



**think local
act personal**

**DEVELOPING A WELLBEING AND
STRENGTHS-BASED APPROACH
TO SOCIAL WORK PRACTICE:**

CHANGING CULTURE



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The images used throughout this document are taken from Hertfordshire's 'The Great Leap' project, detailed in Appendix 4.

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FOREWORD FROM THE DEPARTMENT OF HEALTH

This publication is of vital importance for social care and social work. It supports the Department of Health's ambition to transform the social care sector and reinforces the role of social work in supporting people to have better lives.

Developing a Wellbeing and Strengths-based Approach to Social Work Practice exemplifies the deep and sustainable changes that are required so that the core values, knowledge and skills of great social work are at the heart of improving people's lives and delivering the policy intentions of the Care Act 2014.

It provides advice and guidance to support social workers consider how they might deliver the changes needed for a strengths, rights and co-production approach.

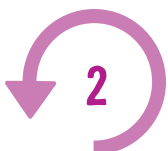
The social model has always underpinned social work with its focus on offering people self-determination, choice and control over their care and support; as well as its emphasises on dignity, respect, valuing diversity and a non-judgmental way of working.

However, as is highlighted, using a production approach and pursuing performance indicators as measures of success have acted as perverse incentives to relational social work and the development of connection, social inclusion and citizenship.

Modern 21st century social work must reclaim the profession and improve practice through true collaboration with people who use services and those who care for and about them. This requires different conversations with people to make sure they really are being listened to and are empowered along with their families/carers to lead with solutions of their own.

What matters and can make a difference to improving people's lives is exploring possibilities and providing hope and opportunities.

Lyn Romeo, *Chief Social Worker for Adults at the Department of Health*



The community perspective

Talk to social workers of a certain vintage about community development and many will begin to recall fondly the days of 'community social work', when social workers were expected to think whole-community in their approach to supporting people and perhaps even had the time and freedom to do so. Since that period, pressures upon social workers have increased with rising demand and falling budgets. The professionalisation of social work took the sector away from community social work, which was sometimes seen as hazily defined and weak on evidence of outcomes.

It would be foolish to believe there was a 'golden age' and this paper is not a call to return to the past. Despite increasing pressures, social care can claim to have reformed itself more radically than any other public service sector. The concept of 'personalisation' is still contested and imperfectly implemented, but it is unarguable that thousands of disabled and older people have a level of choice and control which was unheard of until recently. Half a million people have personal budgets and a fifth of those have taken their personal budget as a cash Direct Payment, enabling them to create and manage an entirely new workforce of Personal Assistants. There are hundreds of innovative small and micro-scale enterprises, helping people to live well through interventions which look nothing like traditional services. Community-based interventions like Shared Lives are growing rapidly despite the pressures of austerity.

So there is much innovation in services and support, alongside much-raised standards of skill and accountability amongst social workers, but we are also starting to understand the limitations of services acting on their own and the huge potential for support which fits around and enables people's informal support relationships with their families and communities. That change does not make social work any less important, but it will require a new (or rediscovered) set of social work skills and attitudes: a social care workforce with the humility to use its power and access to resources not to take charge, but to enable people and families to take charge. It will need to be a workforce confident in its expertise but also more confident in the expertise and potential of individuals, families and communities. Models like Local Area Coordination and community navigators create the space in which professionals can get to know individuals and families well enough to understand what their goals and capabilities are, as well as their needs.

Making those deeper relationships the norm will be a huge challenge in a financially stressed social care system, but meeting that challenge is the only way to a sustainable system, good lives for people with long term conditions and a workforce which is the best it can be.

Alex Fox, CEO of Shared Lives Plus and TLAP board member for Building Community Capacity

From the perspective of people who use services

Back in my community development days I used to share an office with social workers. I remember one social worker in particular, she was a fierce advocate for her clients. Such a fierce advocate in fact that people who use services wanted her to be their social worker and management were keen to give in if they possibly could.

Over the years social work has faced many challenges from the introduction of community care in the early 1990s, to personalisation, and now austerity. One of the consequences along the way has been a growing disconnect between social workers, people who use services and their families. This Paper offers practical ways to reconnect.

So much can be achieved by people who use services and their families by planning and working together with social workers to find solution to support needs and to enhance quality of life. The independent living movement itself would not have happened without the involvement of like-minded social workers who grasped the possibilities and worked with disabled people to achieve their goals.

These are not easy times for social care, but that is why it is more important than ever to work together and use what we have to greatest effect. Social workers and those of us who need support along with our families need to make common cause to achieve participation in our communities as equal citizens.

Sue Bott CBE, *Disability Rights UK and Chair of Self Directed Support Forum, TLAP*



EXECUTIVE SUMMARY

This paper takes personalisation, in the context of the Care Act, as a starting point – the normative way of doing adult social care business. From this standpoint it explains how the workforce¹ can be realigned around the concept of wellbeing, and it examines the value of doing this:

- Creating better physical and mental health and social care outcomes for people living more actively in their local communities.
- Generating greater satisfaction for people using services and their carers.
- Creating a motivated adult social care workforce.

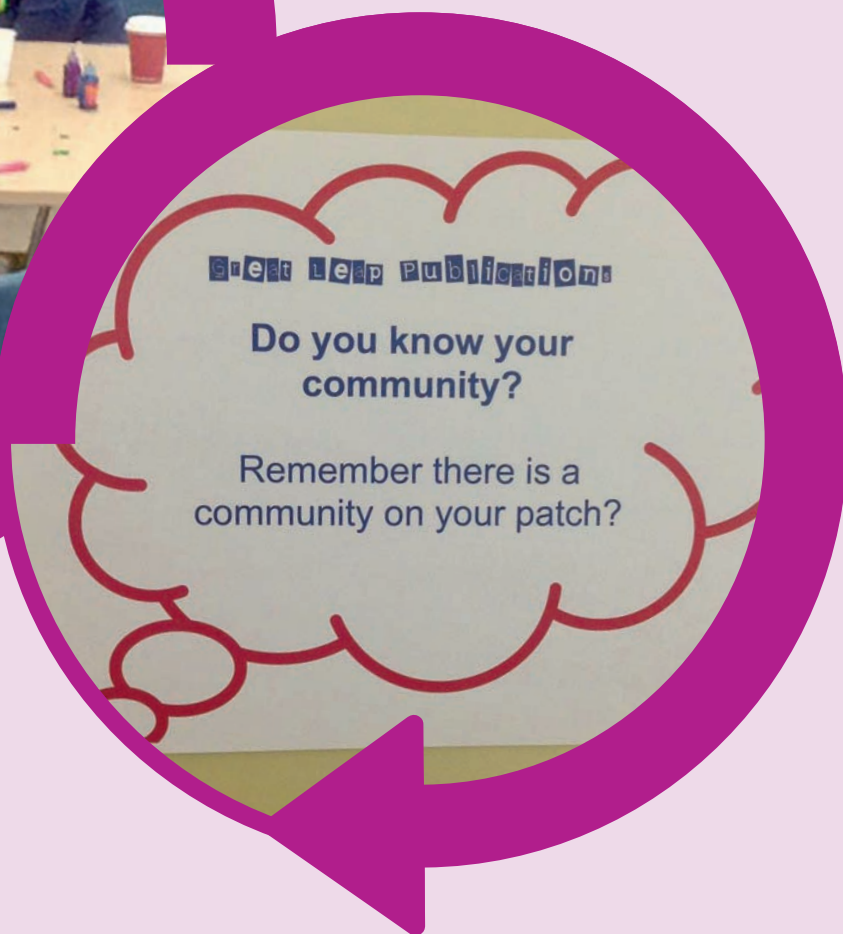
The paper then sets out the key knowledge and skills the social care workforce needs to apply strengths-based approaches in improving people's lives. However, the paper goes further than this. It also considers the emerging business case for pursuing a strengths-based approach, and provides some examples of how various councils, along with their health partners, are creating new workforce cultures that deliver an alternative health and social care operating model.²

Specifically, the paper aims to support development of an adult social care workforce that:

- Promotes the skills, abilities and knowledge of the person with care and support needs and their carers
- Promotes individual wellbeing by encouraging independence, self-care, support and learning opportunities for informal carers, before specific service solutions are sourced; challenging those services to align themselves with the contribution, knowledge and skills of the individual and their support network

1 What we mean by 'the workforce' is described in Appendix 1

2 There will of course be many more examples we could have used from around the country. TLAP would like to hear from councils and their partners who have good practice to share. If you would like to see your case study written up and shared more widely please contact tim.gollins@scie.org.uk



- A social care workforce that is comfortable delivering professional support, by which we mean employing their own skills and knowledge and using their own personal abilities to further the health and wellbeing of a person with care and support needs (i.e. using an assessment as a meaningful intervention not as a gateway for services)
- A social care workforce that is skilled at enabling people to put together their own bespoke packages of care, support and learning, and ensuring the right kind of support structures are in place for them in relation to their personal outcomes

BACKGROUND

There are some key strategic issues for adult social care as we move into 2016: ongoing integration and the Better Care Fund (BCF), transfers out of hospital care and winter pressures, implementing the spirit and letter of the Care Act, devolution, market oversight, making safeguarding personal, ongoing personalisation and use of direct payments, person centred service, outcome-based commissioning, sector led improvement and peer review, demographic and technological demand pressures, alongside increasing expectations and widening inequality, and of course, managing the impact of ongoing austerity. Priorities seem to expand inexorably whilst resources to deal with them continue to be restricted.

The impact of these kinds of pressures can be seen in the priorities set by strategic directors in care and support organisations. For example, at a priority setting process in Yorkshire and Humber directors of adult social services from across the region listed the workforce and the importance of cultural change as one of its two top priorities, second only to integration.

One of the reasons why workforce issues are so high on the agenda of adult social care directors is that the Care Act 2014 introduced a bold new duty: the promotion of individual wellbeing. At first glance, it is an innocuous looking proposal, but in reality it is one of the most ambitious goals for public service reform in recent times.³

Wellbeing is defined broadly, that is, not just as obtaining physical and mental health; but also it means being an active citizen, being able to pursue employment, being a family member. These are goals which even well-funded and well-organised traditional services cannot deliver on their own: they extend deep into a territory in which the most important factors for success are people's own resources and their informal relationships, not their relationships with professionals.

³ Fox 2014

Delivering the ambitions of the Care Act will demand of all social care services that they have the humility to recognise the reality of their status as junior partners in a wider system of relationships and support networks. The implications of this are that services need to organise themselves around people's 'natural' family and friendship support networks, always asking whether they are suitably supporting and enabling them, but importantly, also making sure that their actions are not unintentionally undermining them.

Organisation and service-based social care – the solution for some, but also part of the problem for many

Most people need social care services at particular moments in their life or that of a family member, or on a long-term basis to manage a disability or long-term condition. Generally, these services still tend to be of three kinds: residential care, domiciliary care, or day care, although personal budgets, and in particular cash direct payments are helping to grow non-traditional provision.

Formal support services are and will remain vital, and for some, life-saving. But the remit and reach of many services remains relatively narrow and short term, whilst it is increasingly accepted that individual wellbeing, as defined by the Care Act, depends not just upon access to essential support, but upon an individual's ability to draw upon their own resources and to build and maintain family relationships, social networks, and active citizenship.⁴ Where formal services are delivered without regard for an individual's sometimes fragile network of connections and support, the overall impact can be to leave people more isolated and disconnected than they were before the intervention.⁵ Even high quality interventions can have unintended negative impacts: they can reduce autonomy, disrupt routines, stigmatize people who use them, and exclude carers, families and informal networks, just at the point when an individual needs them most. This is not to undermine the need for quality formal services at the right time for the right people- they are invaluable. However, when they are supplied too early, or inappropriately, they can be ineffective at achieving social care outcomes. This is because if services are offered before there is a clear and comprehensive understanding of the individual needs and personal outcomes in a holistic and strengths-based approach manner, the 'solution' may not be the 'right' one for the individual and may not promote the individual wellbeing or enable them to achieve their personal outcomes

4 Fox, 2013; *The Guardian* 16th October 2013; *The Guardian* 27 November 2013

5 *Inclusive Change* 2015

Significantly, when services are systematically sourced as solutions for all and individual skills, abilities, knowledge and personal context are minimised, social care workers find themselves operating as part of an institutional machine, using only a fraction of their skills, experience, empathy, respect, and knowledge. This can mean that most of the limited time a social worker has available is concentrated on deciding if the person is eligible for support, with little scope for creative planning.⁶

There are also organisational drivers which can constrain the responsiveness of services to individual circumstances. Organisational structures, resource constraints, and policies as well as leadership and management knowledge, trust in front-line practitioners and professionals, attitudes and personal qualities can prove a major barrier to organisations who might intend to deliver good quality person centred services.⁷ Specifically, financial systems may not facilitate payments for new interventions, dis-incentives may be present that work against the change needed, and the regulatory processes may not be aligned with what's needed either.⁸

Personalisation is a policy direction that seeks to resolve these kinds of difficulties, focusing as it does on shifting choice and control to the individual, and enabling them to take the lead, and its associated responsibility, for their care and support should they chose to do so. However, important as it is, creating a policy framework (for this read the Care Act 2014) that enables people who use services to lead their care and support arrangements through their required choice and control is only half of what is needed. Statutory health and social care organisations must also change so that their activity and organisation supports the growth of personalised or person-centred approaches too. Only with both sides of this 'equation' in place can permanent and longstanding transformation of the sector happen.



⁶ *It should be noted that since the Care Act people have eligible or ineligible needs and councils have the duty to meet eligible needs, and to ensure they are met, but they can be met by others (carer, church, neighbour, community, etc.). Eligible needs do not have to be met by the provision of council services*

⁷ *Kirkley et al 2011*

⁸ *NICE 2007*

INTRODUCTION

A brief account of modern social work in adult social care

Community social work was once a mainstream part of social workers' training and role description. It was built into the ethos and values of the profession that the purpose of social work was to support people within the context of their families and communities. For social work, community means more than just people living in a particular place. It expresses the idea that people identify with the area in which they live and the people who live there. Social work practice is rooted in the belief that people want to experience a sense of belonging and inclusion and that those feelings are central to people's wellbeing. As the role of a social worker became more focused on care management, however, community social work started to fade and in many places disappeared entirely.⁹

Nevertheless, we can learn much from the past and social work's accumulated wisdom. In the 1970s there were three elements to social work theory: case work, group work and community work, and they were of equal status. In 1968 one of the foundation documents of modern social work, describes the basis of an effective service as being housing, prevention, research and the community.¹⁰

In 1982 the ground-breaking Barclay report on the role and tasks of social workers regarded social work as comprising two major strands, counselling and "social care planning". The latter was not only concerned with the problems of individuals, families or groups but also with developing and strengthening community groups and informal networks of support.¹¹ The report's concluding chapter, *Towards Community Social Work*, is particularly relevant. In the language of the time it recognises the role of carers and informal networks in a way even more pertinent today than it was 30 years ago. A section of it is worth quoting in full:

"The bulk of social care is provided not by the statutory or voluntary social services agencies, but by ordinary people who may be linked into informal caring networks in their communities. Care of this kind is often maintained at great personal cost to the carers.

9 *The College of Social Work's series of papers on the Business Case for social work with adults*

10 *Seebohm 1968*

11 *Barclay 1982*

For example, a substantial proportion of those receiving help, and in particular the very old and people with chronic physical handicaps, are largely or entirely dependent upon one caring person – often an unmarried relative and usually a woman. The demands on the individuals concerned can become enormous, and it's scarcely surprising that some break down under the stresses and strains involved.

“The informal caring networks, in other words, are vulnerable and fragile, and it is precisely when they give way that large numbers of referrals are made to social services departments and voluntary agencies. If social work policy and practice were directed more to the support and strengthening of informal networks, to caring for the carers and less to the rescue of casualties when networks fail, it is likely that the need for such referrals would be reduced.”

The introduction of care management under the NHS and Community Care Act 1990 saw direct, relationship-based work with adult users replaced with bureaucracy aimed at rationing resources. In the 1990s, the social work degree which was introduced, was underpinned by a preoccupation with producing a reliable and compliant workforce to work to the direction of managers. This saw the introduction of various bureaucratic, and increasingly electronic, processes and systems which, jointly with quantitative performance indicators, directed activity, but inadvertently subordinated relationships between social workers and people who needed their help and support, to the needs of managers and their organisations.

Arguably, social work became a matter of filling in forms and running computer case management systems so that evidence of meeting targets and ‘processing’ people could be seen. Rationing increasingly scarce resources became the overriding goal. Consequently, councils adapted to meet their imposed targets rather than the real needs of the adults and children and families they needed to be supporting.

The noughties saw continued reform of the adult social care sector, with the introduction of greater collaboration with Primary Care Trusts. Direct payments and personal budgets were used to drive forward a self-directed support approach to adult social care with an emphasis on involving people who use services in commissioning, and understanding the individual as an expert by experience.¹² Successive governments developed personalisation policies, but they were very much layered on to a process based, managerial and case management model of social care rather than a professional competency based model of social work.

12 Alcock and May 2014

Into the present with the wellbeing principle

The Care Act 2014 consolidates personalisation and places it at the centre of adult social care, replacing previous legislation that developed incrementally over several decades. The Act sets out new duties for local authorities and partners, and new rights for people who use services and carers. Specifically, a number of key clauses in the Care Act places personalisation in the centre of what a modern health and social care operating model should be like:

Clause 1, establishes wellbeing as an underpinning principle for the whole act, and despite the difficulties of deciding when it has been achieved, the act clearly states that social care statutory activity must promote individual wellbeing as well as establishing the presence of eligible needs.

Clause 2, places prevention and early intervention at the forefront of the social care system. This means that the local authority with their partners in health, housing, welfare and employment services must now take steps to prevent or reduce or delay local people's needs.

Clause 4, makes provision of good quality information and advice an essential activity for councils and their partners, but it extends this duty by requiring councils and partners to facilitate access to the information and advice and to provide independent advocacy for those who need it.¹³

Clause 6, creates a statutory requirement for local authorities to collaborate, cooperate and integrate with other public authorities; and for partners to cooperate and work in partnership with the local authority

Clause 9, entitles anyone who appears to have care and support needs to have an assessment, and that the assessment must focus on needs and outcomes important to the individual

Clause 10, defines carers and provides them with the same rights as the person they care for. For example, a right to have an assessment of their own needs if there is appearance of need for support and enabling them to receive a personal budget.

Social work after the Care Act 2014 is different from care management as it has been practiced for the past 20 years with its emphasis on process rather than people.

¹³ *A small but significant point to note is that the Advocate's key role is to represent the individual, whilst the Independent Advocate's key role is to maximise the individual's involvement*

Indeed, The Business Case for Social Work with Adults discussion paper, published by The College of Social Work in 2012, refers to social workers being “freed from the shackles of care management”.

Key clauses in the 2014 Care Act change the parameters for what counts as successful social work. In the ‘industrialised’ process driven social work of the last decade or so, success entailed timely completion of an ‘objective’ assessment of whether or not an individual had eligible needs; and of course, the subsequent specification and supply of the services that would meet any identified eligible needs. However, the success of social work post Care Act must be judged differently. Post Care Act, successful social work must be about producing a comprehensive holistic assessment, which is a meaningful intervention in its own right. Eligibility is only established on completion of this holistic assessment,¹⁴ and importantly whatever the level of needs, the assessment must lead to activity, and not necessarily services, that enables the individual to improve their wellbeing. This means social workers need to understand the person in front of them. They must grapple with the subjectivity of people’s aspirations and ambitions for the future and their abilities to achieve them – they must respond to the person’s strengths as well as their deficits. In practice this means they must have a clear understanding of the person’s sense of wellbeing, their personal priorities as well as their immediate family and community networks, assessing all the needs and exploring all the areas of the person’s life that impact on their wellbeing (see Appendix 2 for more information).

Taking a strengths-based approach: what needs to change?

The accurate and empathetic assessment of people’s needs will remain an important skill for social workers, but equally important will be an ability to look not just for people’s needs but also for their strengths, resilience and potential. Deploying the workforce effectively is critical to achieving this. Understanding and differentiating the roles of social workers and other social care staff is important. Arguably, early intervention and prevention activity becomes a priority for social care staff, who may not be qualified social workers but have other qualifications and experience that can be best utilised in this area. Leaving more complex cases and perhaps hospital discharges to be the focus of qualified social care staff.

¹⁴ *The eligibility judgement is important, but it is imperative that this is not the pre-occupation of the assessment*

What is clear is that training both sets of staff to operate to a strengths-based approach is essential if better outcomes are going to be achieved. For example, when Australia introduced local area coordination (LAC) as its route to reforming care and support, a layer not dissimilar to care management was removed, with social workers tending to move into roles which were either embedded in community work, or into more specialised and therapeutic roles.¹⁵

Local Area Co-ordination (LAC)

Local area coordination suggests a new approach to working with communities which could be highly complementary to community social work. A local area coordinator is typically based in a small area and has an open door to work with any adult who seems in need of support. The approach is to get to know the individual in depth in a more informal way than for an assessment of their needs: what is their life like now? What are their needs but also their strengths and potential strengths? What kind of relationship do they have and could they have with those around them?

The coordinator has the ability to spend small amounts of money to facilitate change, but their main tools are their links into community groups and their ability to help people within an area to connect with each other, so that neighbours who had previously felt concerned about an elderly man who had lost control of his garden and house were able to lend a hand with a collective effort to tidy things up, which led him to reconnect with his neighbours and ended his isolation.

Community-based social work in Leeds

In a successful community-based system, social care workers need the training, time and mandate to be able to utilise the whole of an individual's resources, and their family's or community's resources, rather than feeling restricted to a narrow range of service responses.

An example of this kind of community-based approach can be found in Leeds, where innovative Neighbourhood Networks have supported older people for nearly 20 years.

¹⁵ Clark, S. and Broad, R. 2011



In a relatively recent development, local communities have begun to take responsibility for older people in their areas, providing social capital that goes beyond volunteering to a broader community support role which helps reshape individual care packages and turn them into comprehensive 'living plans'.

Older people can have their personal budgets managed by the Neighbourhood Networks, with their support commissioned by the networks and supplemented by locally provided social capital inputs. These living plans look different from the care packages that preceded them. They draw on a wider range of care and support contributors, responding to social isolation as well as care needs for example, but the net result may be less money spent on professional and informal care.

Shared Lives – supporting individuals in communities

Isolation can be as risky for health as more recognised risks such as obesity and smoking.¹⁶ Helping someone to become or remain a visible, valued member of a community can be one of the most effective safeguarding interventions, in comparison to placing the individual in a situation in which they are entirely reliant upon paid staff, particularly if those staff are poorly paid, trained, supported and led.

Take "Shared Lives" as an example.¹⁷ In Shared Lives, an adult (and sometimes a 16/17-year-old) who needs support and/or accommodation moves in with or regularly visits an approved Shared Lives carer, after they have been matched for compatibility.

¹⁶ For example, Holt-Lunstadt J. et al 2010

¹⁷ There are approximately 8,000 Shared Lives carers in the UK, who are recruited, trained and approved by 152 local schemes, which are regulated by the government's social care inspectors

Together, they share family and community life. It is a good example of an approach in which personal care is delivered not just in a 'community setting', but in and of the community, recognising that 'community' is not a location but a set of relationships¹⁸ and that people with learning disabilities and other long term support needs might need extra support to build and maintain their community.

In many cases the individual becomes a settled part of a supportive family, although Shared Lives offers other opportunities such as: day support, as breaks for unpaid family carers, as home from hospital care and as a stepping stone for someone to get their own place. Surveys of users suggest that many get involved in clubs, activities and volunteering for the first time, which Robert Putnam, in *Bowling Alone*, argues could cut in half the individual's chances of dying over the following 12 months.^{19, 20}

Making Safeguarding Personal

The Making Safeguarding Personal initiative, sponsored by the Local Government Association and the Association of Directors of Adult Social Services,²¹ now fully embedded as law in the Care Act, aims to develop person-centred responses to safeguarding so people who have experienced harm and abuse feel empowered and supported to get the outcome they want to see. One of the approaches used is similar to family group conferencing, bringing together the person at risk with their family and friends to explore the options available to them. Although there needs to be some caution as the number of authorities involved is very small, those using family group conferencing have reported a significant cultural shift. Social workers have to think about the person's family network and the resources they can bring from an early stage, i.e. an asset-based or strengths-based approach.

18 *Shared Lives is on average £26,000 per year cheaper than other forms of regulated care for people with learning disabilities. Social Finance, (2013)*

19 *Putnam R (2000)*

20 *See also the Joseph Rowntree Foundation report 'Widening Choices' report that stresses the value of mutuality for older people with high support needs and found that many non-traditional service solutions were not widely known about and therefore under the radar of many commissioning activities. Bowers et al (2013)*

21 *LGA (2014)*

What is the business case for these kinds of community interventions?

The business case for taking these strengths-based social work and community-based development approaches lies in:

- Better utilisation of people's own capabilities, knowledge, skills and their natural support networks.
- The added value of local community groups and charities.
- The creation of new social bonds and 'social capital'.
- The reduction in the inadvertent creation of dependency and undermining of natural support networks which can happen when services are not intentionally arranged around people's family and community life.
- More motivated and rewarded workforce.
- Robust and more sustainable promotion of individual's wellbeing.

There is a tendency to label these kinds of benefits as 'prevention', but this may not be helpful. 'Prevention' as the basis for a business case has a number of problems:

- The term 'prevention' is often used loosely to mean a number of different things, including early intervention, the prevention of decline in wellbeing and the avoidance of costs.
- Prevention is negatively framed as a concept: it's about what doesn't happen, not what does and it is often framed from the point of view of the service (preventing need for a service) rather than from the point of view of the individual (maintaining wellbeing).
- The language of prevention can feel medicalised and carries negative connotations for people with lifelong conditions which are not preventable.

An alternative framing for the 'preventative' gains of community approaches would be 'future focused'. Future focused interventions do not only respond to the current level of need and past circumstances, but aim to leave the individual and their networks stronger in the future.

Such interventions are an investment in the resilience of the individual and of the network of friends and family which can play an important part in sustaining their wellbeing. Where resilience increases, the individual may be less at risk of reliance on state-funded services, but effective interventions are unlikely to start with that aim.

Rather, such interventions set services' goals and organisational imperatives to one side, recognising that the organisation, the professional and the service may form only a small part, not of a service system, but a support ecosystem.²²

This requires considerable humility and self-awareness. Professionals need to look for the possible negative effects of their interventions on the individual's family and community relationships and weigh them up against a realistic analysis of their possible benefits.²³

For example, does the intervention carry stigma, or place practical or physical barriers between the individual and their natural support networks?

The social work changes over the last few decades have been real and substantial. However, whilst the rhetoric of taking a strengths-based approach to social care may be appealing, returning us as it does to a more community-based model of social work, is there really any hard evidence that it works? With the caveat that this work is relatively new and emerging, there is some good empirical evidence that social care investment in communities and people works.²⁴ For example, Professor Martin Knapp at the London School of Economics (LSE) found that three community building initiatives 'generated net economic benefits in quite a short time period.'²⁵

- Time banking, in which participants trade hours of time contributed to each other or their community, cost £450 per member per year, but generated value of more than £1300, and improved outcomes for individuals.



22 See Appendix 2 for further details of how a strengths-based approaches works

23 The need for these kinds of complex judgements are recognised in the British Association of Social Workers Code of Ethics 2011, a code which directly references the need for social workers to be concerned with the whole person, and to identify and develop the strengths of individuals, groups and communities

24 See SCIE's web site on strengths-based approaches: www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-based-approach/resources.asp See also work from Scotland: www.iriss.org.uk/resources/strengths-based-approaches-working-individuals, and Canada: www.resiliencyinitiatives.ca/cms/wp-content/uploads/2013/03/STRENGTH_BASED_PERSPECTIVE-Dec-10-2012.pdf&ved=0ahUKEwifpl-s-43LAhUBkrQKHVnxA1AQFgggMAE&usq=AFQjCNFcmG7D9Benhxm-Kg349SBP2Tb4hg&sig2=g0KvOn-Zq5PE9A20-d2DWg

25 Think Local Act Personal, 2011

- Befriending, aiming to reduce social isolation, loneliness and depression, cost £80 per older person per year and generated £35 per person in the first year, rising to up to £300 per person per annum in the third year, due to a reduced need for treatment and mental health problems.
- A community navigator scheme, using volunteers to provide a direct link between marginalised people and public services, cost £300 per person and generated savings of £900 per person in the first year alone.

In addition, Western Australia's LAC-based system provides services for a greater proportion of potential people who use services at a lower cost per person than Australia as a whole. It should also be noted that in Western Australia the cost for 6,981 people in 2003 was \$28 Million, and in 2013 for 9,445 people was \$26 Million.²⁶

Whilst the empirical evidence base is still emerging, there seems to be substantial and reliable qualitative evidence, about the success of adopting strengths-based approaches in adult social care. For example, a Guardian *round table discussion* for sector leaders late in 2014 focusing on the acute financial pressures confronting adult social care, considered how a new role for social workers beckoned in this context. One participant said, "we are now training social workers to say, "What can you do for yourself? What can the community and family do?" There appeared to be agreement that this approach had the potential to save "thousands, even millions".

The most heartening paragraph in the round table report said that the "panel agreed that the challenge of developing these personalised solutions was unleashing social workers' creativity. As one person put it, 'I have seen more creativity in the past two years than in the previous twenty. If you have a group of social workers in a room with no money they are far more innovative.'

Shropshire Council

Various councils have begun to implement a strengths-based approach on the back of the Care Act, however, some are more advanced than others.²⁷ Since 2012 Shropshire, for example, have pursued a strengths-based approach through a social enterprise called People 2 People, which delivers adult social work and occupational therapy.

²⁶ NDA 2015

²⁷ LGA 2010

The success of this model is based on supporting and enabling people to build their personal and social resilience, maximising relationships and wellbeing before supplying state services to meet needs. Thereby avoiding two key problems of care management approaches (both mentioned earlier):

- Premature intervention, which takes over from people's natural support structures increasing the risk of isolation, creating dependency, and providing 'solutions' that do not enable the individual to achieve their personal outcomes, but which instead, superficially 'patch' the problem or presenting need.
- Over provision, which creates long-term dependency and narrows opportunities for change reducing independence and individual wellbeing.

A detailed case study of the workforce culture change process that Shropshire Council embarked on is shared later in this report, here it is sufficient to mention some of the key performance information that has been achieved through this initiative and the Council's broader strategic work to transform the way it works.²⁸

- Significant reductions in the spend for adult social care.
- More people supported but with reduced demand on traditional services because 75% of people are able to have their issue resolved through skilled conversations at the first point of contact.
- Of the remaining 25% of people who would benefit from further exploration of their issue, the majority (usually between 80-97%) are invited to attend a 'let's talk local' appointment in their locality, where a tailored set of arrangements are put in place which maximise use of peer support, self-help, informal care and suitable community activities.
- The result is that only 3% people who enquire about state help receive a statutory service, that is domiciliary care, day opportunities or residential care.

The model developed in Shropshire is now supporting change within a small number of other local authorities across the country who are adapting it and building on Shropshire's learning to explore potential for such things as integration at a community level with health services as well as its application to support children and young people. As part of the National Development Team for Inclusion's 'Community Led Support' Programme these councils are sharing their learning and experiences through a national network and together will contribute to the growing evidence base that demonstrates not only improved outcomes for local people but more efficient use of resources.

28 All data presented at the NCAS conference in 2015

Calderdale Council

Focussing on prevention and early intervention, Calderdale Council wanted to invest in their domiciliary care offer to citizens. After developing a Personalisation engagement team 800 people were contacted to find out what they wanted from a home care service. Following these discussions three choices were provided to current domiciliary care recipients:

- 1) Take a personal budget as a direct payment and use the direct payment support service to help manage independently.
- 2) Take an individual service fund (ISF) and chose a provider who will work to identify innovative ways of achieving personal outcomes and wellbeing taking a strengths-based approach.
- 3) Commit to the Councils block purchased service of 3 geographically located service providers.

The choices made by people using services changed. The number of people accepting a council managed one-size fits all service went down, the number of people taking a more personalised ISF option increased and direct payments uptake also went up.

The economic result of adopting these kinds of strengths-based approaches to domiciliary care by focussing on direct payments and using ISF options, was that even though there was an increase in the price paid for domiciliary care, the new activity reduced admissions to residential care, and the total cost of both residential care and domiciliary care came down by an average of £19,000 per week, over a year this equates to a £1million saving.²⁹

The evidence base for economic efficiencies in delivering strengths-based social work over the more traditional case management approach is partial, but with good reason – it is new and practice is emerging following implementation of the Care Act. The primary reason for the developing business case for social work is that the whole system needs to change, it's not just a simple matter of changing a bit of practice here and there. However, is it an unreasonable hope that another golden age for community social work is on the horizon? Perhaps this is excessively optimistic for some tastes, but the time has rarely been more propitious for a radical shift in the focus of social work.

So how are strengths-based approaches achieved? What do providers, councils, and employers need to do to change the culture of their work force to make such approaches to social care real? The next section of this report focuses on these questions.

29 *Presentation from Calderdale at Yorkshire and Humber ADASS Domiciliary Care Event December 2015 Leeds*

CULTURE CHANGE AND STRENGTHS-BASED APPROACHES

Social work culture change case study: Shropshire

People2People is a social enterprise and was established in Shropshire as one of the Department of Health's Adult Social Work Practice Pilot sites. It is a Community Interest Company which was established in January 2012 and now delivers the majority of community based adult social work and occupational therapy in the county. Although it has grown in the last 4 years from a team of 8 to approximately 130, its journey and development have been determined by its adherence to its core principles and values that were agreed at the outset:

- Local people will have a say in how it is run and be encouraged to be involved as volunteers or getting involved in local advisory groups.
- Staff will be able to influence their own practice as a team and have a say in how the organisation is run.
- There will be an emphasis on trusting and valuing professional judgement.
- People will be supported to be as independent as possible, to connect with their community and to remain in control of their lives.
- Local voluntary, third sector and other statutory agencies will be involved as true partners, supporting people at a local level.
- People will be supported in a proportionate and timely way.
- There will be continual effort to make the system recording and processes as efficient as possible, with minimal bureaucracy.

Work to implement these principles was based on a strong partnership and shared vision between Shropshire Council and People2People. Delegated powers and decision making were agreed and there were freedoms and flexibilities to work outside the established process to 'prototype' new ways of working with continual review and refinement. Teams had autonomy to establish their own working arrangements within agreed boundaries and this enabled the differences between, for example, working across a large geographically dispersed area to working in larger conurbations like Shrewsbury, to be recognised.

A locally devised training programme was rolled out by the Council's Professional Development Unit which involved training, workshops and action learning sets and local people and national experts were involved in the delivery of this. In addition, all staff, volunteers, directors and some voluntary sector partners received training in person centred approaches and creative support planning. Importantly there was a consistent application of this new way of working through team meetings, individual support and supervision discussions and by being able to refer back to the organisational principles and values.

Celebrating the successes through individual stories is another powerful way of confirming the new approach as well as continually learning where things can be improved and by checking with people who have contacted the service whether they had a good experience and whether their issue was resolved.

Shropshire's achievements, therefore, are not dependent on any one thing but are a combination of factors which can be summarised as:

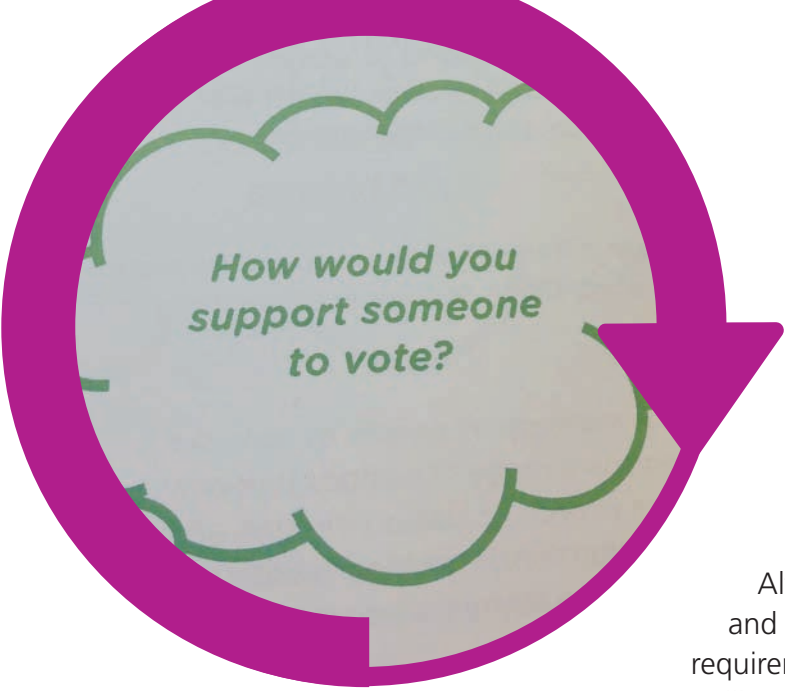
- Strong values and a clear vision that is well communicated and understood.
- Harnessing enthusiasm, commitment and innovation.
- Strong leadership to support and implement change at every level.
- Empowered, skilled and valued staff team who have both autonomy and support.
- Working alongside local people with lived experience who are valued as experts by experience.
- A positive approach to risk at an organisational and individual level.
- A recognition that the system may need to change to support new ways of working.
- Real partnership at a community level.

Social work culture change case study: Essex County Council

Sam Newman, Partners for Change Director and Karen Wright, Care Act Implementation Lead for Essex, have written publically about how Essex County Council are changing the delivery of adult social care support³⁰

'We recognised that the traditional approach, involving a large call centre diverting people away or passing them through to social care teams, was simply 'sucking people in'. It had to change.

³⁰ Taken from: www.linkedin.com/pulse/how-essex-county-council-changing-delivery-adult-social-sam-newman?forceNoSplash=true 25th January 2016



How would you support someone to vote?

Moreover, most of the community teams had become part of the 'assessment for services' factory. This to some extent presumed the solution for people was some reablement-focused activity, mainly supporting people coming out of hospital and/or formal paid care services.

Although this system worked efficiently and well, it was never going to meet the requirements of the Care Act – with its emphasis on wellbeing, prevention and independence.

Likewise, with the financial pressures on all local authorities we could no longer afford to continue as before.

As a result, by reclaiming social work, Essex is adopting a simple and different approach. Having created a number of innovation sites, and coached staff in the art of having three different conversations, evidence is emerging to show that this is the way forward.

The conversations are:

- 'How can I connect you to things that will help you get on with your life – based on assets, strengths and those of your family and neighbourhood? What do you want to do? What can I connect you to?'
- When people are at risk – 'What needs to change to make you safe? How do I help to make that happen? What offers do I have at my disposal, including small amounts of money and using my knowledge of community, to support you? How can I pull them together in an emergency plan and stay with you to make sure it works?'
- 'What is a fair personal budget and where do the sources of funding come from? What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in good support planning?'

Although all three conversations are proportionate 'assessment conversations' under the Care Act, staff are encouraged to leave behind their old 'assessment' culture and practice and learn how to have proper conversations that listen to what people have to say.

This is not an invitation to a fluffy and non-specific chat; there are some clear and simple rules, which include:

- Always start with the assets and strengths, knowledge and skills of people, their families and their communities and think about services last.

- You have to prove to your peers that you have exhausted conversations one and two before embarking on conversation three.
- You can't have conversation one effectively without knowing the communities and neighbourhoods of those people you are listening to.
- If someone is in crisis and having conversation two, never plan long term. You must 'stick to them like glue' for a short time to ensure the plan has a maximum chance of success.
- You must really know what you are doing and the impact you are having through the daily collection of data, and reflect on it and your practice all the time to keep learning.

There are a series of 'banned words' and activities that innovators are trying not to use, these include 'assessment', 'referral', 'allocation', 'waiting list', 'handoff', 'triage', 'services' and others.

Changing the approach of providing information and guidance to one that is more interested in 'connecting people to people' rather than to services, and referring to 'my colleague' when needing to gain specific input of others rather than handing off or referring, has also started the cultural change journey towards integration.

The usual local government approach to change management programmes is to do a lot of thinking before testing the approach. This time we rapidly communicated our intention to work very differently according to these rules and then asked for volunteers, who were prepared to change how they were working, adopt this new approach and commit to gathering data as evidence of the impact every day and learn together.

Within 2 months eight 'innovation sites' had emerged and not all led by the council. In fact, the first to step forward was health. All had to describe very precisely what they were going to do, and how they were going to use the core approach. Sites include a number of specialist advisors within the contact centre; a team of people including a GP, Care Advisor and Voluntary Sector having conversations with people identified from a GP frailty list, a site within an acute hospital ward, another working with known adults and carers with long-term conditions and a cohort of people living in a supported living unit.

So what have we found – 9 months in?

- The nature of the conversations is fundamentally different. People listening in to the contact centre can immediately detect a difference between the old conversation (a formulaic list of questions) and the new one. This is where the person is really being listened to and is leading the conversation. In the supported living unit families heard that the review was taking place and expected the usual tick box activity. They were surprised to experience people being interested in the lives of their sons and daughters – and how they could get better (hence the name of our programme – 'Good Lives').

- Having a system that is not built around the assumption that formal care services are solutions means that fewer people end up with them. Early evidence suggests that the rate at which people end up with care teams significantly reduces and the rate in which they become recipients of ongoing support has halved. What has been demonstrated is that with a truly local approach and one which is committed to paying attention to what people really want, rather than what service we can give them, peoples' issues get resolved quicker and without recourse to paid care. In fact, evidence so far is suggesting that no one supported in a crisis has been resolved with a residential solution.
- Staff love this way of working. They say they don't want to go back to the old way; person-centred practice is valued and while some social workers thought they already worked in this way, they also recognised that having the time to build relationships with people moved them away from the traditional role of care management. One nurse thought her practice was holistic, but realised the pressures within the hospital had stopped her thinking about the wellbeing of the patient. Having a different conversation has regained the identity of the patient. Everyone fed back that they liked working closer with colleagues and the sites stopped talking about referrals.
- Gathering data every day and publicly scrutinising it was crucial – we were able to evidence the financial business case for 'Good Lives' with innovation sites reporting that if it rolled out across all teams, upwards of between £3m-£12m of benefits across the health and social care system would be realised. In addition, we were able to look at key performance data differently shifting from measuring by activity (where productivity equals numbers of assessments 'done') to one that looks at outcomes. This will enable us to change our recording systems so that we can gather information systematically. We can now shape commissioning decisions about investment for preventative services on evidence we hold for the first time about connections that have worked. Who would think that a ward would prescribe pet therapy as part of a discharge/'conversation' plan alongside reablement services, time banking and other community resources?
- While system leaders are looking at how integration will be developed and delivered strategically, innovation sites are showing how people can work together, hence the term 'colleague' and the potential for different roles to work closer together; for example, GP Care Advisors and Community Agents alongside Third Sector Partners and Social Workers possibly through a community hub?
- It's not all plain sailing – we still have the usual issues of sharing information and systems that can talk to one another, but there is a willingness to resolve these and we are now at the stage of thinking about how we scale up to ensure a sustainable change. The next four innovation sites have already emerged, including a Transition from Children's services keen to learn from the others and take the journey for themselves.

Despite all the pressures and challenges, it's an exciting time!' If we can halve the number of people in social care organisations who have ongoing recurring packages of support, doesn't austerity go away?'

Social work culture change case study: Hertfordshire

Hertfordshire's 'Great Leap' asked three fundamental questions of front line social work:

- What does social work mean to citizens?
- What is the outcome we want from social work?
- What are the ethos, background and values we want to see?

The great Leap focused on the learning disability sector, but has since broadened to now challenge the culture and activity of social work across Hertfordshire, asking **why** they do what they do...and **what** it is they actually do?

The key twin problems the great leap has addressed is resistance to change and industrialised thinking. By which is meant resistance to personalised approaches within social care, and the pursuit of process over professional judgement. The outcome Hertfordshire was looking for was getting people energised, included and respected as citizens within the community.

The great leap project continually evaluated the reality of life for people with projects such as the 'big bed time audit' a review by social workers of what people with learning disabilities are doing 8.30pm across all residential placements in learning disability services on one identified day of the week – Friday.³¹

The big bedtime audit results unearthed a problem – care management. It was system and service driven, minimising risks and creating 'safe care' for professionals and service providers. Fundamentally, it wasn't creating a life for people, it wasn't generating outcomes that the social work profession should be proud of (see Appendix 3 for the guiding principles of the Great Leap).



³¹ Two thirds of social workers agreed to do this unannounced audit out of good will

Key issues the Great Leap had to address

The time problem: A person centred – asset-based approach takes longer. Time has to be found by avoiding unnecessary process, and reducing demand on formal services. The first is solved by focusing resources on assessment and review and by leaving care and support planning, in the main, with individuals and families properly supported if need be by specialist voluntary sector organisations. The goal of social work practice was to ensure that all care and support plans were aimed at delivering citizenship. If you can enable citizenship then you have provided the right care. Providing care in itself does not enable true citizenship or a real life.

The latter is achieved by allowing people to develop solutions that work for them and their informal networks, this leads to less time spent resolving the result of mis-matched services, for example, fewer safeguarding incidents and re-assessments.

Fundamentally, when people are supported to have a better life, they are more connected to their families and their communities, and need statutory interventions less. Getting it right first time saves cash. Hertfordshire like many other local authorities had to make significant savings a feat it managed ahead of time by ensuring social work valued the individual and supported them to achieve aspirations and real inclusions rather than more costly institutional and restrictive care arrangements.

How did Hertfordshire do it?

They didn't pursue a formal programme or project management approach. Their culture change was more organic, focused on raising awareness of the need for change amongst social work teams, connecting social work back to community and community practice, embracing community capacity – people and organisations in communities.

The Great leap answered the question: how do you take a strength-based approach when you assess and review with a deficit model? Its answer was: change the assessment, change the review, and change the practice. And support this with good communications.

The Great Leap was applied across 7 community learning disability teams, 2 transition teams and 1 Asperger's team

Performance management by target setting was actively ignored. The performance assessment that was applied was in outcomes for people and social work practice line management.

Techniques/tools employed

The great leap key process was that everyone had to link all of their work to the great leap values i.e. every decision either positive or negative had to support the great leap values (see Appendix 3).

Risk awareness sessions were run covering the way in which risk averse activity restrict opportunities.³² Risk audits and reflection were undertaken using CAIRO – the Climate Assessment Inventory for Risk and Opportunity. All teams, senior managers and board members undertook these exercises. Some teams came out more risk averse than others and highlighted major informal divergent practice and decisions across and within teams.

The Great Leap then expanded to ask what building community capacity (BCC) meant for social work teams and nurses. 14 training days were held with social workers and 3 or 4 community members who used learning disability services ran workshops on BCC and Asset-based community development (ABCD). TLAP's Making it real (MIR) 'I statements' were used to focus on citizenship.

Conversations with commissioning officers changed, and started to develop along the lines of 'stop buying things and start to create these kinds of opportunities'.

An event was organised where 7 social work teams each had to bring with them a community organisation. Workshops with providers were led by social workers getting care staff to understand their own assets and the opportunity they had to use and share them, then asking why people with a learning disability did not have the same opportunity. Overall, culture change took 2 years but the practice is ever developing.

Barriers

Barriers identified were teams that insist on formal programme management principles that tie professional social work to dogmatic procedures; IT systems that condition activity at the front line; equipment not fit for purpose; social workers not applying the human rights and value based practice that brought them in to the profession in the first place.

³² Bates. P and LyMBERy, M. 2011

Supports

Fully co-producing the project and having people with a learning disability training staff and running events. The passion and dedication of social workers feeling liberated to practice again. Libraries which acted as community information points and supported the social workers when they ran community connecting events.

Key lessons learned from Hertfordshire:

- Values and principles of taking a strength-based approach need to be highlighted and kept in the forefront of all activity.
- Getting managers 'buy in' is essential, as it is about leadership and practice development. Quality of relationships matter.
- Leadership has to keep an eye on stats and movement of cases, resources allocated etc., but values and principles must lead innovation, it's better (for people who use services) for leaders of culture change to give apologies than to ask for permissions.
- One key phrase in the Hertfordshire culture change programme was: 'don't cast a shadow shine a light'.
- And in terms of doing this in a formal programme management approach the message is simple: set up a movement not a project, this is about whole systems, and person-centred social work practice, not little bits of structural alteration and predictable change management.

Overall, Hertfordshire's culture change campaign fundamentally looks at ideas of connecting people and understanding that everyone, no matter how disabled society deems them, has something to give and contribute. This activity has started to truly engage people with their communities rather than make them tourists within it. For more detail please see Hertfordshire's full case study in Appendix 4.



Social work culture change case study: Calderdale

Calderdale's change programme began 3 years ago with the director leading 'road shows' with social work teams. These road shows were a platform to have a discussion about the role of social work and the purpose of social workers. From these discussions some shared conclusions were drawn across the adult social work teams:

- Social care has become process driven – mechanistic even.
- The experience of social care by people who need help is overwhelmingly that it is disempowering.
- The experience of social care by staff engaged in delivering it is that it is disempowering.
- There is no professional identity.
- There is not a clear understanding of the role of social work and social care more broadly in the borough.

The senior management team then reflected on what they heard and together, in ongoing dialogue with front-line social workers, a concrete idea of what social care is aiming to do in Calderdale was crystallized:

- i) Maximise independence regardless of age, race, gender or disability.
- ii) Safeguard vulnerable people.

This simple vision of what social care is aiming to achieve was then taken on another series of road shows across social work teams, but this time with a different objective. The aim of this second set of discussions was to find out how people's actual experience of social care matched up to this vision.

The kinds of questions that were discussed were:

- How do we make sure people are able to take risks and have choices?
- How do we make sure that people who want to self-manage, with or without a personal budget, can do so?
- How do we make sure that people who want external organised support, independent advocacy, or peer support, are able to get it, with or without a personal budget?
- How do we make sure that people who want the council to manage the process and the decisions for them get the services they are satisfied with?

And fundamentally,

- How do we make sure we can offer all of these things, to all the people who want them, at the right time, in the right way, and in the right place?

This last point recognised issues raised frequently during earlier road shows, that the council has, at various points in time, done each of these things quite well, but has never been able to sustain the diversity of these areas of activity, to a high standard, all of the time.

The result of this second round of discussions with social work teams produced a focus on two areas of activity:

- 1) Assessment.
- 2) The customer journey.

The former area of practice was reviewed and revised, with a strengths-based and human rights based approaches in mind. Assessments became focussed on the strengths people have, the rights they have, and how connected they are to communities they live in, their families and their informal networks.

The latter, the customer journey, applied a human rights and strengths-based approach across all parts of the various journeys through the system the individual takes. See Appendix 5 for a diagrammatic representation of the various customer journeys.

The senior management team realised, that to support social care teams to do assessments and manage the customer journey differently, resources had to be distributed differently:

- 1) Resources, both staffing and money, had to be spent 'upstream' at the first point of contact, in prevention activity.
- 2) Resources also had to be moved to the early intervention and the intermediate/re-ablement tier.
- 3) Time had to be found for more holistic assessments.

To address these points strengths-based conversations were introduced at first point of contact, and then consistently applied though the customer journey. The conversation aimed to promote independence and put in place informal, sustainable arrangements to keep people safe. The outcome after 24 months, was that only 3% of people who contacted the council who needed to have a full social work assessment.

During the two years of work 're-calibrating' social care in Calderdale, the senior management team were vigilant. Social work teams and senior management were both acutely aware of the risk that addressing 97% of contact enquiries without a formal assessment, could if care was not taken, mean people were simply left isolated and return a few weeks or months later with greater needs. And this revolving door would mean that cost would be higher the second or third time round. Higher than if they had been dealt with via a formal assessment in the first place.

This work is ongoing, but confidence in this strengths-based approach is high in Calderdale. The overwhelming feeling is that getting it right first time, i.e. simultaneously promoting independence and keeping people safe, by focusing on professional social work, is enabling adult social care to find the balance between, enabling people to help themselves, providing support to enable people to help themselves, and providing the right services at the right time.

The key message from Calderdale, is the need to invest in front-line social work, and their Top Ten Tips for doing this are:

- 1) Listen to and value people who use services, social workers and social care workers – understand the centrality of coproduction within social work.
- 2) 'I trust you', 'I believe in you', and 'I will invest in you' should be the key messages from senior management to social care front line workers.
- 3) There must be investment in good quality supervision and training during the 1st year of assessed practice.
- 4) There needs to be a good structure of line management accountability.
- 5) There needs to be professional progression into specialist roles such as Mental Capacity ACT/Deprivation of Liberty safeguards work/Advanced Mental Health Practitioner and practice teacher roles.
- 6) Create up-front investment of social work expertise i.e. as close to the first point of contact as possible, later in the customer journey, professional expertise is applied too late, alternatives to services have already been missed.
- 7) People need linking to local communities, conversations between community commissioners and social work teams is essential.
- 8) Risk panels are a useful resource, but not to challenge the level of budgets and the quality of care and support plans. Instead, they need to support social workers with their difficult cases. To provide a mechanism for peer review, at the request of social workers, and help social workers to address challenging situations.
- 9) Fundamentally, strengths-based approaches are about providing the right training and competencies for social workers, then trusting their training and competencies, making sure there is professional line-management, and then supporting professional judgements.
- 10) Understand that the more a council and its social work teams use strength-based approaches to social care, the better the practice, the greater people's competencies and the better the outcomes become. But it takes leadership, capacity, and time.

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APPENDIX 1: Who is the workforce?

The adult social care workforce can be split into formal and informal workers. Skills for Care manages, on behalf of the Department of Health, the National Minimum Data Set for Social Care (NMDS-SC). This is an online workforce data collection system for the formal social care sector. It is the leading source of reliable workforce intelligence for adult social care. Skills for Care has been collecting information about this workforce since 2006. As a result of this work Skills for Care are able to state that:

- There are about 1.52 million jobs involved in the adult social care sector being carried out by 1.45 million workers. This workforce is estimated to have grown by around 15% since 2009 with the creation of around 200,000 jobs. This includes around 18,000 social workers, and demonstrates the importance of social workers working with other social care staff.
- The private sector is by far the largest employer employing over two thirds (circa 900,000) of all adult social care workers. The voluntary sector employs just over a fifth of all workers while the statutory sector employs just over 1 in 10 workers.
- Around half of the workforce are employed in residential settings while a further 38% are employed in domiciliary care settings. Looking at the workforce by broad job role group, almost three quarters of the workforce are working in a direct-care providing role. Just over half the workforce (52%) are considered to be full-time while 36% hold a part-time role.

(The state of the Adult Social Care Sector and Workforce March 2015 p.2)

However, the size of the formal social care workforce is dwarfed by the informal social care workforce. There are 10.6 million people who have a caring role for a disabled, older or seriously ill relative or friend Carers UK (2014).

In this informal workforce over half (53%) of carers responding to the survey have experience of social care services such as home care or respite care. Of these, 27% report positive experiences of these services (7% excellent and 20% good) while 21% report negative experiences (8% bad and 13% terrible). Half say that their experiences have been mixed (42%) or fair (10%) (State of Caring 2015 Carers UK p.7).

Why are these workforces important?

Both the formal and informal workforces matter. The total economic value of the formal adult social care sector in England is estimated at £43 billion. It was also found that the sector supports a total of 2.8 million fulltime equivalent jobs across the economy. This is of course on top of the positive caring experiences they are able to offer people who use their services. By 2020/21, the number of people expected to be using services will be 1,075,000 (Age UK Care in Crisis 2014 p.17).

In 2011 it was estimated that of the 2 million older people with care and support needs, 800,000 received no support at all from public or private sector agencies.

How are these workforces changing?

Formal sector

The changes in the adult social care sector since 2009 are:

- The increasing size of the workforce (up 15% between 2009 and 2013).
- The shift away from local authority services to independent employers.
- The continued increase in the personalisation of adult social care services.

Informal sector

The rapidly ageing population combined with longer life expectancy means the number of people with care needs will outstrip the number of people of working age able to provide care informally as early as 2017. The number of people caring around-the-clock is already growing rapidly; there has been a 25% increase in the number of carers providing 50 or more hours a week of unpaid care in just 10 years (Pickard, L. 'A growing care gap? The supply of unpaid care for older people by their adult children in England to 2032', Ageing and Society (2013) cited in Carers UK 2014).

APPENDIX 2: What is a 'strengths-based' approach?

A conceptual framework

Strengths-based social care entails three key components: **resilience**, **targeted prevention services** and **assessment and purchasing** (see diagram for a pictorial representation of this framework). The first of these is the fundamental concept which underpins the others.

1) RESILIENCE: The ability of an individual to be independent from the state, and or other institutional support, by maximising three resource domains:

- a) **Personal resources:** the acquisition and deployment of personal skills and knowledge.
- b) **Networks of support:** the participation in and use of close support networks such as immediate family, relatives, friends, and neighbours.
- c) **Community resources:** the participation in and use of universal services, informal organisations such as clubs, pubs, and local groups.

Most people who live independent lives live using these three resource domains, however, the extent to which an individual utilises each of these types of resources is highly variable from one person to another. For example, some people may choose to be highly independent, may have only a small family group who may be some distance away, but have strong relationships with friends through pubs, clubs and leisure activities of one kind or another. Others may choose to do the opposite, spending much of their time with immediate family members and friends and spending very little time making use of publically available culture, leisure or informal facilities and networks. Whatever the individual choices, maximising activity in these three spheres of someone's life helps, create, develop and support 'resilient individuals' – people who can manage independently even when their needs may be increasing.

Needs can increase for complex reasons, and when they do the ideal situation is for those needs to be contained within the three spheres of resources identified above. In other words, increasing needs are accommodated or met by the resilient individual employing their own personal skills and knowledge to solve their problems, making use of family and friendship relationships, or finding support in local community peer support groups and organisations. Of course, some needs are not going to be addressed within these immediate resources spheres, some needs will eventually 'trigger' a statutory response.

Before statutory/formal services are provided, however, there are things commissioners can do to increase the personal resilience of individuals. The fundamental contention is that increasing individual reliance by focussing on individual skills and abilities, immediate support networks and informal community services will increase the likelihood of needs being accommodated, thereby delaying or even avoiding the need for formal input.

Developing resilience

a) Personal resources

People have a wide range of personal experience which has given them knowledge, skills and abilities that they can use to live their lives independently, face and overcome problems (Skills for care 2014). These are intrinsic to who we are, and we develop them in a wide variety of ways. More often than not, we grow these skills in families and in communities, through experiences, but we also develop them in formal settings like schools and in work. This kind of 'situated knowledge' – knowledge we hold about ourselves and our immediate environment that enables us to navigate our lives successfully at a very personal level (Dominelli and Gollins, *Sociological Review*, 1997).

Recognising and validating people's situated knowledge is vital to supporting self-determination. Maslow recognised this in his term 'self-actualisation' which sits at the top of his hierarchy of need– the achievement of 'one's full potential'. To achieve full potential people have to develop their own personal skills and abilities, and reflect on their own values and attitudes and how they impact on their lives. If people can develop a wide variety of personal knowledge, skills and abilities it helps them identify and articulate feelings and emotions better, learn to manage new or difficult situations (practical or emotional) positively, and form and maintain effective relationships with a wide range of people.

Developing this kind of personal resilience is important to social care in general and to the promotion of individual wellbeing in particular, as it helps people build their networks of support.

b) Networks of support

One of the most effective ways for us to be safe and happy is to have a range of people active in our personal lives – this will vary depending on individual's need and priorities. Having people to provide ideas and support promotes health and wellbeing and reduces the potential for harm. We naturally develop unique friendship circles and relationships with immediate and extended family members, and sometimes quality relationships with neighbours. Also important, but not as personal, is an extended network of support made up of paid and unpaid specialists like doctors, solicitors, counsellors, clubs and association members, employers, work colleagues, teachers, and religious leaders. This extended network of individuals and groups are available to us when we need specialised support.

Each person's network of support is likely to be different and change over time as circumstances alter. Therefore, developing and maintaining a healthy personal and extended support network is not always that easy. In particular disability and age can be two factors that, inadvertently, reduce people's personal and extended support networks. As a result, the support available to us when our needs increase may not be substantial enough to afford assistance and protection when we need it, pushing individuals towards formal interventions.

Recognising when support networks are weak, and galvanising the support around an individual is an important way of increasing a person's resilience. Informal support networks are an invaluable source for support planning, problem solving and social interaction which can alleviate many social care issues without recourse to statutory services. But it may take a conscious professional effort to make organising and establishing informal support arrangements for individuals a priority of social care activity, as it is not the way adult social care currently relates to informal networks of support (Gollins, 2006).

c) Community resources

People live in communities and interact with their support networks in those communities. When people are more involved in these kinds of informal relationships (with an organisation, club or group) they are more physically and mentally active as a result, which benefits their wellbeing and health.

The extent to which opportunities to establish informal links with others (peers), or organisations such as user led organisations (ULOs), voluntary organisations (from churches to community groups), and more formally constituted clubs, time banks and support groups, is highly variable depending upon the communities people live in. However, even when there are opportunities in a locality, one of the greatest difficulties people have is finding out about them. Providing quality accessible information and advice about low or nominal cost community clubs, groups and local activities is essential to enable people to maintain their independence.

Information and advice systems such as Connect to Support: www.connecttosupport.org are invaluable in establishing an accessible 'offer' of informal support solutions in any particular community. Web-based tools of this kind are, however, only part of the solution. Linking powerful technological solutions such as Connect to Support with informal peer support networks makes a much more potent preventative arrangement for vulnerable people. A network of peer support groups and organisations or individuals who are able to help users learn the benefits of technology, signpost directly and provide information and advice cost effectively to people with increasing need, will help people to source social care solutions independently from councils. Such a peer support network will bring together people with increasing needs with informal support solutions well before the statutory trigger points are met.

A major challenge for commissioners is investing a comprehensive informal peer support network across client groups across communities at a time of reducing social care expenditure. The TLAP web site: www.thinklocalactpersonal.org.uk contains a good deal of information on how this kind of social capital can be developed. But it is clear that more evidence is needed on how peer support networks in particular can be supported by councils at minimal cost.

Maximising the use of universal services

There is one easy win for councils in developing communities, and it picks up on the New Economics Foundation work which notes that:

The conventional delivery model does not address underlying problems that lead many to rely on public services and thus carries the seeds of its own demise. These include a tendency to disempower people who are supposed to benefit from services, to create waste by failing to recognise people who use services' own strengths and assets, and to engender a culture of dependency that stimulates demand.

We have a unique opportunity to rethink and reshape the relationship between citizens and the state. If we get it right, then co-production will help rebuild public services as equal and reciprocal partnerships between professionals and the people they serve. If we get it wrong then we may see the post-war welfare state dismantled without sustainable alternatives, while citizens – especially those who are poor and powerless – are left to fend for themselves.

NEF 2010 p3.

The most basic activity necessary to maintain needs below the statutory 'trigger point' (see below) is making public or universal services more person centred and 'socially aware'.

For example, if the local theatre or swimming pool has suitable changing spaces, or if a public bus driver is aware of the needs of older people and the bus is adapted to the needs of disabled people, the likelihood of independence being maintained is enhanced. Similarly, if local shops are 'dementia aware' then simple interactions can enhance the lives of many older people enabling them to maintain independence, self-esteem and wellbeing for longer.

There are many other examples that could be given for how a little bit of socially aware interaction or 'coproduction' can increase the wellbeing and health of someone with social care needs, including making sure check out staff at supermarkets, slimming club organisers are able to respond appropriately to people with physical disabilities and learning disabilities. The important point to note is that commissioners need to have a plan for developing more socially aware public services, organisations and groups. An effective strategy for making everyday life more socially aware would increase the resilience of individuals which in turn would enable them to better accommodate their increasing need.

2) TARGETED PREVENTION SERVICES: Targeted interventions are delivered once certain trigger points are reached. But all interventions need to be focussed on creating and re-creating resilient individuals.

Targeted services are necessary to address increasing need. Many preventative services already exist, such as intermediate care services, extra care housing, occupational therapy services, and some domiciliary care, and day care services. These services target specific problems and populations and are 'triggered' by an assessment of some kind. In other words, they often (but not always) respond to a deficit model of social care, an assessment identifies a 'needs gap' and this absence is 'plugged' with the most appropriate cost effective service, more often than not procured on a block basis by the council.

Responding to identified unmet need by providing a targeted service can, of course, be the right response from adult social care. However, on many occasions there will be a whole range of alternative or additional solutions that may be available to any individual before such targeted services are necessary. Prior to a targeted service response, adult social care needs to make sure that everything is being done to maximise the resilience of the individual across the three resource domains discussed earlier: personal skills and knowledge, the immediate circle of support and links to the immediate community. Only then, after the resilience of the individual has been maximised through a relationship with the social care worker should targeted services be identified. If this order of events is not followed there is a risk that services will be put in place that, at best, may be unnecessary, and at worst, may reduce rather than increase the independence of the person concerned.

Putting in place a dialogue between social care worker and the individual about an individual's resilience and doing work to enhance it prior to services being supplied is one step towards an asset-based approach. However, there is also work to be done in the targeted services themselves to promote resilience. Looking at targeted services from an asset-based perspective, suggests that they need to broaden their scope. Working with a customer on a specific health or social care issue is not sufficient; the service provider should also review how they can work with the individual to develop their personal resilience across the three resource domains identified. They then need to provide quality information and advice about where they can get the peer support they need from their local community to take any necessary steps identified.

3) ASSESSMENT AND PURCHASING: There have been various publications discussing the need to slim down social care systems and processes to the minimum requirements.

Whilst this is generally accepted, there has not been much specific discussion about what practical and strategic changes are needed by the social care workforce and their managers as a result of a new personalised customer journey. Whilst a number of key issues are understood, steps towards practical solutions are slow to emerge for a host of complex reasons linked to financial constraints, the risk of 'meddling' with statutory duties, and the difficulties of changing culture and entrenched professional practices. Considering adult social care from an asset-based perspective enables some clarity to be brought to this complex picture.

Assessment

Adult social care assessments are all too often service led rather than needs led. From an asset-based perspective, in an authentic personalised social care world, individual needs and carers assessments have to clearly identify four things:

- 1) What strengths, values, skills and resources the individual has/had and would like to develop?
- 2) What information, advice and support does the individual need to enhance personal resilience? i.e. personal skills and knowledge development, and improve or maintain their wellbeing?
- 3) Is it necessary to re-engage or develop immediate circle of support, and if so, what help or support is needed to achieve this?

- 4) To the extent that 1 and 2 are not able to address identified needs, what more informal and/or formal support is required from organisations or people in the person's local community to help them source the right solutions for themselves?

A fifth question may be relevant, which is: What risks do we need to manage to help achieve these plans?

In other words, the output of a community care assessment needs to change from being a prescription for services to being a statement of desirable outcomes for the individual, followed up by:

- A personal development plan if one is needed.
- A circle of support agreement which may or may not include informal voluntary, or private sector peer support groups and agencies.
- A risk enablement plan to support achievement of these arrangements, if that is necessary, including an assessment of the risk to the 'public purse'.

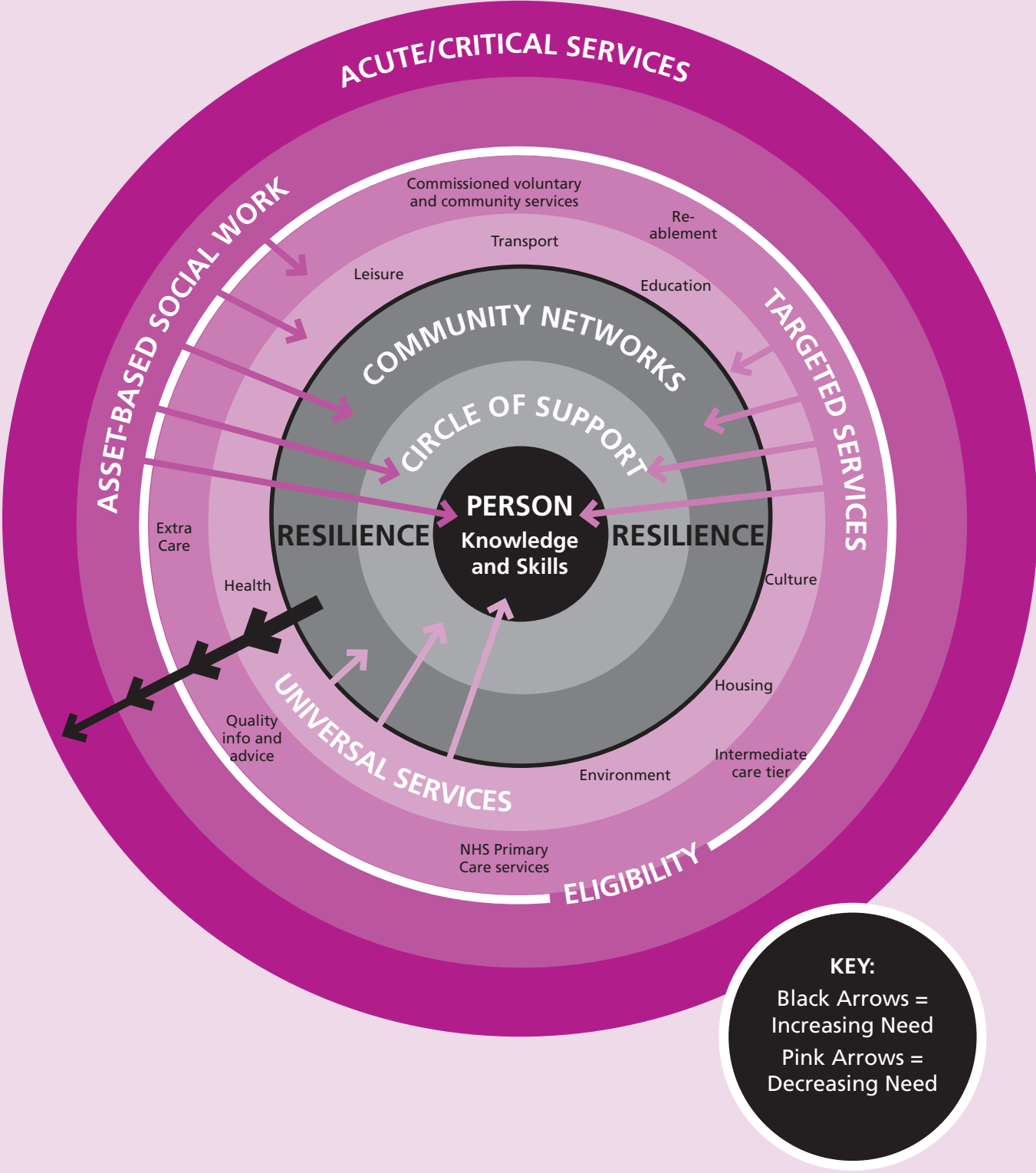
Purchasing can then be done externally to the state supported by their agreed circle of support.³³

This model of strengths-based social work makes the most of people's own knowledge and abilities, it maximises the support available from family, friends and informal networks. Essentially, the model reduces statutory support to an essential minimum, but makes its impact as significant as possible, guiding the 'resilience arrangements' for the individual concerned.

For a diagrammatic representation of this strengths-based approach see the 'onion' diagram opposite.

³³ *In a streamlined system resources would be allocated to the individual on the basis of their needs, not services. However, it is worth considering whether or not resources could be allocated on the basis of outcomes to be achieved given definite time scales to achieve them*

Asset Based Social Care: A Whole System Approach



APPENDIX 3: The Guiding Principles of the Great Leap Forward³⁴

For the individual

- Equal and proportionate access and response from your local team.
- Provide local information, options or signposting to enhance the individuals' options.
- Promote and support the development of skills to gain greater independence.
- Guiding principles of The Great Leap Forward.
- Promote and support personal responsibility to find a way of having needs met and developing opportunities.
- Promote and support access to non-commissioned community options.
- Review with the individual outcomes achieved as defined by them and where needed agree the next outcomes to be achieved.
- Work alongside the individual to promote, advance and obtain access to true citizenship.

For the team

- Up to date knowledge of the area you serve, its nature, demographic and culture.
- Working knowledge of and relationship with local community groups/facilities.
- Ensure proportionate access to all who may require our support and or advice.
- Work alongside the individual to develop rather than disable them.
- Promote the development of personal skills towards clear outcomes.
- Develop the team's presence within the community and actively take part in community development opportunities.

³⁴ See HCPC: www.hcpc-uk.org/publications/standards/index.asp?id=38 for further information on standards and ethics of social work practice

- Promote and think in a flexible and imaginative way when supporting individuals to develop plans of support and care.
- Actively support and develop providers to deliver full services. Working with them in a positive way if things go wrong.

For the social worker

- Support and freedom to increase autonomy and confidence in practice and decision making.
- Committed to knowing the community you serve and develop links and opportunities within it.
- Adhere to the concepts of the PCF and strive to keep your knowledge and practice at the front line of social care.
- Remember why you became a social worker.
- Proportionate but accountable case-working and recording.
- Enable social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being.

Professionalism

- Be able to meet the requirements of the professional regulator.
- Promote the profession in a growing range of contexts.
- Social workers have a professional duty to raise concerns, disclose information and escalate as suitable.
- Take responsibility for obtaining regular, effective supervision from a social worker for effective practice, reflection and career development.
- Maintain professionalism in the face of more challenging circumstances.
- Manage workload independently, seeking support and suggesting solutions for workload difficulties.
- Maintain appropriate personal/professional boundaries in more challenging circumstances.
- We choose to be social workers for a reason, we are employed as social workers for a reason, let's not forget those reasons colleagues from whom to seek advice and expertise.
- Make skilled use of self as part of your interventions.
- Maintain awareness of own professional limitations and knowledge gaps. Establish a network of internal and external.
- Identify and act on learning needs for CPD, including through supervision.
- Routinely promote well-being at work.

APPENDIX 4: Hertfordshire's Culture Change Campaign – in their own words

Background

The project has taken place within Hertfordshire Community Learning Disability Service (HCLDS). The service itself forms part of Hertfordshire County Councils Health and Community Services. Within HCLDS there are 7 geographical Community teams that deliver social work and nursing support to local citizens. Further to this we run two transition teams for 16-25 year olds, two health liaison teams to support primary and secondary general health care and an Asperger social care team. The key functions of these teams are to provide all statutory social work and nursing functions to adults with a learning disability within Hertfordshire. This will average approx 4000 active cases at any one time. The service employs approx. 60 wte social workers and 40 wte equivalent nurses as well as a number of support roles to meet the need of local citizens. Over the last 4 -5 years the service, as with most social care and health settings, has undergone significant change. This has included 3 restructures and reductions of the social care workforce. The seven community teams moved from local offices to two large offices at either end of the county. Again, as with all public sector depts. Our service had to make significant savings over the last 2 years. These were delivered as requested but we believe and hope with minimal if not zero impact on people who use our service.

The above "brief description" is the scene from which the Great Leap project emerged. Having undergone such regular change in both structure but also accommodation it was time to reflect on the impact on practice and culture within our service and it is fair to say that it had been damaged. One of our concerns was that regular change was all very well, staff change and carry on, but what was being broken each time. The change management processes in local authorities are generally system and structural and hence only focus on this. Culture and practice are often forgotten or assumed to be the responsibility of the individual.

This was becoming evident in our service and there was a nagging concern that our drive towards change was damaging our commitment to personalisation and citizenship. There was evidence that the industrialisation of social care was becoming a reality. We had left the community and forgotten the wonder and opportunity that it offered not only to the people we worked with but also to our staff in the drive towards real citizenship.

Initial activity

For this journey to succeed we need to ensure that we were resilient enough to deliver but also imaginative enough to make it a reality. The project in its first phase was slightly covert. Senior Heads and Directors showed great faith and trust and allowed us to run with this project, knowing only its name and our promise that the cultural outcome will be positive. After all culture eats strategy for breakfast!

The Great Leap project worked on two themes, firstly Social Work – Improved practice and social work pride and secondly Personalisation – inclusion and true community. Both of these principles were underpinned by the concept of True Citizenship with the idea that if you can work alongside people to be true citizens then not only have you followed your core values as a social worker but also supported to deliver personalisation. In reality the project became much bigger and branches of practice and innovation developed within the culture of the project that allowed social workers and people we support to try new things and ideas.

And so it began. Initially managers and social workers were brought together to start to test and debate the ideas of social work more importantly community social work within a local authority. We tested our hypothesis that social workers did not have a relationship with the communities, towns and villages they served. Very few of our social workers lived in the patches they worked. When asked if they had shopped in the shops their service users did or whether they had walked through the high streets of the town they served the answer was often no. As a service we had created a door to door service. Office door to person's door and back. Social workers needed to re immerse themselves in the community.

"We become what we behold. We shape our tools and then our tools shape us."

Marshall McLuhan

What we did

It is hard to capture the many branches of the Great Leap Project in words. The focus has been to work with our teams and develop a new cultural shift that enables social work practice and innovation to take root and grow. The testimony of people we support who have become co-community leads and agents for change will hopefully also give you an insight into how this is a journey for all and not just social workers.

The Great Leap project was first conceived in 2013. Initial conversations and challenges were had with team managers and social workers. The challenge put, was that despite all of the good work we were not at the forefront of innovative practice that drove the ideas of personalisation and true citizenship. Those early conversations were difficult but allowed us to start to re-ignite the concepts of true citizenship and just as importantly let social workers practice as social workers. Meetings turned into workshops and ideas turned into events and slowly the project started to gain shape and momentum.

Firstly, we developed a number of principles for our delivery of statutory social work that were compatible with not just social work but also modern social care delivery within a local authority. The principles were aimed at challenging a level of practice that had become about service and not community. If you needed care we were the people to come to. We were efficient at assessing and finding the right placement/service. In reality however we were risk averse and appeared to have industrialised social care. This, a real risk to any social worker who operates within a statutory setting, was our starting point. Our senior practitioners were asked to set up “peer groups” within each team. These groups were to allow social workers to focus purely on practice, models, theories and relevant case law etc. Alongside this we developed what we called our Great Leap Guerrilla poster campaign. Each week two new practice related posters were placed around the team offices. Some morale boosting, some informative and some challenging. Soon our walls had over 100 posters and pictures discussing and promoting social work.

Workshops were set up, team meetings took place

<https://twitter.com/HertsCLDS/status/474481221444325376>

We undertook risk aversion audits and reflected on the outcomes with clear actions. We challenged the very principles of being a social worker and started to re-construct our culture. We wanted to ensure that the impact our practice had on the lives of others enhanced their ability to be citizens. A monthly forum was held with all managers to work

on mini projects to support the Great Leap. Guides to assessment and reviews, principles of the great leap, community asset mapping were all strands that came to life. Managers were urged to lead the project and practice and not just manage care managers.

We designed a handbook for social workers based on the PCF and our expectations of social work practice <http://mwharveyblog.wordpress.com/2014/08/18/a-handbook-for-social-workers-2/> and a pen to remind them they should be proud.

The second phase of the Great Leap was to re-embed ourselves in the communities we serve. In order to achieve this we looked at the use and principles of Asset Based Community Development (ABCD), Local Area Co-ordination (LAC) and Community Circles. The project sought to develop these principles as core practice that can be driven by social workers and people who use services in a co-produced way.

Firstly we got Social workers to map their own assets to understand the principles. <http://mwharveyblog.wordpress.com/2014/03/29/understanding-your-own-community-gifts-assets-will-make-you-a-better-practitioner>

Our NQSWs led the way, one returning to University to talk of our project, her role and encourage students to hold on to their values of citizenship. <http://changetheworldoncommunityatime.wordpress.com/2014/05/26/the-future-of-social-work-is-in-safe-hands>
<https://twitter.com/HertsCLDS/status/494805107310342144>

In this description I have barely touched on the whole project but tried to give a sense of the journey we have been and are going on. There is so much more that our social workers have achieved within this project. Teams joining local chambers of commerce to influence business, conferences run to study, value and celebrate community social work and many co-produced pieces of work to ensure assessment and support planning does all it can to support true citizenship and inclusion.



What was its impact?

The purpose of the Great Leap Project is to ensure citizenship is a true option for all, one that we can deliver via modern social work practice. We feel that the project has significantly shifted the approach and culture of social work practice within our teams. With the concepts of community social work and inclusion as a key driver, underpinned by the PCF and the imagination and skills of staff we have taken a great leap forward in the work we do. Every social worker ensures that individual's skills and assets are explored with them rather than a "what's wrong, lets fix it" approach. These skills, assets and aspirations help form the basis of personalised assessment and support planning that takes a community first option. This approach ensures we work with individuals to explore support that enables a focus on citizenship. No longer do we take services first approach. Social Workers explore with people the communities that surround us all. Why go to a "learning disability centre" to plant things when you could join an allotment society. Why pat a dog in a day centre when you could own one or work with animals. <https://twitter.com/HertsCLDS/status/492263007661993984>

Our practice fundamentally looks at ideas of connecting people and understanding that everyone, no matter how disabled society deems them, has something to give and contribute. Such assessment and support planning has started to truly engage people with their communities rather than make them tourists within it.

Part of the project focused on community assets and mapping. To achieve this we developed a community leads programme that is run jointly between the teams and people who use our services. The focus of this programme is to understand and practice the models of

community capacity building and develop practice to deliver more inclusive communities. The programme has been a great success and the learning is not only being channelled back to teams but also to providers and communities alike. Our service user leads have been so passionate about leading that they have required the approach to be taken on by the housing services they use. They have even been invited to present to executive boards within housing associations.

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<https://twitter.com/HertsCLDS/status/486906489765122048>



Further to this the CLDTs have been running local community ideas events with people who use services. This Great Leap idea takes the principles of ABCD and LAC and explores them within a community event. Each team has been inviting true local community groups and businesses to run stalls to advertise what they do or seek volunteers and employees. Service provider stalls are banned. Attended by people who use services to see the real options open to them locally. When an individual sees an opportunity they want to explore, social workers are on hand to do some impromptu planning to see how it can be made a reality. Support staff that have attended with individuals are challenged to support individuals to build and maintain these real links with the community. The events also help people to map their skills and look at ways they can use them.

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<https://twitter.com/HertsCLDS/status/490130651308650497>

<https://twitter.com/HertsCLDS/status/492261281525923840>

The teams will have run 9 community ideas events by November, connecting people with people and starting to erode the barriers of service worlds and real communities.

We knew we had to influence key partners, commissioners and providers etc. The journey we had taken needed to spread wider and take route in strategies as they are developed. Commissioners were encouraged to join our community leads group and we facilitated service user meetings to advise commissioners of their expectation in line with the Great Leap. We have rolled out the Great Leap project to providers to embed the principles in their service delivery. With this approach we can help influence change more rapidly.

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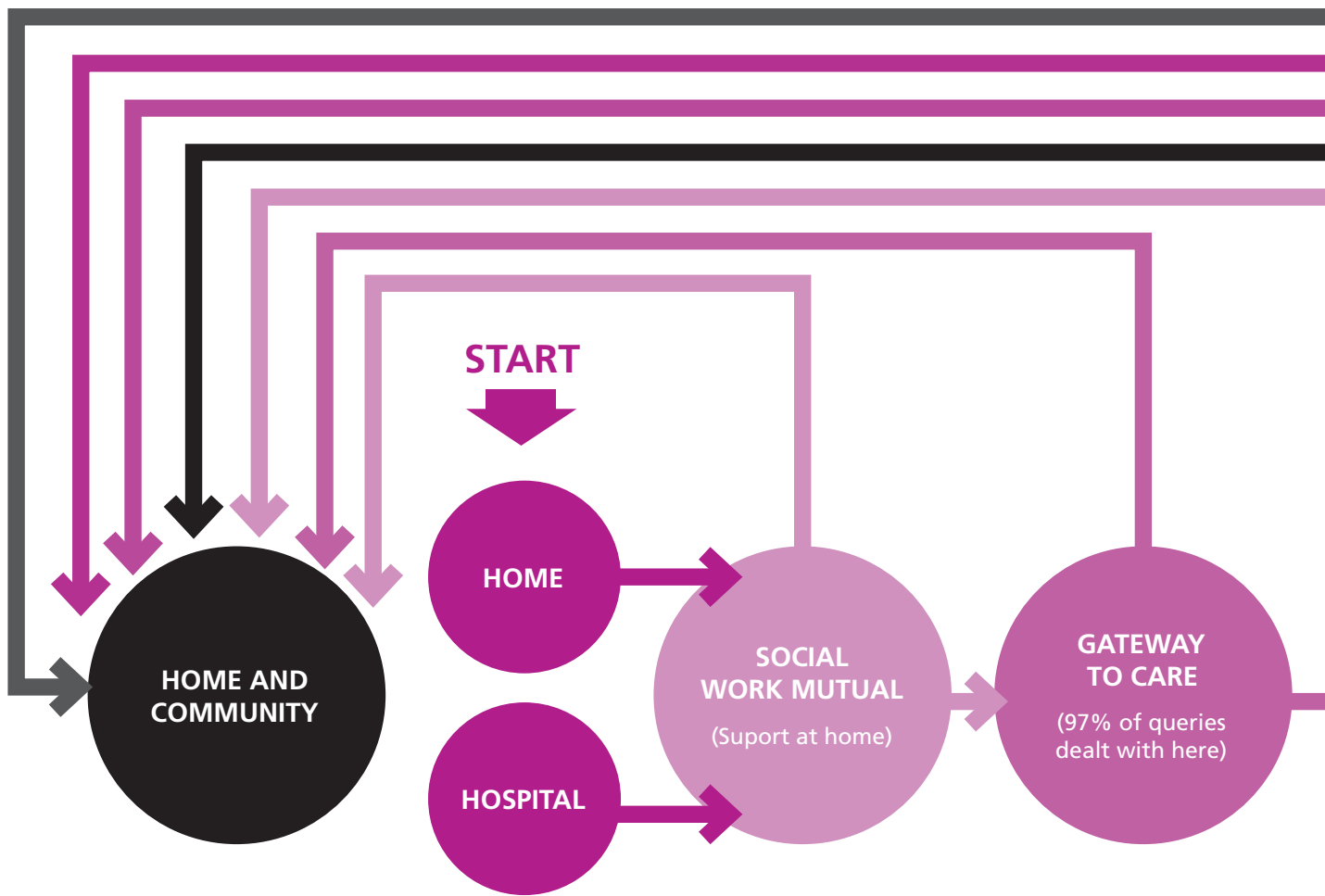
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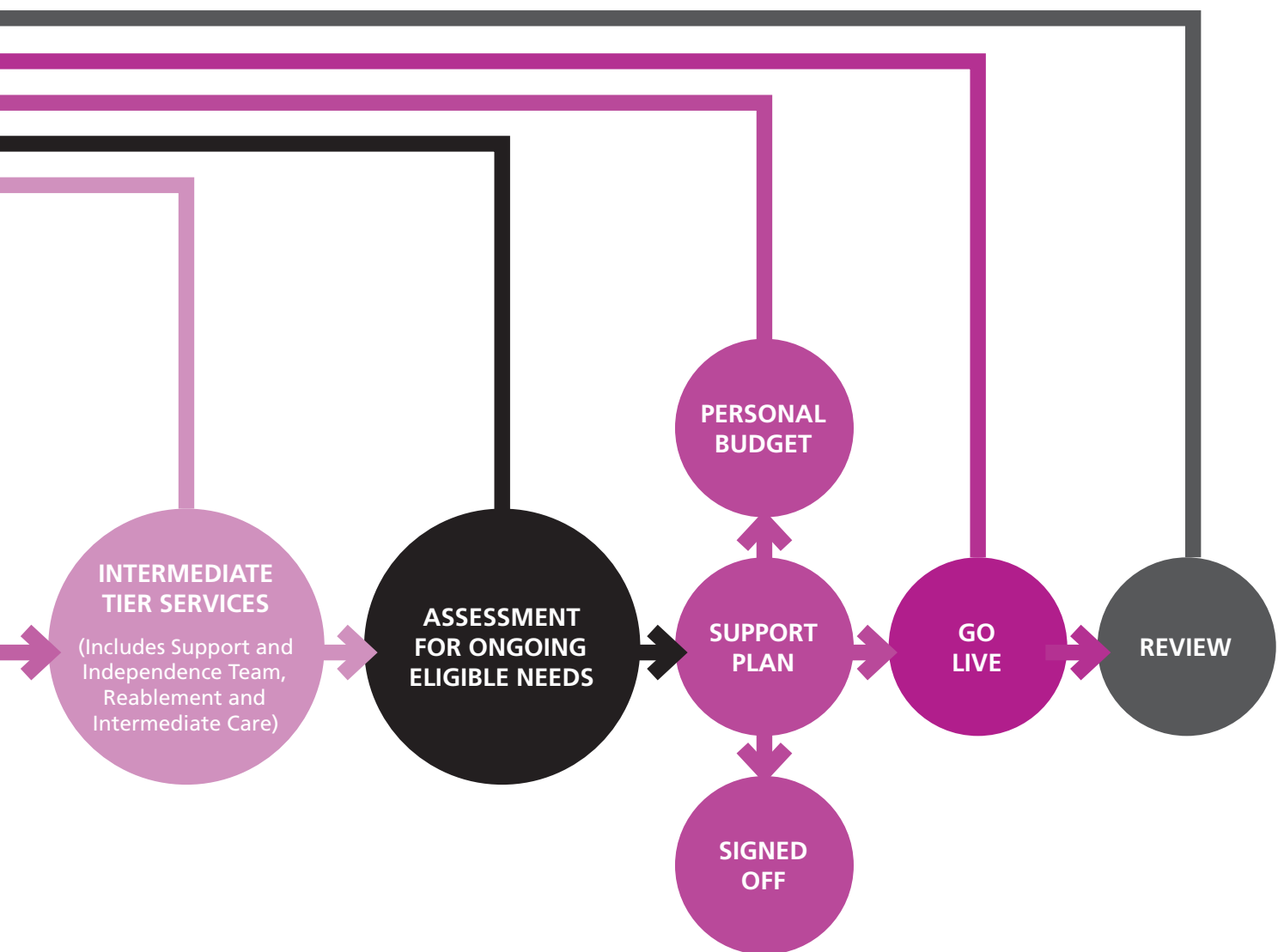
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These are just a few of the positive outcomes of the Great Leap. The project has encouraged innovation and thinking within our social workers to develop new plans and ideas. New voting projects to enable our service users to vote, a joint "think safe project" with the police and fire service www.herts.police.uk/pdf/policing_in_hertfordshire_for_everyone_july_2014.pdf to support people to do the things they want safely rather than being "kept safe" away from the community. We have set up Great Leap Lectures where speakers come to challenge and reflect with us on our project. www.local.gov.uk/place-i-call-home-l-journal_content/56/10180/6326042/ARTICLE

These are just a few of the many exciting pieces of work that make the Great Leap what it is and us all proud to be Social Workers.

APPENDIX 5: Calderdale's customer journey





Think Local Act Personal

Think Local Act Personal (TLAP) is a national strategic partnership of more than 50 organisations committed to supporting the continued implementation of personalisation and community-based health, care and support.

web: www.thinklocalactpersonal.org.uk

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