Report to:	Executive Cabinet Member - Deputy Leader's Portfolio and Executive Cabinet Member - Regeneration and Resources Portfolio	
Date:	30, June 2014	
Report of:	Adrian Crook, Assistant Director Integration and Provider Services	**Report No:**
Contact Officer:	Nicki Lomax Consultant in Public Health	**Tel No:** 01204 33 7823
Report Title:	**Staying Well Programme Proposal**	

Non-Confidential	This report does not contain information which warrants its consideration in the absence of the press or members of the pubic
Purpose:	To establish the posts required to deliver Bolton's proposed Staying Well programme of targeted prevention and early intervention for older people at risk of dependency on health and social care services. The aim of the Staying Well programme is to enable people to stay healthy, happy and independent and to reduce dependence on expensive secondary healthcare and social services.
Recommendations:	It is recommended that the Executive Cabinet Member: 1. Endorses the proposal and commits the investment required for implementation; 2. Establishes the posts as requested 3. Receives further updates and evaluation prior to larger scale implementation in April 2015.
Decision:	
Background Doc(s):	

1. EXECUTIVE SUMMARY

1.1 This report sets out a proposal to establish a Staying Well programme, delivering targeted prevention and early intervention to older people at high risk of dependency on health and social care services and at risk of hospital admission. It describes the proposed service model, investment required and expected benefits.

1.2 The proposed service offer responds to the familiar drivers of public sector reform: increasing demand from a growing population of older people; reducing public sector resources; opportunities for increased effectiveness, efficiency and innovation, and improved quality and outcomes.

1.3 The service model has been shaped by evidence, national policy direction, best practice and evaluation of the Bolton Staying Well pilot. It is proposed that the Staying Well offer is embedded and aligned within the emerging local system of integrated care, ensuring a whole system approach to reducing demand and optimising the health and wellbeing of older people.

1.4 The Staying Well approach offers an opportunity to 'shift the curve', enabling targeted investment in prevention to stem the further escalation of demand.

2. INTRODUCTION: RATIONALE FOR THE STAYING WELL OFFER

2.1 The importance of Risk Stratification and Long Term Conditions

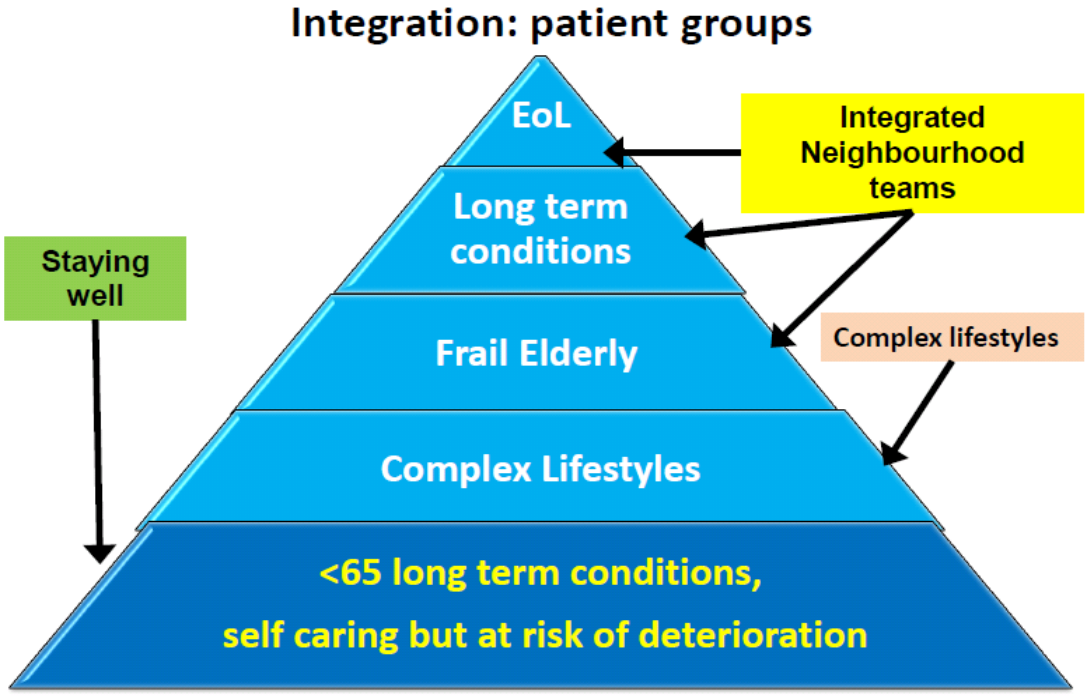
2.1.1 There are over 44,000 people aged 65 and over in Bolton. Using the Potential Care Need Index (PCNI) it is estimated that of these over 13,064 people are at risk of developing future health and social care needs. The PCNI is a stratification tool enables proactive and systematic targeting (case finding) of at risk older people through GP practice lists.

2.1.2 The Combined Predictive Model (CPM) is a risk stratification tool which aims to predict the likelihood that a patient will be admitted to hospital in an emergency in the next 12 months. It is a national model that has been in use in the NHS for many years. The model takes primary and secondary care data and outputs a risk score for each patient, regardless of whether they have accessed any secondary care resources before. The risk score is a probability score between 0 and 100, where 100 is the highest risk score.[1].

2.1.3 Following application of this tool to Bolton's population data approximately 3500 people can be seen to be at high risk of admission to hospital, scoring over 50. A score of 50 means there is a 50% likelihood of the person being admitted to hospital in the next 12 months. This means a hospital admission is 6 ½ times more likely than the average Bolton Resident.

2.1.4 A further 11,236 people aged 65 and over score over 20 which means there is a 20% likelihood of them being admitted to hospital in the next 12 months. This means a hospital admission is 2 ½ times more likely than the average Bolton resident. Whilst a 20% likelihood is considerably less than the 3500 people mentioned above it is at a level of risk that most older people would rather reduce if at all possible.

2.1.5 A review of these patients allows their needs to be themed as illustrated in this diagram:

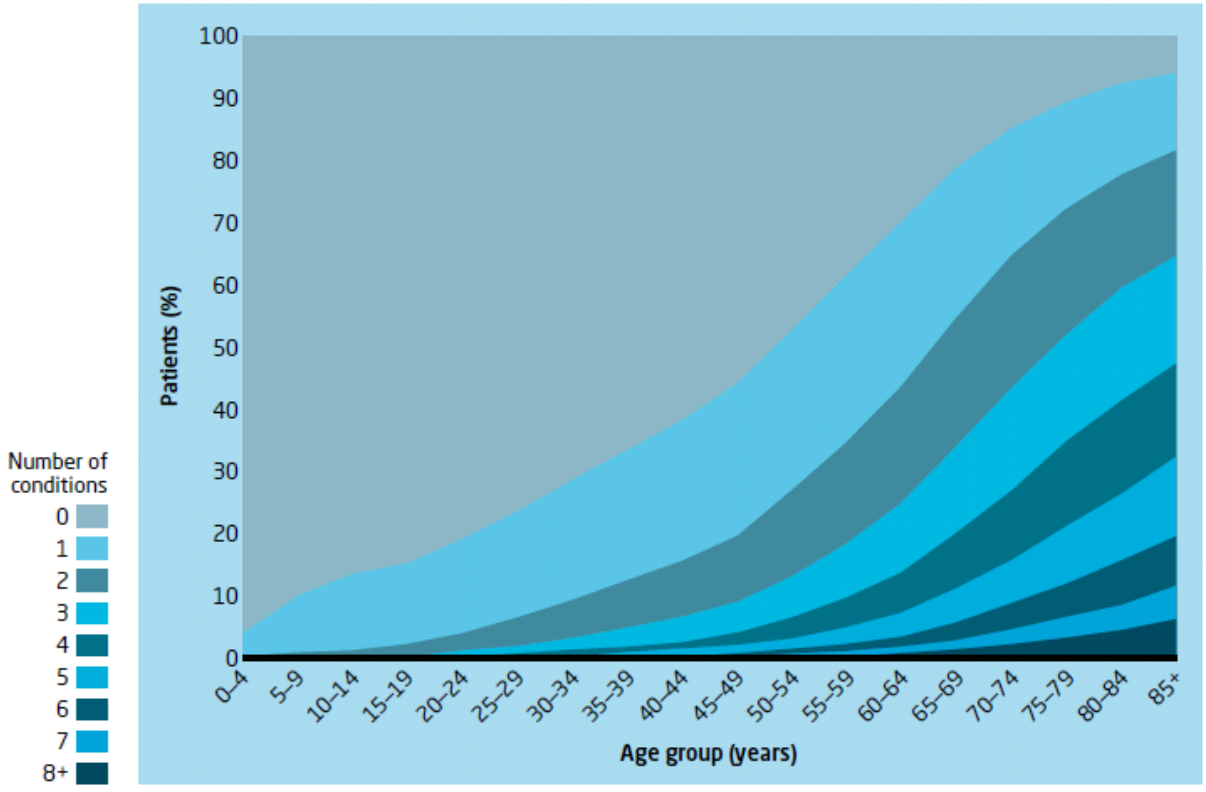


2.1.6 The 3500 who score over 50 and who are at high risk of hospital admission are found in the top 4 groups above and will be the focus of new care delivery models being developed alongside but separately to this proposal.

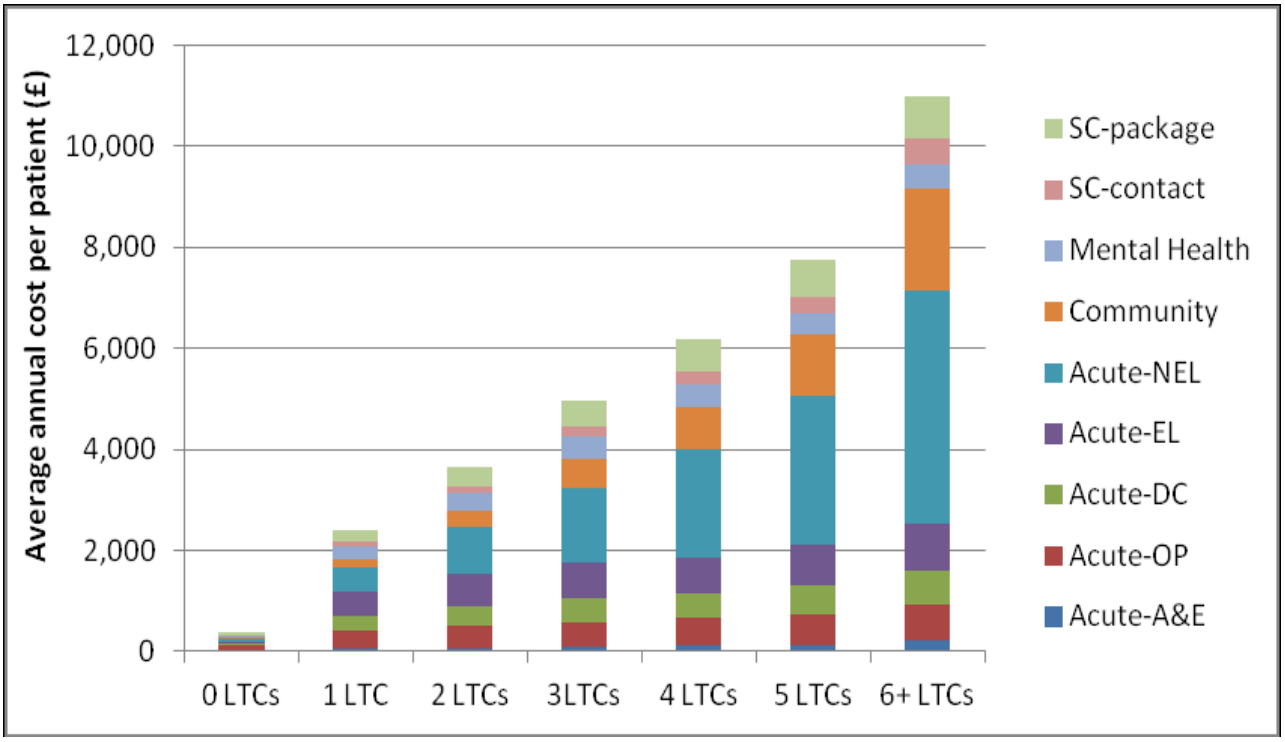
2.1.7 The 11,236 people aged 65 and over who score over 20 can be found in the fifth group above, described as 'long term conditions who are at present self caring'.

2.1.8 A long term condition is life limiting and disabling condition that cannot be cured but can be controlled with medication or other therapies and include illnesses such as heart failure, diabetes, chronic obstructive pulmonary disease, arthritis and high blood pressure. The number of people with long term conditions is expected to rise over the next 10 years, especially those with 3 or more. Caring for people with long term conditions currently accounts for 70% of the money we spend on health and social care.

2.1.9 The diagram below illustrates how the number of long term conditions a person has is likely to increase with age



2.1.10 The following diagram illustrates how there is a direct link between the number of long term conditions a person has and the amount of health and social care services a person uses



2.1.11 Adopting healthier lifestyles in old age and learning how to self-care is shown to yield significant benefits and it is estimated that over half of the burden of disease among people aged over 60 is avoidable through changes in lifestyle such as regular exercise, not smoking, reducing alcohol consumption and healthy eating.

2.1.12 It is important that we work proactively with people with long term conditions to ensure wherever possible we prevent, delay and reduce the progression of these illnesses and the demands on health and social care services.

2.2 The importance of 'minor' needs

2.2.1 Whilst public services struggle to meet the needs of a growing and more dependent population many struggle to provide support to people's lower or 'minor' needs

2.2.2 These include:

- Social isolation and loneliness;
- Common conditions of older age that limit independence (eg mobility problems, foot health, chronic pain, visual or hearing impairment, incontinence, malnutrition, oral health);
- Housing and fuel poverty;
- Practical support needs (eg minor household repairs);
- Promotion of healthier lifestyles, including nutrition and food poverty.

2.2.3 Needs classed as minor can have significant effects on independence, well-being a social engagement and loneliness, social isolation and social exclusion are known to be important risk factors for ill health and mortality in older people[2]

2.2.4 It is important we help people meet their 'minor' needs as often services and support are commonly available in the community but awareness and access is low in the very group that need them

3. A SYMPTOM OF RATIONING

3.1 The current system of care invests too much capacity in 'demand management' and fails to tap into the potential of individuals and communities to enhance their own health and wellbeing: far too many older people only come to the attention of health and social care services once they have reached a crisis point in their lives and begin a downward spiral of decline and dependency.

3.2 A significant proportion of activity within adult health and social care services can be described as 'failure demand' which is demand caused by a failure to do something or do something right for the customer. It has been estimated that this can account for up to 80 per cent of demand into health and social care services. Failure demand includes re-presentation with the same problem, re-screening and reassessment, all creating high volumes of work for health and social care services.

3.3 This pattern is seen locally here in Bolton. Whilst 40% of older people approaching social care for support every year are found to eligible, 60% are found ineligible and turned away. There is currently no alternative for these older people who despite asking for and feeling they are in need of support receive none as they are found ineligible.

3.4 The inevitable effect of rationing to manage demand for health and social care services is to leave individuals experiencing a poor quality of life and to make them repeatedly present until their problem is found to be serious enough that they can be found eligible for care. This results in the service user presenting in crisis which is evidenced to results in a larger amount of in service delivered than when the service user presents not in crisis.[3]

3.5 It is vital we strive to 'shift the curve' from high cost reactive care to care that is preventative, proactive and based close to people and their homes. Care focusing on wellness and the factors that our residents value such as the ability to remain at home in clean, warm, affordable accommodation; to remain socially engaged; to continue with activities that give their life meaning; to contribute to their family or community; to feel safe and to maintain independence, choice, control, personal appearance and dignity; to be free from discrimination; and to feel they are not a 'burden' to their own families and that they can continue their own role as caregivers[4]

3.6 Learning from the Bolton Staying Well pilot corresponds with this national and international evidence and highlights the potential to improve outcomes and reduce dependency across a range of key performance areas, including Community Care Based Standards and the Public Health Outcomes Framework. A summary of the outcomes delivered by the initial staying well pilot that has now worked with 136 service users is found in Appendix 1 along with a description of the intervention

4. The Proposed Model – Staying Well

4.1 Staying Well is a targeted prevention and early intervention offer to older people that will increase their opportunities to enjoy long healthy lives, feeling safe at home and connected to their community.

4.2 The key principles underlying the proposed model are:

- An asset based approach, promoting maximum independence and self-determination of older people;
- An place based approach to use and development of community assets/resources
- Integration within a whole system of care, community and place

4.3 The offer is based on the delivery of a Staying Well intervention comprising the following elements:

- A person-centred conversation about needs and assets using the holistic Staying Well tool, covering 12 key dimensions of health and wellbeing (see appendix 1):
- Individual goal orientated action planning to ensure patient/service user activation;
- Time limited interventions that support and motivate behavioural change to improve health and well-being;
- Facilitation to helping people to navigate the system and information sources, signposting on with support, checking back on progress and immediate outcomes;
- Support, information or advice to encourage self-care and self-management;

4.4 The intervention will be delivered by '*Health and Wellbeing Co-ordinators'* (tba[1]) recruited and trained to deliver the holistic Staying Well intervention described above. Co-ordinators will use a range of knowledge and skills to support these steps and encourage a self-help approach. The service will also maximise the opportunities for self management, peer support and support from local community, voluntary and faith sector groups.

4.5 As with the original staying well pilot residents in receipt of other statutory services such as long term conditions practitioner and or social work will be excluded to ensure that there is no duplication

5. Roll Out 2014/15

5.1 For the roll out in 2014/15 it is proposed that the Staying Well offer is accessed via three routes:

- **Multi-Disciplinary Teams / Integrated Locality Teams**: using the Potential Care Needs Index tool to systematically, pro-actively identify older people at risk and offering an intervention for patients/service user accessing the MDTs that are currently being developed in the west of the borough;
- **Pre-'STARS' social services front door service**: offering an alternative pathway of support and early intervention for older people who self-present are or referred to social services but are not eligible for statutory social care under fair access to care criteria.
- **Continuation of existing work with 6 GP practices**
    - Pike View Medical Centre
    - Kearsley Medical Centre
    - Dalefield Surgery
    - Little Lever Health Centre
    - Shanti Medical Centre
    - Halliwell Surgery

5.2 The Pre-STARS social care front door will be a redesign of the social care customer pathway, developing a pre-assessment 'early intervention staying well service' as the front door of Adult Services to enable, signpost, and maximise independence which will prevent, delay and reduce the need for care. This redesign will roll out the 'early intervention and staying well service' as a Bolton wide offer from September 2014.

5.3 Regardless of access route the proposal is to deliver a consistent, holistic Staying Well intervention through small teams of Health and Wellbeing Co-ordinators located in each of the service settings above.

5.4 As with the original staying well pilot residents in receipt of other statutory services such as from a long term conditions practitioner, health trainer and/or social work will be excluded to

[1] To be agreed – options include Health and Wellbeing Co-ordinator/Navigator/Worker

ensure that there is no duplication with interventions being developed by our Integrated Neighbourhood teams or other services. Appendix 13 contains a summary of the interventions currently available and how this one differs.

6. Community Capacity Building

6.1 Underpinning the individual Staying Well offer, delivered through the Staying Well service, it is proposed that there is a specific work stream to stimulate and develop community capacity to support older people's health and wellbeing. This community capacity building work stream is absolutely essential to fully realise the potential of communities, neighbourhoods and their residents to assist in the delivery of prevention and early intervention, and to address the many inequalities in outcomes for older people across the borough.

6.2 The voluntary, community and faith groups sector has a key role to play in developing stronger, healthier and age-friendly communities. Integral to the Staying Well vision is the shaping of a voluntary, community and faith group sector response to the needs and assets of Bolton's older people. Valuable new intelligence will be generated through the Staying Well intervention with individual older people, building a richer understanding of needs, perceived 'deficits' and opportunities for asset-based working in localities, neighbourhoods and borough wide.

6.3 Many examples are beginning to emerge as health and social care economies across the United Kingdom adopt similar approaches to maximising the health and well-being of their residents, some of the initiatives in the north of the country are highlighted below

Wigan's 'The Deal' and Community Investment Fund
Liverpool's Healthy Homes Program
Manchester's Community First Fund
Leeds Community Foundation
Stockport's People Powered Health

6.4 Additional organisational capacity is required to lead and co-ordinate the community capacity work stream. It is proposed to recruit to a Community Capacity Development post to lead and facilitate the development of an asset based approach across the voluntary and community sector. This will ensure consistency in working with the sector, and the development of processes and governance to underpin a collaborative approach to investment.

6.5 The post-holder would take direction from the commissioning partners within the council and clinical commissioning group and work with the voluntary, community and faith groups sector to deliver on key objectives of this work stream, including:

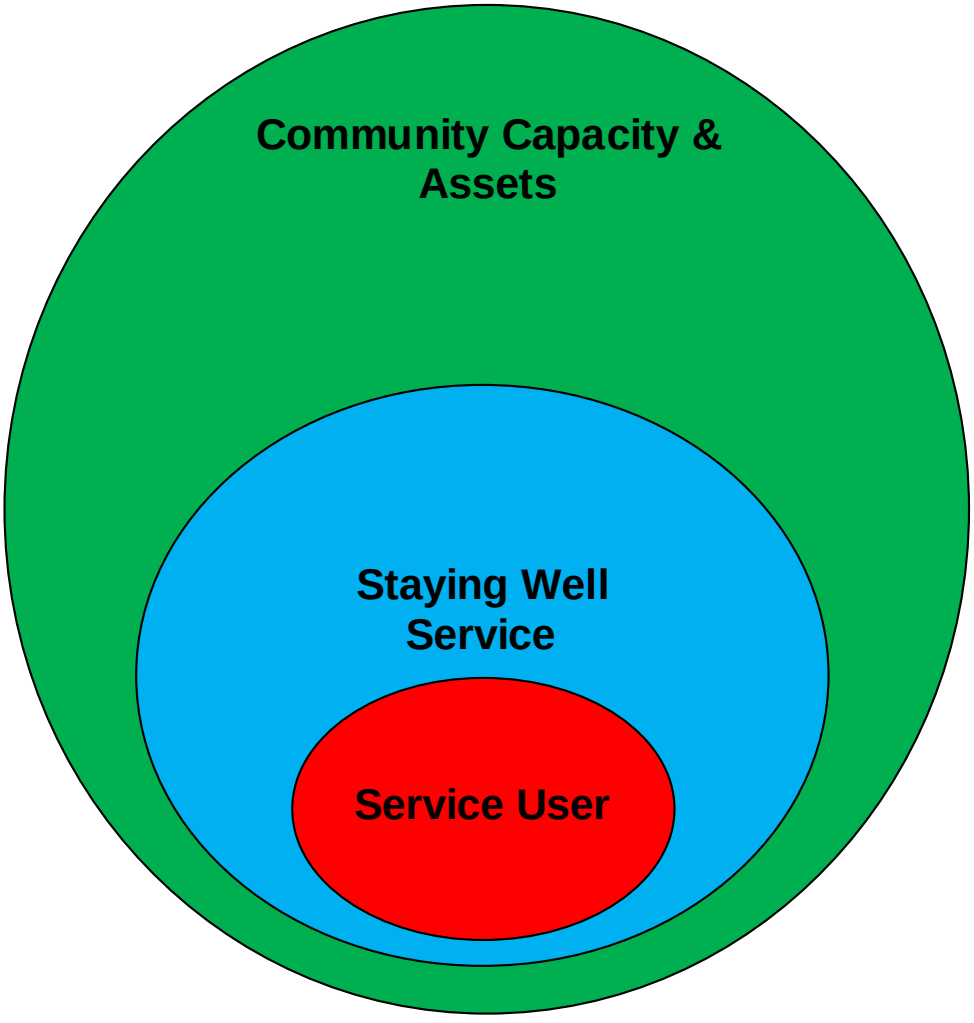
- Identification of mapping of community assets at neighbourhood and borough level;
- Identification of gap/deficits at neighbourhood and borough level
- Assess the potential for existing assets to deliver services more successfully
- Plan stimulation of developments at community level to meet these gaps/deficits, testing new approaches during the phased roll-out;
- Qualify the outcomes and benefits delivered
- Develop new and robust arrangements for governance and collaboration.

7. Proposed Service Model and staffing structure

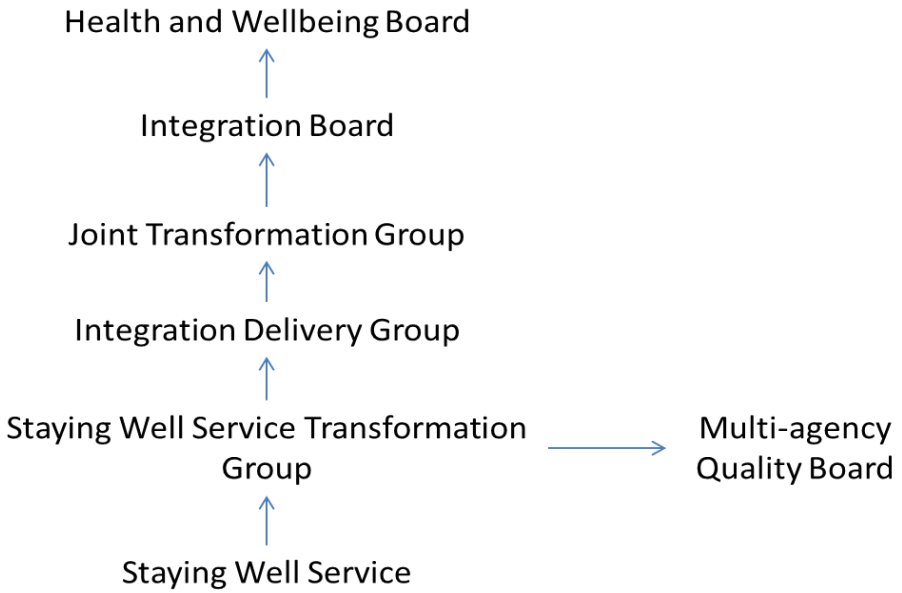
7.1 For the 2014-15 roll out it is proposed that the Staying Well service is located within Adult social care, a transition from the current location of the pilot within Public Health. This will enable closer integration with emerging new pathways at the social care front door and in the integrated locality teams, and will be a better operational fit with service provision to older adults.

7.2 The Public Health team and older people's Public Health Specialist would continue to provide support to the implementation and evaluation of the whole Staying Well offer and form members of the multi-agency quality board

7.3 Service Model



7.4 Governance



7.5 Establishment

The Staying Well roll out in 2014-15 will require the establishment of the following new posts:

Post	Grade	FTE(s)
Deputy Team Manager	10	1.00
Social Worker	8	2.00
Community Assessment Officer	7	3.00
Sensory Officer	7	0.50
Telecare Officer	7	0.50
Disability Officer	7	0.60
Team Leaders	6	2.00
Project Support Officer	6	1.00
Health and Wellbeing Coordinators	5	7.50
Community Capacity Lead	10	1.00

8. Job Descriptions

Job Descriptions for the above posts can be found in the **appendices:**

3 Deputy Team Manager
4 Social Worker
5 Community Assessment Officer
6 Sensory Officer

7 Telecare Officer
8 Disability Officer
9 Team Leaders
10 Project Support Officer
11 Health and Wellbeing Coordinators
12 Community Capacity Lead

9. Resources Required

9.1 The resource required for this part year roll out of the new elements list above is £214,000. This amount is funded from the 14/15 Better Care Fund Allocation

9.2 The full year resource required is £644,500.

9.3 In recognition of the importance that 'shifting the curve' plays in maximising the health and well-being of this group of our residents and helping reduce, delay and prevent the future need for health and social care services £1,496,000 has been allocated as part of the Better Care Fund for 15/16 for ongoing provision of services that support this fifth cohort of residents in Bolton who require support to 'Stay Well'.

9.4 Whilst there has been no formal notification of allocations to the Better Care Fund after 2015/16 it is expected that the investment in Integrated Health and Social Care will continue beyond this and the CCG have reflected this in their 5 year strategic plan.

10. Evaluation

10.1 The Staying Well offer and delivery model will be subject to continuous evaluation and review to further refine and shape the delivery of the targeted prevention and early intervention offer for older people.

10.2 Learning and evaluation from the wider roll out will allow testing of:

- The operational model: including pathways, interdependencies, and refinement of the holistic intervention (e.g. balance of navigation/advocacy/behaviour change, management of caseloads/through-flow);
- Estimated impacts and benefits, including cost benefits;
- The success of asset based approaches at community and service user level
- Opportunities for further innovation in service delivery including working with non-statutory partners
- Innovate methods of community asset building

10.3 Understanding what 'success' looks like from an older service users perspective will be central to the evaluation. Methods used will ensure that service users are at the heart of service design and our service users will become an active partner in service design and improvement.

11. Recommendation

11.1 Implementation of the Staying Well offer – embedded within the whole system transformation - will begin to 'shift the curve' from high-cost, reactive and bed-based care to care that is preventative, proactive and based closer to people's homes, delivered at

neighbourhood level, maximising our service users and their communities wellbeing rather than merely responding to illness.

11.2 It is recommended that Executive Cabinet Member:

- Endorses the proposal and commits the investment required for implementation;
- Establishes the posts as requested
- Receives further updates and evaluation prior to large scale implementation in April 2015.

12. References

1. Combined Predicted Model, Final Report, Kings Fund 2006
2. Making out health and care systems fit for an ageing population, King Fund 2014
3. Year of Care Program, NHS IQ, 2014
4. Personal Social Services Research 2010

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thinking today for tomorrow

Bolton Council

NHS
Bolton Clinical Commissioning Group

Quality of life wheel

Using the scale at the bottom of this page, tell us how happy or unhappy you are using the key categories from the quality of life wheel. Please rate these from 0-5.

Scoring of 0-2 will need a further detailed conversation to identify appropriate information, advice and support

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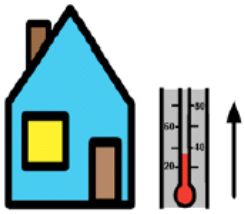
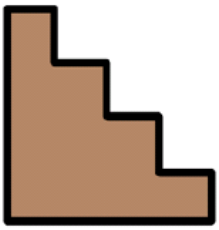
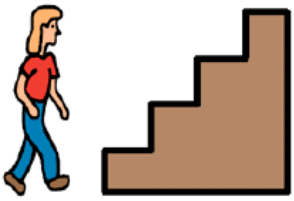
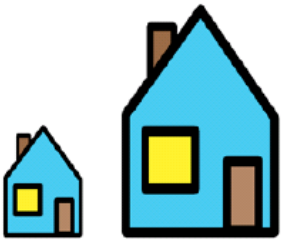
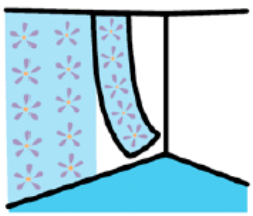
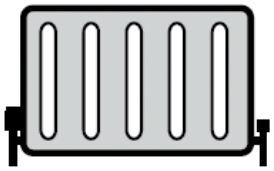
House & Home

 Feel safe	 Keep warm	 Safe appliances
 Manage your garden	 Housing costs	 Home repairs
 Easy access	 Home adaptations	 House too big
 The future	 Damp / mould	 Efficient heating

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Staying Well holistic check (Quality of Life Wheel)

The focus of the check is to help individuals remain healthy, happy and independent at home for longer. To assist in this goal, the wellbeing coordinators used a specially designed Staying Well Check Tool to work with individuals and identify their personal risk factors for future health and social care need.

The tool has been designed to support a two way open conversation between the coordinator and the individual. A quality of life wheel and visual picture cards were developed as part of the tool, and have proven to be particularly useful with clients who have language and communication difficulties.

The wheel encourages conversation around the factors and conditions that shapes an individual's quality of life, while the picture cards are used to support this conversation, and overcome communications barriers.

The 12 key themes covered by the Staying Well Quality of Life Wheel are:

1. Health (i.e. memory, healthy eating, screening)
2. Carer Support (i.e. break from role, emotional well-being)
3. Emotional Wellbeing (i.e. thinking clearly, making decisions, feeling sad)
4. Getting Out and About (i.e. driving, managing stairs, shopping, going to the bank)
5. Personal Care and Daily Tasks (i.e. feeding, dressing, cleaning home)
6. House and Home (i.e. home repairs, minor and major adaptions, moving home)
7. Managing Medication (i.e. taking the right dose at the right time, reading labels)
8. Managing Money (i.e. debt advice, heating costs, benefits advice)
9. Friends, Family and People (i.e. trust, relationships, loneliness)
10. Communication (i.e. hearing, seeing, reading)
11. Volunteering and Work (i.e. skills, training, working hours)
12. Hobbies and Interest (i.e. shopping, puzzles, eating out)

Staying Well Outcomes

Staying well has seen 136 clients to date (as of 10/6/14). The take up rate is currently 69%, with 23% declining, and 7% becoming ineligible (e.g. becoming terminally ill or dying) in the time between the sample being drawn and being invited for their check.

Outcomes: Quality of life Wheel Scores

The Wellbeing Coordinator helps the client to identify areas of concern for them, and they jointly agree and set actions intended to improve these areas of concern. The Staying Well Check tools, including the Quality of Life Wheel, are used to inform this discussion. The Quality of Life Wheel is then repeated on client sign off to check for changes, together with an evaluation questionnaire asking about changes that have happened to clients since they have been involved with Staying Well.

Across all clients so far involved in the pilot, the category with considerably the lowest average score, indicating the greatest level of need is health. This is followed by getting out and about, personal care and daily tasks, house and home, and emotional wellbeing. Where clients indicated a need, this triggered further questions. From responses to these questions we can see that pain was the most often identified health need (77% of clients with a health need), followed by physical health need (74%). Clients with physical health needs tended to be those with multiple health conditions. Other notable health concerns include sleep (55%), breathing (48%), physical activity (35%), and skin issues (35%).

To focus on the clients who were in need of further support, the initial and sign off Wheel Scores of those clients who rated at least one theme as 0-2 (indicating a potential cause for concern) were examined. Overall, these clients showed a positive improvement across all the categories in which they initially had concerns.

Quality of Life Wheel Theme	% initially scoring ≤2 indicating a concern	Average change in this theme (Quality of life points)
Health	45%	1.4
House and home	16%	2.0
Personal care/ daily tasks	16%	2.4
Getting out and about	15%	2.0
Communications	12%	1.9
Emotional wellbeing	12%	1.1
Carer support	10%	3.0
Hobbies and interests	9%	0.8
Family and friends	9%	1.8
Managing and taking medication	3%	1.0
Managing your money	2%	5.0
Volunteering and work	0%	-
Total	*54%*	*2.7*

Outcomes: Exit questionnaire
On sign off, clients are also asked to complete a questionnaire asking about the impact they feel that Staying Well has made on their lives. This questionnaire asks about a number of potential outcomes clients may have experienced; because of the wide ranging scope of Staying Well, not all outcomes will be relevant to all individuals.

The top two most relevant outcomes where Staying Well has had the most positive impact are both wellbeing outcomes: 'My contact with Staying Well has improved my confidence', and 'Due to the support of Staying Well I can cope with life better'. Both Friends and Family outcomes featured here too: 'I feel less lonely due to the contact with Staying Well helping me improve my social networks', 'My contact with Staying Well has helped me spend more time with my friends & family'. Positive impacts were also seen in several health/ medication together with house and home outcomes: 'Contact with Staying Well has made sure I'm on the right medication for me', 'My contact with Staying Well has helped me get more physically active', 'My contact with Staying Well has helped me to feel happier in my home', 'My contact with Staying Well has meant that my home is now adapted for my needs'.

Overall, 98% of clients rated Staying Well as either good or very good. 19% of clients said that if they had not been offered the Staying Well intervention they thought it was either highly likely or likely that they would have reached a crisis or been unable to cope; 20% were not sure. 67% of clients agreed that contact with Staying Well had helped them to maintain their independence.

Outcomes: Client Actions
The Staying Well Coordinator and the client together set actions for the coordinator, the service, and the client themselves to complete. The coordinator then then follows up and supports the client to complete their actions. Identifying and completing actions is the main route by which Staying Well aims to impact on clients' lives. An average 3.8 actions were set per client. At the time of the download, 52% of actions were completed, however this varied by type of action: 78% of referrals were completed, compared with 35% of service recommendations, and 41% of

information given to read actions. Some actions coded as uncompleted at the time the download was taken will therefore subsequently be completed.

The largest proportion of actions (38%) related to health or healthcare related issues. Note that the actions included in this were broader than just the health segment of the Quality of Life Wheel, incorporating themes that would fall under segments such as communications, medication and emotional wellbeing. The most frequent actions in this theme were to see the GP practice, a referral to the long term conditions team, a mental health or wellbeing action (most of these involved contacting the Think Positive service), audiology or hearing issues, and dental or tooth care issues.

Contacting local voluntary groups was involved in 16% of actions; the most frequently recommended organisations were Bolton Citizens Advice Bureau, Age UK Bolton, and Bolton Carers Support. Care or support actions were also frequently set (15% of all actions), the most common related to contacting the Independent living team, who provided/ loan a range of equipment for enabling people to maintain independence and safety in their own home, and carer issues.

Learning

Key learning so far:

- Taking time to engage and form a relationship with clients and support for their behaviour change is vital.
- Staying Well is not as was feared, creating demand for high cost acute services – because most health needs were appropriately met by GP with other needs met by local voluntary services and other relatively low cost services such as equipment to maintain independence.

APPENDIX 2

Key outcome areas
Expected impact areas of the Staying Well offer:

Community Care Based Standards

- More uptake of screening
- More pharmacy reviews for new medicines
- More people losing weight, stopping smoking and reducing alcohol intake
- Fewer people admitted to hospital due to alcohol
- Increased percentage of eligible people being vaccinated
- Better availability and access to psychological therapies
- More carers who are able to maintain their quality of life
- More homes meeting the decent homes standards in each borough
- Increased knowledge and awareness about keeping healthy and maintaining good wellbeing Increased personal responsibility and independence
- People will experience improved physical and mental health and wellbeing
- People are informed how to access a range of services to keep them well

Public Health Outcomes Framework:

Domain 1 **Improving the wider determinants of health**
Fuel poverty
Perception of safety is an important factor in helping older people to maintain their independence and activity and to avoid social isolation.

Domain 2 **Health improvement**
Falls and fall injuries in the over 65s

Domain 3 **Health protection**
Flu vaccination coverage (over 65s).

Domain 4 **Healthcare public health and preventing premature mortality**
Excess winter deaths
Dementia and its impacts

APPENDIX 3 – Deputy Team Manager

JOB DESCRIPTION

Department	**ADULT AND COMMUNITY SERVICES**
Job Title	**DEPUTY TEAM LEADER – SOCIAL WORK**
Grade	**GRADE 10**
Primary Purpose of the Job	To do everything possible to ensure the Department provides an efficient and effective social work service
Responsible to	TEAM LEADER – SOCIAL WORK
Responsible for	Ensuring the Department provides an efficient and effective Social Work Service
Principal Responsibilities	Assisting Team Leaders in the management of the Social Work Service within Adult and Community Services

MAIN DUTIES	
1	To deputise for the Team Leader as appropriate
2	To assist in the management of risk at organisational, professional and individual levels.
3	To work within multi-disciplinary and multi-organisational teams, networks and systems and enhance productive working relationships to achieve good outcomes for individuals.
4	To work within national and departmental standards of social work practice and ensure own professional development
5	To provide leadership the work of teams and support individuals to achieve Council objectives
6	To assist in the management and control of resources and expenditure of budgets.
7	To assist the Team Manager in ensuring that the work of the team is allocated and to contribute towards the overall management of the team's workload.
8	To contribute to continuous quality improvement and assist in the implementation and monitoring of quality assurance systems
9	To interact with individuals, families and carers to achieve change and development to improve outcomes for individuals
10	To promote best social work practice with an emphasis on Safeguarding Adults.
11	To prepare for, facilitate, chair and participate the resolution of complaints, safeguarding investigations and decision-making forums

12	To apply disciplinary and grievance procedures as necessary
13	To assist in the investigation of complaints in accordance with Departmental processes
14	To reach decisions in relation to the level of response necessary for referrals.
15	To assist the Team Manager in the effective management, support and supervision of staff by identifying and working with them on their own development and training needs where appropriate.
16	To contribute to the recruitment and selection process.
17	To undertake other duties and responsibilities as may be determined by the Director of Adult and Community Services from time to time.

ORGANISATIONAL COMPETENCIES
Valuing Diversity To be responsible for contributions to the achievement of the Authority's Valuing Diversity Policy, both in you work and in your role as a Manager through the implementation of the supporting action plans. To provide a supportive open environment where all employees have the opportunity to reach their full potential. To ensure that the Elected Members are encouraged to share in and reflect policy in their work.
Caring for Customers To continually review, develop and improve systems, processes and services in support of the Council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.
Developing Yourself and Supporting Others To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.
Health and Safety To operate safely within the workplace with regard to Health and Safety legislation.
Confidentiality An acknowledgement of the need to maintain confidentiality at all times and to become aware of the National, Corporate and Departmental policies on Confidentiality, and the management and sharing of information.
Limits of Authority Within the framework of Council and Departmental policies and instructions, and subject to the overriding authority of his/her line manager, the officer holding this post is authorised to undertake all duties appertaining to the areas of work outlined above, and in line with the General Social Care Council's Code of Practice/Conduct.
Energy Efficiency To promote energy efficiency throughout the service area and within own area of activity

Date Job Description Prepared/Updated **June 2009**
Job Description Prepared By **I Southern**

Date Evaluated

APPENDIX 4 – Social Worker

Job Description

Department	**HEALTH AND ADULT SOCIAL CARE**
Job Title	**SOCIAL WORKER**
Grade	**GRADE 8**
Primary Purpose of the Job	To assist the Adults Social Care Team to do everything possible to ensure the service fulfils its primary purpose both effectively and efficiently.
Responsible to	Team Leader
Responsible for	Developing and arranging appropriate packages of care/services for service users, their families and carers, and providing direct support where necessary.
Principal Responsibilities	Provision of social work and case management support to service users, their carers and families. Liaison with agencies which commission or provide services to ensure service users their families/carers have access to a range of services appropriate to their needs.

Main Duties

1. Prepare for social work contact and involvement
2. Work with individual families, carers, groups and communities to help them make informed decisions.
3. Assess needs and options to recommend a course of action.
4. Respond to crisis situations using appropriate legal procedural intervention.
5. Work with individuals, families, carers, group's communities and professionals to achieve change and development to improve life opportunities.
6. Prepare, produce, implement and evaluate plans with individuals, families, carers, groups, communities and professional colleagues.
7. Work with groups to promote individual growth, development and independence.
8. Address behaviour, which presents a risk to individuals, families, carers, groups and communities.

9. Advocate with, and on behalf of, individuals, families, carers, groups and communities.

10. Prepare for, and participate in decision-making forums.

11. Assess and manage risks to individuals, families, carers, groups and communities. Assess, minimise and manage risk to self and colleagues.

12. Manage and be accountable for your own work.

13. Contribute to the management of resources and services.

14. Manage, present and share records and reports

15. Work within multi-disciplinary and multi-organisational teams, networks and systems.

16. Research, analyse, evaluate and use current knowledge and contribute to the promotion of best social work practice.

17. Work within agreed standards of social work practice and ensure own professional development.

18. Manage complex ethical issues, dilemmas and conflicts.

19. Organise and maintain the effective use of information technology systems and software

20. **Customer Care -** To continually review, develop and improve systems, processes and services in support of the council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.

21. **Promoting equality and diversity -** To accept everyone has a right to his or her distinct identity. To treat everyone with dignity and respect and to ensure that what our customers tell us is valued by reporting it back into the organisation. To promote and participate in the council's work to eliminate discrimination; advance equality of opportunity; and foster good relations between our diverse communities.

22. **Developing Self and Others** - To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.

23. **Responding to Civil Contingencies -** Bolton Council has a statutory duty under the Civil Contingencies Act to respond in the event of an emergency. If Bolton Council's Emergency Management Plan is activated, you could be required to assist, or assist others, in the continued maintenance or delivery of key Council services and of support to the community. This could require working outside of routine working hours and could entail working from places other than your normal place of work.

    N.B. Emergencies requiring activation of the Bolton Council Emergency Management Plan only occur very infrequently. If you are asked to respond to an emergency, your personal circumstances at the time will be taken into account.

Date Job Description ~~prepared~~/updated November 2013

APPENDIX 5 – Community Assessment Officer

JOB DESCRIPTION

Department	**ADULT AND COMMUNITY SERVICES**
Job Title	**COMMUNITY ASSESSMENT OFFICER**
Grade	**GRADE 7**
Primary Purpose of the Job	To assist the Team Leader to do everything possible to ensure the Department fulfils its primary purpose both effectively and efficiently
Responsible to	Team Leader
Responsible for	The provision of an effective and efficient social work service within Adult Social Care
Principal Responsibilities	The provision of an Advice and Assessment and Care Planning Service to service users and their carers, including Community Care Assessments and Reviews.

MAIN DUTIES	
1	To develop, maintain and improve relationships with service users and carers
2	To contribute to planning, monitoring and reviewing the delivery of services for individuals
3	To carry out screening and referral assessments where appropriate
4	To participate in inter-disciplinary team working to support individuals
5	To provide information to support decision-making
6	To contribute to promoting the effectiveness of the Team
7	To manage and continuously develop your own practice
8	To support, record and facilitate meetings
9	To organise and maintain the effective and efficient use of information technology systems and software
10	To promote effective communication for and with individuals, their carers and families
11	To contribute to care planning and review
12	To support individuals to represent their own needs and wishes at decision-making forum

MAIN DUTIES	
13	To support individuals to retain, regain and develop the skills to manage their lives and environment
14	To contribute to the identification of the risk of danger to individuals
15	To develop practices which are person centred and will promote choice, well-being and protection of individuals

ORGANISATIONAL COMPETENCIES	COMPETENCY
Valuing Diversity To accept everyone has a right to their distinct identity. To treat everyone with dignity and respect and to ensure that what all our customers tell us is valued by reporting it back into the organisation. To be responsible for promoting and participating in the achievement of the departmental valuing diversity action plan.	BM1
Caring for Customers To provide quality services that are what our customers want and need. To give customers the opportunity to comment or complain if they need to. To work with customers and do what needs to be done to meet their needs. To inform your manager about what customers say in relation to the services delivered.	BM2
Developing Yourself and Supporting Others To make every effort to access development opportunities and ensure you spend time with your manager identifying your development needs through your personal development plan. To be ready to share learning with others.	BM3
Health and Safety To operate safely within the workplace with regard to Health and Safety legislation.	BM4
Confidentiality An acknowledgement of the need to maintain confidentiality at all times and to become aware of the National, Corporate and Departmental policies on Confidentiality, and the management and sharing of information.	BM5
Limits of Authority Within the framework of Council and Departmental policies and instructions, and subject to the overriding authority of his/her line manager, the officer holding this post is authorised to undertake all duties appertaining to the areas of work outlined above, and in line with the General Social Care Council's Code of Practice/Conduct.	BM6
Energy Efficiency To promote energy efficiency throughout the service area and within own area of activity	BM7

Date Job Description Prepared/Updated **December 2009**
Job Description Prepared By **S Unsworth/D Royle**

APPENDIX 6 – Sensory Officer

JD & Person Spec needs inserting here please

APPENDIX 7 – Telecare Officer

JOB DESCRIPTION

Department	**ADULT SERVICES**
Job Title	**TELECARE DEVELOPMENT CO-ORDINATOR**
Grade	**PO4**
Primary Purpose of the Job	To assist the Team Leader to do everything possible to ensure the department fulfils its primary purpose both effectively and efficiently
Responsible to	Team Leader (Community Services)
Responsible for	Commissioning of services using the Telecare Prevention Grant.
Principal Responsibilities	To co-ordinate the development of Telecare and Telehealth in Bolton including the expansion of the existing service and identifying ways of increasing the use of new technologies. To work in partnership with Bolton at Home to increase capacity to meet the departments targets for increasing Telecare. To investigate new technologies and develop care pathways for their effective implementation.

MAIN DUTIES	
1	Develop and implement operational plans
2	Manage a project
3	Develop productive working relationships with colleagues and stakeholders
4	Manage business processes
5	Provide and control the provision of advice and guidance
6	Improve organisational performance
7	Present individual's needs and preferences
8	Put the strategic business plan into action
9	Encourage innovation in your area of responsibility
10	Contribute to care planning and review
11	Support individuals to communicate using technology
12	Secure resources for the work of the service
13	Manage finance for your area of responsibility
14	Allocate and monitor the progress and quality of work

MAIN DUTIES	
15	Ensure compliance with legal, regulatory, ethical and social requirements.
16	Manage complex ethical issues, dilemmas and conflicts.
17	Promote the values and principles underpinning best practice.
18	To continuously manage and develop your own time and resources and adapt your practice to meet change in your area of work.
19	Organise, maintain and support the use of information technology systems and software.
20	Research, analyse and report information.
21	To provide information to support decision making.
22	To arrange and co-ordinate planning meetings and reviews as required.

ORGANISATIONAL COMPETENCIES
Valuing Diversity To be responsible for contributions to the achievement of the Authority's Valuing Diversity Policy, both in you work and in your role as a Manager through the implementation of the supporting action plans. To provide a supportive open environment where all employees have the opportunity to reach their full potential. To ensure that the Elected Members are encouraged to share in and reflect policy in their work.
Caring for Customers To continually review, develop and improve systems, processes and services in support of the Council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.
Developing Yourself and Supporting Others To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.
Health and Safety To operate safely within the workplace with regard to Health and Safety legislation.
Confidentiality An acknowledgement of the need to maintain confidentiality at all times and to become aware of the National, Corporate and Departmental policies on Confidentiality, and the management and sharing of information.
Limits of Authority Within the framework of Council and Departmental policies and instructions, and subject to the overriding authority of his/her line manager, the officer holding this post is authorised to undertake all duties appertaining to the areas of work outlined above, and in line with the General Social Care Council's Code of Practice/Conduct.
Energy Efficiency To promote energy efficiency throughout the service area and within own area of activity.

Date Job Description Prepared/Updated **11 September 2006**

Job Description Prepared By **Elaine McPhillips/Larry Hollando**

APPENDIX 8 – Disability Officer

Job Description

Department	**ADULT AND COMMUNITY SERVICES**
Job Title	**DISABILITY OFFICER – PHYSICAL DISABILITY SERVICE**
Grade	**GRADE 7**
Primary Purpose of the Job	To do everything possible to ensure that the Department fulfils its primary purposes both effectively and efficiently to physically disabled people. The specific responsibilities to the post relate to providing a technical and practical service to physically disabled people.
Responsible to	Team Leader – Physical Disability Service
Responsible for	N/A

Principal Responsibilities

Main Duties

1. To assess the needs of physically disabled people and to provide or recommend such aids to daily living/adaptions and/or other technical/practical/professional services so as to enhance maximum personal independence.

2. To participate in the organisation and administration of the work of the post so that the job of providing the service gets done.

3. To provide Management information to assist in the setting, implementing and monitoring of the Department's Strategies and Services.

4. To communicate and to work with other professionals, agencies, organisations and volunteers to meet the needs of the service users.

5. To undertake assessment of need with a view to providing aids to daily living and adaptions where necessary.

6. To liaise as necessary with the Team Leader Disability Service, Health and Local Authority personnel in the processing of adaptations/aids to daily living requests.

7. To undertake risk assessments as part of the assessment process and review as necessary.

8. To fit minor pieces of equipment.

9. To provide guidance and advice to clients and their families when aids to daily living and/or adaptations are provided.

10. To provide information to clients and their families relating to the nature, availability and location of services and facilities available to physically disabled people.

11. To maintain appropriate, adequate records of assessment and other client contact.

12. To maintain records for ensuring effective stock control of aids to daily living provided to clients.

13. **Customer Care -** To continually review, develop and improve systems, processes and services in support of the council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.

14. **Promoting equality and diversity -** To accept everyone has a right to his or her distinct identity. To treat everyone with dignity and respect and to ensure that what our customers tell us is valued by reporting it back into the organisation. To promote and participate in the council's work to eliminate discrimination; advance equality of opportunity; and foster good relations between our diverse communities.

15. **Developing Self and Others** - To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.

16. **Responding to Civil Contingencies -** Bolton Council has a statutory duty under the Civil Contingencies Act to respond in the event of an emergency. If Bolton Council's Emergency Management Plan is activated, you could be required to assist, or assist others, in the continued maintenance or delivery of key Council services and of support to the community. This could require working outside of routine working hours and could entail working from places other than your normal place of work.

    N.B. Emergencies requiring activation of the Bolton Council Emergency Management Plan only occur very infrequently. If you are asked to respond to an emergency, your personal circumstances at the time will be taken into account.

Date Job Description ~~prepared~~/updated 16th August 2012

Job Description prepared by Michele Tynan

APPENDIX 9 – Team Leader

Job Description

Department	**CHILDREN'S AND ADULTS SERVICES - PUBLIC HEALTH**
Job Title	**STAYING WELL TEAM LEADER**
Grade	**GRADE 6 (£21,734-£24,892)??**
Primary Purpose of the Job	Improve health, well-being and quality of life enabling people to stay healthy, happy and promote independence in their own homes by reducing risk and preventing future crisis
Responsible to	Older Adults Lead-Public Health
Responsible for	Staying Well Co-ordinators

Principal Responsibilities

- Using a defined 'Staying Well' Checklist tool to identify potential risks/needs to improve the health and wellbeing of a defined group of GP practice patients during a person centred home based visit
- To identify individual and community assets to promote self help and empowerment amongst Staying Well clients
- To support and advocate for the individual ensuring they are able to access appropriate support and services to enhance quality of life and maintain their independence.
- To organise and facilitate client group sessions to maximise client outcomes and promote peer support amongst clients who have been through the service.
- Undertake the full range of generic Staying Well Co-ordinator duties and tasks to include managing own caseload of patients. In addition to the generic duties a Staying Well Team Leader will be responsible for a team of Staying Well Co-ordinators including line management, personal development and appraisals. Staying Well Team Leaders will identify the training needs of their own team, as well as the wider Staying Well Team. They will be involved in the planning, development and implementation of training sessions.
- Act as role model for Staying Well Co-ordinators. They will have leadership qualities, be highly organised, and have strong commitment to inspire others as well as themselves to achieve project aims and objectives.
- To support and guide Staying Co-ordinators to effectively and productively manage their client caseloads, ensuring the best client outcomes when authorising client sign off's.
- To undertake and maintain accurate and comprehensive data collection to inform project evaluation
- To build and maintain positive working relationships with GP practices, services and other key stakeholders of the project

Main Duties

1. To identify ways of enabling patients and their carers selected from defined GP practices in Bolton to stay well and maintain their independence.

- To liaise with GP practice staff to produce a list of contacts in line with project criteria
- To explore various methods to invite and arrange appointments for home-based person centred conversation with the aim of maximising up take, using persuasive and motivational skills.
- This will involve providing and receiving complex personal sensitive information, where persuasive, motivational, negotiating, empathic and re-assurance skills are required. For example having a conversation about managing personal finances, emotional well-being, hobbies and interests, and personal health, with the aim of finding out existing and potential needs/issues/barriers and assets.
- To work with individuals to identify actions and solutions that can be taken up to help maintain independence and enhance quality of life with the aim of maximising self-management. This will include providing and receiving of personal or delicate information.

2. To support the patient and their carer to identify and access help to remain independent

- To effectively and productively manage client caseload ensuring the best client outcomes
- To identify sources of help and support through service databases, community networks and research
- To provide guidance, advice and information to patients/carers and their families on the availability of support and help on a range of issues relevant to their needs
- To build positive empathetic and working relationships with the patient, their carer, family, services, support groups and projects to enable communication and tailoring of patient centred provision.
- To support and advocate for individuals in a timely, resourceful and flexible manner to ensure their needs are addressed, looking beyond usual service options.

3. To collect information to help demonstrate the success of the project

- To motivate, support and encourage individuals to make behaviour changes
- To identify individual and community assets to create a self-help culture empowering individuals to support others and themselves
- To identify and report on barriers, issues and service gaps which limit the ability to address identified need
- To contribute to service improvement and project evaluation by identifying solutions to issues and ways of improving patient satisfaction.

4.

- To maintain accurate records, files, data for planning and evaluation purposes.
- Attend to relevant correspondence, as appropriate and to agreed standards.

To manage, support and supervise a team of Staying Well Co-ordinators

- To assist in the recruitment of new Staying Well Co-ordinator posts
- Provide line management to a team of Staying Well Co-ordinators
- To undertake day to day supervision, staff appraisal and personal development
- Attend regular Staying Well Team meetings
- Provide guidance, training and supervision to Staying Well Co-ordinators as appropriate to enable them to achieve their competencies.
- Support new staff through induction process
- Support Staying Well Co-ordinators with planning and development of training and client sessions
- Provide guidance and support to Staying Well Co-ordinators to effectively manage their client caseloads, ensuring maximum productivity

5.

- Contribute and comply with the development and maintenance of protocols, standards and legislation.
- Contribute towards the on-going quality of service and advise Line Manager of any potential issues
- Provide regular written and verbal team progress reports to the Staying Well Project Manager to ensure continue improvement of the project.
- To authorise and support decision making when signing clients off , ensuring the needs of the clients have been best met.

Other key duties and responsibilities

- To keep accurate and up to date confidential records and to provide routine monitoring information as required
- To attend meetings and training opportunities as requested and agreed by Line Manager.
- The job holder will be required to work independently within work related guidelines and boundaries, however equally recognise when it is necessary to refer to their manager.

6.

- To attend one to one or group progress meetings in particular during the delivery phase of the project to review the results/outcomes with their Line Manager.
- To embrace our corporate values and policies in everything we do
- To undertake any other duties that are requested and that are commensurate with grade and remit of the post
- To implement policies for own work area and to contribute to the implementation of new policy, proposing changes to working practices by identifying, gathering and sharing any learning from the project and contributing to service development, ensuring any learning is embedded into mainstream services.

7.

Health, Safety and Security:

All employees have a duty to report any accidents, complaints, defects in equipment, near misses and untoward incidents, following Bolton Council procedure.

8.

To ensure that Health and Safety legislation is complied with at all times, including COSHH, Workplace Risk Assessment and Control of Infection.

Safeguarding Vulnerable People (Children and Adults)

9. All employees have a responsibility to protect and safeguard vulnerable people (children and adults). They must be aware of child and adult protection procedures and who to contact within Bolton Council for further advice. All employees are required to attend safeguarding awareness training and to undertake additional training appropriate to their role.

Confidentiality:
All information relating to patients and staff gained through your employment with Bolton Council is confidential.

Training:

- Managers are required to take responsibility for their own and their staff's development.
- All employees have a duty to attend all mandatory training sessions as required by Bolton Council.
- Any other general requirements as appropriate to the post and location
- The range of duties and responsibilities outlined above are indicative only and are intended to give a broad flavour of the range and type of duties that will be allocated. They are subject to modification in the light of changing service demands and the development requirements of the postholder.

10. **Customer Care -** To continually review, develop and improve systems, processes and services in support of the council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.

11. **Promoting equality and diversity -** To accept everyone has a right to his or her distinct identity. To treat everyone with dignity and respect and to ensure that what our customers tell us is valued by reporting it back into the organisation. To promote and participate in the council's work to eliminate discrimination; advance equality of opportunity; and foster good relations between our diverse communities.

12. **Developing Self and Others** - To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.

13. **Responding to Civil Contingencies -** Bolton Council has a statutory duty under the Civil Contingencies Act to respond in the event of an emergency. If Bolton Council's Emergency Management Plan is activated, you could be required to assist, or assist others, in the continued maintenance or delivery of key Council services and of support to the community. This could require working outside of routine working hours and could entail working from places other than your normal place of work.

N.B. Emergencies requiring activation of the Bolton Council Emergency Management Plan only occur very infrequently. If you are asked to respond to an emergency, your personal circumstances at the time will be taken into account.

Date Job Description prepared/updated 21/04/2014

Job Description prepared by Munisha Savania

APPENDIX 10 – Project Support Officer

JOB DESCRIPTION

Department	**CHILDREN'S AND ADULTS SERVICES**
Job Title	**PROJECT SUPPORT OFFICER (STAYING WELL)**
Grade	**GRADE 6 (£21,734-£24,892) TBC**
Primary Purpose of the Job	To support the improvement of health, well-being and quality of life enabling people to stay healthy, happy and promote independence in their own homes by reducing risk and preventing future crisis To assist with the delivery of the Staying Well project, including assistance with all elements of the project management life cycle, and support to provide project analysis , and research
Responsible to	Staying Well Project Manager
Principal Responsibilities	To provide project support to effectively and efficiently implement and deliver the Staying Well project, including administrative tasks. To undertake and maintain accurate and comprehensive data collection to inform project evaluation To assist with the collation, and production of research requests for the Staying Well project

MAIN DUTIES

1. To provide support for organising and co-ordinating community and training events in relation to the Staying Well Project

2. To develop and maintain relationships with participating GP practices, services, key partners and clients to support implementation and delivery of the Staying Well project.

3. Support and attend designated meetings including, preparing resources, minutes and progressing issues on his/her own initiative

4. To act as first point of contact for clients and the Staying Well team and deal with telephone/written queries as they arise in an efficient and effective manner

5. Act as an information librarian for all project documentation and provide copies as required

6. Assist in the quality review of project deliverables

7. To support the Project Manager by providing information to support reports for relevant projects to groups, governing body and committee meetings.

8. To be responsible for designing and adapting appropriate paper-based and electronic information systems in order to manage, collect, collate and present information as necessary ensuring such systems meet the specifications requested by the Project Team and updated as and when required.
9. To co-ordinate and support marketing and promotional activities in relation to the project

10. Ability to respect confidentiality of clients
11. To undertake continuing professional development including mandatory training, and maintain a portfolio for use during appraisals.

12. Undertake other duties not specified within the job description but within the general scope of the post as determined by the Project Manager.

ORGANISATIONAL COMPETENCIES

13. **Customer Care -** To continually review, develop and improve systems, processes and services in support of the council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.

14. **Promoting equality and diversity -** To accept everyone has a right to his or her distinct identity. To treat everyone with dignity and respect and to ensure that what our customers tell us is valued by reporting it back into the organisation. To promote and participate in the council's work to eliminate discrimination; advance equality of opportunity; and foster good relations between our diverse communities.

15. **Developing Self and Others** - To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.

16. **Responding to Civil Contingencies -** Bolton Council has a statutory duty under the Civil Contingencies Act to respond in the event of an emergency. If Bolton Council's Emergency Management Plan is activated, you could be required to assist, or assist others, in the continued maintenance or delivery of key Council services and of support to the community. This could require working outside of routine working hours and could entail working from places other than your normal place of work.

    N.B. Emergencies requiring activation of the Bolton Council Emergency Management Plan only occur very infrequently. If you are asked to respond to an emergency, your personal circumstances at the time will be taken into account.

Date Job Description prepared/updated	14/04/14
Job Description prepared by	Munisha Savania-Public Health

APPENDIX 11 – Health and Wellbeing Coordinator

Job Description

Department	**CHILDREN'S AND ADULTS SERVICES - PUBLIC HEALTH**
Job Title	**STAYING WELL CO-ORDINATOR**
Grade	**GRADE 5 (£19,317-£21,734)**
Primary Purpose of the Job	Improve health, well-being and quality of life enabling people to stay healthy, happy and promote independence in their own homes by reducing risk and preventing future crisis
Responsible to	Staying Well Team Leader
Responsible for	

Principal Responsibilities

- Using a defined 'Staying Well' Checklist tool to identify potential risks/needs to improve the health and wellbeing of a defined group of GP practice patients during a person centred home based visit
- To identify individual and community assets to promote self help and empowerment amongst Staying Well clients
- To support and advocate for the individual ensuring they are able to access appropriate support and services to enhance quality of life and maintain their independence.
- To organise and facilitate client group sessions to maximise client outcomes and promote peer support amongst clients who have been through the service.
- To undertake and maintain accurate and comprehensive data collection to inform project evaluation
- To build and maintain positive working relationships with GP practices, services and other key stakeholders of the project

Main Duties

1. To identify ways of enabling patients and their carers selected from defined GP practices in Bolton to stay well and maintain their independence.

    - To liaise with GP practice staff to produce a list of contacts in line with project criteria
    - To explore various methods to invite and arrange appointments for home-based person centred conversation with the aim of maximising up take, using persuasive and motivational skills.
    - This will involve providing and receiving complex personal sensitive information,

where persuasive, motivational, negotiating, empathic and re-assurance skills are required. For example having a conversation about managing personal finances, emotional well-being, hobbies and interests, and personal health, with the aim of finding out existing and potential needs/issues/barriers and assets.

- To work with individuals to identify actions and solutions that can be taken up to help maintain independence and enhance quality of life with the aim of maximising self-management. This will include providing and receiving of personal or delicate information.

2. To support the patient and their carer to identify and access help to remain independent

- To effectively and productively manage client caseload ensuring the best client outcomes
- To identify sources of help and support through service databases, community networks and research
- To provide guidance, advice and information to patients/carers and their families on the availability of support and help on a range of issues relevant to their needs
- To build positive empathetic and working relationships with the patient, their carer, family, services, support groups and projects to enable communication and tailoring of patient centred provision.
- To support and advocate for individuals in a timely, resourceful and flexible manner to ensure their needs are addressed, looking beyond usual service options.
- To motivate, support and encourage individuals to make behaviour changes
- To identify individual and community assets to create a self-help culture empowering individuals to support others and themselves

3. To collect information to help demonstrate the success of the project

- To identify and report on barriers, issues and service gaps which limit the ability to address identified need
- To contribute to service improvement and project evaluation by identifying solutions to issues and ways of improving patient satisfaction.
- To maintain accurate records, files, data for planning and evaluation purposes.
- Attend to relevant correspondence, as appropriate and to agreed standards.

4. Other key duties and responsibilities

- To keep accurate and up to date confidential records and to provide routine monitoring information as required
- To attend meetings and training opportunities as requested and agreed by Line Manager.
- The job holder will be required to work independently within work related guidelines and boundaries, however equally recognise when it is necessary to refer to their manager.
- To attend one to one or group progress meetings in particular during the delivery phase of the project to review the results/outcomes with their Line Manager.
- To embrace our corporate values and policies in everything we do
- To undertake any other duties that are requested and that are

commensurate with grade and remit of the post

- To implement policies for own work area and to contribute to the implementation of new policy, proposing changes to working practices by identifying, gathering and sharing any learning from the project and contributing to service development, ensuring any learning is embedded into mainstream services.

Health, Safety and Security:

5.

- All employees have a duty to report any accidents, complaints, defects in equipment, near misses and untoward incidents, following Bolton Council procedure.

- To ensure that Health and Safety legislation is complied with at all times, including COSHH, Workplace Risk Assessment and Control of Infection.

Safeguarding Vulnerable People (Children and Adults)

6.

- All employees have a responsibility to protect and safeguard vulnerable people (children and adults). They must be aware of child and adult protection procedures and who to contact within Bolton Council for further advice. All employees are required to attend safeguarding awareness training and to undertake additional training appropriate to their role.

Confidentiality:

7.

- All information relating to patients and staff gained through your employment with Bolton Council is confidential.

Training:

8.

- Managers are required to take responsibility for their own and their staff's development.
- All employees have a duty to attend all mandatory training sessions as required by Bolton Council.
- Any other general requirements as appropriate to the post and location
- The range of duties and responsibilities outlined above are indicative only and are intended to give a broad flavour of the range and type of duties that will be allocated. They are subject to modification in the light of changing service demands and the development requirements of the post holder

9. **Customer Care -** To continually review, develop and improve systems, processes and services in support of the council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.

10. **Promoting equality and diversity -** To accept everyone has a right to his or her distinct identity. To treat everyone with dignity and respect and to ensure that what our customers tell us is valued by reporting it back into the organisation. To promote and participate in the council's work to eliminate discrimination; advance equality of opportunity; and foster good relations between our diverse communities.

11. **Developing Self and Others** - To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals

and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.

12. **Responding to Civil Contingencies -** Bolton Council has a statutory duty under the Civil Contingencies Act to respond in the event of an emergency. If Bolton Council's Emergency Management Plan is activated, you could be required to assist, or assist others, in the continued maintenance or delivery of key Council services and of support to the community. This could require working outside of routine working hours and could entail working from places other than your normal place of work.

N.B. Emergencies requiring activation of the Bolton Council Emergency Management Plan only occur very infrequently. If you are asked to respond to an emergency, your personal circumstances at the time will be taken into account.

Date Job Description prepared/updated	21/04/2014
Job Description prepared by	Munisha Savania

APPENDIX 12 – Community Capacity Lead

Job Description

Bolton Council

Department	**CHILDREN'S AND ADULTS**
Job Title	**COMMUNITY CAPACITY LEAD (STAYING WELL)**
Grade	**10 (TBC)**
Primary Purpose of the Job	To lead the development and delivery of community capacity building within the Staying Well programme, developing and facilitating a new approach to improve health, wellbeing and reduce dependency of older people.
Responsible to	Head of Service, Adult Social Care
Responsible for	n/a
Principal Responsibilities	To lead the development, delivery and evaluation of a community capacity building programme that will transform approaches to promoting the health, wellbeing and independence of older people in Bolton. To use asset based and community development approaches to plan and deliver a range of community capacity building activities and strategies to improve outcomes for older people. To realise the partnership potential of working with older people, communities and the voluntary and community sector to develop this approach. To provide management information to assist with the evaluation of the programme towards building a business case to scale up

Main Duties

1. To lead, facilitate, co-ordinate and test a coherent approach to community capacity building to enhance the Staying Well programme and improve the outcomes of older people in Bolton.

2. To use asset based approaches, community asset mapping and local intelligence to inform and shape this work.

3. To maximise the engagement, involvement and empowerment of the community and voluntary sector in developing community capacity.

4. To lead on the effective development, coordination, commissioning and provision of community initiatives that promote the health, wellbeing and inclusion of older people.

   To lead, advise and support partnership and governance arrangements involving the community, elected members, commissioning partners and service providers.

5. To work collaboratively and across boundaries to ensure that strategies that promote community capacity building are connected across different agendas and public sector reform programmes

7. To ensure that any delegated budgets are effectively managed and programmed to have maximum impact for older people.

8. **Customer Care -** To continually review, develop and improve systems, processes and services in support of the council's pursuit of excellence in service delivery. To recognise the value of its people as a resource.

9. **Valuing Diversity -** To be responsible for contributions to the achievement of the Authority's Valuing Diversity Policy, both in your work and in your role as a Manager through the implementation of the supporting action plans. To provide a supportive open environment where all employees have the opportunity to reach their full potential. To ensure that the elected members are encouraged to share in and reflect policy in their work.

10. **Developing Self and Others** - To use processes and put processes in place to generate a learning environment. To focus on the strengths and requirements of all individuals and enable them to further their skills and knowledge. To actively pursue your own development. To be self-aware and role model continuous self-development.

11. **Responding to Civil Contingencies -** Bolton Council has a statutory duty under the Civil Contingencies Act to respond in the event of an emergency. If Bolton Council's Emergency Management Plan is activated, you could be required to assist, or assist others, in the continued maintenance or delivery of key Council services and of support to the community. This could require working outside of routine working hours and could entail working from places other than your normal place of work.

    N.B. Emergencies requiring activation of the Bolton Council Emergency Management Plan only occur very infrequently. If you are asked to respond to an emergency, your personal circumstances at the time will be taken into account.

Date Job Description prepared	Nicki Lomax
Job Description prepared by	12 June 2014

Bolton Metropolitan Borough Council

PERSON SPECIFICATION

Department **CHILDREN'S AND ADULTS**

Job Title **COMMUNITY CAPACITY LEAD (STAYING WELL)**

STAGE ONE Disabled Candidates are guaranteed an interview if they meet the essential criteria

MINIMUM ESSENTIAL REQUIREMENTS		METHOD OF ASSESSMENT
1.	**Skills and Knowledge**	
1.	Good understanding of the national, regional and local policy agenda facing local government and the public sector, particularly Public Service Reform.	Application form/interview/assessment centre
2.	Experience and understanding of asset based approaches, community development and community engagement	Application form/interview/assessment centre
3.	Experience and understanding of working collaboratively with partnerships and communities	Application form/interview/assessment centre
4.	Strong political awareness and the ability to operate effectively in a political environment.	Application form/interview/assessment centre
5.	Good organisational awareness and an understanding of the leadership and management issues facing large and complex councils.	Application form/interview/assessment centre
6.	Excellent inter personal and communication skills and the ability to influence and engage effectively Members, managers, community representatives and local people.	Application form/interview/assessment centre
7	Ability to build and maintain relationships with individuals and colleagues across the health and social care integration partnership, including staff at senior level, Members, community and voluntary sector stakeholders	Application form/interview/assessment centre
8.	Good project management skills and the ability to deliver local projects effectively working with others.	Application form/interview/assessment centre
9.	Experience and understanding of evaluation and research methods	Application form/interview/assessment centre
10.	Good performance management and financial management skills.	Application form/interview/assessment centre

MINIMUM ESSENTIAL REQUIREMENTS		METHOD OF ASSESSMENT
1.	**Skills and Knowledge**	
11.	**Valuing Diversity -** Listen, support and monitor the diverse contributions made to service development without prejudice. Challenge behaviours and processes which do not positively advance the diversity agenda whilst being prepared to accept feedback about own behaviour. Recognise people's strengths, aspirations and abilities and helps to develop their potential. Understand how Valuing Diversity can improve our ability to deliver better services and reduce disadvantage.	Interview/application form/assessment centre
12	**Customer Care** - Listen and respond to customer need, seek out innovative ways of consulting service users and engaging partners. Network with others to develop services for the benefit of the service users	Interview/application form/assessment centre
13.	**Developing Self and Others -** Coach and mentor others. Be willing to share learning and encourage others to do the same. Listen to others and respond to their needs. Apply a range of development activities to develop and train staff. Endorse the principles of Investor in People. Strives for improvement and take responsibility for own development. Be self-confident and lead by example	Interview/application form/assessment centre

2.	**Experience/Qualifications/Training etc**	
1.	Educated to degree level or equivalent	Application Form
2.	A demonstrable track record of delivering programmes, policies and initiatives within disadvantaged communities Minimum three years.	Application form
3.	Experience of working in an environment which involves working with Elected Politicians as well as partner organisations.	Application Form

3.	**Work Related Circumstances**	
1.	Subject to the agreement of the line manager, a flexi time system is in operation	Application Form/interview
2.	Will be required to work outside normal working hours to meet service demands	Application Form/interview

STAGE TWO Will only be used in the event of a large number of applicants meeting the minimum essential requirements

ADDITIONAL REQUIREMENTS		METHOD OF ASSESSMENT
1.	**Skills and Knowledge**	

ADDITIONAL REQUIREMENTS	METHOD OF ASSESSMENT
1. Experience of working in the voluntary and community sector at a senior practitioner/manager level.	

2.	Experience/Qualifications/Training etc	
	n/a	

Note to Applicants**: Please try to show in your application form, how best you meet these requirements**

Date Person Specification prepared: 12 June 2014

Person Specification Prepared by Nicki Lomax

APPENDIX 13

Summary Health & Social Care Interventions for Older Adults

DRAFT

	Staying Well (pilot model)	Primary Care Health Check	Health Trainers	Over 75 Check
Eligibility Criteria	Age 65 plus and identified as requiring substantial health or social care services within the next 5 years	Any patient aged 40 plus	Mainly patients aged 40 plus on chronic disease registers and/or identified via a primary care health check as being at future CVD risk	
Rationale for Intervention	Early diagnosis and intervention to prevent deterioration in health **and** social circumstances.	Early diagnosis to prevent the likelihood of CVD and Cancer events in older adults.	Early intervention to prevent the likelihood of CVD and Cancer events in older adults.	
Motivation to Engage with Primary Care	Low. These clients are currently relatively physically and mentally well.	Moderate to High. These patients are potentially motivated worried well and/or well informed on physical health risks relating to CVD and Cancer in particular.	High. These patients are engaged, have set goals and agreed a support plan to improve physical health. Some will be highly able to self-care.	
Method of Engagement	Proactive targeting via GP list using risk tool.	Reactive presentation as a result of GP letter of invitation or primary care consultation.	Mainly reactive presentation as a result of primary care health check, Audit C (alcohol screening results) or chronic disease.	
Place of Initial Assessment	Patient's own home.	GP surgery or community venue.	GP surgery or community venue.	
Type of Assessment	Holistic health and social care assessment covering 12 point quality of life wheel (attached)	Physical health check including weight, exercise, alcohol use, cholesterol, blood pressure	Physical and mental health check. Primarily patients focus on improving one or more health	

			conditions. Usually these are those relating to CVD risk such as smoking cessation.	
Typical Client	Limited use of primary care. Generally well but beginning to show signs of future dependency. Often isolated with a poorer than average quality of life and unmotivated to improve health.	Any patient aged 40 plus motivated enough to attend a GP surgery/community venue for a health check.	Any patient referred to the health trainer service motivated enough to continue to engage with the interventions that will help them achieve their (mainly) physical health goals e.g. weight loss.	
Length of Intervention	Indeterminate. Depends on number and complexity of individual health and social care needs.	Maximum 1 hour every 5 years.	Indeterminate. Depends on how long it takes for individuals to achieve health goals.	
Type of Intervention	Person centred, needs led focusing on the full range of holistic health and social care outcomes.	Based on national template.	Person centred, primarily physical health needs led focusing on a small number of health outcomes.	
Target Outcomes from Interventions	Improved physical, mental and social functioning. Improved housing, debt and welfare circumstances. Improved health and mental wellbeing.	Healthy weight, increased physical activity, optimum blood pressure, optimum cholesterol, smoking cessation, moderate alcohol use. Improved health and mental wellbeing.	Healthy weight, increased physical activity, optimum blood pressure, optimum cholesterol, smoking cessation, moderate alcohol use. Improved health and mental wellbeing.	