This document sets out the reablement policies, procedures and guidelines for staff working with service users, carers, families and relevant parties for the provision of short-term care and support to help ensure residents with adult social care needs and outcomes are: Independent, Safe and Well.
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1 Community Wellbeing and Independence Services

1.1 Service overview

Reablement provision is part of the London Borough of Waltham Forest Community Wellbeing and Independence Service.

The Community Wellbeing and Independence Service (CW&IS) is responsible for managing short-term care and support for people with low level non-eligible needs to support improved wellbeing and prevention and people with assessed eligible needs where reablement and rehabilitation support improves independence, wellbeing and safety.

The service is accountable for the development and delivery of:

- web content and self-service capabilities to support people to identify and resolve adult social care enquiries and needs
- provision of information, advice and signposting
- managing incoming contact and referrals (customer service)
- screening and triaging of all referrals and requests for care and support
- provision of services and products to promote improvements in wellbeing, prevent the escalation and worsening of social care needs and help people to connect to local resources and services – non-eligible needs
- hospital assessment and discharge planning - working as part of a multi-disciplinary hospital team supporting assessment and discharge planning for people medically optimised and ready for discharge
- provision of person-centred managed care and support to meet reablement and rehabilitation potential working closely with partners in health and provider services – eligible needs
- review progress against care and support plans on a regular basis with service users and relevant others

The CW&IS is comprised of four teams:

1. Wellbeing and Prevention Team
2. Independent Living Team
3. Hospital Team
4. Integrated Care Management

The team responsible for the delivery of reablement and rehabilitation care and support is the Independent Living Team,

1.2 Our values

To support delivery of high quality, person-centred short-term care and support the London Borough of Waltham Forest work within a ‘strengths based’ approach to maximise people’s independence, safety and wellbeing by building on the person’s strengths and assets and using the strengths and assets of those around them including family, friends, community and local services.

Our objectives are to:

- support people to connect to local informal care and support
- support people where there is a risk and put in high quality, person-centred short-term care and support (reablement and rehabilitation) and;
• support people who are moving into long-term care and support arrangements to live a good life

The above approach is very similar to the recognised 3 conversations model developed by Partners 4 Change – see below:

Figure 1 3 Conversations Model (Partners 4 Change)

There are a number of values which underpin our way of working:

1. **Putting the person at the centre of care and support** – implementing our strengths based approach and ensuring the ‘voice’ of the person, carer, family and relevant others is heard and people are fully engaged so we can; improve the person’s experience, learn from their expertise (they know their condition best) and continue to improve the service based on their feedback

2. **Caring and competent workforce** – ensuring are staff are caring and understanding and have the right skills, experience and training to deliver high quality, person-centred care and support that promotes; independence, wellbeing and safety

3. **An Independent Living Offer** – a wellbeing, prevention and early intervention offer for residents that gives people support and products to improve their wellbeing and effectively manage their conditions and risk

4. **Therapeutic-led Care Approach** - Reablement Therapists or Occupational Therapists will work closely with the person, carers and relevant others to use their skills, experience and expertise to determine when interventions have helped people to maximise their independence – in some instances people may receive short-term care and support that extends beyond 6 weeks

5. **Dynamic Care Management** - the implementation of a dynamic care management approach means we will more frequently review and assess people’s care and support needs having regular contact and conversations with them to understand what matters to them and what is important for them.

6. **Collaborative working with informal care networks and partners** – working closely with the voluntary, charitable and third sector as well as partners in health services to join up services to support holistic care and support planning and delivery
7. **Key Principles for Triage and Assessment** – having the right conversations to help resolve enquiries early and using proportionate person-centred assessment to understand presenting needs and pausing assessments to try services/products. Triage and assessment is not about ticking boxes, it is about understanding the person, the impact on them arising from social care needs and what is important to them – their outcomes.

8. **Proportionate Approach to Risk** – developing different approaches and solutions to help the person, carer, family and the Council to manage and mitigate risk supporting people to have choice and control, while ensuring people are protected from abuse and neglect. This will include: using assistive technology to better understand risk, taking a proportionate risk based approach to practice.

### 1.3 Community Independence and Wellbeing Structure

The Community Wellbeing and Independence Service structure is set out below:

![Staffing Structure (including Independent Living Team/Reablement)](image_url)
2 Workforce Development Strategy 2018 - 2020

2.1 Aim

Adult Social Care has a Workforce Development Strategy that describes what we want our workforce to be, to do, and how we want our staff to act.

The aim of workforce development strategy is to:

“Ensure adult social care has a highly skilled, flexible workforce that supports the residents of Waltham Forest who have adult social care needs to be able to live independent, safe and well lives as part of their communities, recognising the strengths and assets of individuals, families, neighbours and communities to support people informally and formally to meet their social care needs and outcomes”.

2.2 Objectives

The objectives of the workforce development strategy are:

- To recruit and retain a competent and flexible adult social care workforce to support residents with adult social care needs to live independent, safe and well lives
- To develop and support the adult social care workforce to implement ‘strength based’ working across all staff groups
- To promote confidence within the adult social care workforce to have the right conversations across all staff groups with residents with adult social care needs, their families and other relevant groups and organisations e.g. health colleagues – using a recognised model i.e. Three Conversation Model
- To support and evidence the professional development of the adult social care workforce to achieve, maintain and develop their professional practice and achieve recognised practice statuses i.e. Approved Mental Health Practitioner, as well as registration with appropriate professional bodies e.g. Health and Care Professions Council
- To deliver person-centred, compliant practice in line with adult social care and workforce standards e.g. National Minimum Standards, Health and Social Care Act (Regulated Activities) Regulations 2014 and Care Quality Standards and Guidance e.g. Managing medicines in care homes, Autism, Intermediate care including reablement.
- To provide a wide range of training and development courses to upskill and maintain the adult social care workforce skills base and qualifications, including; mandatory, essential and desirable training and development courses

2.3 Workforce characteristics

Our Workforce Development Strategy sets out what we expect of staff which is relevant and applies to staff working in the ILT delivering reablement/rehabilitative care and support:

Leadership

It is important that leadership staff demonstrate clear and effective leadership, taking accountability for ensuring the service and teams deliver high quality, legally compliant person-centred care and support that allows us to quickly implement the adult’s target operating model and demonstrate how adults is delivering the ‘Think Families 2020’ strategy.

Our leaders need to inspire their teams and colleagues and model at all times the Council’s values and provide the working environment for everyone to make a positive contribution at work. The level
of change required both structurally for teams and culturally in terms of practice is considerable. Our leader needs to provide; creative, innovative and imaginative solutions to support change and make the change stick.

Our leader must not accept partial change but provide the leadership needed to ensure our residents are able to be; independent, safe and well and are able to achieve the outcomes important to them.

Our leaders must demonstrate strengths based working and the three conversations approach.

Management

It is important that our senior and principal officers provide clear and effective management, ensuring that the adult social care needs and outcomes of residents are met in a professional, efficient and sustainable way. It is important that our managers ensure professional standards and regulatory standards and guidance are adhered to and exceeded and that the practice of both qualified and unqualified staff is first class.

We want all our services to be high quality and centred on the service user's social care needs and outcomes. Managers should always consider the experience of users which should be positive and our managers should ensure that users and carers are always involved where they want to be and fully engaged.

Our managers must also make sure that the delivery of social care as well as being professional and compliant is also affordable and sustainable. They should be effective at managing both staff and resources and make informed decisions based on data, information and business intelligence, driving forward both practice and service improvements.

Our managers must demonstrate strengths based working and the three conversations approach.

Qualified practice

It is vital that we continue to recruit and retain qualified staff such as; social workers, occupational therapists and reablement therapists and the Council is committed to attracting talent to Waltham Forest with excellent terms and conditions for qualified staff.

Our practitioners must drive forward the changes required to allow us to implement a therapeutic-led care approach and realise dynamic care management. It is essential that qualified staff maintain their registration and actively participate in professional development with a focus on evidence based practice.

Qualified staff should work collaboratively with users, carers, colleagues and partners to help people make the best use of their strengths, assets and informal care networks – we do not want our qualified staff to be ticking boxes, blindly following process and letting cases go passive.

Our qualified staff must demonstrate strengths based working and the three conversations approach.

Officer staff

It is important that all our officer staff deliver first class high quality care and support that effectively meets people's adult social care needs and outcomes. Our officer staff must demonstrate a person-centred approach that delivers care and support in a dignified way that respects the wishes, opinions and views of users.
Our officer staff must ensure that service users are safe, well and independent and protected from neglect and harm. It is important that our officer staff work co-operatively with users, carers and the wider family, being knowledgeable about what is happening and available in the areas in which they work.

Our officer staff must demonstrate strengths based working and the three conversations approach.

2.4 Outcomes

The workforce development strategy must support the implementation and delivery of the adult’s target operating model and changes to practice which sees us deliver a therapeutic-led care approach when supporting people in short-term care and support needs and a dynamic care management approach when supporting people in long-term care and support needs.

The workforce strategy sets out at a high level our aim and ambitions and is an integral part of an overall approach that includes:

- The Performance Management Framework
- Competencies Framework
- Practice Standards
- Regulatory Standards and Guidance
- Training needs analysis
- Training and development plan

Through the combination of the strategy and the above we want our staff to be:

1. **Confident** – able to have the right conversations with people, make positive decisions knowing where required they have the support of managers and colleagues
2. **Competent** – able to use their professional judgement and display effective evidenced based practice grounded in their training, skills and experience
3. **Collaborative** – able to operate effectively across the team, service and directorate, as well as engaging and working in partnership with users, carers, families, communities and allied agencies and organisations in the delivery of adult social care
4. **Consistent** – able to deliver high quality care and support across all aspects of their role ensuring user’s social care needs and outcomes are met and the Council is able to meet its statutory and regulatory requirements
5. **Compelling** – able to champion and understand the changes the Council is making to improve residents quality of life, service delivery and infrastructure and demonstrate and share these values with others
6. **Courageous** – able to effectively balance supporting users to achieve their outcomes with the requirement to work within Council and adult policies and process, identify risks and concerns and respond appropriately to ensure users are safeguarded and protected where something isn’t right or doesn’t feel right
7. **Considerate** – able to know how to respond appropriately when working with service users, carers and families often at a time of stress and upheaval or following a significant life event showing **caring and compassion**, as well as working with people in a dignified way, respecting their views, opinions and decisions

2.5 Practice Standards

There are clear expectations of staff in terms of their professional practice set out in law, regulations, guidance and knowledge sharing on best practice.
There are clear standards set out in The Health and Social Care Regulations 2008 (Regulated Activities) 2014 including requirements around the role of Registered Manager, standards associated with membership of professional bodies such as: Health and Care Professions Council, Corporate London Borough of Waltham Forest standards i.e. Performance Management Framework, Competencies Framework and adult social care standards that have been agreed.

The Adult Social Care Practice Standards are:

“I will treat everyone with dignity and respect”.

“I will ensure your care and support is safe and I will work with you to identify risks and put in place plans and actions to mitigate these so they don’t turn into an incident”

“I will ensure you are protected from abuse and neglect, appropriately supported to make decisions or have someone else who can support you where you don’t have capacity and make sure the service you receive is the least restrictive”.

“I will ensure I am professional, registered where I need to be, well trained so I can offer you the best person-centred care and support”.

“I will provide honest information that is easy to understand and in an accessible format or language”.

“I will support you to be as resilient and independent as possible”.

“I will work in a “person-centred” way and treat you and everyone like an individual recognising your preferences, your nutritional and hydration needs and building on the strengths and assets of you and those around you: carers, family and communities”.

“I will listen to your views and those close to you and deal with any complaints you have, ensuring I act on them so we will continually evaluate and improve our service to meet the highest standards”.

Please see Practice Standards Adult Social Care.

2.6 Training and development

Training and development is a key priority within the Independent living team especially for frontline staff delivering services in service users home, including; the delivery of personal care services.

The key areas covered in reablement/rehabilitative support are:

- Infection, pressure area and continence care - 3 yearly
- Dignity in care – 3 yearly
- Infection prevention and control – 3 yearly
- Medication – yearly
- First aid at home – yearly
- Manual handling – yearly
- Fire safety - yearly
- Risk assessment awareness
- Managing behaviours that challenge
- Safeguarding (in-house)
- Mental capacity awareness (in-house)
- Prevent training
- Dementia awareness
- Fluid and nutrition
• Food hygiene
• Diabetes awareness
• Goal setting
• Person-centred care planning
• Supervision training (in-house)
• Appraisal Training (in-house)

In addition to the training provided above people are able to undertake other professional
development training that will lead to qualifications and certificates including; professional courses in
occupational therapy, social work and completion of the Care Certificate – see
attached/following.

A training and development record is kept of all staff training.
3 Independent Living Team Overview

3.1 Scope:

The Community Wellbeing and Independence Service will have screened and triaged incoming work and requests and decided which team will deal with the referral/request.

The Independent Living Team (ILT) is a multi-disciplinary team consisting of:

- Team Manager
- Practice Manager x 2
- Reablement Therapist x 7
- Social Worker x 5
- Occupational Therapists x 2
- Social Care Assistants x 7
- Reablement Officer x 17
- Intensive Dementia Outreach Officer x 9

The team will provide independent living support for vulnerable adults and carers with eligible social care needs where a referral has been made and/or a request for care and support. The team will:

- receive referrals and requests for care and support from the screening and triaging function including; community referrals and hospital referrals
- provide social care support (personal care) for certain people e.g. discharge to assess patients returning home needing support on day 1
- contact the person to start the initial conversation within 24 hours including a discussion around consent and financial assessment and charging
- deal with any safeguarding concerns and/or enquiries
- run drop-in clinics to manage referrals and requests for support
- run therapy-led courses that support and improve functional independence e.g. core and strength conditioning/exercises
- provide social work support
- provide complex equipment to support out of borough hospital discharge
- manage disabled facility grant applications
- complete a full Care Act Assessment to determine and understand present needs and determine eligibility
- complete other assessments as required e.g. Functional Independence Measures
- provide support, advice and assessment around manual handling and complex OT
- participate in multi-disciplinary meetings (hospital and integrated case management) and liaise with multi-disciplinary colleagues e.g. hospital staff around the outcomes of assessment
- manage pathway discussions and pathway referrals e.g. reablement, discharge to assess step-down beds, community recovery etc.
- develop and agree support plans
- directly provide short-term care and support in people’s home or appropriate settings e.g. personal care reablement support and personal care dementia outreach support
- facilitate access to community-led initiatives for an agreed length of time in line with the support plan
- monitor and evaluate the effectiveness of early intervention support
- review progress against any agreed plans and outcomes and evidence and record the outcome of interventions
• referral to appropriate services if there is on-going need eligible need that needs long-term care and support i.e. Complex Care Team
• broker ongoing long-term care and support with brokerage team
• work jointly with specialist social work teams i.e. complex care team to provide support and input around; transfer of cases, changes in circumstance and care package variation requests

3.2 Objectives:

There are several objectives the ILT are aiming to achieve:

Table 1 Reablement Objectives

<table>
<thead>
<tr>
<th>Area</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information, advice and signposting</td>
<td>Increase the number of people who are able to self-serve and self-manage their care and support needs without needing the Council through information, advice and signposting and available online tools</td>
</tr>
<tr>
<td></td>
<td>Increase the number of people who are able to self-serve and self-manage their care and support needs without needing the Council through information, advice and signposting and available online tools</td>
</tr>
<tr>
<td></td>
<td>Provide information and advice on volunteering, vocational and employment opportunities</td>
</tr>
<tr>
<td></td>
<td>Offer advice and support around suitable accommodation and tenancy options</td>
</tr>
<tr>
<td>Contact and referral management</td>
<td>Manage referrals effectively such as:</td>
</tr>
<tr>
<td></td>
<td>• safeguarding concerns</td>
</tr>
<tr>
<td></td>
<td>• provision of complex equipment and major adaptations to support daily living</td>
</tr>
<tr>
<td></td>
<td>• request for care and support for people with eligible social care needs and outcomes</td>
</tr>
<tr>
<td></td>
<td>Ensure people have a quick response when a referral and/or request for care and support is made – a conversation takes place within 24 hours and an assessment within 24 to 48 hours</td>
</tr>
<tr>
<td>Person-centred care and support</td>
<td>Ensure the person is at the centre of the care and support process and their voice, preferences and outcomes are clearly understood and recorded</td>
</tr>
<tr>
<td></td>
<td>Develop and agree with the person, carer, family and relevant others person-centred care and support plan – the care and support plan will:</td>
</tr>
</tbody>
</table>

P a g e  | 14
<table>
<thead>
<tr>
<th>Hospital Discharge</th>
<th>Support effective hospital discharge managing against the appropriate hospital discharge pathway:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Pathway 0 – non-complex</td>
</tr>
<tr>
<td></td>
<td>- Pathway 1 – reablement and discharge to assess</td>
</tr>
<tr>
<td></td>
<td>- Pathway 2 – complex discharge</td>
</tr>
<tr>
<td></td>
<td>- Pathway 3 – palliative and end of life</td>
</tr>
<tr>
<td>Manage assessment notifications undertaking a full Care Act Assessment (where it appears the person would be eligible for social care support) within 24 hours and discharge notification generated by the hospital</td>
<td></td>
</tr>
</tbody>
</table>

| Provision of equipment                                                          | Provide appropriate equipment and assistive technology solutions to meet needs and better understand and manage risk |

<p>| Assessment and Eligibility                                                       | Based on the information from the conversation, the assessment and outcome of the eligibility decision either: |
|                                                                                  | - provide information, advice or signposting and close                                             |
|                                                                                  | - provide equipment or adaptations to support daily living                                          |
|                                                                                  | - provide managed care and support.                                                                |
| Identify the areas where support to maintain and/or improve independence is being provided across all Care Act outcome areas |</p>
<table>
<thead>
<tr>
<th>Safeguarding</th>
<th>Ensure vulnerable adults are protected from abuse and neglect</th>
</tr>
</thead>
</table>
| Case work and team work | Play an active role in the hospital multi-disciplinary meetings  
Play an active role in the integrated case management meetings  
Maximise people’s strengths and assets and those of the community and partners to meet needs themselves or through informal care and support – connecting people to support in communities and those provided by the voluntary, charitable and third sector and checking to see this has resolved the enquiry  
Manage cases within the therapeutic care approach – transfer cases when we have maximised independence and no further improvements in functional independence can be made  
Provide practical support to people in an agreed way to manage their condition and risk and offer advice and support on the best way to meet their social care needs and outcomes important to them |
| Social Work | Provide short-term social work support to help people and carers manage risk and resolve any care and support needs during our interventions, lessening the need for more intensive interventions such as:  
- determine capacity and best interest  
- appointeeships/deputyship  
- advice and support around protection of property  
- food banks  
- house cleans/deep cleans  
- no recourse to public funds  
- strategies to manage risk |
| Outcomes and ending reablement | Set out what will happen after reablement/rehabilitative care and support will end  
Use service user, carer and other feedback to continually improve service delivery and the person’s experience of care and support  
Increase the number of people who no longer need on-going support post reablement/rehabilitative intervention |
Reduce the number of people who move on to long-term care and support
Evidence the effectiveness of our early intervention and initiatives

3.3 Multidisciplinary working:

The ILT will work in a multi-disciplinary way to ensure we can maximise a person’s independence and promote improved wellbeing and prevention. Work will be on a short-term basis but may last up to 20 to 24 weeks depending on which pathway the person is in. There are three reablement/rehabilitative pathways:

- **Reablement pathway** only providing care and support to manage social care needs and meet outcomes with a clear focus on promoting independence through goal setting to regain and improve functional independence – no significant therapy needs
- **Discharge to Assess pathway** focused on a patient in hospital that shows rehabilitation potential. This pathway allows a patient to have their needs assessed in their usual place of residence, or own home, as soon as they are medically optimised and safe to leave hospital.
- **Community Recovery Pathway** to increase independence in the community – more geared to community referrals focused on double handed to single handed packages of care, people leaving hospital with an increase in their long-term package of care and supporting step-down from residential care

It is expected that the Social Workers in the ILT will lead on safeguarding concerns, deprivation of liberty ensuring the least restrictive arrangements for care and support, as well as providing support to people and/or team colleagues around social work function such as; determining capacity and best interest, providing advice around protection of property and acting on behalf of someone (Deputyship and Lasting Power of Attorney). They will be the caseworker for a number of reablement users.

The Reablement Therapists and Occupational Therapists will work closely with the person, carers and relevant others to use their skills, experience and expertise to determine when interventions have helped people to maximise their independence. They will also work with the Equipment and Assistive Technology Lead and will lead on the provision of small items of equipment to support daily living and complex items of equipment as well as major adaptations. The Reablement Therapists and Occupational Therapists will provide complex OT including; manual handling and provide support and advice to colleagues around how equipment and assistive technology can be used and applied to promote wellbeing, reduce and mitigate risk and prevent conditions/needs worsening. Reablement Therapists and Occupational Therapists will be the caseworker for a number of users on a discharge to assess and community recovery pathway.

The Social Care Assistants will hold a number of cases for users on a reablement pathway where it is determined short-term support is needed (as outlined in an agreed plan in the care and support plan). This will include working with the person and/or carer to develop strategies to support independent living and access community-led services and products to improve wellbeing and independence.

The Reablement Officers will deliver high quality, person-centred care and support in people home in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Act 2014. They will have positive relationships with the person, carer and relevant others to ensure social care needs and outcomes are met.
The Business Support Officers will provide administrative support to the team, assisting with gathering, analysing and assessing feedback on the service as well as producing the rosters and schedules to support care and support visits.

All staff will contribute to the person’s record and ensuring the appropriate worksteps, tasks and activities are completed in the social care case management system Mosaic in the person has the relevant information in their home to support effective service delivery.

3.4 Service User Groups:

The ILT will work mainly with the following service users groups offering reablement and rehabilitative care and support:

- carers
- working aged adults – physical impairments
- older adults 65+
- frailty 85+
- early on-set dementia (joint working with Intensive Dementia Outreach Worker in Independent Living Team)

The following groups who require reablement or rehabilitative support will be supported by different arrangements:

- Learning Disabilities – Community Learning Disabilities Team
- Mental Health – Nelft Mental Health Teams
- Sensory Impairment – Action for Hearing Loss
- Drugs and Alcohol – Lifeline

3.5 Supporting processes:

There are a number of supporting processes that facilitate the delivery of reablement and rehabilitative and ensure the person, carer, family or relevant others are informed of the Council processes, especially around Charging and contributing to the cost of care and support if it goes over 6 weeks or they move into long-term care and support within the period of reablement/rehabilitative support, these are:

- Financial Assessment
- Fairer Contribution and Charging

3.6 Allied Services:

The Council and partners also provide a number of services and support that promote wellbeing and help with maintaining independence. These include (are not limited to):

- Social Prescribing
- Living Well Waltham Forest
- Local Area Coordinators
- Waltham Forest Falls Prevention Service
- Metropolitan – wellbeing at home
- Fire, Safe and well
- Joint assessments, minor aids and adaptations and handyman services
- Warm Homes Project
- Carers Services
• Voluntary, Charitable and Third Sector
• Waltham Forest Housing
• Housing Providers
• Integrated discharge management
• Intermediate care – health
• Integrated case management to support primary healthcare and prevent hospital admission/readmission
4 Reablement Pathways

4.1 Reablement Model

The London Borough of Waltham Forest has a reablement model that has three key pathways: reablement only, discharge to assess and community recovery pathway. The model is outlined below:

![Reablement Model Diagram](image)

**Figure 3 Reablement Model**

4.2 Reablement Only Pathway

Referral for reablement only support are received from community and hospital pathways – currently there are about 80+ people a month receiving reablement support. The referrals will be sent to the Community Wellbeing and Independence Service for screening and triage and then referred to the Independent Living Team.

**Hospital:**

We need to be clear very early on at the point of the social work assessment conducted in the Hospital within 24 hours of an assessment notice that the person meets the national eligibility threshold – if they don’t they should not be referred to the Community Wellbeing and Independence Service for reablement support. A discharge notification informs the anticipated discharge date. The notifications are received by the Hospital Business Support staff who enters these onto Mosaic.
If following the assessment in hospital they are not eligible but have some low level need where the social worker feels offering some products or service would promote and improve wellbeing or prevent deterioration and worsening of the low level needs then a referral could be made to the Community Wellbeing and Independence service for support via the Wellbeing and Prevention Team.

For those who meet the eligibility criteria and have eligible social care needs that may be best met through short-term reablement support only a referral can be made from the hospital to the Community Wellbeing and Independence Service – reablement support only is where the patient would benefit from a reablement approach to build skills and confidence, but there is little therapy input - in a discharge to assess pathway or community recovery pathway there would be significant therapy input. This will include patients discharged to George Mason Lodge step-down beds

Following assessment and the development of the care and support plan all support plans must have a cost against them – a resource allocation based on an average market hourly rate.

A financial Assessment must also be conducted (within the four weeks) and the service user notified of any contribution to the cost of care if the care and support extends beyond 6 weeks or their needs are such that a long-term care and support package is required earlier.

The goal is to work closely with the service user, carer, family or relevant others to build skills and confidence with a goal to step-down care and support via reablement so people either exit the service and require no more support or they move into long-term care (handed over to the Complex Care Team) with the right sized package of care.

During this time it is important to actively manage the case/intervention and keep case notes and/or update any agreed plans in place e.g. care and support plan. The service user and others should be kept up to date and have the opportunity to feedback on their experience.

The outcome(s) will be:

- services/products meeting needs no further service needed
- on-going unmet eligible need that has significantly worsened broker a long-term package of care and transfer the case to the complex care team.

Community:

Referrals will be received by the Community Wellbeing and Independence Service and screened and triaged to assess the potential for reablement. If there is reablement potential then it will be referred to the Independent Living Team.

The first point of action is to complete a full assessment (if one has not already been done) to determine the person’s eligibility. This assessment will be completed by either a social worker or social care assistant within 48 hours in the team who will manage the case. Only people who are eligible will receive reablement service. However, a person with needs who requires support will not be left without support – once the assessment and eligibility decision is complete the most appropriate service to deliver support will be engaged.

If following the assessment the person is not eligible but they have some low level need where the social worker feels offering some products or service would promote and improve wellbeing or prevent deterioration and worsening of the low level needs the a referral could be made to the Community Wellbeing and Independence service for support via the Wellbeing and Prevention Team.
For those with eligible needs who would benefit from reablement but need little therapy input the case will be held by the social worker or social care assistant who will work closely with the person, carer, family and relevant others to develop and agree the care and support, identify risks and agree mitigations and set reablement goals – support may be provided by therapist within the team to support goal setting.

Where there are reablement needs such as; family, employment, using community facilities - need that sit outside of direct care such as; bathing, nutrition etc. – then these needs may be met by the Social Care Assistant(s).

The goal is to improve independence, build skills and confidence and step-down care and support via reablement so people either exit the service and require no more support being able to live independently, safe and well through informal care and support or they move into long-term care (handed over to the Complex Care Team) with the right sized package of care.

Following assessment and the development of the care and support plan all support plans must have a cost against them – a resource allocation based on an average market hourly rate.

A financial Assessment must also be conducted (within the four week) and the service user notified of any contribution to the cost of care if the care and support extends beyond 6 weeks or their needs are such that a long-term care and support package is required earlier.

Any service that extends beyond 6 weeks will be chargeable subject to the outcome of the financial assessment.

During this time it is important to actively manage the case/intervention and keep case notes and/or update any agreed plans in place e.g. care and support plan. The service user and others should be kept up to date and have the opportunity to feedback on their experience.

The outcome(s) will be:

- low level needs are being met by services/products so no further service needed
- on-going unmet eligible need that has significantly worsened, broker a long-term package of care and transfer the case to the complex care team.

4.3 Discharge to assess pathway

The determination for discharge to assess pathway takes place in the Hospital. It is for patients who have been medically optimised and are ready for discharge. An assessment notification is raised requesting assessment, which must be completed within 24 hours by the hospital social work team. A discharge notification informs the expected date of discharge. The notifications are received by the Hospital Business Support staff and entered onto Mosaic (the social care case management system).

Currently there are approximately 25 patients a month on a discharge to assess pathway. In 2018 the intention is to phase an increase in the number of patients on a discharge to assess pathway to 30 and then 50 a month.

A referral will be made to the Community Wellbeing and Independence Service for screening and triage and then referred to the Independent Living Team.

Accepted discharge to assess patients will be case managed by a Reablement Therapist or Occupational Therapist in the Independent Living Team.

The current criteria is outlined below:
• Patient requires further assessment, rehabilitation and reablement at home
• Assessment and discharge notification to social work required or patient can be referred directly to D2A and Reablement from therapist to therapist and inpatient rehabilitation
• Patient may have short term equipment needs, or prescribed equipment on discharge

We need to be clear very early on at the point of the social work assessment conducted in the Hospital within 24 hours of an assessment notice that the person meets the national eligibility threshold – if they don’t they should not be on a discharge to assess pathway (they should be Pathway 0 non-complex).

When the person is ready for discharge the Hospital Therapists and Independent Living Team Therapists will liaise to assess and determine future care needs – this assessment is about determining how functional independence will be improved as part of the person’s rehabilitation potential and should give sufficient information to develop the care and support plan including goal setting and how outcomes will be achieved, as well as the level of practical social care support to be delivered (hours of care, frequency etc.). This will include patients discharged to Ainslie step-down beds.

Where required (it is clear support may continue beyond 6 weeks) a financial assessment should be requested (within the four weeks) to determine any contribution the individual may need to make if support extends beyond 6 weeks or their needs are such that a long-term care and support package is required earlier.

Meeting personal care needs will be commissioned but the therapist will continue to hold the case.

If there are social work issues to resolve during the delivery of service the therapists will be able to draw on the support of social workers within the team, this may include: assessment of capacity, best interest assessment, protection of property etc.

Where there are reablement needs such as; family, employment, using community facilities - need that sit outside of direct care such as; bathing, nutrition etc. – then these needs may be met by the Social Care Assistant.

Any service that extends beyond 6 weeks will be chargeable subject to the outcome of the financial assessment.

During this time it is important to actively manage the case/intervention and keep case notes and/or update any agreed plans in place e.g. care and support plan. The service user and others should be kept up to date and have the opportunity to feedback on their experience.

The outcome(s) will be:

• services/products meeting needs no further service input needed – hand over to family/carer for on-going support
• handover to OT/Physio in WFRC/ICT for on-going support
• on-going unmet eligible need that has significantly worsened – refer to complex care team

4.4 Community Recovery Pathway

Referrals for the community recovery pathway are received from community and hospital pathways and there are likely to be 10 to 20 people a month on this pathway.
The referrals will be sent to the Community Wellbeing and Independence Service for screening and triage and then referred to the Independent Living Team.

Hospital:

These will be people who already have a package of care and support in place and be with the complex care team but may have been admitted to hospital and once medically optimised are ready for discharge. An assessment notification is raised requesting assessment, which must be completed within 24 hours by the hospital social work team. A discharge notification informs the expected date of discharge. The notifications are received by the Hospital Business Support staff and entered onto Mosaic (case management system).

Part of the assessment process while in hospital will have identified the need for an increase in the package of care to support discharge or a recommendation on a different care setting/placement.

The Independent Living Team should be the first point of referral where there is a proposed increase in the package of care or recommendation around a change in care setting.

The Therapists in the team can work closely with both the hospital social worker and allocated worker in Complex Care where there is a change in circumstances necessitating a review/reassessment of care needs and a step-up in care and support – the complex care team should engage with the Independent living team to determine the level of step-up (variation) needed. This will include patients discharged who are on the community ‘Step-down List’.

The case for stepping-up (variation) care should clearly state:

- what the proposed step-up in care will achieve in terms of meeting increased care and support needs
- how a step-up in care and support will contributes to achievement of outcomes
- how a step-up in care and support will contribute to preventing further escalation of needs that may necessitate a different placement i.e. if the package is not stepped-up the person would need to move from home to a residential care placement
- how long the step-up is needed – is it temporary while the independent living team therapist(s) stabilise and work with the individual to regain their previous functional independence or is it permanent with a reason why the person would not re-achieve their previous level of functional independence so the additional assistance is required.

Meeting personal care needs will be commissioned but the therapist will continue to hold the case.

We must be clear on the original care cost and the recommended increase post discharge so we can be clear with users and carer if they are any additional financial impacts on the individual e.g. an increase in their rate of financial contribution.

The goal is to step-down care and support via therapeutic input to determine how people’s functional independence can be improved over a period of agreed time post the discharge, before a long-term financial commitment against the cost of the care package is made.

During this time it is important to actively manage the case/intervention and keep case notes and/or update any agreed plans in place e.g. care and support plan. The service user and others should be kept up to date and have the opportunity to feedback on their experience.

The outcome(s) will be:

- on-going need requiring a long-term increase in the package of care
• on-going need requiring a temporary increase in the package of care and a return post intervention to the original cost for the package of care.

Community:

Referrals will be received by the Community Wellbeing and Independence Service and screened and triaged to assess the potential for maximising someone’s functional independence through a short-term therapeutic care intervention. A referral will be made to the Independent Living Team.

The Therapist will work with the allocated worker in Complex Care to support step-downs in care and support for people in long-term care and support provision.

This will include interventions such as:

• reviewing and assessing the needs for double handed packages of care and support to see if they can be reduce to single handed packages
• step-down from residential to other care setting
• increases in care and support for complex service users

If there is reablement/rehabilitative potential then the therapist will develop and agree the short-term care and support plan based on their assessment and understanding of how functional independence can be improved. They will lead the intervention and work closely with Complex Care, the provider of care and support, the user, carer, family and relevant others.

The goal is to step-down in care and support via reablement and therapeutic input so we can right sized package of care in the longer-term and improve the person’s wellbeing and independence, as well as supporting care in the least restrictive setting.

During this time it is important to actively manage the case/intervention and keep case notes and/or update any agreed plans in place e.g. care and support plan. The service user and others should be kept up to date and have the opportunity to feedback on their experience.

The outcome(s) will be:

• handover to complex care for on-going support/long-term package of care

4.5 Hospital Discharge Pathways

As part of effective discharge planning and to ensure delayed transfers of care are minimised and reduced a number of hospital discharge pathways have been agreed with clear criteria in place to inform the right discharge pathway.

The discharge pathways are outlined below:
An overview of how the pathways work in terms of decision making is outlined below:

**Pathway 0**
- **Non complex**
  - Patient medically optimised and ready to leave hospital, does not require support on discharge.
  - TTA’s, discharge letter and transport to be arranged if patient requires this support
  - Patient flow coordinators and ward staff to arrange discharge

**Pathway 1**
- **Period of assessment, D2A and/or rehabilitation**
  - Patient requires further assessment, rehabilitation or Reablement at home
  - Assessment and discharge notification to social work required or patient can be referred directly to D2A or Reablement from therapist to therapist and inpatient rehabilitation – refer to out of hospital discharge pathway
  - Patient may have short term equipment needs, or prescribed equipment on discharge

**Pathway 2**
- **Complex discharge**
  - Patient has complex health and/or social care needs requires support in the community, home or bed based care including interim nursing or residential care.
  - Patient has nursing care needs, requires CMC check list to be considered for health care funding. MDT decision to be made for CMC or Social Work referral pending check list outcome. Discharge without prejudice to be applied – pending agreement.
  - Patient requires adaptations or equipment to facilitate safe discharge
  - Patient has neurorehabilitation care needs – refer to stroke or neuro pathway pending.

**Pathway 3**
- **Palliative and End of Life Care**
  - Patient requires ‘fast track’ health care support at home and/or hospice
  - Patient requires palliative care and requires palliative care at home or hospital
  - Patient is End of Life Care (EoL) - refer to Barts Trust Compassionate EoL care pathway and EoL Rapid

**Figure 4 Hospital Discharge Pathways**
**PATHWAY 0-3: Overview**

**Non Complex: Pathway 0**
- Patient has been deemed medically optimised and does not require support on discharge.
- TTA’s, discharge letter and transport to be written/booked and completed by patient flow co-ordinators and ward staff.

**Period of assessment, D2A and rehabilitation: Pathway 1**
- Patient requires further assessment, rehabilitation or Reablement at home.
- Assessment and discharge notification to social work required or patient can be referred directly to D2A or Reablement from therapist to therapist and inpatient rehabilitation – refer to out of hospital discharge pathway.
- Patient may have short term equipment needs, or prescribed equipment on discharge.

**Complex discharge: Pathway 2**
- Patient has complex health and/or social care needs requires support in the community, home or bed based care including interim nursing or residential care.
- Patient has nursing care needs, requires CHC check list to be considered for health care funding. MDT decision to be made for CHC or Social Work referral pending check list outcome. Discharge without prejudice to be applied – pending agreement.
- Patient requires adaptations or equipment to facilitate safe discharge.
- Patient has neurorehabilitation care needs – refer to stroke or neuro pathway pending.

**Palliative and End of Life Care: Pathway 3**
- Patient requires ‘fast track’ health care support at home and/or hospice.
- Patient requires palliative care and requires palliative care at home or hospital.
- Patient is End of Life Care (EoL) - refer to Barts Trust Compassionate EoL care pathway and EoL Rapid.

**Flowchart**
- Patient admitted onto ward
- Nurses to complete patient admission form
- Clinical assessment by medical team reviewed at MDT
- Patient screened as to whether a period of assessment is required
- Is period of assessment required?
  - Patient to follow Pathway 0
  - Patient to follow Pathway 1
  - Patient to follow Pathway 2
  - Patient to follow Pathway 3
- Does the patient require complex health and social needs?
  - Patient to follow Pathway 1
  - Patient to follow Pathway 2
  - Patient to follow Pathway 3
- Will end of life care/palliative care be required?
5 Reablement Criteria, Referrals and Screening

5.1 Reablement Criteria

Reablement acceptance criteria

The reablement service is part of the new Independent Living Team and offers three pathways for people who have eligible social care needs with reablement and rehabilitation potential. People can receive support for a longer period than 6 weeks depending on the potential to maximise independence and function across the 10 Care Act outcome areas, but the service will be chargeable after 6 weeks depending on the outcome of a financial assessment. The three pathways are:

1. Reablement only – community and hospital referrals where there is reablement potential but no significant therapy-led support is needed, includes step down into George Mason Lodge beds.
2. Discharge to assess – hospital referrals where person is medically optimised on the ward and rehabilitation potential has been identified and agreed by hospital therapist and reablement therapist, includes step down beds at Ainslie.
3. Community recovery – community and hospital referrals for slow rehabilitative recovery requiring therapy-led care and support i.e. double handed to single handed care, step up in care post discharge, includes patients discharged who are on the community ‘step-down’ list.

The criteria:

- People who have had a full assessment of need to determine the impact on the 10 Care Act outcome areas. This covers both: community and hospital referrals. It is expected that a full assessment of need will be completed in the hospital by the social work team where a schedule 2 notification is raised and the person is likely to meet the national eligibility threshold prior to discharge. The outcome of the assessment will help to inform the correct discharge pathway for the patient as part of the multi-disciplinary meetings.
- Following the assessment people who are eligible for LBWF intervention (Care Act Eligibility Criteria) will be accepted. People who are medically optimised/mentally stable. People on a discharge to assess pathway must have rehabilitation potential and the hospital therapist and reablement therapist will agree needs to be met and areas to improve functional independence (should form part of discharge planning).
- Financial Assessment will be completed in the first four weeks and any plan of care and support that goes over 6 weeks may be chargeable based on the outcomes of the financial assessment.
- Reablement has been explained and client consents to referral and is aware that tasks outside of the reablement agenda (e.g. domestic tasks) are not completed by staff unless this is a realistic and agreed goal. Reablement will meet needs across the 10 Care Act outcome areas i.e. accessing community facilities and activities, developing and maintaining family and other personal relationships.
- People have realistic goals identified and agreed to improve or stabilise independence, function and/or quality of life. Staff in the Independent Living Team (Reablement Therapist or Social Care Assistant) will determine the amount of time needed to meet goals.
- Physically and cognitively able to participate in Reablement.
- Able to administer own medication with prompts if needed and in some cases medication may be administered.

Reablement exclusion criteria
- People who don’t meet the national eligibility threshold – where appropriate they may be referred to the Wellbeing and Prevention Team for low level social care support and products to improve wellbeing and prevent escalation and worsening of need.
- People with severe dementia/cognitive impairment who would be unable to participate or fully understand the Reablement programme and/or are unable to follow instructions.
- People who are medically or mentally unstable/unpredictable and where there is risk to the client or others which can’t be managed.
- People who lacks potential to improve functionally.
- People who are at the end of their life.
- People with on-going drug or alcohol abuse impacting on their ability to participate in Reablement.

5.2 Reablement Referrals

Referrals to reablement across the three pathways are received from two areas:

- Community referrals – referrals received from Business Support Contact Centre (customer services following an initial screening of an adult contact and enquiry and from our internal teams such as: Wellbeing and Prevention Team, Integrated Care Management Team or Complex Care Team (part of Specialist Social Work services)
- Hospital referrals – referrals are also received from Whipps Cross Hospital from; discharge to assess, Integrated Discharge Team and Ainslie Discharge Beds (32 rehabilitation beds)

Referrals for reablement from the hospital teams should be made by the Reablement Referral Form (a Word document) and emailed to: reablement@walthamforest.gcsx.gov.uk

Referrals from business support and internal teams should be made via the adult social care case management system Mosaic and tasked to the screening folder of ASC Independent Living Team.

5.3 Reablement Screening

Referrals will be screened within the Community Wellbeing and Independence Service and acceptance to reablement/rehabilitative care and support will be in line with the reablement criteria outlined in section 5.1.

Emailed (Paper) and electronic (Mosaic) referrals will be screened by the practitioners to determine the referral meets the acceptance criteria. If it does not it will be rejected and the referrer will be informed of the decision with the reason why it has been rejected.

For emailed referrals this will be by email or telephone and a case note will be added to Mosaic.

For electronic referrals if it is rejected this will end the ‘workflow’ and a case note will be added to Mosaic with the referrer added as an alert recipient (so they know the referral has been rejected)

Where the referrals is accepted then:

- Screener responds to referrer to communicate referral acceptance.
- Screener records a case note on Mosaic ‘Reablement: Referral acceptance and allocation’ with a brief summary.

For Discharge to Assess, Integrated Discharge Team, Ainslie rehabilitation beds the screener will:

- Screener starts an ‘Adult Enquiry’ on the clients Mosaic page, fills in any mandatory details and attaches the LBWF Reablement Referral to the Adult Enquiry.
• Outcome of the Adult Enquiry is a ‘Reablement Assessment’ which is tasked to an allocated worker in the independent living team to assess on the day of discharge or within 24 hours.
6 Reablement Case Allocation, Rostering, Scheduling and Case Management

6.1 Case Allocation

Cases will be allocated for new and existing social care users according to the pathway they are on and the type of involvement required. Allocations will be made and details of the allocated worker entered onto Mosaic.

Reablement Only Pathway

For service users on the reablement only pathway the case will be allocated to:

- Social Worker
- Social Care Assistant

Discharge to Assess Pathway

For service users on a discharge to assess pathway the case will be allocated to:

- Reablement Therapist
- Occupational Therapist

Community Recovery Pathway

For service users on a community recovery pathway the case will be allocated to:

- Occupational Therapist
- Reablement Therapist

Once a case has been allocated to a worker it will also be assigned a Reablement Officer (in-house) or an Independent Sector Provider who will provide the direct reablement care and support in the person home and in some circumstances outside of the home - this support will primarily be provided by the Social Care Assistants in the Team.

6.2 Rostering, Scheduling and Visit Recording

Once the case is allocated and assigned to a Reablement Officer we will be able to effectively roster and schedule care and support. We are increasingly moving away from a time and task approach to rostering and scheduling towards reablement care and support outcomes, recognising it is important to support people with personal care needs at certain times throughout the day and across the week.

To support the staff delivering care and support we will work on a ‘patch based approach’ across the Borough. The patches are outlined in the table below:

Table 2 Reablement Patches

<table>
<thead>
<tr>
<th>Borough</th>
<th>Wards</th>
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<tbody>
<tr>
<td>North</td>
<td>Chingford Green</td>
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<td>Endlebury</td>
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<td>Larkswood</td>
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<td>Hatch Lane</td>
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</table>
Allocated Caseworkers and Reablement Officers will cover specific wards within patches (where operationally possible) which will help with reducing non-contact time with service users by effectively managing; travel time, allowing greater time to be spent with service users delivering personalised care and support and providing service users with continuity of worker(s) – where possible and operationally feasible. Our goal is to ensure the same Caseworker/ Reablement Officer is available to work with the service users (and others) throughout their duration in short-term care and support.

Once the assessment and care and support plan is in place and agreed (allowing for temporary care and support arrangements to be in place and running while these are agreed) then care and support can be scheduled and rostered.

To support effective scheduling and rostering the London Borough of Waltham Forest uses the IT system CM2000 CallConfirm to schedule and roster staff with the details of visit requirements entered onto the system by Business Support staff and translated/sent to Reablement Officers. As we move increasingly to personalised care and support delivery we will review and optimise CM2000 based on our requirements.

In addition the CM2000 systems supports the recording/logging of visits to ensure they have taken place and there have been no missed calls – this is done through landline and can be done electronically through tags (near field technology) that the Reablement Officer puts their mobile phone against. If a call is missed or runs over an allocated time then an alert/flag is raised so follow up actions can be taken to ensure both the service user and Reablement Officer are safe – see Missing Person/No replies policy/procedures and Lone Working Policy.

Rostering for the provision of commissioned care (discharge to assess) will be the responsibility of the third party provider (independent sector provider) but delivery must be in line with the service users preferences and care and support plan.

### 6.3 Case Management

All cases should be actively case managed ensuring the service user, carer, family and relevant other parties are actively involved and we understand their preferences, social care needs and the outcomes important to them.

The allocated worker will hold the primary relationship and have overall accountability and will work closely with other members of the Independent Living team and others in internal adult social care.
and Council services e.g. Complex Care, Business Support and Customer Services and Brokerage and Commissioning, as well as third party provider in the voluntary or independent sector.

The allocated worker will then be responsible for all actions required such as:

- Assessment(s) including risk assessment, medicine assessment, specialist assessment (Functional Independence Measures) etc.
- Liaison with other relevant parties such as: hospital social work team, hospital therapist(s) and third parties providers of care and support (independent sector providers)
- Care and Support Planning and goal setting involving the user, carers and family
- Delivery of care and support in some cases (non-direct personal care)
- Ensuring appropriate equipment and other services (where required) are involved
- Provision of information and advice including; social work specific tasks
- Ensuring the service user has all relevant information
- Relationship management with the service user, carer, family and other relevant parties including feedback and engagement
- Ensuring care and support meets quality standards, regulations and best practice guidance
- Case note and progress updating
- Review
- Brokeage of care package if the person is to move into long-term care and support
- Case transfer to Complex Care Team
- Closing the case and ending reablement

### 6.4 Therapeutic-led Care Approach

The current reablement service is very effective in improving independence and reducing the need for long-term care and support, with over 75% of people who receive reablement support no longer needing managed care and support after 6 weeks. This is largely down to a therapeutic approach that maximises the person’s skills and independence.

However, what staff tell us is they sometimes need more than 6 weeks to work with service users and if they had more than 6 weeks they could make more progress with people on improving their functional independence – ability to perform daily living tasks and functions with less assistance. As part of a new way of working to deliver strengths based working and personalised care and support, instead of working with people for up to 6 weeks we may support people in short-term services for up to 20 to 24 weeks.

To support this significant change, we will be implementing a therapeutic care approach, where the therapist holding the case (Reablement Therapist or Occupational Therapist) will use their skills, experience and expertise to determine when our interventions have helped people to maximise their independence.

The outcome of this will be two-fold:

- People receive the right amount of care and support to maximise their independence and as a result do not require any further formal managed care and support
- People will have reached a peak level of functional independence but may continue to have assessed eligible needs that will be best met through long-term care and support – at this point the case would transfer from the Therapist to a Social Worker in the Specialist Social Work Service Complex Care Team.
7 Care Act 2014 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

7.1 Care Act 2014, other duties and eligibility

The Care Act (2014) introduced several key duties and responsibilities we need to deliver through our adult social care services and the delivery of our reablement/rehabilitative services must ensure we meet our duties and responsibilities. The key duties and responsibilities include:

- **Wellbeing** – ensuring we prevent, reduce or delay the need for care and support for all local people.
- **Information, advice and advocacy** – ensuring we provide high quality accessible information and advice and arrange independent advocacy if a person is unable to participate in, or understand, the care and support system.
- **Integration and transition** - collaboration, cooperation and integration with others e.g. health and housing and a seamless transition for young people moving to adult social care services.
- **Diverse care markets** – ensuring diversity, quality and enough care providers for people to choose from and supporting people’s care needs if a provider business fails.
- **Safeguarding** - new statutory framework to protect adults from neglect and abuse and setting up safeguarding adults' boards.
- **Assessment and eligibility** – ensuring vulnerable adults and a carer, who appears to need care or support, are entitled to an assessment. The assessment must focus on outcomes important to the individual. Any needs currently being met by a carer should still be included in the assessment. We must then apply a national eligibility threshold to determine whether the individual has eligible needs.
- **Charging and financial assessment** - If the type of care we are considering is chargeable, then we must carry out a financial assessment and where needed offer deferred payments.
- **Person centred care and support planning** - we must help and support the person to decide resources. The care and support plan or support plan for carers will outlines how needs and outcomes will be met and there is an expectation that needs and plans will be reviewed regularly.

In addition to our duties under the Care Act we have other duties to meet set out in legislation such as, Mental Health Act 1983 and 2007, as well as the Mental Capacity Act 2005.

7.2 Determining Eligibility under the Care Act

The independent living team offers reablement/rehabilitative support to people and carers who are ‘eligible’ for social care support.

**People with adult social care needs**

The Care Act sets out how to determine if the needs of the person are eligible needs using 3 conditions to help make the determinations. The three conditions are set out below:

**Condition 1**

The adult’s needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.

This includes if the adult has a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.
**Condition 2**

As a result of the adult’s needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section ‘Eligibility outcomes for adults with care and support needs’.

1. Managing and maintaining nutrition
2. Maintaining personal hygiene
3. Managing toilet needs
4. Being appropriately clothed
5. Maintaining a habitable home environment
6. Being able to make use of the home safely
7. Developing and maintaining family or other personal relationships
8. Accessing and engaging in work, training, education or volunteering
9. Making use of necessary facilities or services in the local community including public transport and recreational facilities or services
10. Carrying out any caring responsibilities the adult has for a child

The Social Care Institute for Excellence gives some examples of what the outcome areas mean:


Local authorities must also be aware that ‘being unable’ to achieve an outcome includes any circumstances where the adult is:

- unable to achieve the outcome without assistance. This includes where an adult would be unable to do so even when assistance is provided. It also includes where the adult may need prompting. For example, some adults may be physically able to wash but need reminding of the importance of personal hygiene.
- able to achieve the outcome without assistance but doing so causes the adult significant pain, distress or anxiety. For example, an older individual with severe arthritis may be able to prepare a meal, but doing so will leave them in severe pain and unable to eat the meal.
- able to achieve the outcome without assistance, but doing so endangers or is likely to endanger the health or safety of the adult, or of others. This would include, for example, cases where the health or safety of another member of the family, including a child, could be endangered when an adult attempts to complete a task or an activity without relevant support;
- able to achieve the outcome without assistance but takes significantly longer than would normally be expected. For example, a physically disabled adult is able to dress themselves in the morning, but it takes them a long time to do this, leaves them exhausted and prevents them from achieving other outcomes.

Local authorities must consider whether the adult is unable to achieve the whole range of outcomes contained in the criteria when making the eligibility determination.

There is no hierarchy to the eligibility outcomes – all are equally important.

**Condition 3**

As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing, determining whether:
• the adult’s needs impact on at least one of the areas of wellbeing in a significant way or
• the cumulative effect of the impact on a number of the areas of wellbeing means that they
  have a significant impact on the adult’s overall wellbeing.

The term ‘significant’ must be understood to have its everyday meaning, as it is not defined by the
Regulations. The wellbeing areas include:

• personal dignity (including treatment of the individual with respect)
• physical and mental health and emotional wellbeing
• protection from abuse and neglect
• control by the individual over their day-to-day life (including over care and support provided
  and the way they are provided)
• participation in work, education, training or recreation
• social and economic wellbeing
• domestic, family and personal domains
• suitability of the individual’s living accommodation
• the individual’s contribution to society

Carers

The Care Act also sets out how to determine eligibility for Carers too.

Condition 1

The carer’s needs for support arise because they are providing necessary care to an adult.

Carers can be eligible for support whether or not the adult for whom they care has eligible needs.

The carer must also be providing ‘necessary’ care (i.e. activities that the individual requiring support
should be able to carry out as part of normal daily life but is unable to do so). If the carer is providing
Care and support for needs that the adult is capable of meeting themselves, the carer may not be
providing ‘necessary’ care and support. However, necessary care includes care provided to support
needs that are not eligible.

Condition 2

As a result of their caring responsibilities, the carer’s physical or mental health is either deteriorating
or is at risk of doing so or the carer is unable to achieve any of the outcomes.

• Carrying out any caring responsibilities the carer has for a child
• Providing care to other persons for whom the carer provides care
• Maintaining a habitable home environment in the carer’s home, whether or not this is also
  the home of the adult needing care
• Managing and maintaining nutrition
• Developing and maintaining family or other personal relationships
• Engaging in work, training, education or volunteering
• Making use of necessary facilities or services in the local community, including recreational
  facilities or services
• Engaging in recreational activities.

Local authorities must also be aware that ‘being unable’ to achieve an outcome includes
circumstances where the carer:
• is unable to achieve the outcome without assistance. This includes where the carer would be unable to achieve an outcome even if assistance were provided. For example, a carer might be unable to fulfil their parental responsibilities unless they receive support in their caring role.

• is able to achieve the outcome without assistance, but doing so causes or is likely to cause significant pain, distress or anxiety. For example, a carer might be able to care for the adult and undertake full-time employment, but if doing both causes the carer significant distress, the carer should not be considered able to engage in employment.

• is able to achieve the outcome without assistance but doing so is likely to endanger the health or safety of themselves or any adults or children for whom they provide care. For example, a carer might be able to provide care for their family and deliver necessary care for the adult with care and support needs, but, where this endangers the adult – for example, because the adult receiving care would have to be left alone while other responsibilities are met – the carer should not be considered able to meet the outcome of caring for their family.

Local authorities must consider whether the carer is unable to achieve the whole range of outcomes in the eligibility criteria when making the eligibility determination.

There is no hierarchy to the eligibility outcomes – all are equally important.

**Condition 3**

As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the carer’s wellbeing, determining whether:

• the carer's needs impact on at least one of the areas of wellbeing in a significant way or

• the cumulative effect of the impact on a number of the areas of wellbeing means that they have a significant impact on the carer’s overall wellbeing.

The term 'significant' must be understood to have its everyday meaning, as it is not defined by the Regulations

### 7.3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Care and Support services generally fall into two categories:

- **Regulated Activity** – as defined under Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These services must be registered with the Care Quality Commission (CQC) and include services such as; personal care.

- **Exempted Activity** – there are a number of activities that are exempted from registration such as: individual budgets, individual user trusts and self-funded personal care and nursing care.

The providers of care and support need to be clear about the type of care and support they are delivering and whether as a result of that they need to be registered. To support providers in determining whether they need to be registered as it pertains to personal care the CQC have developed a ‘Decision Tree for Personal Care’ – see diagram below:
The Reablement and Rehabilitative service offered by the London Borough of Waltham Forest is providing personal care and therefore regulated activity and is therefore Registered.
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 established a set of Fundamental Standards, these are:

- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse and improper treatment
- Meeting nutritional and hydration needs
- Premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons employed
- Duty of candour
- Requirement as to display of performance assessments

A copy of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 follows.

7.4 Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.

The CQC purpose is:

“We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.”

They role is:

- register care providers.
- monitor, inspect and rate services.
- take action to protect people who use services.
- speak with an independent voice, publishing their views on major quality issues in health and social care.

Throughout their work they:

- Protect the rights of vulnerable people, including those restricted under the Mental Health Act.
- Listen to and act on people’s experiences.
- Involve the public and people who receive care
- Work with other organisations and public groups.

Their values are:

- Excellence – being a high-performing organisation
- Caring – treating everyone with dignity and respect
- Integrity – doing the right thing
- Teamwork – learning from each other to be the best we can
The CQC have five key lines of enquiry during and inspection of service, these are:

1. Is the service safe?
2. Is the service effective?
3. Is the service caring?
4. Is the service responsive?
5. Is the service well-led?
8 Consent and Information Sharing

8.1 Consent Form and Financial Declaration Form

The London Borough of Waltham Forest adult social care services has a clear approach to getting the appropriate consent from service users and/or relevant others.

The consent form covers a number of key areas such as:

- permission to share information
- receiving a copy of assessment and support plan
- acting on behalf of arrangements for people who lack capacity
- financial declaration

The Consent Form is attached and it is mandatory that a signed copy of this is in place to support service commencement and delivery.

8.2 The Caldicott Principles revised 2013

In 1997 the Caldicott Committee, chaired by Dame Fiona Caldicott, issued a report on the protection of personally identifiable information within the health services (includes social care). The report identified standards/principles to be implemented.

A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012.


The Caldicott principles are:

Principle 1 - Justify the purpose(s) for using confidential information
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2 - Don't use personal confidential data unless it is absolutely necessary
Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3 - Use the minimum necessary personal confidential data
Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

Principle 4 - Access to personal confidential data should be on a strict need-to-know basis
Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.
Principle 5 - Everyone with access to personal confidential data should be aware of their responsibilities
Action should be taken to ensure that those handling personal confidential data - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6 - Comply with the law
Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

8.3 Code of Practice on Handling Personal Information

The code of practice applies to:
- All LBWF permanent and temporary (including students) employees with access to personal information.
- All contractors / sub-contractors engaged by Waltham Forest Council with access to personal information.
- Every person obtaining or using personal information as part of his / her normal duties and responsibilities is required to comply with the provisions of this code.
- Preferred Provider agencies who deliver services on behalf of LBWF are expected to conform to their own code of practice on handling personal information.

A copy of the Code of Practice follows.

8.4 Data Protection Act 1988

The Data Protection Act 1998 seeks to strike a balance between the rights of individuals and the sometimes competing interests of those with legitimate reasons for using personal information. The DPA gives individuals certain rights regarding information held about them. It places obligations on those who process information (data controllers) while giving rights to those who are the subject of that data (data subjects). Personal information covers both facts and opinions about the individual.

Under the Data Protection Act, individuals can exercise what is called a subject access right - they can request to see the information about themselves that is held on both computer and on paper. If an individual wants to exercise this right, they should apply in writing to the person or organisation that they believe is processing the data.

A subject access request must be made in writing and must be accompanied by the appropriate fee (although this fee is waived where the request concerns Adult Social Care). The request must include enough information to (a) enable the person or organisation to whom the subject is writing to satisfy itself as to their identity and (b) to locate the information requested.

A reply must be received within 40 calendar days of the request being made. The data controller should act promptly in requesting any further information necessary to fulfil the request. If a data controller is not processing personal information of which this individual is the data subject, the data controller must reply saying so.

The Code of Practice on Handling Personal Information contains the procedure for handling Subject Access Requests.

8.5 Information Governance
Information Governance covers all areas such as information security, compliance, data quality assurance, and information management.

Information governance hinges on having a culture of Responsibility embedded across Council from the Chief Executive to the front line staff.

Information should be:

- Shared appropriately and legally
- Held securely
- Used effectively and ethically
- Obtained quickly and efficiently
- Recorded accurately and reliably

Definitions

Information security

This means protecting information and information systems from unauthorised access, use, disclosure, modification or destructions. It provides assurance of the confidentiality, integrity, accessibility of our information. By ensuring we have good information security this will enable us to know what information we hold, how sensitive it is and should access it.

Compliance

Being compliant with regards to our information means that we fulfil all of our statutory obligations in regards to the way in which we create, hold, transfer, archive and ultimately destroy our information. It also means that we make information available to our customers in accordance with the Data Protection Act 1998 and the Freedom of Information Act 2000.

Data quality

This means having confidence in our information and making informed decisions based on accurate and up to date information.

Good quality data is:

- Accurate
- Valid
- Reliable
- Timely
- Relevant
- Complete

8.6 Record Management

Records Management is a prominent issue for the council and whilst not in existence at the current time, the Corporate Information Governance Board will address records issues as a matter of course. Records Management, however, concerns all records and does not solely focus on Client Records.
Good records management is the basis for implementing FOI successfully and the Corporate Information Governance Board will be responsible for Corporate Records Management (the remit of this Board will include acting as a conduit back into the respective Directorates, identify the current situation with regards to records management, storage and problem areas.

The Records Retention Schedule (RRS) aims to provide a single point of reference for locating recorded information held by the Council and providing guidance on retention periods for those documents. This will promote consistent and efficient records management and will efficient compliance with Data Protection and Freedom of Information duties imposed on the Council.

Table 3 Client Services Records Management Schedules

<p>| “Looked after” children | | | |
|-------------------------|-------------------------------|----------------|----------------|----------|
| Children in Care/Looked After, who have been awarded damages | Kept until child eligible to manage own affairs | Paper | Statutory | P |
| | | | | Strategy &amp; Resources | Community Services |
| | | | | | |
| “Looked after” children client files (including residential care children files) | Destroy 75 years from 18th Birthday | Corporate | Social Services | Community Services |
| | | | | | |
| Children looked after who dies before reaching 18 years | Keep for 15 years after death | Corporate | Social Services | Community Services |
| | | | | | |
| Adoption files | Destroy 75 years from 18th Birthday | Corporate | Social Services | Community Services |
| | | | | | |
| Privately fostered children’s file | Destroy 75 years from 18th Birthday | Corporate | Social Services | Community Services |
| | | | | | |
| Guardian CAFCASS | Destroy 75 years from 18th Birthday | Corporate | Main file held by court | Social Services | Community Services |
| | | | | | |
| Guardian ad litem | Destroy 75 years from 18th Birthday | Corporate | Social Services | Community Services |
| | | | | | |
| Children and young people files subject to supervision orders | Destroy 21 years from DOB | Corporate | Social Services | Community Services |
| | | | | | |
| Adoptive parents counselling files | Destroy 21 years from DOB | Corporate | Social Services | Community Services |
| | | | | | |
| Approved adopters files | Destroy 25 years from DOB | Corporate | Social Services | Community Services |
| | | | | | |
| Foster care files | Destroy 35 years after carer has ceased to foster | Corporate | Social Services | Community Services |
| | | | | | |
| Supported lodging files | Destroy 35 years after carer has ceased to foster | Corporate | Social Services | Community Services |
| | | | | | |
| Child Protection Register | Permanent | Corporate | Social Services | Community Services |
| | | | | | |
| Case Management of adults convicted of Schedule 1 offences | Permanent | Corporate | Social Services | Community Services |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Retention Period</th>
<th>Ownership</th>
<th>Department</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child protection case files which contain conference minutes, core assessments, investigation and registration</strong></td>
<td>Destroy 75 years from 18th Birthday</td>
<td>Corporate</td>
<td>Social Services</td>
<td>Community Services</td>
</tr>
<tr>
<td><strong>Child protection files that contain initial assessment and advice only</strong></td>
<td>Destroy 5 years from closure</td>
<td>Corporate</td>
<td>Not automatic destruction seek advice</td>
<td>Social Services</td>
</tr>
<tr>
<td><strong>Case Management – General Children’s Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children in need where section 17 payments made</td>
<td>Last payment plus 3 years</td>
<td>Corporate</td>
<td>Social Services</td>
<td>Community Services</td>
</tr>
<tr>
<td>Individual case management of services/support to unaccompanied minors (eg Asylum seekers) if not “looked aft”</td>
<td>Destroy 10 years from closure</td>
<td>Corporate</td>
<td>Social Services</td>
<td>Community Services</td>
</tr>
<tr>
<td>Individual Case Management of services/support to 16+</td>
<td>Destroy 25 years from DOB or 10 years from last contact</td>
<td>Corporate</td>
<td>Social Services</td>
<td>Community Services</td>
</tr>
<tr>
<td><strong>Special Education Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statements of Special Needs under Education Acts or Disabled Persons Act 1986</td>
<td>6 years</td>
<td>Corporate</td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td><strong>Family Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual case management in provision of support by Local authority to families regarding parenting skills, special education, attendance records and project files</td>
<td>Destroy 7 years from file closure Paper and electronic</td>
<td>Corporate</td>
<td>EduAction</td>
<td>Life Long Learning</td>
</tr>
<tr>
<td>Assessing family’s suitability in the care of children</td>
<td>Destroy 25 years from DOB of child Paper and electronic</td>
<td>Corporate</td>
<td>EduAction</td>
<td>Life Long Learning</td>
</tr>
<tr>
<td><strong>Adult and Elderly case files</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Files</td>
<td>Destroy 7 years after last contact/assessment Paper and electronic</td>
<td>Corporate</td>
<td>Social Services</td>
<td>Community Services</td>
</tr>
<tr>
<td>Blind and partial sight registration</td>
<td>Keep until death plus one year</td>
<td>Corporate</td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td>Adaptations for people with a disability that SSD responsible for servicing (not Independence Equipment)</td>
<td>Keep while adaptation or equipment in use</td>
<td>Corporate</td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td>Equipment Referral Cards</td>
<td>4 years</td>
<td>Corporate</td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td>Blue Badge Applications</td>
<td>4 years</td>
<td>Corporate</td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td>Learning Difficulties Services</td>
<td>Keep until service users death plus one year</td>
<td>Corporate</td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td>Local Authority and Independent Sector Residential and Day Care</td>
<td>Keep until end of placement</td>
<td>Corporate</td>
<td>Financial records to be kept for 6</td>
<td>Community Services</td>
</tr>
<tr>
<td>Placements and Home Care files</td>
<td>plus one year, except.</td>
<td>years.</td>
<td>Community Services</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------</td>
<td>--------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Any file where an episode provides clear evidence of potential danger to self, staff or others</td>
<td>Review 3 yearly</td>
<td>Corporate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any file recording the death or serious injury of a user which may lead to legal action.</td>
<td>Review 3 yearly</td>
<td>Corporate</td>
<td>For example, a coroner’s enquiry.</td>
<td></td>
</tr>
<tr>
<td>Financial support under Community Care</td>
<td>6 years</td>
<td>Corporate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asylum Seekers (Single Adults and Children &amp; Families)</td>
<td>6 years from last payment</td>
<td>Corporate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Admission and Exclusions of case files

<table>
<thead>
<tr>
<th>Admission Appeals files</th>
<th>Destroy 3 years from last action</th>
<th>Paper and electronic</th>
<th>Corporate</th>
<th>EduAction/Democratic Services</th>
<th>Life Log Learning/Corporate Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion files</td>
<td>Destroy 3 years from first birthday of child</td>
<td>Paper and electronic</td>
<td>Corporate</td>
<td>EduAction/Democratic Services</td>
<td>Life Long Learning/Corporate Services</td>
</tr>
</tbody>
</table>

### Programme Management and Development

<table>
<thead>
<tr>
<th>Development of services/programmes for children</th>
<th>Destroy 7 years from closure</th>
<th>Corporate</th>
<th>Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of services/programmes to support development of children eg attendance records, course reports</td>
<td>Destroy 25 years from closure</td>
<td>Corporate</td>
<td>Community Services</td>
</tr>
<tr>
<td>Provision of services/programmes to support development of young people</td>
<td>Destroy 15 years from closure</td>
<td>Corporate</td>
<td>Community Services</td>
</tr>
<tr>
<td>Provision of services/programmes to adults</td>
<td>Destroy 7 years from closure</td>
<td>Corporate</td>
<td>Community Services</td>
</tr>
</tbody>
</table>

### 8.7 Social Care File Service

The Social Care File Service is based at Lockwood Way, Walthamstow. The current facility houses more than 40,000 archived Social Services client files and it is the intention that all closed client files will eventually be stored there together.

The service operates a retrieval system whereby files held by them are retrieved and delivered within three working days or less, wherever possible.

Further information on the London Borough of Waltham Forest policies and procedures in this areas can be found on ForestHub.
9 Triage, Assessment(s) and determining eligibility

The London Borough of Waltham Forest has an agreed set of Assessment and Triage Principles that we work to inform our practice and ensure that assessment is an open, transparent and engaging process.

9.1 Triage principles

Our approach to triage is not about ticking boxes to deal with a person’s enquiry or request for care and support. It is about having a person-centred conversation with the individual to understand the nature of their request and identifying how they may be able to resolve it or how others may be able to help such as family, friends and community based services. It is routed in the ‘three conversations’ approach – conversation 1 and 2.

Triage key principles include:

- Triage should be person-centred and focussed on understanding the root of the person’s request for help
- Triage should help us to identify the factors that means the person may be vulnerable and may need care and support or be at risk and need protecting from abuse or harm
- Triage should assist us to identify what may help to alleviate or worsen the person’s circumstances that led to a request for help
- Effective triage should help identify the potential solutions that can help meet the person’s request for help and manage any identified risks
- Effective triaging helps us to prioritise referrals
- The outcome of the triage process will be an evidence based decision that addresses the initial request for help and any identified factors that needed addressing

9.2 Assessment principles

Our approach to assessment is to engage the person and relevant others in the process of assessment to understand their presenting needs, identify risks and the outcomes that matter to them. Assessment should be proportionate and based on the presenting needs, risks and outcomes.

In some cases, this could be mean a light touch assessment is conducted that quickly identifies the person’s social care needs, any risks and the outcomes they want to achieve. Based on the information gathered a decision can be made with the person about how to meet their needs, manage the risks and facilitate the desired outcomes which can often be met through short-term interventions – conversation 2.

In other cases, the assessment process may identify the person has unmet eligible needs that are best met through the provision of long-term care and support – conversation 3.

Assessment key principles include:

- Assessment must be person-centred and encourage the participation of the individual, carer or relevant others i.e. family or advocates
- Assessment information and the assessment process should be inclusive and where required include the provision of information in accessible formats e.g. Braille and/or in different languages
- Assessment is not just a business process but a way in which we can explore the needs of a person and put in place interventions that may delay or reduce the onset of greater needs
- Assessment should be strength based looking at the capability of the individual and those around them as well as other support that may be available to them
- Assessment must be appropriate and proportionate and can be carried out in different ways i.e. face to face, telephone
- The assessment process starts at initial contact with the Council when we first start to gather information and continues throughout others parts of the customer journey i.e. reablement
- Assessments can be paused while services are put in place and dependent on the outcome restarted as required
- The Assessor must be appropriately trained
- The assessment process must be open, transparent and inclusive
- Where appropriate joint assessments may be required including partners and professionals i.e. health

9.3 Types of assessment

There are a number of different assessments that can take place with an individual before a referral to reablement/rehabilitative support and/or once accepted to reablement/rehabilitative support. These are:

- Self-assessment (on-line tool)
- Care Act Assessment (FACE Overview Assessment)
- Mental Capacity Assessment
- Best Interest Assessment
- Carers Assessment (FACE Carers Assessment)
- Risk Assessment
- Medication Assessment
- Specialised Falls Assessment (carried out by the Falls Prevention Service)
- Equipment and Assistive Technology Assessment
- Reablement Assessment (this is the FACE Overview Assessment which will be filled in separately or with a hospital therapist)
- Functional Independence Measure (FIM assessment separate or with hospital therapist)
- Occupational Therapy Manual Handling Assessment
- Financial Assessment

The purpose of the different types of assessment is to help us based on the involvement of the service user, carer, family and relevant others to get a full understanding of the service users and their presenting social care needs, the impact of those needs on Care Act outcome areas and wellbeing (see section 7.2) and outcomes that are important to the service user and involved others e.g. carer.

Some of the assessment used are primarily practitioner tools such as; FIM Assessment which is a basic indicator of severity of disability across a number of functional areas i.e. self-care, mobility, communication etc. The functional ability of a patient changes during rehabilitation and the FIM is used to track those changes. Functional change is a key outcome measure of rehabilitation episodes where we expect to see increased functional ability post intervention.

Please see copy of FACE Overview Assessment and FACE Overview Assessment Aide Memoire

9.4 Approach to determining eligibility

Based on the information gathered from our proportionate assessment, our understanding of the impact of the needs on individual outcome areas and/or carer’s outcome areas, and the impact on
the individual’s wellbeing we can identify eligible and non-eligible need in line with the National Framework.

When determining eligibility for individuals and carers we will do so in line with statutory requirements around eligibility. The Social Care Institute for Excellence has clear guidance around the thresholds and criteria for both individuals and carers:


In the delivery of our services we will meet both eligible needs and non-eligible needs:

- **Eligible needs** – needs that may best be met and funded (in whole or part) by the Council through the provision of short-term care and support i.e. *reablement* and/or provision of bespoke equipment and adaptations.
- **Non-eligible needs** – needs that may be met and funded (in whole or part) by the Council because in providing wellbeing and prevention support the presenting needs do not lead to a more significant impact on a person’s wellbeing or a worsening and deterioration in their ability to manage their conditions and needs (prevent, delay or reduce)

The aim is to **ensure where we can and where it is appropriate we try and meet eligible needs firstly through the provision of short-term care and support** where it is reasonable to do so.

However, there may be people who following assessment have eligible needs that would be best met by arranging a long-term package of care and support immediately e.g. people on an end of life care pathway or people with significant complex needs. In these cases, it is appropriate to refer them straight to Complex Care Teams and arrange long-term packages of care without going through the wellbeing, prevention and independent living offer.

We expect the numbers of new cases (community and hospital) going straight into long-term packages of care to decrease significantly as the implementation of the service offer in wellbeing, prevention and independent living roll out and the new approaches and ways of working embed into every day practice.

The outcomes of the financial assessment will help us make a decision around the person’s eligibility for Council funding to meet their eligible needs and outcomes or determine whether the person will need to contribute in part or full after 6 weeks free short-term care and support if they remain in short-term services for longer than 6 weeks.
10 Financial Assessment and Fairer Contribution Policy

10.1 Fairer Contribution Policy

The London Borough of Waltham Forest Fairer Contribution Policy is set in line with the following statutory and regulatory context:

- Sections 14-17 and 69-70 of the Care Act 2014 which sets out a single legal framework for charging users and carers for their care and support. This section of the Act covers the legislation for charging those in residential care and individuals receiving care and support provided in the community.
- A local authority has the discretion to choose whether or not to charge service users and carer's under section 14 of the Care Act 2014 following a person's needs assessment or a carer’s support need. Where a Council does charge it must follow the Care and Support (Charging and Assessment of Resources) Regulations 2014 and have regard to the Care and Support Statutory Guidance 2014.

Regulation

Guidance

The Fairer Contribution Policy sets out exceptions within the policy – see attached policy document, one of which is not charging for reablement services for a maximum of 6 weeks.

“The Local Authority must not charge for the following types of care and support which must be arranged free, namely;

- Intermediate Care Services (including reablement services) for a maximum of 6 weeks”

10.2 Financial Assessment

To determine what the contribution should be the Council carries out a financial assessment. The process is:

- The resident’s financial circumstances will be considered at the time of the assessment of need. Each resident will be required to have a means-tested financial assessment based on their income and expenditure in order to assess their ability to contribute towards the costs of their care and support services.
- The Council will complete a financial assessment for all residents unless:
  - A light touch assessment applies; or
  - They are in receipt of a flat rate service only.- a flat rate contribution will apply
- A financial assessment will be undertaken at the earliest opportunity after the initial needs assessment and approved Personal Budget.
- A financial assessment form will be given to the resident or one will be sent with a letter outlining what financial information is required to complete the financial assessment.

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1 Fairer Contribution Policy – Non-residential care and support and personal budgets - 2017
• Where required the resident will be visited at home and a full benefits check, advice and practical support to apply for benefits they may be entitled to is provided. Basic signposting is offered to self-funders.
• Where the individual has capital over the maximum amount, currently £23,250, they can disclose that their capital is over the limit without disclosing further information. In these circumstances the contribution will be based upon the cost of the care and support service.
• A non-disclosure assessment will be applied where a resident assessed with eligible needs:
  o Refuses to complete a financial assessment; or
  o Fails to keep two pre-arranged meetings organised for the purpose of obtaining the necessary information for a financial assessment or review; or
  o Fails to provide proof of income, expenditure or assets within 7 working days of the request from the Council.
• However in cases where the individual lacks capacity or is unable to provide the financial information, the Council may use their discretion to apply a provisional contribution until a full financial assessment can be completed and a retrospective contribution applied.

See The Fairer Contribution Policy 2017 for further information on contributing to the cost of care and financial assessment.

10.3 Financial Protection

It is important that both service user and staff are protected when dealing with service user’s financial matters and handling money. The London Borough of Waltham Forest reablement service has a policy in place for dealing with service user’s financial matters and handling money – see policy that follows.

The aim is to ensure that service user’s money is protected and safely handled and that Reablement Officers are not put in a position that would compromise them or leave them open to allegations of financial abuse.

See Policy ‘Handling Money and Financial Matters on behalf of Service User’
11 Health and Safety at Work

11.1 Health and Safety at work

The London Borough of Waltham Forest is a responsible employer and strives to ensure people are safe at work and work in a healthy and safe environment. – see Health and Safety at Work Policy.

Additional information on policies and procedures related to health and safety at work can be found on ForestHub:


11.2 Health and safety training

The Council takes reasonable precautions and works closely with managers and others to ensure people have the correct training and equipment to do their jobs including an understanding about people’s disability and impairments.

Staff training – Reablement Officers have the following training (not limited to):

- risk assessment awareness training
- first aid at home
- infection prevention and control
- managing behaviours that challenge
- manual handling training
- fire safety training
- diabetes awareness
- dementia awareness
- fluid and nutrition
- food hygiene

11.3 Infection Control and Provision of Personal Protective Equipment

It is important as part of our health and safety approach and risk management approach that we prioritise infection control management and protect users, carers and staff effectively. We want to minimise the incidents of infection and prevent the spread of infection dealing appropriately with any outbreaks, spillages and personal care needs such as: continence – see Infection Control Policy

To minimise incidents of infection and reduce and prevent spread it is important we work closely with all parties that may/are involved in care and support, such as; carers, family and allied agencies such as; health colleagues and GPs.

In addition to reporting and management procedures staff are also provided with a range of personal protective equipment (PPE) to support the delivery of care and support and prevent the spread of infection. These include:

- suitable clothing
- disposable gloves
- general purpose utility gloves
- disposable plastic aprons
- face masks and eye protection
The provision and use of PPE is freely available with sufficient stocks in place and easy access for staff.

**11.4 Lone Working Policy**

The Council is committed to protecting staff when carrying out their duties and responsibilities especially when they are away from an office base and working in people’s homes and communities.

The definition of a lone worker is:

“A worker whose activities involve a large percentage of their working time operating without the benefit of interaction with other workers for support”

This includes our Reablement Officers who fit the above definition. The Lone Working Policy is intended to ensure that our Reablement Officers can safely perform their duties and are not placed at any avoidable risk of harm by the fact they are working in the community alone and to ensure emergency response measures are in place.

**Please see the Lone Working Policy.**
12 Risk management approach

12.1 Risk management approach

There are two main areas we are concerned with when we talk about identifying and managing risk, these are:

- identifying and managing risk as it relates to the person’s capacity and capability to understand reasonable risk and make informed decision that balance the individual’s choice and control against the risk of harm, abuse or neglect
- identifying and managing risk associated with the practical delivery of care and support such as; the risk of falling, manual handling risks and risks associated with the caring environment e.g. access

Our approach is about promoting the best solutions that maximise independence, safety and wellbeing and involves and consults with the service user, carer and wider informal care networks to ensure people’s care and support needs and outcomes are effectively met.

Therefore it is important that we develop different approaches and solutions to identify and manage risk to get the optimum balance between individual choice and control and risk management and mitigation.

12.2 Identifying risk(s)

A risk is: something that may happen as part of the person’s disability/impairment, work undertaken with the person as part of the care and support plan or the result of the environment in which care and support is delivered that if it happened may cause harm to the person or carer (Care Worker) that may be low, moderate or severe.

We have a number of ways we can do this and several processes/tools to help users, carers and staff identify risks, quantify the impact of risk(s) and develop plans to mitigate risk.

The processes and tools include:

- The care assessment – identifying and understanding presenting needs and the impact of needs on Care Act outcomes (ability to carry out a range of daily living, family, economic and community activities) and wellbeing
- Reablement referral form – initial identification of risk i.e. medication ability, home safety and mental capacity
- Reablement assessment form – specific sections of the reablement assessment form focussed on identifying:
  - access issues that may present a risk
  - functional ability and risks associated with this e.g. falls risks, mobility and transfer risks
  - how risks will be managed and whether unaddressed they may lead to a safeguarding concern
- Specific risk assessment form(s) such as:
  - specialised falls assessment
  - medication risk assessment
  - infection risk control

12.3 Risk mitigation

Once a risk is identified it is important that we identify and assess how the risk can be mitigated.
Risk mitigation is: taking action to ensure that an identified risk does not happen therefore becoming an issue, which may be an accident or near miss incident.

There are several ways we can mitigate identified risks based on the risk assessment, discussion with the user and others and based on previous experience and professional skills, these include (but are not limited to):

- raising awareness with the service user, carer, family and relevant others about the potential risks associated with their disability/impairment, care and support and/or home and surrounding environment
- prompting service users to ensure that any identified mitigating actions (to eliminate or reduce risk) are undertaken
- supervising users during activity to ensure awareness and actions address risk e.g. using a walking aid if there is a risk of falls
- actively supporting the person during care and support to avoid risk and/or minimise risk e.g. medication administration
- providing appropriate equipment to mitigate risk and better manage and enable response should the risk materialise i.e. use of assistive technology (pendant alarms/active monitoring), tipping kettles, walking aids etc.
- changing and adapting the home environment to better mitigate and manage risk e.g. provision of hoists and equipment to support manual handling, moving furniture, widening doorways, fitting grab rails etc.

12.4 Accident and incident reporting

Not every mitigating action will reduce risk for users and staff and sometimes accidents and/or incidents will happen – how we respond is important.

If you are in doubt please consult your manager

The purpose of accident and incident reporting is to:

- comply with the law, specifically the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- investigate the causes of accidents and take appropriate corrective action to make the workplace safer
- provide appropriate support to employees that are involved in an accident or incident
- monitor accident and incident trends to prevent recurrences

Accidents and incidents are recorded on the appropriate accident form (hard copy) or via the SAP ICT system.

Additional information on accident and incident reporting can be found on ForestHub:

13 Medicine Management


The regulation make several mentions of medication under the standards, these are:

Safe care and treatment

- where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;
- the proper and safe management of medicines

The management and safe use of medications should be seen in the wider context of the regulations and as a key part of risk assessment and care and support planning.

13.2 NICE Guidance

The National Institute for Health and Care Excellence (NICE) has issued guidance for the provision of intermediate care including reablement. This is available on the NICE website:

https://www.nice.org.uk/guidance/NG74

The guidance includes the provision of an interactive flowchart.

The interactive flowchart for managing medicines for people receiving social care in the community overview can be found at:


Attached is NICE Guidance on:

- Managing medicines for people receiving social care in the community overview
- Ordering, transporting, storing and disposing of medicines for people receiving social care in the community
- Supporting people receiving social care in the community to take their medication

In the care and support planning and risk assessment section there are references to medication:

When planning the person's intermediate care:

- assess and promote the person's ability to self-manage
- tell the person what will be involved
- be aware that the person needs to give consent for their information to be shared
- tell the person that intermediate care is a short-term service and explain what is likely to happen afterwards.

Carry out a risk assessment as part of planning for intermediate care and then regularly afterwards, as well as when something significant changes. This should include:

- assessing the risks associated with the person carrying out particular activities, including taking and looking after their own medicines
• assessing the risks associated with their environment
• balancing the risk of a particular activity with the person's wishes, wellbeing, independence and quality of life.

There is more specific information related to medicine management for people living in a residential care home that we need to be aware of: for recommendations on supporting people in residential care to take and look after their medicines themselves, see what NICE says on managing medicines in care homes and medicines optimisation.

Complete and document a risk plan with the person (and their family and carers, as appropriate) as part of the intermediate care planning process. Ensure that the risk plan includes:

• strategies to manage risk; for example, specialist equipment, use of verbal prompts and use of support from others
• the implications of taking the risk for the person and the member of staff.

13.3 Management of medicines – Joint Policy CCG and Adult Social Care

The purpose of the joint policy between the CCG and Adults Social Care is to promote the safety, independence and wellbeing of service users and to protect them against any risks in supporting them by clear reporting and recording. The aim of the policy is:

• To promote independence by encouraging people to manage their own medicines as far as they are able
• To help people remain in their own homes and prevent avoidable admissions to care homes or hospital. This is achieved by supporting people with their medication appropriately.
• To ensure that staff use the safest possible practices when supporting people with their medication and in accordance with the current legislation and guidance.

This policy must be read and complied with by all members of staff who are involved in the assessment of a person's care needs and all members of staff who are involved in supporting the person with their medication at any level.

The policy takes account of guidance issued by the Care Quality Commission (CQC), guidance from The Royal Pharmaceutical Society, guidance from the United Kingdom Home Care Association (UKHCA) and good practice.

The aim of the service is to promote the independence of the person (service user) receiving support by consulting with them or their representative. The service will endeavour to support the service user to maintain control over their own medication and with consent the service provider will seek support from the other relevant agencies to explore all opportunities for maintaining independence.

The Policy is currently going through a governance process and is expected to have a final revision and go live April 2018.

See Management of Medicines Policy.
14 Person-centred Care and Support Planning

14.1 Person-centred care and support planning - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The regulations on person-centred care state:

1. The care and treatment of service users must--
   a) be appropriate,
   b) meet their needs, and
   c) reflect their preferences.
2. But paragraph (1) does not apply to the extent that the provision of care or treatment would result in
   a) a breach of regulation 11.
3. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include--
   a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user;
   b) designing care or treatment with a view to achieving service users’ preferences and ensuring their needs are met;
   c) enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment;
   d) enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible;
   e) providing opportunities for relevant persons to manage the service user's care or treatment;
   f) involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's care or treatment;
   g) providing relevant persons with the information they would reasonably need for the purposes of sub-paragraphs (c) to (f);
   h) making reasonable adjustments to enable the service user to receive their care or treatment;
   i) where meeting a service user's nutritional and hydration needs, having regard to the service user's well-being.
4. Paragraphs (1) and (3) apply subject to paragraphs (5) and (6).
5. If the service user is 16 or over and lacks capacity in relation to a matter to which this regulation applies, paragraphs (1) to (3) are subject to any duty on the registered person under the 2005 Act in relation to that matter.
6. But if Part 4 or 4A of the 1983 Act applies to a service user, care and treatment must be provided in accordance with the provisions of that Act.

14.2 NICE Guidance

NICE has published a set of guideline (2017) on Intermediate care including reablement – see attached/following document.

The guidelines set out a number of key areas for consideration such as:

- Core principles
A key component/consideration is the delivery of person-centred care and support that recognises the individual, their preferences, culture, gender and ethnicity, their social care needs (personal care and others) and their outcomes, as well as the way in which they want care and support to be delivered.

14.3 Person-centred care and support planning

The London Borough of Waltham Forest is committed to the delivery of high quality person-centred care and support. This commitment is reflected in:

- our values
- the design and delivery of our services
- in our recruitment and retention of staff
- in our workforce development strategy
- in our training and development
- in our practice and analysis of service user feedback
- In our quality assurance and audit process

Following the referral and assessment process we will have worked closely with the service user, carer, family and relevant others to build up a comprehensive and rich picture of the person and their informal care network and how this works.

Through the assessment process which should be fully engaging of the service user, carer, family and relevant others we will have gained a clear understanding of their presenting needs, the impact of those needs on a range of areas e.g. the Care Act 10 outcome areas such as; nutrition and hydration, personal hygiene, toileting, maintaining a habitable home environment, making use of necessary facilities in the community and the further impact on the person’s wellbeing.

In addition we will have explored with the person other areas that will inform the care and support plan such as: risks that may affect care and support, the person’s medication needs and health conditions that may have an impact/effect on the delivery of care and support, as well as the potential to work with the service user, carer, family and relevant others on ‘goal setting’ and the achievement of goals and outcomes important to the person.

The care and support plan is a living document and will almost certainly change as care and support is delivered and either; functional improvements are made which mean care and support maybe stepped down (reduced over the duration of reablement/rehabilitative support) or if circumstances change unexpectedly e.g. hospital readmission or increased severity of illness/impairment care and support may be stepped up (increased or delivered in a different setting i.e. step down beds) or in some cases ended e.g. person moves into long-term care and support such as home care or into residential care.

It is important that care and support plans are regularly reviewed and actively and dynamically case managed – see case management section 6. Part of our quality assurance approach and quality audits will address care and support planning practice evidencing how our practice aligns to Regulations, Guidelines and Best Practice and our own commitments.
Gathering feedback from service users, carers, family, relevant others and staff will be a key part of person-centred care and support planning, ensuring we analyse the feedback and action any areas where improvement is needed.

A copy of the Care and Support Plan is attached/follows.
15 Safeguarding and Deprivation of Liberty Safeguards

15.1 Safeguarding and Deprivation of Liberty Safeguards Service

The Safeguarding Adults and Deprivation of Liberty Safeguards Service leads on the multi-agency partnerships safeguarding Adults and DoLS strategy and governance to ensure statutory responsibilities are met to optimise the safety, well-being and quality of life of individuals, ensuring ‘safeguarding adults is everyone’s business’.

Safeguarding in Waltham Forest is overseen by the Safeguarding Adults Partnership Board (SAPB). The SAPB meet regularly to discuss and act upon local safeguarding issues and develop shared plans for safeguarding. The safeguarding plan is published and the SAPB report annually on progress.

The Safeguarding Adults and Deprivation of Liberty Safeguards service supports people over the age of 18 to protect them from abuse and neglect.

A key responsibility of the service is Deprivation of Liberty Safeguards (DoLS), ensuring that the Human Rights of individual are upheld and work is in accordance with relevant legislation and guidance.

Best Interest Assessors will undertake independent Best Interest Assessments and Mental Capacity Assessments related to the Deprivation of Liberty process, in accordance with relevant legislation, policy, statutory guidance and case law. In addition they will also be responsible for advising staff and partners, delivering training, and actively working with care homes, hospitals and health partners in delivering the Council’s statutory duties.

The service is accountable for:

- providing leadership around Adult Safeguarding and Deprivation of Liberty Safeguards
- ensuring vulnerable adults are protected from abuse and neglect
- embedding making safeguarding personal across the partnership
- community engagement to raise awareness of and get view on safeguarding issues
- champion and embed an ‘improving practice framework’
- effectively manage ‘establishment concerns’ to ensure the quality of care provided and that safeguarding concerns are appropriately actioned
- undertake independent best interests assessments and mental capacity assessments in relation to deprivation of liberty process
- promotion of the human rights of individuals in line with statutory requirements
- preparation of specialist professional assessments and other documentation for presentation in the Court of Protection
- attendance at the Court of Protection
- provide information and advice to support to colleagues working on safeguarding concerns, enquiries and plans
- arrange independent advocates to support people in section 42 safeguarding enquiries
- reporting on safeguarding activities and outcomes

15.2 Safeguarding Policy and Procedures

The London Borough of Waltham Forest is part of the Pan London Multi-agency safeguarding procedures – see attached London Multi-agency Safeguarding Policy and Procedures.
In addition to working within the Pan London agreement the London Borough of Waltham Forest has a number of relevant Safeguarding documents, these include:

- Safeguarding adults at risk policy and procedures – Operation Guidance Manual
- LBWF multi-agency self-neglect policy
- Deprivation of Liberty Safeguards code of practice
- Waltham Forest Violence Against Women and Girls Strategy

A number of documents and forms are available on the London Borough of Waltham Forest public website for information and completion. These can be found through the following link:

https://directory.walthamforest.gov.uk/kb5/walthamforest/directory/advice.page?id=7TTu6wnSTXU

15.3 Safeguarding training and development and advice and information

All staff receive in-house training in Safeguarding, as well as training to raise awareness around Mental Capacity.

Frontline staff delivering services must have the confidence to raise any safeguarding concerns and as well as knowing the process for doing this they should be able to access information and advice and support for decision making. This can be provided from the Safeguarding and Deprivation of Liberty Safeguards Service or from colleagues within the Independent Living Team where there are 5 FTE qualified social workers as part of the team.

Any serious safeguarding incidents may involve the police and CQC would be alerted.

Any safeguarding concern, enquiry and investigation, alongside any action plan must make safeguarding personal and put the person at the centre.

15.4 Missing persons, vulnerable adults come to notice and no replies

There is a process in place for organisations to notify others agencies around vulnerable adults. Organisations such as the Police, London Ambulance Service and London Fire Brigade often come across vulnerable adults in the course of their duties.

The Metropolitan Police Service (MPS) in carrying out its duties records and assesses the information it receives from operational activity in relation to vulnerable adults, vulnerable by means of; mental health, age, illness and disability and where a safeguarding concern is raised.

This information is recorded on the MPS Merlin Information System under the category of ‘Adult Come to Notice’. The MPS Merlin Information System holds a broader set of data and information than just ‘adult come to notice’. It is used to record and assess children coming to notice and missing persons.

The information is reviewed and assessed by the Public Protection Desks who risk-assess the information and as appropriate refers it to the local authority. These are received by the Local Authority and are referred to as: Police Merlins. There are two sets of forms that can be received known as ‘Form87F’ which is; RISK ASSESSMENT (CASCADEINFO) and ‘J2 form78’ which is; Notification of Pre-Assessment Checklist’. Similar information is received from the London Ambulance Service and London Fire Brigade.

The adult Merlins are uploaded by Children’s Services Front Door Business Support Officers onto the adult’s case management system Mosaic. A Senior Practitioner from Adult Social Care screens the Merlins and confirms the action to be taken.
As such; Police Merlins related to ‘adult come to notice’ are received in the ‘AdultMASH’ inbox as pdfs of Form87F and J2 form78.

Approximately 300 plus Adult Police Merlins are received and processed each month. If the person is already known i.e. a reablement service user then an alert will be flagged in the case management system. The majority of adults come to notice contacts are recorded and do not require any significant action, although about 5% turn into safeguarding enquiries.

In addition to missing persons and adults come to notice we need to deal with appointments where there are ‘no replies’ and there is no known reason for it. If a service user is away from home or admitted to hospital generally the reablement service will know about it and appointment visit can be cancelled and rescheduled for the person’s return.

However, sometimes a Reablement Officer will visit a home for the pre-arranged appointment and when they turn up there is ‘no reply’ or we know the person is in but refuses to answer the door. On these occasions it is vital that we know the person is safe and well, we are often dealing with people at risk of falls or who are significantly disabled and often ill.

It is important to prioritise this work and alert appropriate people that there is a no reply so action can be taken. If appropriate and required we should contact the next of kin to ascertain if they know where the person is or what may be happening. If the person cannot be located then we may need to trigger an urgent response or raise a safeguarding concern and if necessary involve emergency services.

The process for dealing with ‘no replies' is attached/follows.
16 Complaints, Quality Assurance and Contract Management

16.1 Complaints - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The regulations related to receiving and acting on complaints states:

1. Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.
2. The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.
3. The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of--
   a) complaints made under such complaints system,
   b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and
   c) any other relevant information in relation to such complaints as the Commission may request.

16.2 Complaints policy and procedure

The London Borough of Waltham Forest has a corporate complaints process.

The complaints process is set out below (taken from the public website):

“Acknowledgement

We send an acknowledgement to you within three working days of receiving your complaint. This applies to all complaints.

Stage 1 - Responding to your complaint

We will send a response within 20 working days from receiving your complaint.

Responses to statutory social services complaints in relation to children’s services are issued within 10 working days.

Escalating your complaint to stage 2

If you’re unhappy with the first response to your complaint, then you can escalate this to a stage 2 complaint using the complaints online form.

When you complete the form, please tell us that it’s a stage 2 complaint and provide the reference number of the original Stage 1 complaint. This will speed up the process of logging and acknowledging your complaint.

Stage 2 complaints are investigated by the Council’s corporate Complaints Team on behalf of the Council’s Chief Executive. The Council has 25 working days to respond to Stage 2 complaints.

Please note:
There is no Stage 2 escalation process for Statutory Social Services complaints about Adult Social Care. When the Stage 1 process is completed, you can escalate your complaint to the Local Government Ombudsman.

The Local Government Ombudsman or Housing Ombudsman Service

If you remain dissatisfied with the council’s response after completing the corporate or statutory complaint procedures, you will have the right to escalate your complaint to the Ombudsman.

We'll tell you which ombudsman to contact as part of our response to your complaint.

The adults social care directorate has a specific process for dealing with complaints and enquiries from elected members (Councillors) – see attached.

The information the reablement/rehabilitative support service shares with service users, carers and family around complaints is outlined below:

“We hope that the experience of the Reablement Team has been a positive one, but problems can arise, which we will wish to learn about and take action.

In the first instance we would wish that you speak to your Senior Reablement Officer, so we can resolve any issues informally. However, if you wish to formally complain or are not satisfied with our initial response, you have a right to do so. Please contact the complaints team for more information on how to make a complaint:

The Complaints Manager, Waltham Forest Adult & Community Services, Freepost London 1081 London E17 5BR - Phone: 020 8496 3247-3248, fax: 020 8496 3659, Minicom: 020 8496 3010 or

Alternatively, you can contact the Care Quality Commission:
103-105 Bunhill Row London EC1Y 8TG - Phone: 03000 616161, email: enquiries@cqc.org.uk"

16.3 Learning for complaints – service improvement

The importance of learning from complaints (and feedback in general) is essential to drive forward service improvement and ensure we can avoid a repeat of errors, omission or practice that fails to meet regulations, guidance and best practice. It will help us to ensure the service is safe, responsive and caring.

Following the complaints process we will analyse complaints and involve a range of staff in reflective practice to see what could have been done differently such as: better communication, improved service delivery, better case management and relationship management etc.

The outcome of the analysis and reflective practice will be shared with the wider staff team through: team meeting and in some cases supervision.

16.4 Quality Assurance

The adult social care directorate is part of the wider Families and Homes portfolio of services that includes; children’s and family services and has a Principal Social Worker that covers both children’s and adults. The Adult Social Care Quality Assurance approach is closely connected to a number of wider Council policies to ensure practice across staff groups meets required standards, regulations, guidance and best practice.

These include:
The Performance Management Framework
Competencies Framework
Practice Standards
Regulatory Standards and Guidance

Having timely, frequent and meaningful supervision and appraisal is critical, mixed with reflective practice, practice observation, team meeting and learning session is key to ensuring we meet Council requirements and external requirements around professional registration and regulations, standards and guidance.

Additional information can be found on ForestNet at the following link:

http://forestnet.lbwf.gov.uk/index/hr/working_learning_and_developing_with_the_council/working_learning_and_developing_with_the_council_policies_and_related_documents/pmd_scheme-2.htm#competencies

Please see Adult Social Care Quality Assurance Approach

Quality monitoring

The following information is shared with the service user, carer, family and relevant others to let them know about the service’s quality monitoring arrangements:

“We hope that by the end of your Reablement Service we have enabled you to become more independent and that the team supporting you have delivered excellent person-centred support

In order to continually improve our service we would like you to complete the quality questionnaire, which can be found at the end of your booklet

It is important to us to learn about your experience of using our service and also suggest improvements

This feedback will mean we can make changes for the future and appreciate your co-operation in completing this form

It is intended we collect this confidential form at your review together with your support plan folder

Our service is inspected by the Care Quality Commission (CQC) on a regular basis, who ensure we are meeting standards required.”

To ensure practice meets the standards of professional practice associated with registration and our practice standards there are several types of quality audits that will be used:

- Statutory returns against national performance indicators – our position against other London boroughs and wider local authorities
- Reflective Practice for professional – evidencing their own practice to maintain registration
- Checklists – audits against specific areas of practice such as; completion of assessment, care and support plans etc.
- Mock inspection – against key lines of enquiry such as: CQC key lines
- Inspection – formal inspection of services

16.5 Continuous Service Improvement
It is vital that we use feedback, observation and the outcomes of audits and inspection to drive continuous service improvement within adult social care. Service users and carers are at the heart of our service and the Council has ambitious plans to transform both its services and the outcomes for residents.

A process of analysis, evaluation and lesson learned will be deployed supported by internal adult social care staff and wider staff in the Council with a responsibility for service improvement and quality assurance.

**16.6 Contract Management**

Some reablement service provision is commissioned from third parties, namely independent sector providers, as part of a broader commissioning approach. The case will be held by the Council who maintains responsibility for managing referrals, screening, triaging, assessment and person-centred care and support planning, as well as assuring service delivery, alongside quality assurance and audit arrangements.

The direct delivery of care (regulated activity) is delivered by the commissioned provider and as part of the commissioning of service and contract management arrangements the Council needs to be sufficiently assured the provider is meeting regulations, standards and guidance. This will be through review of CQC reports and any enforcement notices and contract management arrangements in place for providers.
17 Ending reablement, brokerage and transferring reablement users

17.1 Ending reablement

The reablement and rehabilitative care and support provided is for a short-term period and the first 6 weeks is not chargeable. There are several reasons why reablement and rehabilitative care and support may end, these are:

- eligible social care needs worsen due to their disability, impairment or illness/condition and the person’s needs would be better met in long-term care and support
- the person is admitted to or re-admitted to hospital
- the person moves out of the borough and our involvement may end (or the case transfer)
- the person refuses service
- the person is ‘passes away’ during provision (deceased)
- the person makes sufficient improvement in independence, their recovery or rehabilitation and no longer requires adult social care managed support for their needs and outcomes

It is important to work closely with the service user, carer, family and involved others when reablement is likely to end so people can make informed choices and decisions, such as; whether to arrange and self-fund their care and support if the financial assessment showed they would need to fully contribute to any on-going eligible care needs.

As part of the information shared with service users, carers, family and relevant others the service states:

“At the end of the service

- A Senior Reablement Officer will be monitoring your progress over the six weeks.
- A routine review will normally take place by the 3rd week in order to plan ahead
- If you no longer require support a review may take place earlier as needed
- By the 4th week if longer term support is needed after Reablement has ceased, an assessment to determine what arrangements you would like for us to arrange on your behalf will be made.
- We will be removing your support plan folder at the end of Reablement for our records.”

It is important that ‘ending reablement’ is a managed process and should fully involve and engage a range of people to ensure that the person is not left without appropriate care and support and has had an opportunity to consider options, as well as feedback on their service experience.

17.2 Brokerage of on-going care and support needs post reablement

Following a period of reablement and/or rehabilitative care and support some people may have made improvements but still have on-going eligible care and support needs that require the provision of long-term care and support such as; home care.

In these instances it is important that the right on-going care and support package is brokered and commissioned. The case worker for the individual, along-side the Reablement Officer(s) will have built up a relationship with the person and will know and understand (better than a new worker in long-term care and support provision) the person’s on-going care and support needs.

Therefore, the case worker will be the one who works with brokerage to commission the on-going package of care and support.
17.3 Transferring user to long-term care and support

There will be occasions when the case needs to transfer to a new team and allocated worker when the person moves from short-term care and support to long-term care and support. This will be in line with the system of work for transferring cases and the process in place for case transfer via the case management system (Mosaic).

They reablement/rehabilitative case worker will transfer the service user record providing information in case notes for the new team/allocated worker to the long-term care and support team (most likely Complex Care Team) for the case to be allocated to a new worker.
18 Business Continuity Planning

18.1 Business continuity planning

The reablement and rehabilitative service is an essential frontline service delivered by both; in-house and commissioned staff. It delivers regulated activity to residents that may have complex health and social care needs.

Therefore, it is important that we have a business continuity plan in place to ensure people who are vulnerable adults receive care and support should a significant incident occur that severely disrupts the service such as; bad weather affecting the number of staff able to be on duty.

The Council has in place plans to deal with civil contingencies, emergency planning and response: [http://forestnet.lbwf.gov.uk/index/cor-emerg-respons-planning.htm](http://forestnet.lbwf.gov.uk/index/cor-emerg-respons-planning.htm)

In addition the Council has a recognised approach to Business Continuity Management – see Corporate Business Continuity Management Policy

18.2 Independent Living Team Business Continuity Plan

The Independent Living Team Business Continuity Plan is attached.