North Somerset COUNCIL

Appendix 3

Staff update

Adult Social Care Workforce Consultation Outcome

Foreword

The senior leadership would like to express their sincere thanks to all staff who participated in the consultation. Over 100 staff attended consultation meetings, Hayley Verrico met with 10 members of staff on an individual basis and over 30 email responses to the proposal were received.

The workforce restructure is intended to ensure that we can meet the increase in demand for our services, ensures that we have a service that is ‘fit for the future’ and so that we are better able to demonstrate any increases in staffing needed over the coming years. It is recognised that staff are working as hard as ever to meet the needs of residents and there is no suggestion that any team or service is ‘not working’. The facts are that we have an increase in demand for adult social services, systems will change with the implementation of Liquid Logic and at the same time we still do not have a long-term funding solution for adult social care and so need to work differently to meet the needs of North Somerset residents. With these issues in mind, we cannot do ‘what we have always done’ and so the need for change is stronger and more relevant than it ever has been.

Feedback on the proposal was of an excellent quality and throughout the consultation period it was clear that staff had formed very clear, concise and well considered views in regard to the future direction of our service and what changes would deliver improved outcomes for the residents of North Somerset. Attached to this update is all the feedback received which we have attempted to condense where duplications in opinion were received.

Some aspects of the proposal received more feedback than others and this was especially so regarding the change of remit for the Assessment and Reablement Team (ART). Significant numbers of staff raised concern about the locality teams being able to prioritise hospital transfers along with community referrals and safeguarding concerns for people living in the community. In addition, during in the consultation period, the CCG launched the Integrated Care Bureau (ICB). The ICB is an integrated discharge meeting where multi disciplinary professionals agree a pathway for people to be discharged from hospital. Already in the first 2 months we have seen a significant reduction in inappropriate referrals to ASC. We need to consider this development in the overall context of the workforce proposal. The management response to these concerns are addressed under the ART section of this document.

Some staff fed back that the proposal very much focused on care management and not on occupational therapy services. The senior management team apologise for this and it was not intended. To give assurance, Sarah Shaw and Jo Hopkins, Principal Occupational Therapist has been involved throughout our analysis of the feedback received and will be involved in following through with our restructure.

Many staff also queried our commitment to integrated working and whether this was no longer a priority. As many of you may be aware, NSCP are currently part of a re-tendering process in which the CCG are re-procuring community health services across BNSSG. The outcome of this exercise will take several months, and the outcome is unknown. With this in mind the Senior Management Team feel that we need to press ahead with our plans to remodel our services but where opportunities arise to work with our NSCP colleagues, we will of course do so especially where it results in better outcomes for residents of North Somerset.

Under each proposal within the document we have summarised the feedback received and having listened to staff, what has stayed the same or been amended. At the end of the document we summarise our plans along with timescales to implement the restructure.

Implementation

We need to be mindful that we are soon to launch the new adult social care information system, Liquid Logic (LL), the launch planned for the end of March/beginning of April, the 2 weeks prior to this are business contingency for system downtime. Therefore, we have 10 weeks between 7th January and 18th March to get everything ready for the launch of LL. In that 10 weeks we will deliver an eLearning package in January and a face to face training package in February and March (several hundred hours of staffing time). Much of the senior management time will need to be diverted to the project.

We have spoken to several other local authorities and the impact of the system launch is significant and it will affect everything we do, every recording, every interaction with a member of the public. The advice is, not to underestimate the scale of change.

We are therefore proposing that we break down the workforce restructure into 3 areas:

- What workforce changes can take place pre-implementation of LL
- What background activity can continue throughout the period broadly unaffected by LL
- What changes will realistically have to take place post LL implementation

The timescale and lead for each proposed change is outlined under each service area within this document.

1. Outline of Consultation

1.1. This paper outlines the proposed new structure for adult social care services in North Somerset and the feedback from staff. This proposal does not yet include the final staff deployment to each team, this piece of work being completed throughout January 2019. Staff numbers will then be assigned to each team.

1.2. The scope of the proposal was to define the structure of operational teams delivering assessment, care planning, safeguarding, Social Work and Therapeutic interventions

1.3. The proposal was a formal consultation with affected staff which ran from 1 November 2018 to 7 December 2018. The Union were consulted prior to this on 31 October 2018.

1.4. Staff were invited to comment or put forward questions on any aspect of the proposals within the consultation period. There were a number of 'engagement sessions' which took place on which staff were invited to 'drop in' as required.

1.5. Written feedback was also submitted and individual meetings held

2. Context & Core Principles

2.1. Providing quality social care that promotes wellbeing and ensures the best possible outcomes for people is becoming ever more challenging. Government funding has been falling while the population is growing, and people are living longer with more complex conditions. This is happening in a period of rapid social, economic and technological change bringing new problems alongside new opportunities. More than ever we need to focus on doing the right things, being clear what we aim to achieve and how we will do it.

2.2. Doing our best for people in these challenging times means responding to people's needs differently, otherwise we will end up simply cutting the existing service model more each year, squeezing costs and diluting services. We are determined to avoid this by fundamentally re-thinking and re-designing our approach to adult social care.

2.3. Our structure going forward will align with the principals of the 'Vision' for adult social care; applying the 'strength-based' approach to practice and maximising independence

2.4. The structure should seek to 'future proof' the model of delivery for adult social care to address the challenges facing the service and provide staff with a clear remit and supportive environment in which to practice.

2.5. Our vision for adult social care in North Somerset is

To promote wellbeing by helping people in North Somerset be as independent as possible for as long possible

2.6. To achieve our vision, we have agreed a change management programme that links to and has informed the proposed restructure of adult social care:

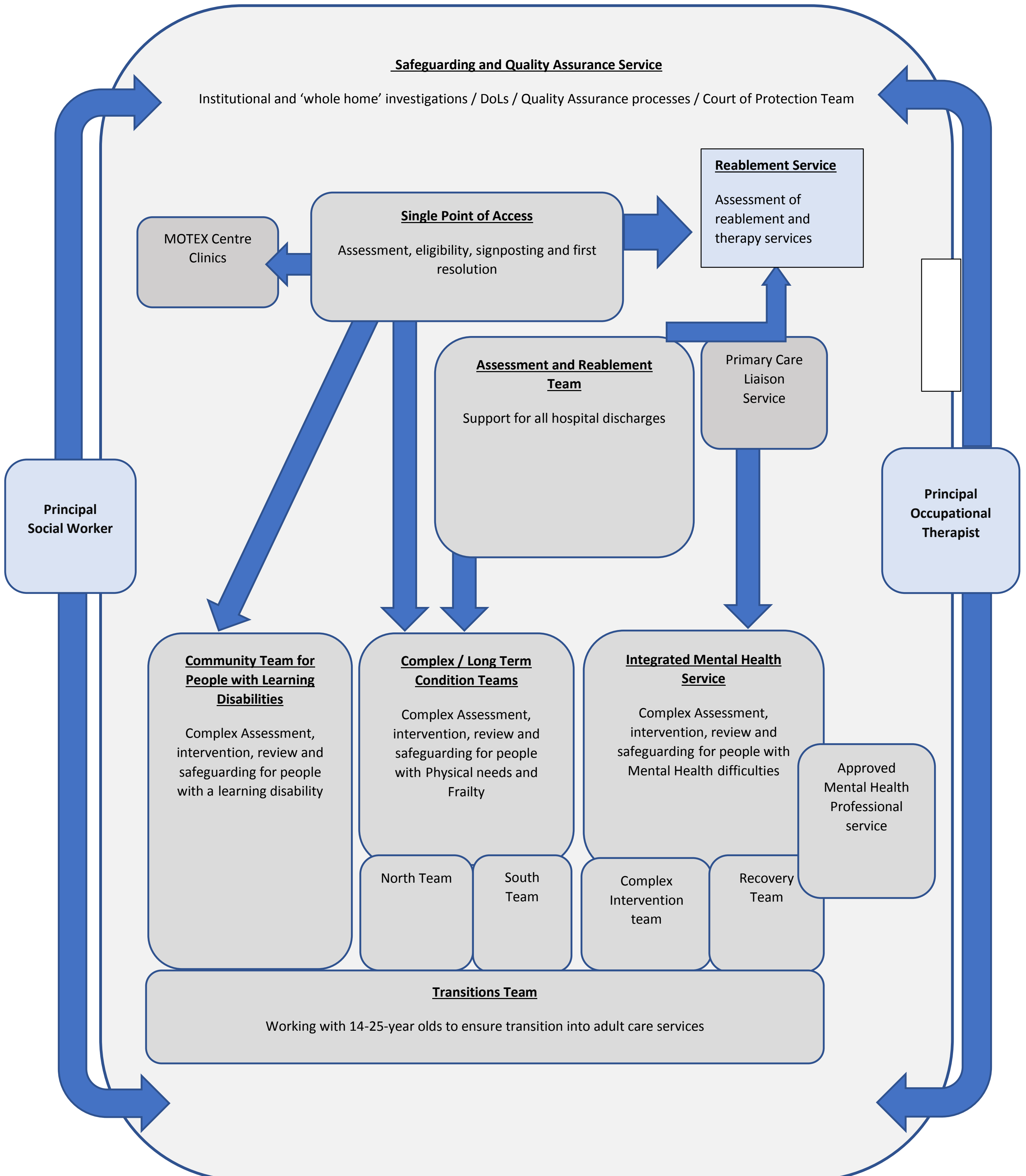
2.6.1. **Right Response** – continue to re-design our ‘front door’ and pathways, including the re-design of the Single Point of Access (SPA) and the community clinic model, reducing the number of unnecessary assessments, helping people to help themselves whenever possible;
2.6.2. **Assistive Technology** – making the most of new technologies to support people to be as independent as possible and ensuring that the systems, processes and services are there to support this;
2.6.3. **Accommodation Options** – scaling up extra-care housing, shared lives and other alternatives to residential and nursing homes;
2.6.4. **Better Reviews** – overhauling our approach to reviews so that whatever we provide, whether a personal budget or service, continues only for as long as needed and is effective in increasing independence;
2.6.5. **Empowering Communities** – empowering communities and volunteers to play a bigger role in supporting people, building on the existing Community Connect approach;
2.6.6. **Systems and Processes** – replacing our electronic case record system and using this opportunity to review, streamline and standardise our key business processes, achieving a step change in our use of information;
2.6.7. **Savings Delivery** – maximising delivery of existing savings, cost avoidance and income plans through robust monitoring and management.

2.7. This proposal is not seeking any programme of redundancy and there will be no overall reduction in staffing numbers. There may be implications for individual staff given that the proposed restructuring does involve changes to the size and remit of some teams and the nature of some roles; this may entail staff moving work location or changing job role. Any changes of this nature will be addressed through formal process as outlined below.

3. Diagram of the agreed structure

3.1. Figure one provides an overview of the newly agreed structure

Figure 1



4. Detail of Proposals and feedback received

This section outlines the specific detail of the proposed structure, feedback received and a management response

4.1. Single Point of Access

The aim continues for the Single Point of Access (SPA) to increase the resolution rate of referrals received. The service offer will continue to be developed to provide timely solutions, wherever possible, to a wider range of enquiries. It is hoped that effective early intervention at SPA may assist in managing the demand for statutory social care support and allow the locality teams to focus on the complex long-term conditions.

4.1.1 SPA will assist if issues can be resolved in a quick and 'simple' way i.e. where there is direct access to services and provision. The service will need to continue to work at pace to ensure effective resolution and turnover of cases.

4.1.2 SPA staff will triage referrals to either provide information, advice, signposting and resolve, conduct assessments via telephone or at clinics and address the identified eligible need or to refer on to a more appropriate service.

4.1.3 SPA will embed a 'strengths-based' approach to resolving presenting needs and explore options within the person's function and social sphere to address needs wherever possible.

4.1.4 SPA will also develop to enable review of work they have initiated, where appropriate, to prevent service users having to be seen by numerous professionals and any delay or omission in this process.

4.1.5 SPA statutory provision could include accessing emergency placements, Occupational Therapy input, advice and equipment provision, changes to existing packages, straightforward financial 'threshold' cases. The service will develop a social provision for increased social prescription i.e. preventative groups at the Motex centre.

4.1.6 Community Connect (Curo) will continue to have a regular presence in SPA to help signpost to non-statutory services and will increase links with localities to ensure local knowledge in teams is shared to improve the effectiveness of the signposting service provided.

4.1.7 SPA will continue to support development of the information resource for staff reference detailing community services and groups.

4.1.8 SPA Social Workers will also explore options for resolving an increased number of safeguarding referrals i.e. institutional issues: medication errors, resident-on-resident incidents.

4.1.9 SPA Occupational Therapists will continue to support the housing role assisting progression of DFGs from teams and clinics. It will also explore additional options for clinic and group support.

4.1.10 SPA will also be developing support of the following areas:
- Blue Badge assessments
- Self-funder pathway
- Learning Disability referral route
- Transitions referral route

4.1.11 SPA will require some additional resource from elsewhere in the service to fulfil the development requirements.

Feedback and Timescales

Overall staff support the concept of resolving more cases within SPA however there is concern about the capacity of SPA to do this given the current workforce. Some staff raised concern about having to move to SPA as it is seen as a desk based, triaging position with limited ability to utilise social work and occupational therapist skills. The Senior Management Team believe that the work of SPA is very skills based on relies on excellent assessment skills and the ability to undertake robust risk assessments. SPA is pivotal to managing demand and working in the team provides an excellent opportunity to work in a high performing, fast moving and developing team.

In the meantime, managers are meeting fortnightly to progress developments in SPA and we are still intending to source a facility in the North to undertake assessments in a 'clinic' like setting and linking preventative services to SPA. We are also still committed to increasing resolution rates thus reducing the work on duty teams, which was noted as an ongoing concern in the locality teams. Our ambition is to offer all clients, where appropriate, preventative services including occupational therapy and reablement before assessing for a long-term service, this follows our vision of maximising independence and wellbeing. Work on these developments are underway and will continue in 2019. In terms of capacity, we have already increased the hours of the senior OT to reflect the anticipated increase in preventative work. We are currently looking at vacancies across the board to determine if some of the staffing budget can be transferred to SPA and new recruits appointed.

4.2. Assessment and Reablement Team (ART)

4.2.1. The vision is to focus our efforts on enabling people to be as independent as possible and therefore priority will be given to new clients who may have the potential to be re-abled.

4.2.2. There are recruitment and retention difficulties in hospital discharge services; and as such a need to establish a sustainable model for how these services are operated.

4.2.3. The remit of ART will be changed to focus on cases which are either new to social care or those without a current care and support package. ART will provide assessment of needs and reablement of function, working closely with our domiciliary care and residential reablement providers to improve outcomes for people at home or returning home. Development of the links with the health Discharge to Assess and Home First approach will continue to ensure assessment and reablement are conducted in the most appropriate environment. ART will continue to facilitate complex joint health and social care discharges where immediate solutions are not available.

4.2.4. All individuals with an existing service will be addressed by the complex / long terms condition teams who will review care needs and make any necessary arrangements for discharge; as is currently the practice with the Community Team for People with Learning Disabilities and Mental Health services.

4.2.5. ART will continue to hold the monitoring and administrative function in respect of hospital discharge – coordinating the information flow to manage the contact with the acute trusts and the Delayed Transfers of Care (DToC) reporting.

4.2.6. Currently the locality teams manage any hospital discharges from specialist units (brain injury and spinal injury units) – it is proposed these discharges will be managed by ART going forward.

4.2.7. <u>To accommodate this change in remit there may be a need to transfer staffing resources to other areas of the service.</u>

Feedback and Timescales

This aspect of the proposal received more feedback than any other. Significant numbers of staff raised concern about the locality teams being able to prioritise hospital transfers along with safeguarding concerns for people living in the community. In addition, during in the consultation period, the CCG launched the Integrated Care Bureau (ICB) the ICB is an integrated discharge meeting where multi disciplinary professionals agree a pathway for people to be discharged from hospital. Already in the first 2 months we have seen a significant reduction in inappropriate referrals to ASC. With this in mind we need to review the hospital social work team capacity.

There was also feedback to suggest that the work of ART and the reablement team, whilst both invaluable was not always fully understood by some staff and should be looked at as separate functions. Some staff also suggested that the reablement service could be better placed if it was closer aligned to SPA and to our domiciliary care providers who are also commissioned to provide reablement. Feedback also suggested that the remit of the reablement service was not understood especially since we received the Ombudsman judgement in 2018. It was therefore suggested that we needed a clear remit and eligibility criteria for reablement.

The senior management team accept the feedback from staff and so ART **will continue to manage all hospital discharges** apart from those for people with a learning disability or mental health need. We also take on board the feedback about the reablement service and it not being clear who is eligible for reablement or what the expected outcomes for residents should be. The Senior Management team have therefore concluded that the hospital discharge pathways should be clearly defined and reablement needs to be refocused and potentially recognised as a team in its own right. Because we want to ensure that we develop a robust and sustainable plan for reablement going forward, we have concluded that this needs a dedicated project group and to do this piece of work. We have also concluded that to do this work pre-implementation or alongside the liquid logic project is not feasible. We therefore have agreed that a project group to include operational and commissioning staff and private sector providers will be established in the early summer to plan how reablement will work going forward.

Hayley Verrico and Sarah Shaw will lead on this area of development.

4.3. Community Team for People with Learning Disabilities (CTPLD)

4.3.1. The Community Team for People with Learning Disabilities (CTPLD) is currently a partnership arrangement alongside North Somerset Community Partnership.

4.3.2. It is proposed that this team will remain unchanged within the new structure and will continue within this partnership arrangement. A formal 'Memorandum of Understanding' has been developed to more clearly define the partnership arrangements

4.3.3. CTPLD will continue to manage hospital discharge for those individuals who are allocated to the team. (Delayed Transfers of Care)

Feedback and Timescales

There was no specific feedback on the CTPLD

4.4. Complex/Long Term Conditions Teams

4.4.1. There will be two Complex / Long Term Care Teams providing in North Somerset:

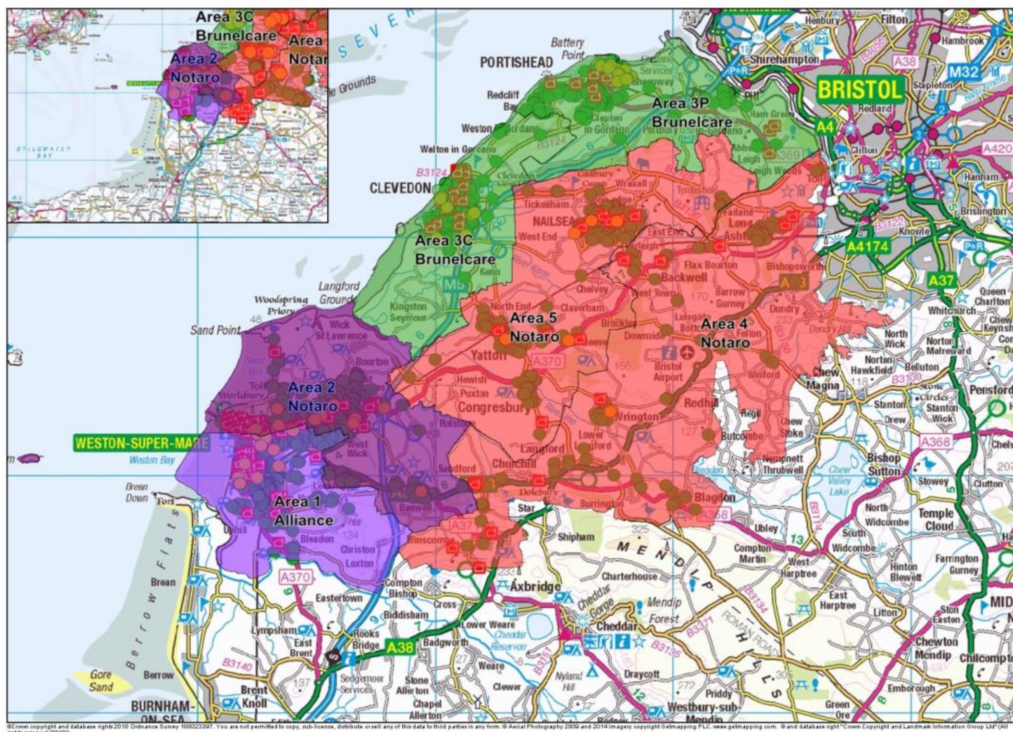
- Adult Social Care: North
- Adult Social Care: South

4.4.2. It is proposed that each team will support people living within a defined geographical area of North Somerset at the time of first contact with adult social care; recognising that where a team has placed someone within another area (North Somerset or elsewhere) that team will remain responsible unless ordinary residence changes.

4.4.3. The teams would support people in North Somerset with physical and sensory impairments as well as older people who have eligible care and support needs (under Care Act 2014).

4.4.4. The geographical split will mirror those currently defined by Adult Commissioning Colleagues.

Area 1 and 2 will form the South. Areas 3C & 3P, 4 and 5 will form the North – overleaf.



4.4.5. It is expected that the work of these teams will be complex social care for people with long term conditions.

4.4.6. It is proposed that there will be a higher resolution of contacts by the SPA team and therefore less demand on the 'duty' position within the team; it should become more of a daily contact for ongoing issues for cases and receiving new contacts / requests / safeguarding contacts.

4.4.7. The team would be expected to establish good working relationships with other NSC teams especially: brokerage, housing, finance, mental health and DoLS. They would be working closely with relevant health professionals and may joint work some cases where this is identified as being in the best interests of the individual.

4.4.8. It is proposed that working across the two teams there will be staff identified with a lead role for reviews. The Local Authority has a duty under the Care Act 2014 to ensure 'all people with a care and support

plan, or support plan have the opportunity to reflect on what is working, what is not working ………. ensure(s) that plans are kept up to date and relevant to the person's needs and aspirations …… mitigate(s) the risks of people entering a crisis situation.' (Care Act 2014; Chapter 13).

4.4.9. The main work of these teams is listed below; please note this is not an exhaustive list but aims to provide the broad scope for the teams:

- Care Assessments;
- Occupational Therapy Assessments;
- supporting work to reduce complex / high packages of care;
- support plans (social care and occupational therapy);
- liaising with brokerage and contracts to commission packages of care;
- leading safeguarding decision making, enquiries and relevant meetings for North Somerset service users (this includes people funding their own care but does not include people who are CHC funded or funded by another LA);
- planned reviews (emphasis on medium and short-term packages of care, recognise that well established packages of care / placements are unlikely to change);
- unplanned reviews;
- risk management;
- mental capacity as required for the work being undertaken by the team;
- financial threshold cases;
- long term care
- transitions cases when the package of care is stable
- review of hospital admissions to support discharge planning when the person is already in receipt of long term services; unless there is an identifiable health change impacting significantly on care needs (see the section on ART above for more detail).

<u>Complex/Long Term Conditions Teams may require some additional resource from elsewhere in the service to fulfil the development requirements.</u>

Feedback and Timescales

The move from 4 locality teams to 2 was not contested and this aspect of the restructure is now underway. Regarding the teams taking on responsibility for some hospital discharges, refer to feedback under section 4.2 (ART). Broadly speaking however, we accept that the locality teams should NOT manage their own discharges from hospital unless they are 'simple' discharges and from the feedback we have had, this is already happening. We also accept that Duty in the localities is under immense pressure and as per the feedback under the SPA section, we are continuing to develop SPA and improved resolution. We will, as part of the reablement work, look to see how reablement can be used to support those case not resolved in SPA to lessen the number of clients automatically being referred to the locality teams.

4.5. Integrated Mental Health Service

4.5.1. The Mental Health Service is currently a partnership / integrated service with Avon and Wiltshire Partnership Mental Health Trust (AWP).

4.5.2. The current structure of services and managerial arrangements align with the AWP model of services (currently the Recovery Team, Complex Intervention Team and other services).

4.5.3. It is proposed that this service will remain unchanged within the new structure and will continue within this arrangement, under a new 'Memorandum of Understanding' agreement.

4.5.4. Mental Health services will continue to manage hospital discharge from Mental Health facilities and for those individuals who are care coordinated. (Delayed Transfers of Care).

Feedback and Timescales

There was no specific feedback on the Integrated Mental Health Service

4.6. Transitions Team

4.6.1. It is proposed to establish a 'Transitions team':

Research indicates that the degree of complexity in transitions cases will continue to rise with the result that the local authority will need to support more individuals with more complex needs into adulthood.

Practice guidance indicates that early planning for adulthood from age 14 is essential to manage the demands and expectations of ongoing lifetime care into adulthood (National Institute Clinical Excellence guideline [NG43] Published date: February 2016)

4.6.2. The remit of this team will be to accept and assess all new referrals from the age of 16 across adult care and to manage all care packages for those from ages 18 to a point of stability when there is an established care package in place which meets the young adult's needs. At which point the case will transfer to the appropriate service. The team will undertake all transitions planning for young people with mental health, physical disabilities and learning disabilities.

4.6.3. Although the number of young adults receiving a care package will be low, many more young people will require an assessment, advice and information and signposting which the team will have a key role in carrying out prior to adulthood.

4.6.4. The team will sit under the structure of the Community Team for People with Learning Disabilities for the purposes of reporting and line management.

4.6.5. The team will undertake the safeguarding function for the cohort of young people they are working with. For other safeguarding cases these will be managed by the usual operational teams, with the Transitions team in a support role where required

4.6.6. Children's services would retain responsibly for all other aspects of care planning and assessment, including child protection, children looked after and child in need and SEN reviews other than transitions until the young person is 18.

4.6.7. The exact staffing of this team will be determined in the full workforce modelling exercise. The development of the proposed 'Transitions team' will entail some shift of staff resources from across the operational teams proportionate to the nature of the cases.

Feedback and Timescales

There was overwhelming support for the development of a Transitions team. In January 2019 work will begin to develop the modelling of the Transitions Team. The remit of the team will be to support all young people entering adult social care so long as they meet eligibility according to the Care Act. We also acknowledge that OT input into the team is vital and so there will be a link/champion made with the Children's OT service. Expressions of interest for the Transitions team will be advertised internally. This work will be led by Martin Hawketts.

4.7. Safeguarding and Quality Assurance

4.7.1. The functions of the Safeguarding Adults Team, Deprivation of Liberty and Court of Protection team will remain unchanged.

4.7.2. Quality assurance activity will develop to become integral across all services supported by the roles of Principal Occupational Therapist and Principal Social Worker.

4.7.3. The service will develop and embed a Quality Assurance Framework. The purpose and aim of the QAF is to:

- Improve outcomes for service users;
- Engender an organisational culture committed to learning and continual improvement;
- Set practice standards against which the quality of services and their impact can be measured;
- Ensure that services provided are of a consistently high standard and sustainable through regular evaluation;

- Support the continuous improvement and development of practice;
- Influence the development of policies and procedures to support staff in delivering good practice;
- Improve the level of feedback from service users, their families, carers, stakeholders and staff;
- Support the continuous development of the ASC workforce.

Feedback and Timescales

Most staff supported the further development of quality assurance. Quality assurance activity will develop throughout 2019 so that it becomes an integral across all services supported by the roles of Principal Occupational Therapist and Principal Social Worker. Jo Baker will lead on this area of work.

4.8. Continuing Health Care Specialist Roles

4.8.1. A revised National Framework for Continuing Health Care (CHC) was launched on 1 October 2018 – the new framework places a far greater emphasis on the involvement of social care in the multi-disciplinary decision-making process for CHC eligibility.

4.8.2. It is proposed that some dedicated staff members (of either Social Work or Occupational Therapy background) will be appointed to act as 'CHC Specialists' working across all adult care areas.

4.8.3. These staff will not be able to work with all CHC cases but will focus on complex cases, disputes and complex joint funding arrangements, as well as provide a point of advice and support for colleagues.

4.8.4. These roles are a 'test and learn' to ascertain the value of focused roles in addressing the CHC process and ensuring that CHC eligibility is applied correctly.

4.8.5. They will be offered initially on a 12-month secondment basis and will be available to all JM1 graded Social Workers or Occupational Therapists.

4.8.6. A Senior Practitioner in one of the Adult locality teams will hold a lead specialism for CHC work and be able to offer clinical supervision and support to the practitioners as well as provide an interface with operational services.

4.8.7. Due to the strategic nature of the work of these roles, there will be an oversight from the Service Leader with overall responsibility for CHC for the duration of the 12-month secondment.

Feedback and Timescales

There was overwhelming support for the development of the CHC roles. Significant numbers of staff requested that the roles are on rotation/secondment. The senior management team accept this proposal. We will begin a process of

expressions of interest for these posts in February 2019 and this work will be led by Kathryn Needham.

4.9. Approved Mental Health Professional (AMHP) service

4.9.1. In the Mental Health workforce structure of the Role of Integrated Team Manager (Approved Mental Health Professional Lead) was created as part of the new social care management structure:

4.9.1.1. This role sits outside of the managerial arrangements with the Avon and Wiltshire Partnership Trust, as the AMHP role must remain independent.

4.9.1.2. It is proposed to rename this role Approved Mental Health Professional Lead and for this role to report directly to the local authority Service Leader for Mental Health.

4.9.2. Policy development work will be undertaken to ensure there is clarity around the role and expectations of AMHPs. Specifically, all Social Work staff recruited into Mental Health services will have a clear expectation to progress on to AMHP training and practice as an AMHP. If a member of staff is either unable or unwilling to undertake the AMHP role there will be an option of redeployment to other areas of Adult Social Care.

Feedback and Timescales

No feedback was received on this aspect of the AMHP Lead proposal and so with immediate affect the AMHP Lead will report to Martin Hawketts.

Policy development work is underway to ensure that we have a clear policy clarifying the role and expectations of AMHPs.

5. Professional support and role of the Principal Social Worker and Principal Occupational Therapist

5.1. The roles of the Principal Social Worker (PSW) and Principal Occupational Therapist (POT) promote their respective professions, ensuring excellent professional practice by focussing on quality assurance, safeguarding, workforce planning, continuing professional development and cultural development. The roles act as a bridge between front-line practice and senior management, ensuring professional values and best practice permeate all levels of service delivery.

5.2. The PSW and POT will play an important role in the delivery of North Somerset Council's vision, working collaboratively with staff to influence professional culture and promote strength-based ways of working. They will

work collaboratively and co-productively with staff via professional forums, newsletters, training sessions, audits and observations of practice.

5.3. The PSW and POT are reviewing North Somerset Council's training offer to ensure staff have access to high quality continuing professional development opportunities, ensuring staff are competent to deliver NSC's vision for the residents of North Somerset.

5.4. It is recognised that investment in professional leadership is key to the implementation of the vision for adult social care. There is an existing remit within the senior management team for strategic oversight of Occupational Therapy. It is intended to seek to increase the PSW role to a full-time position to provide sufficient capacity to cover the remit.

Feedback and Timescales

There was overwhelming support of this proposal. Jo Baker and Hayley Verrico will begin work to determine when the Principal Social Worker can transfer full time to the PSW role but this will be dependent on backfilling management capacity in mental health services

6. Additional Information on Staff Roles

6.1. Adult Social Care Workers

6.1.1. In 2017 a new role of Adult Social Care Worker was created – this role was initially envisioned to cover two grades or 'levels' (a JG5 level 1 role and a JG6 level 2 role). The two levels of role potentially represented a career pathway; each dealing with work appropriate to the grade.

6.1.2. All previously existing roles were mapped to the JG6 grade (level 2), and there is no current use of the JG5 role – any new staff employed have come in on the JG6 grade by virtue of the needs of the service.

6.1.3. It is unclear how the JG5 grade (level 1) role could be successfully utilised operationally; as well as this grade of role having no clear comparator elsewhere across the council.

6.1.4. Any carer progression model between the two grades would be complex to administer and manage.

6.1.5. It is therefore proposed that there are no longer two levels to this role and the JG5 (level 1) will cease, with all Adult Social Care Workers operating on a single JG6 graded job family.

Feedback and Timescales

Some staff asked if senior management would consider restoring the JG7 grade for ASCW's. This request cannot be supported by the senior management team as it was part of a consultation and HR process in 2017.

Work will take place between now and March to formally move workers to the single JG6 grade and Hayley Verrico will lead on this piece of work.

6.2. Review of Job titles

6.2.1. We will review job titles across the service to ensure consistency, excluding the title of 'Adult Social Care Worker'.

Feedback and Timescales

There was no feedback on this aspect of the proposal. Hayley Verrico will begin work on reviewing job titles in February 2019.

6.3. Services and Teams not affected by this proposal

6.3.1. The following teams / services are not directly affected at this time by this proposal:

- Shared Lives
- Staff Canteen
- Community Meals
- Severn Day Centre
- Carlton Centre

7. Performance Management

7.1. We will establish a Performance Management Framework which will outline clear expectations around individual work, duties, caseloads, team and service performance.

7.2. This framework will be designed and refined after the introduction of the new Liquid Logic system when there will be more accurate data available to establish a set of parameters based on a realistic picture of the workload across the service.

7.3. The framework will support the delivery of the vision for adult social care and will sit alongside the professional supervisory structure.

7.4. The purpose of the framework will be:

- To ensure there is equity of workload among the staff group.
- To recognise and record good performance.

- Underperformance can be addressed by managers quickly, fairly and objectively.
- To have a clear understanding of the capacity of a teams and services.
- To protect staff from stress and overwork.

Feedback and Timescales

There was mixed feedback on this aspect of the proposal with many staff supporting the development of a performance framework. However, some staff thought that we should measure the quality of case work and not necessarily the number of cases that staff held and closed. Overall staff supported this proposal but want it recognised that some cases are very complex and so not all staff will have the same turn over or numbers of cases allocated to them. The framework will be developed in the summer of 2019 and we will consult with the Vison focus group on its development and implementation. This area of work will be led by Hayley Verrico and Martin Hawketts but will include consultation with the Principal Social Worker and Principal Occupational Therapist.

8. Implementation of the Proposal

8.1. There will be the opportunity for staff to express interest in any newly created posts and opportunities to relocate to an alternate team.

8.2. Staff contracts state that place of work is defined as 'North Somerset' – it does not form part of the conditions of service to be based in a certain location or office. However, in the first instance we will look at current vacancies to see if the staffing budget can be realigned thus reducing the need for people to move teams.

8.3. Should we need to ask staff to move teams this will be a addressed through a fair and transparent process. Affected staff will be informed of any possibility of relocation, and initial expressions of interest /voluntary moves will be sought. If this does not prove successful a selection exercise will be undertaken by the service leaders which will consider personal circumstances and the needs of the service.

8.4. As previously stated there is no reduction in overall staffing numbers or redundancy being sought as part of the structural change.

8.5 Training

Alongside the proposals and in conjunction with the Principal Social Worker and Principal Occupational Therapist, we are developing a strengths-based assessment programme for all staff. This is to ensure that staff are fully equipped and feel confident to deliver our vision for adult social care.

Feedback and Timescales

Staff welcomed the training needs analysis been undertaken by the Principal Social Worker and Principal Occupational Therapist. The senior management team have recognised that training in adult social care has not always addressed the specific needs of staff and this is especially so in regard to strength-based assessment skills. To address this, we are procuring a training package for all staff both qualified and unquailed. The training package will consist of the following modules:

- Strengths based assessment (
- Defensible decision taking
- Coaching for front line managers
- Goal setting for reablement
- Managing cultural change
- Strength based assessment and defensible decision taking overview for internal and external staff

The tendering process will begin in May 2019 and a contract awarded late May 2019. We intend to use the Vision Focus Group as pilot participants of the training to ensure that the training will meet the needs of staff and can be amended if feedback suggests this is necessary. The full training package will run from September 2019-March 2020 and it will be mandatory requirement for all staff to attend.

8.6 Implementation of the new structure

As said previously in this document, we need to be mindful that we are soon to launch the new adult social care information system, Liquid Logic (LL) this is planned for the end of March/beginning of April, the 2 weeks prior to this are business contingency for system downtime, it is therefore 10 weeks between 7th January and 18th March to get everything ready for the launch of LL. In that 10 weeks we will deliver an eLearning package in January and a face to face training package in February and March (several hundred hours of staffing time). Much of the senior management time will need to be diverted to the project.

We have spoken to several other local authorities and the impact of the system launch is significant and it will affect everything we do, every recording, every interaction with a member of the public. The advice is, not to underestimate the scale of change.

We have therefore broken down the workforce restructure into 3 areas:

- What workforce changes can take place pre-implementation of LL
- What background activity can continue throughout the period broadly unaffected by LL
- What changes will realistically have to take place post LL implementation

In summary

We will proceed with the change from 4 locality teams to 2 teams in January 2019.

In January we will begin to complete the modelling for the Transitions team and the specialist CHC posts and proceed with the expressions of interest out for these posts.

The grading for ASCW roles (removing the JG5 level) can be done immediately, and my minor changes around the AMHP lead and Principal Social Worker role.

Having taken account of the feedback in respect of the ART (hospital social work team) and Reablement our view is that changes to these teams will be better achieved post-LL implementation. This is on the basis that significant change management will be required in addition to discussions with domiciliary care providers, commissioning colleagues and operational staff. A project group to complete this piece of work will be established in the early summer.

The shift of activity to SPA is already being considered and work is in progress and ongoing. In the meantime, we are looking at staffing budgets to see if they can be re-aligned and additional capacity given to SPA however some shift in staffing may be on a transitional basis as to limit the likelihood of staff being asked to move teams.