



**Regional Workload Management Framework  
for  
Social Workers in Adult Services**

**Report of the Pilot**

**January 2017**

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## SECTION 1: INTRODUCTION

### 1.1 Background and Context

In April 2012 *'Improving and Safeguarding Social Wellbeing: A Strategy for Social Work in Northern Ireland 2012-2022'* (*The Strategy*)<sup>1</sup> was produced. The Strategy sets out a vision for social work in the context of the current political, economic and social challenges and their implications for social work. A number of strategic priorities and recommendations are made to help social work and social workers meet the challenges ahead.

The Strategy states (page vi) *"Social work is a skilled profession that offers a unique service to individuals, families and communities. The implementation of this strategy will be a driver to improve outcomes for service-users and strengthen the effectiveness and reputation of social work and social workers."*

Workstream 2 was established (April 2014) to consider workload management in adult services to meet Strategic Priority 2: Building Capacity, Meeting Demand which indicates *'we will improve workforce planning and deployment of social workers to meet demand.'* The main purpose of producing a Workload Management Framework is to improve the service that social workers can provide for the service user.

### 1.2 The Regional Workload Management Framework (January 2015)<sup>2</sup>

This was endorsed by the Social Work Strategy Steering Group. Recommendations of the workstream were broadly agreed and the Steering Group asked that the Framework now be tested out across a range of settings and each HSC Trust and PBNI were invited to participate in a number of pilots.

An Implementation Group was set up to support the development of the pilots and put in place a monitoring and review process so that learning about what works would be disseminated widely.

The aim of this document is to report on the pilot work which has been undertaken across Northern Ireland.

### **1.3 Definitions from the Framework Document**

It is important to highlight from the outset that the Workload management framework uses the following definitions: effective **workload management systems** ensure service users are given access to timely, safe and high quality services.

**Caseload management** focuses on the workload of individual practitioners or a team of workers.

## **SECTION 2: METHODOLOGY**

### **2.1 The Pilot Teams Selected**

Six pilots were selected to test out the Workload Management Framework. The teams were selected from across the five trusts and reflected the range of teams in Adult Services – Hospital social work; Older Peoples services; Mental Health; Learning Disability; Physical Disability.

The Probation Board (NI) expressed an interest in undertaking the pilot but were unable to join given their re-structuring.

The work has been supported by the Leadership Centre and Team Leaders have also been supported through a learning set approach where they were able to identify benefits and challenges.

By way of context Table 1 highlights the number and programme of care of those who participated in the pilots.

**Table 1 Programme of Care of Respondents**

	<b>Number of staff</b>	<b>Percent of total</b>
Community Mental Health	10	22.2
Learning Disability	6	13.3
Physical Disability	8	17.8
Acute Services	8	17.8
Older People's Team 1	8	17.8
Older People's Team 2	5	11.1
<b>TOTAL</b>	<b>45</b>	<b>100</b>

## **2.2 Data Collection Process**

A pre and post questionnaire was designed with an emphasis placed on collecting both qualitative and quantitative responses. The questionnaire was designed and piloted in order to have the potential to measure changes in levels of staffs' satisfaction before and after the workload management tool was put in place.

Dissemination of the questionnaires to participants was organised via the Leadership Centre who provided sessions to support and start the process in each team. Staff were provided with the opportunity to provide additional qualitative comments on the questionnaire itself.

In addition Team Leaders were invited at mid-point of the exercise to provide comment from their perspective on how well the process was working. The detailed feedback and comments from Team Leaders have been collected and are presented in Section 4. Some key messages particularly on outcomes are summarised and presented in Section 3 of this report.

## **SECTION 3: THE FINDINGS**

### **3.1 The Pre- and Post-Questionnaires**

The first part of this section of the report provides details on the findings from the staff questionnaires completed before they started to use a workload management approach (pre-questionnaires) and after (post questionnaires) the pilot was complete. This method enabled the social workers to think about workload management issues at the beginning of the process (baseline and following the introduction of caseload weighting tools deemed appropriate for their sector. Both quantitative and qualitative findings are study are presented in this paper.

The six pilot teams covered the areas of community mental health, acute (general hospital), learning disability, physical disability and older people. The latter were represented in two of the pilots. In total 45 people completed the pre questionnaires.

There were six teams who started out on this journey, only four of the original teams completed the work. There are therefore 45 pre-questionnaires and only 20 post questionnaires. It is difficult to analyse these results and so limited inference is taken. However there are extensive comments before and after the process has been completed and these will be considered further in the analysis section.

### **3.2 Staff Comment on Questionnaire**

Staff were invited to comment on satisfaction prior to the introduction of workload management using an attitudinal scale from 1–7, (1 = least satisfied and 7 = most satisfied). Nine areas were considered for exploration.

The findings are presented in the tables below and relate directly to the questions addressed in the questionnaire. A selection of the comments received from staff were presented for illustrative purposes as these provide some useful commentary on staff's perceptions.

Two questions in the quantitative questionnaire caused some confusion and are answered using qualitative comments only. These are Q5 (which invited comment on the level of satisfaction with supervision) and Q7 (which invited comments in relation to the contribution of a workload management approach).

**Q1. Level of Satisfaction with current caseload on a range of 1–7 with 1 being least satisfied and 7 most satisfied.**

Level of Satisfaction with current caseload	Pre		Post	
	Number	%	Number	%
Total responses	45	100	20	100
Average response on scale	3.84		3.90	
Number below average	21	47	8	40
Number above average	24	53	12	60

This table indicates that the rating for the average response rose from 3.84 to 3.90 which is very marginal improvement in satisfaction. However it is noted that 60% of the staff who completed the post questionnaire were above this average response.

Pre-Questionnaire

A range of comments were received from staff, the majority of which, suggested concerns on the size of caseloads. For example:

“Case load is too high. I am afraid that someone slips through due to high demand on time”

- “I never seem to get on top of things”;
- “Caseload is too high for part time workers”;
- “There is insufficient time to spread work with clients and parents and then complete the necessary paperwork”.

One person said that it depends on “how complex the cases are. It can be seriously unmanageable when you have complex cases that you are working on, the majority of which are high risk”.



The changeable nature of the work was also identified as a factor: “My caseload is manageable but tomorrow this may not be the case.”

In other comments where the person was relatively new to the team or was a student the size of caseloads were identified as satisfactory: “I am new to the team so my caseload is small at present”. Likewise “I am a student, my caseload is manageable at present.”

### Post Questionnaires

From the 20 responses received in the post questionnaire returns additional comment revealed that the situation was quite similar to the situation previously. For example:

- “Our caseloads are too high for the complexity of cases we carry. The quality of social work is questionable due to the constant firefighting on a daily basis”;
- “High caseload - all in the community - very busy caseload”;
- “Caseload currently very high”;
- “Too high”.

One person however indicated:

- “I feel like I am managing my caseload well. Caseload can be very busy at times, I feel like I do not have the required time to fully support those with lower level support needs”.

And for another:

- “I am an AYE social worker currently my caseload is relatively protected and more condensed than Band 6 SW on the team”.

**Q2. Level of Satisfaction with your overall workload on a range of 1–7 with 1 being least satisfied and 7 most satisfied**

Level of Satisfaction with overall workload	Pre		Post	
	Number	%	Number	%
Total responses	45	100	20	100
Average response on scale	3.67		4.00	
Number below average	24	53	8	40
Number above average	21	47	12	60

This table indicates that the rating for the average response rose from 3.67 to 4.0. This is a very marginal improvement in satisfaction. However it is noted that 60% of the staff who completed the post questionnaire were above this average response and therefore were more than satisfied with their overall workload.

Pre-questionnaires

A range of comments were received in response to this question on workload, for example:

- “I enjoy my job but it can be stressful as there is so much work”;
- “The workload is often heavy and I constantly have to prioritize and push back other issues”;
- “Staff issues are so significant this is having a major impact on workload”.

The view that it “can be difficult to keep up with the paperwork” was a comment used frequently in replies. The concern expressed was that this “takes away time from clients”

- “Very busy caseload due to number of clients on caseload and paperwork keeps changing”.

In relation to paper work it was noted that “completing the Northern Ireland Single Assessment Tool (NISAT) assessments can be very time consuming”.

Post questionnaire returns indicated a range of views in relation to workload.

- “I am currently the only other (than Team Leader) full time worker on the team; I receive a lot of new referrals due to same, additional AYE work and crisis work together with managing case load can be difficult at times”;
- “It is difficult to keep work up to date and monitor regularly as required”;
- “I can't do what I am expected to do”;
- “Too much administration”.

Another comment revealed general satisfaction though some reservations in relation to the level of paperwork

- “Generally OK - workload had been very unpredictable over summer months/generally covering for staff absences/sick leave. This has settled down for now. Paperwork difficult to keep up to date/can fluctuates”.

One other person indicated satisfaction if the situation did not alter

- “Good amount of work at present. Feel like I am at my maximum and would not have the capacity for more cases”.

**Q3. Level of Satisfaction that you can manage your current workload on a range of 1–7 with 1 being least satisfied and 7 most satisfied.**

Level of Satisfaction that can manage current workload	Pre		Post	
	Number	%	Number	%
Total responses	45	100	20	100
Average response on scale (pre)	3.96		4.30	
Number below average	20	44	9	45
Number above average	25	56	11	55

This table indicates that the rating for the average response rose from 3.96 to 4.30, this is moderately improved. However it is noted that 55% of the staff who completed the post questionnaire were above this average response and therefore were more than satisfied that they could manage their workload.

#### Pre-questionnaires

A range of comments were received that reflected a number of strategies taken to manage workloads. For example:

- “I can manage by coming in early and working late”;
- “I can manage if I work my lunch break”;
- “Currently I have to prioritise work which means that some work does not get completed in a timely way”;
- “I manage if I am allowed to prioritise my workload”.

A few people however indicated that they have no issues either because “I am very organised and therefore prioritise my workload very effectively or “I have no issues due to the fact that I am so new to the team”.

However being a new member did not always shield staff from reporting that workloads were difficult to manage. One person indicated “I am still finding my feet

and the workload can be overwhelming .... I am running behind. This can be very stressful”.

Post questionnaire returns again revealed a range of replies, some referring to on the benefits of supervision and team work.

- “I feel that I can manage my current workload well. The supervision both formal and informal within the team is a great support”;
- “Good team work helps”;
- “Currently managing caseload as effectively as possible”.

The majority raised concerns of trying to deal with the challenges of balancing work load:

- “This fluctuates and it is difficult to keep on top of caseload. I was left unattended due to unpaid leave to complete training (self-funded) and sick leave. Before going on leave I worked very hard to ensure that everything was up to date and felt very demoralised when it was not maintained during absence despite additional staff being brought in and me giving up pay”;
- “I am very unsatisfied as I feel the quality of my social work is greatly compromised with my current workload and the complexity of cases I hold”;
- “Workload is very busy at present, which is presenting a challenge to try and keep on top of it”;
- “I do my best to manage my workload however I believe that it is unmanageable due to a number of factors, mainly a high caseload number, a high number of complex cases and the ongoing need to regularly, continually accept new referrals despite not having adequate time to carry out work that is already in place”.

The issue of balance and competing demands was also noted:

- “Balancing senior practitioner role and social work tasks poses challenges”.

**Q4. Level of Satisfaction with team workload on a range of 1–7 with 1 being least satisfied and 7 most satisfied.**

Level of Satisfaction with team workload	Pre		Post	
	Number	%	Number	%
Total responses	43	96	19	95
Average response on scale	3.37		3.63	
Number below average	21	49	10	53
Number above average	22	51	9	47

This table indicates that the rating for the average response rose from 3.37 to 3.63, this is very marginal. It is also noted that 53% of the staff who completed the post questionnaire were below average in this response. This implies that staff are less than satisfied with the total team workload.

Pre-questionnaires

A range of comments were received in relation to team workloads for example:

- “Everyone expresses stress within the team”, “This is particularly evident when everyone is under pressure to prevent length of waiting time”;
- “Our team is under pressure due to significant vacancies”;
- “We are very understaffed”;
- “Everyone is stretched”;
- “Continuous sick leave within team adds pressure”;
- “We need to focus on safe discharge rather on time pressures for discharge”;
- “An acute hospital setting is busy and ever changing”;
- “High volumes of referrals without resources for staff to meet pressures” was noted several times in the replies.

On a more positive note it was suggested by one person that “we are a busy team, but we all help each other out”.

This issue was also reiterated in **post questionnaire returns** by one person

- “Team works very well together at present/assist one another/ cover one another if and when necessary”.

### Post questionnaires

Overall the teams’ pressures were noted in the majority of replies in the post questionnaire returns.

- “There are many team members off at present and the team is very fragmented. There are always a high number of referrals for allocation each week which puts everyone under more pressure”;
- “Everyone is very busy at present. I feel more staff would be useful”;
- “Large waiting lists, although this is due to changes to staffing”.

**Q5. Level of Satisfaction with supervision (both formal and informal) on a range of 1–7 with 1 being least satisfied and 7 most satisfied**

*For this question comments only can be drawn from results due to possible confusion completing this question and missing data / entries.*

Pre-questionnaires

There was a general view expressed in the qualitative comments that informal supervision takes place on an on-going basis. Discussion and support from colleagues is a key factor to maintain morale.

Support: It was suggested by a number of participants that support tends to come from “team colleagues” and “very supportive Team Leaders who offer informal supervision”.

For those who indicated that they had formal supervision comments on the value of this were positive:

- “Supervision is very helpful in managing overall workload”;
- “Supervision is very useful as a support”;
- “Lots of support from manager to manage workload and stress”.

A number of replies however indicated less satisfactory comments with the level of supervision when received:

- “Supervision should be two way, not being told what to do”.

For some, however, formal supervision does not, from the replies received happen at all:

- “I haven’t had any formal supervision to date but manager is available for informal supervision”;



- “Haven’t had formal supervision in a long time. Informal support is however available.”;
- “Formal supervision has been infrequent due to work pressures. Informal supervision happens frequently”.

### Post questionnaires

The positive aspects of supervision were woven through the replies for example:

- “I do find supervision very useful, especially ad hoc supervision and receive excellent ongoing support on an ad-hoc basis when I ask for it. Formal supervision with the use of the caseload weighting tool is very useful as it offers the social worker a clear picture of the workload and ongoing work being undertaken. However, unfortunately, it does not remove the level of stress associated with a high level of crisis work which does not ease due to constant demand”;
- “Supervision and support within the team is brilliant”;
- “I am happy with the level of supervision received and do feel that it very much helps me manage my work”.

The less positive aspects centred on concerns regarding access to supervision or the content of supervision:

- “I have not received formal supervision for several months. I have received an operational supervision which was fine”;
- “Supervision appears to be focused on ensuring that paperwork is done and there is mixed messages in setting targets and then acknowledging that it is impossible to meet these targets”;
- “No discussion re: allocation of referrals. Supervision is only once every 6 weeks, therefore manager not always aware of current caseload or workload complexities”.

**Q6. Level of Satisfaction with team allocation of referrals to you as a social worker on a range of 1–7 with 1 being least satisfied and 7 most satisfied**

Level of Satisfaction with team allocation of referrals	Pre		Post	
	Number	%	Number	%
Total responses	41	91	17	85
Average response on scale	4.54		4.71	
Number below average	21	51	8	47
Number above average	20	49	9	53

This table indicates that the rating for the average response rose from 4.54 to 4.71, this is very marginal. It is also noted that 53% of the staff who completed the post questionnaire were above this average in their response. This implies that staff are on average more satisfied with the team allocation of referrals

Pre-questionnaires

A number of replies received in relation to the perception of satisfaction with team allocation of referrals were positive, for example:

- “Usually allocation is done one a rota basis”;
- “I am satisfied with the allocation process”;
- “I am currently satisfied as I have only 20 cases”;
- “My Team Leader discusses allocation of cases with me prior to actual allocation”.

For others who were less satisfied the comments included:

- “Often this is high and unsustainable at times”;
- “Large number of inappropriate referrals in both urgency and suitability of services”;

- “At times it would appear that work is not allocated equally”.

In the post questionnaire returns the pressures of referrals was evident:

- “There is immense pressure in this team to take referrals due to the high number coming through each week”;
- “I have felt under pressure to accept referrals despite not having all my paperwork up to date or individuals reviewed and monitored as frequently as they should be”;
- “There are a high number of referrals to the team and staff shortages. This means that referrals are sometimes higher than what would be ideal. The team generally work well to share referrals”.

In relation to allocations, there are two contradictory views expressed.

In the first example there was no allocation meeting

- “No discussion re: allocation of referrals. Supervision is only once every 6 weeks, therefore manager not always aware of current caseload/workload complexities”.

In the second the allocation meeting was too long

- “I find the allocation meetings are time consuming. I also find that they increase pressure on the social worker to accept referrals, even when a social worker feels that his/her workload is unmanageable. This is due to the fact that when we are discussing cases for allocation, we hear about the various struggles and crises that older people are dealing with whilst waiting for their case to be allocated”.

## **Q7. Do you have a workload management approach in place?**

*For this question comments only can be drawn from results due to possible confusion completing this question and missing data / entries.*

### Pre-questionnaires

For some staff there were negative connotations expressed in the replies in relation to workload management approaches. For example:

- “We are always working on this”;
- “If concerns regarding workload were acted upon it would help”;
- “It is a paper exercise with little outcome”;
- “Does not matter what, things do not change”.

For those who offered suggestions on how work load management approaches could be progressed comments included:

- “More team discussions regarding workload pressures”;
- “Investment in pilot to give credibility to workload management”;
- “Allocation at team meetings”;
- “Inform caseload management by prioritising cases”;
- “Up streaming helps caseload management when time allows”;
- “Caseload weighting might help” was noted in two replies.

### Post questionnaires

The comments made by staff expressed negative views about the pilot of the workload management approach:

- “A workload management approach was trialled and only served to create more work for the team and Senior Social Worker. I feel my manager manages workloads well”;
- “We have been piloting a workload management model, however this has not been beneficial to our team”;
- “I believed workload management was to ensure the right level/ complexity of cases lie with correct Social Work or Social Work Assistant. Cases are transferred from Social Work Assistants to Social Worker. Less complex cases are still not being transferred to Social Work Assistants”;
- “Use the caseload weighting tool to give me an overall picture of my caseload which allows me to prioritise. I do find this tool very useful but have found that it too requires time which I often find I need to spend responding and reacting to crisis as highlighted in question”.

A suggestion was made as to what would benefit the situation:

- What would improve workload management approach – “More resources, lower caseload numbers, less paperwork, and a more clearly defined SW role whereby social workers are not expected to continually undertake work which is not necessarily their responsibility”.

**Q8. Level of satisfaction with current arrangements for closing cases on a range of 1–7 with 1 being least satisfied and 7 most satisfied**

Level of Satisfaction with current arrangements for closing cases	Pre		Post	
	Number	%	Number	%
Total responses	42	93	19	95
Average response on scale	4.79		5.53	
Number below average	19	45	8	42
Number above average	23	55	11	58

This table indicates that the rating for the average response rose from 4.79 to 5.53. This is a marginal improvement and is more positive. It is also noted that 58% of the staff who completed the post questionnaire were above this average in their response. This implies that staff are on average more satisfied with closing cases.

Pre-questionnaires

In a number of replies staff indicated that there were “no issues” in relation to the closure of cases.

- “It works well via discussion with senior or supervisor”.

For others comments included issues in relation to time to do so.

- “The importance of making time” to do this was acknowledged but “finding the time depends on daily workload” was a recurrent theme in replies;
- “It can be difficult to keep up with closures but need to make time for this”;
- “It can be difficult to find the time”;
- It would be helpful to “Rota into weeks work for a few protected hours to close cases” albeit this is difficult to do;

- “Sometimes it takes too long as we are dependent on doctors’ inability to have the time available to discuss cases and closure”.

### Post questionnaires

As in the pre returns the task of closing cases was not viewed as particularly problematic.

- “No issues with closing cases. They can be done quick and effectively”;
- “No issues- very straight forward”;
- “I have no issues with this aspect”.

However some concerns were identified, for example:

- “Ideally cases should be closed in partnership with a senior practitioner in my opinion as soon as they have been identified for closure. Due to the fact that other work continually takes priority”;
- “I believe that there is paperwork which should be completed immediately and this is not always done”.

**Q9. Level of satisfaction with access to training on a range of 1–7 with 1 being least satisfied and 7 most satisfied**

Level of Satisfaction with current arrangements for closing cases	Pre		Post	
	Number	%	Number	%
Total responses	42	93	20	100
Average response on scale	4.38		4.60	
Number below average	18	43	9	45
Number above average	24	57	11	55

This table indicates that the rating for the average response rose from 4.38 to 4.60, this is only marginal rise. It is also noted that 55% of the staff who completed the post questionnaire were above this average in their response which is less than the percentage (57%) before the process was introduced.

Pre-questionnaires

Whilst a higher number of staff answered 5 and above on the quantitative scale when asked to indicate their satisfaction with training a number of qualitative replies indicated less satisfaction with training often due to work pressures or in other cases the lack of accessibility

For a few people positive comments were noted such as “it is easy to access via HRPTS”. This is a computerised system in place in Trusts for accessing training opportunities and actual training via e-learning.

However a number of replies raised concerns about training opportunities available:

- “No training within the Trust”;
- “Lack of training available at present due to cuts”;



- “Very poor training opportunities within the Trust”;
- “Limited opportunities for development”;
- “Little relevant training available”;
- “Haven’t had training in a long time”.

### Post questionnaires

Comments provided in the post questionnaires indicated that for some:

- “There is a good amount of training offered to the team”;
- “Training is encouraged”.

For others whilst training is available work pressures often prevent uptake:

- “At times work prioritises over training”;
- “Limited due to work pressures”.

In two other replies access to training was noted:

- “No training opportunities have been available recently. I have instigated my own training which is recorded as part of my personal development plan but have no support from the Trust in relation to this”;
- “Would like more access to training. Due to workload this is difficult”.

4.5 In the remaining paragraphs of this section of the report a summary of the comments received from Team Leaders at mid-point of the process are presented. The Team Leaders were supported through a learning set approach where they were able to identify a number of benefits and challenges. The approach enabled them to share their difficulties, share tools and to get peer support.

- It is useful to engage in dialogue with staff around weighting each case, it ensures purposeful intervention and facilitates closure;
- Traditionally staff are reluctant to take on new referrals/cases. The workload management approach has led to open and transparent caseloads. There is

no identified team workload threshold; no average number for caseloads it is simply an attempt to be fair and equitable;

- One of the Team Leaders was relatively new to this post and finds the approach timely and useful- She thinks it enables prioritisation, provides structure and order to the work and creates openness with the team;
- Another has reported that this approach takes more time by the Team Leader in supervision (approximately an extra half hour per person) but has great benefits for governance requirements, audit of files and assembly questions. She now feels that she knows her team's workload and caseloads much better.

The detailed comments from Team Leaders are available in Section 5 of this document.

## SECTION 4: ANALYSIS OF THE FINDINGS

### 4.1 Quantitative Information

The information gathered by quantitative questions methods has not produced significant results. There was a minor rise in the positivity of the responses to each question however it has not been possible to demonstrate significance in the post questionnaires.

With support from research statisticians it has become apparent that the results produced are not significant. This is due firstly to the difference between group 1 the total number of staff (45) who completed the questionnaires before the workload management approach was introduced in their team and group 2 the number (20) who completed the post questionnaire ( only four teams completed the whole process)

Given the fact that the returns were not matched independent sample t testing was undertaken between group1 and group 2. The results ranged from: - *Level of satisfaction with caseload* t (63) .133 p 0.894 to *level of satisfaction with closing cases* t (59) 1.91 p 0.061.

This suggests that any changes may have been as a result of chance. The results indicated no discernible significance in the results between groups. Due to the low sample size it was always going to be the case that findings would not be generalisable. However, they still provide insight into the operation of four teams and gives meaning to those involved.

### 4.2 Qualitative Information

The comments made by staff on the pre and post questionnaires' raises some very interesting questions and would merit further consideration by senior managers in Trusts.

Questions 1, 2 and 3 highlight the need for a workload management approach in teams, many staff indicated that caseloads are difficult to manage; there is too much administration and workloads remained difficult even after the introduction of the tools. In question 4 some teams reported good team working which helps to manage workloads but there are also reports of staff shortages bringing pressures.

There is a particular concern with some responses to question 5 - there are staff who have indicated that they do not receive formal supervision

In question 6 staff responded positively to allocation of referrals even before the pilot approach was introduced and also reported a surprising ease in closing cases in Question 8, before and after the workload management approach. This tends to suggest that time is a factor relating to delay in closing cases opposed to a lack of will on the part of staff.

It is disappointing to note in relation to question 7 that staff did not value the workload management approach. For many the pilot simply added more work to already very busy caseloads. Excess workload is associated with emotional exhaustion and cynicism (McFadden, 2013; 2014) and this might explain the feelings from staff, that implementing the tool merely added to workload opposed to support.

There is concern regarding staff reporting lack of training opportunities or that “ there are no training opportunities in the Trust”, given the requirement for all social workers to complete post registration training throughout their career in social work.

The results raise further questions; have social workers become adjusted to some degree to excessive workloads; what can agencies do to reduce the differential in how these issues are managed from team to team?

### 4.3 Reflections on the Team Leaders Views

From the six Team Leaders who reflected on their experience and the impact that the workload management framework on their teams there are a number of observations:

- Additional work completing templates can seem onerous on teams but can bring benefits.
- Where existing information systems e.g Soscare / PARIS can be used to provide information on caseloads and assist with caseload analysis, these should be used.
- While workload management may not be required every month it is useful / essential to be considered at least quarterly. Displaying team information can create a team where transparency is recognised and valued and this in turn can improve staff morale.
- Taking time out of team meetings to consider cases including travel and time required for a carers assessment etc can assist the Team Leader in allocating cases fairly.

## SECTION 5: INDIVIDUAL STORIES BY TEAM LEADERS

### Hospital Social Work

Author Pamela Black Team Leader

#### Rationale for joining the pilot

The aim of the project was to implement a workload management pilot in the Hospital Social Work Team (HSWT). Causeway Hospital Social Work Team was nominated to participate in the Pilot in the first instance.

The Causeway site was chosen as it is a smaller site and had capacity to take on the pilot. Furthermore there was a newly appointed Team Leader and it was felt that by undertaking the pilot it would allow her to familiarise herself with current working arrangements and identify any opportunity to enhance and improve existing processes.

#### Introduction to the Team

Causeway Hospital Social Work Team is currently made up by the following Team members:-

- 1 Full Time Team Leader                      Band 7
- 1 Senior Practitioner                         Band 7
- 3.5 Full Time Social Workers                Band 6
- 1 Full Time Social Worker                    Band 5

Each Hospital Social worker has responsibility for the management of an allocated caseload. This involves daily participation in multi-disciplinary ward rounds, co-ordinating and participating in the assessment of patient's needs, developing care plans to meet assessed need, undertaking Vulnerable Adult cases and being the named worker in complex cases. Within this role social workers are also responsible

for the collection and analysis of information provided at ward rounds in order to prioritise patients ready to discharge from hospital and matters for escalation.

Within the Team there is a breadth of experience ranging from 6 months to 14 years length of service.

### Preparation and support for the pilot

In order to prepare for the pilot the HSWT met to discuss the pilot and to address any issues or concerns any staff members may have or foresee. All members of the Team felt strongly that the detail, complexity and volume of their workload should be captured. As a result all staff actively participated in the development of the workload management tool. This was completed with the support of the Leadership Centre.

Each staff member completed the pre-intervention questionnaire.

The session with the Leadership Centre proved to be very beneficial in that the Team had the opportunity to voice any concerns and issues they may have had and to outline the level of support they would have in the undertaking of the pilot. This enabled the Team to take ownership of the tool and design a bespoke template which would capture the matters of both relevance and importance to hospital social work.

### The Process

The bespoke template was designed to capture the variety of work undertaken by social workers on a daily basis. This was then developed further to capture the level of each case Level 1 to Level 3 – 3 being the most complex. Additional columns were added to capture the number of new end of acute episode (EOAE cases), the number of EOAE cases carried forward and the number of new cases referred for up streaming. Appendix3.

Once implemented we quickly recognised that we were not capturing the patient journey from beginning to end. This was easily rectified by an additional box to capture the number of discharges completed on a daily basis. Appendix 4.

The process and recording was initially reviewed week by week to ensure the Team were maintaining the recording and that no issues were arising. Initially some of the staff felt that their work was under scrutiny and felt they had to “prove they were busy”. These anxieties were quickly dispelled through discussion with colleagues and the Team Leader and over a period of time staff themselves recognised that the tool was useful to identify the volume of work, the pressures and demands on the Team.

The actual input of the data proved to be the most challenging aspect of the project. Initially the patient initials were used to record the information however if the data was not recorded on a daily basis (with the insight of knowledge on each case) it was difficult to ensure an accurate account of the patient journey from beginning to end. This further highlighted the potential for duplication in the numbers, particularly in relation to patients who transferred to other wards during their admission and, resulted in inaccurate capture of the overall data.

It was at this point the data collection sheet was changed. The social workers used numbers to replace initials in each box which proved more beneficial to the input of data but lost the ability to track each patient journey from beginning to end.

### **Summary of findings**

The members of the Team felt strongly at the outset of the pilot that the detail, complexity and volume of their workload should be captured. However all felt that the project did not capture the ethical dilemmas in relation to the social work process versus the demand for timely discharges and that it added to their daily workload.

The majority of staff members felt that the completion of daily sheets was onerous /challenging at times. Staff felt that the tool did not tell them anything in addition to



what they knew and that the information gathered was captured on other systems and was considered duplication of workload.

As a Team Leader difficulties became evident at the point of the data input. Different Social Workers filled in the daily sheet differently due to interpretation of purpose. In addition to this patient identification was required, as opposed to numbers, in order to track each patient's journey from admission to discharge. Local knowledge of cases was required to ensure an accurate account of data input and prevent duplication of numbers.

The most positive aspect of this pilot was the engagement from the social workers within the Team. Despite the initial challenges with a new project the team took ownership of the tool and made every effort to make it work.

## **Conclusions**

Overall the nature of hospital social work is difficult to capture due to the fluid nature of each case, the high turnover of cases, the patient journey from admission to discharge and the potential for complex issues to arise dependent upon the cause for admission.

As such the consensus of the team was that whilst the pilot was valuable in capturing some relevant information such as referral rates and the number of cases that each social worker were involved in on a daily basis, it was felt that the information could be captured and displayed on a whiteboard within the social work department which is visible to all staff and Team Leader. This whiteboard can display the number of cases each social worker is involved in, the level of complexity and the patient pathway throughout the hospital admission.

The team reflected on the objectives outlined at the beginning of the pilot and while it did ensure equal distribution of work across the team, identified capacity among the social workers, the volume of referrals within the social work team on a daily basis, it did not highlight issues arising within complex cases, aid the understanding of the

social work processes to other professionals and management or capture the range and complexity of workload.

The pilot did provide an opportunity for staff to consider the allocation of work within the team and acknowledge that some wards were particularly busier than others. Having the number of cases that each social worker is involved in on a visual display within the department has meant that staff who may have capacity can provide support to their colleagues who may have a busy caseload and has allowed improved team working and team cohesion.

#### Ideas for improving the current approach

- The team will use SOSKARE data instead of daily sheets, which are not adding value (Admin staff can run reports and the data is already available). This approach enabled staff to see that they were using the information system already, effectively.
- Better use of the whiteboard to review capacity (already in use), whiteboard can be more helpful when clients change wards rather than daily sheets
- The Team Leader will provide graphs/visuals to demonstrate workload and display these for staff to see. These would also be discussed at team meetings.
- Look at other ways to quantify time required for each case acknowledging that it is difficult to devise a tool that captures the complexity and time required in hospital SW accurately.

#### Final comment

Going forward - The process and findings of the pilot were discussed and shared at The Hospital Social Work Band 7 team meeting. Particular attention was given to what aspects of the project had worked well and what had not been so beneficial to the team as a whole.

As a result Antrim Area Hospital Social Work Team, whilst not adopting the tool, have implemented the use of the whiteboard in line with the Causeway Team as a means of endeavouring to effectively manage the workload.

## **Physical Health & Disability Team (South & East Sector)**

### **Belfast Health & Social Care Trust**

**(Authors – Jane McMillan, ASM & Deborah McBride, SSW)**

#### **Introduction to the team**

This Physical Health and Disability Team is made up of 1 WTE Senior Social Worker, 1 WTE Senior Social Work Practitioner, 7 WTE Social Workers and 1 WTE Social Care Coordinator.

#### **Rationale for joining the pilot**

The aim of the project was to pilot a workload management system to attempt to improve the service that social workers can provide to service users.

#### **Benefits and challenges**

The pilot went live on 5<sup>th</sup> October 2015. A weighting of the cases was agreed following a meeting with a Team Leader from the Southern HSCT. The weighting tool was amended to accommodate the needs of our service. Each team member met with the Team Leader to attribute a weight to their case load and this was updated and charted on a weekly basis. The information was then collated by admin staff who populated an excel sheet which provided the team with information in pie charts and bar graphs. This was a very visual and effective use of sharing information on a regular basis.

The pilot was formally reviewed and progress reflected upon in November 2016. There was no substantial benefit noted at this time and it was considered that this may be attributed to the Team Leader having a sound working knowledge of the cases held by the team. It was also felt that good use of supervision enables the Team Leader to carry out this function without needing a tool.

A benefit of the tool was that the Team Leader can immediately assess the capacity of each worker and determine who is most appropriate to take a referral. This also enabled team members to see transparent decision-making in progress. Team members could also see that everyone was working equally and that the number of service users on a caseload was not a sufficient way to determine the demands placed on staff.

One of the most useful benefits of this tool was in identifying lower level cases that could be transferred to the Social Care Coordinator (SCC). These cases would often be settled and therefore had the potential to be overlooked within the pressures of a busy caseload.

An interesting observation was in the initial stages some team members underestimated the level of their involvement when weighting individual cases and the tool helped them to acknowledge the complexity of the work they were undertaking.

A challenge that this pilot presented that was not anticipated was that some staff used this tool as a reason to say they were not able to take on new referrals. This had not been an issue prior to the commencement of the pilot.

A further challenge was keeping the data contemporaneous. When staff were absent or did not update the information the tool very quickly become ineffective. It was also apparent that an additional administrative resource would be required to ensure the upkeep of the supporting information.

The time spent in supervision also increased as this tool was updated in each individual session with team members. This was not always seen as a positive use of supervision particularly with the more experienced staff members.

## **Conclusion**

In conclusion there were some benefits in that the caseload weighting tool could aid team members to see their workload and productivity. However it was felt that effective supervision could provide this in a similar way.

Although the practicality of recording all the information is time-consuming it is felt that this would be a beneficial tool to use periodically, e.g. once a quarter to ensure the workload is divided fairly across the team and to aid the auditing process within teams

This tool may benefit teams with larger turnover of cases where the Team Leader is not fully apprised of every case.

The tool itself could be simplified in order to reduce the time and administration required to ensure its effectiveness.

On discussion with staff the overall sense was that this tool benefited Team Leaders more than team members.

## Adult Physical Disability Team Southern Trust

Author/ Team Leader Kathy Lavery

### **Introduction to the team**

The Adult Physical Disability Team for Armagh/ Dungannon area is an integrated team ,made up of 7 social workers, 2 occupational therapist and 2 physiotherapists. All staff are highly experience, with social work staff experience ranging from 5-38yrs. We currently have 2 staff working part-time and one staff member who is also the team's safeguarding lead and holds ASW responsibilities. The Team Leader came into post in 2012 but had worked on the team for 15 yrs. The case load weighting tool was used with social work staff only, but as social workers have recently moved to a new case management model within the SHSCT, the tool could work with all case managers regardless of their profession.

### **Rationale for joining the pilot**

Physical Disability services within the SHSCT had developed a caseload weighting tool in 2010 with the intention that the tool would be used to help manage workload equity across the 3 teams. The tool was developed in response to reports of increased work related stress and workload pressures, although staff could not produce the evidence required to support their views.

### **The process**

The initial tool developed in 2010 was based on 3 categories of complexity each with a weighted score ranging from:

- Category 1 – low level complexity – score 1
- Category 2 – medium risk / complexity – score 4
- Category 3 – high risk / complexity – score 6

During the first 5 years of use of the tool it was felt that complexity of work had increased significantly within physical disability services with increased pressure upon staff regarding highly complex hospital discharges, the introduction of NISAT and the increasing volume of safeguarding cases. It was therefore agreed that a

fourth category would help reflect the range of workload more effectively. Category 4 – very high risk/ complexity – score 8. It was envisaged that very few cases would remain at cat 4 for any longer than 4 – 6 wks.

Staff found the tool straight forward to use. Cases were recorded on a client data base which held a variety of information including case load weighting. The CLW for each case was updated at monthly supervision with the overall total recorded on monthly template which was available for all social work staff to view. This reinforced the openness and transparency of the process. A % reduction in caseload was also reflected for those working part-time hours and those holding additional responsibility eg ASW = 20% reduction in CLW.

Information gathered was used to evidence capacity and support workload planning, with the priority goal of ensuring equitable division of workload across the team. Although the time spent in supervision had increased initially, adding approx. 30 minutes to supervision sessions, this gradually reduced as staff became confident in weighing cases accurately and CLW discussions were reduced and carried out as quality assurance task, particularly for those cases weighted highest. As Team Leader I found the process very straight forward as I had a good working knowledge of many of the cases and could easily have weighted many of the cases without input from the keyworker.

Prior to the commencement of the pilot the team had been using the tool on an ad hoc basis eg when staff stress appeared to be increasing. The pilot provided us with the opportunity to embed the process into normal practice and therefore experience the benefits of the a consistent approach and a recognition that those cases which on the surface appear to be low level can require extensive input and demand on professionals.

## **Outcomes**

The team have now established a consistent routine of updating their caseload weighting prior to supervision. Weightings are now scanned by the Team Leader and random cases selected for discussion to ensure accuracy of the scores. Although



CLW definitions and scores are open to interpretation, the Team Leader role allows for consistency throughout the process.

The tool has provided the evidence that I, as Team Leader, need to ensure equity across the team. The process has clearly evidenced that size of caseload is no indication of the workload demands on an individual worker eg one staff member with a caseload of 32 had a CLW of 156, this compared with another staff member who had a caseload of 51 with a CLW of 142.

### **Team's evaluation and thoughts**

Staff opinion is one of satisfaction - reassurance that cases are allocated fairly across the team; there is recognition for the workload for each team members who are involved with ever increasing highly complex cases, as well as recognition for the additional responsibilities held be staff.

### **Team Leaders conclusions**

As the tool is now well established in the routine of supervision we will continue to use it. However, I do not feel it is essential to complete on a monthly basis, bi-monthly would provide an overview of staff pressures and capacity. It will also be a very useful tool during periods of extended sick leave or maternity leave to ensure additional work is divided fairly.

It should be noted that I have been very fortunate to have run the pilot with a full complement of staff. The information gathered will prove an excellent resource to evidence future workload pressures. This is the information required by senior managers to evidence the need for additional staff.

As the demands on social work are constantly changing the tool will need to be reviewed in the future. The introduction of the Mental Capacity bill will place additional workload pressure upon staff and will need to be reflected in the caseload weighting approach. Further work is also required to quantify the additional responsibilities held by staff. We in the southern trust have concluded that ASW responsibilities should incur a 20% reduction in caseload but similar recognition is required for practice teaching, PQ, project work etc.

## **Community Mental Health Team SET**

**Author/ Service Manager Yvonne Russell Coyles**

### **Rationale for joining the pilot**

The Choice and Partnership Approach (CAPA) was introduced to Community Mental Health teams across Northern Ireland in January 2012. This was an initiative led by the Service Improvement Directorate at the Health and Social Care Board. It developed to varying degrees across each of the five Trusts with limited uptake in the South Eastern Trust. The Trust planned to use this pilot and its support for workload management as an opportunity to focus on this approach (CAPA) for the Community mental health teams in this Trust.

### **Introduction to the team**

One of the Community Mental Health teams in Lisburn began this pilot with support from the Leadership Centre, who provided a half day introductory session. This team completed pre-intervention questionnaires. However due to staff changes this team did not continue with the workload management exercise.

This section is a report of the introduction of CAPA across the Trust led by the Community Mental Health Services Manager and Social Work Lead, Yvonne Russell-Coyles starting with the North Down and Ards Community mental health team.

### **The process**

Prior to the commencement of the pilot, the team had been working on the CAPA model with the support of Rodney Morton, Head of Service Improvement at the HSCB. The Community Mental health team in the North Down and Ards sector developed a proforma to enable staff to capture their working day and to analyse

their work (Reference South Eastern Trust supervision Policy Caseload Management Tool).

This included time spent with service users face to face and indirect care eg travel, reports, recording, attending reviews and Liaison. The Tool also captured the time spent doing organisational tasks eg training, attending professional fora, supervision and team meetings.

This proforma was then developed into an excel spread sheet (see attached) which could be completed on-line. Each team member completes this daily, when they are recording their home visits, appointments, telephone contacts etc on Maxims (information system).

## **Outcomes**

The CAPA approach has been implemented in the Down and Lisburn sectors.

As the proforma has been refined this has enabled us to collate more accurate stats. This information is captured by excel and can calculate face to face direct contact with service users.

The percentage of actual face to face direct contact has steadily increased from 34%, then 43% and more recently 50%. Within the Down sector the teams have achieved on average on 57% face to face contact.

Time is planned for supervision, training and almost all of the teams are using electronic dairies, and a duty system to resolve and address emergencies from within the team's caseloads.

All of these systems have allowed staff to use their time more effectively. In addition the process of introducing CAPA through team discussions and team development days has enabled the team members to recognise the amount of duplication which occurred previously for example previously a letter was sent to GPs following a review, now the staff will send the review minutes instead.

## **Team's evaluation and thoughts**

The staff have welcomed the increased time they are spending with the service users and the renewed focus of their work. The caseload management tool allows the supervisor and supervisee to plan and review each case more effectively (due to the supervisee completing the tool before supervision), discuss interventions and reflect on outcomes as well as manage the workload fairly within the team.

Staff now recognise their own capacity for new work and are discharging cases more effectively.

## **Team Leader's conclusions**

This has been a very worthwhile process. Through the introduction of CAPA we have:

- Increased direct face to face contact with service users
- Enhanced purposeful interventions and enabled discharge planning
- Provided transparent caseload weighting for staff - enabling staff to recognise when they have capacity and when they are becoming over loaded.
- Developed an on-line system to capture current caseloads acknowledging complexity
- Increased staff morale

## **Primary Care Older Peoples services WHSCT**

**Sean Tuck Author / Team Leader**

### **Introduction to the Team**

A workload management approach was used within an Integrated Service delivery team in a Primary Care and Older People (PCOP) setting. This team provides a range of integrated health and social services to clients over 65. The pilot involved the Waterside office which is an urban setting.

The caseload for this team would be 400 + clients and there is 11 staff who work both on a full-time and part-time basis

The rationale for joining the pilot was based on the WHSCT engagement in the DHSSPSNI Social Work Strategy 2012-22 'Work stream 2, Caseload Weighting in Adult Services'. Furthermore, it was recognised that the need to consider the benefits of a caseload weighting model for use in PCOP was important in the context of increasing caseloads, pressures on the service, demographic changes and people living longer with more complex health and social care needs

### **Choosing the model**

Dr Paula Mc Fadden, currently from Queen's University, had developed 'The Simple 1, 2, 3' caseload weighting model (McFadden 2012) based on Cousins (2011) model. following an audit, which involved an analysis of case files across 4 urban and rural teams and provided evidence of the caseload pressures on staff.

Definitions of what each category (1, 2, 3) mean are inserted below.

In summary, the audit conclusions recommended a time based analysis that required cognisance of the time required to manage cases from referral through to assessment and planning process including implementation of care plans, monitoring and reviewing cases and closure. The framework outlined the time required for cases in institutional or community based settings as well as the

requirements for case management in the first year and beyond this point when initial processes were complete (for example, initial assessment, initial review and monitoring / review arrangements).

The first session with the Leadership Centre was very positive and staff engaged well during this session. The staff in the Waterside Team were very keen to engage, and highlighted their hope that this would assist in managing some of the ongoing pressures in PCOP.

### **Definitional Guidance and Priority Levels**

1. Cases categorized as '1' include cases with high levels of risk and / or complexity. The level also applies to new referrals (initial SU and carer assessments), existing complex cases that require immediate attention and reviews that require complex planning. Adult safeguarding cases are in this category when in the investigation, monitoring and review stages of the AS Process (2016).
2. Cases categorised as '2' include cases that currently are settled but have a history of becoming complex and challenging to manage.
3. Cases categorised as '3' are those that are very settled requiring routine monitoring and review at a frequency as set within a supervisory agreement. These cases may be complex but have a good care plan that works well and may have supportive caring family support without concern.
4. Cases will be either 'institutional' or 'community' based. This can be highlighted individually as, for example, I1 = institutional level 1 (high activity) or C3 therefore community based level 3 (settled low level risk).

Please note: Cases can change in category instantaneously as and when a situation changes. The model design is based on 'snap shot' information that can change and hopes to achieve an overview of individual caseload pressures as well as team pressures on a monthly basis

### **Operationalising the 'Simple 1, 2, 3 Model'**

This model is based on two main assumptions. Firstly, a manager with an overview of a team should have day to day knowledge of the cases as categorised as '1'. For example new referrals, cases becoming concerning, cases due for review (as discussed in supervision) or adult safeguarding cases. Secondly, the model assumes honesty, trust and ethical practice (NISCC Standards) as part of the supervisory relationship so that the worker can be trusted to represent their caseload accurately based on the definitional guidance for the categories. As such, and for expedient use of the model for supervisor and worker benefit, workers should obtain a printout of their caseload and categorise their cases in advance of supervision. During supervision, time should be allowed to go through each case to discuss the category and agree the overall weighting for caseloads per member of staff. An overload of cases at level 1 would cause concern for the manager and the member of staff will feel the pressure of this. Likewise, a minority '1' would indicate a member of staff has scope to support others that might be under pressure in the same time frame. This model can support team working so that colleagues look out for each other, recognise pressure and feel the benefit of a reciprocal culture that offers and receives support as required.



## CALCULATING WORKLOAD CAPACITY USING ANNUAL HOURS FRAMEWORK

An analysis of annual working hours was calculated. The amount of hours that a WTE (37.5 hours per week) has in an annual year was calculated using Cousins (2010) framework. Annual hours are calculated as over.

37.5 (hours) x 52 (weeks) = 1950 hours

Minus annual leave – 225 hours (average 30 days) = 1725 hours

Minus 10 statutory days - 75 hours = 1650 hours

Minus Office Duty (9 days per annum or 67 hours) = 1583 hours

Minus statutory NISCC Training Days ( 5 days or 37.5 hours) = 1545.5 hours

Minus Professional meetings (average 6 hours monthly over 10 months) = 1485.5

Minus crises response hours (estimated at 2 hours per month over 10 months) = 1465.5

Total Number of Annual Hours for WTE = 1465.5

Minus Student Support – 8 hours average per month (if relevant) = 80 hours annually

Minus Vulnerable Adults work – 8 hours on average per month (if relevant) = 80 hours

Calculate the number of cases that can be managed by WTE staff in available hours.

### Analysis of caseload data

The analysis of the caseload data for the social work staff demonstrates the percentage number 1 cases on each of the social work caseloads. The percentage figure of number 1 graded cases on each caseload in the month of October 2015 varied from 66% to the lowest figure of 14.3%. These two major differences can be accounted for when we look at the team situation at that time. The staff member who had the lowest percentage of 1 cases at 14.3% was a social work assistant and their total case numbers would be in a community setting only. These cases would be the low level risk cases and the non-care managed cases and this individual had a much higher percentage of number 2 cases and again 42 cases categorised as 3 which would reflect well settled cases.

The individual who had the highest percentage of number 1 cases in October at 66% was a new member of staff who was covering crisis response work and had received

a significant number of new cases in that month. This reflected some of the sickness and absence in the team at that time as several staff were off during this period.

In the month of November (2015) the highest percentage for number 1's on the caseloads was 58% and the lowest 9% and in December the highest percentage was 61% and the lowest percentage no 1's was 7%. Again the highest percentage of number 1's was accounted for on the caseload of a new member of staff who was being allocated new work and who was also covering for some of the staff absent on sick leave. This work involved responding to emergency calls and immediate responses to casework.

In analysing the data for the percentage of number 1 cases for the months of January, February and March 2016 it was clear that most social work caseloads had a percentage of 1's between 13% to 42% indicating the fluid nature of the caseloads from month to month. The social work assistant in the team had percentage figures of 9% on average for these 3 months. This would also reflect the fact that the social work staff should be accounting for the higher number of 1's as the more complex cases requiring input. These cases are adult safeguarding cases, new cases and delayed discharges.

## **Discussion**

Some of the issues that impacted upon this pilot were that during this 6 month period the team experienced staff absence. Given ongoing pressures in the PCOP team it must be acknowledged that this had an impact upon gathering all relevant data. It should also be noted that the caseload weighting tool is a very fluid guide and that cases can transfer from number 1 through to number 3 in the traffic light system very quickly.

The staff engaged positively with the pilot but given some of the pressures that the team experienced during this period we were unable to get complete information for all staff involved. As a supervisor it was also important to discuss with the supervisee their caseload % number 1's on a regular basis in order to assist the staff in their daily workload. When staff experienced periods with a high percentage of number 1

cases this needed to be considered at allocation and reviewed regularly with the staff.

It is important to highlight that the model when used stand alone would have limited impact in terms of managing a caseload. It is recognised that staff also need to regularly cleanse their caseload and close cases when appropriate.

### **Strengths**

The model has assisted in the management and prioritization of workload in an equitable and dynamic way. It facilitates a snapshot of caseload per social worker (WTE) to benchmark capacity in terms of available hours. The model could be used in other settings and it enables first line managers to highlight capacity issues. Staff recognised genuine attempts by management and DHSSPSNI to recognise the pressures. The model also enhances team work as this system enables the team members to recognise when people are under pressure and this is also more clearly apparent and open in this model.

### **Concluding remarks**

The WHSCT is currently involved in undertaking a Service improvement project in order to look at some of the key areas within Primary Care and Older People and as part of this project an audit is to be undertaken surrounding case files. This process will look at each of the five teams' caseload files and establish if files can be recommended for closure / transfer. We incorporated our caseload weighting tool within this audit process and the staff feedback was that it was very beneficial in providing a snapshot of their caseload and it also assisted in considering cases for potential closure or transfer from social work to social work assistant. This process will also assist Managers to get an accurate overview of workload across the PCOP programme and also assist in providing statistical evidence of caseload pressures in order to consider future resource allocation. This will enable the senior management team to have a clear understanding of caseload pressures and significant challenges.

## **Primary Care Older Peoples services NHSCT**

**Author /Senior Practitioner Eithne Lennon**

### **Introduction to the team**

The Older People's Team for Cookstown is an integrated team, made up of social work, district nursing and occupational therapy. There are 3 part time band 6 social workers, 1 band 5 full time (AYE) social worker and a part-time support worker. All staff are highly experienced, with social work staff experience ranging from 5- 38yrs.

### **Rationale for joining the pilot**

#### **The process**

Prior to the commencement of the pilot, the team had been identified as most suitable to engage in the pilot because of its consistent staffing (good record of attendance) and covered both a rural and urban geographical locality.

### **Outcomes**

The team have now established a consistent routine of updating their caseload weighting prior to supervision. Weightings are now scanned by the Team Leader and random cases selected for discussion to ensure accuracy of the scores. Although CLW definitions and scores are open to interpretation, the Team Leader role allows for consistency throughout the process.

The tool has provided the evidence that I, as Team Leader, need to ensure equity across the team. The process has clearly evidenced that size of caseload is no indication of the workload demands on an individual worker eg one staff member with a caseload of 32 had a CLW of 156, this compared with another staff member who had a caseload of 51 with a CLW of 142.

## **Team's evaluation and thoughts**

Staff opinion is one of satisfaction - reassurance that cases are allocated fairly across the team; there is recognition for the workload for each team members who are involved with ever increasing highly complex cases, as well as recognition for the additional responsibilities held be staff.

## **Team Leader's conclusions**

- The Team Leader has recognised – the excessive volume of admin tasks within the social work role, and as a result the reduced time spent face to face with the service user – dilution of social work time with service user.
- The difficulty with balancing the team workload with part-time staff – working variable hours – and the ultimate impact on the full time worker i.e. the SPSN/Team Leader.
- The benefits of weekly case discussions with the team, as a means of progressing the work v12 c v12 one/offing and closing cases or transferring to CCSW e.g. as a means of reducing numbers etc.
- Appreciates volume of new referrals from various sources and whilst not necessary at present – to identify the need create a waiting list – prioritise more efficiently
- The Team Leader recognises the impact of requests from other sources e.g. team manager (and other departments – senior manager) to facilitate audits, completion of information and the pressure on social worker to respond immediately.
- The Team Leader has identified need for team to participate/engage in time management training to enable staff to look at our time management and better use of staff.
- Outcomes from the project are currently being examined by the professional lead and senior management with a further roll out of the tools piloted in Cookstown being planned across the East Antrim Locality of the Community Care Division January / February 2017

## REFERENCES

1. DHSSPS Improving and Safeguarding Social Wellbeing: A Strategy for Social Work in Northern Ireland 2012-2022'
2. Workload Management Framework for Social Worker in Adult Services( Jan. 2015)
3. <http://www.communitycare.co.uk/2010/09/14/how-can-caseloads-be-managed/>  
For further details on the tool, email: [ccousins@tavi-port.org](mailto:ccousins@tavi-port.org)
4. Further information of the Team Leader reports can be found on the HSC knowledge exchange website <http://www.knowledge.hscni.net>

# Appendices

## APPENDIX 1:

### **Membership of Workstream 2 Implementation Group**

Eithne Darragh (Chair) Health and Social Care Board

Anita White & Pamela Black Hospital Social Work NHSCT

Paul Carson South Eastern Health and Social Care Trust

Yvonne Russell Coyles Mental Health service SE Trust

John Mc Cosker Mental Health Service WHSCT

Sean Tuck Older Peoples Service WHSCT

Carmel Drysdale BHSCCT

Jane M Millan & Deborah Mc Bride BHSCCT

Sean Falls & Eithne Lennon Older Peoples NHSCT

Kathy Lavery Physical Disability Service Southern Trust

Paula Mc Fadden Queens University Belfast

Vincent Mc Cauley University of Ulster

Jena Crawford Leadership Centre

David Elder Leadership Centre/ Patricia Rainey Leadership Centre

Paul Rooney Northern Ireland Social Care Council

Jackie Mc Ilroy DHSSPS

Noelle Barton Health and Social Care Board

Janelle Clegg, Health and Social Care Board



## APPENDIX 2

### **WORKLOAD MANAGEMENT TOOLS**

These are a range of workload management tools developed by the Highland Council Social Work Service. They are similar to ones used in children's services, across adult teams in some of the Trusts and to the Choice and Partnership's tools.

Teams are invited to consider these proforma and select those most useful for their team workload management approach/model. It is not expected that all teams will use all proformas. Xcel spread sheets can be used to reduce time spent on filling these in (see IT section)

### Workload Management – Case Planning Form

This form is designed to assist workers and supervisors to jointly undertake detailed case planning and in particular, to agree activity to be undertaken and the resources, including time, to be allocated to the task(s).

### Workload Management – Time Chart (1) - Initial Planning

This form is designed to assist workers and supervisors to jointly undertake a detailed breakdown of time available to the worker and to decide how it will be apportioned across a full range of activity.

### Workload Management – Time Chart (2) - Reviewing

This form is designed to enable workers and supervisors to jointly review how time was actually spent and to adjust activity and allocation of time and resources accordingly.

### Workload Management – Time Chart (3) – Core Times

This brief guidance note is designed to assist the workload management process and should be used initially as a basis only. It lists the activities that are core to the team and should be adjusted for each team member according to the worker's own particular specialism, location and responsibilities. It is useful if this is agreed in a team meeting.

### Workload Management – Time Chart (4) – Summary

The Summary will also be individualised to the individual's workload and will enable the worker and the supervisor to have an overall picture of the range of activity undertaken by the worker in any four-week period.

### Workload Management – Team Monitoring

If all members of a team use the proforma, it will be possible for the manager to collate information about workloads from the individual summaries. It is important to recognise that this proforma needs to be amended to reflect the range of work undertaken within the team and for headings to be used that are consistent with data

WORKLOAD MANAGEMENT – CASE PLANNING FORM					
<b>Case Plan for 4 week period</b>		<b>To</b>		<b>Service user's name/ID</b>	
<b>Worker</b>				<b>Supervisor</b>	
<b>SUMMARY OF CASE PLAN:</b> (This should relate directly to the assessment undertaken)					
<b>BRIEF SUMMARY OF WORK DONE/PRESENT SITUATION:</b>					
<b>Activity</b>					<b>Time Required</b>
Travel (proportionate if several clients in one area)					
<b>Supervisor's comments</b>					
<b>Date of next planning session</b>					

WORKLOAD MANAGEMENT – TIME CHART (1) INITIAL PLANNING					
Case Plan for a 4 week period		To		Service user's name/ID	
Worker				Supervisor	
Activity					Time required
Duty					
Team Meetings					
Supervision and Consultation					
Workload Management					
Cases (See Case Planning Forms)					
Training/Study Time/ Reading					
Record and Computer Updating					
Holidays (Annual Leave and Public Holidays)					
Flexi-Leave/ Toil					
Administration and Forward Planning					
Other (eg Working Groups, Liaison Meetings) (Please Specify)					
				Total Time Required	

	Total Hours Available	
	Surplus/Deficit	
<p><b>Worker's Comments</b></p>		
<p><b>Supervisor's Comments</b></p>		
<p><b>Date of next planning session:</b></p>		

<b>WORKLOAD MANAGEMENT – TIME CHART (2) – REVIEW OF PERIOD</b>			
<b>Period</b>			
<b>Worker</b>		<b>Supervisor</b>	
<p>Please review the estimates from the headings in Time Chart (1) and indicate where these were inaccurate. Record the extent of any changes made and state why they were necessary e.g. sickness, changes in clients' circumstances etc. Ensure there is sufficient detail to make clear the direction of the change.</p>			
<b>Change to Workload Heading</b>	<b>Reason for Change</b>		<b>Change (Hours)</b>
<b>Worker's Comments</b>			
<b>Supervisor's Comment</b>			

### Workload Management – Time Chart (3) – Core Times

Core times will be based on the use of four-week periods and assumes a 35 hour working week i.e. the maximum number of hours available in any four week period will be 4 x 35 hrs = 140 hours.

The team should agree standard deductions for activity and commitments that are planned or can be anticipated. These are estimated here as follows:-

Activity	Number of hours
Team Meetings	1.5 hours per meeting
Workload Management session (Supervision)	1.5 hours per session
Consultation and Professional Development	1.5 hours per session
Informal consultation	1 hour per week
Recording and database updating (Includes case recording only, not report writing)	5 hours per week
Reviews (including, Vulnerable Adults Meetings)	2 hours (inclusive)
Reports	2 hours (lengthier reports should be negotiated individually between the Supervisor and Worker)
Staff/ Student supervision	1.5 hours per worker/ 6 hours per student per week
Administration and forward planning (Includes time for workload management sheets, flexi- and mileage forms)	2 hours per week
Research/ Reading	2 hours per week
Annual Leave (remember to take a pro-rata deduction for core elements when leave is taken)	As Appropriate

### Workload Management – Time Chart (4) – Summary

Worker:

Date:

Case/ Service User*	Type	Direct Contact	Reviews	Confs	Mgs	Reports	Record	Travel	Other

\*headings should reflect activity undertaken

*This proforma will be most effectively used on excel spreadsheet so that it can be easily updated.*



## Workload Management – Team Monitoring

**Team:**

**Month:**

*This proforma needs to be amended to reflect the range of work undertaken within the team, using headings that are consistent with database and performance activity.*

No. of allocated cases:		
No. of cases awaiting allocation:		
No. of Guardianships		
No. of Vulnerable Adults cases		
No. affected by alcohol/drug misuse misuse by:	Individual:	
	Carer/family:	
No. affected by domestic violence:	Individual:	
	Carer/family:	
No. affected by drug misuse:	Individual:	
	Carer/family:	
No. affected by mental health concerns of:	Individual:	
	Carer/family:	
No. adults with a disability:	Physical:	
	Sensory:	
	Learning Disability:	
No. of assessments (specify statutory basis)	Individual	
	Carer Family	
No. on PQC Register:		
No. in receipt of community care service:	Residential Package:	
	Care at home:	
	Supported Living	
	Day care:	
	Respite care:	
	Other: (please specify)	

## CASE CLOSURE SUMMARY

<b>Name of service user</b>		
<b>Date of referral</b>	<b>Date of last review</b>	
<b>Relevant changes in people and circumstances</b>		
<b>Summary of actions and aims achieved since last review:</b>		
<b>Summary of aims not achieved:</b>		
<b>Reason(s) for closure:</b>		
<b>Service user advised of closure: YES/NO</b>		
<b>Consenting to closure: YES/NO</b> (Note: record the detail of any difference of opinion regarding closure/service provided)		
<b>Agency/Worker service user referred to (if appropriate):</b>		
<b>Service user /representative</b>	<b>Worker</b>	<b>Supervisor</b>
<b>Date:</b>	<b>Date:</b>	<b>Date:</b>

## CLOSURE SUMMARY

continued

**Additional information:**

**Information inputted into database:**

**Date:**

**Information transferred to new worker  
/ agency (if appropriate):**

**Date:**

**Case holder**

**Supervisor**

**APPENDIX 3**

**WORKLOAD MANAGEMENT – STAFF QUESTIONNAIRE**

**Baseline Measurement Tool**

Programme of care \_\_\_\_\_

*The following terms are used in this document and are defined as:*

**Case load** is the number of cases open to a professional

**Workload** is the full workload which will include the caseload and may include related duties including practice teaching/ safeguarding vulnerable adults or Approved social worker role/ mentoring AYE // providing professional supervision,

*Please rate your satisfaction (circle) with the following 1 least satisfied 7 most satisfied*

1.How satisfied are you with your current caseload 1 2 3 4 5 6 7

Comment \_\_\_\_\_

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2.How satisfied are you with your overall workload 1 2 3 4 5 6 7

Comment \_\_\_\_\_

---

3.How satisfied are you that you can manage your current workload?

1 2 3 4 5 6 7

Comment \_\_\_\_\_

---

4.How satisfied are you with your team workload 1 2 3 4 5 6 7

Comment \_\_\_\_\_

---

5.How satisfied are you that supervision is helping you manage your work?

1 2 3 4 5 6 7

Formal supervision 1 2 3 4 5 6 7

Informal/ad hoc supervision 1 2 3 4 5 6 7

Comment \_\_\_\_\_

6.How satisfied are you with the Team allocation of referrals to you as a social worker? 1 2 3 4 5 6 7

Comment \_\_\_\_\_

7.Do you have a workload management approach in place? Yes No

If yes, how satisfied are you with this approach 1 2 3 4 5 6 7

What could improve the workload management approach in your team?

Comment \_\_\_\_\_

8.How satisfied are you with current arrangements for closing cases?

1 2 3 4 5 6 7

Comment \_\_\_\_\_

9.How satisfied are you with access to training 1 2 3 4 5 6 7

Comment \_\_\_\_\_

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*Thank you for your time*