Adult Services and Wellbeing
Calderdale Metropolitan Borough Council

Standard Operating Procedure (SOP): Physical Disability and Older People's Locality Teams.

Contents

Procedure Version Control

Procedure Name	**Standard Operating Procedure: Physical Disability and Older People's Locality Teams.**		
Document Description	This Standard Operating Procedure sets out the Physical Disability and Older People's Locality Team's aims, objectives, underlying principles together with consistent ways of working.		
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Version Number	**Date**	**Amendments**
1.0	August 2024	New Document
2.0	December 2024	Amendments Made to Waiting Well process. Consistent naming for the team: Physical Disability and Older People's Locality Teams (rather than PLTS). Consistent Safeguarding Procedures added.

Standard Operating Procedure
Physical Disability & Older People's Locality Teams
Service Area Overview

The Physical Disability and Older People's Locality Teams work with adults aged 18 and over, as well as young people who are 17 years old and transitioning into adulthood, provided they are ordinarily resident in Calderdale and require ongoing care and support.

The Physical Disability and Older People's Locality Teams focus on people whose primary care needs include:

- Physical Impairment
- Brain Injury
- Substance misuse
- Cognitive Impairment
- Older Age

The primary objective of the The Physical Disability and Older People's Locality Team is to enable people to lead fulfilling lives by providing long-term, tailored support that aligns with their unique social care goals.

The The Physical Disability and Older People's Locality Team delivers a range of services, including:

- **(Re)Assessments:** Conducting assessments to understand current needs and plan appropriate support.
- **Active Interventions:** Implementing interventions to address immediate needs and improve well-being.
- **Regular Reviews:** (Scheduled and Unscheduled) Reviewing and updating care and support plans to ensure they remain effective and responsive to changing needs.
- **Safeguarding Adult Enquiries:** (stages 3 and 4) for those who are experiencing or at risk of abuse and neglect, conducting enquiries in line with the principles of Making Safeguarding Personal.(The full process is outlined later in this document).

The Physical Disability and Older People's Locality Team Main Aims

Enhance Quality of Life:

- Improve the overall quality of life for people by addressing social, emotional, and practical needs.
- Support access to education, employment, and leisure activities.

Ensure Holistic and Person-Centred Care:

- Provide care that is tailored to the unique needs and preferences of each person.
- Involve people in planning and decision-making processes to ensure care is relevant and effective.

Promote Social Inclusion and Reduce Stigma:

- Encourage social inclusion by supporting community engagement and reducing isolation.
- Work to combat stigma and discrimination associated with addiction, disability, cognitive impairment or older age.

Support Independence and Autonomy:

- Help people achieve greater independence by supporting daily living activities and life skills development.
- Facilitate access to housing and other essential services that promote autonomy.

Crisis Intervention and Support:

- Provide timely and effective crisis intervention services to prevent escalation and ensure safety.
- Offer ongoing support to people and families during and after a crisis.

Promote Family and Carer Support:

- Recognise the role of families and carers in supporting people with Physical Impairment, Brain Injury Addiction, Cognitive Impairment or Older Age.
- Provide education, resources, and support to families and carers to help them in their roles.

Advocate for People's Rights:

- Advocate for the rights and needs of person's with mental health conditions within the broader community and policy framework.
- Ensure that people are treated with dignity and respect in all interactions.

Promote Prevention and Early Intervention:

- Focus on early identification and intervention to prevent the progression of mental health issues.
- Implement preventative measures that address risk factors and promote overall well-being in its holistic sense.

Promote Recovery and Resilience:

- Support people in their recovery journey by providing personalised care and interventions.
- Encourage self-management and resilience through empowerment and skill-building.

The Physical Disability and Older People's Locality Teams Team Objectives

Assessment and Eligibility: We conduct thorough and person-centred assessments to identify each person's needs and determine their eligibility for care services. This process ensures that person receive support tailored to their specific requirements and circumstances, in line with Care Act principles.

Care and Support Planning and Review: We develop personalised care and support plans that detail the necessary services and interventions to meet each person's assessed needs. These plans are reviewed regularly to ensure they remain relevant and adaptable to any changes in the person's circumstances, ensuring ongoing effectiveness.

Access to Services: We are dedicated to ensuring that people have timely and equitable access to a range of care services, including home care, residential care, day services, and respite care. Our goal is to ensure that the right support is available when and where it is needed.

Collaboration with Key Partner Agencies: We promote effective collaboration and partnership working with health and social care agencies to ensure a coordinated approach to support. This integration allows us to provide comprehensive care that addresses all aspects of a person's needs.

Empowerment and Choice: We empower people to make informed decisions about their care and support by providing clear, accessible information and guidance. This approach supports person in making choices that reflect their personal preferences and needs.

Prevention and Early Intervention: Our focus is on preventative measures and early intervention to help reduce the need for more intensive and long-term care. By identifying and addressing potential risks early, we support people in maintaining their independence and well-being.

Workforce Development: We invest in the recruitment, training, and ongoing development of a skilled and compassionate workforce. Ensuring our team is well-

equipped with the necessary skills and knowledge is essential for delivering high-quality care.

Community Involvement: We encourage and facilitate community engagement and the development of support networks to enhance social inclusion. By fostering community connections, we help people reduce isolation and build a strong sense of belonging.

Quality Assurance: Maintaining high standards of care is a priority for us. We continuously monitor and evaluate the quality of our services, using feedback and data to drive improvements and ensure that our care is consistently effective and person-centred.

Safeguarding: We have established robust safeguarding policies and procedures to protect people at risk of harm. Our safeguarding practices ensure that any concerns are addressed promptly and appropriately, prioritising the safety and well-being of those we support.

System Leadership: We lead multi-agency care planning for people with complex and high-risk needs. By coordinating efforts across various services, we ensure that care plans are comprehensive and address all aspects of a person's needs effectively.

Cost-Effectiveness: We are committed to using resources efficiently to provide high-quality care while managing public funds responsibly. Our approach to cost-effectiveness ensures that we deliver sustainable services that meet the needs of our community both now and in the future.

Service Area Outcomes

Increased Independent Living: As many people as possible are living their healthiest, happiest, and most fulfilling lives in a place they call home, supported to maximise their independence.

Reduced Admissions to Residential Care: People are only admitted to residential care when there is no realistic alternative option, making use of personal budgets enabling more people to meet their needs within the community.

Enhanced Recovery and Housing Outcomes: People successfully complete recovery and recuperation programmes, with improved access to telecare and suitable housing options that support their long-term needs.

Community-Based Support and Safeguarding: People get on with their lives independently without the requirement for long term services, with more people being supported within their communities alongside appropriate safeguarding measures.

Commitment to Equality and Human Rights: The promotion of equality of opportunity, with a focus on embedding equality, diversity, and human rights principles in all strategic decision-making processes.

Safe and Effective Hospital Discharge: Safe and effective hospital discharges are facilitated, ensuring people transition smoothly back into their homes or other care settings.

Rights and Strengths-Based Practice: Increased adoption of rights-based and strengths-based approaches, with a focus on positive risk enablement and empowering people to make informed decisions about their care.

Enhanced Support for Carers: Improved support for carers, recognising and valuing their essential role, and ensuring they have the necessary resources and assistance to sustain their caregiving roles.

Active Community Participation: Greater involvement of local communities as active participants in supporting people, fostering strong support networks that are responsive to people and community needs.

Values and Principles of the Service Area

- The Service aims to provide high quality services, which are efficient, effective and makes the best use of public funds.
- To ensure equity of access and equality of opportunity and outcomes.
- To ensure that people are safeguarded in line with their wishes whilst promoting the Making Safeguarding Personal, (MSP) approach.
- To work effectively in partnership with other services, agencies and communities.
- To be open, transparent and accountable.
- To be a learning organisation and service that seeks continuously to improve.
- To work to our Adult Social Care Wellbeing principles.
- To ensure we practice in relation to our 8Ps Strengths-Based Practice model 8Ps Framework FINAL.pdf

Eligibility Criteria and Contacting the Service

The The Physical Disability and Older People's Locality Teams work with adults aged 18 and over, as well as young people who are 17 years old and transitioning into adulthood, provided they are ordinarily resident in Calderdale and require ongoing care and support.

The PLTS teams focus on people whose primary care needs include:

- **Physical Impairment**
- **Brain Injury**
- **Substance misuse**
- **Cognitive Impairment**
- **Older Age**

Typically, people referred to the The Physical Disability and Older People's Locality Team already have long-term and ongoing social care services in place. However, the team also supports people who have been self-funding their care and support for more than three months and whose capital has fallen below the financial threshold.

The team also works with people who may not currently have ongoing care and support but require longer-term active intervention from a Social Worker or Service Coordinator to help them achieve their goals. This includes those who would typically require support beyond the short-term assistance provided by the Link into Calderdale Team, (LinC).

The team is available to assist people receiving health-funded care who need the involvement of a Social Worker or Service Coordinator as part of a multidisciplinary team to review and consider their funding arrangements.

The team also undertakes Safeguarding Adult Enquiries**:** (stages 3 and 4) for those who are experiencing or at risk of abuse and neglect, conducting enquiries in line with the principles of Making Safeguarding Personal where abuse took place within Calderdale MBC area.

Service Delivery

The Physical Disability and Older People's Locality Teams are organised into five locality-based pods, aligned with the primary care network areas of North Halifax, Upper Valley, Central Halifax, South Halifax, and Lower Valley.

Each team within these pods comprises Team Managers, Team Leaders, Social Workers, Service Coordinators, and Reviewing Officers. 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 Physical Disability and Older People's Locality Teams operate from 8:45 AM to 5:00 PM, Monday to Friday. During these hours, the team is responsible for managing all new referrals received and addressing any queries related to people

currently under their care, ensuring a responsive and coordinated approach to support.

Contact with the personalised long term support 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 service can be emailed on: plts.duty@calderdale.gov.uk

Team Managers (general) email is: pltsmanagementteam@calderdale.gov.uk

Respective Team Management email addresses are as follows:

North Halifax & Upper Valley Team: pltsnorthuppermanagement@calderdale.gov.uk

Central Halifax Team: pltscentralpalliativemanagement@calderdale.gov.uk

Lower Valley and South Halifax: pltssouthlowermanagement@calderdale.gov.uk

Outside of standard office hours, the Emergency Duty Team (EDT) is responsible for handling all adult referrals that require urgent attention. The EDT assesses the level of risk and, where necessary, provides immediate support to mitigate or reduce risks for those who cannot safely wait until the next working day. The team may also coordinate with, or direct other agencies as needed to effectively address and manage any immediate concerns.

Once standard office hours resume, the Emergency Duty Team transfers all relevant concerns to the Gateway to Care. Gateway to Care will then process these concerns in the Client Information System (CIS) and ensure that The Physical Disability and Older People's Locality Team is promptly notified for further action.

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 & Referral Sources:

- **Gateway to Care:** Referrals for people known to Adult Services and Wellbeing, who are living with long-term care and support, are primarily received through Gateway to Care, (GWTC). GWTC is responsible for understanding the reasons for each referral and directing it to the appropriate team. On receipt, Gateway to Care creates a review request in the Client Information System (CIS) and assigns it to the relevant The Physical Disability and Older People's Locality Team. For people who are not previously known but have been self-funding their long-term care and support for more than three months and whose capital has now fallen below the financial threshold, Gateway to Care will create a new record, complete the referral screens, and record the outcome as an assessment required. The referral is then assigned to the appropriate The Physical Disability and Older People's Locality Team.

- **Handover for Known People:** The Link into Calderdale Team, (LiNC) works with people who do not have existing care and support in place on a short-term basis, with the aim of fostering independence, choice and control or conducting assessments and support planning. If the Link into Calderdale Team has commissioned support, they will complete the initial review and assign the subsequent 12-month review to the relevant Physical Disability and Older People's Locality Teams Team. Should the Link into Calderdale Team identify preventative goals that cannot be achieved within a short-term period (typically 6 to 8 weeks), they will arrange a handover to the appropriate Physical Disability and Older People's Locality Teams Team. This process involves a discussion between Team Managers, Team Leaders, or practitioners from both teams, followed by the creation of a referral and its assignment to the relevant team on CIS.

- **Younger People:** Younger people (with primary care needs as outlined in the criteria) involved with Children's Social Care can be considered for direct access to the Personalised Long-Term Support Team from the age of 17. This allows for timely allocation, relationship building, and a smoother transition into adult services. Children's services would usually make their initial contact through Gateway to Care, the record is created on CIS and a referral is created and assigned to the relevant Physical Disability and Older People's Locality Team.

- **Safeguarding:** If the Safeguarding Team identifies a person as meeting the criteria for ongoing safeguarding enquiries at Stage 2, this will be handed over to the relevant Physical Disability and Older People's Locality Team. This

handover includes a verbal briefing at Manager/Team Leader or Practice Lead level from teams and includes practitioners if required. The referral is then created on CIS and assigned to the relevant Personalised Long-Term Support Team.

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 enquiries regarding people we are already supporting. The Duty Social Worker is supported by a Team Leader or Team Manager to ensure effective and timely responses.

Assessment of Urgency & Priority:

On receipt of a new referral, the Team Manager or Team Leader reviews available information and identifies any gaps. They then contact the person, their family, or their network of professionals to gather further information. A judgement call needs to be made as to the timeliness of response that is required, which are categorised and summarised as:

Immediate Response (very high priority): Must be responded to on the day or the next working day of made known out of hours.

- The person has multiple needs, impacting negatively on their wellbeing. They have no support and are unable to keep themselves safe.
- Major injury to a person or several People
- Very Likely to experience harm to themselves or other

Urgent Response (high priority): Must be responded to within 5 days.

- The person has multiple needs, impacting negatively on their wellbeing. They have minimal support in place, can keep themselves safe as there are protective factors, and no concerns for the safety of others.
- Severe injury to a person or several people
- Likely to experience harm to themselves and/or others

Routine Response (medium priority): Would normally be responded to within 20 days.

- Requires support to address social care needs, they are safe, no risk to other people.
- Minor injury or discomfort to a person or several people
- Unlikely to experience harm to themselves /and or others

Immediate Response Examples

The following outlines potential situations where an **immediate** response is required on the day of referral or the next working day if received out of hours. These situations involve very urgent and high-risk circumstances where delay could significantly impact the person's safety, health, or well-being, the list is an indicator and professional judgement must always be used:

Rapid Deterioration in Functioning with Unmet Critical Needs: Referrals where there is a sudden and significant decline in a person's ability to function, resulting in unmet critical (life-sustaining) social care needs.

Domestic Abuse: Immediate response required, particularly for people not currently supported through Domestic Abuse Risk Assessment and Management Meetings (DRAMM) or Multiple Agency Risk Assessment Conference (MARAC).

Referrals Under MARAC or DRAMM: Referrals for people under the remit of MARAC or DRAMM requiring urgent attention.

Self-Neglect / Hoarding: Situations where self-neglect or hoarding poses a direct risk to life.

Carer Breakdown: Breakdown of formal or informal carer arrangements without an alternative contingency plan in place, putting the person at risk.

High Levels of Distress / Recent Traumatic Events: People expressing high levels of distress or those who have recently experienced traumatic events and require immediate intervention.

Severe Stress / Impending Crisis: Referrals indicating severe stress with an impending crisis and high risk of harm.

Suicidal Ideation: Expressions of suicidal ideation with factors that increase the risk of self-harm or suicide.

Urgent Changes to Existing Support Plans: Situations where urgent amendments to existing care and support plans are necessary to address immediate risks.

Significant Changes in Behaviour: Referrals highlighting significant changes in behaviour or increased risks posed by the person, such as aggression or risk to others.

Deterioration in Physical Condition: Situations involving a significant decline in physical health, posing a potential risk to life or risk of unnecessary hospital admission.

Risk of Immediate Breakdown of Usual Living arrangements: Immediate risk of usual living arrangements, necessitating urgent support or intervention.

Risk to Self or Mental Health Act Consideration: Presentations that indicate a risk to self or where an assessment under the Mental Health Act may be required.

Complex Multiple Disadvantages: People presenting with complex multiple disadvantages, such as those identified under the Making Every Adult Matter initiative and deemed high risk.

No Access Visit (NAV): No Access Visits (carer could not gain entry) that have associated risks warranting immediate action.

Urgent Assessment Requests: Requests for urgent assessments of care and support, including mental capacity assessments where immediate risks are identified at the point of referral.

Excessive Substance/Alcohol Use: Situations of excessive substance or alcohol use where there is an increased risk to the person or others.

Significant Risks Related to Exploitation or Homelessness: Referrals involving significant risks related to exploitation, homelessness, asylum seekers, trafficking, or those with No Recourse to Public Funds (NRPF).

Protection of Property and Pets: Situations where there is an immediate need to protect a person's property or pets due to the person's circumstances.

Urgent Response Examples

The following outlines potential situations that require an **urgent** response due to high priority needs. These scenarios involve significant risks that necessitate timely intervention, usually within 5 days, but where immediate risk is mitigated or manageable in the short term, the list is an indicator and professional judgement must always be used:

Hospital Discharge: People requiring urgent social care intervention to support safe and timely discharge from hospital.

Safeguarding Enquiries: Safeguarding concerns that necessitate a social care assessment or the implementation of a protection plan to ensure the person's safety.

Environmental Risks: Situations where environmental risks are present, requiring urgent assessment or intervention to mitigate hazards to the person's well-being.

Imminent Release from Prison: People due for imminent release from prison who require reassessment and support planning to facilitate their reintegration into the community.

Parental Support Needs: Parents needing immediate support due to concerns about their ability to care for their child or unborn child, where intervention is necessary to ensure the safety and well-being of the child.

Change in Carer Support or Support Plan: High levels of risk due to recent changes in carer arrangements or support plans, with a short-term safety plan in place that requires further assessment.

Self-Neglect Concerns: Self-neglect cases that require intervention where some basic amenities are lacking, but immediate risks are not critical.

Legal Framework Concerns: Section 21 challenges, initial Court of Protection (COP) applications, or other legal framework concerns that require urgent attention to safeguard the person's rights and welfare.

Carer Breakdown with Contingency: Formal or informal carer breakdowns where short-term contingency plans are in place, but further intervention is needed to ensure continuity of care.

Requests for (Re)Assessment: Urgent requests for (re)assessment of care and support needs, including mental capacity assessments, where medium risks are identified at the point of referral.

Low-Level Short-Term Intervention: Situations requiring low-level, short-term intervention where medium risks are present and need timely but not immediate attention.

Risk to Self or Others: People presenting with risks to self or others, where an initial risk mitigation plan is already in place but requires further action to ensure safety.

Care and Support Needs with Limited Support Network: People with care and support needs who have limited support networks, such as those living alone or isolated, where basic human needs can be met but additional support is required.

Risk of Disengagement with Services: Referrals involving people at risk of disengaging from services, where urgent intervention could prevent further decline or crisis.

Substance Misuse: New or ongoing substance misuse that poses a risk to the person's ability to manage their own care or the safety of others, necessitating urgent but not immediate intervention.

Routine Response Examples

The following outlines potential scenarios that require a **routine** response due to medium priority needs. These situations involve issues that need assessment or intervention but do not present immediate risks. Timely support (within 20 days) ensures that care remains sustainable and that any emerging needs are addressed before they escalate.

Accommodation and Living Circumstances: Concerns around a person's accommodation or living conditions that are currently sustainable, with no imminent risks identified.

Risk to Self and Others: Situations where there is a risk to the person or others, but adequate support or contingency measures are already in place.

Change in Needs: Changes in the person's needs that require assessment, where there is no immediate risk of deterioration.

Support Plan Modifications: Modifications needed in the existing support plan, where current arrangements are sustainable and adequate.

Planned Respite or Short Breaks: Requests for planned respite or short breaks with no immediate risk of carer breakdown, often requested for future dates.

Care and Support with Limited Network: People with care and support needs who have a limited support network or whose existing care arrangements are meeting their needs.

Transition to Supported Living or Extra Care: Requests for moving into supported living or extra care schemes where current care and support are sufficient, with no immediate risk to the person.

Social Care Assessment Post-Education: Assessments following a person's attendance at college or residential college, addressing any new or ongoing care needs.

Court of Protection (COP) Reviews: Scheduled COP reviews due within 8–12 weeks, requiring routine follow-up.

Substance Misuse Impacting Engagement: Cases where substance misuse affects engagement with an existing support plan, needing routine but not urgent follow-up.

New Social Care Assessment Requests: New requests for social care assessments, including those from people who have fallen below the capital limit threshold with no immediate risks identified.

Substance Misuse with Other Agency Involvement: Substance misuse cases where other agencies, such as drug and alcohol services, are already involved.

Scheduled Annual Reviews: Planned annual reviews that are scheduled based on overdue statuses or organisational business priorities.

Planned Prison Release: Planned release from prison with arrangements in place, requiring routine assessment or support planning.

Mental Health and Safety Assessments: Situations where there is no evidence of suicidal ideation, harm to others, or relapse from a mental disorder, but routine assessment is beneficial.

Potential Mental Capacity Concerns: Potential concerns regarding mental capacity that require exploration, with no immediate risk present.

Administrative Responses: Responding to administrative data issues, such as fee adjustments or PLAG, changing care agency or changing from direct payment to care managed arrangements but current support is sustainable.

Immediate Response

People who are in a crisis situation and are not currently open and active to The Physical Disability and Older People's Locality Teams will initially be supported by the Gateway to Care Duty Social Workers who will stabilise the situation and hand over to the relevant Physical Disability and Older People's Locality Team for onward assessment and review. If the person is open and active to The Physical Disability and Older People's Locality Teams and presents in a crisis requiring an immediate response, then they should be directed to their allocated Social Worker or The Physical Disability and Older People's Locality Team Duty. The response should be proportionate and if suitable and safe to do so, managed remotely, offering direct access to services (for example home care support or urgent community response) to manage risks. Other agencies or internal teams may be utilised to form the response.

Urgent Response:

For people in urgent situations (not deemed to be an immediate crisis where a response is required with 5 days), the team prioritises and provides a proportionate and immediate response. This may include remote assessments if critical and safe to do so and arranging support services or urgent home visits if necessary. The service must respond within 5 days of the receipt of the referral. This should be managed by the existing allocated worker if there is one. If not, then ideally the person will be allocated to a practitioner within the teams to support them through the urgent situation and beyond to bring about stability, if allocation is not possible the immediate situation must be managed by duty and marked for future allocation as a priority. The response should be proportionate and if suitable and safe to do so, managed remotely, offering direct access to services (for example home care support or urgent community response) to manage risks. Other agencies or internal teams may be utilised to form the response to those who fall outside of the 72 hour window requiring Gateway to Care support.

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. If their query can be resolved remotely at this point, possibly with a one-off increase, or a small increase to the existing package of care then this can be done at this stage. For others who require more than this, the person is informed that a Social Worker or Service Co-ordinator will be allocated within 20 days. Contact details are provided for any interim needs.

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.

Arrangements for Allocation:

Allocations are usually agreed on a weekly basis by the Team Leader or Team Manager for each locality team. Team Leaders must have a good awareness of each practitioners' caseloads and ensure work is progressing for people accordingly to ensure involvement is ended in a timely way to create capacity for allocation for new referrals.

Assessment, Review and Eligibility Process

Long-Term Care Assessment: For people requiring long-term social care, assessments are conducted using the Living Well Conversation Record and adhere to the eligibility criteria set out in the Care Act 2014. The strengths-based assessment process uses our 8Ps framework to consider the person's strengths, needs and the availability of informal support, ensuring a person-centred approach that aligns with their desired outcomes.

Unscheduled Reviews: For people with existing care and support arrangements whose needs have changed or where their support plan is no longer effective, the team will review the current care and support. This review determines whether an update to the support plan is necessary or if a reassessment is required. If a reassessment is deemed necessary, it will follow the Long-Term Care Assessment process as described in Sections 9 and 10 of the Care Act.

Scheduled Reviews: Section 27 of the Care Act 2014 outlines the requirements for reviewing care and support plans. According to Section 27, person with established care and support plans are to receive a review at least once every 12 months, or sooner if specified upon the finalisation of the support plan. Scheduled reviews are generated by the Client Information System (CIS) and assigned to Reviewing Officers. Reviewing Officers are responsible for completing the review screens on CIS and determining the outcome. If a reassessment is required, a referral should be raised and assigned to the relevant locality team for further action.

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.

Living Well Conversation (Assessment)

Objective:

- To conduct a thorough, strengths-based person-centred assessment to identify the person's strengths, 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 strengths, 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 strengths, 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 strengths and 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 strengths, needs and preferences.
- **Feedback and Adjustment:** Facilitate 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 Personalised Long-Term Support are generally 'closed to review' when they are stable, and their support plan is working well. Until that point the person should remain with the Social Worker or Service Co-ordinator to ensure 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 Physically Disabled Adults and Older People. 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 relevant The Physical Disability and Older People's Locality Teams 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 relevant The Physical Disability and Older People's Locality 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 Physical Disability and Older People's Locality 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 Physical Disability and Older People's Locality 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 the relevant Physical Disability and Older People's Locality Teams Team Manager, Team Leader or Practice Lead explaining that they have a stage 3 prepared for handover. The Physical Disability and Older People's Locality Teams /Team Leader or Practice Lead should identify a practitioner within their 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 Physical Disability and Older People's Locality Teams.

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 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 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.

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 person is 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 people 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 Disability Related Expenditure, (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. 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 are accountable for all entries 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, strengths-based, 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 person 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 person's care and support.
- **Assess Necessity:** Determine if sharing information is essential to provide care, protect person, or comply with legal obligations.

Consent and Involvement

- **Obtain Consent:** Seek explicit consent from the person to share their information, ensuring they understand what will be shared, with whom, and why.
- **Informed Decisions:** Provide the person with sufficient information to make informed decisions about their consent.
- **Document Consent:** Record the consent given, noting any conditions or preferences expressed by the person.
- **Lack of Consent:** In situations where consent cannot be obtained, information may still be shared if it is necessary to protect the person 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.