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| Adult Care and Quality Standards |
|  **Adult Management Service****Operational Policy**  |
| Adult Social CarePeoples Services |

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# Introduction

This policy sets out the working arrangements for the Adult Care Management Team, London Borough of Waltham Forest.

The Adult Care Management Team is fully integrated with the wider LBWF Adult Social Care Services. The Team holds responsibility for a local population of up to three thousand people. The policy should be read in conjunction with the agreed LBWF policies.

# Purpose of Service

* 1. **Adult Care Management Team**

The. Adults Care Management Team provides support to all long-term service users whose primary support reasons are not severe and enduring mental health or a recognised and confirmed diagnosis of learning disability. The team provides long-term care and support for older people (aged 65 years plus) often with frailty and working aged adults (aged 18 to 64 years of age) whose primary care need arises from their physical impairment or other impairments. They provide active care management for Adults when their needs require it.

The team works with a range of adults defined as working aged adults (18 to 64 years old) and adults over 65 years of age. People have varied complex support needs that can include frailty, physical impairment, early onset dementia, people living with multiple long-term conditions e.g., diabetes, COPD and people with anxiety and depression. The ACMT deliver a range of social work services, these can include assertive casework and care management, coordinating care for people with eligible social care needs.

* 1. **LBWF Adult Care Management service provides the following services.**

In practice therefore the following statutory tasks are conducted.

* To provide Care Act assessments for Adults in the London Borough of Waltham Forest with strength-based person-centred care and support planning, within a Risk Assessment model
* To support adults’ health and wellbeing supporting accessibility to universal health and social care community services
* To support people transitioning from Children’s Social Care settings to Adult Social Care Services.
* Assessment of the needs and provision of support plans for informal carers
* Undertaking Section 42 Enquiries as directed by the Care Act 2014
* Consider safeguards as governed by the Mental Capacity Act 2005 and associated Code of Practice

# Service Structure

The service will be managed through the Adult Social Care Management Team and the Peoples Directorate of the LBWF. The Service is delivered through two Teams consisting of:

* Team Manager (2.0 WTE)
* Practice Managers (4.0 WTE)
* Social Workers (14. WTE)
* Social Work Assistants (10.0 WTE)

Team1 leads on longer term case management and Team 2 focus is Adults discharged from hospital. There is a centralised Adult Care Management duty Team the which triages incoming work from internal and external stakeholders. Practice Managers have management oversight of the service and staff are rotated on the duty service on average 4 days per month.

* 1. **Team management, supervision, and clinical leadership**

The Team Managers have overall responsibility for the line management of the
Practice Managers and the day-to-day operation of the team, including case allocation. He or she will ensure that all relevant policies and procedures of LBWF are fully implemented, and that performance indicators are met. All staff will have monthly line management and clinical supervision of their work.

Monthly clinical supervision will be carried out by the appropriate senior professional. For the social workers, this will be the responsibility of the Practice Managers The team manager will provide clinical supervision to the practice Managers. Appraisals will be carried out by the team manager, with input from the clinical supervisor.

* 1. **Appraisal/Supervision and Training/education**
* Adult Care Management staff will be offered the opportunity to develop skills, knowledge and support required to enhance their practice and provide high standards of care.
* All staff within Adult Care Management Team will receive supervision and annual appraisal which includes a development plan personalised to the needs of the individual practitioner.
* Mandatory training compliance will be monitored in accordance with LBWF policy.
* Adult Care Management Team will explore learned lessons from previous inquiries, incident reviews and complaints at the service monthly meeting and ensure that raised issues and recommendations made are adopted to maintain and develop a good practice.

# Adult Care Management Meetings

* 1. **Operational Team Meeting**
* The four weekly meeting will provide a forum for discussing pressing issues within the service.
* Stakeholder attendance and presentation of their services across LBWF, Health, and Third Sector Partners
	1. **Drop-in** **discussion Group**
* Four weekly drop-in discussion group provide a reflective space for cases to be reviewed. A legal representative is in attendance to support consideration of relevant statutory framework.
* Each Adult Care Management team member will have the opportunity discuss current cases causing concerns in their caseload and highlight any potential changes in risk.
	1. **Self-Neglect Peer Reflective Supervision Group**
	+ Weekly reflective space workshop to consider self - neglect concerns/section 42 enquiry review to support Team Around Person Approach
	1. **Training**
	+ The authority has a comprehensive training plan available for all staff.
	1. **Allocations Meeting**
	+ Management Team Weekly allocations meeting
	1. **Two-weekly management meeting**
	+ Review of operational procedures, innovations, complaints, training, incidents

# Hours of operations

* 1. The service will operate between 09.00 and 17.15 Monday to Friday, with flexible hours for specific tasks and interventions. Rarely staff might need to work beyond their normal hours, particularly when dealing with an event that has passed beyond 17.00.

# Referrals

* 1. **Processing and management of referrals**

ACMT team will discuss referrals at their regular weekly management meeting meetings and provide updates to referrers.

If a referral is declined, the reasons will be outlined in writing to the referrer, by a nominated member of the team providing recommendations for alternative services and/or management options. The referrer will be able to appeal a decision to decline, by writing to the Team Manager in which case the decision will be reviewed via a team discussion. Figure 1 below provides an overview of process for Transfer.

**Figure 1: Transfer process**

Receipt of written transfer form

Screen for basic inclusion

Management discussion to determine suitability.

Accept

Assessment (following risk management model)

Decline

Return

**Possible Tasks for allocation**:

Initial review

Unscheduled Review

Case management

Section 42 Enquiry

Court Of Protection/legal work /Dols

* 1. **Making an Internal Transfer:**

Transfers will be made using the service transfer from within Mosaic (IT platform) and maybe sent to complexcareteam@walthamforest.gov.uk and copied to ACMT manager, Team Manager. This will usually be completed by social worker, or another identified member of the Multi – Disciplinary Team.

# Adult Care Management Assessment

Upon allocation: The allocated Worker will contact the customer and/or carer and undertake an assessment of the Adults needs – as governed Under the Care Act 2014.

The Care and Support Plan will be developed collaboratively with the Adult. The allocated social worker retains responsibility for updating risk assessment, review until the point of closure. Prior to closure the allocated social worker will complete:

* Case closure on Mosaic
* Case transfer on Mosaic
* Chronology of interventions/key events
* Write to Adult to confirm closure.

# Meetings and communication:

* 1. **Care Act Assessment**

Allocated Social Worker will be required to provide and present report of their assessment interventions and overarching goal/s with adult at face-to-face meetings and/or virtual meetings.

Where the Adult progresses to longer Term case Management the social worker will review progress against identified objectives which will be summarised on the Mosaic case record and Care and Support Plan

* 1. **Reviews**

Allocated Social Worker as needed will consider transfer of cases to the Adult Review Team after initial and or unscheduled reviews.

* 1. **Closure Planning**

Closure planning will be considered on a case-by-case basis at the earliest opportunity lead by the allocated Social Worker based on comprehensive review of needs, necessary enquiries and referrals will be made to universal /health services.

Prior to closure from Adult Care Management service, Adult Care Management Team will agree an agreed closure plan for each Adult. This plan will be recorded in the Mosaic case record notes.

Routinely, a letter confirming closure will be sent to the residents GP.

# Roles

* 1. **Social Worker:**

 Adult Care Management Team may on a case-by-case basis will provide care longer term case management.

* 1. **Social Work Assistant:**

 The allocated Social Work assistant will be responsible for undertaking initial reviews and where identified, carers assessments including young people aged 16-18 in transition.

* 1. **Planned and Unscheduled Reviews:**

 Reviews will be arranged by the social worker/social work assistant and will take place yearly.

Staff will consider the use of unscheduled reviews should circumstances call for it, for example where an Adult has a material change in need, there is dispute regarding the care arrangements, is changing accommodation; boroughs; and/or transfer to the local health service under CHC funding.

* 1. **Risk Assessment:**

 Risk assessment will be conducted in line with review, case management processes.

* 1. **Care and Support Plans:**

 Care plans will identify the current needs, together with intervention and agreed actions. Current risk issues will also feature in the care and support plan. Contact details for all agencies involved in delivering care and managing risk will be featured in the care and support plan and shared accordingly. Individual care and support plan and risk assessments will be updated according to any change in presentation or level of assessed risk as soon as practicable.

* 1. **Social Work provision**

Depending on experience and case complexity e ach Social Worker will routinely hold mixed caseload of up to 25-30 residents including case management, safeguarding enquiries, and legal work. The frequency of visits/contact will be assessed on a person-centred risk basis.

Any face-to-face contact either at LBWF premises or at home will be subject to infection control Risk assessment to minimise risk of transmission for example Covid 19, influenza.

Cover for a Social Workers caseload during their leave will be predominantly provided by other members of the ACMT i.e., practice manager and/or duty.

# Ending

The Adult where possible will be fully involved in the planning and decision making of their leaving and transfer to local services as indicated by their identified needs.

A closure letter will be sent to the resident and copied to General Practitioner or other agencies as needed. Distribution of the closure letter will be discussed with the resident and/or representative. A request will be made of the resident for feedback on their experience of the social work intervention.

# Governance arrangements and information sharing

Governance arrangements are in place to support quality assurance monitoring the service i.e., supervision of staff, internal audit of case records, practice observation, obtain consent to share information and /or Best Interest decision making. Records are held and communication made as directed by General Data Protection (GDPR) Data Regulations. Any information shared without informed consent is proportionate to the level of risk identified and is recorded as such.

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* 1. **Information Sharing:**

When it’s noted by team members that a resident’s risks to others or self are judged to be escalating, they will review the adult’s level of Risk. Staff will inform their line manager and consider interventions and escalation to Senior Management and support forums e.g., Clinical Risk forum and other stakeholders involved in the resident’s care e.g., primary healthcare.

Possible information sharing scenarios will include, but not be limited to, GP, MAPPA, MARAC, JIGSAW, and Children’s Services.

Information Sharing must be done securely Via mime cast i email communication is used, including between professionals in health settings and emergency services.

Any difficulties regarding effective communication and information sharing should be dealt with by line manager and /or Duty Practice Manger, Team Manager, with further escalation if need be.

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# Complaints /Compliments

Generally, any complaint about a staff member’s practice member of staff will be processed under LBWF policy. Residents are able to make complaints/complaints via telephone or written communication via enclosed link below:

<https://www.walthamforest.gov.uk/council-and-elections/making-complaint-compliment-or-claim/complaints-and-compliments>

# Incident investigation

Incidents will be reported, i.e., via the Need-to-Know system within LBWF. Locally, ACMT management Team will review untoward Seriou’s incidents so that lessons can be learned by the Team. Information is shared in the wider monthly operational management Team meetings.

Internal LBWF oversight of the Adult Care Management service will take place via:

* The line management structure and supervision i.e., from the Team Managers to the, to the Head of Service, Assistant Director and Corporate Director of the Service
* ACMT management Meeting.
* ACMT Operational Management Meeting
* Full Teams Catch up between the Assistant Director Adult Care and Quality Standards and Assistant Director of Home First

# Service evaluation and effectiveness

Adult Care Management Team review and evaluate the effectiveness of service using agreed audit tools, guidelines to promote good practice and measure outcomes and evaluation stakeholder meetings.

* The list is not exhaustive, but the Audits and meetings include: -
* Monthly Quality Assurance Audit/Practice Observation
* Line management supervision audit of social work caseloads
* Adult Social Care Leaders Group
* Drop-in discussion group.
* Resident feedback

# Record Keeping

LBWF Mosaic IT system will be the primary record keeping system for all clinical activities carried out within the service.

At the point of allocation:

* Standardised Entry to reflect definition of task/s e.g. case management, Section 42 Enquiry, Care Act Assessment
* Associated time scale to task/s

Minimum requirement for progress notes:

* Date and purpose of appointment
* Summary of content
* Plan moving forward.
* Record of supervision within -4-6 weeks
* Chronology of intervention
* Closure summary/transfer summary
* Deallocation case note

All relevant assessments/reports compiled by allocated worker, other agencies or services will be uploaded on LBWF, Mosaic IT system.

# Work safety

All staff within ACMT will adhere to the LBWF Lone worker policy and agreed local lone working safety protocol.

Staff members are to activate the safety procedure/plan and contact relevant emergency services if they are not able to manage or de-escalate a situation effectively.

**16.1 Safety Procedure Summary Plan:**

**Lone Working**: All staff members will have use of a mobile phone and will be responsible for risk assessing their need for lone working and adhere to the ACMT lone working protocol.

# Appendix

# Appendix 1 Governance Structure

**LBWF**

**Peoples Directorate**

**Corporate Director**

**Assistant Director**

 **Head Of Service**

**Millfields Unit**

**Team Managers**

**Practice Managers**

**ACMT 1,2 Team**

# Appendix 1.1 Key Contacts

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| **Role** | **Name** |
| Corporate Director | Darren McAughtrie |
| Assistant Director | Maureen McEleney |
| Head Of Service | Alam Khan |
| Team Manager | Steven Box |
| Team Manager | Neville Green |
| Practice Managers | Pious Wireko- GymaiStewart NevilleAngela DuesburyKamilla GeisingerMehrunnisha Patel |

# Appendix 2: ACMT INFORMATION GOVERNANCE PROTOCOL

The Community Team recognises the importance of sharing information as a key aspect of managing Residents with complex needs whose difficulties pervade many contexts and require a co-ordinated, multi-agency approach to minimise potential harm. This document sets out the expectations for information sharing, including which individuals and agencies should be informed and the amount of information to be shared. This includes what to do when case management intervention identifies a change in risk.

1. **Recording information**

All cases will be opened as a referral on Mosaic. All reports written by team members should be uploaded to Mosaic including assessments, support plans. All contacts will be diarised and outcome with a related progress note describing the meeting.

**Minimum requirements for progress notes**:

* Date of appointment.
* Purpose of Meeting
* Consideration of capacity re specific decisions e.g., care and support, Making Safeguarding Personal outcomes
* Outcome of appointment with a focus on current well-being and risk, including any changes in these.
* Any changes in need provision recommended.
* Date of next appointment.
1. **Information Sharing and Confidentiality**

Information will be shared with primary care (GP) and care and support provider including health as a matter of course and with other agencies involved as needed. The following section outlines the minimum level of information to be shared with partner agencies. The information sharing principles apply as soon as a referral has been formally accepted for assessment and can potentially be seen face-to-face.

1. **From ACMT Team to GP**

Residents are presumed to have capacity in managing their healthcare needs. As part of the assessment, review process contact will be made with GP and other relevant agencies. Community Team members must consider e-mail significant information to the GP, subject to consent, Best Interest Decision. regarding health care concerns. It remains the absolute responsibility of the GP to manage healthcare needs.

In cases of absence/leave, ACMT duty and Practice Mangers will provide nominal cover on a case-by-case basis. The level of the information shared must follow the minimum requirements for progress notes (as above).

1. **Communicating imminent risks**

Where imminent risk to self and/or others is identified, this should be communicated between the Adult Community Team and other agencies on a need-to-know basis. Where necessary – e.g., when the potential harm is of sufficient imminence and severity – the police/ambulance or fire service should be contacted.

1. **Information sharing with other agencies.**

Ancillary agencies involved in the case must be noted early on, to allow for pre-emptive planning of who should be informed about crises and the level of information to be shared. These organisations include:

* Police.
* Domiciliary care provider
* Residential and nursing care
* Emergency Duty Team NELFT.
* Mental health
* Childrens Social services.
* Child protection.
* Substance misuse.
* Education.
* Employment.
* Housing.

**4. Information sharing with referring services**

In line with the expectations of the Integrated Health and Social care System, the Community Team will aim to provide continuity of care by adopting a whole systems approach. The pathways approach requires the receiving service to build on the work completed by previous services, rather than reassessing the case from scratch. Sharing the following information between referring and receiving services will therefore be necessary:

* Transfer summary
* Any health service psychological or psychiatric reports.
* Any significant risk incidents (whether occurring in hospital or the community).
* Discharge date
* Current location.
* Care Provider

**5. Consent to sharing information**

Residents routinely be expected to provide written, informed consent to engage with the service or to give verbal consent for the sharing of information. Where verbal consent is given, this will be case noted.

The level of information shared will conform to a human rights principle of the minimum level of personal information necessary to prevent or minimise harm – in other words, unnecessary personal information, for example about physical health, will not be shared unless it has a direct bearing on risk.

**6.Adult Care Management Model**

Figure 1 on page 19 describes the practice model.

**Figure 1 Adult Care management systemic model**

**Legislative arrangements**

 **Agencies involved.**

**Sharing/Person centred practice Information**

**Safeguards Dols/section 42 enquiries**

**Assessment of Need/Risk**

**Strength based Approach.**

 **Care and Support planning**

 **Review of needs/Risk**

The model aims to integrate best practice attending to statutory framework, in assessment of need, provision of care with proportionate information sharing throughout the system of social care and health care.