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| London Borough of Waltham Forest |
| Adults Multi-Agency Safeguarding Hub |
| Operational Protocol |

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| Version 1.12  5/11/21 |

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| **Purpose** | **This document is intended to act as a guide to enable staff to understand the different pathways and responsibilities of the teams that receive safeguarding and non-safeguarding referrals into Adult Social Care, to ensure that referrals are managed appropriately and routed to the correct destination. This process will initially include weekly touchpoints between managers in MASH, the Home First Service (HFS) and the Adult Care Management Team (ACMT), with the frequency reducing soon after the new workflow arrangements have been embedded.** |
| **Contributing Authors** | **Mohammed Ahmed**  **Neville Green**  **Danielle Hatton**  **Alam Kahn**  **Michael Kite**  **Luan Mills**  **Rob Parfrey**  **Sharon Samain** |
| **Date Authorised / Authorisers** |  |
| **Date reviewed** |  |

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1. Adults Multi-Agency Safeguarding Hub (MASH) Introduction

****1.1 Adults Multi-Agency Safeguarding Hub (MASH) Team****

The Adults Multi-Agency Safeguarding Hub (MASH) is a team of professionals from a range of organisations and agencies who work together to safeguard adults who may be at risk of abuse, harm or neglect, and to support the screening of non-safeguarding referrals in the new Adult Social Care structure. The MASH aims to improve the responses to safeguarding concerns (SGC) through stronger links and better information sharing between organisations and agencies to promote better outcomes for adults. From 23/8/21 MASH will receive SGCs, Merlin’s and non-safeguarding referrals.

1.2 Primary aims of the service

The primary aim is to ensure that residents are safe and supported within the community. The Adults MASH will receive referrals, Triage safeguarding concerns, and assess need to identify the most appropriate service to promote the independence and wellbeing of residents who are referred. If emergency provision is required to maintain the safety of a resident, this will be initiated, and the resident’s situation will be stabilised within MASH. The referral will then be passed to the team that is best placed to further assess and support the individual.

1.3 Working hours

Adults MASH operates Monday to Thursday 9am-5.15pm and Friday 9am-5pm. In response to the COVID-19 pandemic, operational hours may change to suit the service demands and to support staffing requirements within the borough.

1.4 Work setting

The team is presently based at Willow House, 869 Forest Road, Walthamstow, E17 4UH on the ground floor. The team is predominantly office based. However, some welfare checks require staff to carry out home visits. Team members may also be working remotely from other locations and when doing so they will follow the council’s policies and procedures regarding remote working.

1.5 Roles and Responsibilities

The team currently comprises a MASH Group Manager who oversees both Children and Adults MASH operations.

Adults MASH staffing is under review at present due to the expansion of its role but is currently staffed by:

* A Team Manager – operational lead for day-to-day activities, overseeing case work. Responsible for supervising the Adults MASH staff. Currently also carrying out inter-agency working to identify pathways and support the new integrated MASH model.
* Practice Manager x 1 – day to day Practice Manager who supports the TM, brag rates and oversees work in the folders, provides advice and guidance to ASC Partners. Supports with screening and bragging cases.
* Social Workers x 4 who carry out the Adult MASH function to Screen, Triage and outcome all referrals into ASC
* Social Work Assistant 1 x Supports the team with screening & triaging all referrals with supervision from a SW

1.6 Team Structure

The team has expanded, incorporating new staffing and development of new referral pathways. The current structure is as follows, with Business Support staff in the Adult Front Door Team supporting the Adult MASH duty workers by carrying out call handling duties and undertaking first tier screening of inbound referrals. Customer Service staff / Business Support Officers also assist the Children’s MASH practitioners:

Key:

AD – Assistant Director

HoS – Head of Service

MGM – MASH Group Manager

TM - Team Manager

PM – Practice Manager

SW – Social Worker

SCA – Social Care Assistant

FTE – Full-Time Equivalent

2.0 MASH Interface Protocol

This summary describes the interface between Adults MASH and the teams below:

* Hub (Hospital) Active Recovery Team (HART) – under the ASC Home First Service
* Community Active Recovery Team (CART) – under the ASC Home First Service
* Adult Care Management Team (ACMT)
* Other specialist services such as Mental Health, Learning Disabilities and Special Educational Needs & Disability’s Team.

2.1 Purpose

The protocol will support decision making and gives guidance as to who will respond in a timely responsive manner to:

1. Safeguarding Concerns.
2. Non-Safeguarding referrals including:
   1. Urgent Responses for New Service Users
   2. Urgent Falls Response for New and Known service users
   3. Requests for information and Advice or Initial Assessment under the Care Act 2014

2.2 Aim

The aim is to support efficiency in the transferring of cases from MASH,when the appropriate service area to respond to the needs of residents referred in has been identified. The referral pathways of MASH are outlined to ensure effective allocation of resources on a case-by-case basis as required, to enable LBWF residents to receive the right care, at the right time and for the right duration.

In some circumstances, urgent decision making will be required for safeguarding concerns and high-risk case allocations as part of urgent safety planning. This could include relocation of residents, depending on the severity and degree of risk presented in a referral. Due consideration needs to be given to the requirement for residents who lack the mental capacity to make informed decisions about their care and support needs to be assisted in ways that are least restrictive, in accordance with the Mental Capacity Act 2005.

1. Overview of the Services

3.1 Adult Front Door (AFD)

Customer Service and Business Support Adult Front Door Team is the first point of contact for the customer’s journey into Adult Social Care. The team provide information and advice for people with physical and sensory disabilities, older people, family members and informal carers. They are the team to contact for all initial enquiries about Adult Social Care, including safeguarding concerns.

The Adult Front Door is where information is gathered, and decisions made about which pathways to follow for different contacts and referrals. This may lead to an assessment by Adult Social Care staff – i.e. a statutory response – or support may be arranged via the Health and Wellbeing Network, or universal services.

The Adult Front Door also offer first tier screening for independent living and wellbeing needs and will refer on for Social Prescribing or a Health & Wellbeing Link Worker Service. Essentially, the task is for AFD to establish the following:

* Is the resident “new” or “known” to ASC – i.e. is the query a referral or a contact on an existing client?
* Does the query relate to a safeguarding matter or a non-safeguarding issue?
* Is the referral urgent or non-urgent?
* Does the resident appear to have unmet eligible needs?
* Does the resident appear to have unmet emerging needs?

3.2 Home First Service (HFS)

ASC input into the Home First Service consists of 2 main sub-teams:

* Hub (Hospital) Active Recovery Team (HART)
* Community Active Recovery Team (CART)

The Hub Active Recovery Team will receive cases via the Integrated Discharge Hub that is operated jointly by NELFT, Bart’s Health and Adult Social Care.

The Community Active Recovery Team will receive cases that have been screened via AFD and Adults MASH Duty.

The Community Active Recovery Team is a short-term (42 day) assessment team that focuses on prevention and independence over a 6-week period. The team completes assessments primarily for reablement cases where the resident has up to 42 days of assistance to promote their independence. Cases are dynamically managed so that residents can be re-abled during the 42-day window. The team works closely with Occupational Therapists and other clinicians in NELFT to help residents achieve their goals. The team also supports informal carers and will complete a carer’s assessment with individuals who need to be assessed.

Residents supported by HFS should have two clear Care Act 2014 eligible needs at the point of screening or should be eligible for a carer’s assessment. Residents who need support to achieve outcomes in just one domain of the Care Act are identified as having emerging needs, and they should be supported by either the Health and Wellbeing Network or by the broader partnership.

3.3 Adult Care Management Team (ACMT)

The Adults Care Management Team provides support to residents who need extended social work involvement due to ongoing difficulties. Their primary support reasons are linked to physical or sensory disabilities and/or psychological challenges but not severe and enduring mental health issues or a recognised and confirmed diagnosis of learning disability. The team provides ongoing care and support for older people (65+) with a level of disability and working age adults (18 to 64) whose primary care need arises from their physical impairment or other difficulties, such as a sensory disability. They provide active care management for service users and carers when their needs require it.

Residents with ongoing eligible needs may have varied complex support requirements that arise from physical impairment, early onset dementia, and multiple long-term conditions e.g. diabetes, COPD, and less severe mental health issues such as anxiety and depression. ACMT staff deliver a range of social work services, including assertive casework and proactive care management, and coordinating care for people with eligible social care needs

3.4 Community Learning Disability Team (CLDT)

CLDT provides assessments to determine the best way to support adults with learning disabilities and their carers to be as independent as possible and to maintain their health and wellbeing. CLDT staff work closely with health colleagues from NELFT, using an MDT approach. The MDT is made up of community learning disability nurses, psychiatrists, psychologists, occupational therapists, speech and language therapists, physiotherapists, and social workers. The service offers therapy clinics and drop-in sessions.

The social work team provides advice and carries out assessments under the Care Act. They also help plan and arrange care and support for adults with learning disabilities and their carers. After the assessment they can help people access services to meet their eligible needs – e.g. via day care, respite care, health services, education, employment support, occupational therapy, physiotherapy, speech therapy and support funded via Direct Payments.

3.5 Mental Health Single Point of Access (MH SPA)

The MH SPA provides an access and assessment service for adults aged 18 and over needing community mental health services. They provide a single telephone number for anyone enquiring about mental health services in the borough, urgent mental health assessments where needed, and management of referrals to other specialist mental health services.

The broader MH front door includes SPA and the Brief Intervention Team. The teams are made up of psychiatrists, community mental health nurses, mental health social workers, support time and recovery workers and occupational therapists.

3.6 Mental Health Community Recovery Team (MH CRT)

The MH CRT provides specialist mental health services for adults aged 18 to 65 with serious and/or enduring mental health issues. The support provided includes multidisciplinary assessments to identify needs with each client/carer, community interventions and a range of community-based services formulated in a care plan and delivered through the Care Program Approach (CPA). The team works with clients, carers, and other agencies to promote recovery.

3.7 Special Educational Needs and Disabilities Team (SEND)

The Special Educational Needs and Disabilities (SEND) Team and the Education and Early Help Teams are a service responsible for:

* arranging the placement of children and young people with Education and Health Care (EHC) plans (or statements of Special Educational Needs) in school
* planning for any special provision to meet the needs of the child / young person
* overseeing the annual review process

3.8 Waltham Forest Social Prescribing service

Social Prescribing aims to support residents over 18 years old with emerging needs who require non-medical support to improve their health and wellbeing. Examples include:

• Receiving welfare advice regarding entitlement to benefits and how to manage debt

• Increasing physical activity or healthy eating

• Joining in with local activities such as art classes or gardening groups

• Connecting to peer support for people experiencing bereavement or living with long term conditions

• Connecting to local befriending or volunteering schemes

• Training to help build confidence or getting back into work

• Receiving assistance with a cold home or energy bills

• Enabling patients/residents to access support for ‘Long Covid’ recovery e.g. return to work (paid/unpaid)

The Social Prescribing service provides support over the phone. Staff do not undertake face to face visits.

3.9 Health and Wellbeing Link Worker Service

The Health and Wellbeing Link Worker Service is targeted at residents with emerging and multiple needs, who might otherwise require support from statutory services without early intervention.

The role of the Health and Wellbeing Link worker is to provide a strengths-based approach to support people to achieve their goals using a range of person-centered interventions. This will enable better outcomes and reduce the demand on statutory provision.

Health and Wellbeing Link Workers use an asset-based approach to support adults experiencing adversity and barriers to health and wellbeing. They work holistically, and in a trauma informed way, using a range of practical tools, to explore what is impacting on the health and wellbeing of the resident. Through reflective conversations, service users are encouraged to identify what is important to them and what they would like to see happen, and utilize skills, abilities, and motivation to enable them to achieve their goals. The Health and Wellbeing Link Workers will connect service users with available support in the community, enabling them to feel safe, well, connected, resilient and independent.

1. Adults Safeguarding Process Overview

4.1 Overview of Adult Safeguarding Pathways

Allocated to Worker

Unallocated: New or Known

Safeguarding’s in Acute Setting

\*AFD send all allocated/unallocated safeguarding work directly to LD if the case is open to the team

**Integrated Discharge**

**HUB**

**AFD**

**ACMT**

**MASH**

Adult Front Door (AFD) and MASH Business Support (BS) receive all community referrals for safeguarding matters. They identify ‘Referral Pathways’ and undertake first tier screening before assigning to MASH.

4.2 NEW clients and Safeguarding Concerns *(processed via ASC – Adult MASH Safeguarding)*

If unallocated and ‘new’, the safeguarding concern will be routed via MASH.

‘New’ clients are residents that are not in receipt of an ASC-funded package of care and not known to a team.

AFD/MASH BS will raise a ‘*Request for Support or Protection/Safeguarding’ (RSPS)* to MASH who will screen and triage. MASH will then:

1. Refer cases for specialist team input where it is required – or
2. Consider if a ‘*Safeguarding Concern’* episode is required and then
   1. Close – If threshold not met
   2. Assign Safeguarding Enquiry (s42) to the ACMT Team Incoming Work folder via ASC – Adult Care Management Team
   3. Adults MASH contact the referrer and advise whether this is going to Progress to a S.42 or be closed down at Stage 1 Concern. This could be by telephone or email.

Adult MASH should also offer support, advice, and information as required.

4.3 EXISTING clients and Safeguarding Concerns *(processed via ASC – Adult MASH duty if un-allocated – processed via the allocated worker if assigned)*

* *‘Contact on an Existing Client’* Work Steps are raised on all referrals for existing service users, but allowing for the following exceptions:
* RSPSs to be raised on all MH cases, both new and existing.
* RSPSs to be raised on any non-MH cases where it is not possible to verify categorically that the resident is an existing service user.

In this scheme of operation, raising an RSPS is the default position on all MH cases and any non-MH cases where the new / existing status of the resident is unclear.

4.4 EXISTING allocated clients and Safeguarding Concerns *(processed via the allocated worker)*

If there is an **allocated worker** – A *‘Contact on an Existing Client’* Work Stepis to be raised by AFD with the Safeguarding Concern attached and this is then passed to the corresponding team folder on Mosaic **(not routed via MASH).**

N.B. If an allocated worker identifies an issue on a case that they hold, which could be a safeguarding concern, they must discuss the case with their line manager immediately. Allocated workers may raise a ‘*safeguarding concern’* episode without the need for a response via MASH or AFD.

4.5 EXISTING unallocated clients and Safeguarding Concerns *(processed via ASC – Adult MASH Safeguarding)*

If the client is unallocated and existing, the safeguarding alert will be routed via MASH.

Existing clients are residents who are in receipt of an ASC-funded package of care and known to a team.

AFD/MASH BS will raise a **‘*Contact on an Existing Client’*** Work Stepto MASH who will screen and triage. MASH will consider if a ‘*Safeguarding Concern’* episode is required and then:

* 1. Close – If threshold not met
  2. Assign Safeguarding Enquiry (s42) to the Adult Care Management Team (ACMT) via Mosaic

4.6 Safeguarding Concerns in a General Hospital setting *(processed via ASC – HART Allocations or ASC – Adult MASH Safeguarding, depending on the circumstances)*

For all Safeguarding Concerns and Merlin’s regarding an incident that has **happened in hospital** – MASH will assign the *Request for Support or Protection / Safeguarding (RSPS)* or*Contact on an Existing Client* Work Step to the ASC – HART Allocations Mosaic folder and email [WXUHsocialworkteam@walthamforest.gov.uk](mailto:WXUHsocialworkteam@walthamforest.gov.uk)

If the vulnerable adult is an inpatient and the alleged harm occurred in the community then the workflow is as follows:

Cases where the alleged harm has no bearing on the discharge planning:

* If AFD / MASH are first notified of the SA referral and the case is un-allocated:  MASH will progress.
* If AFD / MASH are first notified of the SA referral and the case is allocated: AFD will pass the SA referral to the incoming work folder of the team where the allocated worker is based.

Cases where the alleged harm is likely to impact upon the discharge planning:

* If AFD / MASH are first notified of the SA referral:

* AFD will raise the SA referral Work Step and assign to ASC – HART Allocations.
* A MASH manager will liaise with a manager in HART.
* A HART SW will be tasked with screening the referral.
* If the SA threshold is met, the HART worker will complete the SA referral Work Step and outcome this to an s42 enquiry that is sent to ACMT.
* If the SA threshold is not met, the HART worker will close the SA referral Work Step and provide case management follow up as required.
* If a HART worker is first notified of the SA referral:
* The HART worker will raise the SA referral Work Step and assign to ASC – HART Allocations.
* A HART manager will liaise with a manager in MASH.
* A HART SW will be tasked with screening the referral.
* If the SA threshold is met, the HART worker will complete the SA referral Work Step and outcome this to an s42 enquiry that is sent to ACMT.
* If the SA threshold is not met, the HART worker will close the SA referral Work Step and provide case management follow up as required.

4.7 Case Examples

|  |  |  |
| --- | --- | --- |
| *Via General Hospital* | Incident in hospital | Incident in community |
| Person in Hospital, Not Known to ACMT | ASC-HART complete SGC and s42 where required | ASC-HART complete SGC. If s42 needed, s42 sent to ACMT |
| Person in Hospital and known to ACMT | ASC-HART complete SGC and s42 where required | ASC-HART complete SGC. If s42 needed, s42 sent to ACMT |

|  |  |
| --- | --- |
| Person transferred to Hospital and referral that comes in has no bearing on discharge planning | MASH screen and pass SGC to ACMT or refer SGC to a specialist team |

|  |  |  |
| --- | --- | --- |
| *Via AFD* | New | Known |
| Allocated |  | The allocated worker will complete SGC and s42 if required.  AFD will raise this via a Contact on an Existing Client Work Step. |
| Unallocated | SGC via MASH, MASH refer on to specialist teams or ACMT | SGC via MASH, MASH refer on to specialist teams or ACMT |

|  |  |
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| Allocated worker identifies an SGC | The allocated worker must discuss the case with their line manager. An SGC can be raised via the individual’s mosaic profile – AFD/MASH not involved. |

[16:55] Michael Kite

4.8 Referring on to other Specialist Teams

**NELFT MH Single Point of Access / Brief Intervention Team / CRT (subject to change)**

MASH/AFD will close the RSPS or Contact Work Step and email the documents to WF Single Point of Access [WFMerlins@nelft.nhs.uk](mailto:WFMerlins@nelft.nhs.uk), [wfaa.team@nhs.net](mailto:wfaa.team@nhs.net), [wfcrt@nelft.nhs.uk](mailto:wfcrt@nelft.nhs.uk)

If **Not known** and there is a mental health Safeguarding Concern

MASH/AFD will close the RSPS and email the documents to MH Single Point of Access [WFMerlins@nelft.nhs.uk](mailto:WFMerlins@nelft.nhs.uk) & [wfaa.team@nhs.net](mailto:wfaa.team@nhs.net)

In each case the relevant team in NELFT is required to send an acknowledgement e-mail back to AFD/MASH, to confirm that the referral sent from AFD/MASH has been received. This acknowledgement e-mail is then uploaded into case notes by either AFD or an Adult MASH Duty worker.

**Learning Disability**

SGC’s / Merlin’s, New or existing and unallocated – with a diagnosis of a Learning Disability

MASH/AFD will assign the RSPS or Contact Work Step to Mosaic Duty Social Worker (LD) folder and email the LD Duty Worker [LDduty@walthamforest.gov.uk](mailto:LDduty@walthamforest.gov.uk)

CLDT are required to send an acknowledgement e-mail back to AFD/MASH, to confirm that the referral sent from MASH has been received. This acknowledgement e-mail is then uploaded into case notes by either AFD or an Adult MASH Duty worker.

**SEND Team**

SGC’s / Merlin’s – Open to SEND/or allocated worker – MASH to assign the RSPS or Contact Work Step to DES Disability Enablement DES Duty Worker Folder and email [senteam@walthamforest.gov.uk](mailto:senteam@walthamforest.gov.uk)

SEND are required to send an acknowledgement e-mail back to AFD/MASH, to confirm that the referral sent from MASH has been received. This acknowledgement e-mail is then uploaded into case notes by either AFD or an Adult MASH Duty worker.

4.9 Transferring Cases / High Risk Cases

When dealing with high risk cases or crisis incidents – immediate contact with team managers will be required as part of the Adults MASH duty process

Cases should be transferred in accordance the [ASC Transfer Policy (Click to Access)](file:///C:\Users\MKite\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\5V73PQXV\ASC%20Transfer%20Policy%20(Click%20to%20Access))

The checklist for good practice can be applied and this can be found under Appendix A

Guiding principles and processes

1. Passing cases automatically to another team is not good practice and there should be a rational for each transfer
2. It is important the thresholds for intervention and the eligibility criteria of teams are clearly understood and applied
3. Statutory requirements are always adhered to
4. Records and core documents must be up to date as per the Case Recording Policy
5. Any disputes will be escalated via the Heads of Service
6. The timetable for transfers should be sensitive to the service user’s situation

5.0 Non-Safeguarding (Adult MASH Duty)

5.1 Non-Safeguarding referrals on ‘Existing’ clients *(processed via the ACMT team Incoming Work folder)*

‘Existing’ cases are residents with ASC-funded services (allocated or unallocated). Should an ‘Existing’ case require an urgent response, a *Contact on an Existing Client Work Step* will be raised by Adult Front Door (AFD) and sent via a request message to the ACMT Team Incoming Work folder. All urgent responses for known cases in other specialist teams will also be raised directly from AFD to the corresponding duty service for LD, SEND and Mental Health.

The exception will be where there is a referral via the Urgent Falls Service to the HFS urgent falls social worker to provide an emergency package of care to an ‘Existing’ service user. These referrals are processed by MASH, and the relevant process is outlined in the Standard Operating Procedure for the Urgent Falls Service.

5.2 Non-Safeguarding referrals on ‘New’ clients *(processed via ASC – Adult MASH Duty (non-safeguarding)*

‘New’ cases are residents who do not have an ASC-funded service and are not open to a team.

Referrals received for ‘New’ cases are first received in AFD, usually either via the self-assessment portal, email to [wfdliaison@walthamforest.gov.uk](mailto:wfdliaison@walthamforest.gov.uk), or via telephone (020 8496 3000).

AFD will undertake first tier screening of referrals, and direct residents to universal services or the Health and Wellbeing Network where required. AFD can refer residents to services such as Social Prescribing or the Health and Wellbeing Link Workers. The Adults MASH non-safeguarding duty manager will support and guide AFD staff when needed. If the request is for an assessment or urgent response on new cases the referrals will be raised on a *Request for Support or Protection / Safeguarding* (RSPS) to **ASC -** Adult MASH duty (non-safeguarding)*.*

All ‘New’ community cases for ASC input will follow the procedure set out below. Most cases that require an assessment will be directed to ASC– Community Active Recovery Team (CART).

|  |  |  |
| --- | --- | --- |
|  | New | Known |
| Urgent response via Rapid Response (Urgent Falls Service) | Urgent Falls Service SW to prioritise case following the UFS procedure | Urgent Falls Service SW to prioritise case following the UFS procedure |
| Immediate / Urgent response via AFD | Adult MASH Duty case | ACMT / specialist team’s Duty case |
| Non-urgent queries – unallocated case | Adult MASH Duty case | ACMT / specialist team’s Duty case |
| Non-urgent queries – allocated case |  | Sent direct to allocated worker via the teams incoming work folder |

New requests for carers assessments, whether the cared-for person is known, allocated or unallocated, should progress via ACMT Duty. Therefore Cared-for = existing and allocated - referral for the carer goes to the allocated worker Team Incoming work folder.

**5.3 Referrals for carer’s assessments**

Requests for support for informal carers are attended to according to whether or not the cared-for person is an existing service user. Ideally, carer’s assessments should always be completed at the same time as a reassessment for the cared-for person if the person being cared for is in receipt of ASC-funded support.

* If the cared-for person is not an existing service user, an RSPS will be raised, and the referral will be screened by an Adult MASH Duty worker and then passed to ***ASC – CART Allocations*** if a carer’s assessment is required.
* If the cared for person is awaiting an assessment with NELFT SPA because there care needs arise out of a MH condition, the request will be shared with SPA, but remain with MASH until an outcome is achieved as to whether or not the cared for will be taken on by secondary MHS. If they are not taken on, the carers Assessment will progress to ***ASC - CART Allocations*** via MASH.
* If the cared-for person is an existing service user and their case is allocated, the request for a carer’s assessment will be raised as an RSPS and passed to the Team Incoming Work folder of the team where the allocated worker for the cared-for person is based.
* If the cared-for person is an existing service user and their case is not allocated, the process to follow depends upon whether or not a review of the cared-for person’s needs is due soon:
* If the cared-for person’s reassessment is due within the next 6 weeks, ACMT / ART can be asked to bring that review forward, and the request for a carer’s assessment can then be passed to the team Incoming Team folder for ART, to be assigned to the worker allocated to the cared-for person’s case, so that carer and cared-for are seen together by the same worker.
* If the cared-for person’s reassessment is not due within the next 6 weeks, the request for a carer’s assessment should be passed to ***ASC – CART Allocations***. The annual review for the cared-for person and the annual carer’s review (if funded services are agreed for the carer) can then be synchronised by ART at the next annual review date for the cared-for person.

**5.4 Transfers from EDT**

In some circumstances, emergency ASC-funded support has to be set up by EDT out of hours, in order to mitigate risks to a resident’s safety. EDT have no budget to cover the cost of the services that they commission on an emergency basis, and therefore funding has to be agreed retrospectively by day services in ASC. This involves the following process:

* On the first working after notification is received from EDT that emergency provision has been arranged, AFD will raise an RSPS or a Contact on an Existing Client Work Step and send to Adult MASH Duty.
* The case is then screened and:
* Forwarded to ***ASC – CART Allocation*** for urgent allocation if the resident is new.
* Forwarded to the relevant case management team if the resident is an existing service user.

The relevant Responsible Team will then complete either a Care Act assessment (for a new service users) or an unscheduled reassessment (for an existing one) as set out in sections 5.1 and 5.2 above.

**5.5 Management Pre-Screening**

The MASH management team will identify cases for an urgent / immediate response (RAG-rated red) when pre-screening the RSPSs that are routed to the Adults MASH Duty folder. The MASH screening manager’s responsibility is to check each RSPS and assign a RAG rating from the options below, then pass the RSPS to an Adult MASH duty worker to follow up.

5.6 Screening

**Red RAG rating (Immediate Response):** Case assigned to an Adults MASH worker. A welfare visit may be needed within 4hrs of the referral being raised. Emergency packages of care may be required, with funding approved via a Chair’s Action request to an Adult MASH Manager or an ASC Head of Service. The case will be allocated straight away if necessary, to an assessor in the HFS-Community Active Recovery Team (CART).

**Amber RAG rating (Urgent Response):** MASH will follow up within 24-48hrs of the referral being raised and aim to have resolved the case for allocation within this time.

**Green RAG rating (All Other Responses):** MASH will complete their analysis of the referral within 72 hours, but this may take up to 5 days.

5.7 Screening decisions

When an RSPS is processed throughMASH, it will need to be have an outcome for an assessment or for No Further Action (NFA).

Where an assessment is required, MASH will identify if the case is for an Adult Early Help Initial Assessment (for Reablement), a RAS assessment (used for long-term care from the get-go), or a carer’s assessment. MASH will be required to choose a Mosaic folder for the assessment Work Step and add a note to the Work Step next action section to support the allocation of a case in the Community Active Recovery Team. The language should be set out as: priority rating, SW/SCA, age of service user and particular issue or condition: I.e. **PR2, SW, 81, Dementia & accommodation.** The Mosaic folder will be called *ASC - CART Allocations*.

MASH will completed the RSPS and case note alert the MASH manager for approval. The manager should check the note on the next actions and ensure that the right folder is selected and be confident that the case is stable.

N.B. Complex cases where the ASC Reablement offer is not appropriate, and support cannot be planned and provided within 6 weeks are to go directly to ACMT following screening. These will include requests for assessment due to:

* Hoarding
* Substance misuse
* MAPPA

5.8 Priority Ratings for case allocation in the Home First Service

Cases are rated by for case allocation:

The determining factors in giving priority to cases awaiting allocation will be the urgency of the assessment request, whether support is already in place, the level of risks involved, and the likelihood of the risk arising.

**P1:** Assessment due within 48hrs to meet care and support needs. Cases likely to have high risks attached. May be high cost with short term care agreed.

**P2:** Care and support required within the week of allocation or up to 14 days but usually within 7 days – e.g. In cases where existing CCG-funded services provided by the NHS will end. Cases are likely to need urgent action from allocation with progressive steps taken to reduce risk / crisis.

**P3:** Care and support required but may have protective factors in place. Case ideally allocated and supported within the first week but may not present as urgent and could wait beyond 7-14 days.

**P4:** Care and support required, low risk level in cases awaiting allocation.

5.9 Young Carers Referrals into ASC

Young Carers will require an assessment at the point in which they transition from 17-18. At 17 ½ years, young carers known to Children’s Social Care (CSC) will start to be referred to Adult Social Care (ASC).

The young carers are considered ‘known’ and so their referral will be sent in the form of a ‘Young adult’s carers assessment’ form on mosaic.

Young Carers & NEW Cared-For

These referrals for ASC support where the ‘cared-for’ is not known will come via the Adult MASH Duty **(non-safeguarding)** virtual worker. They can be screened by MASH staff and will either be progressed to:

1. Carers Assessment in the Community Active Recovery Team or
2. No Further Action (NFA) due to ineligibility, the young carer declining the assessment or non-engagement.

\*All non-engagement cases should be followed up with at least three attempts and a letter. A discussion with the practice manager is required to consider the impact of sensory needs or language barriers.

Young Carers & KNOWN Cared-For

Young Carer referrals to ASC, where the ‘cared-for’ is known, will go via ACMT and the assessment for the ‘cared-for’ person will be brought forward.

Young Carer’s Protocol should be used for further guidance and includes CSC Early Help process through to case examples that are sent to ASC-CART, SEND or ACMT.

5.10 Duty Workflow

6.0**Post-screening, Home First Service Case Allocations**

6.1 Waiting list

Cases ready for allocation will appear in ASC - CART Allocations folder as either a Carers Assessment, Adult Early Help Initial Assessment or RAS Assessment with a note such as PR2, SW, 81, Dementia & accommodation.

The cases awaiting allocation are also recorded on the Waitlist Spreadsheet held on the (O:) Drive by the allocating Practice Managers in the Community Active Recovery Team. The cases are listed to clearly identify the priority rating, assessment type and whether the case is for a SW or SCA.

PR 1 cases are allocated outside of the weekly allocations meeting and added to the waitlist spreadsheet on an ad hoc basis.

Cases rated PR2 are prioritised and allocated first, then PR3, and PR4 are allocated according to the length of time they have waited, and the level of risk involved. This needs to be reviewed via periodic re-screening for cases that remain on the Community Active Recovery Team wait list for more than 2 weeks.

6.2 Waiting list and Urgent Responses

While a case is on the Community Active Recovery Team wait list, it is the responsibility of that team unless an urgent response is required, and the case is unallocated. In this scenario the urgent response to stabilise the risk will need to be undertaken by Adult MASH staff, because the responsibility for urgent responses for new unallocated cases sits with Adult MASH.

This is intended to cover scenarios whereby a resident has requested an assessment and the referral is RAG-rated PR3, then while on the wait list their carer falls ill, or they have a fall and need emergency support from Adult Social Care.

In these circumstances, at the end of an urgent response delivered by Adult MASH Duty, a change in priority rating may be warranted. This can be amended by reassigning the same RSPS to the Community Active Recovery Team with a new PR rating. The RSPS should stay in the CART Allocations folder throughout.

Some urgent responses may be complex and time consuming where a conversation with the allocating Practice Managers in the Community Active Recovery Team would be required to consider a Priority 1 case allocation.

6.3 Monitoring for changes to Priority ratings

It should be noted that cases which are already given a priority rating may change over time. Community Active Recovery Team PM’s who are responsible for allocations to CART assessors are required to keep track of cases awaiting allocation.

Any PR3/4 cases waiting more than 2 weeks should be discussed at the allocations meeting to decide if the PR level should be adjusted. Usually cases will move up a priority level after 2-4 weeks of waiting. The wait time for allocation is dependent upon capacity, throughput and the number of new referrals that require a priority response.

6.4 Allocating cases to CART assessors *This does not apply to the CHC social workers in the Community Active Recovery Team who will have their allocations via a separate process.*

Case allocation meetings are held for CART assessors on Monday afternoons (Tuesdays on Bank Holiday weeks) and are attended by the CART Practice Managers who supervise the staff involved.

Cases rated PR2, PR3 or PR4 are allocated early in the week following the case allocation meetings.

Cases that are rated PR1 will require an immediate response and can be allocated outside of the case allocation meetings. This will follow a conversation between the Adult MASH duty manager and the CART Practice Managers who are allocating cases.

A maximum of 4 cases are allocated to full-time workers in CART and a maximum of 2 cases to part-time workers, with no more than two PR1 or PR2 cases per person.

There may be exceptions to the above dependent on the level of risk to service users, or service demand. Staff should discuss the priority of cases which they are allocated with their line manager if they are allocated more than the maximum.

CART Practice Managers will assign the relevant Mosaic Work Step to the allocated worker and add a case note for the allocation to be reflected in the case note chronology. A follow up email is sent to notify the worker of the allocation.

In addition to the above, the CART Practice Managers will add ASC - Community Active Recovery Team as the Responsible Team via the ‘Organisation Relationships’ option from the Mosaic personal profile of the individual. Practice Managers will also add the allocated worker's name to the Mosaic profile using the ‘Worker Relationships’ options. These will be either Allocated Social Worker (SW) or Case Manager (SCA). In safeguarding cases, additional worker relationships will be added to include the Safeguarding Enquiry Officer (SW) and the Safeguarding Adults Manager (PM).

7.0 Emergency packages of care

7.1 Information for emergency care packages

Funding requests for emergency care packages should be summarised using a Chair’s Action request form (Appendix C). The form should aim to cover in short paragraphs the following:

* Context and network of support – e.g. resident is 39 years of age, lives with their husband and two children, has a sister who visits weekly to provide support. Identify who else contributes to the resident’s informal support network
* Communication – e.g. resident uses a communication board or requires an Urdu-speaking interpreter.
* Medical History – e.g. resident has the following conditions – X, Y, Z
* Functional impact / risks arising from the resident’s disabilities – e.g. due to advancing Parkinson’s Disease, resident is experiencing pain and tremors which affect them when preparing hot drinks as they could burn themselves
* Mental capacity – e.g. resident is assessed as lacking mental capacity to make informed decisions about their care and support need(s) and a decision was made in their best interests
* Alternatives and proposed care: Breakdown of support in a clear narrative consistent with the funding request to identify if Adult Early Help (Reablement) or long-term care is required (see example below)

***Chairs Action Request:***

1. ***Adult Early Help input AM, 1 carer 45mins x 7/7***
2. ***Adult Early Help input Lunch, 1 carer 30mins x 7/7***

***Cost = £121.98pw***

7.2 Funding Approval limits

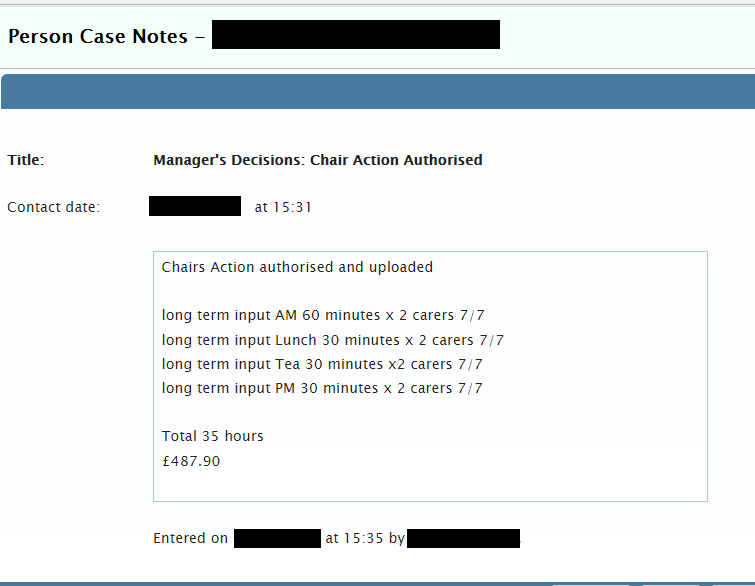
The cost of emergency support determines which manager has delegated authority to authorise the funding:

1. Where the cost of care is under £250pw, the Chair’s Action request is not needed and the case note should be recorded as RAM. This is referred to as a “Resource Allocation Meeting” (RAM) which is inputted following a discussion between the assessor and a PM or TM. This can be agreed by either an Adult MASH manager, Team Manager or Practice Manager.
2. Where the cost of care is over £250pw, the Chair’s Action request requires an ASC Head of Service to approve. These should be forwarded from the MASH Team Manager or Assistant Team Manager/Practice Manager to the HoS. Long-arm consultation support is available from Heads of Service in ASC.

7.3 Recording the Funding approvals

Once funding approval has been granted, the Chair’s Action paperwork should be uploaded into docs by the Adult MASH duty worker and a Brokerage Work Step is required to implement the support. It is important that the Brokerage Team is contacted, and the Work Step is marked as urgent to ensure swift implementation of the support.

Each package of care requires a funding approval case note. The care package should have a case note identifying that it is an emergency care package signed off via a Chair’s Action request or RAM. The TM or PM is responsible for uploading the case note on to mosaic and this should give an overview of the package (see image below).

**Where a case is under £250**, the case note should be recorded as RAM. This is referred to as a “Resource Allocation Meeting” (RAM) which is inputted following a discussion between the assessor and a PM or TM.

**Where a case is over £250**, the case note should be recorded as a Chairs Action Authorised.

8.0 Responding to MP / Councillor enquiries

8.1 Receiving MP / Councillor enquires

All MP and Councillors enquiries should be sent to the team manager of the team where the case is held. If the case is new and not open to a team the enquiry will be attended to by Adult MASH managers. These enquires should be distributed to the team manager via AFD or directly from the Leadership Office and Councillor Enquiries Team (Cllr.Enquiries@walthamforest.gov.uk).

MPs have been asked to send casework enquiries to [MPEnquiry@walthamforest.gov.uk](mailto:MPEnquiry@walthamforest.gov.uk). These enquiries are coordinated by the Leadership Office and Cllr Enquiries team. All casework enquiries should be replied to via this mailbox as quickly as possible, and no later than ten working days.

MPs have been asked to send all other enquiries to the Leader’s office via  [leader@walthamforest.gov.uk](mailto:leader@walthamforest.gov.uk). The Leadership Office will coordinate a response with relevant senior officers and Cabinet Members

8.2 Enquiries in an emergency

As laid out in the contact from MPs document, MPs have been told that if they need to raise an urgent case outside of normal business hours, they should call the Council’s Contact Resolution Centre on 020 8496 3000 so they can be directed to the appropriate service.

8.3 Direct enquiries

There should not be any direct enquiries from MPs or their staff to individual Council officers. If a direct enquiry is received, the coordinated response is to be used by sending the following back to the MP or their staff member.

*Dear MP*

*Thank you for your email.*

*I have forwarded your enquiry to the MP Enquiry mailbox/Leader’s office to arrange for a response to be provided.*

*Signature*

8.4 Responding to an enquiry

Final versions of each enquiry should go to the relevant emails below with a copy to [CSPAHub@walthamforest.gov.uk](mailto:CSPAHub@walthamforest.gov.uk) for tracking – in all cases:

1. Councillor’s enquiries:  [Cllr.Enquiries@walthamforest.gov.uk](mailto:Cllr.Enquiries@walthamforest.gov.uk)
2. Enquiries from the Leader: [Cllr.Enquiries@walthamforest.gov.uk](mailto:Cllr.Enquiries@walthamforest.gov.uk) and [Leader@walthamforest.gov.uk](mailto:Leader@walthamforest.gov.uk)
3. MP’s enquiries: [MPEnquiry@walthamforest.gov.uk](mailto:MPEnquiry@walthamforest.gov.uk)
4. Chief Exec’s enquiries (i.e. from Martin Esom’s office – Claire Saunders and Kimberley Ramsey provide his executive PA support): [ChiefExecutive@walthamforest.gov.uk](mailto:ChiefExecutive@walthamforest.gov.uk) with a copy to Claire and Kimberley

A response should be given within 10 working days.

Glossary:

|  |  |
| --- | --- |
| Teams | |
| ACMT | Adult Care Management Team |
| AFD | Adult Front Door – the business support staff aligned to Adult Social Care within the Contact Resolution Centre. |
| BS | Business Support |
| CLDT | Community Learning Disability Team |
| CRT | Community Recovery Team |
| HFS | Home First Service |
| MASH | Multi-Agency Safeguarding Hub |
| MASH BS | ‘Business Support’ officers aligned to ‘Multi-Agency Safeguarding Hub’ |
| MHS / MH SPA | Mental Health Service / Mental Health SPA |
| SEND | Special Educational Needs and Disabilities Team |
| Terms | |
| Adult Early Help / Adult Early Help Initial Assessment | Also referred to as ‘recovery and progression’ or ‘reablement’. A non-chargeable service for up to 6 weeks to maximise independence, with dynamic case management from an HFS assessor and input from a physio or OT. Assessed using an Adult Early Help Initial Assessment form. |
| Contact on an Existing Client Work Step | A Work Step on Mosaic that allows information to be shared with an allocated worker / team |
| CART | Community Active Recovery Team - HFS team that attends to non-safeguarding referrals from the community, routed via MASH |
| Case Managers | SW/SCAs or other professional completing assessment-based casework |
| Chair’s Action Request | A word document that is used for emergency funding and funding over £250pw |
| Emerging Needs | Emerging needs arise where a resident requires support to achieve outcomes in one Care Act 2014 domain |
| HART | Hub Active Recovery Team - HFS team that attends to referrals from the hospital, routed via the Integrated Discharge Hub |
| Long term | Often used to describe a package of care that is chargeable and has had or is awaiting a financial assessment following a Care Act 2014 ‘eligible’ assessment. |
| ‘Known’ | A Known Case (or Known User / Client). A client that already has ASC-funded services in place (whether allocated on not allocated) and is under a responsible team such as ACMT, MHT, CLDT. |
| Merlin | A document produced by the Police to refer incidents to the LA |
| ‘New’ | A ‘New’ case refers to a resident who does not already have an ASC-funded package of care |
| NFA | No Further Action |
| PR | Priority Rating – used to support the cases waiting for allocation in HFS |
| RAG | ‘Red, Amber, Green’ ratings used to prioritise screening. |
| RAM | Resource Allocation Meeting – when a team manager or practice manager authorises funding under £250pw. Also used to identify a funding case note |
| RAS | Resource Allocation System – the system on Mosaic that generates an indicative budget or personal budget when a ‘FACE Overview’ assessment questionnaire is completed to assess Care Act 2014 eligibility for long term support. |
| RSPS | Request for Support or Protection / Safeguarding – A Work Step on Mosaic that allows for new case referrals and safeguarding concerns to be raised |
| Duty worker | A worker in Adult MASH who is responsible for gathering information to make decisions on the referrals that are received. |
| SGCs | Safeguarding Concerns or the ‘Safeguarding Concern’ Work Step |
| s42 | Generally used to refer to the section 42 Safeguarding Enquiry Work Step or a ‘Safeguarding Enquiry’ |
| Specialisms / Specialist Teams | Generally referring to teams that include MH SPA and the Brief Intervention Team, CRT, CLDT and SEND |

Appendix A

Safeguarding Principles and Good Practice checklist

Principles

The policy and procedures are based on The Six Principles of Safeguarding of the Multi-Agency Adult Safeguarding Policy and Procedures that underpin all adult safeguarding work.

|  |  |  |
| --- | --- | --- |
| Empowerment | Adults are encouraged to make their own decisions and are provided with support and information | I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens |
| Prevention | Strategies are developed to prevent abuse and neglect that promotes resilience and self determination | I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help |
| Proportionate | A proportionate and least intrusive response is made balanced with the level of risk | I am confident that the professionals will work in my interest and only get involved as much as needed |
| Protection | Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding | I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able |
| Partnerships | Local solutions through services working together within their communities | I am confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my own situation |
| Accountable | Accountability and transparency in delivering a safeguarding response | I am clear about the roles and responsibilities of all those involved in the solution to the problem |

Checklist of Good Practice questions

* Is this a case that warrants a safeguarding response?
* Did the safeguarding occur within the borough, or is there a need for another borough to be informed of the safeguarding concern?
* Is the service user new or existing? If existing, is the resident under the care of HFS, ACMT or MH services / CLDT?
* Is the case un-allocated or allocated?
  + If un-allocated, the SA decision is made by MASH (unless the resident is under the care of MH services or CLDT)
  + If allocated, the SA referral is passed to the allocated worker for them to progress
* What are the clinical/diagnostic details?
* Are there any risks to be managed in the immediate future? If yes, then make the resident safe for the ensuing 24-48 hours
* Check to ensure the case is in fact a safeguarding case. Gather collateral details and decide on whether to progress to an s42 enquiry (if un-allocated) before passing onto to another service
* Is this a high-risk case? If yes, the MASH manager should speak with the ACMT/ relevant service area asap
* Apply the correct eligibility criteria. Passing cases automatically to another team is not good practice and there should be a rational for the referral being transferred elsewhere

Appendix – B

Incorporating New Urgent Response Referrals

What are the possible outcomes from the safeguarding referral or an urgent non-safeguarding referral into MASH?

First tier screening: Residents with emerging needs: Self Help and Prevention

* Signposting to universal services
* Referral to GP
* Referral to the Library Plus Service
* Referral to Carer’s First
* Referral to Social Prescribing
* Referral to the Health and Wellbeing Network
* No further action – when a section 42 enquiry is not required, case management follow up is not needed, and no signposting or referral is required to other organisations or teams.

Second tier screening: Residents with eligible needs:

* Signposting or referral to other services/organisations – where a section 42 enquiry is not required, for example, care management or quality of care concerns (organisational concerns) are identified.
* Referral for Care Act assessment – short-term response / urgent response when required
* Referral to NELFT Community Health services (via Community Health SPA or directly) – Falls Prevention Service, Rapid Response Service, WF Rehab Service, IAPT / talking therapies
* Referral to local authority Occupational Therapy Team
* Referral to NELFT Mental Health Services
* Referral to Housing Services / assessments under the Homelessness Reduction Act 2017
* Referrals to Change Grow Live, Community Safety services, Domestic Abuse support services

(This is not an exhaustive list)

Second tier screening: Residents with complex needs / requiring long-term support

* Referral for carer’s assessment – progress and assigned to Community Active Recovery Team
* Referral for Care Act assessment – progress and assigned to Community Active Recovery Team
* Referral for secondary health care input via Mental Health and Learning Disability services – close and progress to relevant MH and LD teams
* Referral for specialist mental health input – perinatal, eating disorder, personality disorder
* Referral for end of life care

(This is not an exhaustive list)

Second tier screening: Safeguarding Adults and high risk / crisis response

* Section 42 enquiries are required – where the MASH determine that a section 42 enquiry is required, they will inform the relevant ASC team, depending on where the allegation took place (see Pan London guidance for out of borough arrangements).
* An urgent response is required from Adult MASH Duty to non-safeguarding referrals that are RAG rated red, meaning that a calamity is likely on the day of referral or the next day unless some urgent action is taken. Adult MASH Duty will remain involved for up to 5 days, until the resident’s situation is stable enough for their case to be added to the Community Active Recovery Team wait list for allocation

Appendix C: ASC – Chair’s Action Request Form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mosaic Number:** |  | | | |
| **Service User’s Name:** |  | | | |
| **Date of Birth:** |  | | | |
| **Present Address:** |  | | | |
| **IB:** | £ | | | |
| **Current Support Plan details and cost:** |  | | | |
| **Proposed Support Plan details and cost:** |  | | | |
| **Current Location:** |  | | | |
| **Social Worker:** |  | | | |
| **Team:** |  | | | |
| **Manager:** |  | | | |
| **Date to authorising Manger:** |  | | | |
| **Adults - Service Requested:**  Please Tick Relevant Box | Residential  Community  Extra Care Sheltered Housing ECSH | | |  |
| **Learning Disabilities - Service Requested:**  Please Tick Relevant Box | High  Medium  Low |  | Residential  Community  Extra Care Sheltered Housing ECSH  Supported Living |  |
| **Mental Health -**  **Service Requested:**  Please Tick Relevant Box | High  Medium  Low |  | Residential  Community  Extra Care Sheltered Housing ECSH  Supported Living  Carers Support |  |
| **Outcome sought from Chair’s Action request** (Max 10 Words) |  | | | |
| **Brief Details of Case:**   * Context (Demographic/support network / Communication) * Medical History * Functional Impact of need & risk * Mental Capacity * Alternatives considered * Proposed Care |  | | | |
| **Workers signature:** |  | | | |
| **Line managers signature:** |  | | | |
| **Authoriser’s signature:** |  | | | |
| **Date:** |  | | | |