skillsforcare

Support for employers and their personal assistants

following the introduction of personal health budgets

March 2016

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Preface

This report represents the first time that this research has been completed with organisations and colleagues from the NHS and builds on the work Skills for Care has done previously with local authorities. This development is of particular importance given the continued focus on integration to achieve person centred co-ordinated care and the need, as discussed within this report, to recognise people in need of care and support employing personal assistants (PAs) as a shared population across social care and health.

The report captures the progress being made at a sample of sites committed to the delivery of personal health budgets (PHBs) and PA working, as well as the challenges that remain. The accompanying case studies give real, tangible examples of how clinical commissioning groups (CCGs) and commissioning support units (CSUs) are tackling and resolving these challenges; they detail innovative and robust approaches to delegation, PAs in hospitals and training, as well as embedding PHBs.

Perhaps most importantly, what emerges throughout the report findings and case studies is the value respondents attributed to PAs; where PHBs and PA working are at their best, PAs are recognised as flexible and skilled workers.

In addition to the messages and lessons for local teams in this report, Skills for Care will continue to work with our partners, including NHS England, local authorities and the PA Framework steering group to support the PA workforce and the continued implementation of PHBs.

Sharon Allen,
CEO, Skills for Care

Executive summary

This report outlines findings from a recent study which set out to establish the support available to personal health budget (PHB) holders employing personal assistants (PAs) in England. Commissioned by NHS England and researched and written by Skills for Care, this report and the accompanying case studies (chapter 6) demonstrate the successes and challenges reported by sites which have introduced and started to embed PHBs and PA working.

The 60 responses to the survey conducted as part of this research cover approximately 50 clinical commissioning group (CCG) areas in England. The report findings have been further informed by interviews with individuals and teams from 10 participating sites.

The responses received included examples of sites progressing well with the introduction of PHBs and PA working and their experience has valuable lessons for all organisations with a responsibility to introduce, embed and/or support PHBs and PA working. Our research found that:

Support available to personal health budget holders employing a personal assistant (PA)

- A core offer of support to PHB holders choosing to employ a PA is available across responding sites, including: information about employing a PA, access to a payroll service and guidance concerning legal requirements and what to do when an employment relationship breaks down.

- Support with regard to issues of safeguarding and employment was one of the most commonly covered areas of support available to PHB holders.

- A number of areas are reporting successful approaches to PHBs and PA working, and have emphasised the important roles being played by dedicated NHS teams, private and voluntary organisations and local authorities.

Support available to personal assistants (PAs)

- The information received concerning the support available to PAs presents a complex picture. This study's findings indicate that some degree of specific support is available to most PAs however the extent, formality and regularity of that support is mixed.

- Respondents were overwhelmingly positive about the PA role; PAs were described as flexible and skilled workers.

Overcoming barriers to PA working

The emergence of challenges and issues in relation to PA working is to be expected; PHBs and PA working are new to health. The case studies in chapter six of this report show how these challenges are being overcome:

- CCGs and NHS organisations are developing frameworks for the delegation of clinical tasks and useful principles for PAs accompanying PHB holders admitted to hospital.

- Interviewees talked positively about the delegation of health care tasks to PAs and, where issues existed, emphasised the need to develop robust systems of delegation to support increased choice and control over the care received.

Shaping the PA market

- Over 85% of respondents were working with someone who had moved from receiving social care funding to a PHB. With this in mind the PA workforce has to be recognised as a market shared by both the NHS and local authorities.

- The supply and long-term retention of PAs is an issue raised by many respondents. NHS organisations, local authorities, user-led and independent organisations as well as national stakeholders need to work in partnership to develop approaches to address this. Part of the solution could include continued efforts to grow the profile of the PA role across health and social care.

- Nationally, more work is needed to understand new model of PA employment that are emerging. These include the development of organisations that take on the 'employer' responsibilities typically associated with receiving care and support from a PA, whilst enabling the individual to maintain a high level of choice and control over their care and support.

Conclusion

The move towards PA working in health is as much a cultural shift as it is a pragmatic process-based change. Considering the relative infancy of PHBs and associated PA employment it is unsurprising that a number of barriers and challenges remain; it will take time for local solutions to these to emerge and become embedded. However responses to the survey and the subsequent interviews show:

- in many responding areas, a core offer of support is emerging

- best practice examples, demonstrating local responses to the more complex elements of PA working in health, are available

- a broad support market is emerging as areas progress with PHBs

- PHB teams and leads are adopting the principles of personalisation and talk with confidence about the transformative effect that PHBs and good PA working can have.

A series of recommendations have been based on the findings of this report. These are detailed on the next page.

Recommendations

Training

1. CCGs should consider establishing local frameworks for the delegation of health care tasks. Locally agreed frameworks for delegation can contribute to providing a robust and safe process for identifying training and assessing competence. This provides NHS clinicians with the necessary protocols and contributes to the culture of support and reassurance, needed to confidently delegate tasks. See case studies four and five.

2. CCGs should consider establishing an offer of core training for PAs. In the emerging good examples, core training for PAs has become part of the local PHB offer with a consistent and comprehensive approach taken to induction training. This is often being mapped against the 15 standards of the Care Certificate where appropriate. See case study one.

3. As the employment of PAs by PHB holders continues to increase there is the potential for capacity issues to emerge in relation to training, sign-off and monitoring of competence. CCGs should consider establishing dedicated roles in relation to training, signing off and reviewing competence. This could include working with training providers.

PA support

4. Peer support or other means of networking for PAs is an important part of developing and maintaining an effective workforce. In areas where peer support for PAs is considered unachievable in the short term, the focus could instead be placed on the provision of a single point of contact for PAs with workplace or HR based questions or issues that cannot be resolved with their employer. To avoid conflicts of interest this role needs to sit separately from the function of employer support.

   In the longer term, peer support or other means of networking PAs should be the ambition; isolation can be associated with the role.

Recruitment and retention

5. NHS organisations, local authorities, user-led and independent organisations, as well as national stakeholders need to work in partnership to address issues in the recruitment and retention of PAs. This links closely to the provision of consistent training and support, considered in recommendations two and four.

6. Nationally, work needs to be done to understand the possible implications of potential new models of PA employment on existing initiatives.

Context, aims and methodology

The introduction of personal health budgets (PHBs) in the NHS and the ability to receive a PHB as a direct payment has opened up the potential for people to employ their own personal assistants (PAs) to support their health needs. From 1 October 2014 all those in receipt of NHS continuing health care (CHC) and continuing care for children and young people have had the right to have a PHB.[1] In addition to this, the government's mandate to the NHS in 2014 set out the objective that "patients who could benefit will have the option to hold their own PHB as a way to have even more control over their care"[2]. The refreshed mandate to NHS England for 2016-17[3] published in December 2015 sets out a clear expectation that by 2020 between 50,000 and 100,000 people will have a personal health budget or integrated personal budget.

Giving people more control over their care and support, including through PHBs and integrated personal budgets across health and social care is a core part of the NHS Five Year Forward View, which sets out that a step to empowering patients is to "increase the direct control patients have over the care that is provided to them".[4] Understanding the nature of the emerging PA workforce in health and how best to support and develop this workforce is a critical element in enabling choice and control. Conducted in parallel with research from local authorities, this research forms a key part of the holistic picture of the successes that exist in relation to individual employer and PA working. It also allows us to consider the shared challenges and barriers that still exist across social care and health.

This research builds on work done by Skills for Care and Learn to Care with local authorities between 2012 and 2015.

An electronic survey was sent to CCGs and Commissioning Support Units (CSUs) across England. In order to gain a wider perspective this survey was also sent to private and voluntary support organisations, including user-led organisations (ULOs).

Responses came from 43 organisations and following the aggregation of CSU responses to account for the CCGs they reported supporting, a total of 60 complete responses were returned; NHS organisations account for 44 of these 60 responses.

[1] The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013, SI No. 2891 (DH, 2013)

[2] The Mandate: A mandate from the Government to NHS England: April 2014 to March 2015 (DH, 2014) https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

[3] The NHS Mandate 16/17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf

[4] Five year forward view. NHS. October 2014, https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Survey results were analysed for both quantitative and qualitative information. Ten face-to-face site visits then took place with specific respondents, whose survey responses had included examples of good or innovative practice.

N.B: In some cases respondents were able to provide more than one answer to a question (e.g. to confirm that specific support was available from both the NHS and a ULO) therefore the total percentage of responses exceeds 100% in some graphs.

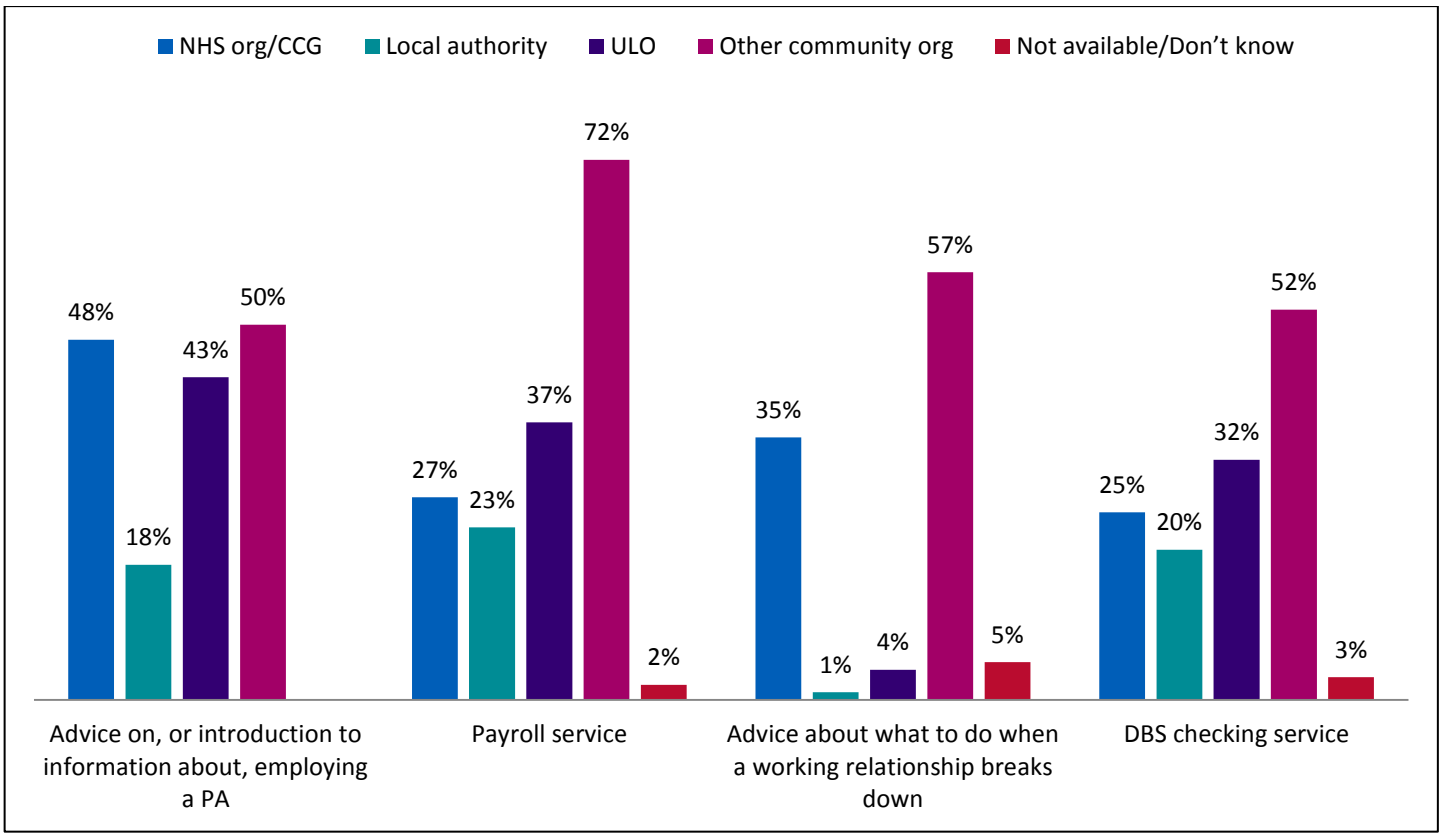
1. Support available to personal health budget holders employing a PA

At the time of writing there are approximately 4,000 Personal Health Budget (PHB) holders in England and of the sites responding to this research the majority of PHB holders were using at least some of their budget to employ a personal assistant (PA) or a team of PAs.

Despite the relative infancy of PHBs, information and support for PHB holders choosing to employ (PAs) already appears to be well embedded in some areas.

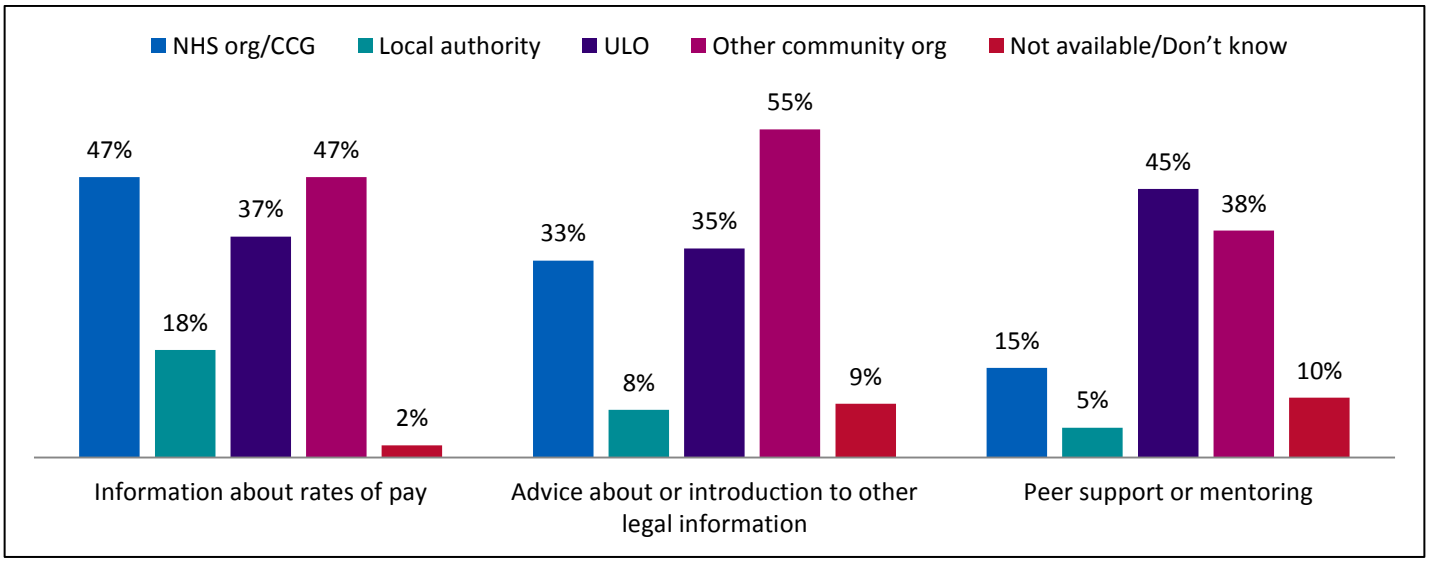
When asked about the support available to PHB holders employing a PA, the majority of respondents indicated that each of the four types of support highlighted (information about employing a PA; access to a payroll service; guidance concerning legal requirements and what to do where an employment relationship breaks down; Disclosure & Barring Service (DBS) checking) were available in their area, either directly from themselves or from another provider (figure 1.1).

Figure 1.1 – support available to PHB holders (n=60)



The core offer of support described above (figure 1.1) is further supplemented by information about rates of pay, legal information and peer support or mentoring which are similarly widely available (figure 1.2).

Figure 1.2 – support available to PHB holders (n=60)

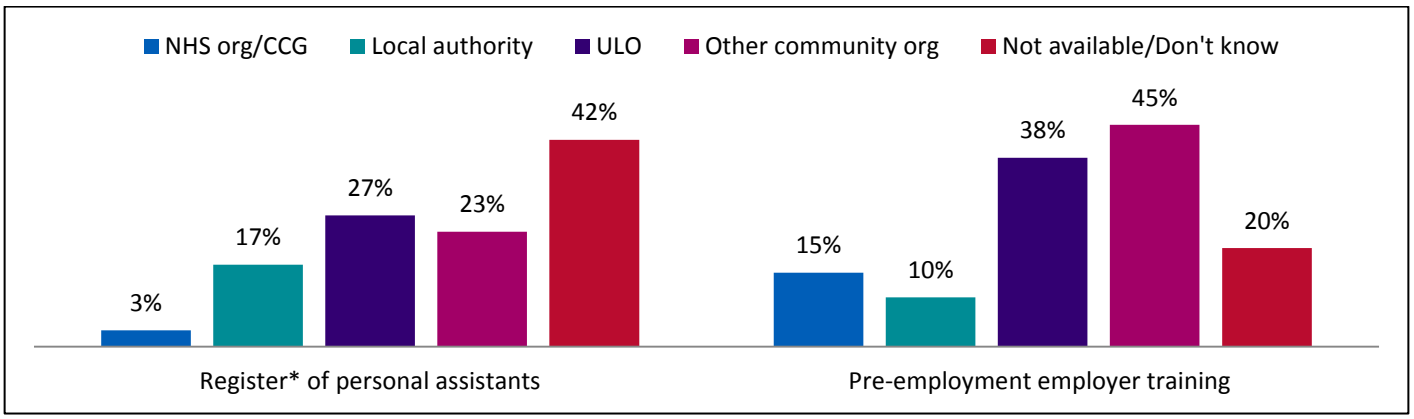


The strong provision in some areas is testament to the work of NHS organisations in embedding PHBs and also reflects an existing market that NHS organisations have been able to access; many of the independent organisations offering brokerage and support have grown in response to the use of direct payments and PAs in social care.

While it should be viewed with some caution, reports of the availability of peer support in some localities, discussed in more detail later in this chapter, is particularly encouraging; this is a valuable model of support which is often difficult to establish.

Training for PHB holders new to an 'employer' role was reported as available by four-fifths of respondents; although the extent to which this represents support with recruitment, interviewing, HR and management as opposed to more traditional training and learning is not clear (figure 1.3).

Figure 1.3 – support available to PHB holders (n=60)



Perhaps unsurprisingly the availability of a PA register is less common than other support resources; 42% of respondents reported either that a PA register was unavailable or that they were unaware of one (figure 1.3).

A number of respondents to this survey and previous research have identified issues in establishing PA registers; not least that it can be (initially) resource intensive and success is closely linked to the available 'supply' of PAs (see chapter 4). However, it is important to remember that good examples of working registers do exist.

Research with local authorities conducted between 2012[5] and 2015[6] shows a steady year-on-year increase in the availability of PA registers (from 41% in 2012 to 80% in 2015). It may be that a similar expansion will take place alongside the growth of the PA workforce in health.

PA registers, or similar alternative initiatives, are likely to become important resources for two key reasons both cited by a number of respondents:

- to support the supply or recruitment of PAs
- as a place to find 'last minute' or 'replacement' PAs, e.g. when somebody's regular PA is off sick or on leave.

Given the condition or task-specific training and knowledge that many PAs have, this latter function of registers does have limitations. However, as the number of PHB holders grows (and in turn the likely number employing PAs) the availability of these sorts of 'pools' could be increasingly important. Advice and information for organisations looking to establish a PA register is available in 'Guidance on how to develop a PA register'[7], published by Skills for Care.

1.2 Sources of support

As figures 1.1 and 1.2 demonstrate, there is considerable variation in the sources of support available to PHB holders in many areas. It is clear that in addition to NHS services, independent support or brokerage agencies have an important role. This finding is mirrored in this year's research with local authorities.

We should note that regardless of organisation type, the individuals interviewed as part of this research made clear that for PHBs and PA working to succeed a commitment to embedding personalisation was necessary.

[5] Better understanding of levels of support for individual employers and their personal assistants (PAs), Skills for Care, 2013

[6] Supporting individual employers and their personal assistants: research into local authorities' support for people that employ personal assistants, Skills for Care, 2016

[7] Guidance on how to develop a personal assistant register, Skills for Care, 2014

1.2.1 NHS teams

Across 90% of survey responses from NHS organisations (44 of all responses), the NHS was directly providing at least some of the employment support. This was most likely to include information about employing a PA and rates of pay. The survey responses received also show a number of NHS organisations making their own full end-to-end support offer to PHB holders, as well as there being alternative options provided by the user-led and independent organisations in their area.

Those commissioning support units (CSUs) or clinical commissioning groups (CCGs) that had dedicated teams or individuals for PHBs stressed the value of that resource. This approach also allows the identification of a single point of contact, not just for PHB holders but also for colleagues and local organisations, and demonstrates the breadth of support required to successfully deliver PHBs and PA working.

The case study in chapter 6, '**Embedding personal health budgets (PHBs) and PA working**,' describes how NHS Arden & GEM CSU have responded to the emergence of PHBs and PA working; including building a dedicated team, establishing consistency across the area they work in and maintaining a focus on personalisation.

1.2.3 Local authorities

Although reported levels of provision of support from local authorities to PHB holders were relatively low compared with that from NHS or independent organisations (figures 1.1 and 1.2), in their qualitative and interview responses, respondents suggested that they were still a valuable source of information and experience. In areas where joint funding arrangements with the local authority were in place (approximately 23% of areas covered by this research), respondents were quick to praise this approach. Often arranged under a Section 75 agreement[8], respondents reported that these joint arrangements:

- offered consistency to individuals making the transition from social care to health and maintained (from their perspective at least) a seamless service; they also reduced the bureaucracy experienced by some PHB or direct payment recipients
- allowed more time to focus on the service being provided for an individual (as opposed to the processes used to achieve it)
- represent an opportunity to achieve an economy of scale by avoiding the cost of duplicating processes and resources locally.

Given the continued emphasis on integration (including integrated personal commissioning (IPC)), these types of arrangement, when suitably set up and delivered, have the potential to play a significant role.

[8] Section 75 of the Nation Health Service Act 2005, regarding agreements with local authorities.

1.2.4 User-led and independent (private and voluntary) organisations

Whilst some NHS organisations reported issues (particularly around independent brokerages) regarding securing timely, effective and consistent support, the value of user-led and independent organisations was not underestimated. They are, either as commissioned or independent services, making a significant amount of support available.

Where working they are well placed to offer flexible and creative solutions to some of the barriers faced by both individual employers themselves and NHS organisations. This flexibility is demonstrated by two different, but equally valid initiatives being delivered in different parts of England:

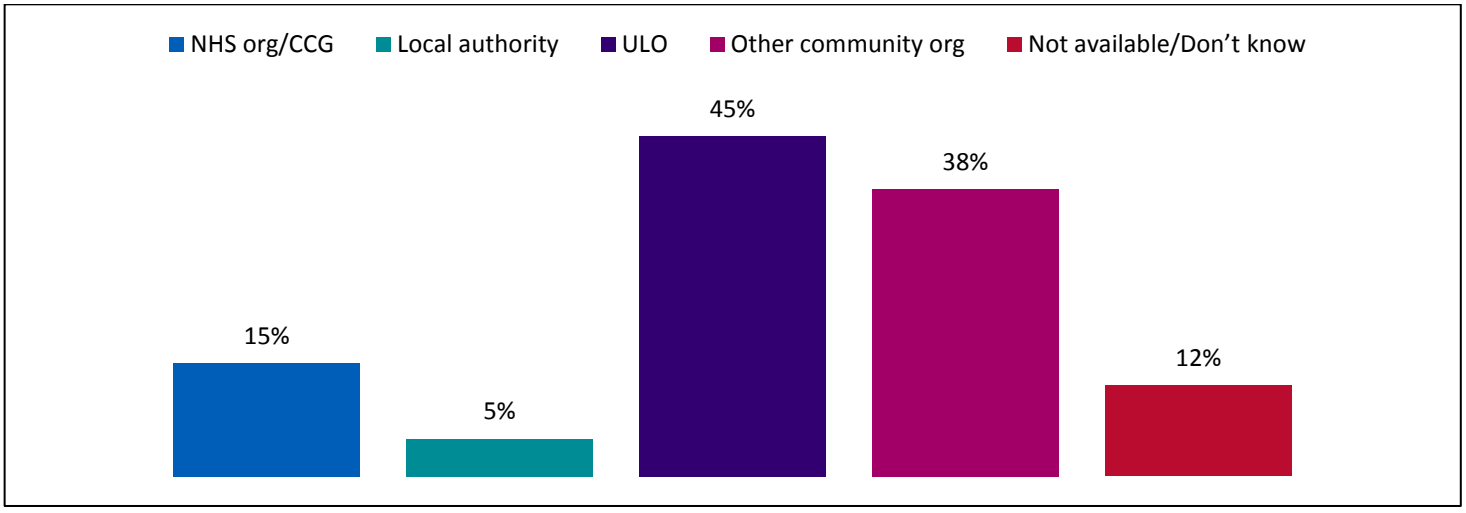
The case study in chapter 6, '**A new model of PA working: The Continuing Independence Agency**,' describes how the user-led organisation The Fed, are piloting a way of working which removes the employment responsibility of having a PA from a PHB holder, but maintains the choice and control that comes with PA working.

The case study in Chapter 6, '**Delegated tasks and PA working in hospitals**,' describes how the community interest company (CIC) Salvere, working closely with the CSU, have approached the challenges of training for delegated tasks and PA working in hospitals.

1.3 Peer support

The number of respondents indicating that peer support or mentoring was available to PHB holders is significantly higher than the figures reported in social care in previous years and is higher than the availability of 74% that local authorities reported in 2015[9]. Nine out of ten respondents to this survey indicated some local provision (figure. 1.4).

Figure 1.4 – who Provides peer support for PHB holders locally? (n=60)



[9] Supporting individual employers and their personal assistants: research into local authorities' support for people that employ personal assistants, Skills for Care, 2016

There are a number of possible factors for this: the relatively small number of PHB holders makes it easier to identify and communicate with people and the NHS does not face the same challenge in reaching self-funders that local authorities have. The emphasis placed nationally on peer support during the introduction of PHBs has also had a positive impact: many respondents talked about the work done by People Hub[10].

We must include a note of caution here: the survey asked about the *availability* of peer support. Encouraging take-up and establishing continued engagement were both often reported as challenges. It may also be possible that in a number of instances the *availability* of peer support was understood by respondents to mean the existence of a local ULO, rather than them having specific knowledge of a structured programme or forum.

There can be no doubt that user-led and independent organisations play a significant role in the provision of peer support (see figure. 1.4); 45% and 38% of provision respectively.

Further significance is added to this finding when it is considered in the context of last year's research[11]; ULOs reported significantly higher availability of peer support (68%) than local authorities (37%).

1.4 Safeguarding (inc. DBS checks)

Provision in regard to safeguarding and employment was identified as one of the strongest areas of support available to employers.

The findings of this research demonstrate that in most places more than one process is in place to support safeguarding (figure.1.5). These include:

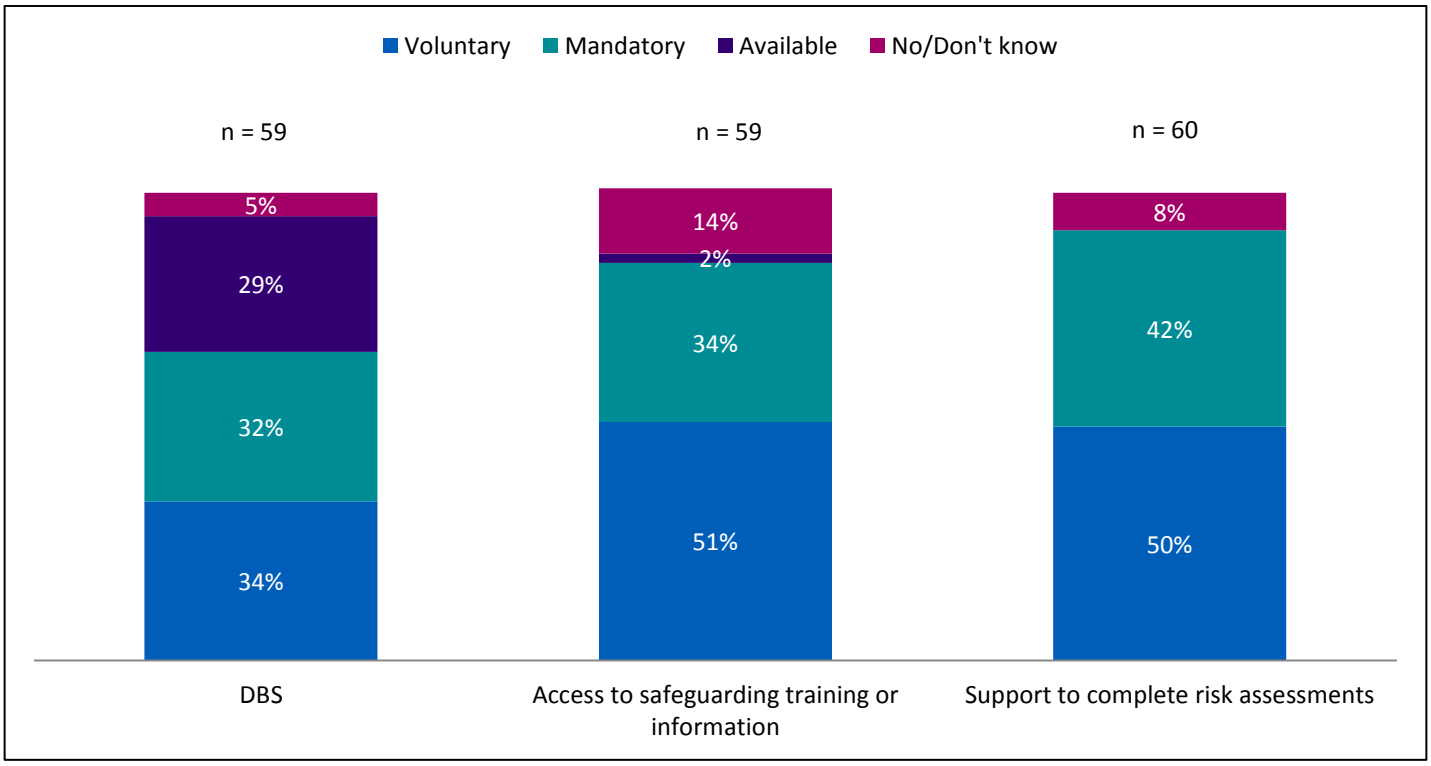
- Disclosure and Barring Service (DBS) checks (availability of 95%)
- specific information or training available for safeguarding (85%)
- considerable support with completing risk assessments (92%).

Every site visited as part of this research highlighted both the value and expertise often inherent in the PA role, but also the need for support in relation to isolated working.

[10] http://www.peoplehub.org.uk/

[11] Supporting individual employers and their personal assistants: research into local authorities' support for people that employ personal assistants, Skills for Care, 2015

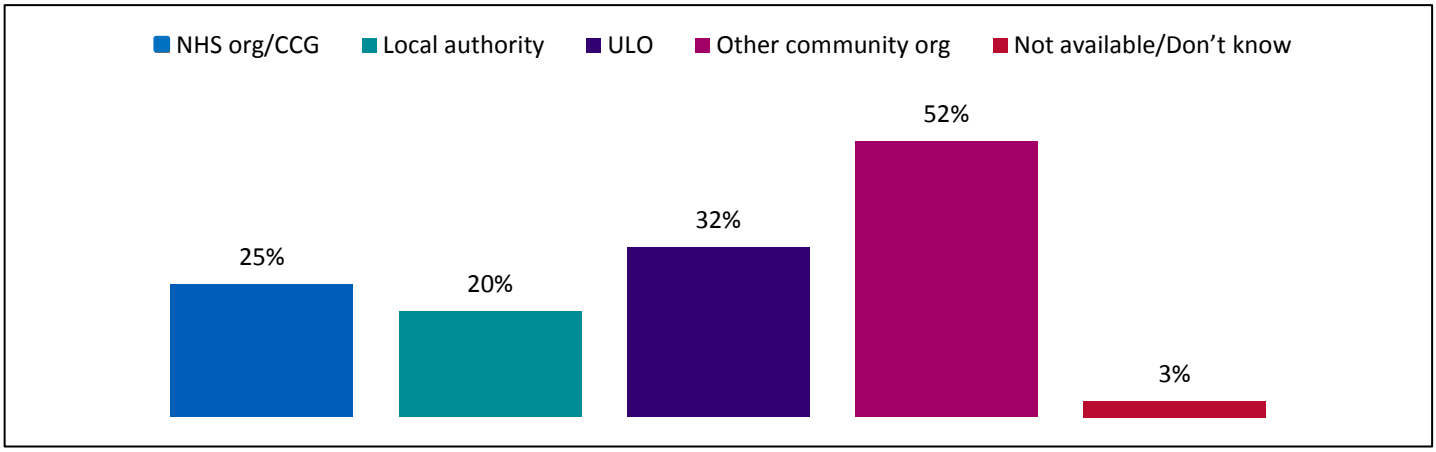
Figure 1.5 – are employers able to access specific safeguarding support?



The case study in chapter 6, '**A new model of PA working: The Continuing Independence Agency**,' describes how the user-led organisation The Fed, are using a Support with Confidence scheme to train and quality assure PAs.

Only two responses to the survey (3% of all total responses (n = 60)) indicated that access to DBS checking services was not available; and 100% of respondents from NHS organisations reported the availability of support with securing a DBS check. As with many of the support elements available to employers the source of this support was mixed (figure 1.6).

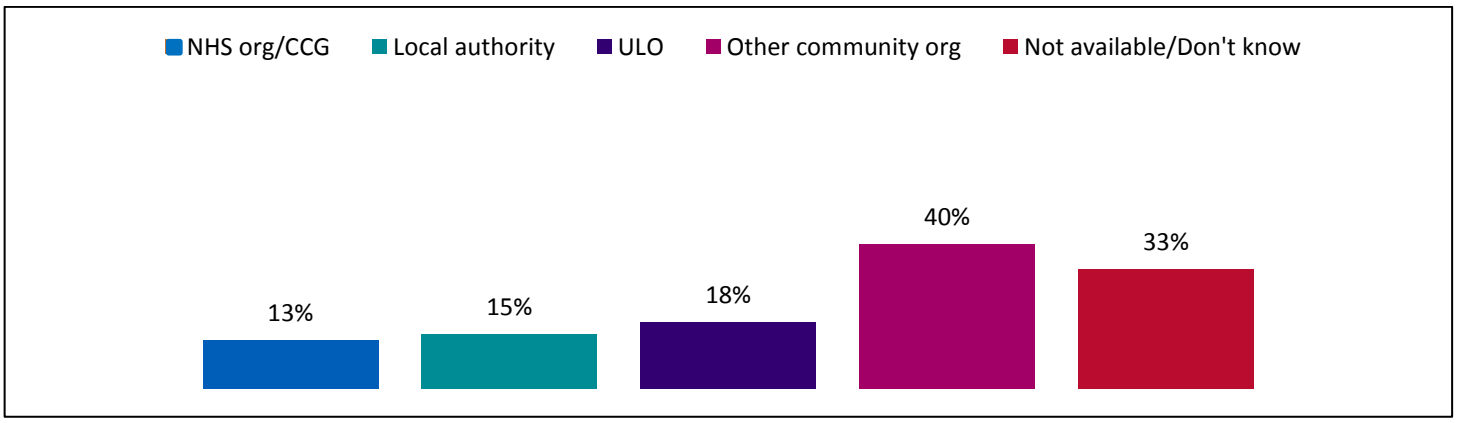
Figure 1.6 – who provides a DBS checking service? (n=60)



2. Support available to personal assistants (PAs)

The information received concerning the support available to PAs presents a complex picture: qualitative feedback from survey respondents often cited support for PAs as an area requiring further work locally, but the quantitative data available indicates that a reasonably healthy support market exists in some areas.

Figure 2.1 – is advice/information about working as a PA available and who provides this? (n=60)



Some clear gaps can be identified (peer support and access to a PA register), while the data suggests that other types of support are being embedded but still require a further increase in provision, e.g. information about working as a PA (figure. 2.1).

All of the following are all more likely to be available to PAs (figure 2.2), than not:

- pre-employment training
- learning and development opportunities
- advice when an employment relationship breaks down
- access to legal information.

When considering the apparent contradiction in the responses received, two significant factors should be considered: the source of the available support and what constitutes a particular type of support locally.

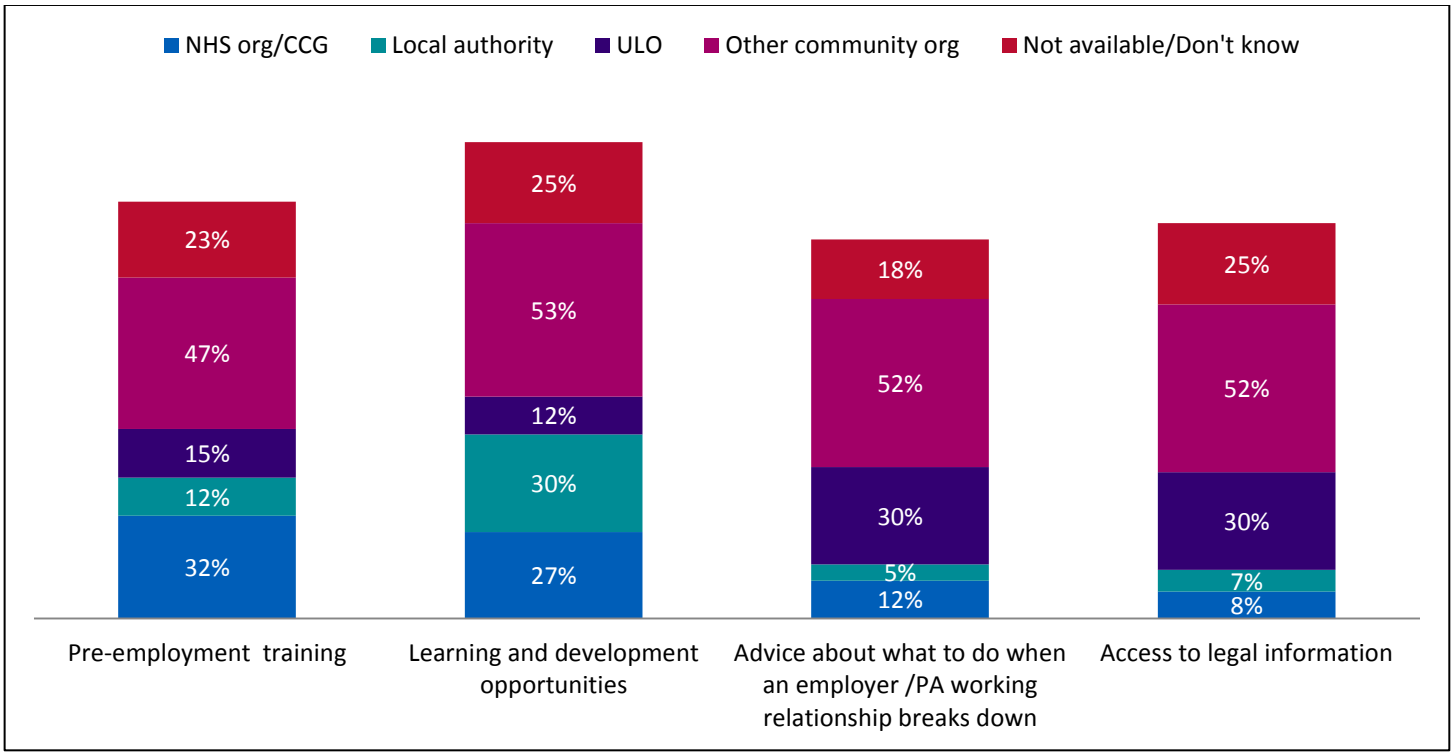
2.1 The source of support

User-led and other independent support organisations (including brokerages) were more likely to be identified by respondents as providing support to PAs than the local NHS organisation or local authority (figure 2.2).

Many of these organisations have emerged in response to the needs of people in need of care and support employing PAs, rather than the needs of PAs themselves. More than one survey respondent identified that while information was made available to PAs by a local ULO, the ULO was not obliged to provide this service. Another observed:

"There is a gap in terms of support for PAs; employers have a support service available for HR issues, etc. which does not exist (certainly locally) for PAs"

Figure 2.2 – what support is available to PAs? (n=60)



Comparing awareness of the availability of a PA register to employers and to PAs respectively, further hints at this distinction (fig. 2.3): while relatively small, the gap (circa 10%) shows a bias toward the employer.

Figure 2.3 – what proportion of respondents were unsure of the availablity of a PA register to: PHB holders; PAs (n=60)

Respondents highlighted the support available to PAs from user-led and independent organisations and these observations were borne out in the quantitative data. Where they reported that this support was informal or not obligatory they were not being critical of the provider organisations but rather acknowledging that the focus of much provision (to date) has focused on the employer, as opposed to the PA.

2.2 Variations in the support offer to PAs

During the course of this research wide variations have emerged between areas in what constitutes a particular support offer.

For instance, in relation to PA training, one survey respondent reported that, beyond training for delegated tasks, only safeguarding and moving and handling training are mandatory for PAs. By contrast, in other areas a comprehensive training programme is available and mandated for all PAs.

What we might begin to infer is that some degree of specific support is available to most PAs in most places participating in this research (as the statistical information available would suggest), but that the extent, quality and regularity of that support is mixed.

As one respondent notes:

"…a specific gap remains around PA support. Whilst some informal support can occur naturally in larger teams, lone working PAs (or those not in these sorts of teams) are often missing a single point of contact."

This lends itself well to the next area for consideration: peer support.

2.3 Peer support

The research shows one or more sources of peer support for PHB holders in 90% of areas, but for PAs it exists in only 45% of areas. The greater availability to PHB holders than to their PAs reinforces the observation made above: infrastructure and support have typically grown around the employer/person in need of care and support, rather than the PA.

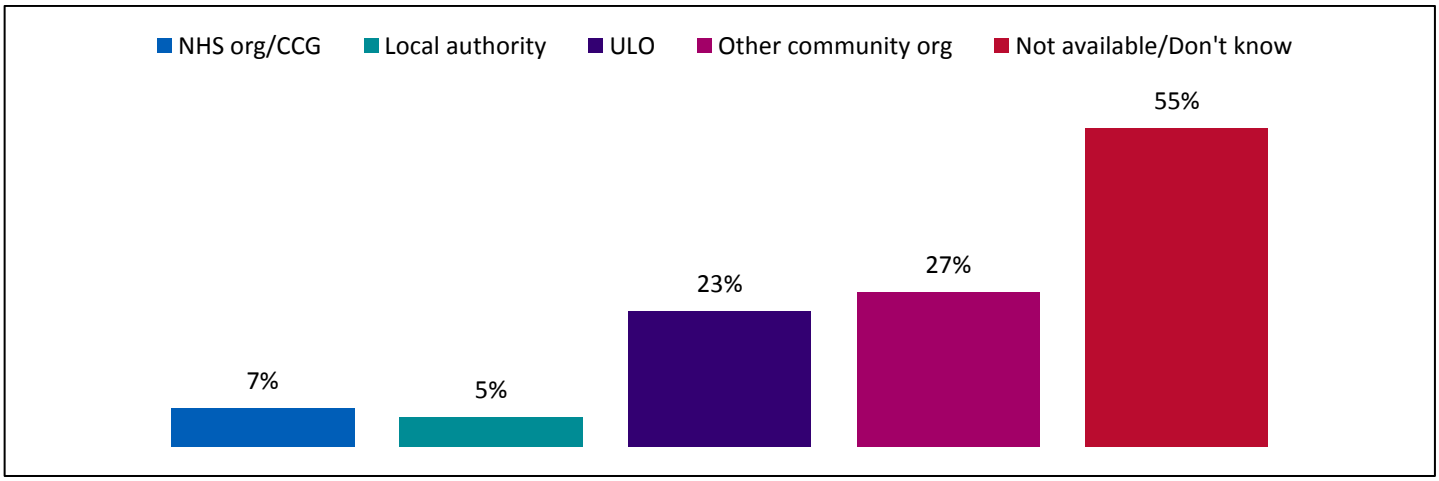
Where peer support is reported as available to PAs it is most likely to come from a ULO or other PVI community or support organisation (figure 2.4).

As with peer support for employers, the difficulty of establishing and embedding peer support to PAs was discussed by participants in this research. One suggestion is that where creating peer support for PAs might be seen as impractical or over-ambitious, the emphasis should be placed initially on establishing the provision of a single point of contact for PAs in which they can have confidence.

While it is evident that there are challenges in establishing peer support for PAs, good practice examples where peer support is working well are available. The case study from Barnsley Metropolitan Borough Council, 'The PA Network Group (PANG)' included in last year's research report, is one such example[12].

[12] Supporting individual employers and their personal assistants: research into local authorities' support for people that employ personal assistants, Skills for Care, 2015

Figure 2.4 – is peer support or mentoring available for PAs? (n=60)



2.4 Training (in addition to training needed to meet specific care requirements)

Training (including induction or core training) or learning and development opportunities for PAs are available in three quarters of the areas covered by responses from the survey. It is common for this training to be available from more than one source (figure. 2.2).

Compared with other types of support, training was more likely to be directly provided by the NHS or local authority. This is to be expected, given their responsibility for funding and arranging any training necessary to deliver the care package safely and effectively. Further, it may be that they are able to allow PAs access to existing (often on-line) training or offer PAs places on specific internal face-to-face training courses.

As with the wider support offer, respondents detailed considerable variation in the training and development opportunities available to PAs. Research participants identified a need for greater opportunities in this area in order to raise the profile of the PA role and make it a more integral part of a career pathway. It is likely that a gap exists between provision of the training a PA needs to fulfil their role and the training which, in a more traditional employment setting, might be associated with development and progression.

As a minimum, mandatory training focused on safeguarding (reported as available by 85% of respondents) and moving and handling (in addition to any specific care training required). In the best examples, training for PAs has become part of business as usual with a consistent and comprehensive approach taken to induction/mandatory training.

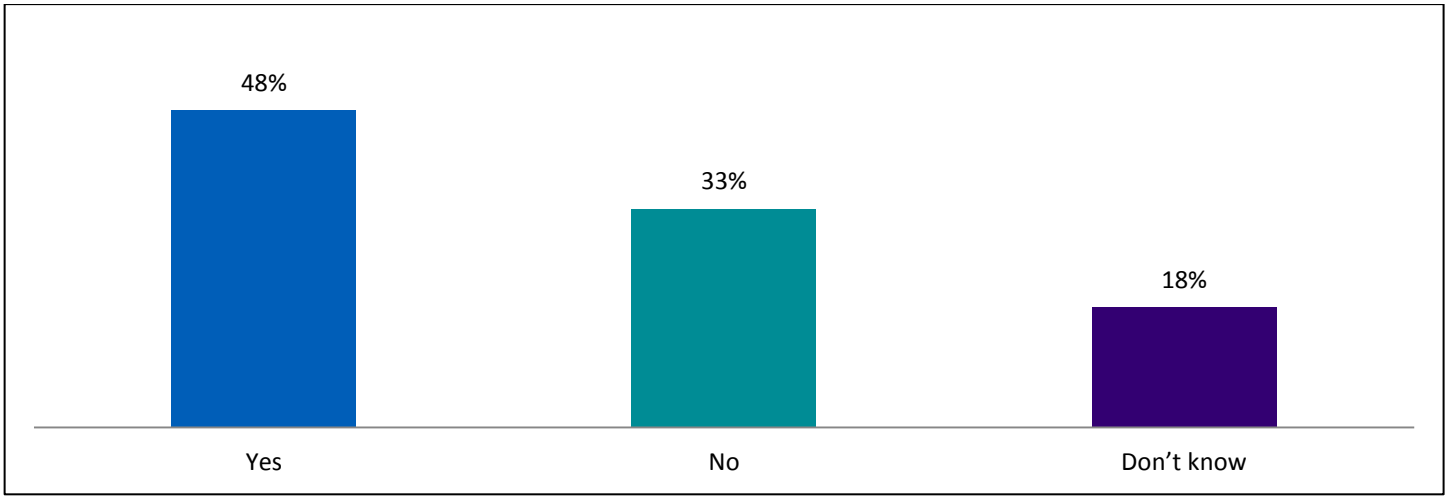
The case study in chapter 6, '**Mandatory and induction personal assistant (PA) training**,' describes the emphasis and approach taken to training by North & East London (NEL) CSU. The CSU mandates that all PAs must complete training mapped to the 15 standards of the Care Certificate. The CSU works with a number of local providers to offer flexible provision.

The NEL CSU case study cited above and discussions with other NHS teams highlight the need to work closely with local training providers. This allows for greater provision of flexible bespoke training, including supporting employers and their PAs to access training outside of the traditional '9 to 5' working day and training delivered in the care setting.

This follows on from the observation made by some participants that the supply side (training providers) are still working to understand the individual employer and PA market.

Half of all survey respondents reported that use of the Care Certificate was being considered as a potential quality assurance or training resource locally (figure 2.5). A smaller number of sites are already piloting the Care Certificate for PAs or using training or induction programmes mapped to the Care Certificate.

Figure 2.5 – has your service considered using the Care Certificate as a potential quality assurance and learning and development benchmark for PAs? (n=60)



Crucially, as well as offering a reliable knowledge base for training, the use of the Care Certificate or training based on its standards may help to emphasise that PAs are part of the social care and health sector, rather than being somehow removed— as may be implied by the unregulated and often isolated and disparate nature of PA work. Whether achieved via the Care Certificate or other means, this ambition to situate PAs within the wider social care and health workforce is crucial to growing the profile of the PA role and the understanding of PAs as skilled workers, as discussed elsewhere in this report.

3. Overcoming barriers to PA working

Before discussing the existing challenges and barriers to PA working in health we must make two crucial observations:

- at the time of writing, PHBs have been enshrined in law (a right to have for people in receipt of NHS continuing health care and children and young people's continuing care) for a relatively short time; the emergence of issues to be resolved is to be expected and NHS England has a national delivery team working with CSUs and CCGs to support them where necessary

- none of the barriers or obstacles identified by respondents were considered to be immovable; rather, participants focused on the work-arounds and progress they were making. This is best demonstrated by the case studies in chapter 6.

3.1 Delegation of healthcare tasks

Respondents to the survey and interviewees from NHS organisations were positive about the delegation of health care tasks to PAs and, where issues existed, were quick to emphasise the need to develop robust systems of delegation to support increased choice and control over the care received. The primary drivers for this were the direct benefits to patients: personalised, safe and consistent care delivered by someone known and trusted. Most respondents also took the time to acknowledge the wider benefits as well, including the opportunity to reclaim capacity for those NHS staff who are otherwise performing these tasks.

Where delegation was working most effectively it was within locally agreed frameworks intended to enable and support delegation.

The case study in chapter 6 '**The Shared Care Protocols (SCPs)**,' introduces the agreed framework being used in Oxford by the NHS, local authority and third party providers to enable the delegation of tasks to PAs.

The case study in chapter 6 '**Delegated tasks**,' describes the processes, policies and checks being used in Staffordshire and its surrounding areas to embed the delegation of tasks to PAs as business as usual.

Despite the success stories emerging from some areas, many more indicated that barriers remain to delegation. Further, a minority of respondents from NHS organisations reported that no training in regard to delegation (and in turn no delegation) was taking place at all (between approximately 5% and 10%). Respondents reported that for the delegation of health care tasks to PAs to work:

- a greater understanding of accountability was needed including some emphasis on the need to recognise that clinicians are being asked to sign off competence rather than "promising that a PA will never get anything wrong"

- teams and individuals need to work to develop protocols for positive risk management

- a sense of context is needed – many respondents noted as contradictory a willingness to train family members or unpaid carers, but not PAs

- more needs to be done to embed systems for delegation throughout organisations – examples exist within areas where one team will train or delegate while another will not.

There can be no doubt that resolving the issue of delegation is dependent on a cultural shift within some NHS organisations. Linked to this is the need to view the role of the PA (and the profile of the role) in a new light. Considerable differences exist between localities in regard to how PAs are perceived and the degree to which PAs are viewed as skilled workers with the potential to develop and grow in their role.

What emerged from all of the interviews that supported this research was a genuine appreciation of the PA role, which needs to be shared more widely. Many of these discussions emphasised the need to recognise the skills and knowledge that PAs can develop and hold.

3.2 PA working in hospitals

PA working in hospitals was not explicitly asked about in the survey, but was an area followed up anecdotally with a number of respondents. With that in mind, the following are broad observations.

Although arrangements are often being made on a case-by-case basis, PA working in hospitals is taking place and is often welcomed. Hospital teams are recognising that the presence of a PA or PAs who can perform certain tasks frees up their own time and (as mentioned elsewhere) helps to ensure that people are receiving personalised care where possible. The presence of PAs can also be of benefit around very person-specific approaches to particular tasks which might not be within the skills or experience of the hospital team.

Where concerns do exist they tend to focus on either the perceived danger of double-funding or what tasks a PA can perform in hospital. In both instances, making a distinction (as described well in the case study in chapter 6 'Delegated tasks and PAs in hospitals') between a person's 'well' and 'unwell'

health needs is useful. Where appropriate, a PA can continue to perform those support functions for which they would normally be responsible – the individual's 'well' needs.

Those respondents who contributed their thoughts on this matter were also quick to highlight that, whether supporting their employer in hospital or not, a PA will (for a certain period at least) continue to be employed and paid while their employer is in hospital. With this and the previous observation with regard to 'well' needs in mind, some would argue that, rather than increase the likelihood of double funding, involving PAs in hospital care actually reduces this risk. It can also support more speedy and effective discharge from hospital.

3.3 Moving between settings

Moving from social care to health was not discussed as a barrier to PA working by respondents, but was acknowledged as an area of potential or particular complexity. With 86% of respondents reporting that they were working with someone who had moved from social care to health funding (figure 3.1) it warrants consideration here.

Figure 3.1 – are you supporting anyone employing a personal assistant who has moved from a social care to a health budget? (n=59)

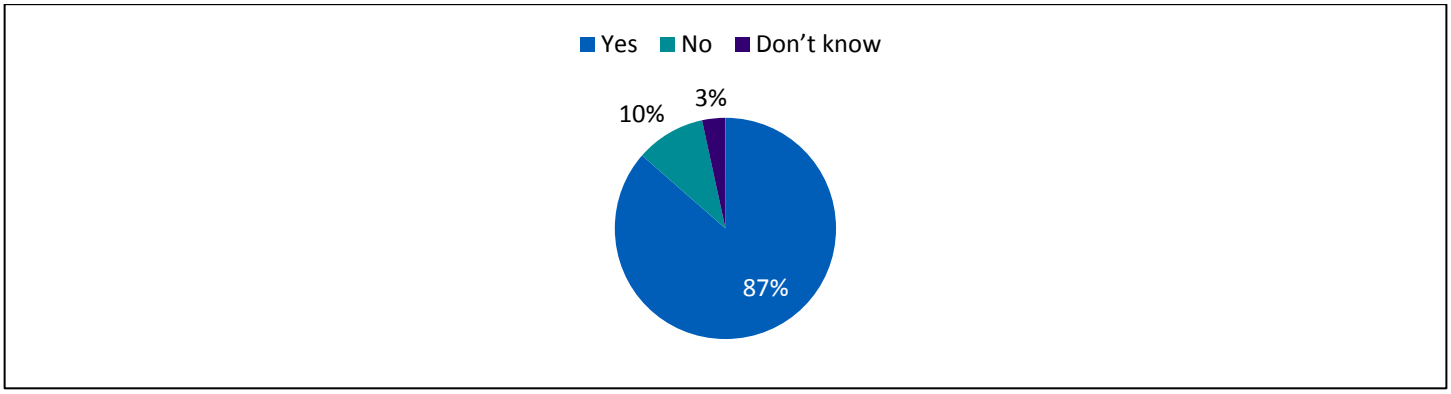
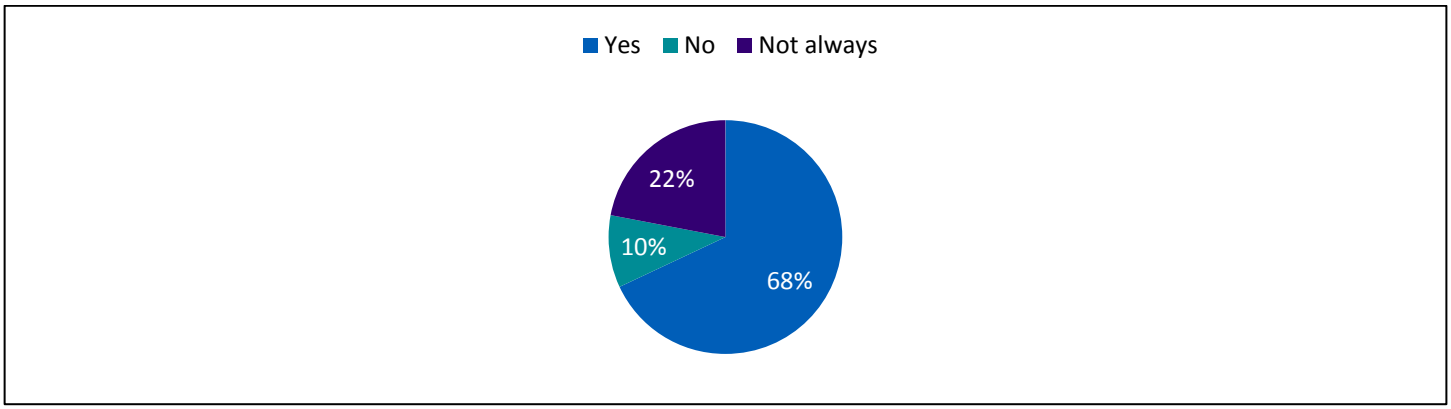


Figure 3.2 – has an individual's move from social care to health change a PA's role? (n=49)



From a workforce perspective, issues were most likely to arise where individuals bought staff across with them from social care; 68% of respondents reported that this move changed the PA role (figure 3.2).

This change was almost always related to the additional training required to ensure that PAs could perform the more ‘health’ related care functions asked of them; most often, but not always, in relation to delegated tasks.

In some instances, particularly where either an employer had been receiving care from the same PA for some time or a PA was long serving, these additional requirements could create tensions. Where this was happening work was needed to help people understand issues and change their attitudes to safety, planning and training. It should be recognised though, that equally this additional training could be well received:

“*The PAs we work with report enjoying it [training] and family members are very pleased it is taking place*” – PHB lead.

A number of respondents also raise examples of individual cases where an employer moved from social care to health with a ‘self-employed’ PA.

N.B: Under most circumstances HMRC considers PAs to be employees and not self-employed. Where PHB holders report using self-employed PAs, it is recommended that NHS organisations work closely with the individual to look at whether the employment arrangements in place fit with HMRC’s guidance with regard to self-employed status. Where it doesn’t already exist, it may be helpful for colleagues from the NHS and local authorities to establish a shared understanding in regard of PA employment status.

4. Shaping the PA market and the profile of the role

The majority of PHB holders supported by respondents to this research were using at least some of their budget to employ a PA or team of PAs. Although PHBs are not right for everyone or an appropriate way to provide every NHS service their number is expected to grow over the coming years and if trends remain the same, this will drive the creation of a large number of new PA roles. In social care approximately 70,000 direct payment recipients are employing their own staff[13].

With this in mind, local authorities and the NHS need to consider in partnership how they will ensure that sufficient numbers of PAs are recruited and retained in order to meet likely increasing demand in the coming years.

4.1 Recruitment

After delegation of healthcare tasks, the recruitment of PAs was the issue most often highlighted by survey respondents. In the main, it was the issue of demand outstripping supply that was discussed: however the intensive nature of recruiting PAs was also acknowledged (with reference often made to the need to manage expectations with regard to timescales).

Respondents were quick to highlight the profile of PA working and misconceptions about the role as barriers to recruitment and the cause of supply issues (a lack of people willing to become PAs or with an understanding of how to become a PA).

The emerging picture offers a sense that, while greater support is needed for PAs (as identified in chapter 2), it is not the role itself which needs to change, but rather perceptions of it. Respondents frequently highlighted the impact of a PA (or team of PAs) employed using a PHB on someone's life and that the role itself offered a significant degree of flexibility (which was often mutually beneficial), in a stable and often informal environment:

"*For those with the most complex needs PHBs have changed people's lives*" – Personal Health Budgets Co-ordinator

"*PHBs have the potential to offer more suitable and stable care for people*" – Personal Health Budgets Manager

Approaches to recruitment typically involved adverts in local press, news agents, etc. as well as word of mouth and work by NHS teams with local brokers. Other approaches which those involved in PA recruitment may wish to consider included:

- attendance at university Freshers' events

[13] The size and structure of the adult social care sector and workforce in England, Skills for Care, 2015

- (with particular reference to children's services) sourcing PAs from among local special needs schools' teaching assistants who are looking for additional work
- recruiting students completing care- or health-related courses e.g. nursing
- direct work with the local Jobcentre Plus (JCP).

Finally on the subject of recruitment, the lack of 'skilled' PAs (those with previous care experience) was not necessarily the issue; values, attitude and a willingness to do the job were all considered more important. It was felt that training was available for PAs without previous experience – this has been discussed in chapter 3 above, but raises our next subject, the retention of PAs.

4.2 Retention

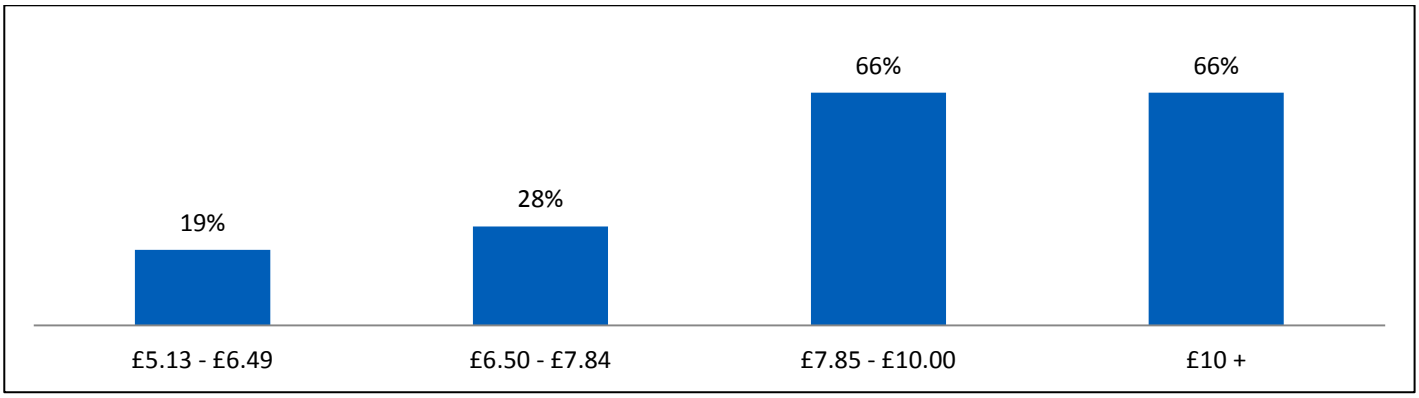
Among those who mentioned it, retention was being thought about not in relation to individual cases but at a more strategic level. A number of respondents felt that the coming years will see the emergence of pools of experienced PAs who are well trained but out of employment.

They cited the current lack of a robust mechanism to keep PAs "*in the system*" or to bring them back into employment either where an employer's needs had changed significantly or the employer had passed away. Given the infancy of PA working in health, it is unsurprising that frameworks for retention do not exist. Much like work to raise the profile of the PA role, there is an emerging feeling that some framework or model to retain and redeploy PAs is needed if the role is to be established as a career pathway.

4.3 Pay

Responses to both this research (figure 4.1) and the corresponding [14]local authority research' demonstrate that PAs are ordinarily being paid more than the national minimum wage (NMW) and in many cases are receiving an hourly rate equivalent to the national living wage or higher.

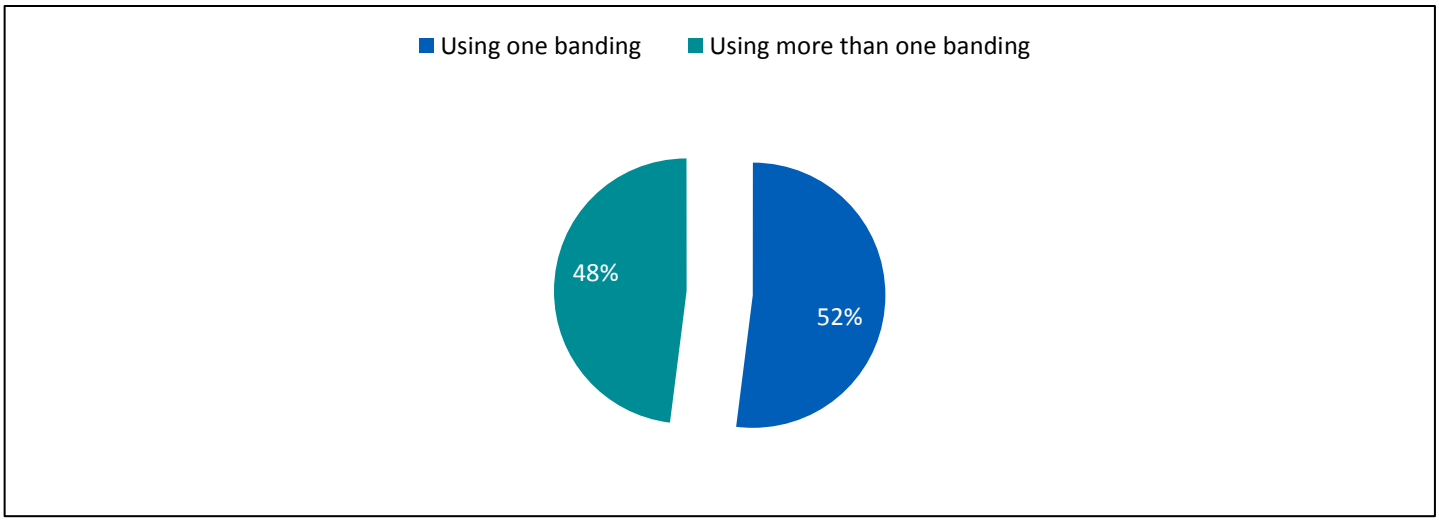
Figure 4.1 – when setting a PHB, what hourly rate for personal assistant time do you use? (n=59)



[14] Supporting individual employers and their personal assistants: research into local authorities' support for people that employ personal assistants, Skills for Care, 2016

N.B: (with reference to figure 4.1) as noted in the methodology at the start of this report, where respondents were able to provide more than one answer to a question the total percentage will exceed 100%.

Figure 4.2 – organisations using more than one pay band (n=59)



In many areas, the suggested hourly rates for PAs are aligned with the tasks they perform or the nature of specific roles; so (for instance) those performing more complex tasks are receiving a higher level of remuneration. The number of areas responding to the survey to indicate the use of more than one rate (figure 4.2) and anecdotal information suggests that this is wide-spread.

At best, and used carefully, this approach may help to demonstrate the recognition of skills and encourage career development.

Without exception, all interviewees who participated in this research confirmed that provided the money could be found within a PHB and that it could be demonstrated and agreed to be an appropriate use of resources, a PHB holder could offer a different rate to the one suggested by the individual or team supporting the care planning process. This flexibility is in line with the principles of personalisation.

4.4 New models of working

"*For some people being an employer is too much or they simply don't want those responsibilities; but they do want the choice and control that comes with employing a PA*" – The Fed, Brighton

As evidenced by the case study in chapter 6 provided by The Fed, it is possible to speculate that new models of PA working are starting to emerge which remove the 'employer' element typically associated with receiving care and support from a PA. A number of similar initiatives can be identified in other areas.

It is not for this research to make a judgement on the 'correct' model of PA working, but it should be noted that a small number of respondents from NHS teams also highlighted that they would welcome access to a third party provider who would employ PAs on behalf of a PHB holder.

Developments in this area should be watched with interest at both local and national levels. If in fact a new approach to PA employment is emerging, the workforce needs and considerations it prompts must be noted. It is worth emphasising that in the examples available the distinction between the 'PA' role and more traditional care and support workers is seen as crucial.

Although it makes no suggestion as to the type of provision being purchased, given the clear links between PA working in social care and health, the observation made in the most recent '*Size & Structure of the adult social care sector and workforce in England*'[15] gives grounds for further thought:

"*Evidence suggests that increasingly people in receipt of direct payments are moving away from the model of becoming employers themselves, to a model of buying in the services they require*"

[15] The size and structure of the adult social care sector and workforce in England, Skills for Care, 2015

5. Summary and recommendations

Summary

This report provides a snap shot which demonstrates the progress being made by a number of CCGs and CSUs with regard to embedding PHBs and PA working. As demonstrated in the case studies in chapter 6 of this report, organisations are dealing successfully day-to-day with the practicalities of PA working. Further, the principles of personalisation are being talked about, put into practice and embedded.

In sites surveyed, support for those individuals using a PHB to employ a PA is available, particularly with regard to up-front information and safeguarding measures. This is coming from a wide range of sources, including user-led and independent providers.

The availability of peer support (90%) for PHB holders employing a PA is particularly note-worthy; this is a valuable means of support which can often be difficult to establish.

Despite the considerable progress that has been made in some areas, since and ahead of (in the case of many respondents to this survey) the mainstreaming of PHBs, respondents to this research reported that:

- barriers to the successful delegation of health care tasks remain
- although available to some degree, in some areas support for PAs is inconsistent
- the flexibility, skills and values that PAs can bring to care and support are not always fully understood or recognised
- a greater supply of PAs is needed to support the continued success and expansion of personal health budgets.

There was good evidence of organisations working in partnership with over 70% of survey respondents reporting working with colleagues from other agencies. The case studies at the end of this report illustrate some of the ways in which partnership working can help develop solutions.

A series of recommendations have been based on the findings of this report. These are detailed on the next page.

Recommendations

Training

1. CCGs should consider establishing local frameworks for the delegation of health care tasks. Locally agreed frameworks for delegation can contribute to providing a robust and safe process for identifying training and assessing competence. This provides NHS clinicians with the necessary protocols and contributes to the culture of support and reassurance, needed to confidently delegate tasks. See case studies four and five.

2. CCGs should consider establishing an offer of core training for PAs. In the emerging good examples, core training for PAs has become part of the local PHB offer with a consistent and comprehensive approach taken to induction training. This is often being mapped against the 15 standards of the Care Certificate where appropriate. See case study one.

3. As the employment of PAs by PHB holders continues to increase there is the potential for capacity issues to emerge in relation to training, sign-off and monitoring of competence. CCGs should consider establishing dedicated roles in relation to training and signing off and reviewing competence. This could include working with training providers.

PA support

4. Peer support or other means of networking for PAs is an important part of developing and maintaining an effective workforce. In areas where peer support for PAs is considered unachievable in the short term, the focus could instead be placed on the provision of a single point of contact for PAs with workplace or HR based questions or issues that cannot be resolved with their employer. To avoid conflicts of interest this role needs to sit separately from the function of employer support.

   In the longer term, peer support or other means of networking PAs should be the ambition; isolation can be associated with the role.

Recruitment and retention

5. NHS organisations, local authorities, user-led and independent organisations, as well as national stakeholders need to work in partnership to address issues in the recruitment and retention of PAs. This links closely to the provision of consistent training and support, considered in recommendations two and four.

6. Nationally, work needs to be done to understand the possible implications of potential new models of PA employment on existing initiatives.

6. Case studies

The following case studies highlight examples of emerging best practice and approaches to PA working being taken by organisations across England:

- Mandatory and induction PA training: North & East London CSU
- Embedding PHBs and PA working: NHS Arden & Greater East Midlands CSU
- Delegated tasks and PAs in hospitals: Midlands & Lancashire CSU and Salvere CIC
- Shared protocols for delegation: Oxford Health NHS Foundation Trust (children's services)
- Delegated tasks: Staffordshire & Surrounds CCGs
- A new model of PA working 'The Continuing Independence Agency': The Fed

Mandatory and induction personal assistant (PA) training

North and East London (NEL) Commissioning Support Unit (CSU)

Introduction

North and East London (NEL) Commissioning Support Unit (CSU) have a dedicated personal health budget (PHB) team who provide support to PHB holders in all aspects of being an individual employer. This in-house team provides end-to-end support from setting a budget, assisting with how it is spent and monitoring budgets. They put real emphasis on meeting the mandatory and induction training needs of PAs:

"*Training is often something which doesn't get as much time spent on it as it should; the personal assistants (PAs) we work with report enjoying it and family members are very pleased it is taking place.*"

The CSU received a 96% satisfaction rating earlier in the year from PHB holders and currently 100% of PHB holders have at least some PA support as part of their care plan.

Background

All PAs supporting the PHB holders that the CSU works with are required to have completed or comply with mandatory training which is equivalent to the Care Certificate (in addition to any training needed to meet specific care requirements). This training is mapped to the 15 standards of the Care Certificate and is provided (most often) by one, or a mix, of three local training providers.

The CSU has made training mandatory where someone is being paid. Where an employer has an existing PA who has done training in the last 12 months and can provide certificates to evidence this, the PA's refresher training is timetabled as appropriate. Where an employer has an existing PA who has training needs (e.g. as someone transitions from social care to health) the CSU is clear that:

- someone cannot work alone until they have completed their training
- the PA must enrol on training as soon as possible
- delegated tasks will be performed by an NHS clinician or an existing care agency until the PA has received appropriate training and can be signed off as competent.

What is being done

Funding for training is included in a person's PHB, based on the support identified in their care plan. Employers (PHB holders) then source their PA's training from one of three local providers with support from the CSU. All three providers are approved by the CSU; all three are providers of wider training activity and PA training is an addition to their core business.

Employers also have the option of sourcing their own training provider, other than the three offered by the CSU. Where PHB holders wish to do this the CSU quality assures the training provider before the PHB holder can purchase training.

All three of the CSU's regular training providers offer a mix of training, including: access to regular scheduled sessions, a 'drop-in' option for particular courses and the ability to request bespoke courses at a time and venue that suits the PHB holder and their PAs. All of the training provided is face-to-face and routine observation always takes place one to three months after training.

The CSU operates an 'odd-years and even-years' policy in regard to refresher training. On all odd years (including year one) PAs must complete full training and be subject to observation; on all even years PAs must complete refresher courses and be subject to observation. Where a PHB holder has a particularly large team or rapidly changing needs, full training can also be specified each year.

What has been achieved

- A well-established model for training new and existing PAs exists, which has helped to establish PHBs and PA working as 'business-as-usual' within the CSU.

- Working closely with three providers (while supporting employers who wish to use another provider) has allowed the CSU to take an approach which is straight forward and 'hassle free', while maintaining choice and control for individual PHB holders.

- The three training providers predominantly used by the CSU provide good examples of where the supply side, working closely with the NHS, has been able to broaden its existing offer to PAs. All three have core business quite distinct from PA working, including:

    - training for care homes, teams within the CSU and other 'traditional' services

    - work and training predominantly with ambulance and emergency services

    - training their own staff (one provider is the training arm of a local care agency).

What has been learnt

- The availability of bespoke training, including when and where it is delivered is important. This is particularly true where PHB holders have large teams of PAs or where training within the care environment is necessary.

- The CSU has avoided the use of an on-line learning option; all training takes place face-to-face. This approach ensures that PAs engage and interact with their training and provides reassurances for the CSU about quality.

- Although some individuals transitioning from social care to health are uncomfortable with training being mandatory, most welcome and enjoy it. Similarly, the overwhelming majority of PHB holders like the fact that observation is completed with their PA one to three months after training.

Next steps

PHBs and PA working are now part of ‘business-as-usual’ for the CSU and the CCGs with which they work.

Embedding personal health budgets (PHBs) and personal assistant (PA) working

NHS Arden & Greater East Midlands (GEM) Commissioning Support Unit (CSU)

Introduction

NHS Arden & Greater East Midlands (GEM) Commissioning Support Unit (CSU) has embedded personal health budgets (PHBs) and PA working successfully with over 70 individuals in receipt of PHBs, the majority of whom use one or more PAs to meet at least some of their care and support needs. The approach taken by the CSU includes a strong focus on keeping the person at the centre of all of their work and processes: "*If we produced a support plan for an individual and it was identical to someone else's we would know we'd got something wrong.*"

Background

NHS Arden & GEM CSU was one of three CSUs involved in the national second wave pilot for PHBs and their approach and infrastructure has built on this early work. When the pilot started one nurse and one project lead were in place; since then the dedicated team has grown to four. This has allowed the CSU to put a real focus on the case management approach they take to PHBs, and PHB holders often prefer the CSU over local brokerage services when it comes to choosing help with their support planning.

A local steering group which meets monthly has been a critical tool in joining up and streamlining processes with local stakeholders (including the local authority and clinical commissioning groups (CCGs)); approximately 45% of budgets are joint funded with social care and a similar number of PHB holders have moved from local authority funding.

What has been done

Having recognised that, beyond the pilot, PHBs were going to grow substantially in the NHS and in response to local demand, the CSU embedded and grew its dedicated PHB team, ensuring that PHB holders and NHS colleagues have a single point of contact and that the CSU can make an end-to-end case management offer.

Ensuring a strong clinical presence in the set-up and promotion of PHBs had two interlinked benefits: driving the growth in demand for PHBs and starting to address the concerns that existed around PA working (including the actual and perceived risks associated with it) and delegated tasks.

On-going promotion includes discussions at the continuing health care (CHC) funding assessment and eligibility stage and mailshots to individuals with CHC funding, co-ordinated by the CSU team. Word of mouth within CHC networks and also via local health professionals who recognise the benefits of PHBs has also driven demand and raised interest.

Given the comparatively small number of PHBs by comparison with local authority direct payments and the number of PHB holders either joint funded or moving between social care and health,

payments and financial monitoring are delivered by the local authority under a Section 75 agreement. This has avoided duplication in systems and has been supported by the creation of a post in the local authority (funded by CCGs) to facilitate this work.

In order to support and normalise PA working the CSU team works closely with stakeholders within and external to the NHS. This includes:

- presentations to local providers of more traditional forms of care (e.g. domiciliary care); highlighting the need for more PAs and an emerging gap in the local employment market

- attending the local peer network for PHB and CHC funding holders; this provides an opportunity for the team to learn from patients and hear experiences of day-to-day PA working.

The CSU is also piloting the use of the Care Certificate with PAs.

What has been achieved

- The case management offer from the CSU team provides a single point of access for PHB holders and those interested in taking up a PHB.

- Close working with local authority colleagues and the transfer of responsibility for making and monitoring payments means that from a user perspective provision is seamless between social care and health; this is aided by the single point of contact for PHB holders. This also reduces costs to the CSU.

- Paperwork including forms, templates and letters have been standardised and are now used across the area the CSU covers; this avoids duplication of effort and allows more time to focus on needs rather than processes.

- The positive impact of PHBs and PA working has been well documented but is worth reiterating; examples locally include fewer hospital admissions and the wider positive impact on families, including relatives being able to return to work.

What has been learnt

- The Care Certificate has the potential to address a number of issues with PA working; it offers a reliable knowledge base for mandatory training and wider completion or compliance with the Care Certificate has the potential to benefit the profile of the PA role, making it part of a career.

  N.B. it should be noted that members of the CSU team have completed the Care Certificate in order to understand its application to PAs.

- Having a dedicated team (rather than trying to add responsibility to existing roles) provides the capacity to make a full (end-to-end) case management offer to PHB holders and in turn this drives take-up; the amount of time needed to effectively case-manage PHBs must not be underestimated.

Next steps

The CSU continues to promote the up-take of PHBs and, as part of a PA training project, are working closely with local nursing teams to give them the information and confidence they need to sign-off tasks for PAs. Further, work taking place now will ensure that in the longer term (as the number of PHB holders' increases) the capacity exists for the sign-off and monitoring of competence.

The Care Certificate will be piloted with PAs until April 2016 and then evaluated.

Delegated tasks and PAs in hospitals

Midlands & Lancashire Commissioning Support Unit (CSU) and Salvere

Introduction

"*…this is a transformational process that has to happen at a grassroots level; this includes changing culture and attitudes to risk*"

Background

The Midlands & Lancashire commissioning support unit (CSU) and Salvere a community interest company (CIC) have worked closely to road-test the use of PHBs and PAs in Lancashire, jointly developing and piloting policies and procedures. This joint work has seen the emergence of an end-to-end offer to PHB holders from Salvere that includes: brokerage, planning, budgeting, recruitment, HR, payroll and on-going support.

Both organisations recognise that some issues remain (understandably, given how new PA working is to health), including:

- the delegation of clinical tasks to PAs
- establishing PA working in hospitals as the norm.

These are being overcome by the development of local processes and policies, as well as regular engagement with local stakeholders and a steering group including NHS, local authority and third party representation.

What has been done

Delegated tasks

A process is in place so that when a support plan is drawn up Salvere engages with two independent complex case nurses who are engaged to develop a training plan to accompany the support plan. The same nurses deliver training to the staff (PAs) who will support the PHB holder and take responsibility for on-going monitoring of the competency of staff.[16]

As well as taking on this independent role, both nurses continue to work part-time for NHS services (further ensuring the currency of their practice); one nurse comes from an adults' background while the other has a background in children's services. The cost of training and on-going checks on competence are included in the PHB by the CSU. Sign-off and accountability for the delegation of tasks remains with the relevant clinical commissioning group (CCG).

[16] In any instance where the independent complex case nurses are unable to training PAs within the care package, Salvere works with the CSU to identify support from within local community or district nurse teams.

PA working in hospitals

The CSU and Salvere have worked hard with local hospitals to develop an understanding regarding PA working in hospitals. On the potential issue of 'double-funding' where a PA performs support in hospital, it is recognised that PAs will still need to be retained during their employer's time in hospital and that they should be able to continue to perform the support functions for which they are normally responsible. This understanding is supported by a distinction being drawn between someone's 'well' and 'unwell' health needs; the same distinction is useful when a nursing care plan is being drawn up for someone on admission.

Salvere is also developing a process which they hope will avoid delays in agreeing a PA's role on admission. Where a PHB holder has a history of regular hospital admissions a separate care plan regarding what happens at the point of going to hospital (including the role of any PAs) is drawn up in advance, alongside their regular care plan.

What has been achieved

The use of the two independent complex case nurses means that:

- demands are not being made on the capacity of existing nursing and community teams, and arrangements are in place for a rapid response to the identification of training needs when care planning

- training delivered by registered nurses (still working in the NHS) and the clear responsibility the complex case nurses have for the on-going assessment of competency offers reassurance to those clinicians responsible for delegation.

With regard to PA working in hospital:

- The distinction between 'well' and 'unwell' health needs is useful and helps to ensure that PAs can continue to provide personalised support to PHB holders in hospital settings. This has important connotations for continuity of care and retaining PAs during hospital admissions.

- The working being done to establish a process where two care plans are developed in parallel (where a history of regular hospital admission exists), represents a holistic and end-to-end approach to planning and support.

What has been learnt

- Embedding PHB and PA working and tackling some of the associated issues is about culture as much as about process; both Salvere and the CSU regularly attend the team meetings held by stakeholders (including NHS services).

- By comparison with social care (where Salvere have a longstanding established offer), PHBs typically require much more intensive support

- NHS organisations and brokerage support organisations work together most effectively when they are working in partnership.

- Engaging with a PHB peer group helps to work through the difficult questions such as the reality of hospital admissions and the creation of hospital care plans (and how well these have worked) and to develop solutions

- Working closely with all stakeholders from the outset, and ensuring the views of operational staff, the peer group, PHB support services (including Salvere) and local third party budget organisations have been considered, ensures a collective response and understanding informs all steering group decisions.

Next steps

Efforts are underway to look at how all elements of PA training can be streamlined, so that a holistic package of training which covers bespoke health care tasks, mandatory training or the Care Certificate and the completion of health and social care diplomas (where appropriate) is available.

Shared protocols for delegation

Oxford Health NHS Foundation Trust (children's services)

Introduction

The Shared Care Protocols (SCPs) are a local tool for training and competency sign-off. They represent an agreed framework between Oxford Health, the local authority and the local Barnardos[17] for what tasks can be delegated, what level of training they require and the pre-requisites for training (e.g. if certain learning has to be already in place to allow for further training).

Background

Oxford health and their partners developed the SCPs in 2000; a similar exercise had started or was taking place in adult services at the same time. They were most recently reviewed in 2012 and a further review of the SCPs started in the second half of 2015.

Originally developed with a focus on homecare services, the parallels that exist with the tasks that PAs perform, meant that when personal health budgets (PHBs) were introduced an existing model for training, assessment and delegation was already in place locally.

What is being done

Training, assessment and delegation are completed in line with the SCPs. When a task for delegation is identified in the care planning process the SCPs are used to identify the training needed and a request form for training and delegation is sent to the Children's Community Nursing (CCN) team. The CCN team has a training co-ordinator who reviews the application and works with the team to identify the most appropriate person to deliver training.

Training for delegated tasks is prioritised and once completed (provided the trainer has assessed the PA as competent) they sign-off on delegation of the task. As required, responsibility for monitoring competence sits with the nurse who delivers the training; all timings for monitoring are set out in the SCPs. Similarly, the protocols set out where responsibility sits for scheduling refresher training. This can be negotiated on an individual basis; as a minimum refresher training would be yearly.

Where someone is trained but is not yet ready to be signed off as competent the SCP contains an action plan for further training that can be tailored to individuals.

Having been embedded over a number of years, and with the work needed to transform the culture around delegation having taking place when the SCPs were first developed, the delegation of tasks to PAs is done safely and effectively. The SCPs are familiar and well used locally.

[17] Barnardos are a key partner and service provider locally.

What has been achieved

The Share Care Protocols:

- underpin a robust and safe process of identifying training and assessing for competence against delegated tasks
- offer all parties a clear understanding of their (and each other's) responsibilities
- ensure the most appropriate person is the one delivering training
- allow for training to be co-ordinated and delivered in a timely manner, as well as underpinning a culture where delegation is part of business as usual.

What has been learnt

- The lessons learned from delegation to other groups, those in more 'traditional' homecare roles or family carers, can be applied to PA working effectively
- Designated time to promote approaches and engage with all stake holders "top to bottom" in different services is important.

Next steps

The SCPs are undergoing review and any changes that are needed in regard to PA working will be considered. Part of this may involve looking at how approaches to taking a PA from the beginning to the end of training around specific tasks can be done safely.

Delegated tasks

Staffordshire & Surrounds Clinical Commissioning Groups (CCGs)

Introduction

"*What we have done well is to embed the processes we need, ahead of the continued rapid expansion of personal health budgets*"

Background

Across Staffordshire and its surrounding areas seven clinical commissioning groups (CCGs) have agreed to establish a single point of contact for personal health budgets (PHBs). Sat within Staffordshire CCG a PHB co-ordinator has full oversight of PHB working locally, including the delegation of healthcare tasks, care planning and maintaining relationships with local brokerage and training services.

Having a central co-ordinator has supported the development and embedding of policies and procedures which support efforts to make PHBs and PA working business as usual, including those around delegated tasks.

What is being done

All seven CCGs are working to an agreed framework for delegation. This framework is part of the PHB-specific operational policy in place and is based on the Royal College of Nursing's (RCN's) framework for delegation. The framework includes full principles for delegation, including:

- when a task can be delegated
- to whom the task can be delegated to
- the level of training required for delegation
- the frequency of monitoring required following delegation.

When a budget and care plan is set up a clinical recommendations form is completed. Based on this information the PHB co-ordinator takes responsibility for identifying the appropriate training and training provider. Training comes from a number of sources, including:

- local specialist teams
- nursing agencies
- a training provider with strong links to one of the local brokerage organisations.

N.B: With regard to the latter, all parties have worked hard to establish a strong and trusting relationship built on communication. This helps provide the CCG with the reassurance it needs to purchase clinical training.

The PHB co-ordinator collates all of the evidence for completed training and makes a recommendation about delegation. A risk enablement panel meeting bi-monthly and attended by senior managers

nominated as responsible for delegation, drawn from two of the CCGs provides a regular opportunity to maintain consistency, resolve any issues and quality assure on-going activity (from both sides). The opportunity for virtual meetings in between panel meetings also exists.

Regular monitoring and oversight is provided by a mix of NHS teams and local agencies. This approach recognises that capacity is a significant factor in establishing on going roles and support.

Training is bespoke and takes into account the PA's on going and unsupervised role. For instance, during recent training for PAs the clinical team delivering training used an iPad to record a video that can be used as a reference material by PAs in between formal reviews and updates (once every six months).

What has been achieved

- Clear examples of the innovative use of technology to support and embed learning are available, including a scenario where reference materials (including a video) for PAs were developed as part of the training they received.

- The risk enablement panel and PHB co-ordinator have a reciprocal relationship; each party offers support, guidance and reassurance to the other, within a well-defined framework.

- Good relationships and understanding exist between the CCG and their local supply market; this expands choice for budget holders and also helps to address capacity issues.

- The delegation of tasks to PAs is established as business as usual.

What has been learnt

- Linking the individual receiving a budget and their family into the training and sign-off process keeps them at the centre of process and gives the co-ordinator the chance to hear budget holders feedback on the training being provided.

- A framework for delegation avoids confusion and allows for safe and progressive precedents to develop.

Next steps

With robust processes in place the immediate focus in Stafford and its' surrounding areas is on the growth of PHB uptake.

It has also been noted that as uptake increases there will be opportunities for community specialist support teams to extend their contracts and offers to CCGs as part of a developing market.

A new model of PA working ‘The Continuing Independence Agency’

The Fed

Introduction

The Continuing Independence Agency is being piloted by user-led organisation (ULO) The Fed. Testing a new model of PA working, The Fed takes full responsibility for the employment of the PA, but the recruitment and management of the PA is fully driven by the wishes of the person needing care and support. “*For some people being an employer is too much or they simply don’t want those responsibilities; but they do want the choice and control that comes with employing a PA.*”

Background

The Fed is a Brighton based ULO established in 1981. Since it opened it has put numerous local services in place and has a long history of working with the local authority and NHS organisations in Brighton and East Sussex.

The Continuing Independence Agency pilot started in 2014 in response to discussions with local individual employers and budget holders; many wanted the choice and control that came with employing a PA but without the administrative responsibilities of being an employer (payroll and pensions, arranging checks, calculating annual leave entitlements, etc.). This has led to a model in which The Fed itself takes on the employer role.

What has been done

The Fed starts by looking with the budget holder at their care plan and talking to them about what they want from a PA. From this activity The Fed and the budget holder work together to write an advert and job description; The Fed then takes responsibility for advertising the vacancy as part of their wider recruitment activity via local networks, fresher’s fairs, work (funded by the DWP) on the ‘Journey to Employment’ programme, and The Fed’s own PA notice board.

Once The Fed has received applications they work with the budget holder to jointly identify candidates for interview. Interviews are done jointly by The Fed and the budget holder and the final decision on to whom to offer the role is made by the budget holder.

The Fed then conducts all of the necessary safeguarding checks, including requesting references from previous employers and DBS checking. DBS checks are compulsory and, as the employer, The Fed makes the suitability decision following the outcome of the check.

All PAs are expected to complete mandatory training run via the local authority's 'Support with Confidence' scheme.[18] This scheme trains people towards the 15 Care Certificate standards and also includes regular group mentoring sessions (as opposed to one-to-one supervision), which deal with issues in a "global" way and allows for some informal peer support. Training in relation to clinical tasks is arranged on a case-by-case basis with the appropriate local NHS teams.

As part of the process of setting up support The Fed works with the budget holder to understand their responsibilities and good practice. In terms of day-to-day work PAs are taught to understand their duty of care to themselves; beyond this, control over day-to-day tasks and activities (including how they want things done) sits with the budget holder.

Supervision is regular and is a three-way discussion between the budget holder, the PA and The Fed. The Fed works with the budget holder, local NHS organisation and/or local authority to establish back-up plans (e.g. if a PA calls in sick).

What has been achieved

- This model helps to solve the issue of safeguarding for the local CCG and offers the confidence that all PAs have been through the necessary checks and training before they start to work with PHB holders. That the agency is fully CQC-registered offers further reassurance.

- The Fed's resources mean that it can support very bespoke recruitment in certain instances: for example they have TUPE'd staff into the Continuing Independence Agency from other services as an employer has transitioned from social care to health, and have recruited PAs from communities traditionally considered as 'hard-to-reach'.

- The Fed's experience has allowed it to develop a model which retains the choice and control elements of employing a PA, without the budget holder having to take on responsibility for employment.

- The Continuing Independence Agency means that The Fed can work directly with groups of individuals who wish to pool budgets to purchase care and support.

What has been learnt

- Expectations have to be managed; it takes time to recruit the right staff and all parties need to recognise this.

[18] Support with Confidence is a joint scheme between a local authority and trading standards, which provides a list of available PAs who have: been successfully approved, have demonstrated that they have undertaken appropriate training and have met background checks.

- Gaps remain in the understanding of the PA role; it is important to keep selling the benefits of the role to stakeholders and emphasising the skills that PAs can bring to care. Similarly, more must be done to emphasise to potential recruits how rewarding and flexible the role can be.

- Recruitment is about being proactive, according to The Fed; having the jobs board is “the easy bit”. The Fed has a dedicated member of staff to maintain the jobs board and work with PAs to update profiles and match PAs with employers. Similarly, as part of the ‘Journey to Employment’ programme The Fed has a member of staff based in the local job centre

- Talk about personalisation first; then budgets and mechanisms.

Next steps

The Fed will continue to pilot and evaluate the Continuing Independence Agency. It is are also part of the on-going NHS England PHB ‘Gearing Up’ programme.

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