THE COLLEGE OF SOCIALWORK
The voice of social work in England

Social Work with Adults

What does the future hold?

Part of the TCSW Business Case for social work with adults

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Introduction

This paper is part of The College of Social Work's Business Case for social work with adults. This series of publications is designed to make the social and economic case for public sector investment in social work, even against a background of financial cutbacks.

Our London Summit, *Social Work with Adults: What Does the Future Hold?*, held in December 2013, forms the basis of this paper. It builds on the *Business Case for Social Work with Adults* discussion paper published in 2012 and sits alongside a series of other Business Case reports we brought out in April 2014, which variously argued for the importance of social work leadership, social work in mental health and with older people, and social work as a guarantee of the safety and quality of services.

We are using the findings of the Business Case to ensure that the vital contribution of social work is fully recognised by government and employers. This work programme is closely allied with our work on the new Care Act, where we are seeking to ensure that the interests of social work and the people who use its services are reflected in practice guidance and learning and development materials.

Social work practice and leadership will be critical if rising demand on health and social care is to be met successfully. In this paper, we aim to show why this is so.

Changing policy landscape

The rapidly changing policy landscape in health and social care presents both opportunities and challenges for social work with adults. But how can the profession forge a clear identity and establish its importance at a time when local authorities are making deep cuts in services?

That was one of the questions considered by our London Summit, *Social Work with Adults: What Does the Future Hold?* It brought together social workers, academics and sector leaders to consider how to build on the evidence base for the importance and economic value of social work as set out in our *Business Case for Social Work with Adults* discussion paper.

The event was chaired by Jo Cleary, Chair of The College of Social Work (TCSW), who described the Care Act and TCSW's initiatives to strengthen the position of social workers in adult social care as a significant opportunity for the profession.

"The Care Act is the equivalent of the Children Act for social workers in adult settings," she said. "So often social workers in adult settings feel they are the Cinderellas of social work and that what they do is under-valued and less understood than what their children's

colleagues do. That needs to change, starting with a renewed emphasis on the value and contribution of social work with adults."

More details of the Summit can be found here, but the purpose of this paper is to summarise its contribution to our Business Case for Social Work with Adults and its main recommendations for action. It includes several new case studies which support the Business Case, the kernel of which is that a strategic investment in social work can have a substantial cost benefit in addition to its immense social and moral value. We hope that social workers and decision-makers will find it helpful in developing their local workforce strategies, and TCSW will use it to campaign for the proper recognition of social work with adults.

Why do we need to make a business case for social work in the first place? At our Summit chief social worker Lyn Romeo painted in the financial background which makes a business case to prove the economic value of social work imperative: the Local Government Association estimates that spending on adult social care will pass 45% of council budgets by 2019, while the NHS faces a £30 billion funding gap by the following year given current service models and levels of investment. The business case argues that investing in social work is key to containing these soaring costs.

The care and support White Paper *Caring for our Future*, published by the Government in 2012, says: 'Social workers have a **crucial role to play** in the reformed care and support system.' The College of Social Work (TCSW) agrees. However, as local government adjusts to austere times, social work must be able to show not just that it makes a unique contribution to the lives of service users but that it makes financial sense too.

The 'Business Case' for social work with adults must demonstrate to employers that it is a false economy to delete social work posts without first taking care to ensure that the short-term savings are not outweighed by the long-term costs. The point of our *Business Case for Social Work with Adults* discussion paper, published in December 2012, was to indicate where social workers fit into modern models of care and sketch the outlines of an argument that the cost-benefit analysis comes out in their favour.

The Government wants to see the integration of health, social care and housing in every locality, so that public money moves out of acute care into the community. We believe that social workers should have a leadership role in taking this policy forward because they are best qualified to work with GPs and coordinate these agencies in the interests of service users.

Modern social work is about promoting choice and control, supporting people to live independently as active citizens in their communities. As public funding evaporates and the state downsizes its public service role, the principles of modern social work need to be translated into the details of local policy and practice. Social workers will be critical to giving the term 'active citizens' real significance because they are uniquely prepared by their education and training to foster the social capital which makes active citizenship in thriving communities a genuine possibility.

Summit delegates asked The College to take forward several important actions, which included improving public understanding of the profession and strengthening the research and the evidence base for social work. These actions and our responses are summarised at the end of this paper.

First, we will focus on three of the actions most pertinent to our Business Case:

1. *Support proactive collaboration between social workers and GPs in talks with new clinical commissioning groups (CCGs) about developing new-look, community-based services;*
2. *Demonstrate the "social return on investment" in social work, proving the cost benefit of relationship-building, reducing isolation, bonding with communities and building community capacity;*
3. *Ensuring that social work makes a strong contribution to the implementation of the new Care Act, particularly in relation to assessment, eligibility and safeguarding.*

Social workers, GPs and community-based care

At the heart of the Business Case is the notion that community-based social work is essential if people are to be helped to live independently for longer and avoid spending time unnecessarily in hospital. This could unleash resources locked up in hospitals to be used much more cost effectively in community settings.

This will require a much freer flow of funding across the health and social care economy and an end to the financial protectionism that hinders change. But it will also require much closer cooperation between social workers and GPs, and more broadly between social care and primary care.

Through its Business Case TCSW is formulating arguments for the social return on investment in social work and the role of social workers in collaborating with GP practices. We are working with the Royal College of General Practitioners (RCGP) on a model of good practice which we will put forward as part of our Business Case as we campaign for fuller recognition of the role of social work with adults from employers and government.

In announcing changes to the GP contract, in November 2013, health secretary Jeremy Hunt promised that four million NHS patients aged 75 or over would have a named GP. "This means giving elderly people the care they need and preventing unnecessary trips to hospital," he said.

The RCGP welcomed the announcement as "it will help us get back to our real job of providing care where it is most needed rather than more box-ticking." It is proposed that GPs will oversee personalised care plans integrating all services so that frail older people are better cared for in the community and hospital admissions are reduced.

The success of this policy of looking after more people closer to home will depend on the

contribution of social workers working alongside GPs within the broader framework of health and social care integration. The College of Social Work will champion this role of social workers and will argue for it in its discussions with local authorities and health and wellbeing boards.

RCGP national clinical lead David Paynton, who spoke at the Summit, believes there is an opportunity not to be missed of bringing the two cultures of health and social care together in the context of the new GP contract and the government's £3.8 billion Better Care Fund, under which NHS money will be earmarked for the integration of health and social care in 2015.

Below we illustrate how social workers in three localities are contributing to new kinds of service provision. But if social work is to take the lead in these transformative changes, as they unfold across the country, education and training will have to follow suit by giving social workers opportunities to acquire essential skills in, among other things, interdisciplinary work, community capacity-building and establishing relationships with service users.

Social work leadership

Social work leadership will be crucial in realising the aims of the GP contract and the Better Care Fund, as discussed in the previous section. Effective leadership of direct practice will be just as important as strategic and managerial leadership.

Chief social worker for adults Lyn Romeo told the Summit that integrated responses were key to the success of personalisation. Sterile debates about who does what from various agencies, whether they are social workers, nurses or doctors, must be avoided if the experience for service users is to be good.

But social workers must also be willing to argue for the benefits, through their collaborations with GPs and primary care professionals, of creative approaches to community-based services.

This social work practice leadership will be an important factor in tilting the balance from hospital to the community. "We need to be clear about social workers being strong, confident professionals who are listened to in various settings, and that the focus remains on the whole person and their needs and wants," Romeo said.

The point was reinforced by Andrew Milroy, assistant director of adult social care in Derbyshire, who said that the renewed drive for an integrated system of care had to be seen as "in, with and for the community". He added: "It's crucial that social workers are seen and heard as leaders among community, professional and organisational networks. The imperative is that social workers have the confidence to speak what needs to be said, and the reputation to be heard when speaking."

Social workers who have the knowledge and confidence to speak with the same authority as nurses and doctors will be instrumental in reshaping health and social care. In

becoming “leaders among community, professional and organisational networks,” they can expand the imaginations of their health colleagues by showing them that the realm of possibilities for independent living is much greater than they had thought.

Social work and integration: Case study

Social work leadership to change attitudes in primary health care has had a high priority in Derbyshire. Social workers there have discarded old-style care management systems and now work in community teams which have gradually aligned their role with GPs and primary health care teams.

There are now formal liaison arrangements with all GP practices and an emerging investment in virtual multi-disciplinary community support teams, targeting co-ordinated care and support for those people most at risk of community break down and admission to hospital or residential/nursing home care.

An important ingredient of the new mix are knowledgeable and confident social workers who, when well connected to their local community and to their fellow professionals, are able to use their relationship skills to influence the way primary care perceives and responds to social care needs. Social workers and social care staff need to explain what they do, why they do it and evidence the impact and outcomes of their contribution.

Further reducing the number of older people being admitted to permanent residential care is a priority. With more than 50% of referrals coming from or influenced by the NHS, reducing admissions to residential or nursing home care depends partly on persuading GPs and primary health care teams that there are alternatives that deliver the right care and support at the right time.

One social worker noted a recent liaison meeting. “I attended the Practice Meeting this morning and GPs wanted to discuss L (L was in her late 80s and living alone). I informed them of the conversation I had had with L’s neighbour and main supporter yesterday and the conversation I had with the hospital ward. They said that several health professionals had assessed L and they think she should be in residential care.”

The social worker had spoken with L prior to admission to hospital to ask what she wanted and at that time she did not want to go anywhere for respite or into long term care. She wanted to remain in her own home.

By forming a carefully considered understanding of L’s situation, the social worker was able to work with her and the network of friends and services to help her achieve her wish. She remained at home until her death despite periods of heightened anxiety for L and professionals alike.

Managing risk and anxiety across a range of relationships is a critical task for most social workers and a key contribution to work with GPs and primary healthcare teams.

Social work’s practice leadership role also extends to coordinating the contributions of social care, public health, the NHS, families and their communities, ensuring that care and support are person-centred and that the efforts of all agencies capitalise on the strengths of individuals and their networks.

As The College of Social Work said in *The Business Case for Social Work with Adults*:

> "It requires social workers who think creatively (and cost effectively) about meeting the needs and aspirations of the population they serve. Restrictive care management processes do not allow social workers the autonomy to work with vulnerable people in this way, yet its potential for steering people away from high-cost, high-dependency residential and home care services is still unrealised in too many localities.
>
> "Councils still spend approximately half of social care funding on residential care for publicly funded clients, while self-funders often enter residential care unnecessarily, become dependent before their time, and later turn to the local authority to finance expensive placements for longer than would otherwise have been the case when their money has run out. Many of these people could live independently as part of their communities, given a more imaginative use of social workers by their local authority employers."

Residential care is also all too often the default option when older people are discharged from hospital. Social workers, working collaboratively with their GP partners, can do much to alter fixed clinical mind-sets, something they will be particularly well placed to do if, as seems likely, many more of them are located in GP surgeries.

People who use services have said that they want this culture change. As Peter Beresford, chair of Shaping our Lives, told our previous adult social work summit in February 2012, social work with adults "must be assured the key role that service users themselves think it should be guaranteed."

He added: "In this way, integrated services can at last fully take on the holistic approach that we know matches service users' preferences and perceptions and that truly makes support services person-centred and fit for purpose."

Social return on investment

It is one of the main arguments of our Business Case that the "social return on investment" that can come from good social work is often neglected in the standard cost-benefit analyses. Strong, inclusive communities with resilient individuals living as *part* of them – and the emphasis here is significant – can contribute to the public purse, whereas dysfunctional communities are a drain on it.

That is the whole point of allowing social workers, as the *Caring for Our Future* White Paper puts it, "to focus on promoting active and inclusive communities, and empowering people to make their own decisions about their care." The financial benefits of creative, new styles of social work in our communities are only just beginning to be quantified.

Many good case studies are beginning to emerge: we will be looking for others, but three excellent examples were presented at the Summit, involving social workers in the London boroughs of Lambeth and Sutton, and in Derbyshire.

Lambeth

The cost effectiveness of prevention and early intervention is starting to emerge from a south London social work practice called TOPAZ (see case study below). The team comprises three social workers, including the practice director Dee Kemp, a part-time occupational therapist and a community worker. They operate in Lambeth and aim to create resilient communities by providing advice, support and advocacy, especially to people from black, Asian and minority ethnic groups.

TOPAZ tackles the problems that arise when older people face rising living costs and falling incomes, and services face rising demand and reduced funding. Its preventive ethos encourages citizens and services to work together to co-produce and improve outcomes for people.

Personalisation is fundamental to its approach and it aims to reach the 94.3% of older people who live independently in Lambeth, supporting them and their carers to be self-sufficient. People are given timely information and helped to be part of networks of support within their communities.

Kemp told the Summit that the TOPAZ team were able to spend much more time with clients than many other social workers, getting involved well before the crises that usually trigger interventions and finding out what they have to say about their lives and the services already available to them.

Sometimes their problems are simple, perhaps easily resolved by overcoming a language barrier; sometimes they are more complex, perhaps requiring collaboration with the community safety team so that people feel less afraid of hate crime and more confident outdoors and engaged with their neighbourhoods.

The underlying principle is that older people want community spaces where they can come together, building on existing models of mutual support and developing new ones through activities and social interaction. Being able to travel safely and without fear is a precondition of success.

Success itself would be: a sense of community, where older people are visible, actively engaged, feel safe, valued, respected and understood; sustainable and flourishing community groups, that reach those in need, and the establishment of new “communities” of older people. Success is measured by: increased participation and attendance at older people’s groups; increased numbers of groups established to support older people, including faith based organisations; reduction in social isolation; and an established network of welcoming community spaces and evidence of older people involved in schools.

The service specification agreed with the London borough of Lambeth stipulates that no more than 15% of the people TOPAZ reviews should be referred to statutory adult social care within a year. “In fact we’ve only sent 2% of people back into social care,” Kemp said, “so we’ve saved the council money as well.”

Social work and prevention: Case study

One of the strengths of the Lambeth-based TOPAZ prevention project is that it can identify people who would soon come into the statutory care system in the absence of an early intervention by the team.

Here is a case in point involving a mother ("Mrs M") and her daughter ("Mrs D"). Mrs D was her mother's carer, but the caring relationship was coming under increasing strain and was in danger of breaking down altogether. So a TOPAZ social worker completed a telephone review with Mrs D to provide support to her in her role as the primary carer for Mrs M.

Mrs M was 76 years old. Mrs D said that her mother used a walking stick and a white cane since she was registered blind. During the review Mrs D reported that Mrs M had become increasingly forgetful, that she suspected her mother had dementia and that they were waiting for an appointment for a scan.

It also became clear that mother and daughter slept in the same bed, although Mrs M would often get up several times during the night. Mrs D said she felt "incredibly stressed," "overwhelmed" and "isolated," unable to see friends. She was considering placing her mother in a care home.

The social worker was able to offer some solutions: the daughter could access respite whereby carers would come to her home so that she could have a break. Mrs D felt that this would be beneficial and, when the associated costs were discussed, she said she would be able to fund this herself. Furthermore, there were assistive technology aids that would ensure that Mrs M could safely sleep in her own bed, while allowing her daughter peace of mind.

There were other problems. Firstly, Mrs D prepared the meals, as she had noticed that Mrs M would put bread in the toaster and promptly forget about it. Secondly, it appeared that the mother had to be reminded about her medication and then helped to take it. The social worker assured Mrs D that there were aides that could assist with the medication regime and potential dangers in the kitchen.

It was further advised that Mrs M would probably be eligible for Attendance Allowance which could contribute to the costs of care. Other issues taken up with a view to maintaining Mrs M's independence for as long as possible were access to transport, medical help, and social events. Another crucial component was a carer's assessment for Mrs D.

Sutton

We reported on the early findings of another community social work project, in the London borough of Sutton, in our Business Case discussion paper. A community social worker had been appointed to work with 30 older people with personal budgets in a deprived neighbourhood with a view to building social capital. The results were promising: service user feedback was "extremely positive" and there was an average reduction of 15% in statutory care packages.

It prompted a more ambitious attempt to embed the same community social work principles across the whole borough. A new team, comprising a senior practitioner, six social workers, a community care assessor and a community art therapist, have been taking all new referrals except for those discharged from hospital.

Staff were briefed to find out about local resources, develop social capital by building

resilience in individuals, families and communities, and divert people away from statutory services by calling on the skills of the voluntary sector.

Speaking at the Summit, Sutton director Adi Cooper said it was here that the Business Case could make a difference because "the biggest chunk of (unitary) Councils' budget is for adult social care." The question to be explored was, could social workers delivering prevention and early intervention strategies result in fewer people coming forward for statutory services (meeting eligibility requirements)?

The purpose of the community social work project, she said, was to explore "how can our social workers work with people in communities and families, using an asset-based model, looking at people's strengths, and looking at what their neighbours, their families and their communities bring?" Social workers had to put an effort into developing some of those networks and communities so that individuals did not need statutory services. An evaluation is expected to be published later this year.

Part of the work involves a rethink of safeguarding adults. Cooper has been at the forefront of the Making Safeguarding Personal project which in 2013/14 has encompassed 53 local authorities and has experimented with a much less process-focused and more personalised model of safeguarding.

She said: "Safeguarding adults is not just about going through a process, it's actually about putting a person who is at risk of harm or abuse in the centre, asking them what they want for an outcome from the safeguarding intervention, and working with them, as that outcome is very likely to change as the safeguarding process proceeds. It is about using a critical, core set of social work skills."

"I believe that safeguarding adults' work is part of the Business Case, working at the end of the spectrum where you're dealing with highly complex and challenging circumstances and where I think social work skills are very important to enable better outcomes for people in difficult situations."

Derbyshire

In Derbyshire the main objective, said assistant director Andrew Milroy, was to establish "a safe, sustainable system of personalised and self-directed adult social care support – respected and valued as a part of an integrated system of care in, with and for the community."

Social workers had to be adept at creating, understanding and using relationships with people and families, the community and with professional and service networks, he said. These relationships go to the heart of social work, which should be person and family-centred, community-focused and "full cost conscious."

What does it mean to be "full cost conscious"? The point of The College's *Business Case for Social Work with Adults* discussion paper was to indicate where social workers fit into modern models of care and sketch the outlines of an argument that a cost-benefit analysis

of the contribution of social work comes out in the profession's favour. In other words, investing in social work saves costs elsewhere in the system in the long term.

For Derbyshire this has been a crucial concept and at the heart of the transition from care management to self-directed care. Skilled, confident and respected social workers, deployed in community social work teams based on the eight districts of Derbyshire, underpin this approach. The development and use of the FACE resource allocation system (RAS) provides social workers with a proficient and reliable way of capturing, through their casework, the lowest level of public funding necessary to meet assessed eligible care needs and achieve the best possible agreed personal outcomes.

Social workers and community social work teams focus wherever possible on prevention, re-ablement and early intervention. Derbyshire's approach to casework practice and community development work shapes the way social workers think about and organise personalised and self-directed social care support. The aim is to avoid, delay or minimise the need for funded social care support. Where funded care and support is required, teams and social workers have access to the RAS data to assist detailed discussion about the professional judgements that inform the allocation of personal budgets.

The availability of extensive detailed data, which can be analysed by social workers and teams, links to the investment made in professional training and development. Each community social work team is supported by at least one senior practitioner social worker (or occupational therapist). The aim has been to create a professionally led and organisationally supported approach to service delivery.

The concept of being "full cost conscious" is central to this shift in leadership and practice. Data about expenditure resulting from casework and assessment decisions, taken by social workers and community teams, is continuously discussed in the context of the TCSW Business Case and seen in the light of what is known as the "Derbyshire £". Publicly funded interventions, whether provided by the council directly, or via commissioned and independent/voluntary sector services, or the NHS or district councils, use resource that is then not available for someone else.

Ultimately being "full cost conscious" is also being alert to the cost to local people or local communities. This cost might be financial if funds are being used without regard to priorities. However it is also the cost carried by local people, families and communities of doing or not doing things, or the time it takes to respond.

As illustrated by the case study below, these costs are often incurred by people being subject to more intrusive or avoidably restrictive care and support because there is a failure to take a positive and person-centred approach to managing risks. Excellence in community social work involves thinking along two key dimensions – organisational utility and person-centred experience.

Social workers with a thorough knowledge of their communities and the matrix of statutory, voluntary and private sources of support will be able to tailor them to the specific needs, wishes and strengths of service users.

But contrary to the naïve claims sometimes made in the name of personalisation, people's "needs, wishes and strengths" do not always lie on the surface and that is another reason why social workers are necessary. Social workers are equipped by training to observe the small, subtle particularities of each service user's presenting condition; however, as *The Business Case for Social Work with Adults* put it, "managerialist policies tend to forget that service users often do not come as 'sets' of readily identifiable needs, but require those needs to be teased out, interpreted and met creatively from the social assets of the family and local communities."

Andrew Milroy corroborated this argument at the Summit. If giving people "choice and control" was simply a matter of doing whatever they wanted, it would have been done a long time ago. But the truth was quite different, he said, since there was much more involved in the social work relationship with service users.

"For many people there are important issues to be considered about what they want," Milroy commented, "but also [there are issues about] what they might need, because the things we might want aren't necessarily what we need, and what we might need isn't what we might want. So that ability to have uncomfortable conversations about what people might want and might need is an important part of what social workers bring."

The rebirth of this kind of relationship-based social work, Milroy said, would require a new culture of practice which rather than being "managerially led and professionally supported" became instead "professionally led and managerially supported."

From hospital to home: Case study

Pat is 82 years old, lives in Derbyshire, and has a history of depression and recurrent chest infections. Married for over 50 years she lives with her 86 year old husband David who is her main carer. Funded social care support assists managing her personal care.

She was admitted to hospital with an infection. Prior this she was able to mobilise with the support of one person. Pat stayed in hospital for six weeks and her mobility significantly deteriorated. She was deemed to need "all care in bed" and the hospital physiotherapist felt inpatient rehabilitation was not an option as Pat had not engaged with therapy.

The hospital discharge plan proposed that Pat should return home with a significant range of costly equipment and substantially increased funded social care support (two carers four times daily). The hospital was pressing for her discharge home.

Pat, her husband and family were concerned about her rapid deterioration while in hospital. In particular, David was concerned about his ability to care for and support her. He appeared resigned to the idea she would need permanent residential care.

The social worker shared David's concerns. She came to the view that if Pat returned home from hospital, with significant and intrusive equipment and a high level of funded care, there was a real risk this would create an irretrievable dependency on costly services and increased carer stress, probably leading to permanent residential care.

Working with Pat, David and the family, the social worker negotiated access to a re-ablement flat in her local community as an alternative to the original hospital discharge plan. Pat spent

Case study continued….

12 days at the flat supported by the local re-ablement team before returning home with her previous level of funded care and support and without the need for intrusive additional equipment.

Pat's social worker said: "Initially, I felt that Pat may be marginalised due to being an older adult with mental health issues. Often older adults are not referred for specialist treatment and the medical model can place an emphasis on treating individuals rather than tackling underlying sources of distress."

By building positive relationships with Pat and her husband, the social worker focused on their concerns, aspirations and realisable personal assets, recognising their rights and her professional responsibilities.

As part of a holistic assessment she explored hospital records as well as liaising with the clinical and nursing staff. She said: "This enabled me to ascertain how her care was being conducted and what had been happening to Pat in terms of her weight, mobility/falls etc."

While respecting the views of the other professionals involved in her care, she formulated her own questions - "What had led to this significant change in need?", "Why was she not engaging with the physiotherapist?", "Was she still suffering from an infection?", "Was she experiencing pain that meant she was avoiding tasks?" or "Was there a physical or cognitive reason?"

This further exploration established that there was no health or physical reason why Pat was unable to mobilise. The social worker was able to reveal that Pat's anti-depressants had been stopped without a clear medical reason being identified and that this may have contributed to her appearing to be withdrawn and unwilling to engage in her rehabilitation therapy.

Dealing with Pat's situation required close attention to a variety of legal duties and powers including the NHS and Community Care Act 1990 and guidance on Fair Access to Care Services (DH 2010). Pat's presenting care needs had to be considered in terms of the level of risk to her independence, health and competence in self-care, if support was withdrawn.

"I was aware Pat was a private and quiet lady, which could be misconstrued as non-compliance, and I was mindful of the principles of the Mental Capacity Act 2005," the social worker said.

She kept Pat at the centre of her intervention, listening to both her and her husband, working on promoting her strengths and enabling them to see and achieve realistic possibilities. The financial benefits to health and social care services illustrated by this case are clear as are the benefits and reduced costs to Pat and her family – extended personal independence and the avoidance of intrusive dependency on care services and equipment.

Implications for knowledge and skills

Reconciling the two cultures of health and social care will depend on professional relationships, not least between social workers and GPs. One answer suggested at the Summit was interdisciplinary CPD across health and social care as a prerequisite of re-registration. Among other things this would improve mutual understanding between social workers and GPs, paving the way to more fruitful working partnerships. More social

workers could be located in primary care, helping to bridge the gap with social care.

In his social work education review, *Re-visioning Social Work Education* (Department of Health, February 2014), David Croisdale-Appleby spoke about how social workers must be prepared for the "transformative changes in the way in which care and support services are taking place." He gave the examples of health and social care integration, personal health budgets, the new Care Act's requirement to promote well-being, and greater involvement of people who use services in planning and designing their own care.

But he added that the care sector had found it difficult to "elicit and promulgate a sector-wide view of the changes to social work education which will facilitate and contribute to this re-visioning" (p22). Social work qualifying programmes and CPD still needed to adjust to the new world.

Professional Capabilities Framework

The Professional Capabilities Framework (PCF) will be highly relevant to this adjustment. For example the domains of "Intervention and Skills" and "Contexts and Organisations" are especially germane to the discussions at the Summit. In terms of the former, social work's emergence from care management and renewed emphasis on working in communities will have particular resonance with the PCF's requirement that social workers "use judgement and authority to intervene with individuals, families and communities to promote independence, provide support and prevent harm, neglect and abuse."

As for the latter domain, social workers are urged by the PCF to "engage with, inform, and adapt to changing contexts that shape practice" and "operate effectively within multi-agency and inter-professional settings." It will require a commitment to reach across cultural barriers and a willingness to experiment with new styles of working with health.

Post-qualifying training will need to reflect these demands. Care management and community development skill-sets look very different and as more social workers attend to the delicate balance between independent living and effective safeguarding, they will require professional development opportunities to match.

In Sutton, for example, social workers have gone on adult safeguarding courses which highlight "risk enablement," so that people are both protected and supported to take the risks involved in managing their own lives and maintaining their independence. Practitioners there have also received training in attachment theory because there is a premium on strong relationships with service users in a way that was never the case with care management.

Sutton director Adi Cooper explained her thinking in the *Business Case for Social Work with Adults* discussion paper:

> "Adult social workers have been deskilled by care management over the past 20 years. The model is a very process-driven approach in terms of assessment, care planning and identifying need. We have lost the skills of relationship-building and reflecting. The

> attachment-based work is to help social workers going into complex situations, particularly where there are issues of loss or identity, to look below the surface of presenting needs and understand more about what is going on."

Principles of safeguarding based on outcomes-focused, person-centred practice have now been spelt out as part of the Making Safeguarding Personal initiative.

A new "charter for social work"

Speaking while the Care Act 2014 was still passing through parliament, chief social worker Lyn Romeo described it as a "charter for social work in adult services," adding that success would depend on the consolidation of a modern, confident profession, able to articulate its role and contribution in working with clients and their families at all stages of assessment and care planning.

The new legislation is an unsurpassed chance to put people's "well being" at the heart of social work rather than the "deficit model" focused mainly on providing statutory services to meet basic needs.

"The duty to promote well-being in the Care [Act] really allows us to focus on asset-based or strengths-based responses to support people in their own communities," Romeo told the Summit. "And the success of the Care [Act] will rest on strong, modern social work practice, not only with people who use services but other professionals who need to be part of the multi-disciplinary response."

She said that modern social work had reoriented itself towards person-centred, integrated styles of practice which set out to improve the experience of service users. The focus had to be on the "whole person and their needs and wants".

But if the Care Act's principle of well being is to be honoured, investment in social work below service eligibility thresholds will be necessary. Financially viable forms of preventive social work are both feasible and the *only* method of promoting independence and community engagement to avoid the later need for costly statutory care services above the eligibility threshold.

The College of Social Work was active in lobbying MPs and Peers during the Care Act's passage through parliament and joined forces with the chief social worker with the aim of ensuring that social work was properly represented in the guidance accompanying the legislation. Clarity about the role of social workers in implementing the Care Act will help local authorities, commissioners and providers with workforce planning and deploying social workers appropriately.

Here is a brief summary of TCSW's position on the Act, both as it passed through parliament and now that it is being implemented in practice:

Well-being and prevention: To meet the agenda put forward by the Government, social work with adults, carers and families will have to reinvent itself and not rely upon the old

verities of care management. Local authority styles of social work must evolve from a paternalistic relationship with a caseload of 'clients' into a partnership with service users who aspire to be 'active citizens.' But huge financial challenges could easily separate these aspirations from reality, hence the need for the business case to demonstrate the cost effectiveness of social work.

Assessments of need: Assessments should be conducted or overseen by social workers; they should be conducted by social workers where needs are complex and the Care Act guidance should give examples of what is meant by "complex needs". Effective assessments require highly skilled practitioners, otherwise inappropriate / incomplete decisions may result in poor packages of care and support that do not enable individuals to live independently as active citizens in their communities wherever possible.

Working with the individual, a good assessor sets out to create a complete picture of a person's strengths, capabilities and aspirations, and co-designs a care and support plan which allows them the fullest possible expression and achievement.

Information and advice: Social workers should be readily available to local information and advice services, particularly where there is complexity and risk, and social work advice, support or intervention could prevent a foreseeable requirement for statutory services.

Safeguarding: We support plans to put Safeguarding Adults Boards (SABs) on a statutory footing. Our view is that social workers should be appointed to supervise safeguarding enquiries because they alone have the theoretical, legal and policy knowledge to undertake complex, politically charged and sensitive pieces of safeguarding investigative work that may require co-operation and co-ordination with other professionals and organisations.

Wherever possible, local authority representatives on SABs should be social work-qualified or, failing that, they must be directly supported by the social worker with lead responsibility for safeguarding in the local authority, such as the Principal Social Worker for Adults. We will advocate nationwide adoption of the personalised approach set out in Making Safeguarding Personal.

Our advice notes on social work practice published in the spring, *Roles and Functions of Social Workers in England* and *The Role of the Social Worker in Adult Mental Health Services*, have reinforced our Business Case for social work with adults. Our contributions to the Care Act guidance consultation, in particular, have highlighted sections of the *Roles and Functions* advice note that require the use of a social worker in assessment and safeguarding roles. Other sections address themselves to the Act's provisions on well-being and prevention, especially "promoting independence and autonomy" (situation 4) and "prevention and early intervention" (situation 5).

TCSW will also take up the matter directly with employers and other stakeholders with an interest in the deployment of social workers. We are developing a strategy to ensure that social workers are an integral part of Care Act implementation plans locally.

More actions from the Summit

a) *Building the evidence base for social work by commissioning much more research on the efficacy of social work interventions;*

b) *Embedding quality assurance in social work with a clear set of measurable outcomes for social work interventions.*

c) *TCSW should develop a brochure showing the evidence base for social work and helping commissioners commission for quality social work.*

The Department of Health spends about £1 billion every year on research, mostly in the medical and health fields. But social work could easily bid for a bigger slice of the funding, as became clear at the Summit.

There has been significant spending on social **care** research – for example, the LSE-based School for Social Care Research has been given £3 million a year to fund university research programmes – but relatively little of it has looked specifically at social **work** interventions in adult social care.

Summit participants were clear that this had to change if the evidence base for social work was to pull its weight in demonstrating why the profession is indispensable to the care and support of adults. As Lyn Romeo said: "We need to be better at evidencing social worker input and outcomes in integrated arrangements."

There was a consensus that "fresh energy" was required to galvanise the research community and link it up to social work practice. University academics could design more social work-focused projects, while social workers themselves could try their hand at practitioner research, which the School for Social Care Research and others have been keen to cultivate.

For its part The College of Social Work promised to inject some fresh energy of its own to stimulate social work research, not least to back up the Business Case. One of our immediate priorities is to set up a "Research and Knowledge Exchange," which will be a College forum for debating ideas with academics, bringing forward research proposals and giving more impetus to the study of social work interventions.

Understanding social work

Finally, Summit participants wanted TCSW to ensure that the public understand what social workers do.

Improving public understanding of the role of social workers is a core purpose of The College of Social Work. As social workers step into the new roles outlined in this report, it will become doubly important to explain what they do to the public.

New models of community and safeguarding social work are slowly replacing care

management, providing a renewed opportunity for the public to become acquainted with the profession. Social workers will have a higher profile in communities and will do more face-to-face work with service users.

Public understanding of social work will be instrumental in making the Business Case for social work. There is nothing like public opinion to sway the thinking of local authorities, among others, and in its work with the media The College has prioritised dispelling the damaging myths that distort perceptions of the profession.

An important proposal put forward at the Summit was that The College should produce an easy-read "jargon-buster" guide to the role of social workers which would explain it to the public generally and service users in particular. Such a publication would make a valuable addition to our suite of social work Factfiles.

The Care Act, coupled with the kinds of social work presented in the case studies here, is also a chance for the profession to lay more stress on its supportive, facilitative function as opposed to the rationing, "gatekeeping" side which has been more often in evidence in recent years.

Conclusion

If the Care Act is a "charter for social work," many social workers are signing up to it. Health and social care integration should, given powerful social work leadership, be a chance to assert a "social model" of community-based practice centred on independent living as against a "medical model" focused on diagnosis and cure.

The case studies presented in this report are evidence that social workers have begun to shake off the legacy of care management and put independent living and active citizenship front and centre of their practice. Not only can this be cost-effective, it can enhance the lives of the people with whom they work.

In the coming months, we will be taking forward many of the actions proposed at the Summit and joining forces with the RCGP to highlight examples of social worker and GP partnerships in the vanguard of integrated care.

Well-being is the guiding principle of the Care Act and, if it is to realised in practice, social work will have to insist on its distinct professional identity, less in thrall to care management to be sure, but able to work knowledgeably and confidently with other professionals in the interests of service users.

Next steps

- TCSW is working with the Royal College of General Practitioners (RCGP) on a model of good practice for integrated care, which we will put forward as part of our Business Case as we campaign for fuller recognition of the role of social work with adults from employers and government;

- TCSW will further develop the Business Case:
  - We plan to publish a report by Alex Fox (Chair of Shared Lives Plus) and Bernard Walker (Chair of TCSW Adults Faculty), looking at strengths-based approaches to support more vulnerable adults to live independently in their own communities. It argues that strategic investment in community development social work can save costs elsewhere in the health and social care system and enable people to make an economic contribution;
  - We are holding talks with a group of university academics about work to support a practice development and research programme to build on the evidence base for the Business Case;
- TCSW is setting up a "Research and Knowledge Exchange," which will be a forum for promoting a strong linkage between practice and research, and giving more impetus to the evaluation of social work interventions.
- TCSW is working with the Chief Social Worker, Department of Health and other key partners to make sure that the role of social work is fully and appropriately addressed in the guidance supporting implementation of the Care Act;
- TCSW is producing learning and development materials to support social workers in implementing the Care Act, including a CPD guide and capabilities statements. We are a partner in work being led by Skills for Care on workforce capacity and learning and development needs for implementation of the Act.
- TCSW will hold talks with the RCGP about the potential for jointly producing interdisciplinary CPD materials for GPs and social workers;
- TCSW will produce an easy-read "jargon-buster" guide to the role of social workers for service users and the general public.