Practice Guidance Relating to New Way of Working

Document Control

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Change History

Version	Date	Description	Change ID
0.2	16.05.16	Pg 7 - Reference Social Discipline Window - Wachtel and McCold	
0.3	26.09.16	Update to Tier 2 guidance Updated Review guidance	
0.4	08.12.16	Updated recording grid to include reference to Concise Reviews	
0.5	30.03.2017	Updated recording in relation to Care Director	

This Guidance is not for publication externally

West Berkshire Council

Contents

10 Key Commitments

Our 10 Key Commitments

(Agreed collaboratively in December 2014)

1. We will focus on the strengths and abilities of each individual to support the highest level of independence possible.

2. We will work with families, carers and their wider community networks, not just individuals, in order to find the solutions they are looking for.

3. We believe in support that reduces dependency.

4. We are here to work with you, rather than to do to or for you.

5. Our first offer to you is expertise, knowledge and experience.

6. We will do as much as possible, as quickly as possible, for your and our benefit.

7. We will stick with you until we find a solution that works.

8. We will not plan long-term with you when you are in crisis.

9. We recognise that, for everybody, life is always changing and we will seek to build flexibility into support plans to reflect changing needs.

10. We will advise how to keep yourself safe and agree how any risks can be minimised.

1. Three Tier Conversation Model

The Three Tier Conversation approach should be used for all work.

2. Description of Three Tier Model

Description of the Three Tier conversations:

Tier One Conversation:

"*Are we connecting people to things that make their life work without us (e.g. information about community groups, a grab rail, etc – whoever pays for it).*"

One of the important details of the Tier One conversation is that we are not worried about whether or not the person who is asking for support is eligible. In this way we can deliver on the Care Act's duty to prevent, reduce or delay the need for care and support.

We are not interested in telling people that they cannot have a service from us. First we are asking, simply, 'what do you need?'

If the person needs practical help from WBC, the worker might use a procurement card for a one-off purchase. Procurement cards should not be used if there is another suitable way to pay for the item (e.g. equipment from BCES, one-off payment to carer, etc).

If some needs remain unmet then you must move to either a Tier 2 or Tier 3 conversation.

Tier Two Conversation:

"*Are we putting a plan together, shaped by the key things that need to immediately change to respond to a crisis and create stability in someone's life.*"

The defining feature of a Tier 2 conversation is the purpose, mode or mentality of the worker. We are following one of our key rules –'never plan long term in a crisis'. If the worker judges that the person is in, or about to be in crisis (this means their life is going to be significantly negatively affected, they are at risk of losing independence, choice, control and/or at risk of becoming dependent on formal health and or care services) the worker adopts a 'Tier 2' mode or mentality which includes:

- Working out with the person what needs to change urgently to reduce or remove the crisis
- Sticking to them like glue for a short period of time to maximise the chance of those changes happening.
- Starting with people's assets strengths and those of their neighbours, friends family and community
- Using small amounts of money if that will make a difference.

Short-term in this context means a matter of weeks, not months.

A Tier 2 conversation is always accompanied by a Tier 2 plan, which is precise and clear about what changes are being worked towards, how the changes are being supported to happen and how the worker is sticking to the person like glue to help make them happen. It will have a stated end-date – the worker's judgement about when the crisis may stabilise.

Tier 2 plans always flex and change. They are not static. If they are not working other things need to be tried. If they are working then the changes that are being enacted will probably mean that new goals can be achieved.

Tier 2 plans are never a service prescription **on its own** (i.e. 6 wks of reablement)

Tier 2 should not be used as a way of tweaking, adjusting or defining Tier 3 conversations (ongoing support) plans. It is possible for someone who has had a Tier 3 conversation to enter a crisis phase, in which case a Tier 2 conversation is appropriate. In this situation, the long-term support remains part of a Tier 3 response and is chargeable. The additional Tier 2 elements will be non-chargeable.

Changes will be made to Resource Panel and authorisation arrangements to ensure that conversation 3 plans can be flexible and that quicker decisions can be reached re simple changes to conversation 3 plans. This is an essential part of good conversation 3 (ongoing support) planning. The detail will be developed in collaboration with colleagues across the Council and circulated once approved.

A Tier 2 plan is not defined purely because it is short term. If we are trying some ongoing support for a short time to see if it works, then that is a short term conversation 3 plan. It is the presence of crisis, and the urgency and therefore our different mode, that makes the difference.

Tier 2 plans should not be used if what in effect is happening is the trialling of a conversation 3 plan (i.e. the person isn't in crisis, eligibility has been determined etc.)

Tier 2 plans are always time-limited (weeks, not months) – and the end date is clearly stated in the plan.

If all the conditions above are met then Tier 2 plans are not chargeable.

Examples:

If someone with an existing plan and clearly eligible needs presents and their plan is not working well, then their conversation 3 plan needs to change until it works better (this is in fact a review – a taking stock of someone's life and the appropriateness of their plan). This is not a conversation 2 plan but a reworking of a conversation 3 plan.

If someone moves in from another area with an ongoing plan of support the Care Act requires us to honour that level of support unless or until the information we have deems it inappropriate. So if these circumstances pertain and:

- On arrival the person descends into crisis we move into conversation 2 planning and attempt in the short term to help someone move out of crisis
- On arrival there is no crisis but we think we can make improvements to the plan we need to demonstrate how this will be the case and from the individuals point of view convince them – this could include making better connections between the person and their new community which may lead to reductions in direct care costs.

If someone with an existing support plan has temporarily increased needs then a change to the conversation 3 plan may be required. This is not a conversation 2 plan because it is planned and there is no urgent crisis. This increase is part of what will be chargeable.

Please note, Carer Breakdown funding is still available as a specific source of support.

If there are still unmet needs following the relevant Tier 1 and Tier 2 conversations, you must progress to a Tier 3.

Tier Three Conversation:

"*Are we talking about how someone can get on with their life long term with some support?"*

If there is no suitable result other than long-term support the Team Leader will make an application to Resource Panel in the usual way, including an Assessment against eligibility.

Services provided to a person following a Tier 3 conversation are chargeable (unless being provided to a carer).

Changes to the Resource Panel process are being developed to introduce greater flexibility to Tier 3 planning.

Tier 3 cases will be closed under Review.

Explicit request for a Social Care Assessment

If at any time you are explicitly asked for an Assessment against eligibility, you must complete an Initial Contact and Assessment document and the section that relates to elgibility determination.

Respite/Replacement Care

Where respite/replacement care is agreed, it will be considered an ongoing commitment. This does not remove the requirement to review the need through a Carer's Review annually.

Indicative Budget Tool guidance (Refer to Appendix 8)

Where Assessment determines eligible unmet need, the 'Indicative Budget Tool is to be used to gain an Indicative Budget to enable the start of support planning. Remember it is a guide figure not actual at this stage.

The tool should be introduced in a way that involves the service user and/or carer. The questions are formulated to include the Care Act Criteria for Service Users and Carers.

The questions have 3 columns-

1. One for Service User view
2. One for Informal Carer view

3. The last is the shared view which is the figure that determines the Indicative Budget from the cost banding.

The shared figure is the **professional view** and needs to be what the assessor can evidence as unmet need against Care Act eligibility as it is ultimately the figure used for funding panel.

At this stage Tier 1and 2 conversations would have taken place and possibly tier 2 plans. By this stage you will know the people you are working with to complete the Indicative Budget Tool, so will be aware if there is likely to be a difference of opinion with need.

If difference of opinion.

You may what to consider at this stage if you can wait and have further conversations to work things through and then revisit the Indicative Budget Tool.

If there continues to be a difference of opinion then it is worth revisiting the eligibility criteria with the people involved and relate this to the Indicative Budget Tool.

Ultimately if the scores are low (high need) on the Indicative Budget Tool and the evidence is not in the assessment then this would indicate the Indicative Budget Tool is not a true reflection of need. In a restorative way this would need to be explained to the Service User and Carer that the shared/agreed score does need to reflect needs against the Care Act eligibility to be able to move forward.

Use your supervision to talk through the assessment and the Indicative Budget Tool to agree a way forward.

There is more work and testing of this document which will commence once Care Director has been operational for a while. Feedback in the mean time will be very useful.

What happens if the person lacks capacity?

If a person lacks capacity then use the carers section as the guide as long as the carer is acting as an 'appropriate' adult.
If the client does not have capacity then an independent advocate should be appointed.

>What about if there is more than one carer?

If there is more than one carer then an agreed figure by all carers would be put down.

>What if the person has no informal carer – but a formal care provider?

The section is meant to be for informal carers/family. If there isn't any 'informal' person to complete it with and the person lacks capacity then this would have been stated in the assessment.

>What happens if the figure is not high enough i,e because they have complex/high needs

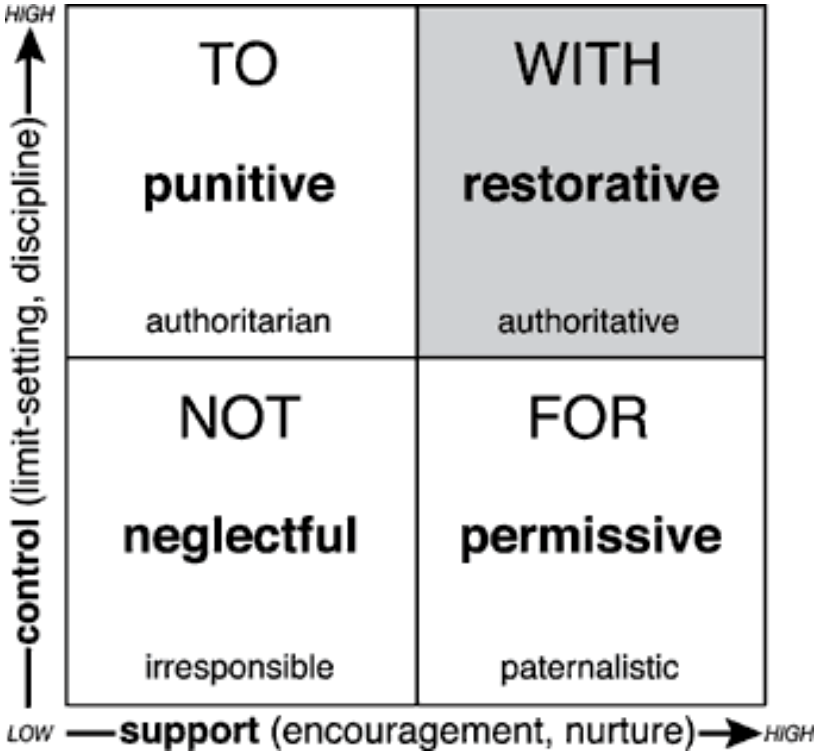
Where the costs are not high enough, explanation in the rationale as to what is needed and the breakdown of costs will be required. This will be further developed through the support planning process which will be taken to panel for authorisation.

3. Restorative Practice

Restorative Practice is a broad term which can be applicable in a wide range of settings and is adaptable depending on the context. Adult Social Care staff should use a restorative approach wherever possible. This will include work with clients as well as other settings such as team meetings.

Restorative Practice is a way of doing things which is inclusive and in which people work with each other on an equal footing. One party will not seek to impose a solution on others. It involves high levels of challenge accompanied by high levels of support. Effective relationships are central.

A simple way to represent a restorative approach is through the restorative **'social discipline window'**[1], which is reproduced here for reference:



In this approach, a person with care and support needs will be recognised as an expert in their own life and practitioners will work collaboratively with them to identify solutions.

Restorative approaches often make use of circles as a way to build relationships and to respond to conflict. They create a forum in which people can speak and listen to one another; they offer an alternative to a hierarchical approach in which arguments are either won or lost.

[1] Restorative practices – Social Discipline window, Wachtel and McCold

4. Managing new contacts

The new way of working aims to reduce hand-offs from one team to another and from one worker to another.

To support this, ASC will not have an 'intake team' but will have locality teams which receive new contacts and which have all three conversations.

All new calls will come via the Contact Centre, which will route calls to the relevant locality team. The guidance provided to the Contact Centre team is provided at Appendix 3.

Calls will be handled using the Pro-Center call handling system, which records data about call volumes, abandoned calls, peak times, etc.

Locality Managers will need to ensure that there is a duty worker available throughout the working day (08.30-17.00 Mon-Thurs; 08.30-16.30 on Fri) to receive incoming calls routed from the contact centre.

All staff receiving calls will need instruction on how to use the Pro-Center system and will need to develop skills in handling the diverse range of contacts received. This will primarily be through peer support.

As a starting principle, staff taking the initial contact over the phone will allocate the case to themselves. They will start with a Tier 1 conversation. The member of staff will allocate to themselves unless:

- They do not have capacity to take on additional work
- They do not have the relevant skills/ knowledge to undertake the work expected

(These decisions will need to be informed through discussion with Team Leaders).

Where the member of staff does not believe they should continue with the work (based on the above considerations), they will designate the case as 'Awaiting Allocation'. This will generate an automated email to the team inbox. Team Leaders and duty workers will need to monitor and respond.

Existing Team email accounts (e.g. AFAAdmin, PDAdmin) will need to close where team names no longer apply. This will be managed by the outgoing Team Manager.

A 'front-door' email account will still be required (currently these are CCenquiries/ AccessGCSX but may be renamed in due course). The front-door email account will be monitored by a designated Admin team. They will then forward emails to the relevant locality team.

Email accounts will be as follows:

CCEnquiries/AccessGCSX		
ASCWest	ASCCentral	ASCEast
DutyWest 1	DutyCentral1	DutyEast1
DutyWest 2	DutyCentral2	Duty East2
DutyWest 3 (once formed)		
ASCReviews		
SensoryNeeds		

5. Base Localities

When a worker receives a new contact, they will need to create (or update) a person record in CareDirector. Within that screen the worker must identify the Base Locality.

Please see Appendix 5 for a screen shot of base localities.

The base locality must be identified in order to ensure that following reviews/ hospital admissions, etc, cases are returned to the correct team. Even during a review/ hospital stay, the base locality will remain unchanged.

The Base Locality is defined according to registration with a GP (or home address) (see Appendix 3).

If we are notified that a person has changed GP surgery or their home address, their base locality will need to be refreshed.

There will be instances where a person is placed out of area and therefore their GP practice and home address will be out of area. In these cases, the Base Locality will not change.

For carers, the Base Locality will be defined by the Base Locality of the cared-for person.

6. Hospital Admissions / Discharge/ OT Homesafe

The following approach covers MI and Locality Team responsibilities with regard to case allocations.

For reference, notifications of a discharge from acute hospitals will be referred to as Section 2 or Section 5. They are defined as follows:

Section 2 – this is notification from the hospital to say that they have a patient who will require a service for discharge.

Section 5 – this is sent 48 hours following receipt of a Section 2 and says that a patient is medically fit for discharge. This gives us 24 hours notice of the proposed discharge date (this is the date the patient will be fit for discharge and may not be the actual date as this would be subject to care being available).

CASES THAT ARE FULLY CLOSED ON CareDirector/ NEW/ AWAITING ALLOCATION

MI will pick up these cases at the point of referral. If a POC is required to facilitate discharge, the JCP will complete the pathway care plan so care can be sourced and discharge arranged.

MI team will continue for 6 week review and then depending on outcome, action as follows:

- No ongoing care – Case closed fully.
- Ongoing care only – MI to take to Panel and then close under review. If change of agency at this point, MI to monitor for at least two weeks.
- Ongoing active involvement following 6 week review and set up of long term care - transfer to locality team following discussion with the team. Ongoing commissioned support must be set up by the Care Placement Team who will commission the package. The package cannot just continue with the same supplier in order to ensure the Approved Provider List is applied appropriately.

Placements

MI will complete assessment against Care Act Eligibility, obtain funding from panel and arrange discharge into specified home and followed up with a 6 week review.

CASES WITH ALLOCATED WORKER IN LOCALITY TEAM

Notification from the hospital will be received through MI team.

MI team will advise the allocated worker (cc. the duty email for the locality team) that a referral has been received, casenote and attach to CareDirector. They will also copy in the link worker so they are aware.

If for increase or new package of care a Pathway care plan will be required before care can be sourced.

The Pathway care plan is sometimes already completed by the ward (Physio and OT's often complete this), or the information is all recorded on the Section 2 but needs transferring to the Pathway care plan, which the OT duty desk will do. However, there are times when the Pathway care plan is not complete and this needs to be completed for JCP. This will be done by the link worker as a default, but the allocated worker may volunteer to do this depending on the nature of their involvement.

The allocated worker and link worker must communicate regularly to agree the best approach in supporting the individual and their family.

The JCP Pathway care plan document always needs to be completed in CareDirector as it provides key reporting information about the reablement episode. Where the Pathway plan has been completed and sent through from the ward, it should be scanned and attached to CareDirector and a JCP Pathway plan must be opened – the document should refer to the detail within the scanned document and statutory reporting fields completed (PSR, Route of Access and Outcomes). The pathwaydesk needs to be advised that care plan is attached so they can send it for sourcing care. Pathway desk contact details are: pathwaydesk@westberks.gov.uk; 01635 292 120.

For ALL JCP referrals an OT or Physio will be allocated (once home) – this could either be Health or MI. The allocated therapist will be assessing for Reablement goals and will deal with any equipment issues etc but the primary allocation needs to remain with the allocated worker in the locality team and they will be involved with the reablement process and ongoing needs post-review. The OT/Physio must communicate with the locality team's allocated worker.

CASES CLOSED UNDER REVIEW

MI will pick up these cases and if for POC, complete pathway care plan so care can be sourced and discharge arranged.

MI team will continue for 6 week review and then depending on outcome, action as follows:

- No ongoing care – Case closed fully
- Ongoing care – MI to take to Panel and then close under review. If change of agency at this point, MI to monitor for at least two weeks.
- Ongoing active involvement following 6 week review and set up of long term care - transfer to locality team following discussion with the team.

Placements

MI will complete assessment against Care Act Eligibility, obtain funding from panel and arrange discharge into specified home and followed up with a 6 week review.

EQUIPMENT ONLY FOR DISCHARGE

MI will order equipment for out of area hospitals and raise a service placement. MI will also follow up for effectiveness for cases which are new, closed under review or closed fully.

If the case is allocated, the locality team will visit post-discharge to ensure equipment is suitable/ necessary.

Hospital Discharge – Assessment or Review

If an individual with a LTS goes into hospital, on notification, commissioning will initially suspend the package of care.

Where the Client is discharged from hospital within 6 weeks - Review

- If no change in need, POC can be restarted as commitment to budget is ongoing.
- ***If*** *the restart involves enough of an overview of the POC, it could be considered an unplanned review* ***if*** *a review document is completed (Practice decision)*
- If there is a change in need, particularly a need to return to panel to request additional funds / services, an 'unplanned review' will need to be completed and panel process completed as normal.

Where the Client is in hospital longer than 6 weeks - Assessment
If the individual is in hospital for an extended period of time (6 weeks plus) commissioning will close down the POC, and there will be no active LTS.
Finance would therefore end the forecast / commitment for this service

On discharge from hospital, there is an expectation that workers will need to complete an **'Assessment'** and return to panel; there would be no ongoing commitment so we would class them as a new client (no current services). Circumstances may be completely different after a client is discharged following a long stay in hospital and it is reasonable to argue that the care package would not be simply restarted without the need to assess need.

RESTARTS – responsibility

Case with allocated worker

If a case has an allocated worker – responsibility for arranging restart is with the allocated worker or locality team in their absence.

MI team will receive the S2 and S5 and will advise allocated worker/team that restart needs to be organised. Where the Council is purchasing the care, the worker must contact Commissioning and inform ward/family etc of start date. MI need to be advised of start date as this is recorded on the S5 paperwork that is sent back to the hospital.

Closed under review/ Awaiting allocation

MI will arrange restart and casenote. No further active involvement will be made by MI.

COMMUNITY REFERRALS TO HOMESAFE

If the client is not in hospital and has reablement goals they will not go through JCP; they should be referred to the Homesafe service.

Any client in the community who is considered to have Reablement goals may be referred to Homesafe service by the care manager/allocated worker.

Homesafe duty desk is open to accept referrals between 10am and 3pm. Call Maximising Independence 01635 292130 and ask for the duty OT.

There will be a discussion with the duty OT as to whether the referral is appropriate or not. The duty OT's decision on this is final. If the referral is accepted, then Homesafe duty OT will take the referral from the care manager/allocated worker. They may ask the care manager to provide further information.

The Duty OT will source the care package (and complete the associated paperwork), applying first to the Reablement team and if they have no capacity, then to commissioning. Duty OT will inform care manager/allocated worker of provider and start date.

It is the care manager /allocated worker's responsibility to inform the client or family of the start date and the provider. However, if the allocated worker is off sick or on leave the duty OT will inform the client or family

An MI Homesafe OT will be secondary allocated within 2 working days where possible to visit and complete an initial Reablement assessment. They will liaise with the care manager/allocated worker throughout. The care manager/allocated worker will continue to manage any social issues. The MI OT will decide on the length of the Reablement period and instruct the care manager/allocated worker regarding ongoing care needs. The care manager will organise this provision. If the client is with the Reablement team, the OT will complete a notification of change form so that commissioning will be alerted to identify a long term package of care with an external agency. If the care manager/allocated worker is an OT, they will be responsible for ordering and assessing any equipment.

Once the MI OT's input is finished, then the care manager will continue to work with the client until work is completed.

It is not appropriate to refer to Homesafe for a free care package to cover a temporary gap in available care or support. It will be case noted that a discussion was had and the reason for declining the request will be noted.

The information that the duty OT will require:
Client's condition
General health
Type of property
Medication and how this needs to be administer deg: prompt, nomad etc.
Personal care
Mobility
Transfers
Nutrition
Equipment
Reablement goals
Requested care package

7. Disabled Facilities Grants

Where contact from a person indicates that a DFG may be required, an OT within the relevant team will be allocated/ secondary allocated(through involvements in CareDirector) the case. The OT will progress the DFG application if considered appropriate and refer to the DFG team in housing.

The case status of 'Awaiting Allocation' should be used for cases where the referral only relates to DFG work; can be allocated to the DFG team but there is no OT available to progress the work.

Refer to DFG procedure – currently being updated

8. Financial Management

Tier 1

Tier 1 conversations may lead to some financial spend. Where this is for equipment a service placement is required.

Where there is a one-off spend by AP2 this will also require a service placement.

One-off payments to carers can only be made where the care manager has considered the needs of the carer and the support that they require. This may be recorded using a full Carer's Assessment but, where the record is sufficient, they may also be recorded using only a Initial Contact and Assessment Form. Team Leaders can authorise one-off payments to carers using an AP2 form against cost centre 58102. The one-off payment must be linked to an established need and used to achieve a specified outcome. The limit for this payment is set at £500. A Service Placement is also needed.

Where there is spend on a procurement card, no service placement is required, but each Locality Team will need to keep a record of spend on procurement cards (Appendix 4 is a screenshot from a Excel spreadsheet which should be used).

Tier 2

Under the new structure, Team Leaders will have greater authority to agree to short-term expenditure. In return, they will need to closely monitor the number and duration of Tier 2 plans. A CareDirector report has been developed to allow managers to actively review these arrangements and this should be used when checking plans and when planning for team meetings.

Tier 2 conversations may lead to time-limited expenditure. Team Leaders will be able to authorise short-term expenditure where there is a Tier 2 plan in place. If services are arranged as the result of a Tier 2 conversation a Tier 2 Plan must be recorded.

Tier 2 plans must be time-limited. Any Tier 2 plans which endure beyond six weeks must be reviewed for effectiveness.

Tier 2 plans will be monitored by Locality Managers, Service Managers and the ASC Business Manager (see Recording and Data Management Section ref CareDirector Reports which support this).

The out-of panel process will become redundant for Locality Teams/ Reviews/ Sensory Needs.

Tier 3

Requests for long-term services following a Tier 3 conversation will need to be presented to Resource Panel by the Team Leader through the completion of the ***Support Planning and Funding Authorisation*** document.
Refer to AS Support Plan and Authorisation Practitioners guide

Team budgets

Locality/Team Managers will hold the staffing budget for their areas. They will also hold a budget for one-off payments to carers. Team Leaders will need to approach the relevant Locality/Team Manager to authorise this spend.

Procurement Cards

Team leaders will need to monitor the expenditure on procurement cards using the relevant spreadsheet (see Appendix 4 for illustrative example) available from Service Manager/ Accountant.

One-off payments to carers
Team Leaders can authorise one-off payments to carers using an AP2 form against cost centre 58102. The one-off payment must be linked to an established need and used to achieve a specified outcome. The limit for this payment is set at £500. A Service Placement is also needed.

9. Recording and Data Management – New Contacts

Recording of responses to New Contacts:

Three-Tier model

When the three tier model is being consistently used in the locality teams, there will be a high number of Tier 1 conversations and a significantly lower number of Tier 2 and Tier 3 conversations. In addition, Tier 2 plans will be time-limited and closely monitored.

For local and statutory reporting, the outcome of any new request for social care support needs to be reported. T1,T2, T3 outcomes will be monitored by the Service plan.

Where the call / contact results in a ***new referral*** on CareDirector and further work then information about the outcome of the enquiry will be captured via the statutory fields and outcomes on the relevant forms (Initial Contact and Assessment form).

- Refer to AS Initial Contact and Assessment – Practitioner guidance

- Refer to Appendix 6 which summarises the Care Director documentation to use.

- Appendix 7 provides a flowchart of work through the Three Tiers.

Individuals should receive written confirmation of the outcome of T1,T2 discussions and any preventative action and solutions agreed. Where a T3 assessment against eligibility has been completed individuals must be given a record of this assessment and their care and support plan.

In order to check that the model is being consistently used with new contacts, Locality . managers will need to review the data relating to these indicators. This is to be reviewed during team meetings using the following report within Care Director New Clients Report

Information, Advice and Signposting (IAS) ONLY

There will be occasions when an enquiry is received and the only outcome is the provision of information, advice and signposting on the back of a short and straightforward conversation. For example, someone might want information about care homes available. Where the call results in the provision of social care related IAS ONLY, we are still required to capture and report on this but this will be recorded in the following ways:

i. Where a case is closed, this contact should be recorded as an **activity** on the person record. The outcome identified should be completed as Information, Advice or Signposting

ii. Where an individual's details are not already on CareDirector (and where it is not felt necessary to record those details) the contact is to be recorded in Survey Monkey (see Statutory Reporting Quick Guide 7 available on CareDirector intranet pages). – The worker is to log details on Survey Monkey at: ***https://www.surveymonkey.co.uk/r/NWWnewcontactsMay16***

**Both mechanisms aim to minimise the work required to record such calls and prevent the requirement for a full referral to be created on CareDirector*

See Statutory Reporting Quick Guide 7 IAS Recording Quick Guide formatted [388kb] *available on CareDirector intranet pages.*

10. Data Management - Recording of Responses to existing contact:

The Duty worker may receive calls from individuals that have a current referral on CareDirector and that are either allocated to a named worker, allocated to a waiting list or closed under review.

RAISE CareDirector Activities (Case Notes) can be used to record where information and advice is provided in these instances.

If the contact constitutes a Review then the Review document should be opened and completed proportionally. **(see review section)**

CareDirector ‘**’LTS Review snapshot’** report has been updated to report on locality / new teams.

LTS002 review report will report on the volume of reviews by outcome.

- Planned review – should relate to Reviewing team
- Unplanned reviews – should relate to Locality teams

Data cleansing reports will be utilised to ensure data accuracy.

11. Data Management – Call volumes

All calls will be handled through the Council’s Pro-center call handling system.

Pro-center requires each call-handler to provider a ‘wrap up reason’ for each call. This will provide local intelligence about overall call volume, call type and reason, which should assist us to understand demand and workflows within teams and the need to adjust our response.

The following recording ‘Quick guide’ provides further detail on recording of pro centre wrap up reasons and information, advice and signposting calls.

7. IAS Recording Quick Guide [388kb]

12. Meetings Schedule

Schedule of meetings/ networking

The following schedule will support the sharing of information, skills and expertise across teams and localities:

Meeting	Frequency	Organiser
Locality Managers	2 monthly	Service Manager
Team Leaders	2 monthly	Locality Manager West
AMHPs	Monthly	Locality Manager Central
Occupational Therapists	4 monthly	Locality Manager East
Social Workers	6 monthly	Principal Social Worker
Admin Managers	2 monthly	Admin Manager
Best Interests Assessors	4 monthly	Safeguarding Manager
Local Team	Weekly	Team Leaders

13. Business Continuity

To be developed by each Team/ Locality Manager for their area of responsibility.

14. Transition Arrangements

Transitions will be managed within the relevant Locality. A Transitions Manager post has been established (with Administrative support). The role of the Transitions Manager will be to advise, support and assure the work, but the practical task of working alongside children, families and other services to establish care and support provision will be carried out by workers in the Locality teams.

Additional work is required to develop the process.

15. Reviews

The Reviewing Team is responsible for planned (scheduled) reviews only.

Within CareDirector, cases which are closed under review are owned by the Locality Team. The Review Team will identify and plan its work using CareDirector Review report to identify reviews that are due.

The Review Team will seek to test and implement a reasonable and proportionate approach to reviewing the services received by people who have ongoing needs, and who are already known to Adult Social Care. The team members will incorporate the tiered conversation approach with people with care needs, their carers and their networks, in order to reduce dependency and find better, more appropriate, ways of meeting their needs.

There is the potential to meet needs in different ways using restorative practice; this means that our own commissioned services should not necessarily be considered as the first port of call.

What is a Review?

A review is an opportunity to ensure that all people with a support plan have the opportunity to reflect on what is working, what is not working, and what might need to change. The review process should be person-centred and outcomes-focused, as well as accessible and proportionate to the needs that are to be met. (See Care and Support Statutory Guidance s12 and s13):

- Has someone's needs significantly changed?

Is their life/plan working?
The Review document in **CareDirector** allows a proportionate response, **skip logic questions** will determine if a full reassessment of need against eligibility is required or whether the review document can be completed in a concise way.
Reviews will be referred to as:

Concise Review
When there is no change to long term services, or there is minimal change but no increase to the allocated budget, the Review form can be completed proportionally with a focus on summarising how an individuals life plan is working and evidence to support this.
Sections in relation to reassessment against eligibility will **not** need to be completed.
(This can include adjustments necessary to better meet the client's needs, such as timings or the addition of a piece of equipment, so long as the overall package is not increased).
Any enablement activity identified in the review must be captured on a related Review /Tier 2 Plan grids.

Full Review
Where people's needs and eligibility status have changed or potentially changed, an increase in funding is likely to be required then a reassessment will be required. This will be completed using the Review document ensuring sections relating to the determination of eligibility are completed, thus making it a more comprehensive or 'full' review.

The Review document can be used to record a review in a placement setting, but the Residential / Nursing Home Review can also be used in the following circumstances

- There are concerns (from the family/adult or service provider perspective)
- There are particular complex or substancial needs
- The individual is moving from residential to community
- The professional judges it appropriate.

Refer to *AS Review Document - Practitioners guide*

Types of Review

Planned Reviews

Planned reviews will reflect the planned work of the Review team.
If conditions can be met, a Concise Review will be completed.

If conditions have not been met. our three-tier conversation model will apply and a Full Review may be required.

Unplanned Reviews

These are most likely to be undertaken by Locality Team members when an issue arises with the client/carer that requires ASC input before the scheduled review date.
The Review should be proportional to the situation and may either reflect a Concise or Full review.

If, during the course of any unplanned work, an audit trail is constructed on CareDirector to support any decisions that could reasonably constitute a review of the individuals current support the review document should be completed.
For example, if a Locality Team care manager has noted that they visited someone, their needs hadn't changed, they were clearly satisfied with their plan and getting on well with it, Review document should be opened,Tier 2 Plancreated if required and a summary of those conversations recorded - this will constitute a review.

If conditions have not been met. our three-tier conversation model will apply and a Full Review against eligibility may be required.

Method of Review for Planned (Scheduled) Reviews

Whilst the method of review may change, the need to prepare people for the review remains the same. The person to be reviewed, and any other interested parties, advocates, carers, providers, etc, must be given sufficient notice to help them prepare.

Other Forms of Review

Self Review

This is in development.

Supported by Third Party

This is in development.

Telephone Review

If a person appears to have no capacity issues (having first screened Raise), the budget is not high cost, there are no known provider concerns and a full support plan is in place on CareDirector, the allocated worker can undertake a planned review with the client by telephone. Although this may start out as a Concise Review, where issues arise it may be necessary to convert to a Full Review.

Face to Face

Concise Review or Full Review document to be used, as deemed appropriate.

Carer Concise Review Document

The same principles for client concise reviews as described above will apply to Carer reviews.

16. Occupational Therapy Referrals for People with Learning Disabilities

As the new structure takes effect and we move in to locality teams, questions have been raised about whether locality OTs will be expected to work with clients with learning disabilities (LD).

Prior to restructuring, OT issues relating to LD clients have been dealt with by the CTPLD OT (Ian Salter).

In the new structure it has been agreed that Ian Salter will continue to work exclusively with LD clients. However there will be an expectation that locality OTs will take on some of the more basic referrals for LD clients with more complex cases being referred on to Ian Salter.

Here are a few examples of the types of referrals Locality OTs will be expected to manage:-

Referrals for:

Grab rails
Bed rails
Bath seats
Toilet seats/frames
Keysafes

Examples of cases to be referred on include:

DFGs
Moving and Positioning
Postural Seating
Epilepsy management
Assistive technology

Environmental controls
Use of restraints (lap belts, bed rails)
Vehicle access

These lists are not exhaustive and further discussions between team managers may be required.

17. Sensory Needs Team

Locality teams may work with clients who have sensory loss. Where this is the case they should discuss their work with the Sensory Needs Team. In some cases, the Sensory Needs team may accept a secondary allocation (. Additionally, it may be appropriate for the Sensory Needs team to take the lead, as negotiated.

The Sensory Needs team accepts referrals from Health colleagues and other sources, including self-referrals.

Adult Social Care teams are encouraged to make contact with the Sensory Needs team on 01635 503704 or sensoryneeds@westberks.gov.uk.

Appendices

Appendix 1 - Illustrative cases from Phases 1 & 2

The cases set out below show how some of the principles of the new way of working can be put into practice.

1.	What happened? Fairly short-term involvement (two months, low intensity). 75 year old man who was struggling to manage because his washing machine and fridge were broken and whose sofas were no longer suitable. Worker helped him to purchase goods online using a tablet computer and enabled him to access the Community Furniture Project to buy replacement sofa. Also referral to 'Happy Feet'.
	Why is this consistent with the New Way of Working? This was a time-limited involvement using a restorative approach (doing 'with', not 'to' or 'for'); connecting him to community resources; facilitating him to use his own resources to meet his own needs; no ongoing support; no hand-offs.
2.	What happened? 54 year old woman requesting bathing assessment. She had a significant number of health conditions and also had very low motivation; she had 'given up'. She described her situation as living 'like a dog', as mobilizing around the house was very difficult and she was unable to manage her home environment. Work included providing a range of equipment in the home as well as time-limited support to de-clutter and clean her home. At the point of closure (case opened in May 15 and closed on Sept) she was reporting a dramatic improvement in her circumstances.
	Why is this consistent with the New Way of Working? Intensive but time-limited work which ended with no ongoing services. Connection to a range of community resources improved person's quality of life in a sustainable way.
3.	What happened? 28 year old woman with learning difficulties, referred because of safeguarding concerns. She has difficulty making friends, is sexually vulnerable and there had been an alleged rape in Dec 14. She had made attempts at suicide. She had been assessed by CMHT but no work was planned; she had received support previously from CTPLD but is not learning disabled. She had very little structure in her day, had limited links to Newbury and an unhealthy social circle. She did not feel safe in her flat following the alleged rape, was low in motivation and had poor self-image. Intervention lasted from May 15 to Sept 15 and focused on building positive relationships within the community, linking to community activities and resources and taking practical steps to improve self-image (e.g. by losing weight and becoming healthier).
	Why is this consistent with the New Way of Working? Time-limited involvement, not resulting in long-term services but focused on connecting to existing assets in the community. Also, undertaking work not based on eligibility for a specific service (CMHT/CTPLD).

4.	What happened? 78 year old woman with cirrhosis of liver, being cared for in bed; daughter requesting supply of a commode. Input from Swanswell, including monitored alcohol intake, facilitated by daughter. Daughter also has some health problems and depression and reported being treated like 'Cinderella'. Equipment provided, liaison with Health services facilitated and a period of OT Homesafe, leading to very significant improvement in mother's functioning and daughter's mood.
	Why is this consistent with the New Way of Working? Time-limited intervention managing the immediate crisis (through a Tier 2 conversation); no long-term services required after the short-term work.
5.	What happened? 80 year old woman with mobility difficulties. Equipment provided. Advice and support given to apply for attendance allowance meaning that she could then privately fund a small package of care.
	Why is this consistent with the New Way of Working? Tier 1 conversation giving person the support they needed to connect to community resources, meaning that the Local Authority have no ongoing input.
6	What happened? 54 year old man with a learning disability. Recently evicted from his family home and now housed in the Vulnerable Unit at Two Saints. Referred by Two Saints due to concerns of financial abuse by his sister; who is also resident at Two Saints. Meeting arranged with service user, his brother and Two Saints key worker. Not Safeguarding. Contact maintained to identify any needs as he was moving into a bedsit in the community 3 weeks after initial referral. Needs identified were social isolation and preparing and cooking meals. Tier 2 plan put in place. Supported to visit Fairclose in the capacity of a volunteer. Brother agreed to support with shopping. Two Saints outreach to support with benefits and finances. OT completed 2 visits to assess use of the microwave and breakfast and lunch preparation. Regular meetings with Housing Manager and s/u who offered support to look for voluntary work and is available daily to help with any problems. At point of closure s/u was happy in his new flat and managing well. Had yet to visit Fairclose again. Visiting with his brother most days.
	Why is this consistent with the New Way of Working? Intervention lasted for 8 weeks and focused on social isolation and meal preparation also ensuring s/u had support in other vulnerable areas. S/U now living independently. No ongoing services needed.

Appendix 2 - Standard Team Meeting Agenda

Team Meeting Agenda

Locality Team:

Date:
Venue:

1. Catch-up/ check-in
2. Review of actions from last meeting
3. Review data from Raise Report
4. Review Tier 2 cases – new or for review
5. Tier 3 cases
6. Any other cases
7. AOB

Appendix 3 - Adult Social Care Guidance for Contact Centre staff

Adult Social Care is responsible for:

- Adults who live in West Berkshire and appear to have a need for care and support
- Adults who plan to live in West Berkshire and appear to have a need for care and support.
- Adults who live outside of West Berkshire but who have had their arrangements for care and support arranged by West Berkshire Council (e.g. placed by us in an out-of-county care home)
- Children and young people (14 years onwards) with care and support needs who will live in West Berkshire as an adult and need to plan for their future.
- Carers of all of the above, wherever the carer lives.

If you receive a call *from* someone who meets these conditions, or *about* someone who meets these conditions, the caller will need to speak to someone in Adult Social Care.

You will be able to route the call through to one of a number of teams in Adult Social Care, based across three localities. The aim is to ensure that people are supported by staff who know their local area and can connect them to their local resources. Each locality will have at least two teams. These are generic teams, staffed by people with a range of skills and knowledge and they will deal with anyone with care and support needs, regardless of the cause of those needs (which may include learning disabilities, physical disabilities, mental health needs, etc).

Using Pro-center:

- Direct the call through to the local team based on the relevant GP surgery or, if relevant, their postcode (see supporting sheet).
- Where the GP surgery is not known, or is out of county, direct the call to the local team based on the postcode of the person with needs.

Where the caller is a carer:

- They will be supported by the same locality as the person they care for.

People with Sensory Needs:

Refer to the Sensory Needs Team.

People in hospital:

Where the call relates to an adult who is in hospital, direct the call to the Maximising Independence Team on 01635 292 130.

West			Central			East		
Eastfield House Surgery	RG14 7LW	Team W1	Burdwood Surgery	RG19 4YF	Team C1	Boathouse Surgery, Pangbourne	RG8 7DP	Team E1
Falkland Surgery	RG14 7DF	Team W2	Downland Practice	RG20 8UY	Team C1			
Hungerford Surgery	RG17 0HY	Team W1	Thatcham Health Centre	RG18 3HD	Team C2	Mortimer Surgery	RG7 3SQ	Team E2
Kintbury & Woolton Hill	RG17 9UX	Team W1	Chapel Row Surgery	RG7 6NS	Team C2	Theale Medical Centre	RG7 5AS	Team E1
Lambourn Surgery	RG17 8PS	Team W1						
Strawberry Hill Surgery	RG14 1JU	Team W2						

If Surgery does not appear on the above list **OR** the GP Surgery is not known, use postcodes prefixes as follows:

RG 14	W2	RG18	C2	RG7	E2
RG17	W1	RG19	C1	RG8	E1
OX12 9	W1	RG20	C1	RG26	E2
SN8	W1	OX12 8	C1	RG30	E2
				RG31	E1

Appendix 4 - Procurement Card Expenditure Spreadsheet example

Procurement Card Monthly Record

Service/Billing Unit Name :-	First Contact Bubble	GPC Account Number :-	
Year :-		Month :-	
Service Credit Limit :-	£0		

Individual Card Credit Limits:	Card 1 :-	£300	Card 2 :-	£300	Card 3 :-	£300
Cardholder :-						
GPC Account Number :-						

Requisition reference No	Date Order Placed	Account Code	Cost Centre	Analysis Code	Item	Net £	VAT £	Total £	Net £	VAT £	Total £	Net £	VAT £	Total £	Total Commitment on Account	Order Placed By	Checked to Statement (show statement date)	Journal Reference
								0.00			0.00			0.00				
								0.00			0.00			0.00				
								0.00			0.00			0.00				
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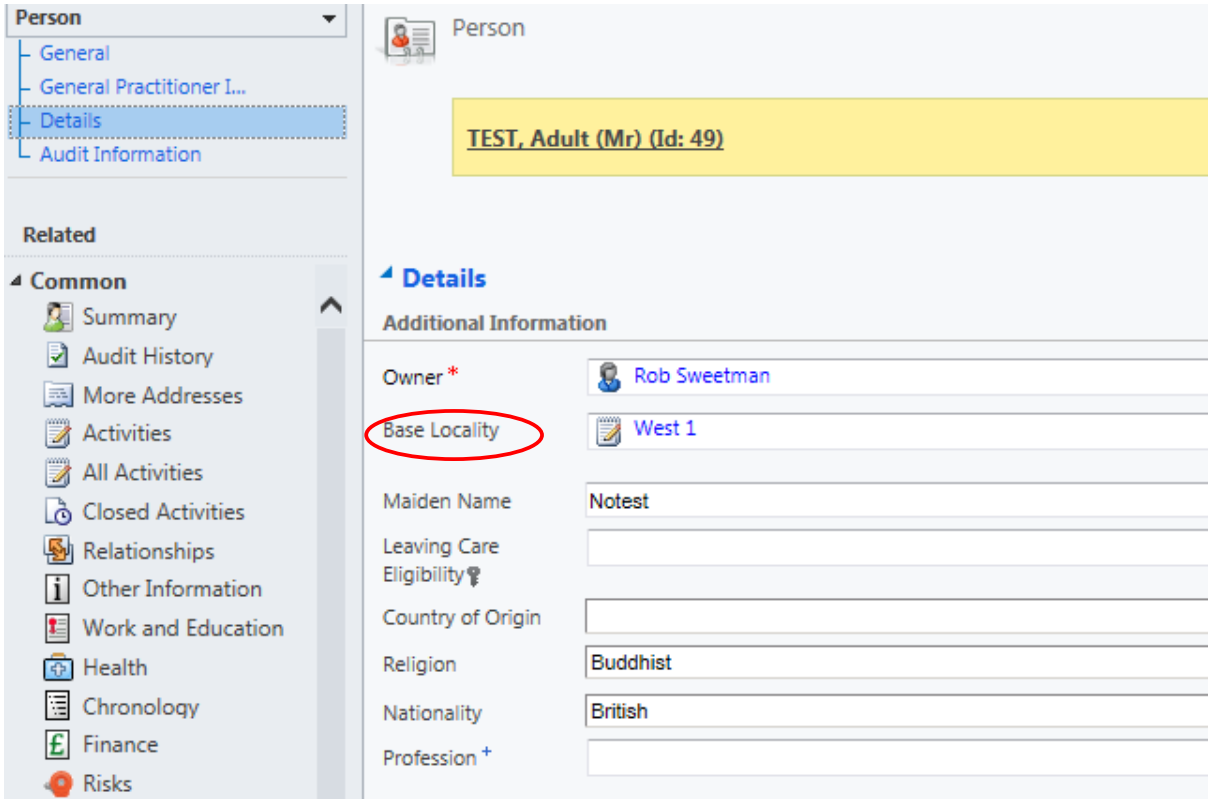
								0.00			0.00			0.00				
Total Commitment on Card						0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
Is Spend Within Credit Limit?								OK			OK			OK	NO - TAKE ACTION			

	Signature :-	Date :-
All items Reconciled to Card Statement		
Journal Processed		
Holding Account Cleared		

This record is to be filed with the monthly card statement when received
Any items not reconciled and paid, to be carried forward to next months record

Appendix 5 – Base Locality



A new 'Base Locality' field has been introduced in CareDirector on the Personal details screen – see above.
This should be set when personal details are set up or refreshed.

Clients:

- Based on GP surgery (Appendix 3)
- If no local surgery, then based on local postcode
- If no local postcode, then most recent historic local postcode

Carers:

- If the carer is a client as well, then they will already have a base locality (based on the rules for clients)
- The carer is given the same locality as the person they care for.
- If the cared for person is not known, then the base locality will be determined by the carers postcode.

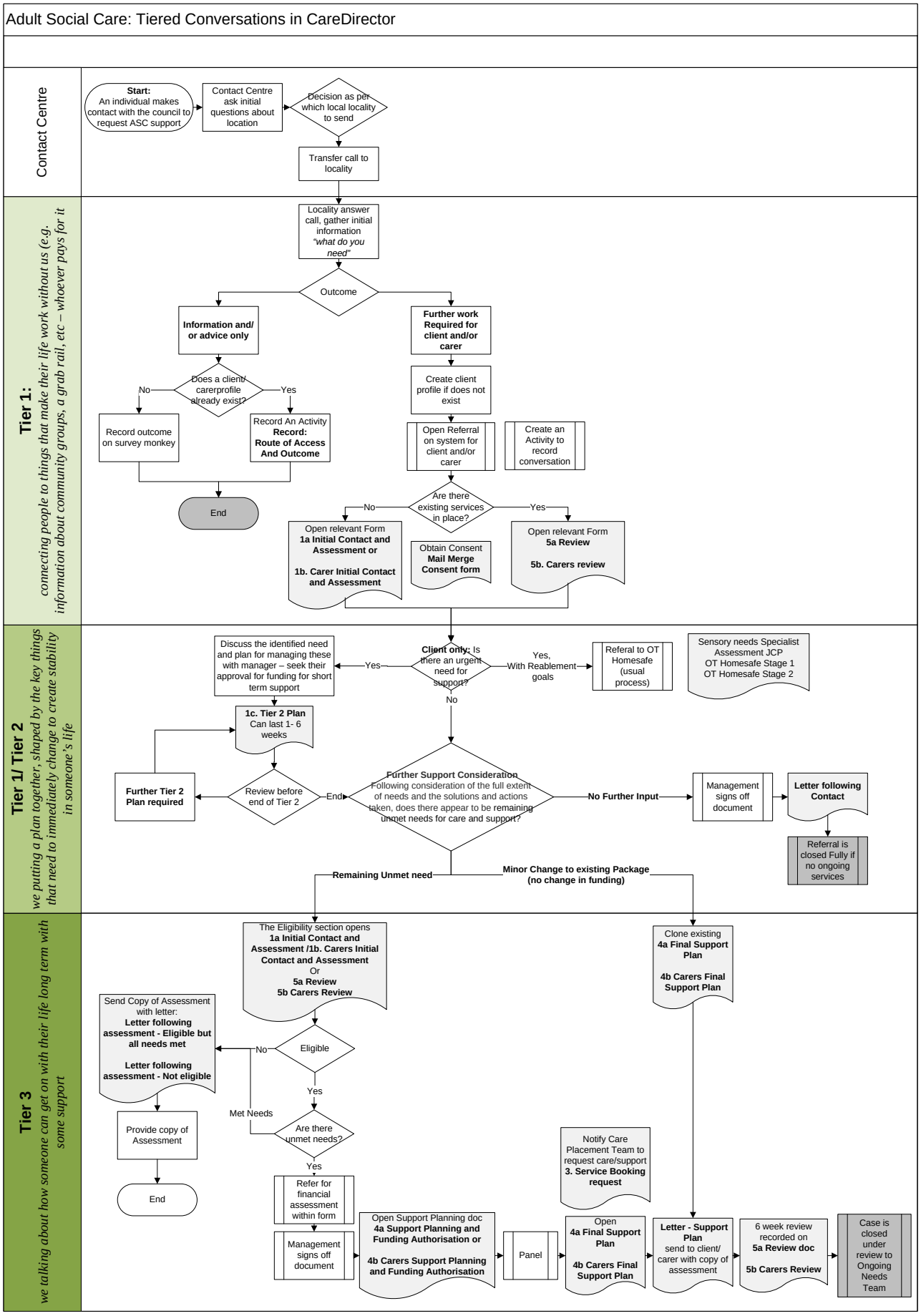
Appendix 6 - Summary of CareDirector documentation (Tiers 1, 2 and 3)

Tier	RAISE documentation required	Actions that can be reported at each Tier *Note – Actions at the lower Tiers can be included in the higher tier outcomes* *i.e An outcome from T3 may be IAS*	Service Placement	Template letters to support communication	Sign off	Quick guide reference
Tier 1	AS1. Initial Contact and Assessment AS1a. Carer Inital Contact and Actions and Assessment Qs prior to eligibility determination	Information and Advice / signposting (IAS/ Universal services) / DFGs Procurement card expenditure Equipment (as per Equipment procedure) Adaptations/ Telecare/Assistive Technology One off payments (direct payments) to individuals – 'preventative' nature (AP2s) No support – self funding / service declined / no identified needs	Spreadsheet maintained by TLs for all procurement card expenditure Service placements required for **all** equipment/adaptations and one off payments (AP2s)	'AS Letter following Contact' to summarise outcome of T1 discussions. Confirms issues discussed and any preventative action / solutions agreed.	Team Leader	1. PSR 2a. Route of Access 2b. Mandatory Info 2c. Significant Events 5. Carers 6. Outcomes 7. IAS Recording
Tier 2	Referenced within.Initial Contact and Assessment **OR** Review document . **AS Tier 2 plan** **OR** **JCP Pathway Plan (MI)** **Homesafe Plan** **Sensory needs doc**	Re ablement / Enablement Short Term Support in a crisis *(Tier 2 plan may also include any actions applicable to Tier 1)*	Service placements for all reablement activity Service placements for all Short term packages of care should be set up with **'Tier 2'** in the service detail – this is critical to ensure that T2 services are excluded from charging and allow overall expenditure to be monitored.	.'AS Letter following Contact' to summarise outcome of T1 / T2 discussions – as above	Team Leader	As above
Tier 3	AS. Initial Contact & Assessment ASReview / Res review AS Carers Initial Contact & Assessment AS Carers Review	Long term Service - Nursing / Residential or Community Respite / Direct Payments Specialist equipment (OT panel decision) Section relating to eligibility must be completed for all long term services and to support am application to panel.	Service placements required for all T3 services This may mean that T2 services need to be rebuiltwithout 'Tier 2' in the service detail.	AS Letter – not eligible AS Letter – eligible all needs met AS Letter Support Plan Copy of assessment Copy of support plan where relevent	Panel	1. PSR 2b. Mandatory Info 3. Reported Health Conditions 5. Carers 6. Outcomes

*Note – Where an enquiry results in the provision of social care related IAS **ONLY** (information/advice/signposting), we are still required to capture and report on this but this will be recorded in the following ways:*

- *Contacts not on CareDirector - Log details on Survey Monkey **https://www.surveymonkey.co.uk/r/NWWnewcontactsMay16***
- *Contacts that exist on CareDirector but no current referral provided IAS only - Log using IAS Significant Events*

Appendix 7 - Tiered Conversations Flowchart for New Enquiries



Appendix 8 - WBC Personal Budget - Indicative Budget Allocation

If, following a Social Care Assessment it is agreed that you have **eligible** care and support needs; we will work with you to identify solutions and agree what we need to do to meet your requirements.

- We will talk to you about your strengths and what you can do independently. We will discuss how your family and carers can help you and what resources are available in the wider community.
- Initially an **'indicative budget'** will be agreed – this is an estimate of what we think you will need to meet your care and support needs
- The initial indicative budget may be increased or decreased depending on decisions made during the development of your care and support plan.
- We will use this estimate to begin your care and support planning, but this will need final approval through WBC funding allocation panel, or agreed Management authorisation. The amount of any one off payments will be determined on an individual basis.
- The final amount of funding agreed to meet your assessed eligible need is referred to as your **'Personal Budget'**.
- The amount of available money will be limited as we need to ensure that funding available to the local authority can meet the needs of the entire population. However, we hope to be able to use available funding in the most flexible way.

West Berkshire - Indicative Budget Calculator

The tool below will be used as part of your assessment / review, to agree a view and determine an indicative budget. It is a guide figure not actual at this stage.

The questions are formulated to include the Care Act Criteria for Service Users and Carers.

	Areas of my life On a scale of 1 to 10, what score would you give the following statements on how able you feel you can achieve them on your own or with the help of my family and friends, 10 being total able, 1 being completely unable.		My View	Carer View	Shared View
1	I can look after myself through the day & night, keeping myself as clean & tidy as I choose	1 5 10 |_____|_____|			
2	I am able to get the food & drink I need and like in order to keep myself healthy & well	1 5 10 |_____|_____|			
3	I can get around inside and outside my home as much as I choose	1 5 10 |_____|_____|			
4	I can manage to look after my home to the standard I choose	1 5 10 |_____|_____|			

5 I have enough opportunities to do what I like to do in the community	1 5 10 |_____|_____|			
6 I feel satisfied that I can spend enough quality time with my family and friends	1 5 10 |_____|_____|			
7 I have enough opportunities to learn and experience new things	1 5 10 |_____|_____|			
8 I feel I am able to stay positive and content in my life	1 5 10 |_____|_____|			
	Total points			
	Indicative budget (see table below)			

If I had this ballpark figure to start thinking about how I want to meet my outcomes, what would I do?

Points	Value
80	£0
70 – 79	£20
60 – 69	£40
50 – 59	£70
40 – 49	£110
30 – 39	£160
20 – 29	£230
10 – 19	£310
Less than 10	£400

The amounts set as part of our Indicative Budget Tool will be subject to regular review and may change.