Coventry City Council

Briefing note

To: **Health and Social Care Scrutiny Board 5** **Date: 01/02/23**

Subject: **Managing Adult Social Care Referrals and Assessments**

1 Purpose of the Note

1.1 At a previous meeting of SB5 the issue of increasing demand for Adult Social Care and the potential impact of this on response times by Adult Social Care when people are either waiting for assessment or review was identified as an issue for consideration. This report is in response to this issue and provides information on how waiting lists for social work or occupational therapy intervention are managed within Adult Social Care

2 Recommendations

2.1 Health and Social Care Scrutiny Board 5 is recommended to:

Review and comment on the work of Adult Social Care, to understand the approaches and mechanism that are in place to manage demand on Adult Social Care and make suggestions and comments as to how this could be improved for consideration by the Cabinet Member for Adult Services.

3 Information/Background

Adult Social Care has a series of assessment duties enshrined in different legislation as follows:

Care Act 2014

3.1 The Care Act 2014 is the primary legislation relating to the delivery of Adult Social Care. Under the Care Act the local authority is required to provide services and support to adults aged 18 or above pursuant to the nationally published eligibility criteria for adult social care. This applies to older people, people with long term conditions, physical disability and sensory impairment, mental ill health, carers and those with needs arising from problems associated with substance misuse.

3.2 Under the Act, the Council has a statutory duty to undertake an assessment for any adult with and appearance of need for care and support and then to determine whether those needs require support or services from the local authority.

3.3 Eligibility must be determined at the point of an assessment. This means that whether the person is likely to fund their own care or that their needs could below the eligibility threshold the assessment is the first consideration in determining eligibility. There are no timescales set within the Care Act 2014 for assessments to be completed but there is the requirement

to carry out an assessment over an appropriate and reasonable timescale taking into account the urgency of needs and a consideration of any fluctuation in those needs.

3.4 An assessment starts as soon as the local authority begins to gather information about the person. This is essentially at the point the person contacts the local authority; however, many people require a comprehensive assessment to support the determination of whether needs are eligible for care and support from the local authority and understanding how the provision of care and support may assist the adult in achieving their desired outcomes.

Mental Health Act 1983

3.5 The Mental Health Act (1983) is the primary legislation that covers the assessment, treatment, and rights of people with a mental health disorder. The Act has specific responsibilities for practitioners in those who require assessment and consideration of detention in an acute Hospital with social workers needing to undertake advanced training and approval to act in this capacity (Approved Mental Health Professional). The duty to assess is specified with specific consideration to harm, acuity and whether the assessment can be completed without detention. This role has a high interdependency with additionally trained medical staff but it is the social care staff that agree and complete the detention.

3.6 The interdependency of social care and health providers in supporting those with mental illness is well established and the Council has in place a formal agreement with Coventry and Warwickshire Partnership NHS Trust (CWPT) this is known as a Section 75 agreement. Social Care have, under the agreement seconded staff to CWPT to undertake integrated work and the delegation of the Care Act duties.

3.7 Responsibility for the delivery of the AMHP service remains the responsibility of the City Council. There has been an increase in activity at local, regional and national levels that is now monitored via performance reporting.

Mental Capacity Act 2005

3.8 The Mental Capacity Act 2005 requires that all professionals assume a person has capacity to make a decision unless there appears to be good reasons to suggest otherwise. If that is the case then a Mental Capacity Assessment should be undertaken, formally recorded and decisions made in the best interests of the person. These assessments can be undertaken by health or social care professionals (not just social workers). This decision can range from how to spend their money to where they should live but is fundamental to the role of Adult Social Care. For the most part the assessments are conducted alongside the Care Act assessments but in some cases the assessments are more specific and relate to a level of care that the person is unable to consent to- a deprivation of liberty.

3.9 The Deprivation of Liberty Safeguards (DOLs) is the procedure prescribed in law when it is necessary to deprive a resident or patient who lacks capacity to consent to their care and treatment of their liberty in order to keep them safe from harm. A DOLs assessment, or Best Interest Decision is required before any restriction is put in place. Best Interest Assessments are undertaken by social workers who are also trained Best Interest Assessors (BIAs). DOLs is due to be replaced with Liberty Protection Safeguards (LPS) although there is no confirmed date for this change. The Council acts as the supervisory body for those in residential, nursing or hospital care.

3.10 However, deprivations that occur in the person's own home can only be authorised by the Court but the Social Worker or BIA would undertake the assessment and support the Court process.

Disabled Facilities Grants (DFG)

3.11 Where individuals approach the local authority seeking an adaptation, or where an adaptation is identified as a way to support an individual then a DFG assessment is required.

3.12 The timescales assessing and completing adaptations is dependent on the urgency and complexity of the adaptations required.

4 Referrals to Social Care

4.1 Referrals can be made from a number of sources including the person themselves, family or friends, GPs, or other health professionals and internally where the presence of a care and support need may have been identified by a different team such as Occupational Therapy. University Hospital Coventry and Warwickshire (UHCW) are also a source of referral where it is considered that care and support is required to facilitate a discharge.

4.2 Although there are a number of referral sources the majority of referrals are received via the online referral form. Self-referrals can be made via the self-assessment tool or by contacting Coventry City Council Customer Services via telephone or email.

4.3 Dependant on the source of referral and the team responsible for responding, different processes are applied to assess risk and prioritise. The types of referrals will vary and will be a combination of new people making contact for the first time, as well as those already in receipt of support but require a reassessment as their situation has changed. Within Adult social care we are seeing an increase in safeguarding referrals and more complex situations, most of which are deemed high risk and high priority, thus require a more urgent response.

4.4 The increased numbers of Safeguarding concerns received demonstrates an increase in awareness of safeguarding more generally. Raising the concern doesn't necessarily mean the threshold is met for an enquiry or investigation but the level of triage results in increased demand, places a significant pressure on Adult Social Care as decision in relation to Safeguarding concerns needs to be made within 2 days, and in many circumstances a same day response is required. As a result, all safeguarding referrals are prioritised which impacts on other assessment activity.

4.5 Once received, all referrals are screened by intake teams within Adult Social Care to prioritise based on risk and determine next steps. Several referrals can be dealt with and closed within the intake team leaving only those that require a further intervention will need to be allocated to a worker in the long-term Teams or to an Occupational Therapist. Approximately 40% of the contacts are resolved at source without the need for further involvement.

5 Responding to needs assessment requests

5.1 All referrals to Adult Social Care are risk assessed and prioritised according to the situation and level of risk and this is recorded on our recording system. This is also reflected in the arrangements in place with Coventry and Warwickshire Partnership NHS Trust where risk assessments form a key component of the triage and assessment process.

5.2 As each person presents with a unique set of circumstances and it is neither possible nor necessary to commence all assessments at the point of referral. As people's situation and circumstances change the associated risk factors can also change.

5.3 Professional determination of priority is defined and formal document in place; 'responding to needs assessment requests. This is included at **Appendix One.**

5.4 This document places the prioritisation of requests for assessment at three levels based on a range of factors including need, priority, status, and chronology:

Urgent

5.5 There is a critical level of risk due to an immediate risk to the person, a sudden and unpredictable change in circumstances or serious abuse has occurred. Safeguarding and manual handling related issues are considered urgent which requires response with a same or next day response determined with decisions related to safeguarding made within 48 hours of referral.

Medium

5.6 There is a substantial level of risk brought about by factors including extensive care and support needs and the risk of collapse of existing arrangements.

Standard

5.7 There is a low to moderate risk where the presence of some care and support needs may impair the person long term ability if not addressed. The person does however have a support network and can ask for/arrange appropriate assistance when needed.

6 Management of Risk

6.1 Overall levels of risk are monitored by Heads of Service with resourcing decisions made as appropriate to manage risk levels within the service. Escalation processes are in place to monitor level of risks and response times to ensure cases are appropriately risk assessed and allocated accordingly. Each week managers review the priority cases on the list for allocation to a worker.

6.2 For the AMHP activity twice daily handover meetings are in place to support the handover between shifts to ensure safe transfer of care.

6.3 Where necessary heads of Service will take action to mitigate risk. Such measures include moving staffing resource to meet demand and manage risks, and the reallocation of cases to enable professionally qualified staff to deal with more complex higher risk cases.

6.4 The assessment of risk is inevitably imperfect in the absence of the formal assessment and relies on information received which may not always be accurate. Professionals make decisions and recommendations based on several factors including whether the person lives alone, has an existing support package in place, the nature of the request and importantly the capacity of the person. This means there are, and will be, occasions where the actual risks are later found to be greater than the initial information would have suggested resulting in harm.

7 Existing levels of demand and risk

Community Teams

7.1 There are approximately 3500 people in receipt of ongoing care and support within Coventry with on average 200 referrals per week into social work teams. Not all referrals to the service will need ongoing support and significant numbers are resolved at source with approximately 40% requiring intervention from a Social Worker or Occupational Therapist.

7.2 The Promoting Independence offer supports this with increased numbers now accessing short term services to support the assessment process and divert from long term statutory provisions.

7.3 This means it is it the more complex cases that are allocated involving safeguarding, deprivations in the community, legal processes or high risk situations. Currently, there are 450 cases awaiting allocation for an assessment or review. This number will change on a daily and weekly basis.

Reviews

7.4 The Care Act statutory guidance states that it is an expectation that authorities should conduct a planned review of the support in place on an annual basis. Currently 55% of people with a support package will have been reviewed within the prescribed time frame. Teams are working on improvement plans to increase our review activity. Due to the lower levels of risk associated with annual reviews, some people will wait longer for a review as other more high-risk cases require interventions. For example, for many people we may complete more than one review/reassessment a year, due their changing needs and situation, which might increase the associated risk. Thus, those with stable care and support arrangements may wait longer for an annual review, as the workforce will be dealing with more high-risk cases and completing multiple reviews/reassessments.

8 Hospital Team

8.1 The hospital social work team also receive a high level of referrals with on average 700 referrals a month.

8.2 Due to the timely nature of hospital discharges, all referrals to the Hospital Social Work team are allocated on the same day. Those who need to be discharged from hospital are not all deemed to be high risk, however, to support the NHS and ensure no delays to hospital discharges, all referrals to the Hospital Social Work Team are prioritised and allocated on the same day. The hospital social work team undertake a different role to community teams as they are not required to undertake Care Act assessments within a hospital setting but instead to ensure short term support is in place where required to discharge people safely from hospital.

8.3 Those that are discharged with short term support are generally discharged from hospital within 2 days from the point of referral

9 Deprivation of Liberty Safeguards

9.1 Deprivation of Liberty safeguards (DOLs) are part of the Mental Capacity Act 2005 but implementation of this element of legislation took place in 2007. In 2014 a landmark case provided a definitive definition and took requests from 681 2014/15 to 2544 2021/22. Year on year the service sees increasing requests for new assessments and renewals.

9.2 The legislative framework enables urgent application by the Managing Authority and beyond that the service applies the nationally agreed ADASS priority framework. The assessments have 3 components and in total 6 assessments that covers the whether the person has a formal diagnosis (a doctor completes), whether the person has capacity to make decisions and whether the restrictions are necessary and proportionate (least restrictive) completed by the Best Interest Assessor.

9.3 The demand on the service is such that there is a waiting period for assessment and there are 327 waiting allocation to a BIA assessor. However, within this there will be people whose circumstances have changed, are less of a priority or are temporarily detained by the Managing Authority pending recovery or where the medical assessment is being completed. Each request is triaged in terms of priority and to assist the service contracts with another agency to complete the less urgent cases.

10 Disabled Facilities Grant (DFG)

10.1 There are 191 cases waiting for their DFG (disabled facility Grant) to be completed. In addition, there are 342 DFG's are in the process of completion either by Coventry City Council or Housing Association.

10.2 The reasons for this will be varied and range from issues with property ownership, agreeing specifications, availability of contractors or service User choice as to when the work can be completed.

10.3 We recognise for some people their DFG is not being completed within a year and we are working closely with Housing and Housing association colleagues to improve this for people. We have an improvement plan in place and working collectively with colleagues we are looking to reduce the time taken for DFG to be completed. In addition, this year we increased what we pay to contractors to increase opportunities for works to be completed.

11 Waiting Times

11.1 The increasing demand on Adult Social Care in terms of complexity of casework and legal standing of some of it, inevitably means waiting times are longer for some. Numbers waiting have remained relatively static in most areas but are likely to be an issue of challenge in the forthcoming CQC Inspections. Whilst waiting times and numbers waiting will feature it is more likely that the management of the situation will be the predominant issue to be addressed.

11.2 There is no consistent way that local authorities collate and report the information which means that comparison or benchmarking in respect of this would be hard to achieve but information collated informally suggests that Coventry is in a very similar position to others locally and across the region. We do have mechanisms in place to prioritise, manage and monitor the situation.

11.3 Waiting times and numbers are monitored closely by the service and the Management Team. This is included on the service risk register is reported regularly.

12 Workforce and Caseloads

12.1 Approaches to Adult Social Care have not increased to any significant level. However, the types of referrals received are more complex in nature, take time to resolve and more are associated with safeguarding vulnerable adults. This complexity impacts on a worker's caseload and subsequently the overall ability to allocate cases within teams. Many Social Workers are presenting cases in the court arena and these cases are high risk and are time intensive in terms of reports and interventions required. Current average caseloads are 20 based on a case load and workload audit completed in 2019/20 and is due to be repeated in 2022/23. There are no national benchmarks in relation to caseloads levels in adult services, however it's important to focus on workload and case weighting as this will focus on risk, complexity and time outputs of any caseload.

12.2 An Adult Services Organisational Health Check 2022/23 was completed between June and August 2022, in which 89% of practitioners expressed that their caseload was appropriate to their experience and knowledge. https://www.coventry.gov.uk/downloads/file/39318/adult-social-care-healthcheck-2022-2023

12.3 Monitoring and oversight of complexity and levels of risk was detailed in previous Scrutiny Board 5 paper titled Keeping People Safe (02/11/22). Access to training and supervision is crucial in supporting staff in assessing risks on individual cases. In addition, further support is provided via Risk Enablement and Legal Planning Meeting.

12.4 Since the pandemic, we have seen increased movement of staff in terms of employees leaving and wishing to pursue other job roles. This reduced workforce impacts on service delivery. Service areas have worked closely with HR colleagues to support recruitment campaigns, however new employees do not always have the experience required to work with more complex case scenarios which impacts on more experienced staff. An increased proportion of our new recruits have been newly qualified social workers that require significant support and development within the first year of employment and beyond, to get them to a place where they are confident in dealing with safeguarding and complex casework.

12.5 Local workforce issues are mirrored at regional and national levels across all professional groups and across the health and social care system.

13 Summary

13.1 Managing risk within a high volume and dynamic environment is part of the daily business of Adult Social Care. Although the numbers of people waiting for an assessment across the services appears high these are all prioritised on the basis of information available in respect of the levels of risk presenting to the person in question.

13.2 Within this number will be many who are already in a stable care and support situation but have experienced a change in care and support needs that may be minimal.

13.3 We recognise that some people wait longer for interventions than others and the average days waiting for assessment is not necessarily what we would want it to be. To mitigate risk and ensure those with greatest need have an assessment completed in a timely manner, we have robust risk assessments and escalations in place.

13.4 Increased complexity of casework impacts on capacity and throughput of cases, thus cases deemed lower risk will wait longer for an assessment or review.

13.5 It is acknowledged that the risk assessment process is imperfect as the reality of a situation is only really known once the living circumstances have been seen. However, triangulating information from other organisations and family/friends helps mitigate this.

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