research in practice

EVIDENCE REVIEW

A brighter social care future: Co-producing the evidence to make five key changes

More resources better used

Dartington Trust

www.researchinpractice.org.uk/social-care-future

Reducing waste and improving efficiency

What this means

The basis for many of our discussions throughout the project – sometimes explicitly, sometimes implicitly - was that there simply is not enough money for social care. Regardless of which key change group they were part of, when asked about the one thing they would like to change about social care, most members of this project said 'more money' – and freedom to use it in different ways.

In the More Resources, Better Used group, there were significant debates on this topic. Many discussions concluded that, while more resources alone would not necessarily **solve** the problems identified and experienced, it was necessary. Creative use of existing money could only go so far.

The group were also keen to highlight that people might often refer in shorthand to 'health' as one system, and 'social care' as another – but, in reality, both were fragmented, with a mix of centralised decision-making, local bodies, private sector interests and voluntary/charity sector involvement. This could cause significant fractures in the response people received from both health and social care.

Yet the group were also realistic about the current context, and one of the first things highlighted was how existing resources could be used in a more effective way. When citizens notice and experience waste and inefficiencies in the health and social care services they come into contact with, it is both frustrating and upsetting. Frustrating, because – in a world where we are told resources are limited – experiencing wasteful practice illustrates the fragmented way in which they are used. Upsetting, because – at times of difficulty – having to explain things over and over again, or to personally absorb the costs of inefficiency in time or money terms, can be especially hard to bear.

In some cases, what people value may be simple and low-cost – so **ask** them! This has the potential to prevent high-cost yet ineffective interventions. More resources might be a financial issue, but **better used** is a cultural one. The group summed up what was needed in **'Four Rs':**

- **Recognition**
  The value of social care, that it is equal in importance to health, and needs a highly skilled, empathetic workforce.
- **Reward**
  Fair pay and conditions.
- **Representation**
  The views of people who draw on social care, and of carers, should be central. People need to be represented on decision and policy-making bodies.
- **Respect**
  For people's choices, needs, and preferences, and for the significant value of unpaid care.

> "Improving efficiency can be linked at virtually every stage with devolving power, co-production, and shared decision-making. Ask people what they want and improve communication."

The research

In 2021, the National Audit Office defined efficiency as being able to spend less to achieve the same or greater outputs (or to spend the same, but achieve more) (National Audit Office, 2021). This means cutting spending, without cutting services – or 'getting more for your money'. This way of defining efficiency is different to how the word is sometimes used as a euphemism for cutting spending only, without the focus on maintaining or improving service: this is the language of 'efficiency savings' (Brien, 2022). Throughout More Resources, Better Used, when the word 'efficiency' is used, it relates to the National Audit Office definition.

Restrictive 'needs testing' is cited as a root cause of inefficiency in social care by the King's Fund (2019). This is where people are prevented from accessing social care because their needs are deemed not serious enough; it is considered inefficient, because lower-level support can help prevent people's needs from deteriorating and causing more expensive interventions later on. This is explored in more depth in the section on [connecting short term and long term]. Avoiding inefficiencies is also discussed in the sections on transitions between services, and co-production.

Person-centred practice and **personalisation** have been cited as ways to increase efficiency of resources in social care (SCIE, 2011); yet this is not a silver bullet for efficiency, particularly in light of budget cuts in adult social care. For example, personalisation needs to be carefully explained to people, with discussions regarding what it means, in practical terms, for people's lives – as some studies have found there can be confusion in the way personalisation is explained and delivered (Kendall & Cameron, 2013). There is also concern that it can be inequitable for those on lower incomes (Carey et al., 2019), who are not able to access its full potential. Personalisation doesn't mean wider work to address inequalities can be sidestepped.

Personalisation and person-centred practice focus on a person's **outcomes** - the impact that support or services have on a person's life (Glendinning et al., 2006). Outcomes-focused services aim to achieve the **aspirations, goals and priorities** that people themselves set - in contrast to more regimented services whose content and/or forms of delivery are standardised, or are determined solely or mainly by professionals who deliver them (Lewis, 2017). Taking an outcomes approach in practice involves trust – because what the individual sees as 'efficient' may not be the same as what an organisation sees as efficient care (Lewis, 2017).

The principle of 'subsidiarity' devolves decision-making and finance to the most local level, and can be a way to address different ideas about efficiency (there is more information on subsidiarity in health and social care **here**). With subsidiarity, the idea is that resources go further and decisions can be taken more quickly (**integrated care systems** in the UK have this as an underpinning principle). Evidence on integrated care systems is still in its infancy, but, already, nine out of ten leaders in integrated care systems say they work in this way (NHS Confederation, 2022a).

What you can do

If you are a senior leader: What do you understand by efficiency? Is it what is efficient for your organisation, or what is efficient for the people you serve? What do you do when there are different views on what is 'efficient'?

The principle of **'systems leadership'** is helpful when thinking about improving efficiency, and balancing different opinions of 'efficiency'. It is a way of working that – rather than focusing on individual organisational reputation or performance – looks towards achieving goals for the collective good (Miller, 2020). A good place to start with systems leadership is considering your own self-assessment – available at the end of **this briefing**.

Further information

Engage

The Local Government Association has gathered together **ten examples of innovative efficient practice in adult social care** (via its Care and Health Improvement Programme). It includes contact details for those involved in the projects and encourages people to reach out and share practice.

Listen

Think Local Act Personal has a **podcast** on personalisation in Black, Asian and ethnic minoritised communities.

What this means

Transitions between services are times when people move from one part of the system to another – for example, between child and adult services, or between health and social care. There are likely to be different policies and procedures between the two points, and sometimes different legal frameworks too. Transitions are particular pinch-points, when cracks in the system can be big enough for people to fall through. All this can come at a time of particular stress. As one group member put it:

> "For many, the first contact with social care is from a position of distress, and having to then negotiate a way through the somewhat labyrinthine system causes further distress."

The key to improved transitions is usually partnership working. This requires trust and time, sharing of vulnerabilities, and the reduction of professional defensiveness.

> "Let's take away the walls."

The research

Supported and timely transitions can make a huge positive difference in people's lives. For instance, looking at the evidence on looked after young people, research suggests that the most influential factor on improving outcomes for care experienced young people is that they are at an older age when leaving care and moving into independent living, with their transition being supported over the longer term (Lee Lough Dennell et al., 2022; Dixon et al., 2020; Stein, 2012).

Transitional safeguarding – where children's and adults' safeguarding work together with each other and the wider networks in a young person's life - similarly frames transition as a journey and not an event (Office of the Chief Social Worker et al., 2021). The group shared a positive example of transitions for young people in Wales, where the Welsh government provided a **guaranteed income to young people leaving care for two years**.

Werner et al. (2019), when looking at transitions from hospital to home for older adults, found the following important factors in determining whether the transition would be a success:

1. Recognition that the hospital-to-home transition was complex, could unfold over several months, and required substantial investment and effort. This **includes** effort from the older adult, and any informal carers.
2. Providing comprehensive information at the point of discharge, including on new routines, self-care, and any financial support the person and carers may be entitled to.
3. Discussing how a person lived their life before going into hospital, how these routines might be maintained, re-established, or changed.
4. A realistic understanding of the capacity someone has for self-care, how this may fluctuate (and, in some cases, deteriorate over time), and support to manage this.

In another study, Oyesanya et al. (2021) looked at younger patients with traumatic brain injury and how they experienced the hospital-to-home transition; similar themes were found, this study describing the process as a 'negotiation' rather than an event. However, it also noted that, from the hospital's point of view, there could be a 'no news is good news' approach - where if people did not 'bounce back' [to hospital], it was assumed that the transition was successful, without considering any other wellbeing factors.

Research into the experiences of people with learning disabilities and/or autistic people in long-stay hospitals has highlighted several barriers to transitioning into living in the community. These include seeing people as 'labels' or diagnoses rather than people, a lack of staff knowledge regarding community support options, and delays in planning and coordinating discharge (Glasby et al., 2023).

The recognition of complexity, clear information and planning, discussion of routines and a realistic understanding of people's capacity for self-care – all mentioned in the Werner et al. (2019) research as key to older people transitioning out of hospital – are, therefore, also highly relevant in these circumstances.

Because hospital discharge is a point where health and social care meet, it is a time when services need to work together. Information sharing is key; this also supports efficiency and person-centred working, as somebody does not have to constantly repeat their story (and potentially re-live their trauma). For example, **patient passports** have been used in healthcare settings, which were originally developed for people with a learning disability. The Centre for Excellence for Information Sharing (2015), when evaluating how Integrated Digital Care Records had been used in the NHS, found they supported efficiency and smoother transitions, where 'Practitioners recognise the benefits that shared access to one view of the patient/citizen care record brings, particularly for processes such as hospital discharge and in supporting integrated teams - for example, GPs, social workers and community staff working together in multi-disciplinary teams' (p.11).

A care record has been piloted in **Wirral**, which also ensured social care information was an equal part of that record. It was developed specifically to bring together data from different health and social care organisations, and to reduce the duplication of information. A similar approach has now been adopted across **Greater Manchester**, which not only brings together health and social care information, but also information from across all ten Greater Manchester boroughs.

Nevertheless, challenges interpreting the law on data sharing remain, and the Centre for Excellence for Information Sharing (2015) also found a technological solution such as a digital care record did **not** mean other aspects of partnership working – such as senior management collaboration - were any less important.

What you can do

For everyone: Supporting people with successful transitions is about collaboration and partnership. If you are in direct practice, or in a leadership role, making the mental shift into thinking that **transitions are a negotiation, or a process, rather than an event,** is vital**.**

If you are in direct practice: One key action you can take on transitions is to be clear on information sharing, and how effective and efficient this is, particularly at transition points. (There is a guide to ***Information Sharing in Social Care*** from NHS England, which you may also find useful.)

The Information Sharing Every Day project (from the NHS in Hertfordshire) has **'Seven golden rules' for information sharing:**

1. **Remember that the *Data Protection Act 2018* is not a barrier to sharing information**, but provides a framework to ensure that personal information about people is shared appropriately.
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how, and with whom, information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without, where possible, disclosing the identity of the person.
4. **Share with consent** where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. If the person (or someone else) is at risk, sharing information may be justified without consent, although it is good practice to tell the person you will be sharing information without their consent (as long as that, in itself, doesn't increase risk). You will need to base your judgement on the facts as presented.
5. **Consider safety and wellbeing**: Base your information-sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure**: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. **Keep a record of your decision** and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

You may consider how confident you feel in information-sharing practice, and speak to your supervisor for areas to work on.

If you are in senior management: Directing resources into transition points, raising awareness of successful transitions as fundamental to people's wellbeing, alongside positive partnership with senior leaders in health and social care, are all key to improving transition experiences for people.

Working with 'place-based partners', with points of action to take, is covered in detail in **this briefing** using information from Think Local Act Personal.

In terms of information-sharing, The Centre for Excellence in Information Sharing (2015) has argued that the following are key at leadership level:

- Having information sharing agreements and local protocols in place (including templates), so everyone is clear about what they can share. This also has the effect of helping to build up trust and relationships across professional boundaries.
- Building relationships at all levels – often starting with a group of committed people and working from there.
- Implementing a communication plan, setting out frequent and clear communication about information-sharing with staff, with information provided directly to people with care and support needs.
- Providing training on information-sharing and embedding this into the induction process.

Further information

Watch

An older person and a social worker **discuss care coordination** and the evidence around it, particularly thinking about improved relationships across health and social care.

This **video from SCIE** interviews young people who move from child to adult mental health services about their experiences, and features a service in Sheffield attempting to address this.

The University of Birmingham's **Why Are We Stuck In Hospital?** project has videos and top tips to support people with learning disabilities and/or autistic people with their transition to life outside long-stay hospitals.

Read

The National Institute for Health and Care Excellence has guidance on **transitions between children's and adults' services** and **inpatient setting to community or care home settings**.

SCIE has a report highlighting good practice in **hospital discharge and preventing unnecessary admissions**.

What this means

The values that citizens appreciate in social workers – particularly of relationship-based practice, helping maintain independence, and preventing future needs developing – can feel squeezed due to the pressure people are working under, and as workers are forced to focus more on crisis management.

Listening to what people say, and standing up for their rights, is invaluable to people with care and support needs. The shift from 'doing for', and 'doing to', people towards 'doing with' is all about social work being an enabling, empathetic profession, having empathy. This type of approach is often the reason why social workers were drawn to the profession – and these qualities need to be supported by the organisations they work for. "Doing things *with me* is the modern day kind of support from social care staff that gives me a degree of choice and control, and *enables* me to enjoy an interesting life," in the words of one group member.

> "Social workers should be seen as an investment by the system, and there should be time and effort invested to keep them. It's investing to save."

The research

As set out by The British Association of Social Workers (BASW)'s ***Code of ethics***, 'Human rights and social justice serve as the motivation and justification for social work action. In solidarity with those who are disadvantaged, the profession strives to alleviate poverty and to work with vulnerable and oppressed people in order to promote social inclusion. Social work values are embodied in the profession's national and international codes of ethics.' The ***Professional standards for social work*** also set out that social workers must '…promote the rights, strengths and wellbeing of people, families and communities' and '…establish and maintain the trust and confidence of people.'

This is very similar to what some people with care and support needs say they value in social work. According to Peter Beresford (2012), in his research on what people want in social work, people 'talk of relationships based on warmth, empathy, reliability and respect' and about social workers as 'friends, not because they confuse the professional relationship they have with them with an informal one, but because they associate it with all the best qualities they hope for from a trusted friend.' Beresford also highlighted that people value the combination of practical and emotional support in social work, because it is through sorting practical issues out that people 'can build the trust and confidence to confide in social workers, and be in a position to gain emotional strength from their support' (Beresford, 2012).

So, if both social workers **and** people with care and support needs value very similar things, what is stopping the development of this productive relationship? One reason may be that the role of social work is not only to build relationships and empower people, but has also developed into a 'gatekeeper' of resources, particularly as social care resources have become scarcer following austerity in the UK (Pentaraki, 2016; Grootegoed & Smith, 2018).

Research looking into the impact of austerity on social workers has found that having to limit contact or gatekeep services is experienced as a breach of ethics, which may often manifest in social workers having to bend the rules or do (often unpaid) overtime to provide what they believe to be an acceptable level of support (Grootegoed & Smith, 2018; Aronson & Sammon, 2000; Pentaraki, 2016).

Grant (2013) found that the empathy needed to provide those aspects of social work so valued by people with care and support needs, also held the potential to affect social workers themselves.

Workers had to be empathetic to do the job, but this could leave workers open to 'empathetic distress', where they may experience secondary trauma and personal upset. 'Moral injury', where people experience distress through actions (or inaction) that violates their moral or ethical code (Greenberg et al., 2020), has been noted in social care, and social care organisations should seek to respond to and prevent moral injury as far as possible (Reamer, 2022).

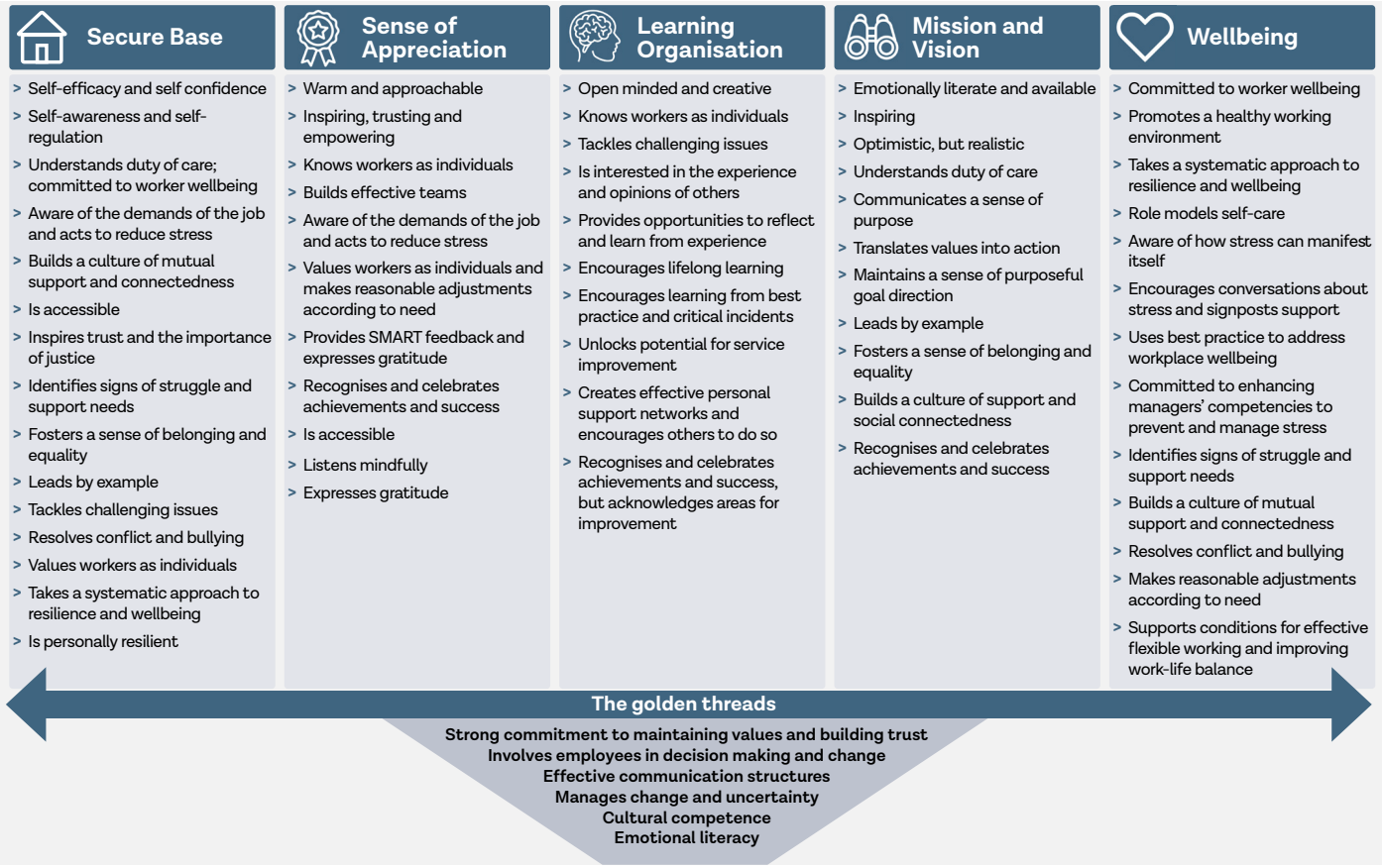
These factors – overwork, ethical stress, empathetic distress, moral injury – are likely to be contributing to the current workforce issues in adult social work. In September 2022, 11.6% of social work posts in local authorities' adult services were vacant, with turnover standing at 17.1% (Skills for Care, 2023).

What you can do

If you are in direct practice: You may feel like you have little control over wider forces, such as austerity and the cost of living crisis, and limited options available for people you work with. The More Resources, Better Used group said they "know the issues for social work are at a higher level than those controlled by the individual social worker" and needed to be addressed at an organisational level. However, all the group wanted social workers to feel empowered to do what **was** within their control. To "feel joy in their work, and be able to contribute to a compassionate culture."

Hopefully, it is heartening to read that people value what social work can offer. This may encourage you to think of the power you **do** have and how you might use it. How can you use the time you do have with people to the fullest? What do they specifically value in the work you do, and how can you maximise this in the time you spend together? Who do you need to talk to if this involves a different balance in your workload?

If you are a leader or manager: It's crucial that organisations consider resilience within social work. The SWORD (Social Work Organisational Resilience Diagnostic) project has found five dimensions that are associated with social work organisational resilience (see next page).



(Grant et al., 2022)

Research in Practice regularly offers **participation in SWORD** (Social Work Organisational Resilience Diagnostic - **https://sword.researchinpractice.org.uk**), which is designed to help leaders and managers create the conditions to sustain and develop resilience according to a tailored evaluation of each of these five dimensions. This is a free service for all organisations who are part of the Research in Practice network. In addition, there is a freely available ***SWORD Workbook*** that outlines several tools and reflections for organisations.

Further information

Read

Chris Perry, a former director of Social Services, reflects on social works value as a resource in ***Change Agents, Not Gatekeepers*** on BASW's website.

Watch

A series of three videos *on **Supporting emotional resilience*** in social work is available on the Research in Practice website.

BASW has a webinar on **resilience and wellbeing** in social work. This includes looking at local authorities where recruitment and retention of social workers has been a positive experience.

Co-production

What this means

Genuine co-production – beginning from an open discussion about what matters to people in terms of how resources are used, and being properly supported through time and payment – is fundamental when arguing for more resources, and ensuring that available resources are used more efficiently. Bringing the right people together, supporting creative thinking and encouraging challenge, leads to well considered and people-led solutions.

The conversation needs to start with people, and not always be framed as "...an issue that the system wants to address." What are the **inefficiencies**[link to waste and inefficiencies section] and **good practice** that citizens identify? How can the conversation start with these factors, rather than those which an organisation has identified? Co-production always needs to be framed as integral to More Resources, Better Used. As one group member simply put it: "Let us help".

> "Co-production needs to be both on a service-wide scale, but also an individual basis – taking people's strengths and preferences into account."

The research

Co-production is of central importance throughout the whole of this evidence review, and you will find it useful to refer to [link to other sections]. In terms of More Resources, Better Used, co-production may reduce inappropriate and wasteful interventions, since co-produced services come from the genuine voice of lived experience (Penny & Slay, 2014).

However, if co-production is not clearly and realistically defined – and co-defined with citizens – there is a danger that its meaning is diluted, and its potential to transform services is reduced (SCIE, 2022; Norah Fry Centre, 2018), or even that it results in poorer outcomes (Crompton, 2019; Osborne et al., 2016). It is of central importance for co-production to be a success, that everyone feels valued, and has an equal say (Weaver, 2019).

Crompton (2019) found that leaders could see co-production as a 'normative policy good', meaning that they could view it as an end in itself (rather than as a method to thoroughly change things). This risked co-production being seen as a box to tick, with challenge from citizens to the existing system not always welcomed, and where citizens were added to existing decision-making structures instead of using co-production to redesign those structures (Crompton, 2019). Telltale signs that this was happening included using technical terms without explaining them fully, and meetings being held 'backstage' without citizen involvement (Crompton, 2019).

What you can do

If you are a senior leader: The More Resources, Better Used group shared examples of what worked for them in co-production. Fair pay, equal representation, support **after** a meeting as well as during it, were all important. One member shared the experience of a co-production group only having **names** on nametags, rather than defining people by a professional or lived experience role. This had the effect of making people feel empowered, and that "Together, we could all share our insights equally."

Think about how you currently co-produce (you may also find it useful to refer to the co-production sections within this Evidence Review. Do you have a co-production policy (and was the policy co-produced)? How are the areas for co-production decided upon? Who decides on them? How are people recruited – both people with lived experience **and** professionals – to a co-production project? Is extra time and training given to understanding technical or complicated budgetary issues, and is this understanding continually checked? Are payment and expectations clearly set out?

You may also consider how co-production is viewed in your organisation. Is it considered as something to improve efficient use of resources – with an openness to far-reaching change – or is it only framed as an ethical way of working? Ensuring it is seen as an **investment** for improved use of resources rather than solely as 'a good thing to do' is crucial. Otherwise, co-production could be seen as an added extra, rather than being mainstreamed as something fundamental to better use of resources. Changing this narrative – by making the link clear between co-production and better use of resources – is something a senior leader can do.

Further information

Read

SCIE has a 2022 guide, ***Co-production: What it is and how to do it***. SCIE has also collated a series of examples of **co-production in social care**.

The National Institute for Health and Care research has some **payment guidelines on involving people in research**, which may also be helpful when thinking about co-production in social care.

Engage

Think Local Act Personal has a **range of resources** to support co-production. This includes the podcast **How do you create the right conditions for co-production?**

The possibilities of technology

What this means

Technology, including assistive technology, is often underused – or used in a way that makes people feel uncomfortable (such as by replacing the personal element of care and support). However, there are enormous opportunities opening up with technology – in terms of flexibility, choice, reduction of stigma, and efficiency.

We always need to ask the question 'In whose interests is the technology being used?' Is it being used to improve lives, or to increase professional ease and/or reduce costs? These aren't always mutually exclusive, but people with care and support needs deserve to have their interests put first.

The research

Studies consistently show that people worry that technology will replace the 'human' side of care (Ninnis et al., 2019) – so ensuring people feel that technology is working **for** them, rather than feeling that duties have been delegated to technology instead of people, is essential. Technology is part of complex personal and social realities, as people perceive and interact with technology in a highly personal way. Technology might complement, improve, or challenge, ways of living. The Living in the Place We Call Home group also highlighted this as important, as did the Communities Where Everyone Belongs group, and there is useful material in those sections as well.

The evidence around occupational therapy (OT)'s role in adult social care is helpful to look at here. OT has traditionally supported:

- Promotion of health and wellbeing.
- Prevention.
- Housing adaptations and the provision of equipment.
- Reablement.

  (Pearman, 2021)

A key principle when thinking about the possibilities of technology is to always start with the circumstances of that particular person, rather than first considering what has worked for others with the same condition. For instance, in a study looking at assistive technology supporting people with neuromuscular conditions, the person's home environment and the role of a family carer were both important variables on whether the assistive technology was ultimately successful - even when two people's conditions were very similar (Pousada Garcia et al., 2019).

In order to do this, occupational therapists work collaboratively with the person; deciding together which occupations to support, setting goals, supporting interventions and measuring outcomes (College of Occupational Therapists, 2015). As De Coninck et al. (2017) argue, '…a high quality OT intervention takes into account a number of characteristics… for this reason, OT interventions will vary, because they are tailored to the personal and environmental characteristics and will therefore rarely be rigidly prescribed.' Taking this person-centred approach, involving what a person themselves is motivated to achieve (rather than a pre-defined set of tasks that it's thought people 'should' achieve) is more likely to yield positive results (Newton, 2012).

This principle of person-centred practice also runs through the use of technology and **digital ways of working**, something occupational therapy has increasingly embraced. It's about how technology can support achieving what people **want** to achieve, rather than dictating what it's felt someone 'should' do. Technology may be rejected, despite fulfilling the job it's designed to do. One older study (Riemer-Reiss & Wacker, 2000) suggests 30-50% of assistive technology is abandoned, resulting in significant costs to health and social care systems.

Known barriers to use include: affordability, uneven access, insufficient instruction, concerns over reliability and durability, and perceived usefulness. Some studies have also explored the psychological component of assistive technology; Coughlin et al. (2007), for example, identified pride as a significant barrier: adopting assistive technology means older people worry that they will be seen as vulnerable, frail or incompetent, with the use of assistive technology damaging to their self-image.

More recent and universal technology can potentially address some of those psychological concerns. Technology such as voice assistants (like **Alexa**) and other innovations like online shopping and banking support convenience in everyday life. Vieira et al. (2022) reported a wide range of tasks that a voice assistant supported for disabled people, from being able to turn the television on without asking someone else, to reminders of medication. Moreover, the use of voice assistants 'reduces disparities between people with disability and people without disability, providing similar conditions and autonomy' (Viera et al., 2022, p.16).

A significant concern for people – both across the general population, but particularly for **older** people - is about cybersecurity and safety, especially when thinking about internet-connected devices (Vieira el al., 2022; Han & Yang, 2018). This is a very valid fear; **Citizens Advice in the UK** has found that almost three-quarters of people in the UK had been targeted by a scammer in 2022, a 14% increase since the previous year. However, there remain concerns about the accessibility of cybersecurity systems for a range of people with disabilities (Renaud, 2022).

What you can do

If you are in direct practice (particularly if you are an occupational therapist): Research suggests that the successful use of technology for older and disabled people is not just about the ability to use it; it's also about the **willingness, confidence** and perceived **utility** that it can bring to people's personal outcomes. How are these considered alongside the more direct work of teaching or supporting people to use technology? How are concerns around scamming and security addressed?

The co-produced Practice Tool from Research in Practice, ***Digital inclusion: Using digital technology positively and safely*** includes a tool to use with people to help understand their skills and preferences in digital technology, and work through any action to take. It is adapted on the following page.

Prompt	Response	Action
What is the person's history with technology? Take some time, via open questions, to find out what they have experienced before.		
Does the person *want* to use technology? Is it appealing to them?		
What does the person think about the internet and other types of technology?		
Do they feel they have enough information to make informed decisions about technology?		
What is the person's current access to digital devices such as smartphones and tablets, and what is their internet connectivity like?		
Is the person frightened or anxious about using digital technologies? Try to find out why this may be.		

If you are in senior management: How confident are you in knowing about new assistive and digital technology, and how it can support better lives for older and disabled citizens? How is technology conceived in your organisation – is it initially thought of in terms of cost, or primarily for how it can support wellbeing?

It's really important to keep up with the cutting edge of assistive technology – thinking of not just what's out now, but what may be coming in the future. (A very basic way to keep up is to read the **blogs and news** from **AbilityNet**, and sign up to their newsletter.)

Further information

Read

Research in Practice has a Frontline Briefing on ***Occupational therapy in adult social care***.

Connect

AbilityNet has a **network of volunteers** who can offer free tech support to older people and disabled people. They also have a free helpline (**0800 048 7642**).

What this means

Legal literacy, when considering More Resources, Better Used, is about awareness of rights in the workforce. Many of the suggestions to improve resource use – such as around prevention – have legal teeth, but they are either not known about, or not enforced.

'The general public that accesses social care can be forgiven for not knowing various parts of the law, and it should not be up to them to have to show workers where and when they have made unlawful decisions.' While it's true that, as the group asserted, "unless people know their rights, they won't have a basis from which to challenge," it was strongly felt that "the onus is on workers to know enough about the law in order to make safe, legal decisions. Then citizens won't have to challenge so many things in order to have their needs met and their rights enforced."

The research

Legal literacy is also a theme in the Leading The Lives We Want To Live and Sharing Power As Equals key changes. It's importance is unsurprising; many of the suggestions in this evidence review, and the research that supports them, are already there - in the ***Care Act 2014***. The 'wellbeing principle' states:

'The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's wellbeing' (*Care Act 2014,* Part 1).

Wellbeing, as defined in the *Care Act 2014*, can be related to any of the following (also known as **the 'Nine domains'):**

1. Personal dignity (including treatment of the individual with respect).
2. Physical and mental health, and emotional wellbeing.
3. Protection from abuse and neglect.
4. Control by the individual over day-to-day life (including care and support, or support, provided to the individual and the way in which it is provided).
5. Participation in work, education, training or recreation.
6. Social and economic wellbeing.
7. Domestic, family and personal relationships.
8. Suitability of living accommodation.
9. The individual's contribution to society.

The wellbeing principle puts person-centred and strength-based work firmly at the centre of adult social care, setting out '**the importance of beginning with the assumption that the individual is best-placed to judge the individual's wellbeing.**' When thinking about More Resources, Better Used it is clear that local authorities fighting legal challenges is a poor use of resources. **Case law** provides examples of how restrictive interpretations of the *Care Act 2014* run the risk of adverse court judgments for the local authority - for example, a 2022 finding of **how a holiday can meet eligible needs under the *Care Act (2014)***.

Lelkes et al. (2021) found that, in social care practice, wellbeing was a fluid and complex concept – and was influenced not only by the person's view of wellbeing, but also the practitioner's view of wellbeing. The study suggested that, when thinking about training on the *Care Act*'s *(2014)* concept of wellbeing, attention could be given to empowering practitioners to hold uncertainty; to not approach wellbeing as a 'tick-box' exercise; and to appreciate that what people view as necessary for their wellbeing can, and does, change (Lelkes et al., 2021).

However, as one group member pointed out, legal literacy "...isn't just about wellbeing. It's in eligibility and assessments and report writing and in support planning and indicative budgets and determining funding and calculating contributions to one's social care and in making allowances for disability-related expenditure and in 101 other things." The further information section below includes many useful, accessible guides and resources related to legal literacy.

The *Care Act 2014* also sets out **new rights for carers**. These include the right to a carer's assessment, a right for carers' eligible needs to be met, and a duty on local authorities to provide information and advice to carers in relation both to their caring role and to their own needs. The context in which this came into force has been significant, as Fernandez et al. (2020) found – the impact of these strengthened rights had been limited, primarily due to cuts in local authorities' budgets, and they had 'not led to greater access to support for carers' (p.4).

Marczak et al. (2021) found that local authorities still tended to approach carers as 'a resource' and support carers mainly in order 'to keep cared for people away from health and social care systems' (p.1711). However, the *Care Act 2014* **had** been important in legitimising carers' needs as distinct from the needs of the person they care for, with increasing recognition of the importance of meeting these needs and promoting carers' wellbeing (Marczak et al., 2021).

The *Care Act 2014* is a legal requirement - it's also one of the key factors supporting a culture change in local authorities to a more person-centred approach to care and support (Ahuja et al., 2022). It is therefore helpful to think of legal literacy and person-centred practice as complementary to one another.

What you can do

If you are in direct practice: How do you currently share information with individuals about their legal rights under the *Care Act 2014* (there are some resources to share in the Further information section, below)? Are you confident in your own knowledge, your ability to clearly communicate people's rights, and your ability to connect people with advocacy services?

The Lelkes et al. (2021) study asked its social care practitioners two questions:

1. What do you understand by the concept of wellbeing?
2. Now, thinking about someone **who lacks mental capacity** to make decisions about their care and support, what do you understand by the concept of wellbeing?

You might ask these questions of yourself, and notice any potential differences in your answers.

If you are in senior management: How legally literate is your workforce? You may wish to consider the **ten standards for legal literacy in an organisation** and consider how you might **evaluate** them.

Further information

Share

The organisation Legal Capacity (which looks at how mental capacity legislation works in everyday life) has **step-by-step information on challenging decisions made under the *Care Act 2014***.

Disability Rights UK has an accessible guide to people's **rights under the *Care Act 2014***, which is designed to be used by people with care and support needs.

Watch

There are online learning packages from Research in Practice on several aspects of the *Care Act 2014*, including **assessment and eligibility**, **care and support planning**, **assessment for carers**, and **outcome-focused approaches**.

Learn

Research in Practice has a suite of resources on **legal literacy** in adult social care.

Connect

CASCAIDr (Centre for Adults' Social Care – Advice, Information and Dispute Resolution is an online specialist advice charity that supports people to uphold their rights in adult social care, and has a searchable database of questions about the adult social care legal framework.

Recognising and rewarding family and informal carers fairly

What this means

Family and informal carers are an enormous fount of knowledge. They have informed ideas about how to improve the systems the person they care for is part of, and the services that support them as carers. While they shouldn't step in to do the work of the state, the fact is that they currently save health and social care enormous amounts of money – and this isn't properly acknowledged in the public narrative. When thinking about positive person-centred work, carers' ideas, experiences, and the empathy carers' show, should be drawn upon, with appropriate recognition and reward.

The group reflected how carers experienced a very difficult time during COVID-19, and there were legacies from this - that support services, including respite care, did not feel fully restored. As one group member said, "Carers are burnt out".

Many carers experience being ignored, having unrealistic expectations forced upon them, being taken for granted, or even being blamed for wider societal or systemic issues. For example, carers can feel erased in conversations about 'hard working families' versus 'economically inactive' people. Other citizens simply do not identify themselves as carers, and therefore miss out on the support they are entitled to. This all needs to stop, with respect and compassion for carers a key part of strength-based and person-centred work.

> "As a carer, you can't just opt out. Who's the backstop? We are."

The research

Official data puts the estimated number of carers across the UK at 5.7 million people. However, Carers UK estimate that the figure could be as high as 10.6 million people in the UK (Carers UK, 2022a). Carers Week (2023) found that 73% of people who currently provide unpaid care, or have done so in the past, have not identified themselves as a carer – missing out on financial and practical support as a consequence.

44% of working-age adults who are caring for 35 hours or more a week are in poverty (Joseph Rowntree Foundation, 2022) even though, through the care they provide, carers in England and Wales contribute an estimated £445 million to the economy **every single day** – equating to £162 billion per year (Petrillo & Bennett, 2023). The value of unpaid care is equivalent to a second NHS in England and Wales (Petrillo & Bennett, 2023).

In terms of the particular issues brought up by the More Resources, Better Used group, some other statistics tell a stark story of the reduction of monetary and other support for carers in the years between 2015/16 and 2020/21:

- An 11% drop in the numbers of carers in receipt of 'direct support'. This represents 13,000 fewer carers who now do not have access to the kind of choice and personalisation that this type of support is designed to offer.
- Access to breaks for carers declined by 42%.
- Local authority gross expenditure on services for carers was reduced by 11%.
- 36,000 carers in this period have been offered information and advice only, instead of support.

  (Paddison & Crellin, 2022)

Carer's Allowance is the lowest benefit of its kind, £76.75 per week at the time of writing, and only available to carers who provide more than 35 hours a week of care, with one in six of all carers currently in debt – something which increases to two in five of all carers on Carer's Allowance (Carers UK, 2022b).

Petrillo et al. (2022) found that the economic and career hit that most carers will experience is not equal. While people in management and professional occupations form the majority of people who become carers every year, those who provide the most intense care – defined by the research as over fifty hours per week – were more likely to come from 'semi-routine and routine' occupations (Petrillo et al., 2022). People in these occupations are less likely to earn higher salaries than those in management or professional occupations (Williams et al., 2020).

The COVID-19 pandemic was found to have impacted carers' mental health, with issues including isolation, exhaustion and reduced trust in statutory services all increasing during the pandemic (Linden et al., 2022). Personal care, socialising, and monitoring at home, often continued or became entirely undertaken by family members (Samsi et al., 2022). Carers felt they had to 'shout louder' than they normally did in order to be heard (Linden et al., 2022) and the lack of respite care, personal space and external activities risked making their caring role unworkable for them (Burrows et al., 2021).

Templeton et al. (2021) found a positive example to support carers in Wales. Where carers' needs assessments were carried out by voluntary sector workers trained in conducting assessment, and who were allocated up to eight hours with each carer to complete the assessment, the reaction from carers was more positive than when the same assessments had been carried out by local authorities, and more people were encouraged to come forward for assessment (Templeton et al., 2021).

What you can do

If you are in senior management: Set the tone for appreciative, empathetic work with carers throughout your workforce. Celebrate carers as the fount of knowledge and experience about both their own needs and strengths, and those of the person they care for. Even small gestures, such as organising events for the annual **Carers Week**, can underline that people's caring work – and the economic value it brings – is acknowledged and appreciated. It may also encourage people who do not identify as carers, but do provide unpaid care, to reach out for support.

Recognise carers' value in co-production [link]. Value their time with money and with your actions. Ensure carers' feedback is regularly and meaningfully sought out, and acted on, to improve your response to carers.

Consider the role of the caring identity and how it may be preventing carers from accessing the support they are entitled to – encourage your workforce, providing more resources where possible, to spend more time with carers to proactively encourage carers in getting the support they are entitled to, including a carers' assessment. Ensure legal literacy training covers rights for carers under the *Care Act 2014*.

If you are a commissioner: Paddison and Crellin (2021) suggest two specific actions for commissioners:

1. As part of place-based commissioning, recognise carers as a group for whom there is clear evidence of poorer health outcomes. Include carers in health inequalities impact assessments, and explicitly include data on carers' health outcomes and care experiences as part of the **Core20Plus5** approach (which is an approach to reduce healthcare inequalities).
2. Develop a succinct plan identifying actions to support carers, with clearly identified indicators of success, and clarity on responsibilities for delivering this.

If you are in direct work: Carers very much value your direct acknowledgement of the hard work they do. Understand their world. Appreciate their stories and their perspectives. Be their champion. Fight for their rights.

Of direct practical importance is your support in helping carers access financial support they are entitled to. The research is clear on the amount of financial stress that carers are facing. Are the carers you are working with getting all the benefits they are entitled to? Are there any local services that can help them? While being sensitive towards shame and stigma, helping with finances and economics is an incredibly important aspect of working with carers.

Further information

Explore

There is a wealth of research knowledge on carers (Research in Practice has an **entire section of its website devoted to carers**, for example). Iriss (based in Scotland) has a **helpful overview of the evidence on carers' mental and physical health**, with an additional focus on finances and employment.

Watch

In **this video**, carers directly explain what they would like from a social worker. The website also contains a number of useful training resources and case studies for positive, strength-based working with carers.

This **video from Carers' Week 2023** provides a selection of carers' voices via tweets and social media posts.

Connect

Carers First has **information and links** on financial support for carers, and an online support service for further help and advice.

Read

Carers' Week 2023 produced a report on **unpaid carer identification**.

What this means

Accountability, auditing and quality assurance are key levers in ensuring resources are used as well as they could be. How services are assessed on an ongoing basis – and how they are held to account if problems occur – is vital. Outcomes-based accountability should support measuring the outcomes that citizens want, rather than those decided on by organisations.

The More Resources, Better Used group shared experiences of incorrect and poor quality assessments and support plans, or ones that didn't represent their lives, needs and strengths accurately. This meant they then had to spend a lot of their own time and energy correcting this. If accountability and quality assurance was strengthened, this would be of direct benefit to people with care and support needs.

Part of this, too, is about who measures success, and when. Citizens, who directly experience services, should be given a far greater role in holding services to account, and judging how they are measured.

> "It's not about just signing a contract and then feeling that the remit has been fulfilled."

The research

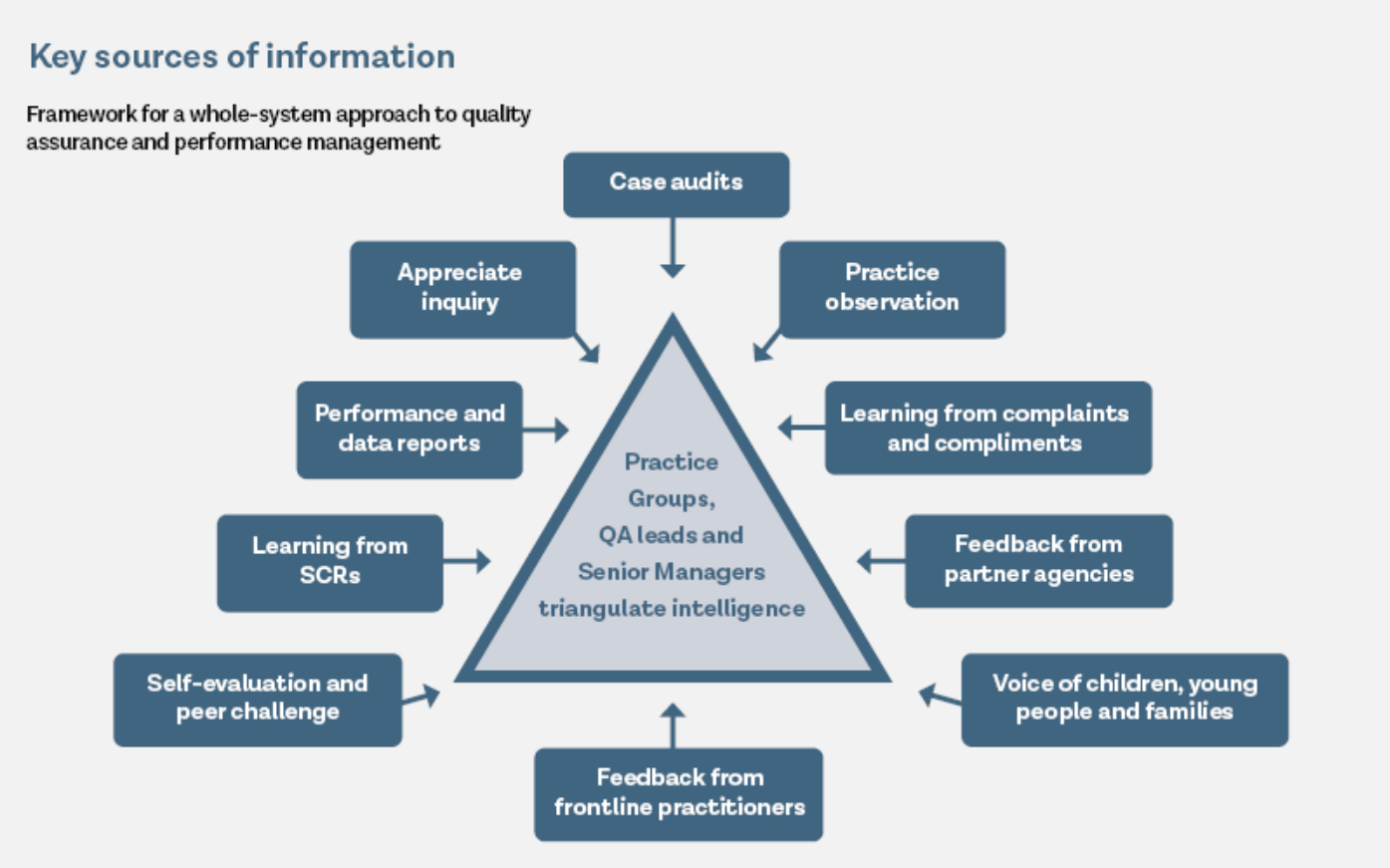
Forrester (2016), although writing in the context of children's social care, highlights why quality assurance is fundamental to More Resources, Better Used:

'Many well-intentioned rational reforms carried out do not appear to have generated genuine positive changes. For me this is because the reforms focus on the what and when of activity, without sufficient attention to why and almost none on how practice should be carried out. This creates a paradoxical system that is very busy, but where it is often unclear why various activities are being done.'

In adult social care, having a strong quality assurance framework in place both supports organisations to measure and evaluate their practice, and also helps cultivate a culture that is committed to learning, continual development and improvement (SCIE, 2021). It's about recognising where inequalities exist – where there are different outcomes for different groups – and then making a proactive plan to tackle this (Care Quality Commission, 2022).

However, quality assurance often measures service delivery process - the 'what' something is spent on, rather than quality of life outcomes for the people who use services (McEwen et al., 2020). Observing practitioners' behaviour and actively collecting feedback from people with care and support needs helps move beyond the effectiveness of processes to the effectiveness of outcomes (McEwen et al., 2014). This might look like, for example, not only counting how many assessments are completed within a desired timeframe, but undertaking the harder work on evaluating how accurate and effective people felt those assessments were, and how they improved (or did not improve) their quality of life.

Quality assurance and auditing in adult social care, therefore, goes well beyond statistical data. The following diagram outlines some of the sources of information that might be might included:



(Adapted from Bowyer et al., 2018)

What you can do

If you are a leader, or are in a quality assurance role, the Social Care Institute for Excellence has produced a **critical review tool** to help social care leaders move towards a strength-based, whole-place approach – that crucially, provides a benchmark against which to measure future impact. The tool sets out nine domains to work through:

- Developing a strength-based vision and framework.
- Leading a strength-based approach.
- Developing a strength-based approach to commissioning.
- Working in partnership.
- Effective and enabling systems, processes and information.
- Delivering to a high standard of quality.
- Co-producing with people who draw on services and carers.
- Developing the skills and capabilities of the workforce.
- Understanding and measuring impact.

Within each domain, there are questions, good examples, and links to further resources.

It is vital for you to **consistently and meaningfully** involve those with care and support needs in your work. Whether things work from an organisational perspective, and whether they work from a person's perspective, can be two different questions. You may consider not only answering the questions in the practice tool within the organisation, but also with a group of people with care and support needs. Are their responses the same? What lies behind the differences? What action do you need to take based on them?

Further information

Read

Although aimed at an audience related to children's services, there are many transferrable messages for adult social care in the Research in Practice strategic briefing ***Building a quality culture in child and family services***.

Connect

Think Local Act Personal hosts a **Care Markets and Quality Forum**, which holds regular events and webinars, and encourages its members to network in their efforts to provide affordable, quality services that people want.

Connecting the short and long-term

What this means

There can be tension between what is effective in the long-term – supporting preventative work and providing true foundations for a better life – and necessary short-term actions to tackle crises, which tend to be expensive and reactive. When time is taken up with the short-term, the long-term work is crowded out, leading to the higher likelihood of crises in the future (and higher expenditure).

Thinking positively, it's also about smarter work to join up the short and long-term – translating the actions that happen on a smaller-scale to larger, longer-term action. People are not greedy, and they will know what needs to be there to prevent needs worsening and/or improving quality of life – it's about harnessing this information for better long-term outcomes and, at the same time, reducing the need for short-term crisis management.

> "Millions of small steps, collectively, put us in a better position."

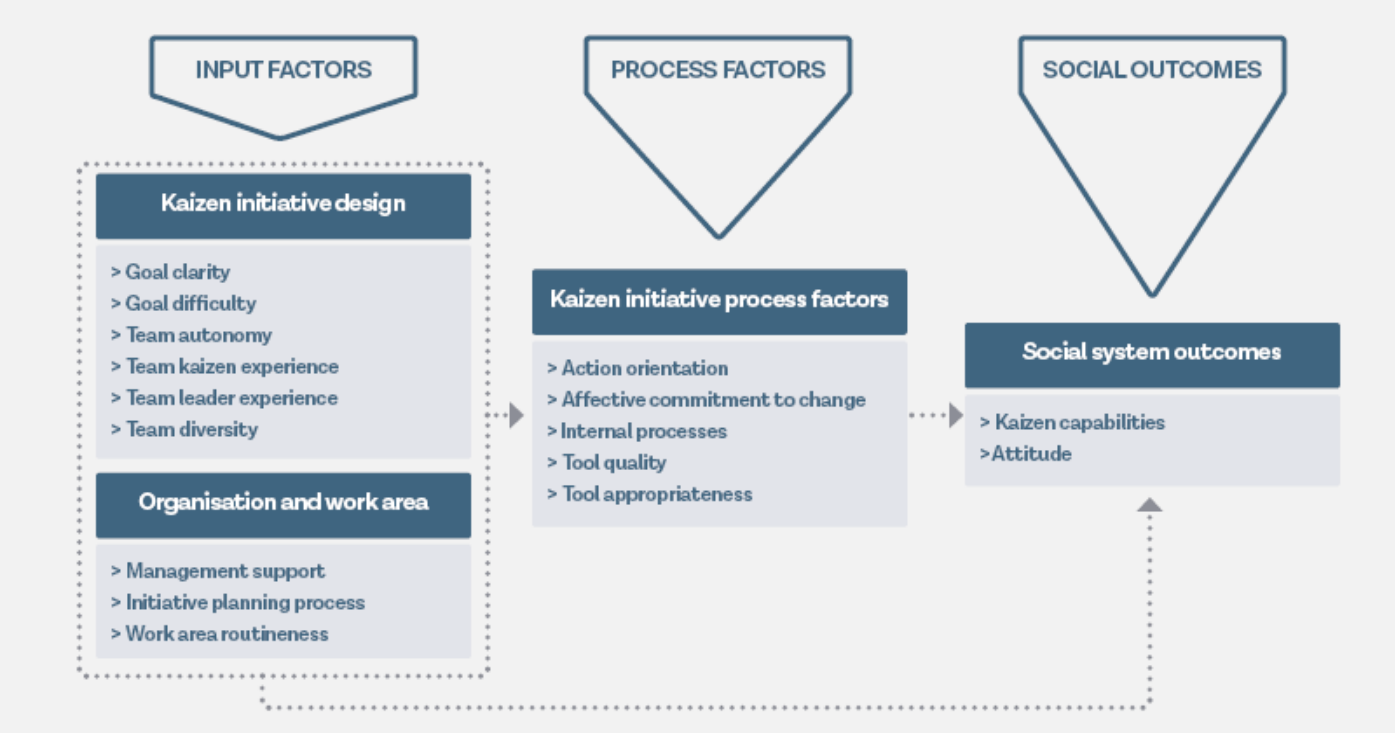
The research

The Care Act's focus on prevention has been found to have only been partially successfully implemented (Burn & Needham, 2021). The study found that 'Given the resource-constrained environment, local authorities were finding it difficult to sustain investment in prevention. A national policy emphasis on addressing delayed transfers of care from NHS services encouraged a focus on providing traditional social care placements rather than exploring preventative alternatives. Reductions in staff headcount had limited the ability of local authorities to embed the cultural changes required for a preventative approach' (Burn & Needham, 2021, p.4).

SCIE (2021) found that the evidence for prevention leading to cost-efficiency in social care is 'underdeveloped'. This is partly because there can be different understandings of what prevention is (is it the prevention of need for services, or is it prevention of barriers emerging to someone's outcomes?). The research has also found difficulties in demonstrating the link between specific preventative interventions and outcomes. There are also, often, long timeframes involved for observing the full consequences of preventative investments (SCIE, 2021).

However, the More Resources, Better Used group offered suggestions to connect up the short and long-term. Particularly considered was the importance of **Kaizen** – the Japanese art of continuous improvement. This is an approach that involves daily improvement actions for everyone in an organisation, at every level from senior leaders to administrative staff, based on the idea that small, ongoing positive changes can yield significant larger change over the longer term – therefore combining the short and long-term. A cornerstone of Kaizen is '…the people who work in the organisation and all that is human about their presence' (Pasmore, 1988, p.25).

A framework for Kaizen was developed by Farris et al. (2009), and looked at which input factors are necessary for, firstly, improvements to process, and, secondly, improvements to outcomes (see following page).



(Adapted from Ferris et al., 2009)

So, for example, people being clear on what Kaizen is and what it aims to achieve (**goal clarity**), would contribute to people adopting it in their work (**action orientation** and **affective commitment to change**) and, then, becoming more skilled in a Kaizen approach (**Kaizen capabilities**).

Bortolotti et al. (2018) studied the use of Kaizen in healthcare settings. They found the following:

- **Goal clarity** was highly important to making Kaizen work in healthcare. It is particularly important when healthcare works alongside other professions, because it can help with overcoming differences in professional approach. It also reduces staff anxiety that Kaizen will compromise patient outcomes.
- **Team autonomy**, not on what Kaizen is but **how it is achieved**, was also found to be important. Trusting that teams can identify their own continuous improvement actions, rather than insisting on a standardised process improvement cycle encouraged 'professionals to be innovative and practice their activities as an art as well as a science' (p569).
- **Management support** – including the allocation of resources – enhances staff motivation to participate actively and enthusiastically in Kaizen initiatives.
- The role of **goal difficulty** was complex. While goals shouldn't feel unachievable and therefore result in frustration, staff did need to feel that their capabilities were being stretched and developed.
- Finally, **affective commitment to change** needed to be cultivated. This was the strong belief that Kaizen would deliver benefits for patients, and help practitioners address many of the issues they see in their working life.

This aligns with much research about what helps change happen in social care; for instance, Miller and Freeman (2015), when looking at change in social care, found the following important:

- Agreeing underlying principles.
- A lead from senior management.
- Co-producing the outcomes for change with people with care and support needs.
- Fostering trust.
- Choosing an approach with buy-in from all who need to implement the change.
- Ensuring staff have sufficient capacity and resilience.

Other suggestions from the group to support improved joining up on short and long-term outcomes included the work of **The Q Community**, the **THIS.Institute** and the **Plan-Do-Study-Act (PDSA) cycles**.

As with all improvement in social care, **what** is improved and ensuring those improvements benefit those with care and support needs, can most effectively be achieved through co-production (Sutton, 2020). This would involve asking people about both short and long-term improvements they wish to see, and co-producing the journey with them.

What you can do

If you are a senior manager: Assessment was an area the More Resources, Better Used group thought was a prime example of how the short and long-term are linked. Improvements to the assessment process could really help the accuracy and effectiveness of assessments, and support better and earlier care planning, which could then help prevent or delay needs worsening.

Thinking along the Kaizen principle of small, daily improvements, what are some of the small, daily improvements that could be made to adult social care assessment in your organisation? You might think about:

- What people with care and support needs think could be improved about the process, and their ideas for doing this.
- What practitioners who carry out the assessment process think could be improved, and their ideas for doing this.
- Any frustrations and blockages you've noticed in the process, for instance with computer systems, forms, or layers of oversight.
- Any gradual improvements that can be made to key practitioner assessment skills, such as analysis, note-taking, preparation, being strengths-based (the Research in Practice handbook on ***Good assessment*** can help practitioners identify and work on these).

The Kaizen approach can be used with numerous aspects of adult social care. What are the key things in your organisation that might benefit from small, continuous improvement?

Further information

Watch

SCIE has a **learning resource on organisational change in social care**.

Read

SCIE has a resource on **prevention in social care**.

Leadership and culture

What this means

Culture in organisations is led by, or at least heavily influenced by, the leadership in that organisation. A blame culture creates so much defensiveness and waste [link], whereas a culture of openness and trust generates goodwill, listening, and respect – and can lead to better use of resources, because people's ideas are listened to, and there's buy-in for collective improvement.

> "The point of action has to be much higher than individual social work level."

The research

Culture in an organisation can be defined as a set of shared, taken-for-granted implicit assumptions that members of that organisation hold – and which determines how people perceive, think about, and react to things (Schein, 1992). As a group member put it, it can mean "...the way we do things around here."

Culture reflects what an organisation values – quality, safety, productivity, survival, power, secrecy, justice, humanity, and so on (West et al., 2014). The Department of Health and Social Care (2019) acknowledges that 'organisational culture is defined by how people inside the organisation interact with each other and with people outside the organisation'. While efforts to reflect on and consciously address social care's workplace culture have arguably increased in recent years – for example, in explicitly moving towards an **anti-racist culture in social work** – the More Resources, Better Used group still felt there was some way to go in explicitly reflecting on workplace cultures in social care more generally.

While everyone in an organisation contributes to culture, the most important determinant of culture is current and future leadership (Schneider & Barbera, 2014). In adult social care, this leadership may include fostering cultures that promote **compassion**, **collaboration**, **resilience**, **anti-racism**, and **strengths-based working**.

Taking strengths-based working culture, for example, one of the barriers identified to this approach in practice is a lack of acknowledgement that it represents a **cultural shift** rather than simply adopting new practices. That it involves co-production with individual people, families and communities, where flexibility and creativity are valued rather than rigid adherence to systems and procedures (Ford, 2019). That it starts with a different conversation (Romeo, 2017), rather than starting with a different method or process, is significant and relates to a culture of belief in relationship-based practice.

What you can do

If you are a senior leader: The More Resources, Better Used group encourages you to reflect on the culture in your workforce. What words would you use to describe it?

A listening culture, embedded throughout an organisation, was considered as one of the most empowering cultures a senior leadership could develop. Listening to citizens, listening to practitioners, listening to teams; all of this empowers people to bring their ideas to the table which, as discussed elsewhere, is fundamental to identifying issues and working towards solutions. Embedding regular (rather than one-off) listening sessions with you and your senior colleagues – where people can bring any ideas and speak freely about issues and positives people see in the organisation – can begin to support a listening culture.

What work is undertaken on bias and stereotyping? How are these issues reflected on, and addressed in your organisation? How are **'difficult conversations'** approached, and how is power considered?

A simple but effective exercise highlighted by the More Resources, Better Used group is "Help/Hinder." This involves thinking about the culture change you want to see, what helps and hinders getting there – and, finally, how you can tackle this.

Further information

Explore

Research in Practice has a comprehensive collection of **leadership resources**.

Read

The Social Care Institute for Excellence has a briefing on **strength-based leadership**, including material on leading culture change.

Skills for Care has a guide on creating a **positive workplace culture** in social care.

References

Ahuja, L., Price, A., Bramwell, C., Briscoe, S., Shaw, L., Nunns, M., O'Rourke, G., Baron, S., & Anderson, R. (2022). Implementation of the Making Safeguarding Personal Approach to Strengths-based Adult Social Care: Systematic Review of Qualitative Research Evidence. *The British Journal of Social Work, 52*(8), 4640–4663. **https://doi.org/10.1093/bjsw/bcac076**

Aronson, J., & Sammon, S. (2000). Practice amid social service cuts and restructuring: Working with the contradictions of 'small victories'. *Canadian Social Work Review, 17*(2), 167-187.

Beresford, P. (2012). *What service users want from social workers.* Community Care. **www.communitycare.co.uk/2012/04/27/what-service-users-want-from-social-workers**

Bottery, S. (2022). *Reform of adult social care: Some progress, but nowhere near enough.* The King's Fund. **www.kingsfund.org.uk/blog/2022/05/reform-adult-social-care-some-progress-nowhere-near-enough**

Bowyer, S., Brooks, C., & Shuttleworth, J. (2018). *Building a quality culture in child and family services.* Research in Practice.

Bortolotti, T., Boscari, S., Danese, P., Medina Suni, H., Rich, N., & Romano, P. (2018). The social benefits of kaizen initiatives in healthcare: An empirical study. *International Journal of Operations & Production Management, 38*(2), 554-578. **https://doi.org/10.1108/IJOPM-02-2017-0085**

Brien, P. (2022). Value for money and budget cuts: What are 'efficiency savings'? House Of Commons Library. **https://commonslibrary.parliament.uk/value-for-money-and-budget-cuts-what-are-efficiency-savings**

Burn, E., & Needman, C. (2021*). Implementing the Care Act 2014 – a synthesis of project reports on the Care Act commissioned by the NIHR Policy Research Programme.* University of Birmingham. **www.birmingham.ac.uk/documents/college-social-sciences/social-policy/publications/implementing-the-care-act-2014.pdf**

Burrows, D., Lyttleton-Smith, J., Sheehan, L., & Jones, S. (2021). *Voices of carers during the COVID-19 pandemic: Messages for the future of unpaid caring in Wales.* Cardiff University. **https://phw.nhs.wales/publications/publications1/voices-of-carers-during-the-covid-19-pandemic-messages-for-the-future-of-unpaid-caring-in-wales**

Care Quality Commission (2022). *State of Care: Tackling Inequalities.* Care Quality Commission. **www.cqc.org.uk/publications/major-report/soc201920_4a_tackling-inequalities**

Carers UK (2022a). *Make caring visible, valued and supported: Carers Week 2022 Report.* Carers UK. **www.carersweek.org/media/qf0p5u4t/carers-week-2022-make-caring-visible-valued-and-supported-report_final.pdf**

Carers UK (2022b). *Heading for crisis: Caught between caring and rising costs.* Carers UK. **www.carersuk.org/media/x5sfjlbx/heading_for_crisis_report.pdf**

Carers UK (n.d.). *Key facts and figures about caring.* Carers UK. **www.carersuk.org/policy-and-research/key-facts-and-figures**

Carers Week (2023). *I Care: Carers Week report on unpaid carer identification.* Carers Week. **www.carersweek.org/about-carers-week/latest-news/posts-folder/2023/june/i-care-carers-week-report-on-unpaid-carer-identification**

Carey, G., Crammond, B., & Malbon, E. (2019). Personalisation schemes in social care and inequality: Review of the evidence and early theorising. *International Journal for Equity in Health, 18*(170). **https://doi.org/10.1186/s12939-019-1075-2**

Centre for Excellence for Information Sharing (2015). *Integrated digital care records: Enabling information sharing.* Centre for Excellence for Information Sharing.
www.scie-socialcareonline.org.uk/integrated-digital-care-records-enabling-information-sharing/r/a11G000000CTJdRIAX

College of Occupational Therapists (2015). *Occupation-centred practice. Essential briefing.* College of Occupational Therapists.
www.rcot.co.uk/practice-resources/occupational-therapy-topics/scope-practice

Coughlin, J.F., D'Ambrosio L.A., Reimer, B., & Pratt, M.R. (2007). Older Adult Perceptions of Smart Home Technologies: Implications for Research, Policy & Market Innovations in Healthcare. Published in *2007 29th Annual International Conference of the IEEE Engineering in Medicine and Biology Society*.
https://ieeexplore.ieee.org/document/4352665

Cream, J., Lamming, L., Downes, N., Ewbank, L., & Perry, G. (2022). *Building capacity and capability for improvement in adult social care.* The King's Fund.
www.kingsfund.org.uk/publications/building-capacity-capability-improvement-adult-social-care

Crompton, A. (2019). Inside co-production: Stakeholder meaning and situated practice. *Social Policy and Administration, 53*(2), 233-248.

De Coninck, L., Bekkering, G., Bouckaert, L., Declercq, A., & Graff, M. (2017). Home and community-based occupational therapy improves functioning in frail older people: A systematic review. *Journal of American Geriatrics Society, 65*(8), 1863-1869.
https://doi.org/10.1111/jgs.14889

Department for Health and Social Care (2019). *Guidance: Strengths-based social work practice framework and handbook.* Department for Health and Social Care.
www.gov.uk/government/publications/strengths-based-social-work-practice-framework-and-handbook

Dixon, J., Cresswell, C., & Ward, J (2020) *The Break: Staying Close, Staying Connected Project.* Department for Education.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/931987/Staying_Close_Break.pdf

Farris, J., Van Aken, E.M., Doolen, T.L., & Worley, J. (2009). Critical success factors for human outcomes in Kaizen events: An empirical study. *International Journal of Production Economics, 117*(1), 42-65.
https://doi.org/10.1016/j.ijpe.2008.08.051

Fernandez, J-L., Marczak, J., Snell, T., Brimblecombe, N., Moriarty, J., Damant, J., Knapp, M., & Manthorpe, J. (2020). *Supporting carers following the implementation of the Care Act 2014: eligibility, support and prevention.* CPEC/NIHR.
www.lse.ac.uk/cpec/assets/documents/cascfinalreport.pdf

Ford, D. (2019). *Developing strengths-based working: Strategic Briefing.* Research in Practice.
www.researchinpractice.org.uk/adults/publications/2019/april/developing-strengths-based-working-strategic-briefing-2019

Forrester, D. (2016). What, when, why and how: Zombie social work and the need for a new narrative. In Solomon, E. (ed.) *Rethinking Children's Services Fit for the Future.* NCB and Catch 22.
www.ncb.org.uk/sites/default/files/uploads/files/Rethinking%2520Childrens%2520Services.pdf

Glasby, J., Miller, R., Glasby, A-M., Ince, R., & Konteh, F. (2023). '*Why are we stuck in hospital?' A guide to overcoming the barriers to people with learning disabilities and/or autistic people leaving 'long stay' hospital.* University of Birmingham.
www.birmingham.ac.uk/news/2023/why-are-we-stuck-in-hospital-research

Glendinning, C., Clarke, S., Hare, P., Kotchetkova, I., Maddison, J., & Newbronner, L. (2006). *Outcomes-focused services for older people.* Social Care Institute for Excellence (SCIE).

Grant, L. (2013). Hearts and minds: Aspects of empathy and wellbeing in social work students. *Social Work Education: The International Journal 33*(3).
http://dx.doi.org/10.1080/02615479.2013.805191

Grant, L., Kinman, G., Alexander, K., & Sharples, A. (2022). *The Social Work Organisational Resilience Diagnostic (SWORD): Tool and Workbook.*
https://sword.researchinpractice.org.uk/media/5989/sword-tool-workbook-2nd-edition-2021.pdf

Greenberg, N., Docherty, M., & Gnanapragasam, S. (2020). Managing mental health challenges faced by healthcare workers during COVID-19 pandemic. *BMJ, 368*:m1211.
www.bmj.com/content/368/bmj.m1211

Grootegoed, E., & Mark, S. (2018). The Emotional Labour of Austerity: How Social Workers Reflect and Work on Their Feelings towards Reducing Support to Needy Children and Families. *The British Journal of Social Work, 48*(7), 1929-1947.
https://doi.org/10.1093/bjsw/bcx151

Hafford-Letchfield, T. (2019). *Leading with compassion: Supervisors' Briefing.* Research in Practice.
www.researchinpractice.org.uk/adults/publications/2019/december/leading-with-compassion-supervisors-briefing-2019

Han, S., & Yang, H. (2018). Understanding adoption of intelligent personal assistants: A parasocial relationship perspective. *Industrial Management & Data Systems, 118*(3), 618-636.
https://doi.org/10.1108/IMDS-05-2017-0214

Joseph Rowntree Foundation (2022). *UK Poverty 2022: The Essential Guide to Understanding Poverty in the UK.* Joseph Rowntree Foundation.
www.jrf.org.uk/file/58886/download?token=8bgbK-4t&filetype=full-report

Kendall, S., & Cameron, A. (2014). Personalisation of adult social care: Self-directed support and the choice and control agenda. *British Journal of Learning Disabilities, 42*(4), 264-271.
https://doi.org/10.1111/bld.12069

King's Fund (2019). *What's your problem, social care?* King's Fund.
www.kingsfund.org.uk/publications/whats-your-problem-social-care

Lee Lough Dennell, B., McGhee, K., & Porter, R. (2022). *Continuing Care: An exploration of implementation.* Centre for Excellence for Children's Care and Protection.
www.celcis.org/application/files/5816/4751/7713/continuing_care_an_exploration_of_implementation.pdf

Lelkes, J., Bouch, A., & Holmstrom, C. (2021). Well-Being: From Concept to Practice?, *Practice*, *33*(4), 289-307.
https://doi.org/10.1080/09503153.2021.1898579

Lewis, S. (2017). *Making an outcomes approach work in practice: Frontline Briefing (2017).* Research in Practice.

Linden, M.A., Forbes, T., Brown, M., Marsh, L., Truesdale, M., McCann, E., Todd, S., & Hughes, N. (2022). Impact of the COVID-19 pandemic on family carers of those with profound and multiple intellectual disabilities: Perspectives from UK and Irish Non-Governmental Organisations. *BMC Public Health, 22,* 2095.
https://doi.org/10.1186/s12889-022-14560-4

Marczak, J., Fernandez, J-L., Manthorpe, J., Brimblecombe, N., Moriaty, J., Knapp., M., & Snell, T. (2021). How have the Care Act 2014 ambitions to support carers translated into local practice? Findings from a process evaluation study of local stakeholders' perceptions of Care Act implementation. *Health and Social Care in the Community, 30*(5), e1711-e1720.
https://doi.org/10.1111/hsc.13599

McEwen, J., Bigby, C., & Douglas, J. (2014). What are Victoria's disability service standards really measuring? *Research and Practice in Intellectual and Developmental Disabilities, 1*(2), 1-12.
https://doi.org/10.1080/23297018.2014.956385

McEwen, J., Bigby, C. & Douglas, J. (2020). Moving on from Quality Assurance: Exploring systems that measure both process and personal outcomes in disability services. *Journal of Policy and Practice in Intellectual Disabilities, 17*(4), 364-375.
https://doi.org/10.1111/jppi.12295

Miller, R., & Freeman, T. (2015). *Managing change in social care.* NIHR School for Social Care Research.
www.sscr.nihr.ac.uk/PDF/Findings/RF47.pdf

Miller, R. (2020). *Systems leadership – enhancing the role of social care: Strategic Briefing.* Research in Practice.
www.researchinpractice.org.uk/adults/publications/2020/march/systems-leadership-enhancing-the-role-of-social-care-strategic-briefing-2020

National Audit Office (2021). *Efficiency in government.* National Audit Office.
www.nao.org.uk/wp-content/uploads/2021/07/Efficiency-in-government.pdf

Newton, C. (2012). Personalising reablement: Inserting the missing link. *Working with Older People, 16*(3), 117-121.
https://doi.org/10.1108/13663661211260934

NHS Confederation (2022a). *The state of integrated care systems 2021/22.* NHS Confederation.
www.nhsconfed.org/system/files/2022-02/State-of-integrated-care-systems.pdf

NHS Confederation (2022b). *System on a cliff edge: Addressing challenges in social care capacity.* NHS Confederation.
www.nhsconfed.org/publications/system-cliff-edge-addressing-challenges-social-care-capacity

Ninnis, K., Van Den Berg, M., Lannin, N.A., George, S., & Laver, K. (2019). Information and communication technology use within occupational therapy home assessments: A scoping review. *British Journal of Occupational Therapy, 82*(3), 141-152.
https://doi.org/10.1177/0308022618786928

Norah Fry Centre (2018). *Getting Things Changed: Final Report.* Norah Fry Centre.
www.bristol.ac.uk/media-library/sites/sps/images/gettingthingschanged/Final%20GTC%20report_web.pdf

Office of the Chief Social Worker for Adults, Research in Practice, Association of Directors of Adult Social Services, BASW, Care and Health Improvement Programme, NWG Network and police colleagues (2021). *Bridging the gap: Transitional safeguarding and the role of social work with adults: Knowledge Briefing.* Department of Health and Social Care.
www.researchinpractice.org.uk/all/publications/2021/june/bridging-the-gap-transitional-safeguarding-and-the-role-of-social-work-with-adults-knowledge-briefing

Osborne, S.P., Radnor, Z., & Strokosch, K. (2016). Co-production and the co-creation of value in public services: A suitable case for treatment? *Public Management Review, 18*(5), 639-653.
https://doi.org/10.1080/14719037.2015.1111927

Oyesanya, T., Harris Walker, G., Loflin, C., & Prvu Bettger, J. (2021). Negotiating the transition from acute hospital care to home: Perspectives of patients with traumatic brain injury, caregivers and healthcare providers. *Journal of Integrated Care, 29*(4), 414-424.

Paddison, C., & Crellin, N. (2022). *Falling short: How far have we come in improving support for unpaid carers in England?* Nuffield Trust.
www.nuffieldtrust.org.uk/research/falling-short-how-far-have-we-come-in-improving-support-for-unpaid-carers-in-england

Pasmore, W. (1988). *Designing Effective Organisations: The Socio-technical Systems Perspective.* Wiley.

Pearman, H. (2021). *Occupational therapy in adult social care: Frontline Briefing (2021).* Research in Practice.
www.researchinpractice.org.uk/adults/publications/2021/september/occupational-therapy-in-adult-social-care-frontline-briefing-2021

Penny, J. & Slay, J. (2014). *Commissioning for outcomes and co-production.* New Economics Foundation.
https://neweconomics.org/2014/06/commissioning-outcomes-co-production

Pentaraki, M. (2016). 'I am in a constant state of insecurity trying to make ends meet, like our service users': Shared austerity reality between social workers and service users – towards a preliminary conceptualisation'. *British Journal of Social Work, 47*(4), 1245-1261.
https://doi.org/10.1093/bjsw/bcw099

Petrillo, M., Bennett, M., & Pryce, G. (2022). *Cycles of caring: Transitions in and out of unpaid care.*
www.carersuk.org/media/bgolg5u2/cuk-carers-rights-day-research-report-2022-web.pdf

Petrillo, M., & Bennett, M. (2023). *Valuing Carers 2021: England and Wales.* Carers UK/Centre For Care.
https://centreforcare.ac.uk/wp-content/uploads/2023/05/Valuing_Carers_WEB2.pdf

Pousada Garcia, T., Pereira, J., Gonzalez, B.G., & Nieto-Rivero, L. (2019). Assistive technology based on client-centered for occupational performance in neuro-muscular conditions. *Medicine 98*(25), e15983.
www.researchgate.net/publication/333951805_Assistive_technology_based_on_client-centered_for_occupational_performance_in_neuromuscular_conditions

Reamer, F. (2022). Moral injury in social work. *Encyclopaedia of Social Work.* National Association of Social Workers and Oxford University Press.
https://doi.org/10.1093/acrefore/9780199975839.013.1629

Renaud, K. (2022). *Accessible Cyber Security: The Next Frontier? Keynote.* Strathclyde University.
https://strathprints.strath.ac.uk/78642/1/Renaud_ICISSP2021_Accessible_cyber_security.pdf

Riemer-Reiss, M., & Wacker, R. (2000). Factors associated with assistive technology discontinuance among individuals with disabilities. *Journal of Rehabilitation 66*(3), 44-50.

Romeo, L. (2017). *Strengths-based social work practice with adults. Roundtable report.* Department of Health.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/652773/Strengths-based_social_work_practice_with_adults.pdf

Samsi, K., Cole, L., Orellana, K., & Manthorpe, J. (2022). Is it worth it? Carers' views and expectations of residential respite for people living with dementia during and beyond the COVID-19 pandemic. *International Journal of Geriatric Psychology, 37*(2).
https://doi.org/10.1002/gps.5680

Schein, E. (1992). *Organizational culture and leadership.* Jossey Bass.

Schneider, B., & Barbera, K.M. (Eds.) (2014). *Oxford handbook of organizational climate and culture.* Oxford University Press.

Social Care Institute for Excellence (SCIE) (2011). *Personalisation, productivity and efficiency.* SCIE.
www.scie.org.uk/personalisation/introduction/productivity-efficiency

Social Care Institute for Excellence (2021). *Unlocking the potential of adult social care: Critical review tool to help social care leaders move towards a strengths-based, whole-place approach.* SCIE.
www.scie.org.uk/files/strengths-based-approaches/leadership/review-tool/unlocking-the-potential-of-adult-social-care.pdf

Social Care Institute for Excellence (2022). *Co-production: What it is and how to do it.* SCIE.
www.scie.org.uk/co-production/what-how

Skills for Care (2023). *Headline social worker information: Social workers employed by local authorities in the adult social care sector.* Skills for Care.
www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/Social-Worker-headline-Feb2023-FINAL.pdf

Stein, M. (2012). *Young People Leaving Care: Supporting pathways to adulthood.* Jessica Kingsley.

Sutton, J. (2020). *Co-production and strengths-based practice: Leaders' Briefing.* Research in Practice.
www.researchinpractice.org.uk/adults/publications/2020/july/co-production-and-strengths-based-practice-leaders-briefing-2020

Templeton, F., Mitchell, D. & Luff, R. (2021). *Review of evidence related to unpaid carers' needs assessments in Wales.* SCIE.
www.scie.org.uk/wales/research/unpaid-carers

Vieira, A., Leite, H., & Lachowski Volochtchuk, A-V. (2022). The impact of voice assistant home devices on people with disabilities: A longitudinal study. *Technological forecasting and social change, 184.*
https://doi.org/10.1016/j.techfore.2022.121961

Warren, S., & Bottery, S. (2021). *A 'radically realistic' vision for adult social care.* King's Fund.
www.kingsfund.org.uk/publications/radically-realistic-vision-adult-social-care

Weaver, B. (2019). Co-production, governance and practice: The dynamics and effects of User Voice Prison Councils. *Social Policy and Administration, 53*(2), 249-264.
https://doi.org/10.1111/spol.12442

Werner, N., Tong, M., Borkenhagen, A., & Holden, R. (2019). Performance-Shaping Factors Affecting Older Adults' Hospital-to-Home Transition Success: A Systems Approach. *The Gerontologist*, *59*(2), 303–314.
https://doi.org/10.1093/geront/gnx199

West, M., Eckert, R., Steward, K., & Pasmore, B. (2014). *Developing collective leadership for health care.* King's Fund.
www.kingsfund.org.uk/sites/default/files/field/field_publication_file/developing-collective-leadership-kingsfund-may14.pdf

Williams, M., Zhou, Y., & Zou, M. (2020). The rise in pay for performance among higher managerial and professional occupations in Britain: Eroding or enhancing the service relationship? *Work Employment and Society, 34*(4), 605-625.
https://doi.org/10.1177/0950017019841552

Authors: Susan Bruce, Kadie Chapman, Laura Collins, Bob Jones, Cath Sorsby and Jeanette Sutton

Additional contributions from:
Sam Daniels

Research in Practice is a programme of The Dartington Hall Trust which is registered in England as a company limited by guarantee and a charity. Company No. 1485560 Charity No. 279756 VAT No. 402196875 Registered Office: The Elmhirst Centre, Dartington Hall, Totnes TQ9 6EL

Research in Practice
The Granary, Dartington Hall
Totnes, Devon, TQ9 6EE
tel: 01803 867692
email: ask@researchinpractice.org.uk

© Research in Practice, December 2023

www.researchinpractice.org.uk/social-care-future