practice. Operate effectively within own organisational frameworks

and contribute to the development of services and organisations. Operate effectively within multi-agency and inter-professional settings

9. **PROFESSIONAL LEADERSHIP** - Take responsibility for the professional learning and development of others through supervision, mentoring, assessing, research, teaching, leadership and management

Further information about the PCF can be found using the link below:
http://www.tcsw.org.uk/pcf.aspx