Department of Health

Named Social Worker

Baseline Report

Introduction

Contents

The Department of Health has initiated this programme in order to build an understanding of how having a named social worker can contribute to individuals with learning disabilities, autism or mental health needs achieving better outcomes; specifically that they and their family are in control of decisions about their own future, and are supported to live with the dignity and independence which we all strive for.

This programme is specifically about trying something different, piloting new ideas and generating early and indicative evidence as to their impact.

Introduction

In the *No Voice Unheard, No Right Ignored*[1] consultation, the government laid out a vision that all disabled people, including those with learning disability, autism or mental health needs, have a right to lead their life like anyone else, with the same opportunities and responsibilities and to be treated with the same dignity and respect.

The uncovering of systemic abuse through the Winterbourne View scandal highlighted that this was far from individual's current experience. *No Voice Unheard, No Right Ignored* also identified that lengths of stay in hospital were often "unacceptably long, and inconsistent with the descriptions of assessment and treatment", and demonstrated the extent to which individuals, their families and carers feel that they lack control and choice in their lives.

One of the recommendations was to have a named social worker for individuals, families and their carers. This named social worker would be a dedicated caseworker with ongoing responsibility for an individual's support, meaning that they would be both the primary point of contact, and be able to use their professional voice to challenge across the system and advocate on the individual's behalf, linking with a range of services, professionals and organisations. This role should be underpinned by social work values, but it pushes the boundaries of what is usually delivered by social workers, in particular the relationship between the social worker and the wider health, care and support system.

In order to test this model of social work, in October 2016, the Department of Health launched a pilot programme for the Named Social Worker (NSW). Over a six month period, six authorities across England will design, implement and refine the role of a named social worker and evaluate the impact that this has had on the lives of individuals with learning disabilities, mental health conditions and autism. The sites that were selected to take part are: Calderdale Council, Camden Council, Hertfordshire County Council, Liverpool City Council, Nottingham City Council and Sheffield City Council.

The Department of Health has set out the core elements of the role and the outcomes it aims to achieve and the six sites will develop this role to fit their local circumstances, cultures and needs. The intention is to test and learn from a number of different approaches to inform the wider system. The Department has provided sites with some financial support to create the space to develop this model, and appointed a delivery partner to provide strategic and technical support to sites.

The delivery partner is Innovation Unit, working in partnership with the Social Care Institute for Excellence. Innovation Unit creates new solutions for thriving communities: solutions which build, support and recognise human potential and the critical importance of thriving relationships. The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works.

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[1]Department of Health, (2015). *No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions*.

Introduction

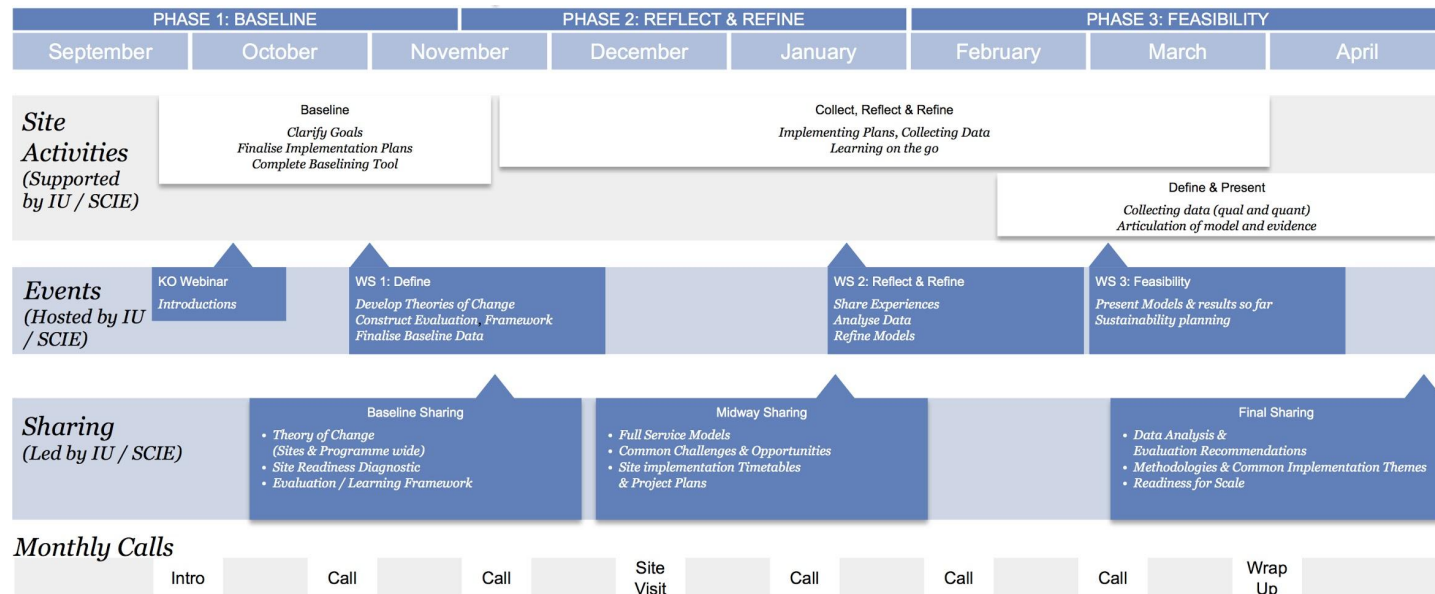The purpose of the NSW programme is to:

- Design, implement and refine the role of a named social worker across six sites,
- Evaluate the impact that the NSW has had in each site on the lives of individuals with learning disabilities, mental health conditions and autism,
- Analyse learning from across the six sites about the implementation and impact of the models,
- Share insights and tools with the wider sector.

The programme is split into three phases:

- **Baseline** - articulating the model and planning for implementation.
- **Reflect & Refine** - gathering data and reflecting on learning.
- **Feasibility** - presenting models, analysing data and planning for sustainability.

In each of these phases there will be: ongoing coaching support for sites from Innovation Unit and SCIE, a whole-programme workshop and a report that shares activities, insights and learning.

This Baselining Report brings together the core hypothesis that each of the sites is testing, an analysis of emerging themes, an outline of the programme's approach to evaluation and mini case studies illustrating different elements of implementation.

	PHASE 1: BASELINE			PHASE 2: REFLECT & REFINE		PHASE 3: FEASIBILITY		
	September	October	November	December	January	February	March	April
***Site Activities** (Supported by IU / SCIE)*		Baseline — *Clarify Goals, Finalise Implementation Plans, Complete Baselining Tool*		Collect, Reflect & Refine — *Implementing Plans, Collecting Data, Learning on the go*			Define & Present — *Collecting data (qual and quant), Articulation of model and evidence*	
***Events** (Hosted by IU / SCIE)*	KO Webinar *Introductions*	WS 1: Define *Develop Theories of Change, Construct Evaluation Framework, Finalise Baseline Data*			WS 2: Reflect & Refine *Share Experiences, Analyse Data, Refine Models*		WS 3: Feasibility *Present Models & results so far, Sustainability planning*	
***Sharing** (Led by IU / SCIE)*		Baseline Sharing • *Theory of Change (Sites & Programme wide)* • *Site Readiness Diagnostic* • *Evaluation / Learning Framework*		Midway Sharing • *Full Service Models* • *Common Challenges & Opportunities* • *Site implementation Timetables & Project Plans*			Final Sharing • *Data Analysis & Evaluation Recommendations* • *Methodologies & Common Implementation Themes* • *Readiness for Scale*	
Monthly Calls	Intro	Call	Call	Site Visit	Call	Call	Call	Wrap Up

Theory of Change: Six Hypotheses

The Case for a Named Social Worker

The Department of Health has initiated this programme in order to build an understanding of how having a named social worker can contribute to individuals with learning disabilities, autism or mental health needs achieving better outcomes; specifically that they and their family are in control of decisions about their own future, and are supported to live with the dignity and independence which we all strive for.

This programme is specifically about trying something different, piloting new ideas and generating early and indicative evidence as to their impact. The starting point for this programme is therefore light on evidence about the impact that a named social worker can have. It is the role of the programme, and specifically the sites, to gather and build this evidence along the way. But we are not starting with nothing; there is a compelling case for the named social worker, which has led the Department to invest in this programme. The first job of sites has been to articulate this logic for themselves, in their own context; what is their Theory of Change?

As a starting point for this work, sites must be able to rigorously test the logic and understand the assumptions they hold as to why they believe their intervention, or model, will deliver the outcomes they suggest. This section shares the core hypothesis that sit at the heart of each of site's theories.

Theory of Change Hypothesis: Calderdale Council

Calderdale Council
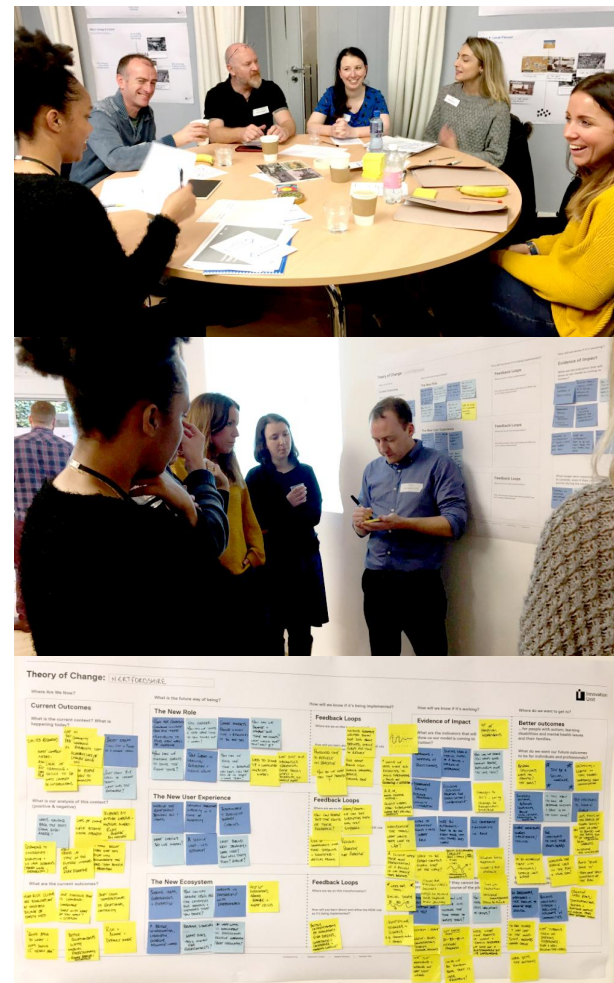
Putting Human Rights at the heart of everything that social workers do to support people to thrive.

Current Outcomes

Individuals labeled with having a 'Learning Disability', who engage with services are often pulled into a web of multiple services ('The System') who then play a dominant role in their lives. Decisions are made about their lives, their privacy is invaded, and expectations for that individual's future sink.

Once within 'The System', individuals are disempowered, they are commonly told what is best for them, and in time become used to and dependent on that. They often become geographically dislocated from their families and communities.

As an agency that fits into the web of services, attends decision making discussions about the individual and passes information about them between services, Social Work is made complicit in that system.

Model

A Named Social Worker is a Social Worker who operates with human rights values at the heart of everything they do.

NSW's will:
- Be experts in human rights and put this at the heart of their relationship with an individual.
- Transition to an arrangement where the individual controls the relationship; for example they decide when to draw on their Social Worker, and when not to.
- Work to prevent individuals being overwhelmed by the system and losing their voice within it.
- Take an external perspective on the system, reflecting on and influencing it by applying human rights values.
- Put the individual at the heart of the system and as the decision maker, and make the system accountable to them.

Social workers are the servants of those we work with, not the masters.

Future Outcomes

Individuals are given the support, respect and privacy to live their lives in the same way that anyone else would expect to be. Supported to communicate their own preferences, to feel empowered and safe, to be resilient and as independent as possible.

They are active citizens as far as possible, with passports and driving licences, jobs and registered to vote. They are supported to make their own decisions about things such as where they live and to pursue their hopes and dreams as anyone would; seeking value, love and status.

Current no. of NSWs: 2   *Current size of cohort:* 40

Next Steps: Holding a workshop with self-advocates for them to challenge us on what role a Named Social Worker should play.

Theory of Change Hypothesis: Camden Council

Camden

Adding additional challenge, accountability and Quality Assurance to ensure the voices of individuals and their families are listened to across the system.

Current Outcomes

The system is characterised by complexity: individuals, their families and professionals have difficulty navigating it or understanding how to initiate change. The voices of individuals and families aren't always heard.

The system is risk averse: decisions are often made to keep individuals in hospital or medicate before considering less restrictive approaches.

Individuals can be kept in hospital for longer than they need to be or are readmitted due to the lack of alternatives. This can be for a number of reasons, including:
- Placement breakdown (which may sometimes be avoidable).
- Transition or crisis plans that aren't always adhered to.
- Lack of robust crisis and preventative resources.
- Providers are not able to manage complex behavioural needs.
- Risk aversion which often means opting for the most restrictive treatment option.

It can be difficult for services to maintain regular contact with some of the individuals on the risk register eg. those who are poor at engaging with services or in distant out-of-borough placements.

Model

Modelled on the Independent Reviewing Officer role, the NSW will be a specialist, independent, additional role who will:

- Ensure the individual and family voice is heard at all stages.
- Hold the system to account to ensure that appropriate, ambitious plans are in place, that SMART goals are set and that these goals are owned, monitored and achieved.
- Have a Quality Assurance role to ensure that goals are suitably ambitious, that less restrictive options are fully considered and that that advocates and appropriate. communication methods are in place
- Bring expertise and challenge to overcome blockages in the system and be a source of support to the professional team.
- Work to achieve informal resolution to any disputes, but initiate a formal dispute resolution process at senior level or through seeking legal advice if required.

The NSW will report to the Council's Principal Social Worker in order to maintain independence from health and care decision makers. The NSW will either chair all Care and Treatment Reviews or be an additional member of the expert panel.

Future Outcomes

Individuals on the TCP risk register will:

- Have more independence, choice and control over their lives.
- Be more integrated in society, less likely to be admitted into hospital and have less contact with the criminal justice system.
- Be offered the least restrictive care and treatment, meaning that medication may not be the only option.

Individuals, families and carers feel supported with a clear plan of action.

Current no. of NSWs: 2

Current size of cohort: 25+

Next Steps: Establishing an **evaluation framework**, identifying an appropriate health outcomes model to use. Coproduce **workflow and process maps.** Explain the pilot to individuals, their families and carers with both a letter and leaflet. Continue convening the pilot **Steering Group**.

Theory of Change Hypothesis: Hertfordshire County Council

Training and building the skills of a team of 8 to diffuse knowledge and empower all 40 staff to confidently collaborate with other services, focus on prevention and sustain great practice.

Current Outcomes	Model	Future Outcomes
Those with the most complex needs already have an allocated SW for consistency. But the NSW pilot is an opportunity, in an environment of economic cuts, to return to and build on good practices and common sense from the ground up: • A lack of early help means that problems escalate, and most resource is focused on crises. • Decisions are made *by services*, rather than *with individuals* who are listened to. • Support from services, particularly medical, can be risk-averse, short-termist and transactional. • There are gaps in services (including between services) for supporting the transition of individuals with complex needs into their communities, meaning services are reluctant to work with these individuals.	Two teams (East and West) operate in the borough, using a shared prevention-focused model that: • Situates the NSW as a lynchpin, a connector and partner with other professionals with and for the individual. • Uses a shared collaborative plan (not duplicated in each profession), to humanise processes, communicate and create consensus between services. • Has room to be creative in finding individual-centred solutions and Asset-Based Community Development. • Is more open; to challenge, to ideas, to input from professionals, individuals, carers and families. • Includes a broader range of feedback opportunities (including multimedia diaries) that individuals can see are taken into consideration and have an impact on decisions and experiences. • Continually builds the case (data and analysis) to show the value of a flexible approach and preventative focus.	• Lives are more stable, with fewer crises, hospital admissions, police involvement and emergencies. • Individual's voices are heard and they are enabled to be more independent. • Outcomes that are meaningful to the individual, and help them thrive through being better connected within their community. • NSWs are skilled and empowered to make a positive change in someone's life, opening up a more positive future. • Overcome the perception that a dichotomy exists between "health 'vs' social care". • NSW staff satisfaction and higher retention rates. Continually confronting perennial issues such as risk-averse culture and roles, and falling back into short-termist and risk-averse default modes that satisfy current processes but don't listen enough to those we serve.

Current no. of NSWs: 8 with aim to skill up all 40 SWs	*Current size of cohort:* 1 per NSW with aim to get to 2-3 per NSW	*Next Steps:* **Training:** Conflict management, ABCD, positive risk management, and particularly legal. **Ethics sign-off and individual consensus** with pilot via easy-read format of NSW Green Paper **Build on ASCOF and contact Calderdale** to tailor a new survey and pilot indicators.

Theory of Change Hypothesis: Liverpool City Council

Providing social workers with the capacity to explore new ways of working, challenging existing practices and processes and to develop 'what good looks like'.

Current Outcomes

Individuals with a Learning Disability (LD) are supported by social workers who:

- Lack specialist knowledge about LD.
- Use generic models of care as part of the transforming care agenda which are not tailored to the individual.
- Have a limited choice of appropriate services to refer individuals to.

They work within a system of services which:

- Have poor joint working between them; for example there is a lack of shared responsibility, coordinated response to assessment, or integrated IT.
- Are navigating a variety of complex relationships with partners in and outside the city, hampering coordination and efficiency for working with individuals.

Model

The named social worker will forge a way through this by:

- Having a smaller caseload so they can explore new ways of working to enhance their understanding of the individual.
- Are able to challenge existing practices and processes in the wider teams, and assumptions in the system.
- Make use of statutory assessments not just as a moment for monitoring to inform care management, but as an opportunity to learn about the individual and their progress.
- Time and space to coach/mentor existing staff – to permeate 'what good looks like'.

The Named Social Worker will become a beacon and advocate for what good social work looks like amongst social work colleagues through a specific work stream to share best practice.

Future Outcomes

Individuals with a LD will have their care needs met by being supported by social workers who:

- Work in a person centred manner to meet need.
- Focus on promoting individuals independence and wellbeing.
- Promote a sustainable 'best practice' of working with adults with a LD.

They will work within a system of services that:
- Will be influenced by the voice of the social worker.
- Tailor packages of support and pathways in line with holistic need.
- Focus on successful transitions from inpatient to community settings.

Current no. of NSWs: *3*   **Current size of cohort:** 19 individuals on the in-patient tracker, and individuals from the risk register

Next Steps: Development of new pathways/processes with the aim of a lasting post NSW legacy, which depicts 'what good looks like'.

Theory of Change Hypothesis: Nottingham City Council

Nottingham City Council

Understanding barriers, then building up the ability of the system to better support an individual's needs before crisis hits.

Current Outcomes

The 'At Risk' register is not being used for its true purpose; to identify individuals who could benefit from additional support. It has become an administrative stepping stone, used as a quick mechanism to admit individuals into hospital. There is evidence to suggest that it is not supporting the prevention of admissions.

When individuals leave hospital, the quality and range of provision is limited. Factors such as not being able to return to previous accommodation and support, new staff teams, and new multi-disciplinary teams often increase the potential for readmission. Social work input in these cases currently varies. The lack of highly intensive, short term, unplanned respite available may also be a significant factor.

There is a 'vicious cycle' where the individual is discharged, goes back to the provider, and then social workers are only brought back into the picture at a point of crisis.

Model

The named social worker will address a number of these challenges in the current system. They will:

- Analyse data from across services and within specific cases to understand whether admission was necessary and where more preventative support is needed.
- Link to the newly created Housing Broker in order to identify gaps in provision and stimulate the market.
- Ensure individuals are placed on the 'At Risk' register earlier in the process so that they can be supported before crisis hits.
- Strengthen the relationship with providers and champion good practice.
- Be assigned a caseload where individuals are not already assigned social workers.
- Develop a 'Progression Model', encouraging providers to develop care plans which enable individuals to become more independent.
- Share good practice with other social workers working with individuals who are part of the Transforming Care cohort.

Future Outcomes

Individuals with learning disabilities, mental health needs or autism will not spend more time in hospital than necessary. They, along with their families or carers, will be more involved in decisions and they will have more stable placements.

The council will have a better understanding of gaps in the market in relation to the range and quality of residential support available. Better relationships with providers will also improve the value for money of the provision available.

Provider staff, including their leadership teams, within residential services will be well trained to support individuals in their care and understand their specific needs. In particular, ensuring that individuals are on the risk register at an earlier stage.

Current no. of NSWs: 2   *Current size of cohort:* 17

Next Steps: Now that backfill has been arranged, holding a 'kick-off meeting with the NSWs'.
Developing an **evaluation plan** and capturing baseline data.
Engaging stakeholders, including providers, in conversations about the new NSW role.

Theory of Change Hypothesis: Sheffield City Council

Shifting from formal support towards to a more continuous, communicative and trusting relationship with a NSW to develop individual independence and reduce crises.

Current Outcomes	Model	Future Outcomes
The economic climate has caused a state of continuous change. The current model allocates SWs to a specific function or stage in the process within the service, which means more handovers and a poorer experience for individuals and SWs.	A more strengths based, preventative model where workers get more opportunity to do "proper" social work.	

Current Outcomes

- Individuals are spending too long in hospitals and out of town facilities, away from their communities.
- Individuals often don't know who to contact when issues arise, meaning initial contact is often during crisis.
- Processes are frustrating and intrusive for individuals, with each stage of interaction likely to be with a different person.
- Individuals are unsafe, recent ASCOF scores are extremely poor.
- Carers are frustrated that focusing SW roles around tasks reduces skills and the chance to build relationships.
- Interactions are short, specific (narrow) and focused on completing tasks and assessments, rather than building independence.

Model

- Proactive and promoting individual wellbeing
- Person-centred and a focus on flexibility and doing the right thing, not filling out the right form and being system or bureaucracy-led.
- NSWs have knowledge of the Care Act and the social model of disability.
- NSWs assist in service navigation and confidently communicate with professional and individuals' networks.
- NSWs are analytical, reflective, challenge the system and enable and support change.
- SWs will be empowered to make judgements on their caseloads, communicating with the head of service and team managers if they are too busy, quiet or foresee fluctuations.

Future Outcomes

- Fewer lives in crisis, fewer hospital admissions, fewer premature deaths.
- Moving individuals back into the city and community from out-of-town facilities and ADUs and multi-service support to make successful transition.
- individuals are safer, and safeguarding processes do not obstruct progress.
- If possible, for the level of independence of the individual to reach a point where the NSW is no longer needed.
- Individuals, carers and staff are heard and empowered, and feel it.

- Staff skills, profile and esteem are raised, building confidence in practice in a system that empowers social workers.
- Commissioning better services.
- Managers are free to supervise and facilitate reflective practice.

Current no. of NSWs:
3, introducing others and intention of 60% of staff

Current size of cohort:
10-15 per NSW

Next Steps: Continuing conversation with CCG heads, LA commissioners, Health Trust and **expanding 'ecosystem'**
Developing **evaluation plan** to capture data during interactions and measure incrementally
involving staff who may become NSWs, look into **expanding cohort** to those not on risk register but high need

Observations from the programme so far

Each of the six sites has come to the programme with their own perspectives, ambitions and model. As the models are developed and refined we are noticing points of similarity and difference, core questions which the sites are grappling with and provocations raised which may resonate further afield.

The NSW can be interpreted in different ways: as a distinct role with components that relate not only to the social worker's relationship with an individual but also other expected tasks and ways of operating; it can also be understood as a description of a relationship between an individual and a social worker - their named professional who is their primary point of contact who advocates for them.

How can the time and space afforded by the NSW pilot and role be used in a way that is both impactful and sustainable?

Developing the NSW model has given sites the space to reflect on the gaps in their current practice and the different approaches they might take to drive change and achieve better outcomes. These fall into three categories:

- UNBLOCK - To understand barriers to social work and influence the system (eg through challenge, expertise, modelling and professional support).
- 'DO THE RIGHT THING' - To build on front-line experiences and use common sense to 'do the right thing' and sustain successful practice through lower case loads.
- DEVELOP- To test and develop something new afforded by the role, and find opportunities to build a different kind of relationship between individuals and their social worker.

By being clear about the details that sit behind these approaches, sites will be able to test their assumptions and gather insights that can feed more widely into their practice after the pilot.

How can the NSW simplify the experience of 'the system' for the individual and the carers, families and professionals supporting them?

The health and care system is complicated at the best of times, but for individuals who are in the Transforming Care cohort who can be involved with 10 or 20 different professionals at any one time, it can feel opaque. The NSW role aims to bring together different strands of the individual's care and support in order to ensure they have their voices heard. Where the NSW pilot might involve introducing a new person into this complex picture, it is even more important to ensure a smooth transition.

> ### *Mini Case Study:*
> **Multi-Service Collaborative Tools in Sheffield**
>
> Sheffield's priority is to quickly shift away from a model which breaks down an individual's journey into stages and functions, each of which may be allocated to a different social worker specialising in that function. They want to move towards a more consistent, coherent experience with the NSW at its heart. Beyond this, they are seeking to further simplify the experience for individuals by ensuring the NSW builds relationships with the other service partners working with an individual. To understand their success at doing so, the team are developing inclusive, collaborative tools such as interviews and surveys of other professionals involved, and seeking feedback from individuals. This will be designed to be as accessible as possible (for example through phone conversations, written feedback or diaries).

Observations from the programme so far

What is the balance between the NSW enabling and supporting an individual and not creating a dependency?

One of the key tasks of a NSW is to work in a more preventative and empowering way. For most sites this means building a stronger, longer term relationship with a individual in order to prevent risks escalating and to support them to meet their needs or work towards their aspirations, whilst ensuring the individual has a meaningful life and is not dependent on the social worker. This suggests that the NSW may have more involvement in the day to day life of the individual. There is also a question of how best the social worker can strike a balance between enabling and supporting the individual without creating dependency. Some sites also raised concerns about whether this might become an unnecessary intrusion into an individual's private life, leading to questions about where the appropriate boundaries should be drawn.

How will named social workers change outcomes for people without changing the fundamental structures of the system?

Social workers hold many responsibilities: their statutory duties, organisational processes and systems, and their standards of practice (including a duty to support the desired outcomes of individuals). In theory these should all be aligned, however, this is not always the case, particularly in relation to an organisation's processes and systems.

The result is that social workers have large amounts of paperwork, and are already managing high case loads which means they have less time to spend with each of the individuals they are working with. The named social worker will operate within this same system and whilst the pilot affords them the space to test new approaches, rewiring or challenging these responsibilities is a much bigger feat.

Mini Case Study:
Upskilling to Empower Staff in Hertfordshire

Hertfordshire's team are focusing on training to improve the ways in which staff interact with other services and professionals, and help sustain proven good practice by measuring the longer-term impact of preventative, better co-ordinated, multi-disciplinary and flexible social work. Hertfordshire are looking to their own organisation first for training resources, and have found professionals and programmes on asset-based community development, conflict management and positive risk management. They will look externally to bolster skills on legal frameworks, the mental health act, human rights, and about rights-based solutions, citizenship, the criminal justice system, and how to challenge the medical model.

Observations from the programme so far

What influence will named social workers have on the system they are operating within? Is 'permission' enough to achieve this?

The 'received wisdom' is that social care professionals do not always have their voices heard within a health setting and a shared intention across all of the sites is for the NSW to begin to overcome this. The mechanisms for achieving this intention are less clear and uniform. Some of the approaches are for the NSWs to:

- Be given a mandate to represent the individual's voice when decisions are being made
- Offer training, advice or support to other professionals who may not be familiar with either a specific individual or client group
- Bring an additional layer of accountability to ensure protocols and plans are adhered to

Ultimately, without structural or statutory powers, the impact of these approaches will be driven by the confidence, character and persistence of the individual named social workers. It's therefore also important to reflect on the kind of support that the NSW might need to increase their ability and capacity for decision making and using professional judgement. This might include training, upskilling or targeted supervision and reflective practice.

Mini Case Study:
Building the capabilities of 'the system' to better identify and manage risk in Nottingham

Nottingham's team believe that one of the reasons that individuals are ending up at crisis point before professionals are brought in, is that local services do not have a strong enough understanding of the individuals in their care or the client group as a whole. As such, one of the elements of the Named Social Worker role will be to offer support to local services (in particular providers) in order to build their capabilities through, for example, training and more informal support. They may do this by assigning each NSW to a provider. They hope that this will create clearer communication channels so that individuals who are in difficulty are identified at a much earlier stage and, therefore, offered the support they need as soon as possible.

Are social workers contributing to, or exterior to, the problems in the system they are trying to shift? In what ways can NSW teams themselves shift the way they respond to risk?

In considering and testing the contribution that a named social worker can make to shaping a new type of experience for individuals of their care and support system, sites are considering how and where to influence that system, but also confronting the role that they may play in perpetuating existing dynamics and ways of working.

- *How does a social worker need to shift their approach to risk?*
- *How does a social worker engage with the processes required by different disciplines?*
- *Is it enough for social workers to model different ways of relating to individuals, encouraging and valuing their ambition for themselves, to influence the way that other professions work with individuals?*

Evaluation & Learning

The inception and testing of new ideas requires a certain type of evaluative and learning mindset. In implementing the model, sites need to evaluate the core hypothesis that sits at the heart of their approach and understand whether the assumptions behind their logic model hold true (e.g. *will basing our social work on values deliver the outcomes we want for individuals?*). They also need to be attuned to the finer details of whether the steps they are taking are amounting to the change in practice that is intended; in other words, to learn from the experience about implementing the model (e.g. *is stating our values enough to enable the team to live by and implement them?*)

As they design their approach to evaluation and learning they are asking themselves questions like:

What impact is the NSW having on the lives of individuals and carers?

How can we gather individuals' and carers' views on our practice and its impact on their lives through existing settings, meetings, or interventions?

How can we use reflective practice for NSW to monitor and evaluate the impact and outcomes of our practice?

How can we use mentoring and coaching in supervision to continuously improve practice on the basis of its continuous evaluation?

How can we understand the impact that Named Social Workers are having in the wider health and care system?

Understanding our impact

There are, of course challenges, in building an understanding of causality when intervening in a complex environment over a short time frame.

The things that sites want to measure in this space broadly fall into two categories: the outcomes achieved for the individual (autonomy and independence) and the experience they have in getting there (nature and quality of the relationship with services). These are not entirely separate categories, for example, that an individual will be in control of decision making about their future, as much as possible, is both an outcome goal and an experiential one.

Whilst the hypotheses articulate the new world which sites are looking to create, these are changes that take a significant period of time to be realised. Whilst they all strive for significant progress, over the course of the pilot, they are looking for a positive trajectory against a series of shorter term indicators which relate to those outcome goals.

Evaluation & Learning

Mini Case Study:

Example Indicators from Sheffield

Sheffield are currently defining their long-term and short-term indicators to ensure a balance of resources between implementing NSW and measuring impact. Some examples of their short and long term indicators include:

Some Example Short-Term Indicators
Intended to demonstrate initial results to refine or support the continuing implementation of the NSW:

- Positive feedback from families
- Fewer hand-offs, fewer people managing one individual
- Higher numbers of observations showing we contacted the individual rather than them contacting us.
- Feedback from other professionals and clinicians working with the same individuals.
- Feedback from the CCG relating to the impact of the named social workers on speedy and successful hospital discharge.

Some Example Long-Term Indicators
Which are to be established during the pilot, but will take longer to measure:
- People who have a NSW moving back to their communities
- Reduced reliance on formal support for those people with a NSW, more links to their community.
- More people who receive long term care and support getting employed
- Improved ASCOF scores

Learning about the model

The second area which sites are learning about is the implementation of the models themselves. For example, having asked their named social workers to be advocates for their clients, it is necessary to understand (from clients and their families, professionals and colleagues) whether this is genuinely happening, and what information, relationships, skills or authority might they need to do this. If barriers prevent the social worker genuinely being able to play this role, then the assumed impact will not materialise, and the logic behind the model will not itself be being tested.

Learning about this throughout the implementation period is crucial; it is an iterative process that requires a reflective mindset. Adapting and evolving the way that they are implementing their model will give sites the best chance for success.

Mini Case Study:

Learning together in Liverpool

The Named Social Workers are encouraged and supported to reflect on and understand the impact of their role on individuals. In recognition that the Named Social Worker Model is uncovering core aspects of what makes a good and effective relationship between an individual and their social worker, Liverpool are building team wide learning days into the programme. These sessions will enable all social workers and team leaders to interrogate and understand the nature of that relationship and 'what good looks like', so that there is a lasting legacy of the Named Social Worker role with good practice being permeated into all community teams.

Evaluation & Learning

Gathering Evidence

Sources of insight will not just sit in routine data collection, because much of what the sites want to understand about outcomes and experiences will not necessarily be surfaced through these routines, for example the sense of control users feel or how easy carers find it to contact the NSW and navigate the health and care system.

Understanding the impact that sites are having requires them to look in multiple places; amongst service users and their families, with practitioners and within the broader 'system'.
In general, the sites are looking at mixed models of data collection to inform this, for example from analysis of diaries completed by individuals or professionals, to adopting and adapting existing metrics on individual outcomes or staff performance.

Mini Case Study:
Storytelling in Calderdale

Calderdale are using a graphic depiction technique to gather the stories of multiple individuals to uncover and understand their experiences. This includes young people at a point of transition within the system, those considered to have high levels of need, a number of people being supported at the point of a crisis and some individuals who are within the Assessment and Treatment system. By asking individuals to convey what matters to them, these stories will expose the human picture of the impact that the pilot has had. It will not be a summative view of the Named Social Worker model, instead through an individual's portrait of their own life we can understand how this relates to the named social worker model.

Mini Case Study:
Operationalising outcome frameworks in Camden

In Camden it is important that the framework used for measuring the impact of the service is both recognisable and credible across the health and care system. At the moment they are thinking about how to operationalise universal tools such as the Health Equality Framework (HEF) and the Health of the Nation Outcomes Scale for people with Learning Disabilities. Other sites are also considering the Adult Social Care Outcomes Framework. These frameworks cover a wide range of factors (such as Social, Genetic and Biological, Communications, Behaviour, Lifestyle and Service Quality for the HEF), enabling sites to track movement in an individual's outcomes across a wide range of components.

Next Steps / More Information

This document represents the first of three phases:

- **Baseline** - articulating the model and planning for implementation.
- **Reflect & Refine** - gathering data and reflecting on learning.
- **Feasibility** - presenting models, analysing data and planning for sustainability.

The six sites will continue to implement their models, supported by the programme through coaching, workshops and sharing knowledge between sites.

If you are interested in developing your own approach to a NSW, we are making the tools used in this programme available to anyone who is interested. To find out more about how to access these, or to understand more about any of the models presented here, **please email chloe.grahame@innovationunit.org**
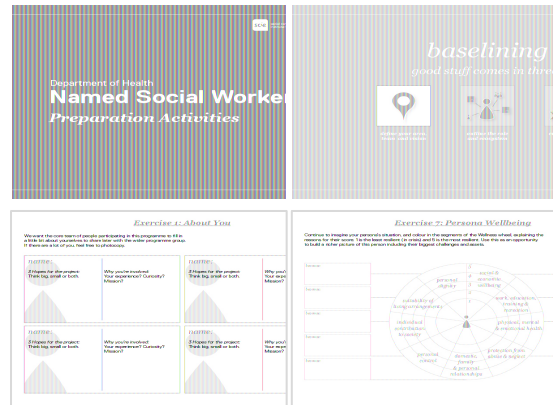

Baseline Prep Activity Book

This booklet contains a range of exercises to explore your ideas and assumptions as a team, and develop your readiness towards implementing your NSW model, including:

- Define your area, team and vision
- Outline the role and ecosystem
- Create a persona and make observations
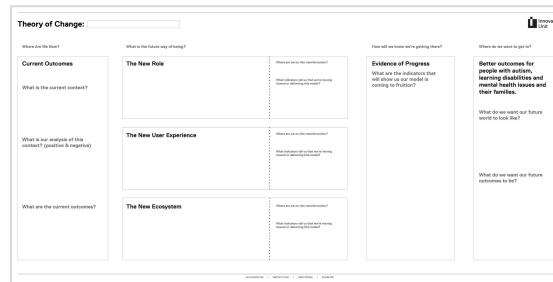
Theory of Change Poster
This Theory of Change poster was used in the first workshop and was used to generate the hypotheses for each of the six sites. It will be revisited in the programme.
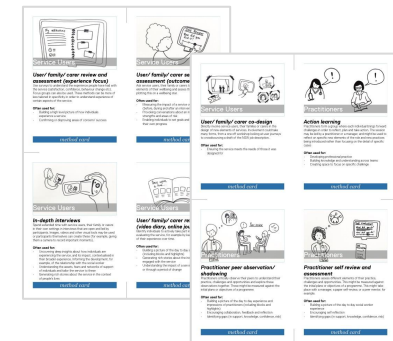
Methodology Cards
These cards offer some example methodologies for capturing data and helping to measure NSW implementation and effectiveness.

Department of Health

Named Social Worker

Baseline Report