Appendix B – Service Description ‘The Specification’:

“My social worker”– named social workers for people with learning disabilities, autism and mental health conditions – creating a community of practice

1. Specification
2. Executive Summary

The Government ran a public consultation “No voice unheard, no right ignored” between March and May 2015 which sought views on strengthening the rights of people with learning disabilities, autism and mental health conditions to enable them to live more independently. Many of the issues raised were about the fundamentals of how to treat people, how to involve them, and how to enable people to challenge decisions in the system.

Responses to the consultation provided a consensus that, as well as people being able to challenge decisions, there was a need for greater professional challenge to support them. This needed to be independent and professionally-based so that challenge could be made across the health and care system.

In November 2015, informed by responses to the consultation, the Government set out a phased series of actions to achieve a significant change in the experience of care and in outcomes for people with learning disabilities, autism and mental health conditions by 2020, including to:

“pilot access to a named social worker who will provide professional advice and support, be the primary point of contact for the service user and their family/ carers wherever the person is being supported, and provide a professional voice across the system”.

This invitation to tender is for appointment of a contractor to work with a number of local areas (number to be determined but likely no more than six) to:

1. prototype and test in practice having named social workers for people with learning disabilities, autism and mental health conditions
2. create a collaborative ‘community of practice’, and share learning from this work with other interested parties
3. support, help shape, and co-ordinate across areas in order to enable robust evaluation and comparison.

Whilst local areas will be expected to evaluate their individual pilots, the Department of Health is currently considering evaluation options for the pilot programme as a whole.

This work envisages a new role for social workers as part of the wider health and care system, but one that draws on the established norms and ethos of social work. It is a real opportunity to realise the vision set out in the “No voice unheard, no right ignored” consultation and to contribute to lasting improvement in the care and support provided to vulnerable people and their families.

**Background**

The original consultation and the Government’s response are available, including in ‘easy read’ formats, at:

<https://www.gov.uk/government/consultations/strengthening-rights-for-people-with-learning-disabilities>

Ultimately, the consultation and subsequent response were motivated by the fact that not enough progress had been made to transform care for people with learning disabilities, autism and mental health conditions – principally to relocate them from inpatient units to community based care – in the wake of Winterbourne View.

Reducing inpatient numbers, and reliance on inpatient care, remains a key goal of a revitalised Transforming Care Programme for system-wide change as set out in the document:

“Building the Right Support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges including those with a mental health condition”

issued jointly by NHS England, the Local Government Association and the Association of Directors of Adult Social Services in October 2015 and available at:

<https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

More broadly, this invitation to tender is put forward in the context of the Government’s stated aim of full health and care integration by 2020, and drawing on long-standing policy aims of encouraging personalised, user-led services and independent living.

Delivering the commitments from “No Voice Unheard, No Right Ignored” forms part of the Department of Health (and partners’) Shared Delivery Plan objective to reduce the health gap between people with mental health problems, learning disabilities and autism and the population as a whole.

1. The Requirement

There are two parts to the programme;

1. Supporting the management, monitoring and evaluation of Local Authority Pilots. This is the core requirement that will be performed by the winning bidder of this tender exercise. The requirement is detailed in section 2.1 below.
2. The requirement for the Local Authority Pilots to deliver the intended outcomes with support from Department of Health funding. Whilst not seeking to be unduly prescriptive, it is intended funding will be used locally to release trained social workers to undertake the named social worker role with appropriate support, measurement and recording of results and experience. This work comprises the test of an effective operating model for named social workers for people with learning disabilities, autism and mental health conditions. This is detailed in The Statement of Intended Local Area Pilot Outcomes provided in section 2.2.

The Department of Health is currently identifying Local Areas to participate as Local Area Pilots. The successful bidder will be provided with a final shortlist of these Local Areas, all of which will be within England.

* 1. Supporting the Management, Monitoring and Evaluation of Local Area Pilots.

The following are the core requirements that will be performed by the winning bidder of this tender exercise.

* + 1. The work consists, fundamentally, of working collaboratively with a range of local areas to design and test an effective operating model (or models) for named social workers for people with learning disabilities, autism and mental health conditions.  This will require local areas, with support, to innovate and test in practice key elements including the role, intended recipients, required support, processes, outputs and outcomes (where possible).  Ultimately the aim is to identify the elements of a best (most effective and viable) model to inform future decisions on wider roll-out, and potential best practice guidance to accompany this.
		2. The intended person and family and service focused outcomes sought are set out in section 2.2 with a high-level description of the role and intended recipients. The aim is to test whether and how Named Social Workers can significantly, viably and sustainably influence achievement of those outcomes, whilst building a ‘community of practice’ to share and embed learning.
		3. The key tasks are to work with identified local areas who will have expressed an interest in developing the Named Social Worker programme to:
1. Prototype and test in practice a way of delivering care outcomes by having Named Social Workers for people with learning disabilities, autism and mental health conditions. This should involve not less than 5 local areas, with a geographical spread and a balance of rural and urban areas. The Department of Health and its partner agencies will identify areas interested in participating.
2. Create a community of practice, a community of practice is a group of people who share a concern or a passion for something they do and proactively learn how to do it better through regular interaction. The purpose of the community of practice shall be to share knowledge and spread lessons learned from the pilots to help promote improvement.
3. Support, help shape, and co-ordinate across the Local Area Pilots. The purpose of this step is to facilitate comparison between areas and options for evaluation of the programme overall. It is anticipated that some local area pilot variables may be adjusted in light of project feedback of available measures
4. Share emerging learning and experience via key professional groups at national level (e.g. the National Learning Disability Board), and with a broader ‘community of engagement’ comprising other local areas identified as having an interest in this programme, and stakeholders at the national level
5. Ensure that information that is collected and collated from the Local Area Pilots is openly available to the Department of Health after the Local Area Pilots have finished.

**Phase 1 - October 2016**

After an initial project implementation meeting, the first deliverable is a brief Baseline Report to be provided to the Department of Health no later than 4 weeks after the start of the contract that:

* Describes the current situation of the identified local areas that will undertake the pilot activities and initial exploration of their state of readiness particularly that the Named Social Workers are equipped with the skills, competencies and capabilities needed to undertake the role
* Proposes a timetable and action list for each local area pilot to turn the Local Area Pilot Intended Outcomes into operational delivery
* Supports the allocation of individual payments to the Local Area Pilots from the Department of Health.
* Identifies the key baseline areas for comparison to facilitate consistent measurement of pilot scheme efficacy and advises on the feasibility of a minimum common dataset

**Phase 2 – October 2016 to April 2017**

Subject to Phase 1 and agreement of the actions derived from the Baseline Report Phase 2 will focus on;

* Support to the Department of Health to determine funds to be assigned to Local Authorities to support the delivery of the intended outcomes
* The management, monitoring and delivery of the pilot programme for a period of not less than 6 months
* Actively building the community of practice through effective communications and collaboration (and secondarily facilitating the wider community of engagement)
* The second deliverable shall be a Mid-Term report that details progress on the overall Local Area Pilot scheme, delivered not later than 4 months after the start of the requirement. The report is required to detail the processes used in seeking to deliver the stated outcomes. To include;
1. An outline of the Named Social Worker Pilots for each local area and reflect the needs of each local area and their communities.
2. Demonstration of how the pilots align with Transforming Care models being developed in local areas.
3. Proposes a timetable and project plan for each pilot site highlighting commonalities for implementation of the “My Social Worker” prototype.

**Phase 3 – April 2017**

Subject to completion of Phase 2, Phase 3 shall focus on;

* Completion of the My Social Worker Local Area Pilot scheme in each local area, facilitating smooth transition where appropriate
* Ensuring local capture of data to allow subsequent analysis and comparison
* Identification of lessons and learning from implementation to date, and dissemination of these
* A final pilot report to be provided to the Department of Health that details the data collected; summarises findings and highlights the aspects of the pilot findings that will impact potential future implementation.
	1. Statement of Intended Local Area Pilot Outcomes.
		1. The following sections; 2.2.2 to 2.2.10 detail the desired outcomes that each Local Area Pilot will aim to deliver.. Funding will be provided directly to the Local Authority from the Department of Health, otherwise it is intended that all other interaction on this programme will be via the successful bidder.
		2. **Person and family-focused outcomes:**
* feeling safe, supported and empowered by having a professional who is knowledgeable about their individual needs, and helped to make the right decisions;
* experiencing a seamless care and support journey, with consistent knowledge of their circumstances within different parts of the system;
* having increased confidence in their care and treatment and social care interactions with staff;
* better social integration and inclusion in the community of their choice;
* feeling more in control of their lives, and having improved health and wellbeing.
	+ 1. **Service-focused outcomes:**
* reduced health inequalities by improved access to services;
* higher quality care through professional challenge and quality assurance of interventions;
* better, person-centred care by giving service-users a greater voice in making decisions;
* reduced incidence/ risk of poor treatment or abuse;
* support for living and integration within the community;
* parity of esteem between mental and physical health, and better integration of health, care and support.
	+ 1. **Main elements or functions of the named social worker role**

The Government’s response to the “No voice unheard, no right ignored” consultation set out the following additional information about the proposed named social worker role:

“The Government intends that people at risk of being admitted to hospital will have access to a named social worker who is accountable for their care and support. We expect that this will be a named social worker rather than a named health professional, given the need for challenge and independence from clinical teams and for the individual to benefit from this role whether they are living in the community or hospital.

It is currently envisaged that this would work in a similar way to Approved Mental Health Professionals (AMHPs) who are professionally responsible for delivering functions for a local authority and provide professional challenge in relation to the Mental Health Act. We see the role as championing the rights and views of vulnerable people, listening to people, understanding their wishes and desires, supporting them to live independently and in the least restrictive setting, and challenging other professionals in the system whilst being a partner in the system.”

The proposed core elements/ functions for named social workers are therefore:

* dedicated caseworker: oversight of the support of the person throughout the health and social care system and related services. This is to ensure that a responsible professional has detailed knowledge of the individual’s particular care requirements, can quality assure interventions and is able to identify any concerns requiring further action;
* primary point of contact: for all matters or enquiries concerning the individual’s care and treatment and social care needs; and actively empowering the individual through the provision of information, support and advice
* professional voice and challenge across the system: helping navigate and understand processes, procedures and challenging to ensure rights are upheld.

A basic principle behind the idea of a named social worker is an enduring, consistent and trusting relationship. However it is also a means to an end: of confident, empowered people included and integrated in their community with sustainable networks of support. In other words, it is envisaged the relationship should endure for as long as necessary to meet needs, but ultimately should aim to be no longer necessary.

The above elements/ functions were tested at a design workshop with key stakeholders. However, as the purpose of the pilots is to test and discover what works, within those broad parameters it is expected that local areas will have their own innovative ideas about how this can best be put into practice and modified to fit local circumstances – and not least through engagement with experts by experience.

It is fundamentally important that local areas have arrangements in place that ensure appointed Named Social Workers are able to carry out the role and provide robust information to meet reporting/ evaluation requirements.

Likely keys to success will be:

* Named Social Workers are equipped with the skills, competencies and capabilities needed to undertake the role, including provision of appropriate training
* Named Social Workers are given sufficient time and capacity to carry out the role effectively
* Named Social Workers are enabled to provide professional challenge and ensure they have the confidence to do so.
	+ 1. **Proposed recipients: Who should get a named social worker?**

The cohort is intended to be based mainly on local ‘at risk’ registers being set up under the aegis of the Transforming Care programme. People currently in assessment and treatment units, or recently discharged from them are also central to this initiative.

It is proposed Named Social Workers focus initially on care and support of adults, plus additionally to work with young people approaching transition to adult services (for example those in their final year of residential care/ education placements). Work is underway by NHS England and partners to facilitate this identification.

This is not intended to be a final and definitive statement on who could benefit from having a named social worker, or to pre-empt future decisions on roll-out, but is a pragmatic starting point.

An important principle, fitting with the ethos of the programme as a whole, is that provision of a named social worker should be voluntary rather than compulsory on the part of the recipient. Some people may decide they do not wish to take this route and should not be compelled to do so.

The number of people that the Named Social Workers’ work with will need to be informed by local circumstances and will provide valuable information on manageable workloads to work effectively with people.  Additionally, the practice methodology that is in place will provide evidence of the framework and culture that allows good social work to flourish.

* + 1. **Relationship to other co-ordinating roles**

There are a number of other current or proposed roles that have some degree of overlap with the proposed functions of the named social worker. For example, the role of the ‘Care and Support Navigator’ proposed under Building the Right Support has some commonality and shares some of its motivations with the idea of a named social worker.

Rather than set out prescriptively these should interact, participants will wish to consider the most appropriate arrangements in their circumstances. For example, the Named Social Worker may be able to fulfil the role of the Care and Support Navigator, and similarly that of the care co-ordinator under the Care Programme Approach (CPA). Learning from this work will be helpful in considering at the national level the degree to which roles with a co-ordinating element can be streamlined.

* + 1. **Measurement of structures/ processes/ outcomes**

The contractor will need to work with the community of practice to develop appropriate measures of structures (provider-level attributes), processes (care processes) and outcomes where possible (end result for the service users, including carers) both for evaluation purposes and to improve the way care and support are delivered during the course of the work.

These should clearly include seeking the views and experiences of service users, families, and carers.

Possible approaches to this would include replication of Adult Social Care Outcomes Framework measures by using the Adult Social Care Survey and the Carers Survey and by collecting the same type of information as used in indicators using data sources other than these surveys (e.g. people in employment) would allow comparison with published figures at national and local level. A potential list is:

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| --- |
| **ASCOF indicators** |
| **1A**: Social care-related quality of life  |
| **1B**: The proportion of people who use services who have control over their daily life |
| **1D**: Carer-reported quality of life  |
| **1E**: Proportion of adults with a learning disability in paid employment  |
| **1F**: Proportion of adults in contact with secondary mental health services in paid employment  |
| **1G**: Proportion of adults with a learning disability who live in their own home or with their family |
| **1H**: Proportion of adults in contact with secondary mental health services who live independently, with or without support  |
| **1I**: Proportion of people who use services and their carers who reported that they had as much social contact as they would like |
| **3A**: Overall satisfaction of people who use services with their care and support  |
| **3B**: Overall satisfaction of carers with social services  |
| **3C**: The proportion of carers who report that they have been included or consulted in discussions about the person they care for |
| **3D**: The proportion of people who use services and carers who find it easy to find information about services  |

An alternative would be the familiar and consistent basis for measuring outcomes via the Health Equalities Framework (HEF). The HEF provides a clear and transparent overarching health-focused outcomes framework with a common language which can aid understanding for everyone involved, particularly between commissioning and service provision and across health and social care settings.

<http://www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf>

The Learning Disability Professional Senate is also undertaking work to define a set of rights-based outcomes measures and expects to conclude this work shortly.

* + 1. **Deliverables the contractor shall provide**

The main deliverables are:

1. A baseline report no later than 4 weeks after the start of the contract.
2. Mid-term report that details progress on the overall pilot schemes, delivered not later than 4 months after the start of the contract.
3. At the end of the contract a final detailed report that sets out what was performed and completed and with the following description:
* what has/ hasn’t worked - key factors in success or otherwise, with evidence
* any measured changes in person-and service-focused outcomes
* service change impact (e.g. number of residential placements)
* perceived impact on service culture
* changes in care options profile
* any insights (with evidence) on:
	+ value for money (i.e. has it delivered maximum public goods at least cost)
	+ scale-ability/ availability of resources to undertake the role
	+ comparison to alternative methods of achieving same aim
* recommendations for social work practice including:
	+ the operating model
	+ potential for innovative use of technology (digital)
	+ implications for data flows
1. participation in a ‘lessons identified/ learned’ workshop.
	* 1. **Specific service elements that the contractor will need to deliver for this requirement**

As the role is clearly predicated on integrated working across different services/ agencies, working in partnership is critical, and having appropriate information governance arrangements in place to facilitate secure sharing of information will be essential.

* + 1. **Key Performance Indicators**
* reporting as set out in this tender
* demonstrable arrangements for partnership working
* demonstrable arrangements for service user/ family involvement
* networking, sharing learning and pooling of knowledge
1. Authority (department of health) Responsibilities
	* 1. The Department of Health will provide a shortlist of Local Areas to participate in the pilot. In addition the Department of Health will provide funding directly to Local Authorities to support the delivery of Intended Local Area Pilot Outcomes. The Department of Health will appoint a representative to act as the contract manager.
2. Contract Management and Monitoring
	* 1. The Contractor and the Department of Health will work closely to ensure the successful outcomes of this contract.

**Phase 1**

* The Department of Health will monitor progress of the Contractor on a monthly basis and expect the Contractor to raise any issues that may impact on the delivery of the report as early as possible.
* The Contractor will be expected to provide a regular update on progress at these monthly meetings – highlighting any risks they have encountered and how they intend to mitigate those risks.
* The Contractor shall provide a Baseline Report in a clear and concise manner – with
* a credible action plan
* identification of key baseline areas for comparison
* support the appraisal and allocation of individual payments to the Local Authority’s participating in the Local Area Pilot from the Department of Health.

**Phase 2**

* Phase 2 is dependent on the results of Phase 1. The Department of Health will have the right to break the contract after Phase 1 if it is clear that the Baseline Report for Phase 2 is not feasible.
* It is required that the Contractor implements clear communication lines with the Department of Health Contract Manager to ensure that all policy and operational delivery objectives can be achieved.

**Phase 3**

Phase 3 is dependent on the results of Phase 2. The Department of Health will consider the project complete after Phase 3 upon;

* Completion of the 6 month pilot across the designated Local Area Pilots.
* Delivery of a final pilot report to be accessible by the Department of Health that details the data collected; summarises findings and highlights the aspects of the pilot findings that will impact potential future implementation. Any research data collected shall be publicly archived for wider research use.
1. Timetable

The Expected start of contract is 9th September 2016.

Phase 1 – ‘Baseline Report’ to be delivered no later than 4 weeks after the start of the contract.

Phase 2 – Mid-term report to be delivered not later than 4 months after the start of the contract.

Phase 3 – Delivery of Named Social Worker prototype and final pilot report. It is anticipated that this should be complete by the end of April 2016.

**Payment Milestones:**

**Phase 1**

1. Upon successful delivery of the Market Report and agreed action plan

**Phase 2**

1. Upon provision of a mid-term report that details progress on the overall Named Social Worker pilots and agreed actions for phase 3.

**Phase 3**

1. Upon delivery of a final pilot report to be provided to the Department of Health that details the data collected; summarises any findings and highlights the aspects of the pilot findings that will impact potential future implementation.

Funding from Department of Health is available in the 2016/17 financial year.

1. Contractor Responsibilities

To perform and manage the service, the Contractor shall:

1. Appoint a Contract Manager to oversee the work and liaise with / report as the Department of Health requires to the Department of Health’s Contract Manager;
2. Liaise regularly, principally by e-mail/ telephone as and when required by the Department of Health Contract Manager;
3. Perform quality assurance on all aspects of the programme;
4. Provide the Department of Health with timely and ongoing evaluation and quality assurance information relating to the programme.
5. Contract Management and Monitoring

The contractor shall:

1. Monitor the quality of the service provision to ensure customer satisfaction in accordance with the key performance indicators outlined in the Contract, unless otherwise approved by the Project Manager;
2. Provide a report on progress in delivering the requirement to the Project Manager on a regular basis, at least quarterly;
3. Attend meetings on site to review progress and discuss the service, as required by the Project Manager; and
4. Attend a post contract review with the Department to review whether the objectives of the contract were met, to review the benefits achieved and to identify any lessons learnt for future projects.
5. Skills and Knowledge Transfer
	* 1. It is vital to ensure that skills and knowledge gained by this requirement are retained by the Department of Health for the longer term and inform evaluation across all the pilot sites. It is intended that this will be achieved via written reports and a lessons identified/ learned workshop between the Department of Health and the Contractor, and by active sharing and spreading of information within the community of practice and to national level structures.
6. Further Information
	* 1. Another highly relevant source of reference is “Supporting people with a learning disability and/or autism who display behaviour that challenges including those with a mental health condition. Service Model for commissioners of health and social care services.” <https://www.england.nhs.uk/learningdisabilities/care/>

Local areas are in the process of organising themselves into Transforming Care Partnerships (TCPs) covering people with learning disability/ autism and involving multiple local authorities in partnership with other agencies (e.g. CCGs).