**Wakefield Council**

**Adult Integrated Care**

**Student Welcome and Introduction**

Welcome to Wakefield Adult Integrated Care Services. Provision within Wakefield comprises of: Assessment and Care Management for Adults and Older People, Physical Disability, Sensory Disability; Learning Disability and Mental Health Services; Personalisation; Safeguarding; Management Information; and Adults Workforce Development.

Wakefield is beginning to transform services through integration with health partners and the third sector.

**Delivering our outcomes**

Wakefield is committed to working in partnership and delivering the priorities of the district. The Wakefield Together Partnership has agreed 27 priority outcomes under four themes:

* **Caring for our People**
* **Caring for our Places**
* **Ambitious for our Young People**
* **Modern Public Services**

As a Modern Public Service Wakefield are transforming how we deliver and work with our partners to do more for less. All services also deliver against the People theme of: reducing hospital admissions, supporting hospital discharge, reducing care home admissions, and supporting our most vulnerable adults.

**Social Work Teams in Wakefield**

**Social Care Direct**

Social Care Direct is the initial point of contact for all adult social care and safeguarding referrals at Wakefield Council.  In practice this means that any adult who feels they need a social worker can contact the team, meaning they deal with a huge variety of enquiries.

Social Care Direct interacts with people with a range of needs including people with physical disabilities, older people, cognitive needs, learning disabilities, drugs and alcohol needs, mental health needs, homelessness, offending etc.

The team triages the referrals, provides advice and signposting, takes any immediate action and directs referrals to appropriate teams.

Much of the day to day work is done over the phone; however there are plenty of opportunities for students to carry out visits in urgent/crisis situations and to assess whether people meet the criteria for social care.

The work at Social Care Direct is fast paced, with a high turnover, and every day is different. Staff have to rely on their experience and knowledge of legislation and policy to make decisions quickly in often complex situations.

Social Care Direct works closely with other professionals and is co-located with other health and social care professionals to allow for greater multi-agency working and decision making.

**Connecting Care Locality Hubs**

The health and social care workforce are working together across Wakefield to support people to live longer, healthier lives, supported by well-co-ordinated care delivered as close to home as possible.

Connecting Care aims to develop a new way of working to create a community health and care service that will mean individuals are able to say yes to all the following:

* I can access information and support that is clear, up to date and consistent
* My care and support is responsive, timely and joined up
* My support is provided by caring, considerate people with the right skills
* I live in a safe and positive community
* I am encouraged and supported to stay healthy
* I am assured that services and resources are efficient

The Connecting Care Partners are:

* Age UK Wakefield District
* South West Yorkshire Partnership NHS Foundation Trust (SWYFT)
* Carers Wakefield & District
* Nova
* Spectrum Community Health CIC
* The Mid Yorkshire Hospitals NHS Trust
* Wakefield Clinical Commissioning Group
* Wakefield Council
* WDH
* Yorkshire Ambulance Service

The purpose of Connecting Care Hubs is to deliver person centred co-ordinated care which achieves better outcomes for Wakefield people who need health and adult social care.

The aim of the Connecting Care Hubs is to ensure that:

* Care is co-ordinated and seamless
* Health and Social Care services such as; district nurses, therapists, social workers, mental health workers and pharmacists, will work together, share information, plan and join up care together for people
* Hubs offer a wider health and social care service and focus on crisis intervention to prevent avoidable hospital admission and support services to enable people to be discharged from hospital earlier
* A clearer, faster access to hub services for acute, primary, clinical and adult social care providers is improved by having one single referral process through the establishment of a single point of access
* People are supported and in control of their condition and care, enjoying independence for longer
* Unpaid carers are prepared and supported to care for longer
* Care is cost effective and within available budgets
* All staff understand the system and work safely and effectively in it

One Hub links up to certain geographical G.Ps on the West side of the district, the other to the East side of the district.

All routine and urgent enquiries are initially received by Social Care Direct (SCD) and Single Point of Contact (SPOC). Information, guidance and signposting is provided where necessary and where this is not possible a decision is made whether the enquiry is urgent or routine and passed to the hub.

The Hub Triage Team, which is made up of a Social Work Manager, Community Manager and Therapy Lead, are responsible for signposting referrals to the most appropriate partner in the Multi-Disciplinary Team (MDT) for Case Management.

All cases are monitored by the Co-ordination Unit which consists of Support Service staff.

All case management is undertaken by the MDT. This includes; social workers, care co-ordinators, specialist staff from both Age UK Wakefield District and Carers Wakefield and District, Mid Yorkshire Therapy Team staff including occupational therapists, physiotherapists, dieticians, and pharmacists. Mental health navigators from SWYFT and wellbeing case workers from WDH are also available.

**Community Teams Learning Disability**

Learning Disability teams are based at east and west of the district. The teams work with people who are 18+ with a learning disability and often with complex care needs. The team will assess, review and commission packages of care to meet assessed needs under the Care Act 2014. They will also undertake holistic assessments joint working with health partner agencies as and when required. They also complete Continuing Health Checklist (CHC) for funding and Decision Support Tool (DST) in conjunction with the CCG. Carer’s assessments are also provided in line with the Care Act 2014 responsibilities

**Shared Lives Team**

Shared Lives is a provider service within Wakefield Council providing both long and short term placements for vulnerable service users. . Working in partnership with Connecting Care Locality Hubs the primary task is to assess carers to determine if they would be able to work as Shared Lives Carers and receive service users into their homes, they are self-employed but are contracted to Wakefield Council.

The Shared Lives scheme is responsible for recruiting, training and approving Shared Lives carers. They are also responsible for ‘matching’ the process by which Shared Lives carers and people who use the service are matched for compatibility, which is the foundation of a successful and mutually beneficial Shared Lives arrangement.

Part of the role is to assess the ongoing suitability and safety of the Shared Lives carer’s home and accommodation, carrying out DBS checks on the shared lives carer, and ensuring the property meets fire, electrical and gas safety regulations.

All arrangements are monitored by the Care Quality Commission (CQC) and inspected on a regular basis

**Community Mental Health Business Unit**

**Single Point of Access**

SPA is a multi-disciplinary service that offers referrers, patients and carers an efficient and timely response when accessing secondary mental health services. SPA provides a streamlined and centralised entry point into adult mental health services. It is an engagement, triage and assessment service, helping users of mental health services keep well in the community and avoid unnecessary hospital admissions. Important features include high quality patient assessments, delivery of interventions to reduce distress and provision of practical help and signposting of patients where appropriate to voluntary sector and primary care services.

The service is available to adults 18 years and above who have issues with their mental well-being that may require secondary mental health service intervention.

SPA accepts referrals from primary and secondary care services and people can self-refer. Referrals can be made by telephone, letter, fax, secure email or in person. There is a single, local phone number for all referrals with an answerphone facility for out-of-hours callers.

SPA is the entry point to IHBT, and can facilitate same day assessment in response to urgency with a commitment to see all non-routine referrals within three days. It assesses routine referrals with 14 days.

**Core Teams**

Core Teams offer assessment, care co-ordination and a range of evidence-based interventions and treatments to improve mental wellbeing and are committed to recovery approaches.

Services are provided in accordance with the Care Programme Approach (CPA).

The model provides for flexible and assertive engagement of service users depending upon the complexity and acuity of their needs. The Core pathway is intended for service users with moderate to severe mental health conditions who require a less complex package of care, predominantly delivered by one clinician. Care packages may also however comprise interventions delivered by more than one practitioner, managed as a standard care package and not requiring a full multi-disciplinary enhanced approach. Core pathway service users may only require brief or short-term mental health intervention, or may require longer-term contact with mental health services during a period of stability**.**

The teams work in partnership with all other areas of mental health and social care services. Their aim is to enable people to live life to the full and improve outcomes for people by providing good quality support to the individual and those close to them.

**Enhanced Teams - East & West Teams**

Enhanced teams work people with complex mental health conditions, who require a correspondingly complex package of care i.e. multiple interventions which require coordination, positive risk management and high levels of support/supervision. These are higher risk people with serious mental health problems, challenging behaviours, who can also be difficult to engage (or sometimes over-engage) in community care and treatment and who require more assertive community treatment models, sophisticated risk management and frequent input from a range of specialist practitioners. The aim of the teams is to improve the quality of life of individuals, promote social inclusion and increase independence. They also work collaboratively with carers and families, providing support and sustaining family relationships.

Services are provided through the Care Programme Approach, and social care support is offered through personalisation and self-directed support.

Enhanced teams offer multi-disciplinary support, based upon recovery-focused principles and underpinned by positive risk-taking, and aim to create the conditions where better outcomes can be achieved for service users and their families, and in the process improve service user safety, supporting the reduction of patient safety incidents and serious incidents, the reduction of hospital admission and the need for IHBT. The teams provide holistic care to enable people to reach their potential and live well in their community.

The teams work to the FACT Flexible assertive Community Treatment – assertive outreach equivalent care for the minority of service users in the team at any one time according to current need. FACT uses the resources of the whole team to provide a flexible period of intensive contact and support by the service users own team.

**Community Mental Health Teams Older People - East and West**

The service provides a specialist integrated service (SWYPFT & Wakefield council) for people who are over 65 years and who are experiencing difficulties with their mental health. The community mental health team aims to provide seamless mental health services that are timely and effective in promoting prevention, recovery and maintenance, whilst encouraging independence and ensuring choice.

The CMHT provides:

* Adult protection – West Yorkshire safeguarding procedure.
* On- going assessment and care coordination – CPA
* Assessment & care management Facilitation of support packages -
* Care home liaison nurse – Assessment, advice and training.
* Approved mental health practitioner – Mental health act assessment
* Best interest assessments
* Capacity assessment
* Support of service users requiring court of protection.
* Individual treatment programmes
* Psychological support
* Psychosocial interventions
* Supportive counselling
* Medication management, advice and support
* Information and advice.(signposting to other services)
* Help with welfare benefits
* Help with accommodation
* Support for carers, individual and via sign posting to groups.
* Independent living skills promotion
* Further development of leisure and social skills
* Joint working with other professionals or Referral to other agencies.
* Individualised medical review
* Lithium monitoring nurse – Blood tests
* Ensuring 7 day follow ups are undertaken
* Supporting inpatient bed management. Admission and discharge process.

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**Hospital Social Work Team**

The Hospital Social Work Team is based at Pinderfields Hospital, Wakefield but covers the whole of the district. The team provides an assessment and care management function for Wakefield residents over the age of 18 who are admitted into a Mid-Yorkshire Trust Hospital (Pontefract Infirmary, Pinderfields Hospital and Dewsbury District Hospital).

The role of team is to assess and provide assistance and support where needed to facilitate a safe discharge from hospital. Always aiming for ‘Home First’ however there may be a need to assist with providing alternative accommodation whilst further assessments take place if required.

The team consists of: social workers, Care coordinators and administrative support working very closely with health colleagues based within the hospitals including doctors, nurses and therapists.

The team attends daily board-rounds and multi-disciplinary team meetings.

**Safeguarding Team**

The Adult Safeguarding team has the overarching responsibility for all safeguarding concerns and enquires of all adults aged 18 and over, who meet the Care Act 2014, Section 42 criteria, this includes:

* Older people
* People with learning disabilities
* People with mental health issues
* Young people aged 18+ who are care managed by Children’s Complex Care Needs Team undergoing transition to adult services

By having a specialist team it ensures consistency in social work investigating, recording of safeguarding concerns and enquiries for the people in Wakefield.

**Forensic Social Work Team** (This team will accept Practice Placement 2)

Newton Lodge is a specialist NHS hospital for Yorkshire and Humberside providing care and treatment to adults with a mental disorder who require conditions of medium security and is part of the Forensic Services Business Delivery Unit (BDU), South West Yorkshire Partnership Foundation NHS Trust. Admissions are taken from Court, Prison, High Secure Hospital and Local Psychiatric Services including low secure facilities. The service offers 90 inpatient beds across eight wards – incorporating specialist care pathways for male mental health; female mental health and men with a Learning Disability. All service users are detained under the provisions of the Mental Health Act 1983. Newton Lodge operates a pathway model whereby service user’s move through an identified care pathway from admission and assessment to either treatment sensitive or enhanced recovery and onto transfer or discharge dependent on their needs.

Newton Lodge Forensic Social Workers are fully integrated within multidisciplinary clinical teams aligned to the care pathways.

Functions of the team include:

* Attending weekly Clinical Team Meetings; contribute to comprehensive assessment of needs and risks; implementation of care plan and delivery of treatment interventions.
* Compiling Social Work assessments/social histories.
* Family interventions.
* Statutory responsibilities in relation to MAPPA and Victim contact.
* Discharge, transfer and transition planning.
* Group work.
* Child Contact assessments and care planning.
* Mental Capacity Act work and Best Interest assessments.
* Provision of Social Circumstances Reports to Tribunals (Mental Health–First Tier); Hospital Managers Hearings and the Ministry of Justice.
* Service user and Carer Involvement.

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