Report to Scrutiny & Policy Development Committee 15-1-20

Report of: Sara Storey and Dawn Shaw

Subject: Locality Social Care & South East Neighbourhood Working Update

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Summary:
Locality Social Care started to be introduced two years ago in October 2017. It was a major change to the structure of the Council's adult social care workforce, and to a long established ways of working. It also introduced major changes to the relationships between adult social care and its partners - both internal and external; and not least, to create a major positive change in the quality of the experience of adult social care for people who use services and their carers.

Neighbourhood Working in the South East of the city to connect practice / services, has been developed through a series of events and workshops with all partners across 'the system' providing services to Adults. The South East Neighbourhood Hub launched on 4th November 2019, providing 'hot desk' facilities and a space for services to come together to share good practice, collaborate and work together to support people who use their services .

Both the Locality and Neighbourhood working initiatives share a set of values and principles and both rely upon each other. This report aims to explain how these two initiatives have begun to bring a more collaborative and joined-up way of doing things, which creates the potential for system-wide efficiencies and improved outcomes for citizens, people who use services, and their carers.

Specifically, this update report:
1. Describes the various values, principles and elements that make up 'locality working' in Adult Social Care and 'neighbourhood working' in Communities
2. Describes key matters for further consideration and sets out some of the ways these are being addressed in both localities and the South East neighbourhood.

3. Acknowledges that the implementation of locality working arrangement and the South East Neighbourhood Hub are not fully established, either in systems and process terms, nor fully embedded in practice yet. Nevertheless, the report explains the difference that is already being made, and the difference getting locality and neighbourhood working right will make in the future for people and carers
4. Explains what key risks there are to these two areas of work, how these risks are being mitigated, and what elements may need further attention

The recommendations to Scrutiny Committee are:

1. To note that both locality working continues to be work in progress, but that advances are being made after a significant period of change and ongoing management of risks.
2. To recognise the potential future for locality working even amidst well discussed national issues of resource pressures across health and social care
3. To note that delivering system-wide benefits will require continued emphasis on the values and principles of locality working, and a commitment to change front-line practice from all system partners
4. To note that the South East Neighbourhood Hub was launched on 4th November and will be evaluated in March 2020.

The report is being presented to Scrutiny Committee to enable it to undertake its role in reviewing the implementation of an agreed policy direction.

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	✓
Other	

The Scrutiny Committee is being asked to:
Consider the details provided and give views, comments and recommendations on the continued development of both locality and neighbourhood working.

Background Papers:

Appendix 1: Details of Conversations Count
Appendix 2: Adult Social Care Localities Map
Appendix 3: Changing the Conversation: Key Messages
Appendix 4: Feedback on Locality Working from the Whole Service Events
Appendix 5: Baseline File Audit Recommendations

Category of Report: OPEN (please specify)

Report of the Director of Adult Social Care
Locality Social Care & South East Neighbourhood Working Update

1. Introduction/Context

Locality Working:

1.1 Managing Employee Reductions (MER 305) was launched on 20th February 2017. May 2017 saw an Achieving Change programme agreed by the Council which introduced significant establishment changes to the Adult Social Care workforce. There was no reduction in staffing as part of this change. Use of agency staffing was reduced through a focus on permanent recruitment to ensure a more stable workforce.

1.2 The establishment structure was changed to enable a move to locality-based working for assessment and care management teams across Adults and Learning Disabilities services, with the creation of seven locality areas and four central teams: 0-25 Preparation for Adulthood, Future Options, First Contact, Hospital and Out of Hours.

1.3 The new structure for locality working Adult Social Care came into place on 4th September 2017.

1.4 Locality working was not a new concept, but it embodied a desire to link adult social care with developments in Housing, Community services, Children's' services, Primary Care, and Community Health services. It was therefore, part of a wider programme of improvements to the responsiveness and co-ordination of support to the public in Sheffield.

1.5 Some of the specific reasons for the development of locality working were:

1.5.1 The need for better co-ordination of care and support services for people where they live, drawing upon a clearer understanding of the assets and strengths of that area, and enabling social care staff to strengthen peoples resilience by supporting people to develop their relationship to their locality.

1.5.2 To make better use of resources, including:

- Better information and access to support greater independence
- Better processes to support greater productivity: less duplication, fewer hand-offs, greater focus on outcomes
- Better signposting and joint working, including a willingness to grasp an opportunity to develop a strong link to neighbourhoods, with the intention of supporting greater prevention activity

1.5.3 To align delivery of services with a new overarching vision and practice principles.

1.6 The vison and practice principles have been agreed and communicated to all adult social care staff and are being used to orientate our work with internal and external partners. The application of the vision and principles in localities is driving the decisions and the priorities we establish in moving locality working forwards:

1.6.1 The vision:

- Independence: Delivery of information and advice at the right time and in the right way, and helping people develop the skills and abilities they need
- Safe: Delivering Making Safeguarding Personal (MSP) , and strengthening the links between commissioning and contracts
- Well: Supporting ‘wellbeing’ – which means helping people to develop personal relationships, friendships, and their access and mobility around a community, enabling access to culture and leisure opportunities, and supporting people with their financial wellbeing

1.6.2 The practice principles:

- Involve: Actively listening to what people want and then agreeing what they need, consistently and fairly, whilst also being person centred
- Record: Making and recording professional decisions that are defendable because they follow the relevant legal frameworks
- Learn: Being self-reflective, learning from complaints (and complements) and focussing on evidence-based practice
- Collaborate: Being responsible for getting others involved (multi-agency), being a leader in a community or a network, that helps people achieve their goals
- Empower: Delivering timely information and advice, and professional support that helps people to develop the skills and abilities they need

1.7 Introducing locality working involved a number of diverse initiatives to support a change in culture and practice. These were;

1.7.1 A specific focus on culture, moving away from a mechanical process driven model of social care to one which valued person-centred practice and strengths-based approaches. This initiative was called ‘Conversations Count’ – a way of changing how Adult Social Care staff carry out their activities (details provided in appendix 1).

1.7.2 Investment in prevention. Investment in the first point of contact between people and adult social care. People who felt they needed some kind of help or information and advice used to have find out which department they had to go to. Only by going to the right department for their issues were they able to access the right help. First Contact was developed based on the principle of ‘no wrong door’, such that adult social care and other departments developed a single contact number and a single place for people to address their issues. People who need ongoing care and support are subsequently transferred across to locality teams. A diagram of the location of locality teams is in appendix 2.

1.7.3 Basing services in the localities they serve. One initiative created a first point of contact in the locality, - a GP service to be precise. This was

known as the ‘Darnall First Local Project’. More details about this in the main body of the report.

1.7.4 A focus on multi-agency working. Linking up of locality social care with neighbourhood working via the ‘South east Neighbourhood Hub project’. This also is explored in more detail in the main body of the report.

South East Neighbourhood working

1.7.5 South East Neighbourhood working is an important priority because of the need to do things differently to reduce health inequalities. It relies of shifting to a prevention focused health and care system but there are a number of problems stopping us from shifting the system e.g. multiple referrals asking for similar interventions; multiple front doors – but waiting lists mean service users stay in a revolving door and potentially hit ‘crisis’ before been seen by anyone – so then reactive response required; lack of Integrated Business Intelligence to inform ‘right’ intervention at ‘right’ time – leading to interventions not being sequential and treating symptoms rather than root causes creating re-referrals; Commissioning not joined up across services and partners.

2. Matters for consideration

Locality working

2.1 This section of the report focuses on some key issues and the difference both locality and neighbourhood working are making.

Culture change

2.2 Conversations Count: putting people at the centre involved developing six key messages (see appendix 3 for details). These conversations are being embedded through a variety of mechanisms, systems and processes to support staff to develop the new ways of working. One of the recent examples of this culture change work was the recent Vision and Principles whole service events run in October, (the outcome of which are in appendix 4).

2.3 The main approaches to continuing to develop the Conversations Count culture are:

2.3.1 Recording: Having implemented a new IT system at the same time as implementing the Conversations Count and the localities MER has been a very significant pressure on staff and resources. The result has been some confusion amongst staff about what information to record in which location and how exactly to do some of the recording. To ascertain the extent of the recording issues a Baseline File Audit was conducted in September 2019. The conclusions are identified in appendix 5.

2.3.2 The quality of recording has been addressed via ‘floor walkers’ and Liquid Logic Training but more emphasis is still required to get this core function correct. A direct action responding to the file audit has been the establishment of a Quality Assurance team

(created within current resources) shared across Localities, Business Support, and Finance, to directly support the improvement of recording practices.

2.3.3 Thematic improvement: A series of workshops have been created for delivery in the New Year 2020 to support staff with a number of different aspects of their work and the recording of that work including:

- Finance conversations with people and carers
- Carers referrals and advocacy
- Safeguarding and the use of case notes
- Professional decisions taking
- Improved understanding in localities of brokerage and social care commissioning and contracting

2.3.4 Preparation for Adulthood: Work with our colleagues in Children's service, SEND and Special Schools has begun to develop our approach to Transitions, emphasising the development of independence and wellbeing between the ages of 14-18 and for some young people to the age of 25 if in full-time education. The aim of which is to support transition of the family as well as the young person to life as an adult with as few restrictions as possible; also with the greatest continuity and avoidance of a 'cliff edge' on entry to adult social care, whilst promoting the greatest quality of life.

2.3.5 Time: One of the persistent and most challenging issues facing locality working is the pressure on social care workers in the field to have the time with people who use services and carers to make their conversations count. A project led by the Practice Development team has analysed a raft of information from across all 7 localities, and a plan to address the findings is in place. The South East Neighbourhood Hub model also brings with it opportunities to save time and use resources in more efficient ways. This initiative represents the potential for a substantial step forward in how locality social care staff will undertake their roles.

Interfaces

2.4 First Point currently provides high quality, quick responses, and tailored information and advice, from one place. If people or their families need to talk with more, perhaps needing some crisis intervention work, First Contact and the associated prevention and early intervention teams will do that work. Everyone presenting at First Point gets a positive response to help them 'get back on their feet'. Broadly however, there are three groups of people that make up the main focus for the First Contact teams:

a) People need support in the community and are not already known to locality teams
b) People who are being discharged from hospital
c) People who have immediate Safeguarding needs

2.5 Once the prevention and early intervention work has been done hopefully individuals have regained their independence and they are

back in control of their wellbeing. However, sometimes people need ongoing care and support. In this case the prevention and early intervention teams will, once they have ensured the person is safe, check which part of Sheffield they live in, and transfer them to their locality team.

2.6 The interfaces between first contact prevention and early intervention teams and localities staff continue to need work, to improve the experience of people who use services and carers. Specifically to reduce the 'hand-offs' and the repetition people have to deliver the same set of experiences. This is particularly in relation to joining up Safeguarding not only between first contact teams and localities, but also between Contracts, Providers and other key partners. This work is underway with specific training developed and now being delivered alongside the Safeguarding Board.

First Local - Darnall

2.1 One of the important ways in which the current First Contact arrangements might develop in future is to build on the learning from an informative pilot site called 'First Local' in Darnall. This innovation site has joined up locality social work and the prevention and early intervention teams in a shared locality setting. The project planning began in early March 2018, and the team started officially on July 2018. The details are as follows:

Aims and vision

2.2 First Local is an innovation site set up during the second phase of the Conversations Count trial process, supported by Business Strategy colleagues. The project involves a multi-skilled team made up of staff from First Contact, Equipment and Adaptations and Locality 6 Team 2 co-locating at the Darnall Primary Care Centre.

2.3 The project is designed to offer a new way for people who could benefit from very early intervention and prevention to engage with Adult Social Care. The team can provide information and advice as well as demonstrate equipment and telecare devices, and visit people in their homes. The aim is to take prevention to the heart of an area of Sheffield that sees a high proportion of GP referrals to Adult Social Care, changing people's perceptions in the process and engaging with people who might otherwise not become known to the Council until they are in a crisis.

2.4 The team initially ran a full-time drop-in service during the surgery's opening hours for anyone to approach them to have a chat about promoting their independence, increasing their level of social inclusion and improving their opportunities in life.

2.5 GPs from Darnall Primary Care Centre itself alongside a number of other GP surgeries in the area are able to direct people to the drop-in as an alternative way of asking Adult Social Care to help.

2.6 The project aims to resolve issues as early as possible, engaging with local communities in the process and collaborating intensively with local voluntary and community organisations as well as with NHS colleagues.

Progress

2.7 The team has collected a great deal of learning about complex partnership working as well as practical and logistical considerations that will help feed in to any future local access points in the city. A lot of time has been spent on building strong relationships with Health staff across surgeries and the CCG, and these will also prove valuable for the future.

2.8 Over the first couple of weeks roughly 2/3 of the 60 people who attended the drop-in had not previously approached Adult Social Care. Most people enquired about issues relating to access and mobility issues (either their own or a relative's), and most people had come because they had either seen a poster or flyer in a GP surgery, or because a GP had suggested they attend directly.

2.9 In terms of the difference the project is having on people's lives, the vast majority of people who spoke to a member of the team would otherwise have done nothing to improve their situation – meaning that their circumstances or those of a loved one may have otherwise deteriorated, unnoticed, until they reached a crisis point.

2.10 Most staff have also reported that they are highly satisfied with this new way of working, as they can see for themselves how they are able to relieve anxiety, respond quickly, spend quality time with people, reassure people that someone is listening to them, and see people go away happier in the knowledge that they don't have to face issues alone.

Case study

One of the innovators at First Local was approached by a person who explained that she had received a letter from her Housing Association demanding that work be done to her bathroom to remedy an issue with the floor. The person in question was distressed and did not know how to deal with the demand.

By listening to the person, the innovator learned that the person was suffering from a brain tumour and that she was climbing in and out of the bath with assistance from her daughter, who was then pouring water over her using a jug. The innovator arranged to visit the person in her home there and then. At the same time, she contacted the Housing Association to explain about the person's medical and personal circumstances – for instance, how her illness was affecting her vision and causing distress – as well as requesting a shower head that could attach to the person's bath taps as an immediate, interim solution.

As a result, a full assessment of the person's home can take place to see how her home might be adapted quickly, and the Housing Association has said that it will stop contacting the person with its demands until the innovator has been able to finish working intensively with the person herself. They have also said that they will look into long-term solutions themselves, such as changing the flooring in the bathroom.

- ➔ The innovator felt as though she has made a real difference in the person's life by preventing her having to continue living under considerable stress
- ➔ Ultimately, the Housing Association would have contacted the Council to get involved and would not have dealt with the person with as much empathy
- ➔ Only now can the person concentrate on her progress and her treatment. If she had not visited First Local, she would still have to contend with significant anxiety that would have added an extra pressure to an already vulnerable person

Summary and next steps

2.11 First Contact and First Contact Prevention have proved successful at bringing a strong, multifaceted preventative approach to people accessing adult social care. Together in a single office, social workers and care managers sit alongside occupational therapists, community support workers, prevention officers, travel trainers and sensory impairment officers – all to the benefit of people who want a streamlined, efficient and effective service based on an in-depth understanding of what a good life looks like to them.

2.12 First Local adds another dimension to this model by creating a local access point focused on enhancing prevention out in the community, and enhancing the 'no wrong door' approach. We are seeking to bring information and advice to the places where people go, rather than try to push people into using existing access channels. We are also seeking out people who may not always seek early help through what they see as 'formal' channels.

2.13 In order to manage additional local access points, building on the learning and success already being achieved through First Local, input from Locality teams alongside the involvement of occupational therapists/occupational therapy assistants and further community based preventative support (e.g. CSW's) would be key in progressing the model and continuing the shift from case management to prevention.

Specialist vs generic working

2.13.1 One of the key challenges to developing locality working has been the necessity to spread specialist teams across the 7 localities rather than have them working closely together located in one building. This has been applied to three specific areas, Continuing Health Care (CHC), learning disability, and connected to this, autism. Expertise in these specific areas has been spread quite thinly and a training programme has begun to develop the specialist experience and knowledge across generic social care workers in all localities.

2.13.2 It should be noted that whilst some specialist teams have been shared across locality sites, other social care functions have remained specialist. For example, mental health social workers who have maintained their seconded arrangements to Sheffield

Health and Social Care Trust (SHSCT), and we continue to work closely with the carers centre and advocacy providers for their specialist support.

2.13.3 The continued specialist teams present challenges for a locality model of working, evidenced by the persistent difficulties report by locality staff in finding community-based mental health workers able to contribute to the support arrangements for people with long-term mental health problems where they live. One of the main reasons for this is the lack of quality communication and information sharing between organisations working with complex individuals, and a similar lack of efficient mechanisms for al organisations to engage better with each other.

2.13.4 The principle way in which this issue is being addressed is by actively supporting and participating in the development of the SE Neighbourhood Hub.

Neighbourhood working

The South East Neighbourhood Hub

2.13.5 The neighbourhood hub provides a direct contact point for professionals who support individuals requiring early help services. The hub enables practitioners to work together effectively to join up their support for individuals so the 'right intervention' takes place.

2.13.6 The Hub is currently developing the Team Around the Person concept through co-production with frontline workers across the 'system', service users and the Townships Primary Care Networks. It is also testing the process through holding and facilitating TAPs with relevant professionals.

The Team Around the Person (TAP)

2.13.7 A Team Around a Person (TAP) is a group of practitioners working with a particular individual and their family.

2.13.8 A TAP is a meeting between some or all of these practitioners and the individual (where appropriate) and / or their careers.

2.13.9 The purpose of a TAP meeting is for practitioners and individuals to share information and to create a solution focussed action plan that best suits the needs of the individual and family.

2.13.10 The TAP model is based on the idea that flexibility is essential if services working with individuals are able to meet the diverse needs of each and every individual. The TAP model places the emphasis firmly on the needs and strengths of the individual rather than organisations or service providers.

Key principles of the TAP

2.13.11 To ensure that individuals are placed at the centre throughout their involvement with TAP

2.13.12 To ensure that individuals are able to identify the significant individuals in their life

2.13.13 To use a strengths based, restorative approach to communicating with and engaging with individuals/families, listening to their story and supporting solutions

2.13.14 To coordinate the provision of multi-agency support that is accessible and meets the needs of individual/ families

2.13.15 To use evidence based approaches and evaluation measures in order to ensure the best possible outcomes for individuals and families

2.13.16 To support individuals to implement and review their action plans to ensure that they are relevant and tailored to their individual needs.

3 What does this mean for the people of Sheffield?

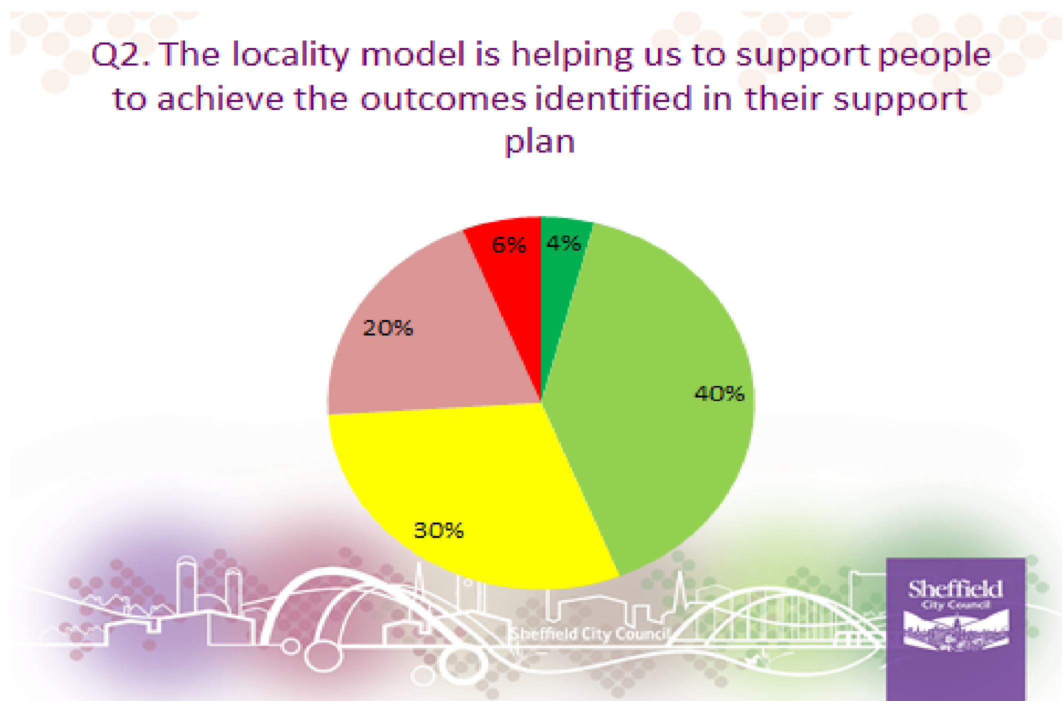
Locality Working

3.1 The impact of the move to locality working in Adult Social Care (ASC) on people who use services and carers is very difficult to measure. There are a range of outcome measures used in ASC to identify progress but they are notoriously affected by a wide range of issues, which have nothing to do with the move to locality working. For example, the external provider market failing to deliver sufficient potential placements might skew the use of a particular service response. Another example would be increasing demand for a particular service outcome, perhaps because of an increase in hospital discharges during winter pressures might increase residential care placements when locality working might be successfully reducing tem.

3.2 The nationally recognised increasing demand for health and social care provision, alongside the success in delaying needs may also generate a greater demand ‘later’ as people return to the adult social care with greater acuity. There are many further variables which mean attributing a positive or negative change in the ASCOF figures to the introduction of locality working would be incorrect.

3.3 Nevertheless, a set of key performance Indicators are being constructed which will track the effectiveness of locality working as best we can over the financial year 2020-21. These will consider indicators in localities of things like the number of hospital admissions avoided, the reduction of residential care placements and the amount of time people remain at home with a care package, the number of carers assessments and advocacy used, and the satisfaction of people who use services and their carers.

3.4 Despite the difficulties of attributing outcome measures to the performance of locality working there are a number of ways in which its success can be judged from an adult social care perspective. One way is to consider the effect of the change to locality working on staff. The following graphic perhaps shows the best evidence of the impact locality working is beginning to have, where Greens are 'strongly agree' and 'agree', yellow is 'neither agree nor disagree', and reds are 'disagree or strongly disagree'. It suggests that broadly 44% are confident that locality working is proving effective for the people we work whilst 30% are unsure. If over the next year these staff members can be convinced of its value over 70% of staff will feel the model is effective in gaining belter outcomes for people.



South East Neighbourhood working

3.5 A summary of 7 TAP 'learning' cases, dealt with in the Neighbourhood Hub at Shortbrook:

- All 7 of the cases are currently involved or had involvement from Adult Social Care
- 6 out of 7 Cases have had involvement from Housing officers
- 6 out of the 7 cases have Home Care packages in place
- 5 out of 7 cases are due to deterioration in hygiene/ cleanliness/hoarding of the home.
- All cases have required involvement from all services around the table

3.6 Currently the following services involved in TAPs are:

- Adult Social Care

- Community Support Workers
- Housing Officers
- Care Managers
- Woodhouse Forum (People Keeping Well)
- District Nursing
- Occupational Therapy

Risks

3.7 Many of the detailed risks associated with both locality working have been described already, along with mitigating activity. In this section the main high-level risks are presented and mitigations are explained.

3.8 All of these risk areas will need close attention to ensure both locality working emerge to be the successful model for both Communities and Adult Social Care that it promises to be. See the table below for further details:

Risk	Mitigations
Ambiguity about practice standards	In localities a series of workshops are scheduled to start in the next quarter to run throughout the year, focussing on thematic elements and the standards that need to be met. A quality assurance team will be created to support staff and correct inaccurate practice. New ways of working in the South East Neighbourhood Hub are being tested and practice standards are being developed and shared for comment.
Ambiguity about internal and external interfaces	Partnership workshops are being delivered across the locality teams to support improved working arrangements, improving communication and relationship building.
Unsuccessfully changing the culture	Culture change is being supported by active leadership, whole service events to explain and communicate vision and practice principles, supported by the thematic workshops and continued investment in the front-line workforce.
Time constraints mean new working arrangements are not effective	Time will be used more efficiently and effectively as a result of: new IT systems, mobile working arrangements, and new IT hardware, clearer processes and decision taking at the lowest possible level in the organisation.
Training is unsuccessful in skilling-up staff in specialist aspects of	The effectiveness of the thematic workshops and the quality assurance team, as well as regular training opportunities will be monitored and any necessary changes will be made if they prove ineffective.

social care and neighbourhood hubs	Supervisions and personal development reviews will also be used to support the skilling-up process
Projects to support multi-agency working do not deliver needed innovations	Project support to monitor important pilots like First Local and the South East Neighbourhood Hub is in place and will react to any issues that arise. A governance structure is in place to enable changes to be made quickly where they are needed.
Performance measures are not robust enough to evidence progress	A performance framework that can be applied to locality working is in development. A governance structure is in place to properly report on performance and instigate corrective actions.

4. Recommendations

4.1 The recommendations to Scrutiny Committee are:

1. To note that locality working continues to be work in progress, but that significant advances are being made after a significant period of change and the ongoing management of risks.

2. To recognise that the potential future for locality working, even amidst well discussed national issues of resource pressures across health and social care

3. To note that delivering system-wide benefits will require continued emphasis on the values and principles of both locality working, and a commitment to change front-line practice from all system partners.

4. To note that the South East Neighbourhood Hub was launched on 4th November and will be evaluated in March 2020.

Conversations Count: changing the conversation in Adult Social Care

We're changing the way we approach adult social care in Sheffield. This paper explains why, and how.

Our new approach is all about the conversations we have with people. It's about listening to people, and talking with people, to really understand who they are, what matters to them, what a good life looks like to them and to their family, and how we and other people can work with them to achieve this. Instead of focusing on what people struggle with, defining them by their needs and assessing them for services, we will look at people's identity, their strengths, what they want to achieve, and what they, their family and community can, or could, do with the right motivation and support.

It's also about liberating workers from the endless forms, referrals and bureaucracy of our current system, and enabling them to explore a new, more exciting and more rewarding way of working – with a new IT system to support them. It's about increasing morale in teams, working together and trusting the professional and personal judgement of staff.

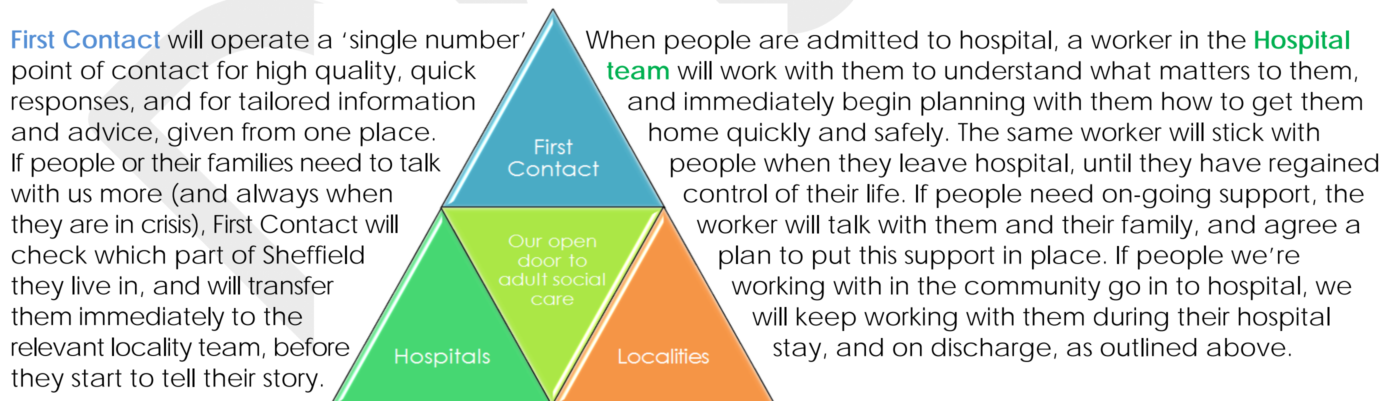
Finally, it's about more equitable use of scarce resources.

Our new way of working is called 'Conversations Count', and it's based on the Partners for Change 3 conversations approach. We're working with Partners for Change to change the conversations we have – not just with the people and families and communities we're working with, but also with each other and our partners in Sheffield – to build relationships and work together to support people to build better lives.

Conversations Count represents a significant cultural and behavioural change for us all. However, it is completely aligned with our core values, and the reasons we all work in adult social care.

Opening our doors

Our new approach will mean people and families will be able to contact us in three main ways. We will have open doors, not closed gates. There will be no wrong door. We will trust and rely on the professional and personal skills and judgement of our staff to focus on what really matters to people.



First Contact will operate a 'single number' point of contact for high quality, quick responses, and for tailored information and advice, given from one place. If people or their families need to talk with us more (and always when they are in crisis), First Contact will check which part of Sheffield they live in, and will transfer them immediately to the relevant locality team, before they start to tell their story.

When people are admitted to hospital, a worker in the Hospital team will work with them to understand what matters to them, and immediately begin planning with them how to get them home quickly and safely. The same worker will stick with people when they leave hospital, until they have regained control of their life. If people need on-going support, the worker will talk with them and their family, and agree a plan to put this support in place. If people we're working with in the community go in to hospital, we will keep working with them during their hospital stay, and on discharge, as outlined above.

Locality teams will know their local neighbourhoods and communities and everything that happens there. People and families new or known to us will be able to contact their Locality team directly, rather than going through First Contact. They will be able to do this either by phone/email or in person at First Local centres in their community. Locality teams will be adequately resourced to be fully involved in their neighbourhood, to play an active role in the lives of all those living locally, to respond immediately where necessary (and always when people are in crisis), and to have detailed knowledge of local opportunities and support, not just formal care services. The primary purpose of Locality teams will be to actively connect people to those local resources, and to be immediately available for intensive short term involvement when people experience crises. Locality teams will work closely with colleagues in primary and community health to ensure a coordinated experience for local people, using the three conversations approach as their working practice. The worker who has the first conversation with people and families will stick with them, bringing in additional people and skills where required. There will be no hand-offs or referrals. Where people have existing support in place, they will know who to contact in their relevant Locality team, and how to contact them.

Working together and sharing decisions

We will work closely within our teams, and will have open and honest conversations where we will question and challenge each other, and reach agreements together. We won't expect senior managers to make decisions about people they've never met. Senior managers will support the professional and personal skills and judgement of front-line staff and managers, who will only ask for support with decision-making where collective agreement can't be reached in the team.

Reducing bureaucracy and process

We will take seriously the Care Act requirement to work appropriately and proportionately. The number, type and length of conversations we have with people will be appropriate and proportionate to what they would like to achieve and to the severity and extent of their needs. We won't obsess about process, but we will be guided by our principles. We will focus on people's lives. We will spend significantly more time with people, and significantly less time in front of a computer.

Using scarce resources effectively

We will connect people to local, effective community resources to help them get on with their lives. We will challenge assumptions that services are solutions, and will reduce dependency on formal care services. We will reduce the number of people who return to us repeatedly because what we've put in place isn't working, we haven't listened or we haven't done what is most effective. This wastes money and time. We will intervene early, when people are less likely to be in crisis, and when they are in crisis we will work quickly and effectively with people rather than leaving them waiting and letting the crisis build. We won't tolerate waiting lists – they are bad for the people we're working with, bad for us, and bad for our budget. We will gather compelling evidence that this way of working is the most effective way of using resources, and delivers the greatest return on our investment for our people, our communities and our organisation.

Continually reflecting and learning

We will support each other in our teams through peer support and reflective practice. We will focus on finding solutions rather than identifying problems. If something isn't working, we will change it.

Redefining our principles

Our Conversations Count principles are fundamental to our approach. If we're not working in a way that promotes our principles, we will need to change the way we're working.

These are our principles.

1. We have conversations with people about their identity, their lives and what matters to them
We listen hard, and have conversations with people based on what they want to say to us, not what we want to ask them. We're interested in how people see themselves, what's important to them and what they'd like to achieve. We don't make assumptions, or prejudge what people's main priorities or concerns will be, or the solutions that will work for them. In our conversations we explore what people enjoy, what they're good at, where their strengths lie, and we talk about how some extra support from their family and friends and their communities could help them live as independently as possible for as long as possible. We have conversations in places where people feel safe, and we allow enough time for relationships and trust to be established.

2. We recognise that everyone is an individual, and we treat people as individuals
We know that people are the experts in their own lives, not us. We take full account of their views, wishes, feelings and beliefs. We don't define or categorise people by their needs, or by their age, disability or health condition. We work with people and their families to support them to live the best life possible, rather than simply operating a pre-defined, 'one-size fits all' assessment for services. The number, type and length of conversations we have with people are appropriate and proportionate to what they would like to achieve and to the severity and extent of their needs.

3. We keep people safe
We make sure that people are, and remain, protected from abuse or neglect. If we're concerned about people's safety, we work intensively with them to make sure they are fully involved and have choice and control over what happens next. We continue to work closely with them until we're satisfied that they have regained some stability and control in their life, they feel safe, and they have the right support in place to get on better with their lives.

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4. We don't expect people to have to tell their story more than once
We never start conversations then pass people on, expecting them to tell their story again and again to different people who are only interested in one small element of their lives. This is particularly important where people are in crisis and need something to change urgently. Where people need more support than we can offer, we bring others in to help. People know how to contact us, and can contact us in a way that works for them.

5. We use language that demonstrates our respect and that is easy to understand
We communicate and provide information in a way that is easy for people and their families to understand, and that shows we respect them. We don't use jargon or acronyms. We identify, record, flag, share and meet people's accessible information and communication needs. We check to make sure that people understand, and can retain and use the information we give them, and can communicate their views, wishes or feelings. If people find this difficult, and they have no one else to help them, we arrange for an independent advocate to support them.

6. We know people's neighbourhoods and communities, and have an active role in them
We consider people in the context of their families and support networks, and take into account the impact of the person's situation on those who support them. We recognise that everyone is part of a community, or several communities, due for example to where they live, their interests, or their circumstances. Their community may have a physical base, or could be virtual. We see people, families and communities as equals. We listen to them. We recognise that people and their families know best about what will work for their lives, and communities know best about what will work in their area. We invest in small projects and initiatives to help them to thrive. We co-design solutions to meet identified gaps.

7. We don't plan long-term support unless there really is no other option
We don't assess people for services. We explore with people all the opportunities and support available within their own networks and communities. If we feel we've exhausted all the options, we check this out with our colleagues before considering more formal, long-term options. We never plan long-term support in a crisis. If people are in crisis, we help them to identify what needs to change urgently for them to regain some stability and control in their life, and work with them intensively to make this happen. We stay around and in contact to make sure the short-term plan is working. Once the crisis is over, we make collaborative decisions about what to do next.

8. We support people to make their own decisions
We always assume that people have the capacity to make a decision, and we explore all possible ways to help them to make their own decision. We understand that people have the right to make what we or others might regard as unwise or unusual decisions. If, following a capacity assessment, we don't feel that people have the capacity to make a specific decision, any action we take, or any decision we make for them or on their behalf, is made in their best interests, with the least restrictive impact upon their basic rights and freedoms.

9. We record conversations, not tick boxes
Liquid Logic supports rather than dictates our Conversations Count approach. We make real-time records of conversations. There is space to write, not boxes to tick. Our records capture, proportionately, who said what and why, and give a sense of people as individuals – their identity, their lives and what matters to them. Our records make sense to the people they're about, and we give people copies in a format that works for them. We make sure that people understand what is going to happen next.

10. We don't review support - we take stock with people about their lives
We want to know whether people's lives are working or not, and what might need to change to make their lives work better. We don't complete tick box reviews after a set number of weeks. We contact people and families after our conversations have finished to check how things are, and take stock at least once a year. If everything is working we record that and leave people alone. If not, we have more conversations to support people to get on better with their lives.

Changing people's lives

Our new approach will change people's lives.

People and families in communities in Sheffield will be more independent, and safer. They'll feel more in control. They'll feel we know them, and feel that we care about the same things they care about.

Staff working in Adult Social Care will feel liberated and trusted, and that their professional judgement and their gut instincts matter. They'll feel happier. They'll feel like they're working in a way that is true to who they are, and true to what they believe.

Services will become less important. People's lives will become what matters. This will become our focus.

Draft

APPENDIX 2

Adult Social Care Localities

Stocksbridge & Upper Don

West Ecclesfield

East Ecclesfield

1

Stannington

Southey

Shiregreen & Brightside

Firth Park

Hillsborough

2

Burngreave

Darnall

Walkley

5

6

Crookes & Crosspool

City

Broomhill & Sharrow Vale

Manor Castle

Fulwood

Nether Edge & Sharrow

Park & Arbourthorne

Richmond

Woodhouse

Ecclesall

Gleadless Valley

3

4

Birley

Beighton

Graves Park

7

Dore & Totley

Beauchief & Greenhill

Mosborough

ASC Locality

- Locality 1
- Locality 2
- Locality 3
- Locality 4
- Locality 5
- Locality 6
- Locality 7
- Wards

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Changing the conversation: six key messages

1. How people initially contact us, and how we then work with them (access and case management)

Vision

We have open doors, not closed gates. There is no wrong door. We trust and rely on the professional and personal skills and judgement of our staff to focus on what really matters to people, and to be useful. When we start a conversation, we either immediately determine that the person needs to speak to someone else and we connect them quickly, or we stay with them, so they don't have to tell their story more than once.

We don't manage 'cases'. We listen to people, and talk with them, to really understand who they are, what matters to them, what a good life looks like to them and to their family, and how we and other people can work with them to achieve this. People matter to us, and we continue to check back in to make sure their lives are working for them.

Action

First Contact will focus on resolving some issues immediately (i.e. through a Conversation 1a) and passing all other work straight to the relevant locality team. We will learn about when we can work with people best from one central point and when they need to be connected immediately to a locality team.

Any urgent or crisis work will always be passed straight through to locality teams.

We won't arrange a package of care in a crisis and the pass to someone else.

We will continue to explore innovative, local and flexible ways of interacting with people e.g. First Local

2. Safeguarding

Vision

We make sure that people are, and remain, protected from abuse or neglect. If we're concerned about people's safety, or think that they are experiencing, or at risk of, abuse or neglect, we work intensively with them to make sure they are fully involved in any decisions and have choice and control over what happens next. We don't rely on forms and processes to keep people safe. We rely on our principles of no hand-offs, and of sticking with people in crises, and we continue to work closely with them until we're satisfied that they have regained some stability and control in their life, they feel safe, and they have the right support in place to get on better with their lives.

Action

Everybody needs to be safe – and we will ensure this through using Conversations Counts practice in teams to support people in a way that keeps them safe. We won't refer them to another team or 'pathway'. We will use excellent safeguarding skills based on Making Safeguarding Personal – and count and measure our performance in relation to keeping people safe. We will use Conversation 2 mode and mentality when people are at risk to put together high quality immediate plans to keep them safe, and stick with them to make sure the plans work.

3. Prevention and reablement

Vision

Prevention is not just the responsibility of a dedicated team. We are all responsible for prevention – collectively (and in collaboration with our partners) in developing wide-scale whole-population initiatives aimed at promoting health and wellbeing, and individually in each and every conversation we have with the people we're working with.

Likewise reablement is not a just a service we throw at people by default, but a way that we work with people to identify and put in place helpful solutions to support them to regain, or learn new, skills and abilities to better get on with their life in a way that works best for them.

Action

Draft

We will coach and mentor our staff to work in a 'prevention and reablement' mindset in all the work that we do, through reflective practice sessions and leadership.

4. Continuing Healthcare (CHC)

Vision
We always retain a focus on the person and avoid lengthy wrangling about funding and cold hand offs. We keep people informed, we explain and we're honest. We have collaborative discussions with our NHS partners rather than rely on bureaucratic processes shaped by forms and timescales.

Action
We will seek to agree with NHS colleagues how best to resolve funding issues in relation to CHC that don't involve lengthy delay for people while professionals dispute who is responsible.

5. Decision making

Vision
We support people to make their own decisions, and never exclude people from decisions about their care and support. We always assume that people have the capacity to make a decision, and we explore all possible ways to help them to make their own decision.

We work closely within our teams, and have open and honest conversations where we question and challenge each other, and reach agreements together. We don't expect senior managers to make decisions about people they've never met. Senior managers support the professional and personal skills and judgement of front-line staff and managers, who only ask for support with decision-making where collective agreement can't be reached in the team.

Action
We will develop sound, transparent and accountable mechanisms for maximum devolution of decision making to frontline staff and teams, whilst ensuring budget holding managers have full visibility of spending decisions and can intervene where necessary.

We will introduce a culture of peer reflection/support where teams work closely together in (locality based) worksites rather than in isolation from home, and feel confident and supported to make decisions collaboratively and challenge constructively where appropriate.

6. Brokerage

Vision
We know people's neighbourhoods and communities, and have an active role in them. We know about the informal, small scale opportunities and local sources of support and we connect people to them. We recognise that people and their families know best about what will work for their lives, and communities know best about what will work in their area. We invest in small projects and initiatives to help them to thrive. We co-design solutions to meet identified gaps. We work collaboratively to make the best use of all the available resources.

Action
We will always attempt to help people, in the first instance, through connecting them to local resources and systems of support in their communities. When we need to help people access formal care we will do this efficiently and collaboratively.

We will collect, maintain and share useful and comprehensive information on community resources and support.

Draft

Feedback on Locality working from the Whole Service Events October 2019

Team	Comment	Principle	category
Localities	Customer Engagement- Better collaboration between front line staff i.e. Business Support & operational staff with O Staff taking/responding to client calls rather than say “take message” resulting in customer frustration not being able to talk to the right person Business Support - Localities	Collaborate	Improvement
Localities	Improve quality of case agency to enable empowerment	Empower	Improvement
Localities	Work in specialist teams to promote confidence in workers & enable them to Empower customers		Structure
Localities	Record. Reduce mistakes once learnt pathways for Liquid Logic	Record	Improvement
Localities	Improve IT e.g. give staff the ability to send secure/encrypted email so that everything doesn’t have to go through business support. Keep an electronically updated list of providers rather than emailing lists that go out of date etc.		Systems
Localities	Conversation model better way of ‘Assessing’	Involve	Comment
Localities	Some Specialised Teams need to be developed to improve the customer journey & increase confidence & reduce waiting times.		Structure
Localities	Ability to truly hear customer experience ‘hubs’	Involve	Comment
Localities	Caseload management: sharing resources effectively across localities.	Collaborate	Improvement
Localities	Network/identify local services	Collaborate	Improvement
Localities	Support level 1 staff to progress to level 2 faster (with protected time to do the portfolio etc)-so that staff feel valued. Most of them are already doing the work!		Staff
Localities	Go back to Specialist Teams		Structure
Localities	It means we can get back to social work and its principles		Comment
Localities	Hubs in localities sound like a good plan-esp if it is multidisciplinary LA/CCg + 3rd sector	Collaborate	Structure
Localities	Time to reflect on practise as a team	Learn	Improvement
Localities	I record my conversation and learning from all I come into contact with	Record	Comment
Localities	Improve communication especially with CCG to stop delays + aid us to collaborate	Collaborate	Improvement

Localities	Providers having bank staff on 0 hours contracts (NOT ALL) the ones that are happy for short term work when they are available-This so people in hospital can come out with the same provider.		Improvement
Localities	Listen to others to see how they'd do it (improve practise)	Learn	Improvement
Localities	Training opportunities to enable staff to be more confident with different customer groups	Learn	Training
Localities	Additional resources or better resource management so we align resources to where they are most needed		Resources
Localities	Recruitment & Retention Strategy- needs developing as struggling to retain talent & increase suitable candidates to vacancies.		Resources
Localities	Increase staffing so we have time for prevention/empowerment not just crisis management.		Resources
Localities	Bed vacancy in Care Homes recorded centrally with information about top up fees	Record	Improvement
Localities	Collaboration is being affected by separation of professionals e.g. Love street –OTS, Physios will be based at different sites, need to maintain the current status quo.	Collaborate	Structure
Localities	Involve people in conversations-collaborate with them + other people both professionals + charity empowering the person to live the life they need		Comment
Localities	More coproduction-Peaks are developing a local forum	Involve	Improvement
Localities	Need consistent support from SLT		Management
Localities	Bullet points on case notes	Record	Improvement
Localities	Use of abbreviations sometimes makes understanding difficult	Record	Improvement
Localities	Create team to collect debt-SW/CM should not have to be debt collectors – ruins relationship when they have to talk about money owed too much…. Does not support conversations count?		Structure
Localities	Poor Quality IT-Liquid Logic has created more problems than it has solved, it is illogical & has got in the way of the innovations & reduction in bureaucracy promoted by Conversations		Systems
Localities	-Pooled budget for JPOC's or agreed e.g.so-so split like for S117 –would then more time ensuring people's needs are met and less arguing about budgets!		Finance

Localities	"Holistic" Collaborative, innovation from all Service, localities areas. Team Players, respect each other's roles not them and us	Collaborate	Comment
Localities	Senior managers should ensure systems are tested to ensure that thye are effective prior to launching a system live! Yes we are talking L.L. + control		Systems
Localities	What needs to change – More staff		Resources
Localities	Events to start in a timely manner 100 staff x 30mins = 50 hours cost to council to sit and chat!		Complaint
Localities	More support on site with L.L. issues having to send emails slows the learning process down and momentum is lost		Systems
Localities	Better collaborative working	Collaborate	Comment
Localities	Start these events on time !!		Complaint
Localities	More staff- chasse (?) the depts to allow service to those who don't shout as loud		Resources
Localities	More collaborative working between-localities-SCAS-commissioning-Providers-PKW-CSW	Collaborate	Comment
Localities	Liquid Logic development & better training & support	Learn	Systems
Localities	Fair distribution of resources –Childrens Services have far more than Adults services		Resources
Localities	Resources linked to Demographics		Resources
Localities	Change management-more consultation prior to change		Change
Localities	Feel more valued by our SCAS departments –work in collaborations	Collaborate	
Localities	I need to clone myself as there isn't enough time to do my job by 1 person		Resources
Localities	Better open market, equity of service for LD + adults, stop being dictated by control		Commissioning
Localities	Better equipment for staff-you talked about staff respecting SU's-something needs to happen in Sheffield –there is little respect for SW's		Complaint
Localities	360 degree feedback –Career development framework-Talent Management Programme –Training need analysis-leading to bespoke learning opps		Development
Localities	Home support-it needs flexible consistent service, quality above quality		Services
Localities	Localities-G drives from localities services to shared access so we repeat-consistent messages from all managers-consistent + clear messages about recording	Record	Improvement
Localities	Clearer processes in a timely Manner		Improvement
Localities	More interaction between team managers		Management

	across services		
Localities	We need to collaborate more with C.C.G	Collaborate	Comment
Localities	Improved home care providers		Services
Localities	Drop down in localities sorted – seems as we mobile work		Systems
Localities	Need to recognise that empowerment, involving Sus etc… takes time to achieve. The pressure from current workload makes This challenging. Team managers need to facilitate This rather than a token gesture!	Empower	Resources
Localities	Some new blood in middle mgt to support new directives.		Management
Localities	Locality working has not achieved what it expected to –still don't know enough about local resources! Too many wider service targets to meet.		Structure
Localities	Investment in more staff. Resources.		Resources
Localities	Quicker payments.		Finance
Localities	Quality of homecare. Bring back Care4You as main provider.		Services
Localities	To have link people in each area so we can know who to go to for information and improve communication across the service	Collaborate	Improvement
Localities	There are far too many managers (service + team) who do not have social work qualifications		Management
Localities	Back to specialism. People's skills and service is diluted. Staff lacking confidence in specific areas.		Structure
Localities	Professionally qualified managers .		Management
Localities	We need to collaborate more with C.C.G.	Collaborate	Comment
Localities	Balance the specialisms in locality teams – part of a robust workforce development place		Structure
Localities	Outcome based commissioning. Our providers need to commit to this & assessors would then write outcome focused plans	Empower	Services
Localities	Localities-Needs to change. Create space & time to have better conversations		Resources
Localities	Notice boards to reflect to all staff & service users it works at Brushes		Improvement
Localities	Whole locality team meetings rather than individual team meetings	Collaborate	Structure
Localities	We are currently starting to collaborate in locality 7 hub. Denise MDT's in Beech Hill- To share responsibility- Inter-professional practise	Collaborate	Improvement
Localities	Specialisms work better in some areas. Bring these back for e.g. supported living & CHC. Better for the person		Structure

Localities	More Autism training	Learn	Training
	feedback from Incident form	Learn	Improvement
	Workshops on site.	Learn	Improvement
Localities	Clearer processes between First contact & localities-Roles & responsibilities are too changeable.	Collaborate	Improvement
Localities	Believe there is still a need for specialist teams. Skills have been diminished and staff lack experience.		Structure
Localities	Care Home Team Req'd.		Structure
	Better locality Bases. Be based in our locality.		Structure
	We need to hear about the good stories	Learn	Communication
	* BRING BACK SPECIALISM TEAMS*		Structure
Localities	Managers to ensure recording really reflects the principles-stand firm & return work which doesn't reflect principles.	Record	Management
Localities	Change: Hospital teams changing regularly. Diagram required of all teams and how and where new teams fit wrap around the person –Tops Team	Collaborate	Structure
Localities	More consistency regarding processes		Systems
Localities	More interaction between team managers (All offer different advice)		Management
Localities	More interaction between team managers across services too.		Management
Localities	Executor services needs to change as cases coming up for COP application when clients and providers requesting funds and being denied. This does not promote independence well-being and is not strength based empowerment approach.	Empower	Improvement
Localities	More time as a team to share & reflect & learn.	Learn	Resources
Localities	Poor management support at present. Managers appear unaware of current stressors within the office and one staff member was supported by a manager outside of locality who was visiting. Bring back Senior Practitioners to support workers		Management
Localities	MDT barrier. Health vs social care. Consultant / MDT barriers respect and being kind.	Collaborate	Comment
Localities	IT equipment		Resources
Localities	Front door into localities	Collaborate	Structure
Localities	OT in each locality	Collaborate	Structure
Localities	Access to insight		Systems

Baseline File Audit Recommendations

September 2019

1. Records must demonstrate how staff have applied practice principles, by:
- Evidencing how staff have supported the person to be involved in conversations and to make decisions about their lives.
- Reflecting on what matters to the person and what has been agreed will help them to live the life they choose (including: what they'll do themselves; what family, friends and others in their support network will do to help; how technology can open up opportunities; what formal support, if any, is included, and how support will be funded).
- Evidencing a collaborative approach to decision-making, clearly demonstrating who has been involved in supporting the person to make decisions about their lives and why the decisions were made.
- Being accurate and up-to-date.
- Creating more transparency in our recordings, to help empower people and support better outcomes for people who already use our services.

2. Work to embed the practice principles must include discussion about what good records look like as well as what good conversations look like. To support this, the Practice Development Team will work with teams to update the recording principles and develop additional recording guidance and exemplars so we have a shared understanding of what good looks like and why it matters.

3. As well as embedding the principles we also need to ensure there is a shared understanding across the service about our legislative requirements, with an emphasis on wellbeing and about eligibility being much more about the person's individual life and goals, not just a lack of knowledge about the legislation.

4. To assure ourselves that the principles are being understood and are being applied consistently into everyday practice, we need to implement a monthly file audit across the service. Auditing records within supervision will enable us to reflect, learn and understand how we could do things different, and how we can improve. It will promote excellent practice where it exists and look at actions for improvement in service delivery