Halton Borough Council
People and Economy Directorate

Making a difference:

A strategy for transforming Care Management in Halton

2015 to 2020

Contents

Foreword

This strategy for transforming care management in Halton is aimed at staff and partner agencies. The overall purpose is to provide a shared vision of the future of care management services and provide a plan to shape our future, over the next five years. I would like to acknowledge the input many of you have made in participating in developing the strategy. I am sure many of you will recognise your contributions as you read through and I would like to take this opportunity to thank you.

We are all aware of the pressures on health and social care and the need to address increasing demand arising from demographic changes, financial pressures, national policy, major legislative reforms and local priorities. The introduction of the Care Act brings care and support legislation together into a single act with a new well-being principle at its heart. It has introduced major reforms to the legal framework for adult care. We need a future vision of assessment and care management services that is responsive to these challenges whilst maintaining high quality, effective and safe practice.

In advancing integrated care we will be embedding our multidisciplinary teams and working to build on and extend our GP partnerships. Working together, we will be developing integrated processes and systems where possible to provide seamless services. We are developing a framework that will enable us to construct a working model of a professional multi-disciplinary care management service that is fit for purpose to absorb increased future demand on services and offer better co-ordinated and integrated interventions.

The strategy sets out our vision, aims and priorities for assessment and care management services. It aims to assist us to progress modern models of social care which builds on looking at strengths based approaches to support vulnerable adults to live independently in their own communities. It is a working document which sets out how we will implement our priorities with a dynamic action plan that is already taking shape and takes us forward. It fully endorses coproduction and offering personalised services to promote active citizenship, and harness mutual support.

A recent review undertaken by the Local Government Association (LGA) identified, one of the key motivating factors that encourage individuals to join the social care profession in particular, is wanting to make a difference to people's lives. In my role as Principal Social Worker, I have recently spent time meeting with a range of practitioners including social workers, occupational therapists, community care workers, a common theme has been, talking about why we came into our professions. I have held events, including, "Building Common Ground" with Occupational therapists and "Social Work Matters Forums" with Social Workers. What I find fascinating is, that we all share a lot in common in the reasons we come into the social care as a vocation. I myself came into social work over some twenty years ago; my reason for doing so is very much the same as those who are experienced in the job also, as well as our newly qualified younger recruits, we all want to make a difference as we touch people's lives. This resonates so

much with us that “Making a difference” seemed to be the fitting strapline for this strategy. I hope you find it informative and motivating.

Marie Lynch
Principal Social Worker/Divisional Manager Assessment and Care Management

Sue Wallace-Bonner
Director of Adult Social Services

Introduction

This Care Management strategy has stemmed from the growing need to identify a future vision of assessment and care management services that are fit for purpose to meet the many challenges at national and local level whilst maintaining high quality, effective and safe practice. Some of the key areas include demographic changes, the Care Act, Personalisation, budgetary constraints, the Integration agenda and a shift in focus to Well-being and Prevention. Cultural and attitudinal changes both at a strategic level and in professional practice are required and we need to understand the processes and architecture as well as the workforce implications to take this forward.

We are all aware that Halton's population aged 65+ will increase by a third over the next 10 years many of whom will be living with multiple long term conditions. Similar increases will be seen across all ages in the numbers of people living with three or more health conditions whether physical or mental or both[1]. Mental health problems are the single largest cause of ill health and disability in the Borough and deprivation across the Borough is widespread and remains a major issue and determinant of health.

Failure to respond effectively to these challenges is reflected in the numbers of people admitted to hospital in an emergency and at least one fifth are estimated to be directly avoidable in some way.[2] Many of these admissions relate to long term conditions and emergency readmissions. Emergency hospital admissions of Halton residents have reduced though remain high. Rising numbers of older people will increase pressure on unplanned hospital activity and we are aware that falls related hospital admissions amongst those aged over 65 is a priority to be addressed.

Potentially the impact of multi-morbidity will be disabling for many people. Prevention, delaying onset and slowing progression of long term conditions can happen through improved public health messaging and targeting, personalised care planning, information and supported self-care. Effective management of a condition can slow progression having a positive impact not only on people's lives but on reducing health and social care costs.

1 Fulfilling potential – Building understanding (ODI 2013)
2 Transforming Primary Care (DH 2014)

Our vision, aims and priorities

Our vision in Halton Borough Council is that:

> ***"Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and quality, sustained by a thriving business community; and safer, stronger and more attractive neighbourhoods."***

Halton's Strategy is focussed on a partnership approach across Health and Social Care on prevention of ill health and poor emotional wellbeing, supporting people to remain independent at home and to manage their long-term conditions, wherever possible avoid unnecessary hospital admissions and in situations where hospital stays are unavoidable ensure that there are no delays to their discharge. This Care Management Strategy will support these aspirations and a whole system integrated approach to local health, care, support and well-being.

The shared plans of Halton Borough Council and NHS Halton CCG for further improving and integrating health and social care services in the Borough are set out in the Better Care Fund (BCF) submission to the Department of Health. This will be achieved by working more closely together through a single pooled budget arrangement to meet assessed health and social care needs. To further develop assessment and care management services and our multi-disciplinary approach to deliver the vision for Halton and meet our statutory responsibilities we have constructed a working model for care management in Halton ***"The Making a Difference Model".***

Through the model we aim to have seamless services across health and social care which are responsive to need and minimise delays by developing and supporting:-

i. **Locality based care management teams aligned with GP practices**
Building on our current configuration we will support implementation of the proposed GP led delivery hub model to strengthen the capacity of the teams, and provide for greater opportunities to work more closely to deliver integrated care and better outcomes and health gains for people in the community.

ii. **Integrated processes and systems where possible**
By sharing relevant information, resources and risk we can avoid duplication, improve outcomes and build resilience and sustainability into the local health and social care system.

iii. **An appropriate care management response to improve support in the community**
Integration will be around pathways of support, care and treatment requiring timely care management interventions to support individuals and families at home avoiding unplanned hospital admissions and facilitating speedy, safe discharges and minimising readmissions.

iv. **Maximise prevention and early intervention**

We will improve quality of life for people with social care needs and their families building on available informal support to prevent, postpone and minimise the need for formal care. A shift in resources is required from high cost complex care to more preventative interventions. We will be proactive in recognising opportunities for health promotion and make effective use of telehealth and telecare to support independence and early detection of health problems.

v. **Personalised and co-ordinated care and support for all**
We will offer access to personalised, timely, evidence-based interventions and approaches that empower people to remain in control of their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

vi. **Effective safeguarding for both adults and children**
We believe that everyone accessing services has the right to live safely and freely from harm and will support a person to understand the risks and benefits associated with a situation. Ultimately the person's wishes will be respected even if they wish to remain in a situation that may cause them harm.

vii. **A well led proficient working environment that values, encourages and supports staff in their personal development**
We want care managers to be able to continue their professional development and adopt "strengths based" working practices that are person centred, innovative and creative.

In aspiring to meet our aims we have identified **five strategic priorities:**

1. **Health and wellbeing of individuals in our community**
2. **Supporting Independence**
3. **Managing complex care to support individuals to remain at home**
4. **Maintaining high quality, personalised care management services**

All of the above underpinned by:

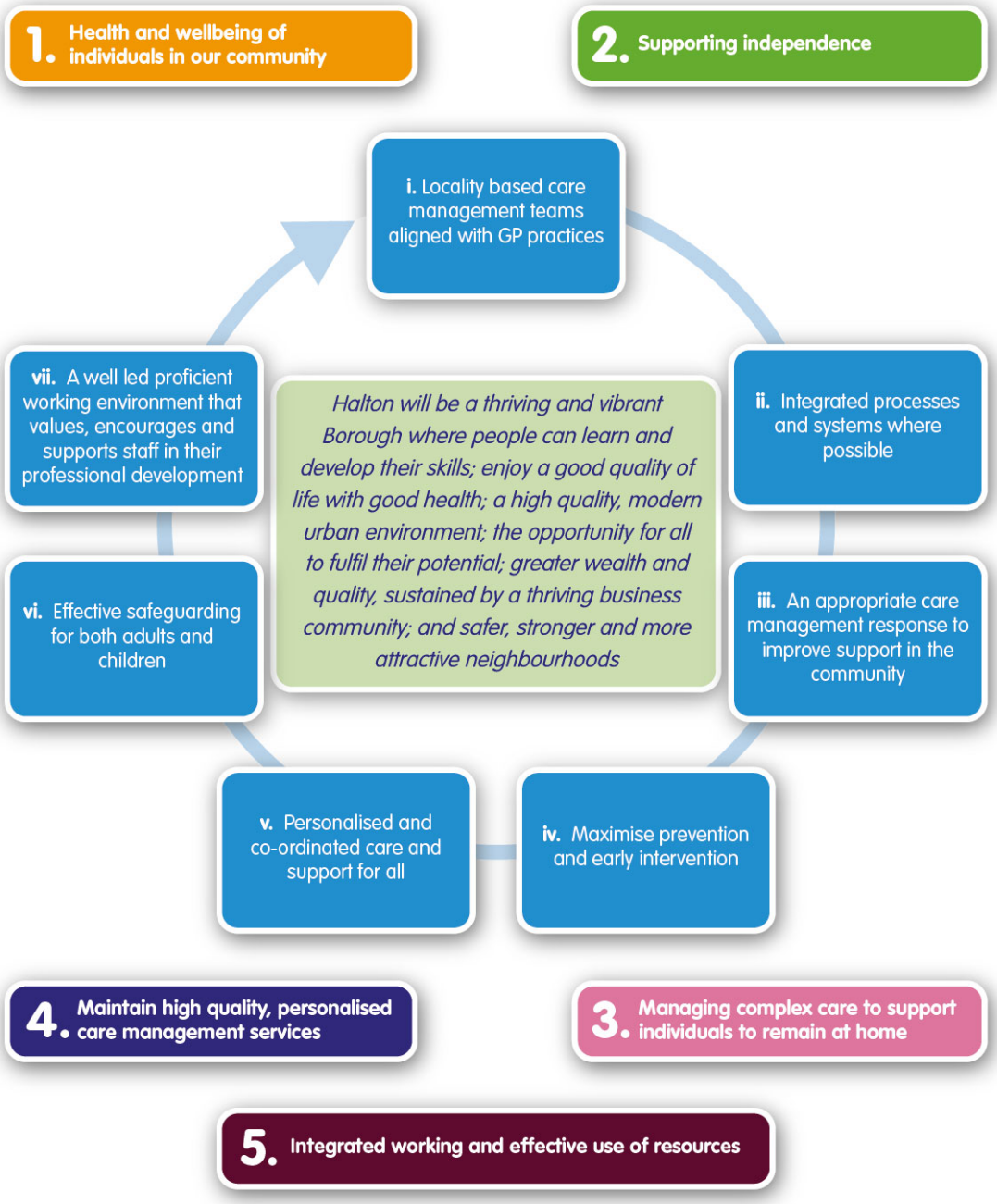
5. **Integrated working and effective use of resources**

The priorities set out in the strategy support the cultural shift to an integrated, strengths (asset) based focus for meeting individual need steering away from the traditional, narrow focussed deficit based model which looks only at vulnerabilities and how this fits with eligibility and service entitlements undermining the resilience of people. The emphasis will be on effective personalised social care intervention with an understanding of what's important to the person, what they can do and at what they have the potential to do with a little help leaving an individual better informed and connected and more confident, supporting the individual's unpaid relationships, informal networks and natural support networks.

We will work with local people and with partner organisations including NHS Halton CCG, service providers and the voluntary sector to ensure that the people of Halton with health and social care needs experience accessible, co-ordinated, integrated and high-quality services to support them to remain safe and well at home. We will embrace the concept of Making Every Contact Count (MECC) to improve the health and wellbeing of people with support needs by using all opportunities to encourage them to make healthier choices to achieve positive long-term behaviour change.

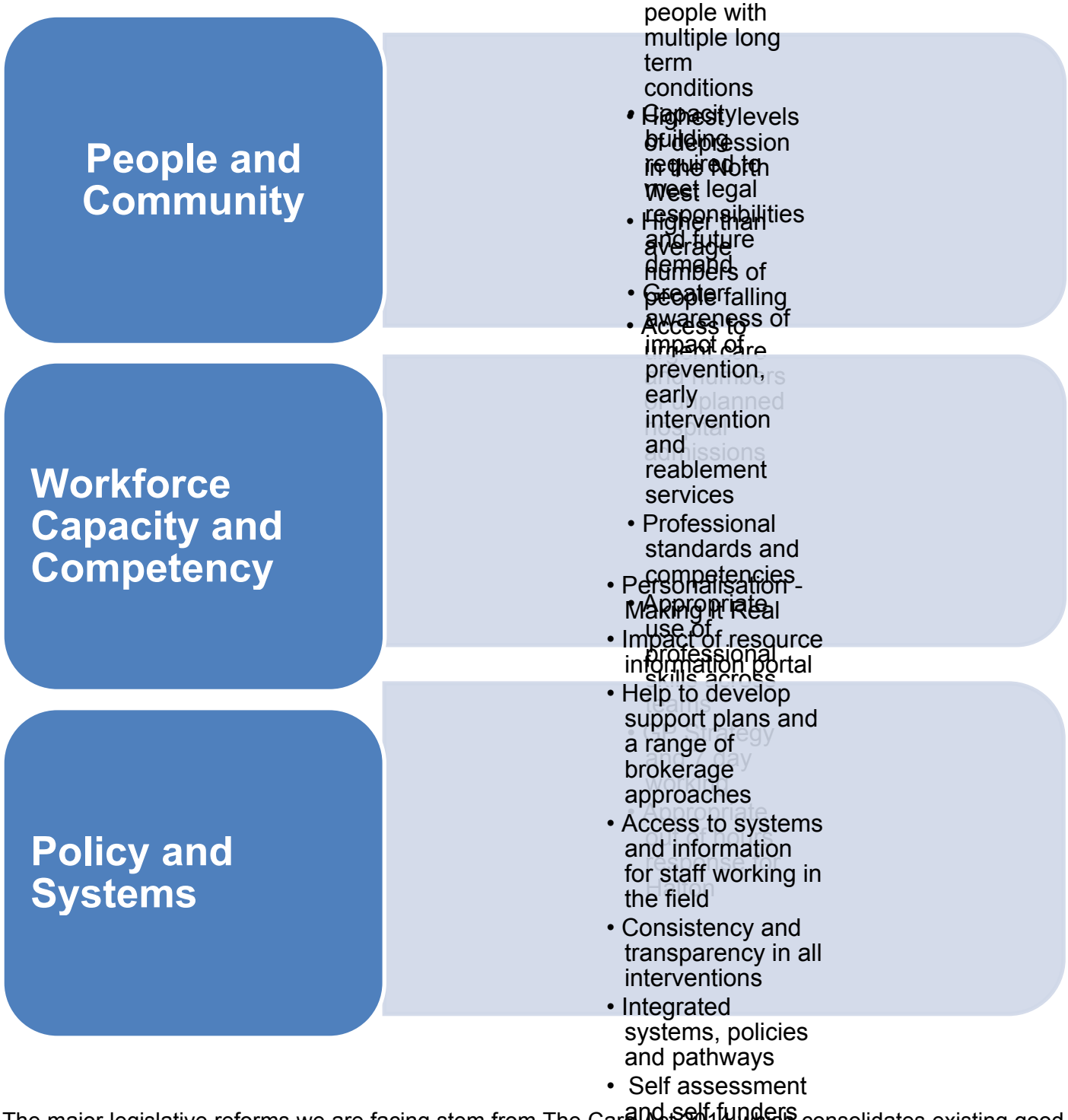
The Making a Difference Model

This model will enable us to construct a working model of a professional, multi-disciplinary care management service that is fit for purpose, able to absorb increased future demand and offer better co-ordinated and integrated interventions.



What are our drivers?

We have already identified the need to respond to increasing demand and financial pressures arising from demographic and legislative changes. Local issues to be addressed are summarised below.



The major legislative reforms we are facing stem from The Care Act 2014 which consolidates existing good practice and policy into statute. There is renewed focus on responsibilities, duties and processes which:

- Reduce demand for formal services
- Adopt preventative and person centred approaches

- Ensure vulnerable adults are safeguarded
- Encourage citizen led commissioning and service delivery
- Supported by skilled social workers with a broader remit to include community development, safeguarding , prevention, early intervention and interpersonal support

Further more detailed explanation of the implications of the Act and other national drivers can be found in the accompanying evidence paper.

Health and Social Care Integration

National policy is directing us to work collaboratively with health partners. The College of Social Work and the Royal College of General Practitioners jointly affirmed partnership between social workers and general practitioners as critical to the development of person centred care and in addressing the looming financial crisis facing both the NHS and social care.[3]

Both Colleges acknowledge that successful partnerships do not happen by chance and differences in funding, professional cultures, training, governance and accountabilities, all need to be recognised, understood and worked through to ensure that the right partnerships are in place and do the right things where it matters, in practice. The report demonstrates through evidence and case studies how GP's and

[3] GPs and Social Workers: Partners for Better Care Delivering health and social care integration together October 2013

Social Workers can work together as local leaders to make integration in local communities a practical reality.

In Halton we are acutely aware of working within scarce resources and that over the next five years Halton Borough Council, NHS Halton CCG (CCG) and our partners face significant financial challenges which are driving us to do things differently and transform all aspects of health, social care and wellbeing. The Better Care Fund (BCF) effective from April 2015 has been established to be shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more collaborative approaches and integrated services for older and disabled people. In Halton we have embraced this through a joint working (Section 75) agreement and pooled budget arrangement for Complex Care. We recognise that by overcoming the boundaries between health and social care and jointly designing and delivering services with NHS Halton CCG we can improve outcomes and quality of life for individuals, carers and the wider community.

GP Strategy

In response to 'A Call to Action'[4] and to inform the challenges facing general practice and provide a sustainable future for membership practices, NHS Halton CCG has begun working with its member practices and key stakeholders to undertake a review of its services and their sustainability. To meet the increasing challenges faced, there is a need to reshape the range of services offered within general Practice, thereby enhancing the sustainability of practices whilst preserving the local roots of general practice that are valued highly by patients.

A strategy for General Practice services in Halton 2014/15-2019/20 describes how NHS Halton CCG is working with its partners and the public to develop and commission standardised high quality General Practice that balance the benefits of organisational scale with preservation of the local nature of general practice.

The following ten principles are emerging and considered fundamental to the future design, configuration, commissioning and delivery of local General Practice:

1. Commissioning and delivering consistent high quality care for every local resident;
2. Reducing unwarranted variation;
3. Strong local clinical leadership;
4. Embracing the opportunity to offer services at scale, delivered locally to individual people;
5. High levels of population and patient engagement;
6. Commissioning and contracting for outcomes, not inputs or processes;
7. Services working in greater collaboration in the community as multi-disciplinary teams of care professionals working together;
8. Improving access to all services and better coordination of care pathways;
9. Focus on prevention;

[4] http://www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf

10. The CCG playing a greater role in contracting services through co-commissioning General Practice with NHS England.

To achieve this, it is proposed that a new model is established with community services centred on people, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together, in a much more integrated way with Community, Mental Health and Wellbeing, Social Care, Urgent Care and Pharmacy services all wrapped around local delivery points.

It is proposed that the model will see services and teams aligned to community 'hubs'. Each 'hub' will determine how to best configure itself to meet the needs of its local population. This includes service delivery, governance, population engagement, performance management and strategic planning. It is recognised that in certain circumstances, it will be advantageous to continue to commission and deliver services across the whole borough of Halton, however, this will be for each 'hub' to determine and influence.

Principles of Integration

This strategy and the accompanying action plan considers the interconnections of the proposed model for GP practice and the implications of this for adult social care in terms of the required skills mix.

The purpose of integrated working is to improve the quality of care and support by keeping the individual, not the organisation or particular profession, as the driving force behind care and support. At a strategic level, integration creates a more seamless experience for individuals.

To support the cultural shift in practice that enables workers to understand each other's roles and contributions, and to build support networks around individuals, Skills for Care have developed 6 principles for integrated care and support which been used to inform our strategic planning. Further detail can be found in the Evidence Paper.

Other influences

The Local Government Association "Standards for employers of Social Workers in England" and The College of Social Work Professional Capabilities Framework are additional important influences that we must embrace and use to sustain high quality outcomes for service users, their families, carers and the wider community.

Consultation

In developing this strategy the views of staff working in the Assessment and Care Management Division, as well as partners across the health and social care sector have been sought and influenced the actions for developing care management services over the next five years. It is important to stress that whilst this strategy covers a five year period it is dynamic and responsive to further national and local policy changes.

Halton Assessment and Care Management Services

This service offers an 'Initial Assessment Team' (IAT), a dedicated multi-disciplinary duty function team, responsible for all referral, screening, signposting and initial assessments. In addition, there are two Operational teams dealing with complex work, (one in Widnes and one in Runcorn) and a Learning Disability Nursing Team. The teams are now integrated with Social workers, Occupational therapists, Learning Disability Nurses and Continuing Health Care Nurses with additional support from the Integrated Safeguarding Unit. The Learning Disability Nursing Team works across the Borough with staff from the Complex Care Teams and the Integrated Safeguarding Unit. Additional developments could look at closer working with District nurses

This model of service delivery was developed as there was and remains an increasing requirement for joint working between health and social care to be facilitated to ensure the population's health inequalities and needs are being addressed. Growing research, data and evidence supports the establishment of multi-professional health and social care teams to address the needs of high risk people within the community.

The aims of the model are:

- To meet the needs of as many people as possible at first contact with the Initial Assessment Team (IAT) which provides universal advice, guidance and acts as a single point of access to all adults with adult social care needs;
- To facilitate people to undertake assessments and support plans with limited social services input;
- To provide a focus throughout all processes on prevention and re-enablement, to promote independence;
- To offer locality based care management services aligned with GP Practices and wherever possible and appropriate, co-located with other professionals;
- To create generic teams covering defined localities helping all adults in the local community according to demand.

As outlined earlier, demographic changes and new legal duties will increase demand for assessments and reviews. Current capacity within the service is summarised in Part Four of the evidence paper. Modelling based on Local Government Association guidance suggests that Halton will need additional care management requirements. Further capacity will be needed if all carers' assessments are conducted in-house rather than through the Carers Centre.

Although community mental health assessment and care management services remain as part of the 5 Boroughs Partnership NHS Foundation Trust, many aspects of this strategy and action plan including continued professional development and workforce planning are inclusive of this service area.

Community Learning Disability Nursing Team

The Learning Disability Nursing Team support Halton individuals who are age 18+ or in transition to adult services, reside in or out of borough, in their own homes, residential or nursing homes. The team offer advice and support to individuals to promote independence and a healthy lifestyle. .Advice information and guidance is given to care management staff which also includes joint working to complete comprehensive assessments of needs.

The team carries out a variety of specialist assessments and provides training to agencies, staff and individuals. The nursing team have link workers within all 19 GP practices in Halton to support reasonable adjustments and uptake of the Learning Disability annual health checks. The team support individuals with learning disabilities and mental Health issues to remain at home during episode of deterioration in their mental health. Should an admission to an inpatient setting be necessary this is supported with discharge planning.

Continuing Healthcare Nurses

Four Continuing Health Care (CHC) nursing posts are integrated with the Complex Care Teams. The main aim of this integration is to ensure that the resources available to both Health and Social Care are effectively used in the delivery of personalised, responsive and holistic care to those who are most in need.

This integration has deepened working relationships across health and social care and the CHC staff are taking on more responsibilities in relation to the care management and commissioning of cases with significantly more involvement in the most complex cases than previously.

Workplace Champions

Our experience of the success of the End of Life Care “Key Champion” role suggests that this is an exemplary approach that may be worth extending to promote best practice and develop staff knowledge and expertise in other areas. It can also be used to effect and embed cultural change within working practice. The “key champion role” is an identified social worker holding a generic social work post within Complex Care who has specialised their knowledge and skills with a dedicated interest in the nominated area. Activity and dissemination of knowledge will typically include:

- Keeping up to date with and share best practice across social care, care providers, District Nurses, nationally and regionally
- Acting in a link role between care providers and care management staff
- Identifying areas where care managers feel they have training needs

Adult Safeguarding

Adult Safeguarding is an integral part of assessment and care management services supported by the Integrated Adult Safeguarding Unit which works across health and social care. The Unit assists and advises care managers on safeguarding referrals for adults aged 18 plus who may live in the community,

receive domiciliary care in their own homes or reside in a residential or nursing home. The Unit will support investigation of complex safeguarding referrals for any domiciliary or residential providers in the Borough and providers outside of the Borough, where appropriate. The Unit also holds the coordinating role for dealing with Deprivation of Liberty Safeguarding requests to the authority and undertaking Best Interest Assessments both in and out of Borough.

The Unit contributes to the safeguarding of adults across the Borough by:

- Providing support to the Halton Safeguarding Adults Board and its sub groups
- Ensuring key linkages with the Domestic Violence Coordinator and services
- Ensuring key linkages with Children's safeguarding
- Supporting the development of effective Interagency Safeguarding Adults Policies and Procedures
- Lead on prevention by responding to those cases that do not meet the threshold for a safeguarding investigation
- Supporting the local authority and its partner agencies to:
  - Fully embed safeguarding adults policies and procedures and thus deliver consistent and robust outcomes for vulnerable adults
  - Monitoring the effectiveness of the delivery of their safeguarding adults activity
  - Providing advice and support regarding individual safeguarding adults cases

The Unit is an example of best practice and provides effective safeguarding for adults. Through its continued involvement with the Making Safeguarding Personal project, the care management service will continue to move towards a more person centred approach to safeguarding, with the focus being on the outcomes the adult at risk would like to achieve following the safeguarding process and to then assess to what extent those outcomes have been achieved.

Workforce Culture and Development

Cultures are complex and difficult to define but in its simplest terms a work place culture has been described as: *"The way we do things around here*" (Bower 1966). As a basis we need to have in place a culture that focuses on greater collaboration between workers, emphasis on partnership working and problem solving through collective responses and be a friendly and caring place to work.

> "*A positive workplace culture is essential in adult social care to provide high quality flexible care and support it not only addresses productivity and the health and wellbeing of staff, but also look to improve outcomes for those who need care and support services".* (Sharon Alllen, CEO Skills for Care).

Where services are integrated ADASS believes that positive work place cultures can support the work force to develop a common vision and shared values. Such cultures also develop trusting and collaborative work practices. Positive workplace cultures bring the following benefits:

- Improved quality
- Stable skilled workforce reduces costs
- Greater resilience in times of change
- Improved reputation and market share

The Hedgehog Concept

In relation to developing a positive work place culture, Skills for Care have developed a "Culture for care" toolkit which will be used to form part of our action plan. There are a number of tasks and group exercises to help us identify, giving a flavour of this is what is described as our organisation's 'hedgehog', which entails, discovering what it is that we do better than anything else. The 'hedgehog' concept uses the parable of the clever, devious fox and the simple hedgehog. The fox keeps coming up with new ideas to eat the hedgehog, but the hedgehog handily defeats him by doing his one trick: rolling into a thorny ball. It is now a concept used widely as an organisational development tool. The hedgehog concept highlights the importance of:

- organisations knowing what they're good at
- keeping strategies simple but effective
- pursuing these strategies with drive and determination.

Most people work best when they believe in and are committed to the service they are providing, so it is important to identify what these things are.

What do we do well? (And equally important—what we do not do well)

In order to build on good practice we can support future planning by identifying our workplace 'hedgehog', to identify answers to the following questions from the circles below:

What do we, the workforce, care passionately about?

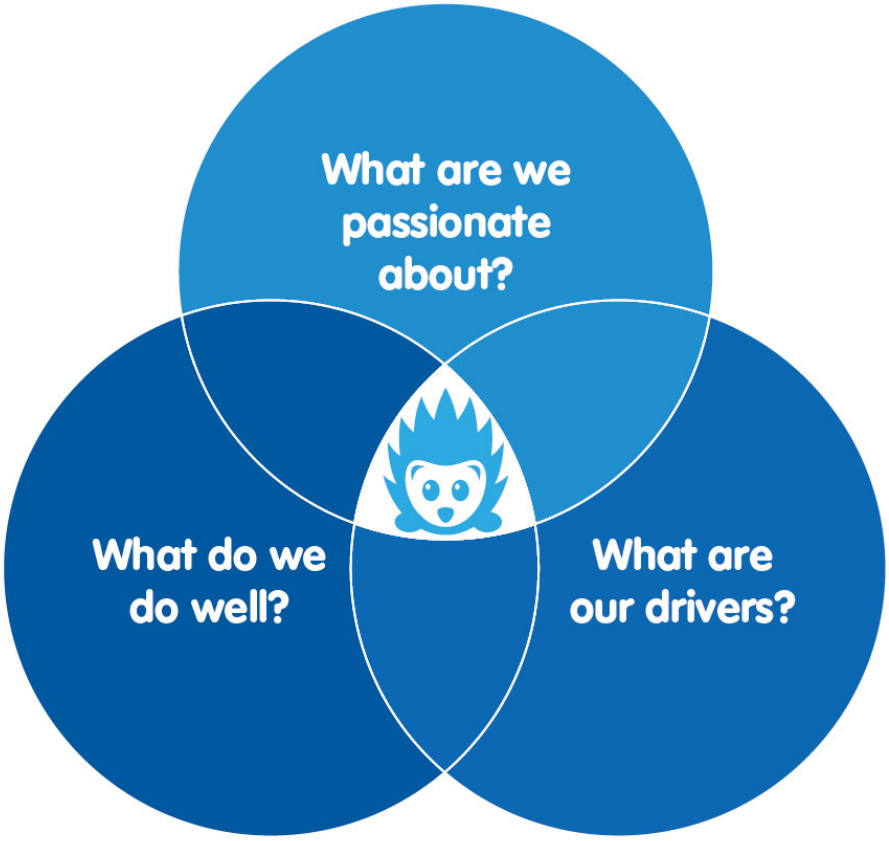
This may be small scale or very focused, for example it could relate to how we support people to use assisted living technology, how we ensure mealtimes are a positive and dignified experience for all, or maybe you have a great induction for new staff.

What are our drivers? How do we measure success?

We might include factors such as reputation, workforce health and wellbeing, or customer satisfaction.

Our Hedgehog

(devised by Jim Collins, in his book "Good to Great")



Workforce integration[5] (Skills for care)

People with care and support needs want care provided in ways that make sense to them, that reflects their lives, their needs and their wishes. This is best achieved through integrated working, with practitioners working together to support individuals, their families and carers. Skills for Care have developed six principles to support practitioners, managers and organisations to think through what is meant by integration, and in particular, how workforce development can contribute to its introduction and implementation and sustainability.

In summary the principles relate to implementing successful integrated working and we will use these to shape our approach to developing our care management service:

> **Principle 1**: Successful workforce integration focuses on better outcomes for people with care and support needs.
>
> **Principle 2:** Workforce integration involves the whole system.
>
> **Principle 3:** To achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities.
>
> **Principle 4:** A confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active and engaged communities is at the heart of workforce integration.
>
> **Principle 5**: Process matters—it gives messages, creates opportunities, and demonstrates the way in which the workforce is valued.
>
> **Principle 6:** Successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies give each of these attention, creating the circumstances in which all can thrive.

A fuller explanation of the questions managers and staff need to explore and the principles of integration can be found in the evidence paper.

Workforce Capacity Planning

To help us prepare to meet the increase in demand for assessments arising from demographic changes and new responsibilities under the Care Act we are working with Skills for Care to help us plan and think about the care management and social worker workforce. Areas being explored include how social workers are deployed, how many will be needed (for the expected increase in assessments) and how assessments are undertaken. This will help us to work out whether or not we have the right mix and numbers of social worker and community care workers with the right skills and knowledge to implement care and support reform. Identification of workforce capacity gaps or surpluses will enable us to begin early transition planning. An Adult Social Care Workload Management system is being developed. A caseload weighting tool is under development that will be aligned to the supervision policy and ties to the professional capability Framework.

[5] http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-integration/principles-of-workforce-integration.pdf

Further detail on the Skills for Care Workforce Model can be found in the accompanying evidence paper.

Workforce Development

The Local Government Association (LGA) has published "Standards for employers of Social Workers in England" to sustain high quality outcomes for service users their families and carers. The eight standards are grouped into three focal areas within the diagram below:

1. **Enabling employers to provide a well led professional environment**
2. **Enabling social work professionals to maintain their professionalism**
3. **Enabling social work professionals to practice more effectively.**

The standards for employers set out shared core expectations of employers which will enable social workers in all employment settings to work effectively. These expectations are being incorporated within self-regulation and improvement frameworks for public services and used by service regulators (Ofsted, CQC). This document sets out what social workers should expect from their employers and we will use these standards to assess our performance and identify areas needing more focus to ensure we retain our professional service and aid retention and recruitment of our workforce.

Social Work Leadership

Our proposed approach regarding leadership is to follow up on discussions with Skills for Care to undertake work which utilises the 'Social work leadership toolkit'.

The refreshed toolkit has been influenced by sector feedback and now includes:

- A 360 degree development tool for social work managers mapped to the Professional Capabilities Framework.
- References to the relevant social work professional and leadership frameworks, including the College of Social Work's Professional Capabilities Framework (PCF).
- New online resources to support social work leaders develop confidence and capability across the nine PCF domains, helping them to be effective in existing and emerging roles and settings.

The new resources include:

1. Leading an ethical social work business
2. Leading an improving service
3. Leading in a professional context
4. Leading with less
5. Scenarios to depict how these resources can be used by different organisations

This 'Social work leadership toolkit' provides tools and resources to support the development of social workers across the experienced, advanced and strategic levels of the PCF. Aspiring managers and leaders, front line managers, advanced social work practitioners and other social workers at a strategic level can be supported by this toolkit. It will also be useful for non-social work professionals who manage or are accountable for the social workers within their service. Further explanation and a link to the toolkit can be found in the evidence paper.

Care Management Professionals

The College of Social Work Professional Capabilities Framework (PCF) sets out the expectations of social workers themselves and is intrinsic to the implementation of the Standards for Employers. The PCF has been developed to help social workers be supported to do the best job they can at all stages of their profession. The evidence paper contains more description of the PCF.

In Halton we are committed to supporting and encouraging staff to continue their professional development and progression. We will look at the current structure of care management professionals within Communities Directorate and develop a concise progression policy aimed at recognising National frameworks and standards for Social Workers and Occupational Therapists. Training requirements regarding experienced social workers are likely to identify the necessity for safeguarding, mental capacity, best interest assessor and deprivation of liberty training as mandatory. Experienced social workers as part of their career progression will undertake supervision of less experienced staff.

There will also be Action Learning Sets for Social Workers and Occupational Therapists to share and promote good practice and support problem solving.

Occupational Therapy

We will be developing a specific Professional Capability Framework for Occupational Therapists based on the College of Occupational Therapists (COT) guidance[6] as a starting point. It states that, Occupational Therapists are living and working in a time when service-user needs are paramount. Drivers are focused towards continuing professional development (CPD) and lifelong learning (LLL) to ensure a competent and capable workforce that can plan and carry out evidence-based interventions. The COT Strategic vision and action plan for lifelong learning (2004) stated a commitment to support a culture of lifelong learning as being a continuum within academic, work and social environments. The plan is informed by the need for diversity and inclusivity and a culture where the achievement of learning is valued, and where creativity and flexibility enables and facilitates transformational learning.

The Post qualifying framework (PQF) has been developed as a means by which occupational therapists can be guided to meet the evolving needs of their professional roles. The framework lists statements that identify capabilities expected to be demonstrated for all levels of occupational therapists within practice, management, education and research. Any learning opportunity taken can be mapped against these statements in order to consider relevance to professional and organisational needs. In addition, the framework will help to determine learning needs applicable to the role development aspirations of the therapist, helping him/her to make plans and engage in development opportunities that could be perceived as being relevant to the chosen role. Issues of preceptorship, supervision, appraisal and personal development planning have been closely linked to ongoing professional development at all stages; this enables the integration of professional, career and workforce development issues. The PQF has been developed to support and meet the learning needs of all members wherever they work.

The Role of the Social Worker in Adult Mental Health Services

The College of Social Work[7] states that Social workers have a crucial part to play in improving mental health services and mental health outcomes for citizens. They bring a distinctive social and rights-based perspective to their work. Their advanced relationship-based skills, and their focus on personalisation and recovery, can support people to make positive, self-directed change. Social workers are trained to work in partnership with people using services, their families and carers, to optimise involvement and collaborative solutions. Social workers also manage some of the most challenging and complex risks for individuals and society, and take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the rights of different parties. This includes, but is not limited to, their vital role as the core of the Approved Mental Health Professional (AMHP) workforce. Yet the role and priorities of social workers in mental health in recent years have often not been well defined. Their status and authority within multidisciplinary settings has sometimes been undermined, and opportunities to realise professional

[6] The Post Qualifying Framework: A resource for occupational therapists (COT 2004)

[7] The voice of Social Work in England

potential have been underdeveloped. The question now is: How can social work play an even greater part in improving adult mental health services and achieve better service user, family and community outcomes?

This strategy will need to recognise, The College of Social Work (TCSW) high ambition for the future impact of social work within mental health and the proposed five key areas of practice that should frame the deployment and development of social workers in mental health as follows:

1. Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority.
2. Promoting recovery and social inclusion with individuals and families.
3. Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.
4. Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship.
5. Leading the Approved Mental Health Professional workforce.

These areas of practice should shape role descriptions, continuing professional development (CPD) opportunities and curricula, and social work leadership in all adult mental health work contexts. The Professional Capabilities Framework (PCF) should be used to guide the development of increasingly effective practice, in breadth and depth.

Non-Registered Social Work Staff

Within our Workforce Plan, there will be development and particular focus upon the role of the non-registered social worker officer in the future, linking to national and regional developments towards a "Qualification Credit Framework." Skills for Care are developing a Level 4 Diploma in Social Care and confirm that the Learning and Development modules are nearly finalised, but awaiting final confirmation of the Regulations and Guidance. Skills for Care have some initial proposals and there may be connections to national workforce development but the North West region are working collaboratively to prioritise this, and ensure all plans are Care Act compliant. Early agreement has identified jointly procuring the production of materials for staff once the Skills for Care modules are available, e.g. printing costs. The role of 'trusted assessor' in partnership with the NHS will also be developed.

Action Learning Sets

The Assessed and Supported Year of Employment (ASYE) along with other reforms following the Social Work Reform Board has, among many other things, thrown renewed focus on developing reflective and analytical practice. The emphasis is on needing to support our staff through 'critically reflective action learning' this can contribute to their professional activity, thereby improving the outcomes for people who need care and support and their professional social work staff. Action learning facilitation is the proposed approach to take with staff, towards individual and organisational practice development, which takes the

challenges of both professional work and organisational change as the vehicles for learning. Working in small groups, people tackle important or problems and learn from their attempts to change things. We are working with Skills for Care to promote, Action Learning facilitation as a useful support package for NQSWs undertaking the ASYE and experienced social workers.

Implementing our priorities

National policy for Adult Social Care places emphasis on Prevent, Reduce, Delay the need for formal care. This is underpinned by integrated approaches which put the person at the centre and focus on context, possibilities and outcomes rather than processes and tasks. In line with national policy, the Council and NHS Halton CCG are working collaboratively to move towards greater integration of services to improve quality of care and ensure effective use of finite resources.

We believe that our priorities can be achieved by:

- **Promoting prevention and early intervention to reduce risk of more costly interventions**
- **Integrated approaches and MDT working to ensure responses are appropriate**
- **Strong leadership and professional accountability**
- **Supporting and promoting good practice and continued professional development;**
- **Having the right mix of skills to meet current and future demand**
- **Adopting 'strengths based' approaches in assessments**

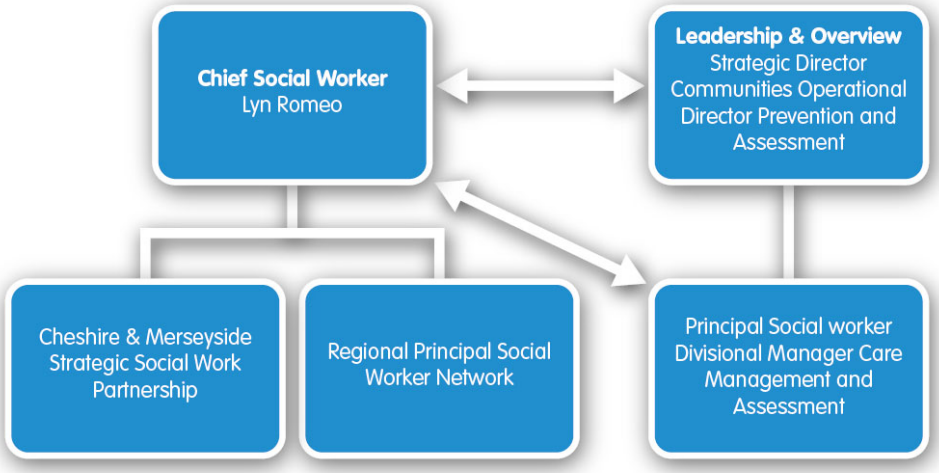
Halton's Professional Capabilities Framework

The Department of Health has set out the social workers vital role in personalising care and support and has established the role of Chief Social Worker (CSW) for an adult who works collaboratively with the Children's counterpart to provide leadership in the profession to drive forward the improvement and reform programme. There is now an expectation that local authorities will appoint a Principal Social Worker (PSW) to use their strategic influence across organisations and develop partnership arrangements. This role will also be the professional lead to ensure accountability and maintain quality across the profession. The Chief Social Worker will lead the national network of PSW's.

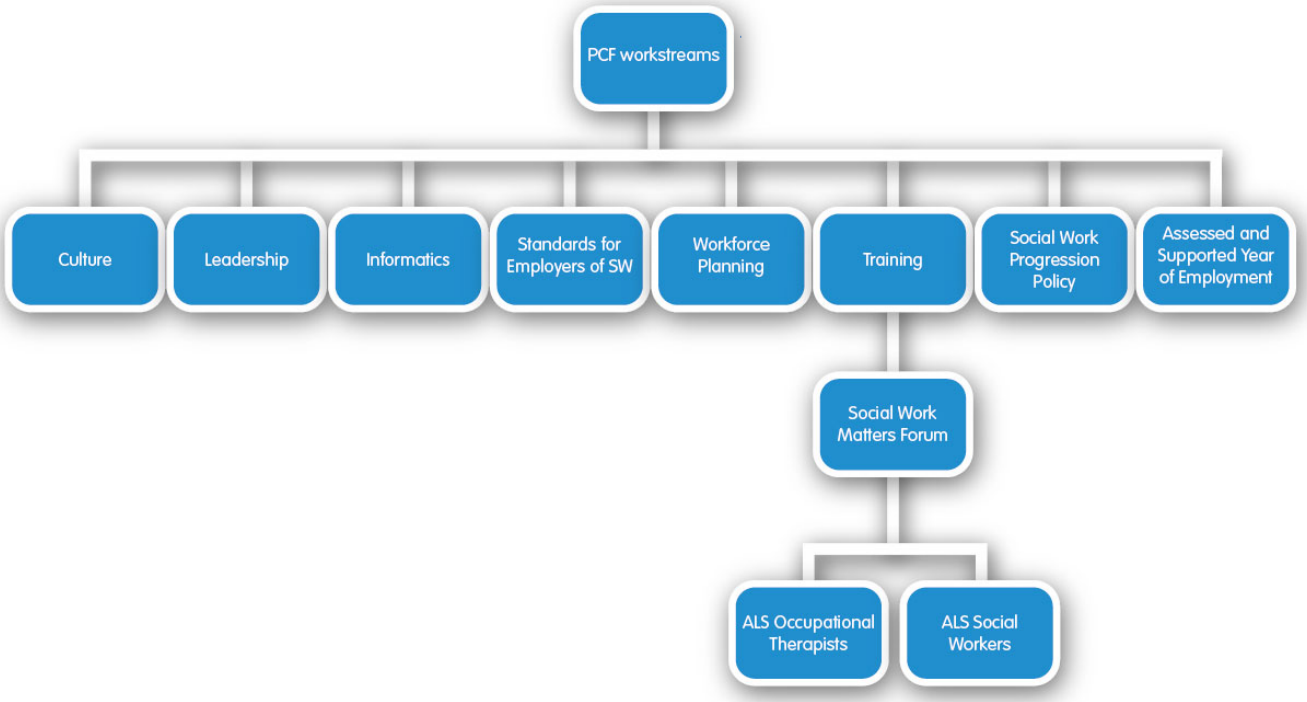
In Halton, the role of PSW is held by the Divisional Manager Assessment and Care Management Services. To support this role the "Professional Capabilities Forum" has been established which provides strategic leadership and overview as well as progressing the following areas of work to support delivery of this care management strategy:-

- Culture
- Leadership
- Informatics
- Standards for Employers of Social Workers
- Social Work Progression Policy
- Training requirements
- Workforce Planning
- Assessed and Supported Year in Employment (AYSE)

Professional Capabilites – Leadership and Overview



Professional Capabilites Forum – Workstreams



This Professional Capabilities Forum chaired by the Principal Social Worker will take responsibility for delivering our action plan through the task and finish groups. The Forum will report on progress and any blockages to the Professional Leadership (Strategic Director and Operational Director) who will keep an overview.

This forum will ensure that Social Workers are able to meet the expectations of them and continue their professional development for progression through the different levels of the National Performance Capability Framework.

A Strengths Based approach

There are increasing budgetary pressures across the health and social care system nationally accompanied by increased demands for services due to changing demographics. The risk for care management in focusing on Fair Access to Care, although highly relevant, potentially leads to a practice where assessment and eligibility is set up to focus exclusively on eligible needs and how services alone can meet those needs, this is known as a 'deficit approach'.

Instead of looking only for an individual's problems, vulnerabilities and at what he or she cannot do, the care management service in line with the Care Act will focus upon need and take a strengths-based approach looking first for what individuals and those close to them can do and at what they have the potential to do with a little help. The strength based approach has two key objectives:

1. Effective social care intervention which leaves an individual better informed, connected and more confident.
2. Every intervention supports the individual's unpaid relationships and informal networks of support and avoids undermining key relationships or isolating the individual from their natural support networks.

To embed a strengths based approach, we need the route towards support to start with an easy-access conversation with someone whose job is to inform, empower and connect people, with services as the last not first resort. This kind of support to plan is so vital to this transformation it should be embedded in the self-directed support process refocusing emphasis on existing information, advice, navigation, advocacy and brokerage providers. This creates a shared purpose between individuals and communities: to help people to help themselves and each other and to reduce the risk of increasing dependence.

This strategy supports the approach that, instead of undermining the resilience of people by only seeking to understand their eligibility and service entitlements, we should start by understanding what's important to them, what they want to do and the strength and nature of their social networks. The key question should then be '*how can these strengths be best supported"*? That's when personal budgets and a wider range of services should come into play.

Co-production

Co-production is potentially a transformative way of thinking about power, resources, partnerships, risks and outcomes; a meeting of minds coming together to find shared solutions. In practice, co-production involves people who use services being consulted, included and working together from the start to the end of any project that affects them. When co-production works best, people who use services and carers are valued by organisations as equal partners, can share power and have influence over decisions made.

Co-production is not a new concept in Halton; it has been around for a number of years and the term is often used at an 'individual' level to refer to the personalised and self-directed support developed in conjunction with health and social care professionals and funded through direct payments or individual budgets leading to:

> …..everyone having choice and control over the shape of their support, along with a greater emphasis on prevention and early intervention.

There is a distinction to be made between this individual co-production (personalisation) and collective co-production where people work together on community issues.

Coproduction offers a route away from a passive consumerist model of personalisation towards one of active citizenship, equality, and mutual support. By transforming the relationship between professionals and people and effectively using the assets that are abundant within the Halton community we can improve people's quality of life and wellbeing.

How will we know if we have been successful?

The Overarching Outcome for this Strategy is:

Seamless services across health and social care which are responsive to need.

This will be achieved by focussing efforts on delivering against the five priorities to achieve the following outcomes:

- **Health and social care practitioners work across boundaries offering high quality personalised care management support**
- **A sustainable and innovative assessment and care management service**
- **Individuals and families share power with professionals and influence decision making**
- **Care managers have career progression and are able to maintain their proficiency**
- **Resources are identified and used to maximum benefit to achieve value for money and excellence in care and support**

It is important to ensure that the implementation of this strategy continues to deliver an effective care management service. There are a number of national audit tools and resources produced by the LGA, ADASS and Skills for Care that we can use for self-assessment to identify areas that need greater focus such as the Skills for Care Social work leadership toolkit and the:

LGA Standards for Employers of Social Workers

There are eight standards - Standard 1 covers the requirement to have a 'clear social work accountability framework' and highlights the social work 'health check' as an important tool in supporting and delivering effective social work. It is a key element of Standard1:

> "All employers should: complete, review and publish an annual **'health check' or audit** to assess whether the practice conditions and working environment of the organisation's social work workforce are safe, effective, caring, responsive and well-led"

We can also use recognised measures already being collated to monitor the benefits arising from the priority actions and the targets summarised below have been set as a measure of our success.

This strategy also supports delivery of the local Better Care Fund targets and progress in implementing the action plan will be overseen by the Better Care Board which is accountable to both the NHS Halton Clinical Commissioning Group's Governing Board and Halton Borough Council's Executive Board.

	Priority	Target to measure success	2015/16 to be agreed 2014/15 baseline
1	Health and wellbeing of individuals in our community	Emergency admissions (all ages) for acute conditions that should not usually require hospital admissions (cumulative rate per 100,000) Emergency readmissions (all ages) within 30 days of discharge from hospital (cumulative)	1794 15.5%
2	Supporting independence	Number Receiving Self-Directed Support	78%
3	Managing complex care to support individuals to remain at home	Admissions to permanent residential and nursing care age 65+per 100,000 population Admissions to permanent residential and nursing care age 18-64 per 100,000 population Adults helped to live at home per 1,000 population: Learning Disabilities Physical and sensory disabilities Mental health	636.6 15.2 4.00 8.00 3.50
4	Maintain high quality, personalised care management services	Adults and older clients receiving a statement of their needs and how they will be met Adults and older clients receiving a review as % of those receiving services	97% 80%
5	Integrated working and effective use of resources	Reduction in number of people out of Borough Adults and older clients receiving a review as % of those receiving a service	32 2013/14 baseline 80%

PRIORITY 1: HEALTH AND WELLBEING OF INDIVIDUALS IN OUR COMMUNITY

Emergency admissions (all ages) for acute conditions that should not usually require hospital admission
Baseline 2014/15 (rate per 100,000) 1794

Emergency readmissions (all ages) within 30 days of discharge from hospital
Baseline 2014/15 15.5%

Why is this a priority?

In Halton we have seen recent improvements in some health conditions and we wish to build on this success to deliver better health outcomes and health gains both mental and physical.

What do we want to achieve?

We want people with care and support needs to have:

- Greater awareness of benefits of good health
- Improved mental health and wellbeing
- Improved physical health
- Better self-management of long term conditions (LTC)
- Reduced need for unplanned hospital admissions
- Improved access to information and advice to self-manage their condition, keep healthy, active and well

	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
1a	**Make Every Contact Count:** Identify opportunities to incorporate health promotion into care management interventions Develop skills, knowledge and confidence of care managers to converse with service users and encourage active self-management of LTC including mental ill health	Improved self-reported wellbeing Slow progression of conditions Avoid unplanned hospital admissions Improved self-reported wellbeing	April 2016 Ongoing	• Health Improvement team input • Training • Support from health professionals	Divisional Manager Assessment and Care Management With Public Health
1b	**Care Act:** Include the Wellbeing Principle in the training programme for staff	Improved feeling of wellbeing among those with care and support needs.	April 2016	• Training	Professional Capabilities Forum

PRIORITY 2: SUPPORTING INDEPENDENCE

Number Receiving Self-Directed Support
Baseline 2014/15 78%

Why is this priority?

Adults of all ages with care and support needs aspire to participate in every aspect of life – home and family, community life, education, training, employment and volunteering. They want the opportunity to participate fully in society and be valued for their contribution.

Having choice and control in their lives is key to people improving their health, maintaining independence and relationships within families and retaining lifestyles.

Halton is committed to empowering people to take control of the decisions made regarding their needs and avoid or move away from dependency on formal care.

What do we want to achieve?

People with care and support needs:

- Have choice and control over their lives
- improve or maintain their mental wellbeing
- are active members of their community
- are financially stable and able to access benefit advice and support

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
2a	Implement the Making It Real action plan to support personalisation and give people control	Co-ordinated personalised health and social care People with support needs in control of their lives	Ongoing	These are identified in the Making it Real action plan	Operational Director Prevention and Assessment
2b	Develop a self-assessment process that self-funders can access	Support approaches to self-assessment Minimise demand for assessments	April 2106	• Staff time • ICT Support	Divisional Manager Assessment and Care Management
2c	Review impact of preventative services and early interventions on demand for assessments and build on successes to further minimise future demand	Maximise independence Minimise demand for care managers assessments	December 2015	• Staff time • Training	Divisional Manager Assessment and Care Management
2c	Promote the benefits to public and professionals of strengths based approaches to assessment of need.	Effective interventions which support a person's informal networks	Ongoing	• Training • Forums and Making it Real events	Divisional Manager Assessment and Care Management
2e	Review adequacy of available information and advice on meeting and preventing need for those not eligible for support to meet new duties of Care Act.	Effective signposting to avoid escalation of need Individuals in control of identifying their low level needs	July 2015	• ICT systems • Publications • Voluntary Sector support	Care Act Implementation Group

PRIORITY 3: MANAGING COMPLEX CARE TO SUPPORT INDIVIDUALS TO REMAIN AT HOME

Admissions to permanent residential and nursing care age 65+ per 100,000 population Baseline 2014/15 636.6

Admissions to permanent residential and nursing care age 18-64 per 100,000 population Baseline 2014/15 15.2

Adults helped to live at home per 1,000 population: Baseline 2014/15 - Learning Disabilities 4.00, Physical and Sensory disabilities 8.00, Mental Health 3.50

Why is this priority?

Increases in life expectancy means people are living longer with disabilities and multiple long term conditions. Evidence shows that those with complex physical and mental health and care needs are at high risk of unplanned admission to hospital. This is distressing and disrupting for them and their families. By improving community based support for those with complex physical health needs these unplanned admissions can be reduced and admission to long term care avoided.

What do we want to achieve?

- Maximise independence and good quality of life
- Younger adults working towards achieving their aspirations
- Equal access to Health Improvement and Health Promotion initiatives
- Access to the right support to avoid unplanned hospital admissions
- Those with complex and on-going care needs retain control over how they are cared for and how they approach end of life
- Those with care and support needs feel safe, respected and maintain their dignity
- Carers are supported to maintain their caring role

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
3a	Explore NMDS and local intelligence e.g. User feedback surveys to benchmark local performance and identify any issues to be addressed.	Effective and responsive care management delivery to reduce unplanned hospital admissions and readmissions	April 2016	• Staff time	Divisional Manager Assessment and Care Management
3b	Continue to access advice and guidance available from the LDNT to further develop staff knowledge across care managers.	Informed and joint assessments of need	Ongoing	• Staff time	Divisional Manager Assessment and Care Management
3c	Explore opportunities to create further Workplace Champions to promote best practice and develop staff knowledge across integrated teams	Best practice remains current across multi - professionals	April 2016	• Staff time • Network links	Professional Capabilities Forum
3d	Ensure any changes in working practice continue to prioritise the safety of vulnerable adults	People accessing services remain safe Safeguarding referrals/Care	Ongoing	• Regular Monitoring reports across health and social care	Integrated Adult Safeguarding Unit

		Concerns are minimised			
3e	Continue to progress Making Safeguarding Personal project	Outcomes focussed approach embedded across IASU and care management	Ongoing	• Staff time	Integrated Adult Safeguarding Unit

PRIORITY4: MAINTAIN HIGH QUALITY PERSONALISED CARE MANAGEMENT SERVICES

Adults and older clients receiving a statement of their needs and how they will be met
Baseline 2014/15 97%

Adults and older clients receiving a review as a percentage of those receiving services
Baseline 2014/15 80%

Why is this a priority?

Personalisation and integration present a real opportunity to:

- **Reposition social work and social workers at the heart of integrated, personalised health and social care**
- **Refocus on social work interventions that make a difference to the lives of the most vulnerable people in society including promoting recovery for those with mental illness**
- **Develop innovative, person-centred approaches in social work practice, using evidence of what works**
  (Chief Social Worker)

Traditional models of support begin by exploring eligibility and entitlement to services which can undermine the resilience of people. By adopting a strengths based approach people who use services, their families and the wider community contribute their in-depth knowledge of their requirements and how best to meet them to assist in the design, commissioning and provision of support and services rather than being passive recipients of services.

What do we want to achieve?

- Strong leadership of the assessment and care management service
- social care professionals and people who use services work in equal partnerships towards shared goals;
- people who use services and carers having an equal, more meaningful and more powerful role in services;
- people who use services and carers are involved in all aspects of a service – the planning, development and actual delivery of the service;
- power and resources are transferred from managers to people who use services and carers;

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
4a	**Leadership** Establish lines of accountability for social work delivery	Clarity in local levels of responsibility and links to regional and national networks	January 2015	• Staff time	Operational Director Prevention and Assessment
4b	**Workforce Capacity Planning** As part of the Skills for Care pilot review	People with care and support needs	September 2015	• Staff time	Divisional Manager

	essential multi-professional assessment and care management functions and determine where these are best carried out and by whom.	will have access to high quality assessment and care management interventions. Capacity to meet increases in demand for assessment including Best Interests/DOLS		• Service reconfiguration within existing resources • Possible new investment dependent on national funding	Assessment and Care Management
	Adopt a Caseload Weighting Tool appropriate to Halton to support allocations policy	Effective allocation policy and targeting of registered and approved staff	September 2015	• Staff time	Principal Managers Complex Care
	Develop performance measures to monitor caseload, referrals and unscheduled reviews	Managers will be alerted to pressures in the system	March 2016	• Staff time	Professional Capabilities Forum
	Identify the skills mix and resources required within care management to support the proposed GP hub model	Seamless services	Dependent on final GP model	Reconfiguration of existing resources	Divisional Manager Assessment and Care Management
4c	**Workforce Culture and Development** Use LGA Social work Standards Audit tool to self-assess the practice conditions and working environment of the social work workforce	Snapshot of where care management services are now and priorities for development	September 2015	• Staff time	Professional Capabilities Forum
	Participate in Skills for Care pilot to embed Integrated working into the culture of care management	Positive workplace culture with a common vision and shared values.	April 2016	• Champions for Change	Divisional Manager Assessment and Care Management
	Develop staff skills to work collaboratively with health professionals	First response is the most appropriate response	April 2016	• Training • Progression policy	Professional Capabilities Forum
4d	**Professional Capabilities** Develop	Effective and	April 2015	• Staff time	Professional

	Professional capabilities framework for OT based on COT post qualifying framework	motivated practitioners			Capabilities Forum
	Review job descriptions against TCSW PCF and OT PCF	Job descriptions reflect PCF experienced practitioner levels	April 2015	• Staff time • HR input	Divisional Manager Assessment and Care Management
	Ensure registered professional competency by identifying staff training needs and opportunities for CPD	Effective and motivated practitioners	Ongoing	• Training budget • Mentoring • Champion roles	Professional Capabilities Forum
	Develop a competency framework for non-registered staff	Retention of a quality care management service	April 2016	• Staff time	Professional Capabilities Forum
	Develop a clear progression policy which links to national professional competency standards	Professional workforce with clear career pathways	April 2016	• Staff time	Professional Capabilities Forum
	Ensure our delivery model reflects the LGA “What to expect as a Social worker?”	Retention of a quality care management service	Ongoing	• Staff time	Professional Capabilities Forum
	Develop partnerships with educational institutions to support students and practice placements	Succession planning and effective recruitment.	September 2016	• Staff time • Training • Mentoring	Professional Capabilities Forum

PRIORITY 5: INTEGRATED WORKING AND EFFECTIVE USE OF RESOURCES

Reduction in number of people out of Borough
2013/14 baseline 32

Adults and older clients receiving a review as a percentage of those receiving services
Baseline 2014/15 80%

Why is this priority?

Both the Council and Clinical Commissioning Group face significant funding reductions accompanied by increased pressures on the system arising from increased life expectancy and increased numbers of people living with multiple long term conditions. Closer integration between health and social care to deliver better, more joined up services are key to addressing these challenges and building sustainability into the system to keep people out of hospital or avoid long term care.

What do we want to achieve?

- People with complex needs enabled to remain independent in their local community
- Utilise Better Care Fund to integrate and join up pathways for those living with complex needs
- Compliance with national minimum eligibility thresholds
- Cost effective and efficient approaches to meet new legislative requirements
- Achieve value for money

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
5a	Review EDT out of hours service to determine the model to support GP 7 day working and Urgent Care Strategy	Seamless service transitions	March 2016	Staff time Redirection of existing finance and staff resources	Divisional Manager Mental Health Services and Divisional Manager Systems Resilience
5b	Work with Public Health and CCG to develop a Making Every Contact Count approach	Improved Health and Wellbeing across the Borough	March 2017	• Possible reconfiguration of existing resources	Public Health
5c	Ensure that fieldworkers have full access to systems and information to fulfil their role and avoid repeated calls	Effective interventions	March 2016	• ICT Systems	Divisional Manager Service Improvement
5d	Review assessment and support planning tools and develop alternative access to assessments for care and support.	Cost effective approaches to manage increased demand for assessments	March 2016	• Staff time • ICT Systems	Professional Capabilities Forum
5e	Ensure joint assessments of need for Learning Disabled adults and those in transition to adult services are embedded into working practices	Comprehensive assessments of needs	March 2016	• Staff time	Professional Capabilities Forum