DRAFT: ACEVO Winterbourne View Steering Group

Workforce Development – thinking through the issues and taking action

Introduction

This paper draws upon Skills for Care and Skills for Health's work and experience co-producing the 'Positive and proactive workforce' guide for the Positive and Safe programme and Skills for Care's work with the Winterbourne View Joint Improvement Programme.

Defining Workforce development

In this paper 'workforce development' is defined as

- WORKFORCE; all those people playing a part in supporting a person in need of care and support; including the person themselves, their family and friends, workers at all levels including senior managers& board members , allied professions such as cleaners gardeners etc., community / mainstream employees, volunteers and students etc.

- DEVELOPMENT; including designing the workforce, finding and selecting and keeping the right people, developing their skills, knowledge and attitudes, developing a person centred learning culture, dealing with poor performance or abuse and learning, development, progression and succession planning, training and education.

Overview

For people to be supported well and in a way that will be sustainable the workforce supporting them must have the right skills, values, knowledge, behaviours and appropriate supporting organisational infrastructures.

Workforce Planning should be an integral but dedicated activity within the process of planning the individual's package of support. It must be based on individualised planning with or for the person and involve the people who know them best. It will succeed where it is inclusive of all the people and organisations who play a part in the person's life and is regularly reviewed monitored and updated.

To help people return to or stay in their local community we envisage several 'workforces' (teams or groups of staff) working in partnership or collaboration when needed;

- A local workforce in place to deliver preventative support, early intervention, independent advocacy and advice on legal, housing, transport issues – working with families and communities to help them support individuals and providing specialist input to longer term support services. This would be aligned with the local offer that local authorities will be required to have in

place from September 2014 as part of the Special educational needs and disabilities (SEND)[1] reforms. Existing community learning disability teams; where these function well, are well placed to provide this.

- Aligned with the above, staff are needed to provide assessment and treatment in local areas so that those needing such treatment receive it while maintaining all their normal family / community / education / employment links and activities.
- People are needed to provide support in a crisis (which could include family carers' crisis or illness) to keep people in their local area – these will need to be flexible and able to move to geographic locations as needed – building on the suggestions in 'Mansall' (Services for People with Learning Disabilities and Challenging Behaviour and/or Mental Health Needs (revised edition) DH (Ed Prof. J Mansell). March 2007 – link in note 2 below)
- Individualised teams or workforces supporting people on a long term basis in their permanent homes – this workforce will support the individual in a person centred way to be happy and healthy and fulfilled helping them to carry out all their chosen activities and to use their local facilities such as health, leisure, transport and education. These teams may include support for day time / employment / educational activities or services for these activities may be provided separately.
- A short term (possibly one year) workforce of co-production partners (individuals, families, health housing and social care etc.) in each local authority or CCG area tasked with working with and for the individuals currently in in-patient setting from their area; planning individual return packages using a dedicated budget.

These workforces can all draw on social care and health expertise and also on workers from community development, transport, leisure, housing and justice. Good individualised support should be seamless and therefore the people providing it must be working and learning in partnership or together.

Recommendations;

We endorse the requirements around workforce development contained in current guidance on good practice in supporting this group and developing the workforce which will do this. This guidance includes;

- Both "Mansall" reports (Department of Health 1993 and 2007)[2]
- 'Positive and Proactive Care – a guide to minimising restrictive practices (Department of Health 2014)[3]

[1] https://www.gov.uk/government/publications/special-educational-needs-and-disabilities-send-reform-letters

[2] 1 Services for People with Learning Disabilities and Challenging Behaviour and/or Mental Health Needs (revised edition) DH (Ed Prof. J Mansell). March 2007 https://www.kent.ac.uk/tizard/research/research_projects/dh2007mansellreport.pdf

- Ensuring quality services, Core principles for the commissioning of services for children, young people, adults and older people with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges[4] ('EQS', Local Government association and NHS England 2014)
- Guide for commissioners of services for people with learning disabilities who challenge services (NDTI)[5]
- As well as our own recent guides; challenging behaviour and a positive and proactive workforce;[6]

In addition to endorsing all the recommendations in these guides we would suggest that training in Positive behaviour Support (PBS) should be based on the PBS competency framework currently being developed by Louise Denne[7] and other academics with support from Skills for Care. Skills for care's 'workforce capacity planning model'[8] can help to develop a workforce development plan for each team or workforce.

Requirements from the above guidance could be summarised as follows;

1. Employers of each of the workforces listed in the summary above must follow an inclusive, person centred approach in managing all aspects of their needs. This will include all elements of workforce development, ensuring and addressing aspects such as of designing their workforce by considering who this workforce is, what skills and knowledge workers they need and how this can be achieved and maintained..
2. Key points from 'EQS'
    a. All support workers receive training in Positive Behaviour Support, which is refreshed at least annually.
    b. All support workers with a leadership role (e.g. shift leaders, direct employers, frontline managers) should have completed or are undergoing more extensive training in PBS which includes practice-based assignments and independent assessment of performance.
    c. All workers with a role (which may be peripatetic or consultant) in respect of assessing or advising on the use of PBS with individuals have completed, or are undergoing, externally-validated training in PBS which includes both practice and theory-based assignments with

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3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

4 http://www.local.gov.uk/documents/10180/12137/L14-105+Ensuring+quality+services/085fff56-ef5c-4883-b1a1-d6810caa925f

5 http://www.ndti.org.uk/uploads/files/Challenging_behaviour_report_VERY_final_v7.pdf

6 http://www.skillsforcare.org.uk/Document-library/Skills/Restrictive-practices/A-positive-and-proactive-workforce-WEB.pdf

7 http://behavioursolutions.net/user/ms-louise-denne

8 http://www.skillsforcare.org.uk/Standards/Care-Act/Workforce-capacity-planning/Workforce-capacity-planning-model/Workforce-capacity-planning-model.aspx

independent assessment of performance at National Qualifications Framework level 5 or above.

d. All workers involved in the development or implementation of PBS strategies receive supervision from an individual with more extensive PBS training and experience.
e. Workers in 'consultant' roles[9] are supervised by an individual (within or outside the organisation) with a relevant postgraduate qualification e.g. applied behaviour analysis, positive behaviour support, and clinical psychology.

3. All learning should be co-produced; including the voices, views and needs of the people being supported and their carers (or advocacy / user led groups) in appropriate formats in design, production, delivery and evaluation.
4. Learning about a human rights based, positive and pro-active, non-aversive approach to supporting people must precede any training on or use of restrictive interventions or practices. Significantly more time should be spent learning about positive and pro-active approaches and non-restrictive alternatives. Any learning about how to carry out restrictive interventions should always focus on good practice where positive pro-active strategies are the norm and are part of an on-going learning pathway.
5. If services use bank / agency / casual / self-employed workers they should receive training and support in line with all other workers in the team.
6. Learning opportunities must be offered to individuals using a service. Their family carers or support network should be included in learning proportionate to their level of their involvement in supporting the individual.
7. Information must be offered to anyone experiencing planned or unplanned restrictive practices, and to their carers.
8. Anyone delivering learning or assessing competence in PBS or in restrictive practices should be occupationally competent and hold or be working towards achieving a recognised teaching /training qualification.
9. Workers in all social care and health services (general or mainstream services) must have an appropriate level of awareness of the specific needs of people with whom they may come into contact. This may include people with dementia, psychosis, autism, borderline personality disorder, head injury, trauma, anxiety, sensory differences, learning disabilities etc., and the ways in which these conditions may lead to behaviour that challenges or a resistance to essential care. Teams which support individuals must have an awareness of any health issues or disabilities / differences affecting those individuals such as the list above plus specific issues such as epilepsy or diabetes.
10. Workers should have an understanding of how to access specialist advice and support for people, which includes advice on the impact of culture and the environment.
11. Executive board members (and their equivalents in non-regulated services) who authorise the use of restrictive interventions in their organisations must fully understand PBS and any physical interventions they authorise.

[9] Consultant roles are described more fully in EQS, briefly this is a PBS expert who advises a team or service and guides them to assess the function of a behaviour of concern and design and implement pro-active and re-active strategies.

12. Anyone who may carry out a restrictive practice or provide learning in this area should have completed training in the Mental Capacity Act which covers the learning outcomes of the QCF unit MCA01, 'Awareness of the Mental Capacity Act 2005' (level 3) and other legislation relevant to their situation (see Appendix D).

We would suggest that adequate guidance already exists on workforce development for the workforces supporting people who have learning disabilities / autism and display or are at risk of displaying challenging behaviour. What is needed is strategic and consistent implementation by redesign of services, ensuring that adequate resources are available for employers and that systems are in place to check that it is happening.

Senior managers / board members must be accountable for the development of the workforce in line with these recommendations

Contracts for services must ensure that discrete funding is identified which is adequate to achieve these recommendations

CQC and other regulators must inspect against these recommendations.

Issues

Whilst we fully understand ACEVO's remit, Skills for Care would argue that the contribution of all parts of the social care sector and specifically individual direct employers and small user led / family led groups and innovative PBS networks must be harnessed to achieve the outcomes needed.

We are aware that there is a belief in some parts of the social care and health infrastructure that the skills required to work with people in crisis or who may need very particular care and support can only be developed within health settings. This must be completely rebutted, We maintain that the skills can be developed anywhere so long as they are based around the individual people's needs, hopes, situation and interests, and that the workers in question have been recruited for the values they hold.

If staff are to be transferred / 'TUPE'd' or redeployed then a robust system of workforce re-design must be in place to ensure they are selected and prepared to operate in a new system and culture. The Skills for Care culture change[10], workforce integration[11] and workforce re-design[12] toolkits can help with this. Where services and the people providing them need to work differently there must always be a comprehensive approach to change management so that people behave differently.

[10] http://www.skillsforcare.org.uk/Skills/Culture/Culture.aspx
[11] http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-integration/The-Principles-of-Workforce-integration.aspx
[12] http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-redesign/Principles-of-Workforce-Redesign-downloads-and-practical-resources.aspx

Training for teams supporting an individual is most effective when delivered to the whole team including operational mangers, and the person and their family carers to an appropriate level for their level of involvement in their support. The specific content for people in each role should be based on the PBS competence framework.

QCF units and qualifications offer a good route to ensure that learning is of a suitable quality and where appropriate transferable. Training for teams should be planned around the individual's needs and then mapped to QCF units to enable workers learning to be assessed in practice and accredited.

Training must be embedded in practice by good practice management; using assessment, supervision, mentoring and de-briefing. It must be refreshed or updated as needs change. All of these activities must be budgeted for in terms of funding and time in specifications, contracts, rotas inspection and monitoring.

There is little evidence of people currently working consistently within a PBS framework, although there are pockets of good practice. Introducing a whole workforce to a PBS approach (from what we have now) is a huge task, and will require a planned, carefully thought through strategic approach, with a range of people working together, that includes training the new workforce as well as the current workforce.

Support providers who wish to carry out robust workforce development and practice management report that competitive processes and year on year funding cuts can hinder them in doing so.

A key barrier for people leaving in-patient facilities is the responsible clinician's decision which will often be based on knowledge of a person only in that in-patient setting and in ignorance of the support that could be offered in a community setting. These decisions are arguably risk averse and do not take into account the well-recognised negative effects that congregate settings have on the frequency and intensity of behaviour which challenges. A recent parliamentary debate also alluded to the potential for conflict of interest in the responsible clinician's employer often being the current [provider of in-patient services. This is a key area of development that is needed, and while it is outwith the remit of Skills for Care we would encourage and support action by possibly the positive and Safe Programme, the royal college of Psychologists or Psychiatrists, NHS England, Health Education England or Skills for Health in taking swift action to address this.

Priority for action

- Establish local short term (possibly one year) 'workforce' of co-production partners (individuals, families, health, housing and social care reps etc.) in each local authority or CCG area. Task this team with working with and for the individuals currently in in-patient setting from their area; and those

currently living in their area and planning individual return (or moving on) packages using a dedicated budget.

- Develop community learning disability teams into robust teams for each area to provide preventative, early intervention and family support for individuals and the services or families that support them with quick and easy access (self-referral) and quick responses. These teams could also offer assessment and treatment to people while in their own home and short break support for family carers. Engage these teams directly in workforce development activity.
- Establish / develop crisis / emergency support as described in the 'Mansall' reports – flexible support up to the required level of staffing that can travel and be provided quickly in someone's own home or in local emergency accommodation. These teams could also provide short break support.
- Ensure that all contracts for support services explicitly include the workforce development requirements listed above and also include funding (or free provision) for this to happen. Ensure that CQC inspect to monitor that this activity is happening.

Conclusions

Active workforce development solutions engage everyone in the process and take account of and development skills knowledge and expertise in all.

To meet the challenges of supporting people getting the workforce development right is essential.

People do not change the way they work and support people unless the culture they are working in is supportive, inclusive and open to challenge and change.

If the workforce development solutions are right, the care and support people have to enable them to live independent lives will be right as well.

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