iReflect

January 2017 • Edition 11

Putting learning, development and good practice into the heart of ASC

Perhaps there is such a thing as a free lunch..

Have you seen flyers advertising **Multi-Professional Liaison Groups (MPLGS)**? Camden Community Education Provider Network (CEPN) is a local health and social care partnership that aims to promote, co-ordinate and deliver multi-disciplinary training and education to support the integrated delivery of care. CEPN is running a number of free training sessions across the borough over the next few months.

Each MPLG session involves teaching on a subject followed by a facilitated group discussion exploring a relevant case study. Participants will be encouraged to use learning from the session and experience from their own different professional backgrounds. MPLGs are based on the assumption that when different professionals learn together, they also find it easier to work together.

The pilot will be evaluated by Middlesex University and so far the sessions have received excellent feedback. All sessions run from 12.30 – 16:00 and include lunch.

There are still sessions available on **end of life care, motivational interviewing** and **quality improvement**. For more information you can contact jane.stokes@thecommunitymatters.co.uk or sally.nieman@camden.gov.uk.

In this edition

New resource: RiPfA Case Law Summaries

Research in Practice for Adults (RiPfA) has introduced a new monthly resource providing an overview and analysis of selected cases, highlighting implications and recommendations for practice. It will also report on new legal guidance as it is published. The cases are summarised in an easily accessible and digestible format.

To access the information go to www.ripfa.org.uk

A week in the life of...

Cath Millen is the Principal Social Worker. She joined Camden ASC in October 2016 from Hackney Social Services. Below she describes a typical week.

MONDAY

Today is the quarterly national Principal Social Worker (PSW) network meeting. Luckily for me it takes place in Camden so I don't have far to travel whereas some people are getting up very early to get here from the north of England. It's a great opportunity to catch up with other PSWs, exchange ideas and hear updates from Lyn Romeo, Chief Social Worker for England.

The two PSW chairs outline their plans to make the forum more productive by focusing on working together to produce useful social work tools rather than each local authority working on the same kinds of issues in isolation. I think this is the right idea as it means that all local authorities will get the chance to use the same tools (e.g. supervision tool) and that the tools will be based on expertise gathered from different parts of the country.

TUESDAY

I am a member of the Named Social Worker steering group. This is an exciting pilot taking place in the Learning Disability Service (one of six taking place nationally) which is aiming to ensure best practice is taking place with service users at risk of admission to hospital and those in hospital. I am providing some independent input as the only member of the steering group who does not work in the Learning Disability Service. It is a really useful way for me to get to know the service as I do not come from a learning disability background but my role covers all areas of adult social work. I've learnt a lot already and it's very interesting to see an integrated service at first hand.

I attend a team meeting to introduce myself and talk about the PSW role. It's taking some time but I'm trying to get around to all the teams so that people can put a face to my name.

WEDNESDAY

Sally Nieman and I get together to moderate the final reports for newly qualified social workers (NQSWs) who have recently completed the Assessed and Supported Year in Employment (ASYE). I'm impressed by the amount of work that is carried out by both the NQSW and the supervisor in the ASYE year in practice. It is hard to do this work at the same time as carrying out all the other day to day work, but from reading the reports the benefits seem clear in terms of professional development.

I start to plan the creation of a staff engagement group for Adult Social Care. This will be one forum to ensure that frontline staff are involved in future service development.

THURSDAY

I attend the high risk panel. It is a well-established panel and I would advise anyone struggling with a case where the risks are high and don't appear to be straightforward to refer to the panel. A range of agencies are represented and everyone has access to their own information systems so it is very easy to gain an understanding of what is happening across the agencies. Everyone seems keen to assist where possible and although there are no easy solutions hopefully the referrers leave feeling that they have had some useful input.

I start writing my second PSW newsletter based around hospital social work day.

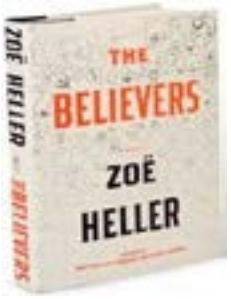
FRIDAY

Friday is a non-working day for me but I look at recent tweets from social care agencies. I am trying to enter the 21st century and become better at social media. It's not my forte though and I'm currently getting some assistance from Jamie Spencer, Care Act Implementation manager!

Social workers on the edge of town

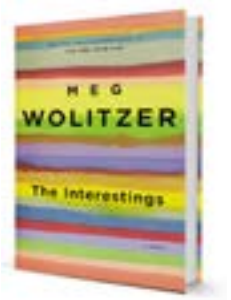
by Martin Hampton

I am searching for a novel where the social worker is the main protagonist and where the details of the profession are the main subject. Until then, the social worker will always be on the edge of town. In the meantime, the titles below might do the trick.

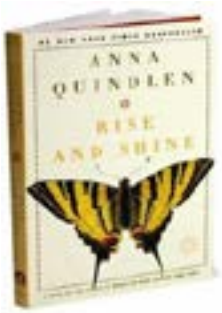


In '***The Believers'*** by **Zoe Heller,** the social worker Karla has a placid exterior underneath which she harbours some distinctly un-nurturing emotions: rage, frustration, coupled with the not infrequent desire to smack her rude mother in the face. Karla is a hospital social worker on the Columbia Presbyterian Geriatric Ward. She lives in a dark apartment permeated by the fumes of *Fabuloso* cleaning liquid. Her clients are difficult: '*That's not my name!*' a client shouts '*My name is Monster!*' Karla's own marriage and the demands of the job are placed within the context of other family members battling their own demons.
The Believers **by Zoe Heller - Penguin Books – ISBN 978-0-670-916-12-2**

'***Fourth of July Creek'*** by **Smith Henderson** is set in an old mining town '*Ten Mile*' in Montana. Social worker Pete Snow attempts to improve the lives of the town's most deprived families. By night he endeavours to repair his own life and the lives of his estranged wife. I share Pete's feeling regarding his social worker ID badge. Pulling out a flimsy laminate he tells the Police: '*I keep telling them I need a badge that don't look like it came out of a dam cereal box'*. Cormac McCarthy's shadow looms heavily across the prose but the story conveys recognisable themes about social work experience and culture.
Fourth of July Creek by Smith Henderson – Windmill Books ISBN 978-0-099-55937-5



Sultry New York summer nights permeate scenes in '***The Interestings'*** by **Meg Wolitzer**. Themes of the novel include finding what you are supposed to do and for Jules that is social work. Jules is a clinical social worker feeling the effects of cuts in the New York State budget (ironically known as '*Managed Care')* where '*most health plans now paid for only a handful of sessions'*. All of Jules' clients are struggling and, though they don't know it, so is their social worker. *The Interestings* is as warm as those summer evenings, whilst acutely perceptive about the feelings and motivations of its characters. ***The Interestings*** **by Meg Wolitzer – Vintage Books ISBN 978-0-099-58409-4).**



'Rise and Shine' by **Ann Quindlen** is the tale of **two sisters,** one of whom, Bridget, is a social worker. Quindlen said of her own sister '*She makes far less money than I do and gets almost no public attention for her work. Yet, I believe what she does is infinitely more important and more difficult than what I do'*. Bridget relaxes after a hard day's social work with an ice cream carton, cat, couch and with her feet in somebody else's lap. She goes running every morning followed by orange juice, western omelette, rye toast and black coffee. Bridget keeps tab of how many times people say to her '*So I hear you are a social worker?*' and then immediately change subject. The writing is sparsely funny: '*There is something oddly soothing about the emergency room of a large New York City hospital. There is nothing that can come through the double doors that the doctors, social workers and nurses have not seen before*'**.**
Rise and Shine by Anna Quindlen ISBN – 978-0-09-950316-3

Embrace the webinars

by Shabnam Ahmed

Recently I sat amongst my colleagues and together we watched a webinar on Risk enablement. I must admit that I did not think that this would be a style of shared learning that would particularly appeal to me; however my mind was to be changed!

The webinar was a Ripfa event hosted by a researcher called Imogen Blood and focused on explaining why risk enablement is key to delivering the requirements of the *Care Act 2014*. She highlighted examples of good practice and gave viewers the opportunity to interact and discuss ways for practitioners to work more effectively with risk. The webinar draws on material from the Ripfa briefing on Risk Enablement.

"A ship in a harbour is safe but that's not why ships were built"

She kicked off with this quote, which aptly introduced the topic of Risk Enablement and reminded us that just because people enter "service or care land" they should not be expected to live lives which are free of risks. Their rights and views on the risks they are prepared to take are paramount. The focus should indeed be on working to enable individuals through carefully considered risk taking.

"Positive risk taking is a collaborative process of balanced decision making in relation to risk, in which the stakeholders weigh up potential risks and benefits and take a shared approach to problem solving".

She took us through an example of a young boy with autism placed in a care home who outlined six wishes in his person centred plan: *1. Live at home with Dad; 2. Go on holiday to Somerset; 3. Have Christmas presents at home; 4. See Toy Story 3 at the cinema; 5. Have breakfast in the bacon shop; 6. Go swimming in Hampton open-air pool*

When his father looked through his care plan and compared it to the one in place, it was obvious that none of his wishes were considered and the existing care-plan was a "system centred plan" not a person centred one.

Imogen considered how a risk enablement approach as opposed to a risk averse one could have promoted elements of the wish list. She introduced a visual way that can enable how we can promote positive risks for people in relation to the **well-being** principles. She termed this the **well-being wheel.** This is a useful tool to consider when completing risk assessments and considering the protective factors, adapting elements to reduce the risk, but balance this with promoting personal outcomes and promote positive risk taking.

1. Which principle(s) does the risk fall under?

2. How does this impact on both the person and on the organisation?

3. What are the barriers to positive risk taking in each area?

4. What would help and enable risk enablement in each area?

The webinar also discussed risk enablement and safeguarding and how "making safeguarding personal" shares features with positive risk taking. She highlighted that it is vital to look at the level of risk that person will allow and recognise people's right to a risky lifestyle.

There was an interactive part to the webinar, where questions were posed and participants added comments in the chat boxes. This was interesting as it yielded some common themes around what practitioners nationally view as obstacles to positive risk taking and what facilitates this.

The Care Act places a duty on us to promote people's well-being: the premise is that people are best placed to judge this and the outcomes that matter to them. What came through strongly for me was that a vision and culture focused on empowerment is key in promoting positive risk taking.

Please join us at the next webinar to embrace a shared learning opportunity.

RIPFA WEBINAR: WORKING WITH PEOPLE WHO HOARD

24 January, online, 12-1pm.

Social care practitioners have a role to play in supporting people who hoard, but where does that role begin and end, and what approaches and interventions are effective? Building on the Ripfa Practice Tool: Working with people who self-neglect, this hour-long webinar will explore the evidence around what works for people who hoard, considering the role of safeguarding adults, mental capacity assessments, multi-agency colleagues, the law and the person-centred, outcomes-focused framework that the Care Act 2014 provides.

Room 11.13 has been booked in 5PS to watch this: contact Sally Nieman if you would like to join.

You can also register to watch the webinar on your own or in another venue as a group. Do this by visiting the Ripfa website www.ripfa.org.uk.

Safeguarding adults conference

by Iulia Minulescu

On 30 November 2016, the Training and Development Service organised the second annual safeguarding adults conference on behalf on the Camden Safeguarding Adults Partnership Board. The event 'Working together towards lives free from abuse' was attended by nearly 200 delegates from around 25 different organisations from across Camden. It was chaired by Councillor Georgia Gould and attracted speakers such as Keir Starmer MP, Nigel Harris and Nezahat Cihan. There was input from Sarah McClinton and Martin Pratt, as well as exceptional service user testimonies from Camden People First, Groundswell and Positively UK.

The conference sought to bring together front-line practitioners from a wide range of organisations and focussed on how we can work together more efficiently and share information to keep Camden residents safe from abuse. Over 80% of delegates rated the conference as either excellent or very good; we hope that those who attended will continue to build on the networks and the ideas generated through this event, leading to improved partnership working and collaboration.

Understanding the difference between health and social care responsibilities by Andrew Reece

What's the difference between a weasel and a stoat? Well, as the old (and still bad) joke goes, one is weasily distinguishable from the other, which is of course, stoatily different. You might get a similarly nonsensical answer to the question, 'what's the difference between health care & social care?' And truth be told, there is no simple answer. Perhaps the best place to start is by reminding ourselves of the key responsibilities placed on the NHS and on councils by primary legislation, case law and guidance.

The Care Act 2014

The Care Act's eligibility framework provides some clarity as to the limits of responsibilities placed on councils, as it was explicitly drafted so as not to bring health care duties into the social care realm, so we need to be clear which 'care domains' the list of eligibility outcomes below does and does not include:

a) Managing and maintaining nutrition

b) Maintaining personal hygiene

c) Managing **toilet** needs

d) Being appropriately clothed

e) Being able to make use of the home safely

f) Maintaining a habitable home environment

g) Developing and maintaining family or other personal relationships

h) Accessing and engaging in work, training, education or volunteering

i) Making use of necessary facilities or services in the local community, including public transport and recreational facilities or services

j) Carrying out caring responsibilities the adult has for a child

The NHS Act 2006

The NHS Act 2006 is the latest iteration of NHS Acts going back to 1948. The Act's core principles have changed little with the core duty being for the Secretary of State to deliver a 'comprehensive' health service to meet 'all reasonable requirements' for health care including: the *'care' of people 'suffering' from an illness* and *'aftercare' for people recovering or recuperating from a period of illness*

Note that learning disabilities and mental health issues are defined by the Act as 'illnesses'. This means that the care of people with learning disabilities or mental health issues, and dealing with the 'symptoms' of those 'illnesses', is an NHS duty. Problematically for social workers, this medicalisation of care does not sit well with the Social Model of Disability.

'Care' Needs that are not Social Care

Care domains that are not covered by the Care Act eligibility framework, meaning that they are 'health care', include:

Management of behaviour that challenges (see case study below)

Support with psychological and emotional needs

Management of medication, including creams, inhalers, eye drops etc (see case study below)

Management of pain and end of life care

Support to manage skin integrity, including dressings and bandages (see case study below)

Support with breathing

Support to manage fits and associated risks

Complex feeding support – see a above

Support to manage continence - see c above

Complex moving and handling issues - see e above

Those of you who are familiar with the Decision Support tool from the NHS Continuing Care Guidance will recognise that these are in effect the care domains of that tool. These needs tend to be long term, hence the term 'continuing care' so as to distinguish them from the NHS's other duty for 'aftercare'. More on that below.

So why, I hear you ask, do we arrange care and support plans that meet the 'health care' needs described above. The CHC geeks among you (and I am definitely one) will know that this is because of the Coughlan Judgement.

The Coughlan Judgment clarified what in effect is a common sense, person centred approach. So, although it is usually 'unlawful' for a ouncil to meet health care needs, we can be expected to meet health care needs where they are **'merely incidental or ancillary'** to a person's social care needs.

Without this flexibility, nearly all care and support packages would need joint funding, and everyone would lose if that were the case.

Joint funding by health and social care

A person qualifies for Continuing Health Care when they have a '**primary need**' for health care, as articulated in the decision support tool. There can be situations when someone does not meet the 'primary need' test, but their health needs are greater than 'incidental or ancillary' to their social care needs. In such circumstances the NHS has a duty to meet or fund these health care needs. The most common example of this is the Funded Nursing Care Contribution for people in Nursing Homes.

Joint funding shouldn't stop there however. You should apply for joint funding from the CCG at any point when meeting health care needs becomes more than an incidental of ancillary part of a person's support plan.

EXAMPLE 1:

85 yr old Mrs A lives at home with her partner. She needs turning every 2 hours to maintain her skin integrity. During the day the paid carers who provide her social care are able to do this, so this health care is '*merely incidental or ancillary*' to the social care already provided so can be funded by the Council.

Mrs A requires no 'social care' at night, so the CCG must fund the care at night required to manage her skin integrity. This care is costly to arrange and separate from any social care so is not 'incidental or ancillary'.

EXAMPLE 2:

J is a young man with a learning disability and behaviour that can place J or others at risk. J lives in supported living with 2 other people. While in his home his support is shared with these 2 people. His support worker prompts J to manage his daily routines in the home and also manages his occasionally risky behaviour in the home. This health need (behaviour) is considered to be 'incidental and ancillary' as it can be delivered by his social care funded support worker without any significant change to the social care support.

Outside of the home J has no sense of danger or risk and is prone to wandering off. He is not able to cross roads or be in a car without 1:1 support. This need for support with his behaviour is a health need. It is considered to be greater than incidental or ancillary, so J's 1:1 support outside of the home is funded through the CCG budget delegated to CLDS.

EXAMPLE 3:

Mr P is 47 and has early onset dementia. He is able to manage his daily routine on his own and wants to retain his independence as much as possible. He has been prescribed medication to try and slow any progression of his symptoms. He is unable to remember to take this and needs a carer to visit twice a day to ensure he takes the medication.

As Mr P has no other eligible social care needs, these health care needs are not 'incidental or ancillary': the GP will need to arrange these medication only visits.

NHS Aftercare

The NHS has a duty to provide 'aftercare' to people during the period of recovery and recuperation from an illness or after an operation. Typically this 'aftercare' is short term (i.e. not continuing) and often provided as 'intermediate care', typically for 6 weeks. It can also be provided as an extended period of rehabilitation, for example after a stroke or traumatic brain injury. Like all NHS care this aftercare is free and the duty to fund this aftercare is not dependent on the location that the aftercare is delivered.

On occasions recuperative aftercare will be needed before a person can start rehabilitation or intermediate care, and the NHS should fund this period of recuperation as part of its aftercare duty.

EXAMPLE 1: Ms A is recovering from surgery to repair a complex fracture and is ready to go home. Mrs A cannot weight bear for 6 weeks, after which she can start her rehabilitation. As Ms A lives alone the CCG agree to fund her care (as aftercare) for the first 6 weeks. Ms A is then offered 4 weeks of intermediate care which includes support from a physio to ensure she is able to regain her previous level of mobility. This is also NHS funded. 10 weeks after her operation Ms A has fully recovered and does not need any ongoing care.

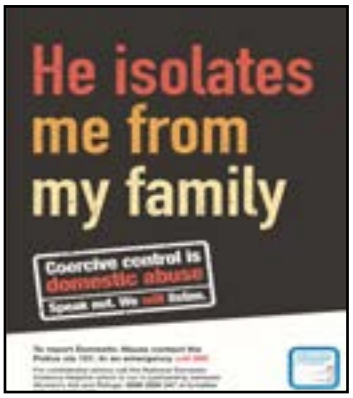
Although care was arranged by the hospital social work team, it was NHS funded.

EXAMPLE 2: Mr M is 82. He has been in hospital for 5 weeks recovering from double pneumonia and associated complications. He no longer needs to be cared for on an acute ward, but after 5 weeks of being cared for in bed he is too weak to return home.

Although Mr M needs a period of intermediate care, all the NHS commissioned intermediate care beds are full, so the Local Authority are asked to fund and arrange his care. The social work team agree to arrange an alternative intermediate care placement but decline to fund that placement as Mr M's 'aftercare' should be funded by the CCG. The CCG agree to fund the placement and Mr M is able to transfer to a private nursing home without delay.

After 4 weeks Mr M has regained his independence and is able to return home with some occasional support from his daughter who lives nearby.

Coercive Control



by Sarah Murphy

I attended a thought-provoking and inspiring event on Coercive Control on 30th November 2016. The day was arranged by Research in Practice for Adults (RiPfA) and Women's Aid. It opened with a key note on this subject from our former Assistant Director, Lyn Romeo , who you will know is now the Chief Social Worker.

Coercive control is now recognised as the behaviour that underpins domestic abuse. It is a pattern of behaviour which seeks to take away the victim's sense of self, minimising their freedom of action and violating their human rights. **The Serious Crime Act 2015** (section 76) creates a new offence of controlling or coercive behaviour in intimate or familial relationships. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members.

The Ripfa microsite is an immensely useful resource which brings together a set of materials and tools to support social workers to put the law into practice. It is constantly being updated with invaluable information and you will find a number of useful resources if you visit the following link http://coercivecontrol.ripfa.org.uk/.

Resources on the Ripfa site include:

* *A resource library*
* *A set of five case studies with learning activities which can be adapted and used in your own CPD programmes*
* *Tools for professional development*
* *Tools for supporting effective, reflective practice*

I am currently in discussion with Sally Nieman about rolling out some briefing sessions to staff: **watch this space.**

Training with SURGE

by Jacqui Robertson

George Evans, the great American cartoonist and ilustrator once said 'Every **student can learn - Just not on the same day or in the same way.'** This statement is true and relevant to student and tutor alike. How many of us have sat through a boring training session full of endless power point slides, willing it to end? And when it does, questioning whether its relevance will make a difference to your working life?

As a trainer, when preparing for a course, it is important to remember not only does the material need to be up to date, interesting and relevant, but also presented in such a way that each student goes away feeling inspired and confident in the subject matter. Each of us has a different style of learning i.e. how we absorb, process, understand and retain information. This generally falls into 4 primary types of learner as defined by Neil Fleming, the educational theorist in 1992 with the **VARK** model: **V**isual, **A**uditory, **R**eading/Writing and **K**inaesthetic.

It is important to structure the training session in a way that you connect with each type of learner, with a mixture of activites. It will not take long for a smart student to detect whether or not a trainer is just 'going through the motions'.

So when I was asked to do a series of joint training sessions around safeguarding with members of the Advocacy Project, SURGE, I jumped at the challenge. **SURGE** stands for **S**peaking **U**p **R**ights **G**roup **E**xperts: their role is to help people with learning disabilities have a say in their health and social care services.

The sessions consisted of a role play acted out by SURGE which highlighted domestic abuse, self-neglect and financial abuse, interspersed with breaks for group discussion. During these breaks the attendees were posed a question to consider about the scenario, with each group being joined by a member of SURGE. Those attending heard directly from service users about their experiences of abuse and how they were supported following a safeguarding referral. The feedback was that this was more meaningful than watching a power point presentation given by a trainer, with no experience in that area.

As a trainer, it made me more aware of how we communicate with each other and how difficult it is at times for service users to understand 'our' world of jargon and acronyms. By making just a few small changes to the way in which we work, the outcome can be more positive for all involved. I am planning more joint training - for more information please get in touch - Jacqueline.Robertson@camden.gov.uk.

Accreditation for Child and Family Social Workers

The Department for Education (DfE) has launched a consultation for the new National Assessment and Accreditation System for child and family social workers (NAAS). The accreditation system will provide consistent assurance that child and family social workers, supervisors and leaders have the knowledge and skills for effective practice. In phase one, DfE will work with 31 volunteer local authorities to accredit their workforce and share the lessons learnt. They also plan to assess and accredit social workers who started their ASYE from November 2014 and are carrying out statutory duties. They expect that the assessments will start taking place in the second half of 2017.

The Department of Health has not indicated any plans to assess and accredit social workers working with adults in the same way, but it makes sense for all social workers to keep a watching brief on developments. The consultation will run until 14 March 2017.

Camden Care Choices

by Jamie Spencer

We've been hearing a lot about prevention, wellbeing and a strengths based approach to social care lately. Sometimes it can be a bit hard to pin down what that means in practice. At its essence it is about understanding what is important to people, and how they can make the best use of the capacity in their own networks and localities to support them to achieve the outcomes they desire.

We heard about a lot of good practice already happening in ASC in this area at the big staff event just before Christmas. A big hand to Martin Hampton, Sean Ahern and Richard Lohan here! I have to say it was a little strange delivering my short piece standing on a dancefloor in a space decked out like the Copacabana...

One big area of change I want to talk about is one we didn't quite have room for on the agenda. The new Camden Care Choices website is the adult social care information and advice portal which covers a range of areas including health and wellbeing, care options, money and legal issues.

The new Camden Care Choices website is for residents, their families or professionals and is accessible and adaptive on mobiles and tablets as well as looking fantastic on a big screen as you can see in the screenshot

Shana Nessa is our information officer and has done a truly brilliant job in bringing this site live.

New features include:

* Information and advice on care and support, including quality data on residential homes and domiciliary providers

* Enhanced self-assessment tool for residents to check eligibility for social care.

* Online marketplace of products and services to enable people to contact third party suppliers

My Community - *a* visual tool to find services in the community

Equipment in the house - an interactive and visual tool to help people find equipment that will help them to live at home more independently

My favourite feature is the highly powerful predictive search engine that enables users to find a range of services and information. In the screenshot below you can see that the site intelligently sees what you are looking for before you've even finished writing it! You can find what you need before even leaving the homepage.

Now the site looks great but this is just the beginning. We are still working hard to ensure that organisations register with us to ensure their details are up to date. We also need to ensure that everything we have on the site is correct - and that is where YOU come in. Please use the site as your go-to resource when supporting the people you work with. Whenever you spot anything that is missing or doesn't seem quite right please let Shana know: Shana.Nessa@camden.gov.uk

We are also working to get smartphones for every frontline practitioner so you can have access to this resource wherever you are. After all, how can you take a strengths based approach if you can't access the right information?

Check out http://camdencarechoices.camden.gov.uk today.