Adult Services and Wellbeing
Calderdale Metropolitan Borough Council

Standard Operating Procedure (SOP): Palliative Care Social Work Team.

Contents

Procedure Version Control

Procedure Name	**Standard Operating Procedure: Palliative Care Social Work Team**		
Document Description	This Standard Operating Procedure sets out the Palliative Care Social Work Team's aims, objectives, underlying principles together with consistent ways of working.		
Document Owner	Anne Flanagan		
Document Author	Alex Townsend	**Date**	August 2024
Status	Live	**Version**	**2.0**
Last Reviewed	**December 2024**	**Next Review Date**	January 2026
Approved by	Anne Flanagan	**Position**	Assistant Director ASW
Signed		**Date Approved**	December 2024

Document Change History

Version Number	Date	Amendments
1.0	August 2024	New Document
2.0	December 2024	Updates made to Waiting Well process and updated with consistent safeguarding procedures.

Standard Operating Procedure Palliative Care Social Work Team

Service Area Overview

Our team provides specialised support to people aged 18 and over residing in Calderdale who are living with a palliative condition and are in the final 12 months of their life. We focus on understanding each person's unique goals and what constitutes a meaningful and dignified end-of-life experience for them. By working closely with other professionals, family members, carers, and friends, we strive to ensure that these goals are met, and that each person receives the compassionate care they deserve.

Service Area Main Aims

Dignity and Respect: We are dedicated to treating everyone with the utmost dignity, respect, and kindness. Our focus is on ensuring that each person's experience is managed with the highest level of compassion and care, recognising the individuality of each person we support.

Autonomy and Control: We strive to empower individuals to maintain control over their lives, care, and support. We carefully document and honour advance decisions and personal wishes within conversation records, living well assessment and care plans, ensuring these are respected and followed. By providing clear information and collaborating with other professionals, we help people make informed choices, keeping them at the heart of all our efforts. Where necessary we uphold the principles of the Mental Capacity Act and apply the legislation to our practice.

Tailored Support: Our approach includes creating personalised support packages that cater to each person's unique needs and preferences. This might involve offering memory boxes, arranging holidays, or planning day trips, all while managing expectations realistically to provide meaningful opportunities for personal fulfilment.

Promoting Independence: We are committed to fostering psycho-emotional approaches that help individuals come to terms with their circumstances. Positive risk-taking is central to our practice, supporting people to enhance their independence. We recognise and advocate for each person's potential, connecting them with opportunities and services that bolster their independence maximising their opportunities to live a fulfilling life (including consideration of equipment and technology).

Family Integration: We value the critical role of family in one's identity and care. We integrate and respect existing family roles within the care and support provided, recognising the importance of relationships and family involvement throughout the care process.

Wellbeing Enhancement: Our aim is to enhance holistic wellbeing by facilitating activities that individuals wish to pursue, such as day trips, holidays, continuing work or voluntary opportunities, and engaging in fundraising or awareness campaigns. We focus on improving the quality of life through comprehensive support and relevant services.

Carer Support: We acknowledge and support the invaluable role of family and friends as unpaid carers. Recognising their wellbeing needs is integral to our approach, and we provide resources and assistance to support their essential contributions while being mindful of their limits and capacities.

Sensitive Conversations: We approach discussions about after-death arrangements with sensitivity, ensuring these conversations are conducted respectfully and with compassion.

Service Area Objectives

Assessment and Eligibility: We adopt a person-centred approach to assessing people's needs, ensuring a thorough understanding of what each person requires at that particular time in their life. Our assessments consider a variety of options, including services from the voluntary sector, social care, and NHS-funded care, to deliver holistic and person-centred support.

Care Planning: Our care planning is meticulously tailored to each person's needs, focusing on what constitutes a good quality of life and a dignified death for that individual. We use a strengths-based approach that integrates personal preferences, family involvement, and desired outcomes. We actively engage in advanced care planning, documenting all discussions, decisions, and actions. Our approach is responsive to both urgent and anticipated needs, addressing crisis sensitively and promptly while preparing for potential challenges.

Access to Services: We ensure that people have access to comprehensive information about a range of services suited to their specific circumstances. Our commitment extends to utilising all available resources to meet holistic needs, encompassing healthcare, social care, and community support.

Integration of Services: Staying informed about both generalist and specialist services is crucial to our practice. We collaborate with various professionals and organisations, including Overgate Hospice, District Nurses, Community and Hospital Palliative Care Nurses, MacMillan, and ICB Funded Care Teams, as well as specialist coordinators for conditions such as Motor Neurone Disease. Our aim is to foster seamless integration and coordination of health and social care services, ensuring that care is both compassionate and cohesive. We work closely with care providers to ensure clarity in their roles and responsibilities in delivering high-quality palliative and end-of-life care.

Workforce Development: We are committed to the recruitment, training, and retention of a skilled and empathetic social care workforce. Our practice emphasises supportive and reflective discussions that build and sustain resilience among team members. We welcome opportunities for students, NQSWs, and secondments, and are dedicated to educating both internal and external stakeholders about our work and the broader scope of palliative care. We also hold our own version of Schwartz Rounds bi-monthly to offer a reflective space that fosters mutual support among practitioners.

Quality Assurance: In partnership with the NHS, we continuously monitor outcomes to ensure alignment with people's preferences, with a priority on achieving their preferred place of death. Our quality assurance framework includes case audits by Team Managers, TeamLeaders and Practice Leads, reflective supervision focused on specific cases, and thorough caseload management oversight. Additionally, we conduct regular audits as part of the directorate's review procedures. Through ongoing evaluations, we ensure that support packages are responsive to people's needs, making necessary adjustments and addressing any quality concerns. We also facilitate the sharing of compliments and concerns both internally and externally as appropriate.

Safeguarding: We are committed to upholding every person's right to live free from abuse, harm, and neglect. We engage people in discussions about their experiences and preferences regarding their safety. When safeguarding concerns arise, we conduct enquiries with a focus on the person's desired outcomes, ensuring that their voices and choices are central to the safeguarding process.

Service Area Outcomes

- **People feel listened to, understood, and respected throughout their engagement with our services.** Every person's voice is valued, and they experience compassionate and respectful care at every stage.
- **People achieve their personal goals in the time leading up to their death.** People successfully fulfil their personal aspirations and wishes, with our support ensuring their goals are realised during this significant time.
- **People's requirements for what they consider to be a good death are met.** Each person's unique definition of a good death is honoured, with care provided in alignment with their values and preferences.
- **People's preferred place of death is achieved.** People die in their chosen location, whether at home, in a hospice, or elsewhere, receiving support that facilitates a comfortable and dignified end-of-life experience.
- **People who deteriorate rapidly receive timely and appropriate care and support.** We address urgent situations within four hours (during working hours), ensuring effective intervention for those experiencing a rapid decline in their condition.
- **Families, friends, and carers feel listened to and supported throughout our involvement.** Those closest to the person are engaged and supported, receiving both emotional and practical assistance throughout the process.
- **People experience coordinated and seamless care across all services.** Care is well-integrated and transitions are managed smoothly, minimising disruptions to the support people receive.
- **People's emotional and psychological needs are addressed.** People receive support to help them cope with the emotional aspects of their illness and end-of-life experience, including counselling and therapeutic interventions as needed.

- **People and their families receive clear and timely information.** All information regarding care plans, available services, and support options is communicated clearly and promptly, enabling informed decision-making.
- **We foster a culture of continuous improvement and learning.** Our practices are regularly reviewed and refined based on feedback and outcomes, enhancing the quality of care and support provided.
- **We advocate for the rights and preferences of people at all times.** Each person’s rights and preferences are respected, with the right level of advocacy ensuring they receive the best possible care and support.
- **People feel safe and secure.** We establish a protective and supportive environment where people’s safety and well-being are prioritised. We actively address and resolve any concerns related to their safety, ensuring a safeguarding-focused approach that promotes a sense of security and trust.

Values and Principles of the Service Area

Excellence in Service Delivery: We strive for excellence by providing services that are not only effective but also delivered with the utmost care and precision. Our commitment is to ensure that every service is both high-quality and responsive to the needs of the people we support.

Commitment to Fairness and Inclusivity: We uphold the principles of fairness and inclusivity, ensuring that every person has equal access to our services. We are dedicated to addressing and removing barriers to care, ensuring that support is accessible to all, regardless of their circumstances.

Prioritising Safety and Well-Being: We are dedicated to safeguarding people’s safety and well-being. Our services are designed to offer protection and security, addressing any concerns promptly and effectively to create a safe and supportive environment.

Collaborative Approach: We believe in the power of collaboration and work closely with other services, agencies, and community organisations. By fostering strong partnerships, we aim to provide cohesive and integrated care that meets the diverse needs of people.

Transparency and Integrity: We operate with integrity and transparency, keeping people informed and involved in their care. We are committed to being open and honest in our interactions and ensuring that our practices are accountable to those we serve.

Innovation and Adaptability: We embrace a culture of innovation and adaptability, continuously seeking ways to improve our services. Our approach includes being flexible and responsive to new ideas, ensuring that our practices evolve to meet changing needs.

Respect and Dignity: We honour the dignity and individuality of every person, ensuring that all care and interactions are conducted with the highest level of respect. We recognise and value each person’s unique needs and preferences.

Holistic Care Approach: Our commitment is to provide holistic care that addresses all aspects of a person’s experience. This includes attending to their physical, emotional, psychological, and social needs in a compassionate and integrated manner.

Empowerment and Advocacy: We advocate for the rights and preferences of people, empowering them to make informed decisions about their care. Our role includes supporting people in asserting their wishes and ensuring that their choices are respected throughout their care journey.

Eligibility Criteria and Contacting the Service

The Palliative Care Social Work Team works with adults who are 18 years old and over who are resident of Calderdale Metropolitan Borough Council (or ordinary resident thereof) and considered to be in the last 12 months of their life. We also provide support to people (who are being considered for Continuing Healthcare Fast-Track) who live in Kirklees Council area who are registered with a Calderdale General Practitioner.

Service Delivery

The service is run by a team of Social Workers under the leadership of a dedicated Team Leader, the Team Manager is shared with Central Halifax Team. A Practice Lead, and a Continuing Healthcare Practice Lead provide support and leadership across the service. The service is overseen by an Operational Manager.

The Palliative Care Team operations from 8:45AM to 5:00PM Monday to Friday. During these hours, the team is responsible for receiving and addressing all new referrals received as well as managing any queries related to people who are currently under their care.

Contact with the palliative care service is via Gateway to Care 01422 393000.

Referrals can be made electronically by completing the Wellbeing Contact Form: https://new.calderdale.gov.uk/dio/request-adult-social-care

The Team also accepts professional referrals on NHS paperwork for example the NHS Continuing Healthcare Fast Track tool.

The service can be emailed on: AHSCpalliativecaresocialworkteam@calderdale.gov.uk

Team Managers email is: pltscentralpalliativemanagement@calderdale.gov.uk

Outside of these standard office hours, the Emergency Duty Team is responsible for considering all adult referrals where there is an urgent requirement to do so. This team assesses risk, and if necessary, provides immediate support to mitigate or reduce risks for those who cannot safely wait until the next working day. If required, the Emergency Duty Team will coordinate with or directs other agencies as necessary to address and manage the concerns. For urgent end-of-life support, the district nurses' out-of-hours service is available 24 hours a day.

Upon the resumption of standard office hours, the Emergency Duty Team will transfer all relevant concerns to the Gateway to Care. Gateway to Care will then process these concerns administratively in the Client Information System (CIS) and ensure that the Palliative Care Team is duly notified.

To contact Emergency Duty Team:

Ring: **01422 288000**

Online Contact: https://new.calderdale.gov.uk/contact/out-hours

Service Area Process and Procedures

Initial Contact and Referral Process

Referral Sources:

- **Gateway to Care:** Referrals for people not previously known to Adult Services and Wellbeing are primarily received via Gateway to Care. Gateway to Care is responsible for understanding the reasons for the referral and ensuring it is directed to the appropriate team. Upon receipt, Gateway to Care creates a record in the Client Information System (CIS), logs the referral details, and assigns it to the Palliative Care Team.
- **Handover for Known People:** For those already known to Adult Services and Wellbeing, other teams should consult with the Palliative Care Team Leader, Team Manager, or Duty Social Worker to determine the appropriateness of transferring the case. If agreed, the person is formally assigned to the Palliative Care Team in CIS.
- **Safeguarding:** If the Safeguarding Team identifies a person as fitting the criteria for ongoing safeguarding enquiries as part of Stage 2, they will hand over the case to the Palliative Care Team. This handover includes a verbal briefing from the safeguarding practitioner to the Duty Social Worker, Team Leader, or Team Manager.

Duty Arrangements

Daily Duty Cover:

- A Duty Social Worker is assigned daily to manage communications, including phone calls, emails, and CIS. This role supports both new referrals and existing cases with queries. The Duty Social Worker is supported by a Team Leader or Team Manager to ensure effective and timely responses.

Assessment of Urgency:

- Upon receiving a new referral, the Duty Social Worker reviews available information and identifies any gaps. They then contact the person, their family, or their network of professionals to gather further information. The urgency of the situation is assessed based on:
    - Rapid deterioration requiring immediate palliative care or referral to another health service.
    - Urgent care needs, such as those requiring NHS Continuing Healthcare (Fast Track) arrangements.
    - Readiness for hospital discharge for example, when the person is medically optimised.
    - Crisis situations, including carer breakdown or safeguarding concerns.

Immediate Response:

For people in urgent situations, the team prioritises and provides a proportionate and immediate response. This may include remote assessments if critical and safe to do so and arranging urgent home visits if necessary. Urgent referrals are escalated to the Team Leader for priority allocation, within 4 to 36 hours as per the person's requirements.

Routine Referrals

Initial Engagement:

- For non-urgent referrals, an introductory phone call is made to the person or their carer. This call gathers additional information, explains the service, and may involve clarifications from other professionals or referrals to external services. The person is informed that a Social Worker will be allocated within 7 days to arrange a visit and provide support. Contact details are provided for any interim needs.

Follow-Up for Known People:

- For people already known to the service whose circumstances change and who require urgent support, they are connected directly with their allocated Social Worker. If the Social Worker is unavailable, the Duty Social Worker provides backup support to ensure continuity of care.

Waiting Safe and Well Process

Due to demand, it is not always possible to respond immediately and sometimes people are waiting for assessment or review. It is particularly important that people waiting for assessment for adult social care are appropriately prioritised and that they receive regular updates, and resources that support their well-being while they wait, in order to reduce risks associated with unmet needs.

On receipt of the referral, the ***Screening Tool for Referral Waiting Lists*** should be used to prioritise referrals – this applies to assessments, re-assessments and reviews. The prioritisation tool will be used to establish the level of need and risk, and to ensure that people are allocated in an equitable manner. People will be recorded as high, medium, or low priority for allocation based on their individual circumstances.

In line with section 6.26 of the Care Act Statutory Guidance, if an immediate response through service provision is required to meet a person's urgent needs to ensure their safety prior to an assessment being undertaken - this should be put in place on an interim basis.

The outcome of the prioritisation should be documented on the Team Referral Spreadsheet which is held by the Team Manager and used in conjunction with the electronic recording system referral lists. The spreadsheet is date ascending for referral submission and color coded for priority rating:

Red	**High Priority**
Yellow	**Medium Priority**
Green	**Low Priority**

As part of the 'waiting safe and well' process, all people awaiting a new assessment will be contacted to determine if their situation has changed and, if needed, relevant safety actions implemented; this may include fast-tracking the persons assessment. This process should be undertaken in line with the ***Waiting Well Framework.***

All people who are waiting for more than two weeks will be sent a standard waiting well letter to confirm that they are still on our waiting list. The letter will provide service contact details, information on how to inform us if their situation changes and will provide signposting to other information and support options (such as CalderConnect, Care Charge calculator). It will also provide details of our Better Lives Drop in Hubs.

Whilst people continue to wait for allocation, we will contact them on a regular basis to review their circumstances and any changes in needs, which may affect the level of risk and their prioritisation. The frequency of contact is tailored and proportionate to their level of priority.

The contact may be through a follow up Waiting Well letter, by telephone or by text.

Where a change in circumstances, need or risk becomes apparent, then the level of priority will be re-assessed using the prioritisation tool.

If a significant risk is identified, this will be escalated to the team manager and appropriate action taken. This could result, for example, in a telephone assessment and interim support arrangements or urgent allocation.

Should it become apparent that the person has resolved their own needs, then the referral will be closed.

Contact will be recorded in the persons case notes on CIS and the Team Manager / Team Leader will update the spreadsheet accordingly during the weekly referral review.

Assessment and Eligibility Process

Eligibility and Initial Engagement:

- The Palliative Care Social Work Team serves individuals aged 18 and over, who are ordinarily resident in Calderdale and are in the last 12 months of life. The team also supports people who live in Kirklees who are registered with a GP in Calderdale (and are being considered for Continuing Healthcare Fast Track). According to the Care Act 2014, initial engagement does not require formal Care Act eligibility assessment. Instead, the team uses the 8Ps strengths-based practice framework to offer early support and engage in end-of-life discussions, aligning with Section 1 of the Care Act 2014, which promotes individual well-being, and Chapter 2 of the Care and Support Statutory Guidance, which emphasises preventative support and early intervention.

Long-Term Care Assessment:

- For those needing long-term social care, assessments are conducted using the Living Well Conversation Record, guided by the Care Act's eligibility criteria (Sections 9 and 10). This includes evaluating the person's needs and the availability of informal support, ensuring the assessment is person-centred and considers their desired outcomes.

Safeguarding Considerations:

- The team remains vigilant to safeguarding concerns, in accordance with Section 42 of the Care Act 2014. Any risks of abuse, neglect, or harm are addressed and reported as necessary. Stage 3 (Safeguarding Planning and Review) and Stage 4 (Closure) procedures will be followed as outlined in the safeguarding procedure **(please see Safeguarding Concerns, Enquiries, Safety Planning, Quality Assurance and Closure Section).**

Living Well Conversation (Assessment)

Objective:

- To conduct a thorough, person-centred assessment to identify the person's needs, preferences, and eligibility for support under the Care Act 2014.

Process:

- **Person-Centred Approach:** Engage with the person, their family, carers, and relevant professionals to gather comprehensive information about their needs and preferences. Ensure the assessment process respects the person’s dignity, choices, and control.
- **Assessment Criteria:** Conduct the assessment in accordance with Section 9 of the Care Act 2014, ensuring it is:
    - **Comprehensive:** Covering physical, emotional, and social needs.
    - **Person-Centred:** Focusing on well-being and preferences as outlined in Section 1 of the Care Act 2014. Assess how needs impact safety, health, and quality of life.
    - **Eligibility Determination:** Using the criteria in Section 13 of the Care Act 2014 to determine eligibility for care and support.
- **Consultation with Professionals:** Consult with other professionals and agencies as needed to ensure a comprehensive evaluation of the person’s needs.

Documentation:

- Record assessment findings in CIS, including notes on needs, preferences, risks, and consultations with other professionals. The Living Well Conversation Record must be attached to the assessment screens in CIS.

Developing and Agreeing the Support Plan

Objective:

- To develop a support plan that addresses identified needs, aligns with the person’s preferences, and outlines the steps to achieve their desired outcomes.

Process:

- **Collaborative Planning:** Work with the person, their family, and relevant professionals to create a support plan that reflects the assessment findings and addresses needs and preferences.
- **Feedback and Adjustment:** Allow the person to review and provide feedback on the support plan, making adjustments as necessary.

- **Resource Identification:** Identify and arrange necessary resources or services to implement the support plan. Coordinate with other services, secure funding if needed, and make referrals as required.

Documentation:

- Record the support plan in CIS, detailing agreed actions, responsible parties, and timeframes. Document any feedback received and how it was incorporated into the final plan.

Monitoring and Review

Objective:

- To monitor the implementation of the support plan and review its effectiveness in meeting the person's needs and achieving their desired outcomes.

Process:

- **Ongoing Monitoring:** People in palliative care are generally not 'closed to review' and remain with the same Social Worker throughout their journey due to the dynamic nature of their condition. Continuous monitoring and updates to the support plan are carried out as needed. If there is no active involvement required for a Social Worker then the episode of involvement may be ended and the support plan set to a scheduled review.
- **Scheduled Reviews:** Conduct formal reviews at agreed intervals or when there are significant changes in the person's circumstances, including feedback from the person and their support network.
- **Feedback and Adjustment:** Adjust the support plan based on feedback and changes in the person's needs to ensure its continued relevance and effectiveness.

Documentation:

- Record monitoring activities and review outcomes in CIS, including any changes to the support plan and reasons for these changes. Ensure documentation reflects the ongoing assessment of needs, effectiveness of the support plan, and the person's satisfaction with services.

Consideration to Carers

Purpose: This Standard Operating Procedure (SOP) outlines the processes for identifying, supporting, and involving carers in the care planning and support process for people who are receiving long-term care services. The SOP ensures that carers' needs are recognised and addressed, and that they are provided with appropriate carers assessment, support and resources.

Scope: This SOP applies to all members of the Personalised Long Term Support Team, including Social Workers, Service Coordinators, and Reviewing Officers who work with people receiving long-term care services.

Definitions:

- **Carer:** A person who provides unpaid care and support to someone due to illness, frailty, disability, a mental health problem (including dementia), or addiction.
- **Carers Count Calderdale:** An organisation that supports carers by providing advice, information, and practical assistance.

Procedure:

Identification of Carers:

  - During initial assessments, reviews, and ongoing support, identify if a person receiving care has a carer.
  - Engage with the person receiving care to determine if there is someone providing significant unpaid care and support.

Assessment of Carers’ Needs:

  - Conduct a Carers’ Assessment to understand the needs and circumstances of the carer. This assessment should be person-centred and consider the carer’s own health, wellbeing, and personal circumstances.
  - Other services maybe accessed through formal Carers’ Assessment, via Carers Count Calderdale. Carers Count Calderdale offers a comprehensive assessment service and can assist in identifying and addressing the carer’s needs.
  - The assessment should include discussions on the impact of caring on the carer’s daily life, including their social, emotional, and financial situation.

Support and Information:

  - Share information with carers about their rights and the support available through Carers Count Calderdale. Provide carers with the Carers Count Calderdale contact details:
    - **Email:** calderdale@carerscount.org.uk
    - **Phone:** 01422 369101

- Provide carers with a public information leaflet about carer support and resources.

Engagement with Carers Count Calderdale:

- Encourage carers to contact Carers Count Calderdale for additional support, which includes advice and information, benefits advice, access to support groups and activities, training, and advocacy.
- Support carers in accessing Carers Count Calderdale’s services, including the Carers Count Forum for having their voices heard and specialist provisions for carers of people with mental health needs.

Involvement in Care Planning:

- Ensure that carers are involved in the care planning process where appropriate. This includes discussing and documenting their perspectives, preferences, and any support they may need.
- Record the carer’s views and needs in the relevant documentation within the Client Information System (CIS).
- Create a carers support plan if required, Carers Personal Budgets can be applied for if deemed required.

Review and Ongoing Support:

- Regularly review the carer’s situation during scheduled reviews and as part of the ongoing care and support process.
- Update the Carers’ Assessment as needed and ensure that any changes in the carer’s needs or circumstances are addressed promptly.

Advocacy and Representation:

- If a carer is unable to consent or make decisions on their own behalf, ensure that appropriate advocacy services are involved.
- Make decisions in the best interests of the carer, considering their needs and preferences as per the Carers Count Calderdale guidelines.

Documentation and Compliance:

- Ensure that all relevant information and documentation related to the carer’s assessment and support are correctly recorded in CIS and updated as required.
- Ensure compliance with all relevant policies and procedures regarding carer support and involvement.

Training and Awareness:

- Engage in ongoing training to stay updated on best practices for supporting carers and to understand the resources available through Carers Count Calderdale.

Contact for Guidance: For additional support and guidance related to carer considerations, including conducting a Carers' Assessment, contact Carers Count Calderdale directly via:

- **Email:** calderdale@carerscount.org.uk
- **Phone:** 01422 369101

Safeguarding Adults

Stage 1: Identification and Reporting of Safeguarding Concerns

Overview*:* Stage 1 involves the identification and reporting of safeguarding concerns before the Safeguarding Adults Practitioners engage with the person at risk or experiencing abuse or neglect.

Practitioners will be mindful of S42 of the Care Act 2014, identifying where there may be a cause for concern that someone with possible care and support needs, in their area may be at risk of or experiencing harm or neglect and unable to protect themselves. This includes but is not limited to; physical abuse, emotional and psychological abuse, financial abuse, sexual abuse, coercive controlling behavior, and self-neglect.

Practitioners will have a responsibility for accurately identifying concerns, the source, type of harm, impact of harm/potential harm and urgency of the concern. Practitioners should consider and follow the Calderdale Threshold Guidance for Safeguarding Adults at Risk prior to raising a concern.

If practitioners are actively involved with a person whereby concern or information is shared, whether factually supported or not, they will make enquiries to ascertain that the person is safe and well and ascertain what action needs to be taken and what legal framework this may be under. This includes considering if this requires raising as a statutory safeguarding concern. This should be led by the person with Making Safeguarding Personal (MSP) underpinning the approach. Capacity to consent to safeguarding concerns should be considered at the point a potential safeguarding concern is identified, ensuring that the person is supported to engage with and understand what this means. In the event a person is deemed to lack capacity to consent, consideration should be given for involving a relevant representative and/or referring for an advocate. Only in circumstances where there is an immediate risk to the person and/or to the safety of another person should consent not be sought prior to raising a safeguarding concern.

Practitioners will formally report a safeguarding concern by completing the standard Calderdale Safeguarding Raising a Concern form and submitting this electronically to Gateway to Care via email. If any social care practitioner (with access to CIS) identifies the concern they will be responsible for completing respective safeguarding stage one screens on CIS.

Practitioners retain a responsibility to promoting the welfare and safeguarding children and young people (s11, Children's Act 2004) also. If information comes to the attention of a worker that a child or young person may be experiencing or at risk of harm or neglect, they will share this information with Children's services within a timely manner. This may be by contacting Multi Agency Screening Team (MAST) or sharing information with an allocated children's worker or team.

How to Raise a Safeguarding Concern

During Office Hours

- **General Public and Professionals**: Concerns can be reported by anyone in accordance with the guidance and consideration to The Threshold Guidance for Adults at Risk in Calderdale. Reports can be made via:
    - **Safeguarding Concern Form**: Complete and submit the form to gatewaytocare@calderdale.gov.uk .
    - **Telephone**: Call Gateway to Care at 01422 393000.

- **Safeguarding Adult Team Contact Details:**
    - **Telephone (Duty):** 01422 393375
    - **Email:** safeguarding.adults@calderdale.gov.uk

- **Specific Agencies**:
    - **Police, Yorkshire Ambulance Service**: These agencies may use their own forms to notify **safeguarding concerns.** These forms are accepted as valid notifications or referrals.
    - **Calderdale & Huddersfield Foundation Trust**: Will submit concerns where the abuse or neglect occurred within a hospital setting to the Hospital Discharge Team. It is likely that the Hospital Discharge Team will give cause to the Hospital to make the safeguarding enquiries, with the Hospital Discharge Team acting as co-ordinators.

Out of Office Hours:

- **Emergency Duty Team (EDT)**: For concerns raised outside standard office hours (5:00 PM to 8:45 AM Monday to Thursday and 4:30 PM to 8:45 AM Friday to Monday), contact the EDT at 01422 288000. The EDT will assess the concern, take necessary immediate actions to address immediate and imminent risks (that cannot safely wait until the next working day), and notify Gateway to Care on the next working day.

Stage 2: Screening and Risk Assessment

Objective: To evaluate the safeguarding concern raised, apply the ‘three stage statutory test’ and assess the level of risk to determine whether a safeguarding enquiry is required.

The Safeguarding Adults Team is responsible for Stage 2 of the Safeguarding Adults Procedures for people with Palliative Care needs. If the three-stage test is met the Safeguarding Adult Team, will complete the stage 2 initial enquiries and if no further enquiries are required they will complete the stage 4 closure process. If further enquiries are needed, following stage 2, the Safeguarding Practitioner will outcome stage 2 to progress to stage 3, and prepare the handover to the Palliative Care Team to undertake stage 3 and 4.

Stage 3: Safeguarding Enquiry, Safety Planning and Review

The stage 3 element of the safeguarding enquiry will be assigned to The Palliative Care Team to complete. The Safeguarding Adult Team retains responsibility for any concerns that are raised naming the alleged perpetrator of abuse as a Calderdale MBC Employee.

It maybe that the Safeguarding Adult Team or The Palliative Care Team gives cause to other agencies (for example the police, Acute and Community NHS Services), to undertake the enquiry. In these cases, the Safeguarding Adult Team or The Palliative Care Team, will co-ordinate and clearly document who is responsible for carrying out the enquiry including the timescales to complete.

Handover Process:

The Safeguarding Adult Team Manager, Team Leader or Practice Lead should review the safeguarding concern and ensure that all necessary action has been undertaken according to this Standard Operating Procedure.

The Safeguarding Adult Team Manager, Team Leader or Practice Lead contacts Palliative Care Team Manager, Team Leader or Practice Lead explaining that they have a stage 3 prepared for handover. The Palliative Care Team Manager/Team Leader or Practice Lead should identify a practitioner within the team to take the work. A meeting should then occur between the two parties. If required and beneficial, the allocated worker within the Safeguarding Adult Team can join the meeting along with the allocated worker within The Palliative Care Team.

Undertaking a Safeguarding Enquiry

Safeguarding Practitioners (allocated workers) will formulate a safeguarding enquiry plan with the safeguarding coordinator (Team Manager, Team Leader, Practice Lead or equivalent), outlining plans and actions immediately required and timescales for completing these. Safeguarding screens will be updated regularly to ensure this captures live action, as opposed to retrospective entry. The enquiry officer must:

- *prioritise the adult's wishes, feelings, and well-being. It should focus on supporting the individual to achieve the outcomes they want, while promoting their rights to make decisions and exercise control.*

- *Ensure the person at risk is fully informed and involved throughout the enquiry process. They should be consulted about their views and desires, unless doing so would increase the risk of harm.*

The safeguarding enquiry officer will collect and evaluate relevant information from multiple sources, including the person at risk, carers, family members, and professionals involved in their care. This should include gathering evidence of abuse or neglect.

Safety Planning

Objective: To develop a safeguarding plan that addresses identified risks, outlines actions to protect and support the person at risk, and ensures their safety and well-being.

Process:

- **Person-Centred Approach:** Develop the safeguarding plan in collaboration with the person at risk, ensuring their views, wishes, and desired outcomes are central to the planning process, in line with the principles of MSP. This approach emphasises the person's empowerment, choice, and control, and respects their rights and preferences.
- **Involvement of Relevant Parties:** With the person's consent, involve relevant parties such as family members, carers, and other professionals in the planning process. This collaborative approach supports a holistic understanding of the person's needs and ensures that all necessary resources are considered.
- **Action Planning and Risk Management:** Clearly outline the actions required to manage identified risks, specifying roles, responsibilities, and timeframes. The plan should be proportionate and prioritise the least restrictive options while empowering the person, as emphasised in the Care Act 2014 statutory guidance (Chapter 14 on safeguarding).
- **Compliance with Statutory and Best Practice Guidance:** Ensure compliance with the Care Act 2014, including Sections 42 (enquiry by local authority) and 44 (safeguarding adult reviews), which mandate enquiries and reviews where necessary. Refer to ADASS guidance on safeguarding roles and responsibilities and the LGA's 'Making Safeguarding Personal Toolkit' for practical strategies to personalise safeguarding efforts and uphold high standards of care.

Documentation:

- Record the safeguarding plan in the Client Information System (CIS), including details of the person’s consent, roles of involved parties, and agreed actions. Documentation should include clear objectives, timelines, and criteria for success.
- Maintain an accurate record of all communications, meetings, and decisions related to the safeguarding plan, ensuring a complete and transparent audit trail.

Review of the Safeguarding Plan (if required):

Objective:
To evaluate the effectiveness of the safeguarding plan and make necessary adjustments to ensure ongoing protection and support.

Process:

- **Scheduled Reviews:** Conduct reviews at appropriate intervals based on the level of risk and complexity of the situation. Reviews should be flexible, allowing for adjustments if significant changes occur in the person’s circumstances or if new risks are identified.
- **Inclusive Review Process:** Involve the person at risk, their support network, and relevant professionals in the review process. This ensures that progress against the safeguarding plan is assessed collaboratively and that adjustments are made in response to the person’s feedback and evolving needs.
- **Adjustments and Continuous Improvement:** Modify the safeguarding plan as needed based on review findings, ensuring it remains relevant and effective in addressing the person’s needs and preferences. Communicate any changes clearly to all involved parties to maintain alignment and understanding.

Documentation:

- Record review outcomes in CIS, including any changes to the safeguarding plan, reasons for adjustments, and feedback from the person. Documentation should reflect ongoing risk assessments, actions taken, and the effectiveness of the plan in meeting the person’s desired outcomes.

Stage 4: Closure of the Safeguarding Enquiry

Closure Process:

Objective:

- To formally close the safeguarding enquiry when identified risks have been appropriately managed and the person's safety and well-being are assured.
- This can occur following Stage 2 or Stage 3. If this element of the procedure is initiated at stage 2 then the Safeguarding Adult Team or Mental Health Team will complete this step. If the person has a stage 3 enquiry, then it is managed within the locality team.

Process:

- **Confirming Outcomes:** Confirm with the person at risk, their support network, and involved professionals that the safeguarding goals have been met and that no further actions are required. The decision to close should be based on the person's sense of safety and their feedback on the safeguarding process.
- **Ensuring Ongoing Support:** Ensure the person feels safe, supported, and informed about how to access help if new concerns arise in the future, in keeping with the MSP principle of ensuring people feel listened to and respected throughout the safeguarding process.
- **Documenting Closure:** Document the decision to close the enquiry in CIS, including the rationale for closure, the person's views, and any final actions agreed upon. Provide a comprehensive summary of the safeguarding process, actions taken, and outcomes achieved.
- **Management Oversight: The team manager or team leader will review all safeguarding enquiries and closures prior to ending the safeguarding enquiry episode.**

Documentation:

- Complete the safeguarding closure form in CIS, ensuring it captures all relevant information, including the person's feedback on their experience of the safeguarding process. Archive all related documents and correspondence in the person's case file, ensuring a thorough record of the safeguarding enquiry.
- Provide the person with a summary of the safeguarding actions taken and confirm how they can access support or re-engage with safeguarding services if necessary.

Continuous Learning and Improvement:

Objective:

To capture learning from safeguarding enquiries to improve future practice and ensure adherence to statutory and best practice standards.

Process:

- **Reflective Practice and Learning:** Use insights from safeguarding enquiries to drive continuous improvement in practice. Engage in reflective practice sessions and internal audits and incorporate learning into procedural updates and team development.
- **Guidance Adherence:** Regularly review procedures against the latest guidance from ADASS (e.g., 'Safeguarding Adults: Roles and Responsibilities') and the LGA, incorporating new recommendations and evidence-based practices. Emphasise the six principles of safeguarding (empowerment, prevention, proportionality, protection, partnership, and accountability) throughout, ensuring the focus remains on outcomes that are meaningful to the person at risk.
- **Updating Procedures:** Update safeguarding procedures based on feedback, audit findings, and evolving guidance to ensure they remain relevant, effective, and centred on the well-being of people at risk.

Mental Capacity & Best Interest Consideration

All allocated Social Workers, Service Coordinators, or Reviewing Officers must adhere to the principles of the Mental Capacity Act 2005 when working with person. If there is a reasonable belief that a person's capacity to make a decision may be impaired, such as in cases where there is a diagnosed (or belief that) there is an impairment of the mind. The worker is required to complete the relevant mental capacity assessments within the Client Information System (CIS) to document the capacity test.

If it is determined that a person lacks capacity, a decision in their best interests must be made in accordance with the Mental Capacity Act 2005. This involves a thorough analysis of all available options and ensuring that the decision-making process complies with the Act's Code of Practice. The Code of Practice provides detailed guidance on how to make best interests decisions, ensuring that the person's preferences, values, and circumstances are considered.

It is not expected that ordinary day to day decisions require a formal capacity test, these types of decisions should be documented within the Living Well Assessment. However, more complex decisions, capacity to decide on where to live, care arrangements or financial arrangements should always be tested and demonstrated within the relevant documentation.

Mental Capacity Act Assessments

Decision Making, Consent and Mental Capacity (opens as a PDF)

Consideration of Continuing Healthcare/Health funded care

Purpose: This Standard Operating Procedure (SOP) outlines the processes for Social Workers and Service Coordinators to consider eligibility for Continuing Healthcare (CHC) and Funded Nursing Care (FNC) in assessments and support planning. It ensures compliance with the latest National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care *2022* and integrates local guidelines to support consistent and person-centred decision-making.

Scope: This SOP applies to all Social Workers, Service Coordinators, and Reviewing Officers within the Adult Services and Wellbeing Department. It covers the identification, assessment, and referral processes for CHC and FNC, including situations where full or partial funding may be appropriate.

Definitions:

- **Continuing Healthcare (CHC):** A package of care funded solely by the NHS for people with complex, ongoing healthcare needs outside of a hospital setting.
- **Funded Nursing Care (FNC):** A payment of £219.71 made by the Calderdale Integrated Care Board (ICB) to fund a Registered Nurse for people with nursing needs in a nursing home.
- **CHC Checklist:** A screening tool used to determine if a full assessment for NHS Continuing Healthcare is required.
- **Best Interests Decision:** A decision made on behalf of a person who lacks the capacity to make specific decisions, in line with the Mental Capacity Act 2005.

Responsibilities:

- **Social Workers/Service Coordinators/Reviewing Officers:**
    - Conduct assessments and reviews that consider CHC and FNC eligibility.
    - Complete CHC Checklists and submit negative checklists to the CHC team if FNC may be applicable.
    - Liaise with relevant health professionals for necessary assessments.
- **Team Leaders/Managers:**
    - Provide oversight and ensure CHC and FNC considerations are documented and actioned appropriately.
    - Review and approve CHC and FNC documentation.
- **Operational Managers/Practice Leads:**
    - Ensure team compliance with CHC and FNC frameworks and provide training and support.

Procedure

Identifying Potential Eligibility for CHC and FNC

- During initial assessments or reviews, evaluate whether the person may be eligible for CHC or FNC based on their health and nursing needs.

- Consider CHC if the person has complex or unpredictable health needs requiring frequent interventions. Consider FNC if the person’s needs do not trigger CHC but still require 24-hour access to a Registered Nurse.

Completing the CHC Checklist

- Complete the CHC Checklist at the appropriate time and location for the person when their ongoing needs are clearer. Ensure full representation, including advocacy support if required.
- Share the public information leaflet: NHS continuing healthcare and NHS-funded nursing care.
- Obtain and document consent using the latest CHC consent form. Consent is required for the CHC process and sharing information with third parties. If there is no consent or a best interests decision, the CHC process cannot proceed.
- Adhere to the 28-day timeframe for the CHC process, ensuring your availability for Decision Support Tool (DST) meetings or arranging alternatives as necessary.

Ensuring Evidence-Based Decisions

- Use all appropriate sources of information and evidence, such as health assessments, to inform the CHC Checklist. The checklist should be evidence-based, with clear documentation of evidence sources.
- Ensure all paperwork, including consent forms, checklists, DST, and End of Determination Review (EDR), is correctly associated with CIS, and update financial sections to reflect current funding arrangements.

Referring for FNC with a Negative CHC Checklist

- If the CHC Checklist does not trigger a full CHC assessment but indicates a need for nursing care, submit the negative checklist and consent form via email to the Integrated Care Board (ICB) at wyicb-cal.shaven@nhs.net. Include the person's name, date of birth, address, next of kin details, and clearly state that FNC is requested, including the contact name and number of the referring professional, the name of the nursing home, and the date of transfer.
- The negative checklist will be screened by the duty nurse:
  - If the checklist indicates the need for 24-hour access to a Registered Nurse, the duty nurse will complete the FNC agreement form.
  - If the person does not require 24-hour access to a Registered Nurse, the duty nurse will inform the referrer that FNC has not been agreed.
- If FNC is agreed:
  - The duty nurse will inform the referrer and send a copy of the FNC agreement.
  - FNC is to be used for permanent nursing home placements or respite nursing home placements.
  - The duty nurse will complete the Service Level Agreement (SLA) and send it to the relevant admin.

  - Update the Business Continuity (BC) system and place the case on a 3-month review list.
  - A review of the case will be completed in 3 months.

Who Can Receive FNC: FNC may be provided to people whose needs cannot be met in a residential home due to nursing requirements, those who require respite with nursing needs, or those needing emergency short-term or long-term placement in a nursing home due to nursing needs.

Addressing Disagreements in Recommendations: For disagreements in CHC or FNC recommendations, request discussion at the local panel resolution level. Inform your manager and the Integrated Care Board, and seek guidance if the process is unclear.

Evaluating Overall Needs and Primary Health Need Test:

- Evaluate whether the person's needs are primarily health-related or social care-related. Consult with the CHC Team or refer to the CHC Framework for further guidance.
- Apply the primary health need test: A decision of ineligibility for CHC can only be made if the required nursing or health services are considered incidental or ancillary to social care.

Additional Support and Guidance: For further guidance or support regarding CHC or FNC processes, contact the CHC team at chcsocialwork@calderdale.gov.uk .

Monitoring and Review

- Team Leaders/Managers will conduct regular audits of CHC and FNC-related documentation to ensure compliance with this SOP.
- Feedback from audits will be used to improve practice and identify training needs.

Training

All relevant staff will receive training on the CHC Framework, FNC processes, and this SOP to ensure consistent and effective application.

Ending Involvement Procedure

When a person's assessment, support plan, review or safeguarding enquiry has reached a satisfactory conclusion, and the person is living well we then consider ending our active involvement. At this stage the allocated Social Worker or Service Co-ordinator or Reviewing Officer should complete the processes for ending involvement and notify their Team Manager or Team Leader that they are ready to end the active involvement. The Manager or Team Leader should utilise the closure checklist and ensure that all the work is completed to a good standard, reverting to the worker where additions or amendments are required.

Finance, financial implication and assessment.

Early Financial Information

Objective: To ensure that people are informed about the financial implications of their care at the earliest opportunity, allowing them to make well-informed decisions about whether or not to received social care services.

Process:

- **Initial Contact:** At the initial contact (duty) stage or upon allocation of a Social Worker, initiate an upfront discussion about the potential financial implications of care services. This early conversation helps manage expectations and ensures that individuals are aware of any financial impact.
- **Financial Information Pack:** The allocated Social Worker is responsible for sending out the financial information pack to the person. This pack should be provided preferably before any home visit, either via email or post based on the person's preference. The pack contains crucial information about potential care costs and can be accessed online via the calculator: Care Charge Calculator.

Documentation:

- Ensure that a record is made in the Client Information System (CIS) that the financial information pack has been sent and received.

Confirmation of Receipt and Financial Information

Objective: To confirm that the person has received the financial information and understands the implications of the financial assessment process.

Process:

- **Confirmation Form:** During the home visit, obtain signed confirmation from the person acknowledging receipt of the financial information pack. Use the form designed for this purpose, which also includes options to:
  - Confirm if they do not wish to proceed with the financial assessment.
  - Indicate if they exceed the capital limit and will therefore pay the full cost of care.
- **Legal Responsibility:** Verify that the person signing has the legal authority to do so, such as having Lasting Power of Attorney.
- **Uploading Documentation:** Upload the signed confirmation form to CIS and associate it with the person's record.

Documentation:

- Ensure the signed confirmation form is accurately uploaded and linked to the person’s record in CIS.

Assisting with Financial Information Form (FIF)

Objective: To support individuals in completing the Financial Information Form (FIF) and ensure timely submission for financial assessment.

Process:

- **Assistance Offer:** If the person is unable to complete the FIF themselves and has no support, offer assistance. Encourage self-service where possible or help them find a financial representative such as a family member or friend.
- **Providing Help:** If providing direct assistance, accept photos of bank statements, pension letters, etc., as evidence. Send these documents to Business Support for uploading after the visit.
- **Disability Related Expenditure (DRE):** Record any disability-related expenditure (DRE) in the conversation record, as stated in the Council's charging policy. This ensures that any additional necessary expenditure due to a disability is accounted for in the financial assessment.

Documentation:

- Record any assistance provided and evidence gathered in CIS. Ensure that DRE is noted in the Living Well conversation record where applicable.

Financial Assessment Completion and Case Management

Objective: To ensure that financial assessments are completed in a timely manner and that cases are managed effectively to avoid any delays in care planning.

Process:

- **Financial Assessment Monitoring:** Check case notes to confirm whether the financial assessment has been completed before closing a case. Ensure that all required financial information is provided within 5 weeks of starting to receive services.
- **Late Submission:** If financial information is not provided within the stipulated time, CAT (Charging Assessment Team) will notify the person that they will be assessed to pay the full cost of care due to non-compliance. Work collaboratively with CAT to resolve any delays in the financial assessment process.
- **Pre-Closure Check:** Before closing a case, verify in CIS that CAT has completed the financial assessment. If there is no record, contact CAT to determine the reason for any delay.

Documentation:

- Maintain accurate records in CIS of all communications with CAT and any actions taken regarding the financial assessment. Ensure that financial assessments are completed before the 6-week review or before case closure.

Case Recording

Case recording is an essential part of daily Social Work practice. It involves:

- recording the views of the adult and their carers;
- writing down the work that has been undertaken;
- life history, assessment and analysis;
- documenting the progress adults make towards their desired outcomes.

Case recording also provides an evidence trail of the work done with an adult, and their carer and is a vital tool to enable staff to reflect on their ongoing work with adults / carers and plan future work. Records should be used as part of supervision, in conjunction with their supervisors / managers.

Staff should always remember that in the event of a safeguarding enquiry or other investigation, case records will be used and scrutinised. Staff will be held accountable for all entries they make and should be mindful of this when documenting their actions and professional judgements.

Staff should also remember that records may be shared with the adult, and this should be reflected in the language used and the manner in which judgements are recorded

Case records should:

- be based on a general principle of openness and accuracy:
- be drawn up in partnership with the adult;
- record the views of the adult, in their own words where appropriate, including whether they have given permission to share information;
- be an accurate and up to date record of work, which is regularly reviewed and summarised;
- include a record of decisions taken and reasons for them;
- include a chronology of significant events;
- be evidence based and ethical;
- separate fact from opinion;
- incorporate assessment, including a risk assessment where appropriate
- include an up to date care and support plan
- record race / ethnicity, gender, religion, language and disability
- be used by the supervisor / line manager as part of overall measurement of staff performance
- include management sign off where appropriate
- be kept securely and shared in accordance with data protection principles (see Data and Protection Act 2018)

In addition to ensuring the principles above underpin case recording, other areas to consider include:

- the adult's voice should not be 'missing' from the case record: whilst actions taken in relation to them are documented, their wishes, feelings, views and understanding of their situation should be clearly recorded. There may be a tendency to focus on the views of a carer who is able to be more vocal, rather than the adult who may have more difficulty in expressing themselves

- the size of the record may make it difficult to manage: records should be focused and important information highlighted and regular summaries /transfer summaries included to make it easier to find for others reading the record

- a completed assessment should be on file: information must be analysed and a plan created for the assessment to be complete. An assessment is not just about collating information

- the record must be written for sharing: making it easy for the adult to read and understand. Language should be plain, clear and respectful, keeping social work terms and abbreviations / acronyms to a minimum. Records should be shared regularly with the adult to encourage them to contribute to the record

- the record should be used as a tool for analysis: it should not simply record what is happening, but also to analyse and hypothesise why particular situations and events are occurring. The use of genograms, chronologies and assessment records can help organise and analyse information.

Information Sharing

Information sharing is a critical component of providing effective and coordinated care. Adhering to these procedures ensure that information is shared appropriately, respecting confidentiality and legal requirements while promoting the well-being of individuals receiving care and support.

Purpose and Necessity

- **Define the Purpose:** Clearly identify the reason for sharing information, ensuring it is relevant and necessary for the individual's care and support.
- **Assess Necessity:** Determine if sharing information is essential to provide care, protect individuals, or comply with legal obligations.

Consent and Involvement

- **Obtain Consent:** Seek explicit consent from the individual to share their information, ensuring they understand what will be shared, with whom, and why.
- **Informed Decisions:** Provide individuals with sufficient information to make informed decisions about their consent.
- **Document Consent:** Record the consent given, noting any conditions or preferences expressed by the individual.

- **Lack of Consent:** In situations where consent cannot be obtained, information may still be shared if it is necessary to protect the individual or others from harm (e.g., safeguarding concerns).

Confidentiality and Data Protection

- **Respect Confidentiality:** Ensure that information shared is kept confidential and shared only with those who have a legitimate need to know.
- **Data Protection Laws:** Comply with data protection laws, such as the General Data Protection Regulation (GDPR), which governs how personal information should be handled and shared.

Information Accuracy and Relevance

- **Ensure Accuracy:** Verify that the information to be shared is accurate, up-to-date, and relevant to the intended purpose.
- **Limit Sharing:** Share only the information necessary to achieve the intended purpose, avoiding the disclosure of excessive or irrelevant details.

Risk Assessment and Safety Planning

Risk assessment and safety planning are integral components of the intervention process for anyone accessing the team’s support. Identifying and assessing risks involves a careful examination of specific factors or circumstances to determine the type, likelihood, and severity of risks, as well as their potential impact on the person or others. This assessment helps to establish which agency or professional is best positioned to address and manage the identified risks, including consideration of any applicable legal frameworks.

Workers will distinguish between risks that are choice-based—reflecting a person’s right to make decisions about their own life—and risks over which the person has no choice or control. Documentation of identified risks, including the timing and any actions taken in response, should be meticulously recorded within the person's electronic case notes.

Risk Documentation Based on Severity

- **Low to Moderate Risks:** For risks deemed low to moderate during the assessment of needs, workers should document these within the Living Well document. This approach provides a contextual framework for understanding how risks may be mitigated and managed, including any relevant legal frameworks.
- **High Risks or Cumulative Risks:** For risks identified as high in severity or when multiple low to moderate risks combine to elevate overall risk, a **Positive Risk Assessment** should be completed. This assessment should directly address the risks and outline appropriate mitigating actions. Emphasis should be placed on what agencies can do to actively involve the person in

safety planning, ensuring that they remain safe in a way that respects their comfort and autonomy.

Positive risk assessments should serve as a practical tool, helping the person to visualise and engage meaningfully in the risk assessment and management process. These documents are also valuable for collaborative work with other agencies, providing a shared understanding of the risks, the steps taken to mitigate them, and any remaining residual risks. Completed positive risk assessments must be associated with the person's electronic record for comprehensive case management.

Review of Risk Assessments and Management Plans

Risk assessments and management plans should be reviewed regularly, and reviews should be responsive to changes in the identified risks and the effectiveness of any mitigating actions. Workers are responsible for determining and documenting the timing of reviews, ensuring that risk management remains relevant and meaningful to the person. The goal is to maintain a dynamic and person-centred approach to risk assessment, continuously adapting to meet the evolving needs and circumstances of the person.

Complex and High-Risk Multi-Agency Planning

People with complex and high-risk needs may be discussed at **Complex Lives Meeting**, DRAMM (for domestic abuse), Antisocial Behaviour Panel, or Hoarding Panel.

These discussions occur when a person is possibly requiring a multiagency response to the requirements they have because there are significant concerns or risks impacting their situation. Adult Social Care has representation at these meetings, and there may be occasions when a person is identified as needing social care intervention or representation in a multi-agency setting. Depending on the type of intervention required, there are two main pathways for addressing these needs:

1. Referral to Social Work Team

A referral may be raised to the Social Work team via the referral email inbox. This could involve:

- A routine assessment of need under the **Care Act 2014**.
- A specific safeguarding concern.

Referrals and concerns are subject to established processes, such as the **Waiting Safe and Well for Assessment Process** or the **Duty Assessment Process.** As part of the social care intervention, the allocated worker may convene a multi-agency meeting to facilitate information sharing and promote a collaborative approach. This approach ensures coherency in the interventions and services offered to the person, aiming to best meet their needs and manage any identified risks.

2. High-Level Multi-Agency Meeting Coordination

Requests for multi-agency involvement can also be generated via email and discussed among the **Service Manager, Operations Manager, and Team Manager.** They will determine the appropriate representative to coordinate and attend a multi-agency meeting. This pathway is generally for cases involving significant levels of risk and complexity with multiple agencies, where collaborative discussion and planning are essential.

This process does not necessarily imply that the person will require long-term social care intervention, but it recognises the crucial role that social care can play as a system leader and coordinator. Agreement will be reached regarding the most suitable person to attend the meeting and the specific responsibilities of that representative.

Safeguarding People’s Rights and Views

For both pathways, Adult Social Care will ensure that people's rights and views are protected and promoted within multi-agency platforms. Social care representatives will identify relevant legal frameworks that apply and outline any further actions to be taken. Positive risk assessments may be conducted to support multi-agency meetings, including outlining risk assessment and safety planning processes, and documenting risks identified by the **Multi-Disciplinary Team (MDT).**

Documentation and Communication

Attendance and the summary of these meetings should be recorded by an agreed minute-taker, with minutes circulated to the MDT. These minutes should be associated with the person’s electronic record and clearly documented within the notes, outlining outcomes, further actions, and timescales for completion or review. Documentation should also clearly state the current and potential future roles of the Local Authority in supporting the person.