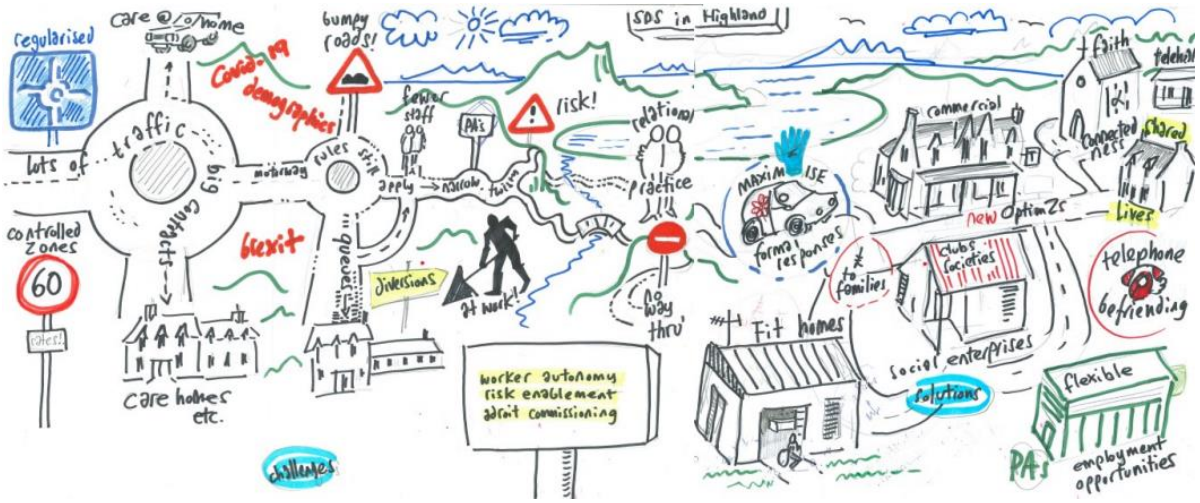
SDS Self-Evaluation and Co-Production in Highland

Discover and Dream: Learning Report from Stage 2



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Introduction

Since the full-day session in Invermoriston, which focused on the 'define' stage of the appreciative inquiry and began to unpick the 'discover' stage, 4 areas for further exploration – to 'discover and dream' - were identified:

- Early transitions
- Flexible commissioning
- Risk enablement
- Worker autonomy

To deepen the understanding of these topics, follow up sessions were arranged and held online. These sessions took a broadly similar format, and asked:

- What is getting in the way of great practice in this area?
- What does great practice in this area look like?
- What is needed to make that happen?

Following this, a fifth emerging topic area was also explored: performance and quality monitoring. This report shares the learning from these conversations, using the words of participants wherever it is possible to do so, and posits some areas to be explored through the design stage.

Topic 1: Early transitions

Introduction

This session involved practitioners from the Highland Council, NHS Highland, and an external agency (Community Contacts). A follow-up conversation with one NHS Highland leader took place to deepen learning on the topic.

Currently there are two approaches to managing transitions for young people to adults' services. In the south and mid localities there is a Joint Transitions Team (JTT) of practitioners in the Highland Council co-located within adult services in NHS Highland, a model in place since 2018. In the west and north localities transitions are managed through generic social work teams. In tandem with this, there are two different models to learning disability nursing, with cradle-to-grave support in west and north, and specialist adult/children nursing in south and mid.

There is work currently underway in the JTT and several locality teams to strengthen relationships with schools and so we should be cognisant of this in our planning so as not to duplicate efforts.

What's getting in the way?

In the full-day session, there were two main barriers highlighted: a lack of services available and therefore a lack of options for young people, particularly exacerbated in rural areas. This was echoed in the discussion sessions, both here

and across other topic areas, but in particular for transitions one practitioner told us:

"It's challenging enough in the centre of Inverness where you've got the college on your doorstep, you've got Cantry Bridge… in our remote and rural areas or less urban areas we've got even bigger challenges. For a younger adult who wants to still stay in their community, who wants to still stay at home but is leaving school, well, who's going to support them and what do they do?" – NHS Highland participant

The challenges of time and social work resource are significant barriers, in particular for generic locality teams who can be juggling a small number of complex transitions cases with a large volume of more straightforward but hugely time-consuming older people cases. This theme of time spent managing assessment and review, and juggling competing priorities is a common one across all of the conversations conducted in this inquiry.

A further area of significant barrier was identified for autistic young people. Many young people with a diagnosis of Autism receive additional support through school, but without a learning disability or diagnosis of enduring mental health problem they fall through the gap in service provision. This was described as being a *'mushroom cloud'* of need:

"…adult social care services have not moved at a pace or with the same approach as children's or educational services have. So what you have is a better diagnostic option for young people to be diagnosed with conditions mainly on the autistic spectrum, but where they wouldn't meet the criteria for severe and enduring mental health. So mental health services door is closed. Then they don't have a diagnosis of learning disability, so learning disability door is closed. But when you take away the structure, the scaffolding and the stability of school and they don't quite work out with what we thought might happen in college or with you know whatever their destination is post school, something goes wrong." – NHS Highland participant

The knock-on effect of this can be seen across multiple different statutory processes and teams – adult protection, criminal justice, antisocial behaviour etc are all impacted as a result of this gap in provision.

Another key area of concern is the feeling of total overwhelm that many parents face during transitions. An example was given of a family who had a PA in place under children's services but the parent had not taken the steps required to gain guardianship, and so support fell through. Practitioners understand how challenging this time can be and do their best to support families, but there is only so much they can do.

"It's a very big journey for the family and I think to do that as a worker without that support around you is quite overwhelming at times." – NHS Highland participant

The pressures of caseloads, reporting, and administration were noted as a challenge. Strong, supportive relationships with good communication can lead to much smoother transitions, but they need time to nurture and develop, which is not readily available:

"…I enjoy having the whole family together… I really enjoy conversating with [father of young person] and trying to help him and encourage him with what he can do, but it's difficult because our time is limited… It's relationship and communication that's key… it's very difficult and challenging for us to have and make that time for our families every week." – Highland Council participant

Within this, the current process of closing cases means that young people do not always have a consistent worker throughout their time with social work. It was described as *'unmanageable'* to have allocated workers within the current structure and resource.

A final key concern is the lack of understanding about the needs of young people across the wider community, as well as the opportunities that might be available in communities through less formal arrangements. This is explored more fully in the next section as it was framed as a 'dream', but the challenge remains. There is a fairly new team of locality link workers in schools, and relationships with this team are developing, but they could provide a valuable resource for joining up processes and supports for young people leaving school and taking more full account of the opportunities in local communities.

Further challenges include encouraging Personal Assistants to move from children's to adult's services with the person they are supporting; lack of joined-up approach with housing providers; a deficit-based approach to assessment; and that there is currently no overarching Autism strategy, although it was noted that this had been explored with autistic people in the past but not fully progressed.

<u>What does great practice look like?</u>

There were a few core themes that emerged as examples of great practice, or aspirations of the group.

Great practice mainly took place when practitioners have the time to form strong and trusted relationships with the people they support. This is a seemingly simple statement, but the conditions that need to be in place for this to happen are more complex and nuanced, and require processes that are not burdensome, practitioners who are confident and supported, and resources that they can offer or use to gain trust. If we break those down we can learn more from what they mean.

If processes are not burdensome then decisions are made quickly, and as close to the person as possible. The delegated authority in practice leads from Highland Council to agree budgets for young people (covered in more detail in the Worker Autonomy section) is a helpful example which illustrates this: families not only receive interventions that can help their situation more responsively, but in addition to this having solutions available quickly builds trust in the local authority, as they are seen as being able to make change happen.

When practitioners are confident and supported through effective supervision, supportive team structures, and have access to training and advice to help them continually learn and develop, they are more able to think creatively, and to advocate on behalf of the families they support. Within this lies the need for strong person-centred planning that takes account of the whole young person's life, assets, and place in the community, which was highlighted in the discussion. As a result this again leads to increased trust from supported people, better solutions in place, and also helps with efficiency and effectiveness of staff time.

In a community that has a strong offer – whether that is through commissioned services or community assets – practitioners have a greater ability to find person-centred solutions to challenges families face. This includes the mechanism to access further education or learning opportunities for those beyond the more urban localities who currently face exclusion and poverty of opportunity.

The result of all of these conditions is not just more successful progress towards outcomes for supported people, but also a gain in satisfaction for staff:

"Relationship based practice is really the thing that allows us to use not just our skills, but also is the thing that gives us joy and pleasure in our work. That's kind of why we come in to doing what we do. We're social beings, we enjoy relationships, we enjoy using those relationships to support people to make change and make their lives better" – NHS Highland participant

There were further ideas, such as the provision of support that would meet the needs of the people identified earlier: young autistic people who might otherwise fall through the gaps. The case for this is clear and the argument strong.

<u>What is needed to make that happen?</u>

Two project ideas were discussed, both of which could require resource planning and so may be beyond the scope of this exercise, but the learning is important to share.

The strongest call for change is around provision of support for the autistic young people. This is not an easy fix, and would require resource to establish, as well as extensive planning with external partners, but the need has been clearly articulated. The *'mushroom cloud'* is no longer an abstract risk over the horizon, but a real and current risk to a significant community in Highland. This was

presented as something different to a traditional support service, but more a means of building structure and support in through transitions, to lessen the shock of losing support entirely.

An idea was presented about bringing together community members in a type of panel process that builds community capacity and resilience to support not just young people with support needs, but whole communities. Central to this idea was the feeling that communities have a great deal to offer, and that a collegiate space for people to share inputs, advice, signposting, or guidance would be valuable:

"I would love to see a transitions panel made-up of the different components across services and communities in Highland… in these meetings it would be 'here's George, this is where George is, this is George's age, this is what George needs at the moment. What can each of you put on the table?' And then we look wider for the deficit." – external partner

Complementary to this is the idea of having communities much more informed about what social work – and self-directed support – is and what it can do.

"We also need to bring this wider language much more into everyday conversations… there are people in community don't know what SDS is. They have no idea what guardianship is until there's a need for it and it really is terrifying for them. So you start off from this really negative relationship because you're there and they don't want you there." – external partner

This is an area that was reflected in Invermoriston from participants who felt that there was a fundamental misunderstanding about the purpose of social work, which led to inappropriate referrals and unmanaged expectations. What it leads to is the idea that communities should be viewed beyond the traditional mindset of recipients of support, and towards being assets to be nurtured and providers of structure and stability who have a clear understanding of what they can offer.

"It takes a village to raise a child, we need to look across the Community Planning Partnership, we also need to look to communities themselves, and that's where we need to get brave." – external partner

Topic 2: Flexible commissioning

Introduction

This session included staff from provider organisations: Highland Home Carers and Keltic Care, as well as an external participant from iHub, alongside team members from both NHS Highland and the Highland Council.

The overarching message from Invermoriston, and indeed from every conversation since, has been that the availability of support services is one of the biggest

barriers to the SDS experience of people living in Highland. While this is leading to some great practice in creative problem solving, it is also resulting in an exhausting and time consuming process for practitioners and back-office staff alike, as they try to reach solutions to meet their obligations. This topic, therefore, is of huge importance to address, and when a solution is found it will support all of the other focus areas.

What's getting in the way of flexible commissioning?

Some initial thoughts centred around questions of definition: how some feel that we describe self-directed support as something different to social care, or how we define our providers in language that may not be helpful:

"At the moment we live and operate in a world both from the funder and the funded and actually we need to get away from that kind of language and that kind of thinking as well, and think we're co-investors" – provider participant

In addition, some fundamental flaws in the way that care and support are described, commissioned, and purchased is a challenge to flexibility. This theme will also be echoed in a later discussion on monitoring:

"We operate in a world of episode of care: times, tariff… as long as we continue to be stuck in that world, we will get nowhere" – provider participant

Recruitment and retention are huge issues for social care across the country, not just in Highland, but it is of particular difficulty in rural areas. In Invermoriston we heard examples of small villages which have no unemployment in people of working age, and in the discover and dream session we heard of the competition in place for providers, from both the hospitality sector and the local authority. The nature of contracts and commissioning is a contributory negative factor within this:

"…having care at home shifts that are split shifts and only 31 hours a week. How are people supposed to live like that? If I'm being completely honest it feels a little bit like we don't trust people to make good use of that other time." – NHS Highland participant

One participant had concerns around a potential conflict of duty, of the need to ensure audit, scrutiny and oversight of public money through current contracting requirements against the inherent flexibility of the SDS legislation. Currently in order to provide a service through options 2 or 3 there is a requirement to have a standard contract with the authority, this is not a competitive process but a safeguarding approach which has requirements for Care Inspectorate registration. This causes potential difficulties for people who wish to use their budgets to purchase non-regulated support to meet their outcomes, in particular for the management of individual service funds:

"…we're not about to hand over a £50,000 ISF package to somebody that we don't know anything about because that would be an unacceptable risk… we've had some issues with people trying to deliver services that they weren't actually qualified, competent or registered for…" – NHS Highland participant

One provider noted that the number of people using option 2 in their Highland services has drastically reduced in recent years – from 129 three years ago to 6 today. It is unclear exactly what has driven this. The lack of incentive for providers to manage ISF was also mentioned as a potential barrier, with some noting that it is a significant back-office undertaking with no additional recompense. It should be noted that In Control Scotland did some work with NHS Highland on creating flexibility in option 2 last year, and there is still a live project underway with scope to address this – and other – challenges in option 2 through an offshoot project from this exercise once the learning is complete.

The safeguarding and audit processes were not seen as overly scrutinous or onerous, and these were not seen as a significant barrier to getting providers to engage, but instead that overall lack of provider availability is the barrier:

"…I'm not aware that we've got a queue of potential new organisations wishing to establish themselves in the adult social care sector in Highland, and I don't think process is an issue… it is as valid and as robust as it needs to be, with some room for agility and a bit of fleetness of foot when required…" – NHS Highland participant

This was echoed by participants in remote and island communities, who noted that there are not providers who are waiting for contracts on Skye. There is a whole system challenge that includes affordable housing and accessible transport which causes difficulties in recruiting care staff:

"…you can have as much flexible commissioning as you want, but if the workforce isn't there and the providers aren't there then it doesn't really help." – NSH Highland participant

Variance in how budgets can be used is a challenge. There is a 'traffic light' system in place for appropriate spend, with some purchases clearly sitting in either 'green' or 'red', but it is within the middle 'amber' area that confusion can be seen:

"…our service users, they'll talk with each other… There's a disparity in what the SDS package can be spent on, which causes us a problem… it seems to be down to different social workers or teams" – NHS Highland participant

In addition to this, families' understanding of what budgets can and should be used for is sometimes lacking, with one participant observing that some families can see a direct payment as *'extra income'* to be spent in whichever way they choose. This causes a challenging difference in balancing the audit requirements of commissioned organisations against the papertrail for those using direct payments.

What would great flexible commissioning look like?

Going back to an early comment in this conversation, there is potentially a need to redefine or rearticulate the way that we describe social care in Highland to enable flexibility in commissioning. This challenge of measuring output in terms of units of time is also raised later in the report (in quality and performance) as a barrier to thinking holistically about what support is and how it can be used.

The concept of strategic workforce commissioning (e.g. some of the ideas in CCPS's 'BIG Ideas' paper, and current work to redesign homecare in Leeds which can be shared) was posited by one of the providers:

[we need to] *"…focus on the workforce, supporting that workforce in terms of how we make best use of those resources, how we develop those resources and skills and learning and training… most importantly building a Fair Work element into this in terms of certainty of income, security of employment and fulfilment opportunities…" – provider participant*

Within this is the issue of trusting staff to use their time effectively, noted above. Great, flexible commissioning would involve authorities trusting their providers – who in turn trust their staff – to use their time flexibly, responsively, and wisely to deliver good outcomes for people. In addition, the concept of place-based commissioning – whereby data on population, need, and community assets is used to inform commissioning activity - was raised as a way of developing good practice:

"We've got really good data in Scotland on how we can weight populations for deprivation, age, morbidity, rurality, and sparsity, so the challenges can be dealt with quite effectively through weighting populations… the higher the volume that we're able to build into that model, the more room for flexibility there is" – provider participant

A current piece of work underway in children's services was noted as an example of evolving good practice in flexible commissioning, whereby an alliance of providers is working collaboratively to support young people coming home from out of authority placements:

"…there's Action for Children, Barnardo's and there's Aberlour and we're looking to create even more people coming to the table… it's about the third sector getting together and rather than being in competition with each other they're sharing projects… it's really responsive…" – Highland Council participant

This model has also been successfully implemented in Aberdeen through the Granite Care Consortium which has successfully reprovisioned homecare services by investing in a core group of providers and trusting them to make decisions about provision more flexibly to great effect. This concept of competition is

important to address as Highland is effectively, in the words of one NHS Highland participant *'a seller's market'*.

And finally, relationships were viewed as paramount over any system or process. The feeling from participants was that there are good, strong relationships across Highland, and that these are a primary contributor to good practice:

"…good things usually happen not because of good processes, they usually happen because of good people… I think we do pretty well in that in the Highland context" – NHS Highland participant

What is needed to make that happen?

A strategic approach to understanding need and creating commissioning opportunities was noted as important. This theme is again reflected later in the discussion on performance and quality but one participant suggested:

"…it would be lovely to see that it was all a bit more joined up with operational management, professional leadership, and it was tied into some of the strategy for health and social care… it all feels a little bit separate to me…" – NHS Highland participant

Providers that are cornerstones within the local community were noted as being valuable, in particular for more rural or remote communities:

"…most of the organisations that have come along and fallen over have been ones that are not firmly rooted in communities, are not firmly rooted in in the Highlands and often are more focused on the for-profit element of their activities rather than the gain and benefit the community." – provider participant

Related to this, negative perceptions of the local authority and a lack of community ownership or engagement must be challenged:

"I think if there was a more grown up relationship with the public, with the community, about 'this is actually how it all works and this is what we need from your community', and if we could work with the community, the local community trusts to start really planning services and looking at how that could happen locally…" – NHS Highland participant

Related again to this, and echoing perspectives in the early transitions group, is the idea of building community capacity and resilience, as well as managing expectations of supported people and communities alike:

"We start off with what can you do for yourself, what informal support networks do you have, and then let's look at what you need to live as full and independent life as possible. But it's almost like the missing link in that whole thing is actually what can the community do to support individuals and support the communities as a whole." – NHS Highland participant

The idea previously mentioned about moving from time and task and amending staff contracts accordingly, to not only place more trust in workers to use their time effectively but also make recruitment more appealing, was seen as important. One participant spoke of how challenging this was on Skye, where the recruitment market is limited:

"…it's become too task oriented, the focus is not realistic. Working split shifts, so instead of using the quiet times to do things like giving somebody a shower, spending time with them, it's a split shift." – NHS Highland participant

"The fact is that Skye does not have enough carers and support workers, it's just not there. To me the community is not taking ownership of the fact that we need an adult care service… for so long NHS Highland has been dependent on providers coming into Skye and it's just not working… " – NHS Highland participant

Learning from similar communities, such as Orkney, was posited. On very small islands, they have looked at how they define the workforce to include the less-formal arrangements that can prevent people from needing to travel off-island to get support, and the governance and safeguarding that can be in place to creatively support these communities by using existing free training such as Open Badge learning without the need for formal training or accreditation. In addition, learning from work in Ayrshire on micro-providers would be valuable to explore:

"…if you're really trying to address specific problems what you're really doing is beginning to get a wider sense of workforce… people who were former nurses, or former teachers etc… a lot of people who are saying, 'I'm not looking to have a full time job which requires all of that [SVQ] and my regulation but I'm willing to give my time and I want to do it in a safe way." – external partner participant

Topic 3: Risk enablement

Introduction

This conversation included staff from NHS Highland, the Highland Council, and an external support agency (Community Contacts). Appropriately managing risk is a huge part of the role of social work, and it was highlighted as important that we ensure that risk management and risk enablement are viewed as separate parts of the same system which can support each other.

What's getting in the way of risk enablement?

Lack of service availability was highlighted as a barrier to taking positive risks, with people sometimes left in difficult or potentially avoidable situations because of a lack of provision:

"Often if people are still left in risky situations and you're aware that there are ongoing risks and we have limited resources for what you can do to mitigate them at times, and that feels quite uncomfortable" – NHS Highland participant

Practitioner confidence, training, and experience could get in the way of enabling risk. It was noted in Invermoriston that there was not a policy in place for risk enablement, and that training is focused on managing statutory risk, potentially missing a broader understanding of risk enablement:

"People have got the right to take risks. It depends on the experience of workers… if we have a new social worker they might jump on a risk and think 'oh this is awful, I'm so worried' but actually helping them to break it down and see that actually this person has a right to live their life this way… One of the things I notice that as you become more experienced your assessment and decision making skills come more quickly." – NHS Highland participant

"Sometimes risk can get lost, or sometimes it can be the full focus of decision making and actually the decision is not in the best interests of the child… Sometimes we could diminish that risk and support the child to stay at home, if we got our early intervention better" – Highland Council participant

Practitioners who worked in children's services, or who were reflecting on transitions cases, highlighted the difficult and nuanced work that takes place when advocating for a level of risk enablement and being able to recognise that young people developmentally need to take risks and that we risk overprotecting people. Similarly when an adult family member becomes in sudden need of support this can raise unchartered waters for families that practitioners must explore. These are difficult tightropes to walk.

"One of the things that can be difficult for workers is where you're having those conversations where you're trying to advocate for or enable risk but understandably when you're having conversations about diff prof thresholds or indeed with families or career that can become very difficult because understandably people want their loved one to be devoid of any risk." – NHS Highland

In the current climate of service scarcity, practitioners can feel obliged to 'engineer' the system to get a result, a theme we also heard in the commissioning conversations, as well as in assessment and resource allocation discussions in Invermoriston. In this situation, it is sometimes felt that risk had to be overemphasised to ensure that support would be prioritised for people in need:

"We recognise that services are really stretched and limited and it's not that we want to over emphasise risk but that's the tool we need to use in order to implement or access or prioritise a service" – NHS Highland participant

A risk-disabling mindset can also lead to services being put in place that are not necessarily required:

"If we have someone in hospital we couldn't possibly have them go to the loo by themselves in case they have a fall and that affects our quality score… what that means is we start to overprescribe and start to manage risk that isn't even there. We need to raise the profile of risk enablement alongside risk management." – NHS Highland participant

In children's services, paperwork and bureaucratic processes were seen as sometimes getting in the way of seeing the whole child, and reducing appetite for risk enablement. This reduces young people's ability to lead an ordinary life:

"…when we have a young person in our care and we're saying 'oh no, you can't go overnight with a foster carer, we have to do this paperwork, and you can't experience a normal childhood because of our bureaucracy.'" – Highland Council participant

It was noted that there can be different thresholds for risk across multidisciplinary teams, and this can bring challenges in reaching consensus. Participants spoke positively about working in a multidisciplinary way, and they found it helpful to have conversations with practitioners from different perspectives, which can lead to deeper understanding or alternative approaches being taken. It was also noted that these differing thresholds can be determined by service availability: examples were given of people with mental health problems who would ordinarily be in hospital but were living in the community because of a lack of inpatient services.

"I find it interesting working in mental health services over a very long period of time how the tolerance level for risk is very much related to the availability of services to manage the risk. And it almost feels as if the pendulum swings that way, and then it swings that way… at the moment we are managing a level of risk in communities with minimal resources because of the pressures on hospital beds, and increasingly trying to develop competence in how to manage these risks, because it is what it is… it has changed post-COVID" – NHS Highland participant

<u>What would great practice look like?</u>

A positively contributing factor to risk enablement is the relationships that practitioners have with the people they support, and the importance of having enough time with people to build supportive relationships in order to advocate for trying something new. Examples were given of successful risk enablement, and these invariably involved a solid relationship where the person trusted their social worker enough to try something new or different.

"I find that some of my most successful situations have been when I know that person and I'm able to advocate for actually, well, they are able to use that bus independently." – Highland Council participant

Alongside this, having strong relationships with supported people and their families can help to manage or avoid conflicts and disputes that might result in

cases being made to the press or elected members, although complaints were not broadly seen as criticism but instead as opportunities for learning:

"…trying to seek that position of understanding so that we can move forward together is much, much more constructive. And in my experience, we get to where we need to be much quicker as well, even if the resources are really difficult. Because once we've understood that, then people start to think a bit more creatively as well and they start to look at the resources that are around them. Families rally round. You know, all sorts of things happen. Not all the time, but it's more likely to if we're in that position of understanding." – external partner

Practitioners having a deep and broad understanding of the local community, what it has to offer, and how supported people can think beyond what they had already experienced works well. When people's aspirations are raised of what they or their family member could do it can be helpful in supporting people to take risks:

"How do people know what to ask, they don't know what's available, and if it's ok for the child to take this risk or that risk, and why should they?" - NHS Highland participant

Participants also reflected on the COVID pandemic, when communities rallied around to offer supports to reduce the pressure on services. This concept of strengthening and utilising communities has been raised across multiple conversations in this inquiry:

"COVID was an amazing example of that. People were rallying round in the community, they were delivering food, they were providing support, they were popping in on their neighbours… and then COVID ended and all that kind of stopped. But that's evidence that that is there and that is available." – NHS Highland participant

<u>What is needed to make that happen?</u>

Much of what was discussed can be reflected here, with a few additional items for consideration. A 'can-do' mindset and creative, collaborative approach to problem solving needs to be prevalent across workers and teams. This must be supported through processes that are useful to practitioners, as well as strong relationships with colleagues and effective line management :

"I think it's so important to be able to work collaboratively with the supported person, but also with colleagues. To be able to develop solutions where there are none or to be able to develop plans that might be sort of around difficult risky situations. But that collaboration and that sort of can-do approach is so important." – NHS Highland participant

Space for practitioners to discuss cases and learn from each other, as well as strong supervision, and the opportunity to speak to people from different disciplines were all stated as being helpful in supporting great practice. This was seen as being complementary and supportive, a space to be challenged when required but also to provide reassurance with more complex cases:

"People quite often know what they're thinking. They just need space to talk through it… it's just having that space to be able to do that." – NHS Highland participant

"I think the likes of huddles or the opportunity to meet with other professions and things as well. Because sometimes what you think about the situation and how you're looking at the risk hearing from other professionals' point of view from a different service can be quite helpful as well to help you kind of balance that up and you know weigh up what is the right thing to do." – NHS Highland participant

In addition to this, the way that adult social work has structured itself – with a team manager and senior social worker for each team with the exception of one still in development - has been supportive for staff regarding enabling risk through better access to support, supervision, and more guidance, as well as sharing the load around some statutory processes. This could be explored in more detail in the later stages of this inquiry. Using the knowledge and skills of people within the team was noted as a valuable resource:

"If we're looking at respite, we actually know that there is a specific person in the office who is really knowledgeable on respite and the processes and how to go about doing that. We've got another person in the office who really knows their stuff when it comes to dementia. So, you know, it's like, can I pick your brains about this?" – NHS Highland participant

Topic 4: Worker autonomy

Introduction

This session involved participants from the Highland Council and NHS Highland. The issue of time was found to be pervasive in all conversations: practitioners feel that challenges of bureaucratic processes and administrative burdens, the pressure of caseloads and staff vacancies, and a constant juggling of priorities is resulting in poorer support being offered to people. There is regular 'engineering' of the system in place to ensure that people can receive support despite the system, as opposed to being a product of an effective system.

The worker autonomy strand feels like a second keystone issue alongside commissioning: if the system did not need to be engineered, if workers had less 'busy work' to do, and if they could respond more quickly to needs and

opportunities as they emerge, they could have more effective conversations and drive positive outcomes more efficiently.

What's getting in the way of great practice?

Bureaucratic processes are often mentioned as being prohibitive in allowing the space and time for good social work practice to take place. When we drill down into that it is clearly a more complex issue than simply stating that we need to reduce process; the role of the social worker will always involve a degree of juggling priorities and flexing to adapt to emerging need, and there were always be a need for checks and balances to support workers by enabling them to do their job well, and to share decision-making and accountability.

"I don't feel like we've got the balance right." – NHS Highland participant

There was a recognition that current system and process is designed around the way things 'used to be', and now that service availability is poorer, but demand remains high, workers strive to be creative in their solutions but find themselves butting against a process that no longer serves their needs. One worker said:

"We're having that good conversation with someone, but then still trying to put people into boxes because of the limited resources." – Highland Council participant

The frustration was noted as being greater in more rural areas, and in fact anywhere beyond Inverness. The way that the current system is organised is based on a landscape that no longer exists:

"The thing that was set up to support isn't running anymore, so how can we make things fit into what's no longer there?" – Highland Council participant

One participant, who is also a DCP panel member, noted that assessments can vary drastically from person-to-person, and told us that it would be helpful if workers put proposals forward that are mindful of what is available rather than knowing that services are not available. While this might be a pragmatic solution, it appears to be another example of 'engineering' the system through necessity, where the system is driving the outcome rather than the person.

The approval of packages was seen as almost an *'abstract concept'* at times, with packages coming to panel, being approved, but never coming to fruition because they have been assessed as needing a service which simply can't be delivered in the current climate. This was described as *'phantom bureaucracies'*, an additional burden for an outcome that does not exist.

"People are living in the old world. They're coming forward to say 'I want approval for a package of two visits four times a day' and the panel says 'yes we'll approve that', but everybody knows that they're not going to get it because it doesn't exist. And that's absolutely nuts." – NHS Highland participant

In addition to this, the current processes are engineered in ways that do not take account of the true need of the person. In Invermoriston we heard from practitioners who try to get budgets under the DCP level to avoid lengthy ACAAG processes, and in other sessions we heard that Highland Council practitioners actively aim to develop support packages under the local authorisation limit to ensure that support can be in place more quickly. These are the actions of a workforce that is committed to meeting people's needs in any way, and feel they have no other option but to subvert the system.

What would great practice look like?

There is a need to strike a balance of autonomy: a system that is supportive to workers and assuring to managers, but which allows practitioners to be spending their time more effectively supporting people. This reflects back to something said in Invermoriston: that we are aiming for 'worker autonomy, not worker abandonment'.

In an ideal system, participants said that decisions would be made as close to the person as possible, with practitioners able to strongly advocate for the people they support. The ability to approve packages up to an agreed level in children's services was noted as being particularly valuable:

"I think Highland Council are a little bit of a step ahead in that we do have the autonomy as practice leads to agree packages up to 10k which I think is really helpful and really works" – Highland Council

It was noted that a large proportion of cases – across both adult and children's services - are at a fairly low budget level, whether that be a few hours of homecare support each week to enable someone to live safely at home, or a few hours of social support to allow a young person to be part of their community. These small cases are often quickly passed by panels, but – for NHS Highland - still require lengthy assessment and approval processes.

There is learning that can be taken from the 'discharge to assess' model already in place. This team have the autonomy to do an initial assessment, provide interim care quickly, have the ability to flex this support over a 6 week period, and as a result have a solid understanding of what the person's needs are. After this, all the evidence for DCP is ready and so is approved very easily. Within this, there is an allocated worker in place to provide consistent oversight and understanding. Essentially, this is putting together packages as a hypothesis or an experiment to try and to learn from (i.e. cycles of learning), rather than undertaking an assessment process in isolation (i.e. assess to assist).

"The discharge to assess model allows people a period of time to do an assessment alongside that individual… that team do have quite a degree of autonomy, so they go and they do an initial assessment, they deliver the care, they

flex it about… and by the time they get to that kind of six week journey we pretty much understand what their needs are and we can commission a service which doesn't get scrutinised at DCP because all the evidence is there to say what we're asking for is what works." – NHS Highland participant

This is in contrast to the process whereby lengthy assessments and waiting times can result in people feeling a strong emotional connection to getting the support they feel they have a right to. One participant said:

"People who have jumped through all these different hurdles – and it can take months and months to get through – are absolutely wedded to that when they get it, because they've had to fight forever to get it." – NHS Highland participant

The opportunity to share ideas and creative solutions through multidisciplinary groups in a collegiate practice-sharing way was seen as a strength in some parts of the current system, whether that be through pre-ACAAG or discussions about risk. This solutions-focused approach, of different disciplines suggesting different options – around ideas for creative support or purchasing equipment for example – results in better and more effective outcomes for people. Where this can be a challenge however is when this is seen as scrutiny, rather than support.

"Things have been set up and they feel like scrutiny and like bars to get over but were set up to be supportive, but it doesn't feel like that anymore." – NHS Highland participant

<u>What is needed to make that happen?</u>

A key element that would need to be in place in an ideal system would be delegated levels of decision making. This is in line with the SDS Framework of Standards, and could involve a staged approach of approval at the levels of individual worker, practice lead, district manager/panel, and so on. There is evidence of this working well in the Highland Council, with the caveats of system engineering already mentioned.

Having a standard set of expectations for what is needed for panel decisions would be a useful change. In the session one participant told us that different panels have different requirements in terms of preparation and reporting which can cause confusion and takes more time:

"Under a certain amount have to go to district manager for the area and each area expects something different in their paperwork, so that's a real challenge." – Highland Council participant

The idea of collegiate spaces and places for practitioners to get advice or guidance has a strong sense of support. In Invermoriston the pre-ACAAG process was noted as being a supportive place for practitioners to stretch their thinking, or to test their understanding. Currently some of the DCP panel members feel that

the multidisciplinary approach taken in some areas is similar to this, and allows for multiple perspectives to think broadly about how support can be creatively designed. If well designed then this process would feel supportive, rather than scrutinous, to be fully effective, and potentially led by people close to practice such as practice leads, rather than senior or financial decision makers.

To create the conditions for all of this to happen it would be important to have in place good training, useful practice guidance, and supportive team structures/supervision to give practitioners the confidence they need to make good decisions, and to strengthen overall solutions.

Topic 5: performance and quality monitoring

Introduction

After the comments on performance monitoring prohibiting risk enablement, a further conversation took place with NHS Highland on how performance is defined and monitored organisationally. It was noted that currently organisation-wide monitoring focuses on activity and expenditure, with data aggregated on areas such as hours of care delivered, delayed discharge, SDS options utilised, carers breaks, and adult protection referrals. Unmet need is recorded for those who have had an assessment and are awaiting a service.

There is a form of practice governance framework but it was noted as being outdated and not as 'sharp' as it could be. Through all of our discussions, practitioners and managers spoke regularly of the importance of good quality assessments, but there is no specific definition, training, monitoring, or learning of what these might be. Practitioner wellbeing data is monitored through HR processes.

It is worthwhile exploring performance monitoring within this exercise, as a move towards defining performance in different terms is an important part of a learning mindset. The aspiration of a learning system is not to no longer monitor data, but to learn from what we monitor, and to use it to drive forward the evolution of practice.

What's getting in the way of good practice?

It was noted that the IT systems utilised are clunky and outdated, but that the performance monitoring team are able to pull information requested. This data is made available to people in senior leadership, with particular attention being paid to delayed discharge which has seen a difficult upward trend following a loss of care home beds. Currently, there is no direct mechanism to link unmet need to strategic commissioning activities other than through conversations at NHS board meetings, which also focus on all health services across the authority.

In an earlier conversation (risk enablement) one practitioner made a comment about current performance measurement that is appropriate to mention here:

"I think as long as we continue to count numbers and hours we've got a problem. We need to move away from that and go to outcomes and you know what's important to the person… It drives me insane. It's an everyday conversation when we talk about numbers, but at the same time we then have a request from Scottish Government, 'let's get upstream, let's do early intervention. But we're still going to ask you to report on your delayed discharges every day'. We need to have a better data collection plan and a better measurement than numbers. – NHS Highland participant

The practice governance data does not support the organisation to learn from what it finds: other than in situations of serious case review there is no direct mechanism to track the impact of practice on supported people at a team or organisational level.

As mentioned earlier, good quality assessments and support planning is regularly noted as being of high importance, but the mechanism to define or learn from this is not set. There have been ideas to introduce a system of case audit to monitor the quality of assessments, but this is still to be fully explored. Staff training is prioritised towards mandatory training of care and support staff to gain SVQs, and practice training was noted as being somewhat left behind.

What would great practice look like?

Ideally, there would be a mechanism which would tie together the learning from opportunities – such as positive risk taking – into system responses that could develop over time into more effective practice. This is largely unexplored in its current state, and so would require some time to think about how this would look. In addition to this, directly and explicitly linking existing data from unmet need to local and strategic commissioning processes would allow for more flexible responses to be made. The mechanisms for this might be more readily available within the current system and easier to pick up as an improvement process.

In tandem with this, having practitioners that are trained, supported, and supervised to be working towards continuous learning, rather than monitoring performance through outputs of interventions delivered, would add huge value to practice.

Reflections and ways forward

There are a number of core themes that weave throughout all of these conversations so far, which can almost be summed up in one reflection: that the core purpose of social work has been diluted to become a transactional process of 'assess to assist', and this is where practitioners spend the majority of their time. Within this, there is a question to answer about how we invest in workers' ability to

advise, support, guide, and walk alongside people of all ages, needs, and abilities as a true partner in supporting them to live a fulfilled life, rather than concentrating our time on assessment and review.

In an interview, one NHS Highland participant said something which struck a chord: *"Sometimes a social worker is the intervention people need."*

Current improvement thinking is invariably in terms of the current system, and how this can be amended, flexed, or streamlined within its current state, and so it is incredibly difficult to think beyond this when it is all that practitioners have experienced. However, we know that the current system – which was designed at a different time and place to where we find ourselves now - is broken. It is important therefore in our next conversations to try to stretch our thinking in ways that might feel unknown or unexplored. In essence, we need to 'get comfortable with being uncomfortable' for true change to happen.

There are a number of opportunities that we can explore and carry out experiments in the design stage, some of these are improvement projects within the current system to make things easier, faster, more person-centred and so on, but there is an additional one that feels more fundamental to also explore: how we decide who we invest our time in.

The original role of Social Workers in the Social Work Scotland Act was to provide advice, guidance, and assistance. Eligibility criteria may define who is entitled to assistance, but this ends there. The ability to provide less formal support, signposting, guidance, or 'the social worker as the intervention' has become limited in the current system.

There is current national interest in eligibility criteria, driven in part by the Feeley review, but also cited in the original self-directed support guidance as an area for improvement, and work in Scottish Government and COSLA is driving forward learning and change. Within this learning exercise across Highland it feels like a fundamental issue to explore through an experiment: what would it look like if our eligibility criteria instead focused more on everyone's eligibility for advice and guidance first, and where appropriate, also assistance?'

There is learning that can be gleaned from across the UK in how this can look and feel in practice. Ultimately, reframing eligibility is not about writing blank cheques, but it is about deepening our understanding of what support is.

The proposal for the 'design' session is to split into teams to design the 'experiments' for the following:

- Early transitions
- Flexible commissioning
- Risk enablement

- Worker autonomy
- Performance and quality (for discussion)
- Eligibility system reset

The proposed agenda for this will follow soon, but would involve us using stimulus examples to engage conversations, discussing a range of ideas, and setting hypotheses for experiments.

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