A GUIDE TO THRESHOLDS AND PRACTICE FOR WORKING WITH PEOPLE, CARERS & FAMILIES IN WALTHAM FOREST

RIGHT CONVERSATION RIGHT CARE RIGHT TIME

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Waltham Forest
Safeguarding
Adults Board

Waltham Forest

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The Guide has been developed to help anyone who supports and works with people, carers and families to understand and apply the Waltham Forest approach to work with them and their communities.

It sets out our vision and values, and the roles and responsibilities of all agencies to work together so that every vulnerable person in the borough has the best possible outcomes.

Foreword

The Think Family vision is for people and families in Waltham Forest to be independent, resilient, well and safe.

People and carers should always have access to support from their family and community, and from universal services, such as GPs and healthcare, Police and the voluntary sector. For most people this support will provide everything they need to reach their potential and to maintain their wellbeing.

However, there are times when people need more support to improve their outcomes, either due to the complexity of their needs, or the impact of external factors in their life.

To support all people to achieve the Think Family vision, we believe we must draw on the evidence-base of what works so that people and their families are equipped and ready to manage the challenges in their life.

Everyone working with people and carers has a role to make this vision a reality. Understanding the roles and responsibilities of the different agencies within the adult services system is critical to ensuring that people, carers and their families get the right action and care at the right level and at the right time, so that we make the best use of resources to improve outcomes.

This Guide builds on previous work across the adult services system and aims to:

- Share our **Think Family vision**, setting out how the agencies in the adult services system work together to deliver good outcomes for people, carers and their families. The Guide is primarily for people who provide support to people, carers and their families, though it may be useful for families to understand the sources of help they can access.
- Support people to develop their skills to have **quality conversations that build relationships and identify the strengths** and needs of people and carers in the context of family, community, environment and their own experiences.
- Provide guidance about **indicators of need** across a broad spectrum, about how to identify and manage risks, and to support information sharing between agencies to help improve outcomes.
- Provide clear, simple information on how to respond with the **right conversation, right care, at the right time**.

The Think Family approach set out in this Guide is the culmination of many years of partnership work across the adult services system, and reflects a huge amount of progress since 2014 when the Care Act was published, including:

- Establishing safeguarding thresholds for work with people and carers and aligning our work with the existing MASH where all safeguarding concerns about people in the borough are now managed;
- Commissioning models of care to deliver high quality services at home and in placements such as residential care homes;
- Developing a new model of care that targets help and support for people with emerging and low-level needs.

Key to driving this progress has been the Health and Wellbeing Board, Better Care Together Board and Waltham Forest Safeguarding Adults Board, which provide critical forums for agencies to collaborate and think collectively about how to improve outcomes for people, carers and their families.

We know that this new document is just one step forward. We want to ensure that the information presented here is accessible and up to date and so we are working hard to ensure our adult services on-line information tools and directory of services are kept up to date.

More important is the work we will do collectively to put the guidance into action, to continue developing our practice to turn our **Think Family** vision into reality. **Building relationships** through quality conversations is what it's all about, and we look forward to working together across the partnership to make this happen.

Helen Taylor
Independent Chair of the
Waltham Forest Safeguarding Adults Board

Councillor Khevyn Limbajee
Lead Member for Adults

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Terminology used in this guidance

'**Waltham Forest**' and '**adult services system**' mean all the organisations and services that work with people, carers and families across Waltham Forest. This includes – but is not limited to – health services and commissioners, voluntary, faith and community organisations, police, probation services, housing providers, local authority and the Safeguarding Adults Board.

Family: we recognise that family means different things to different people. We know that different communities and cultures consider family in different ways, and that each resident will have their own understanding and definition of 'family'. This may include close friends and extended family members. Family is how each resident defines it. When we use the term 'family' we also include parents and carers who support and care for relatives.

Prevention: our approach to providing support to vulnerable people and their families as soon as problems start to emerge or when it is likely that problems will emerge in future. Prevention means taking action to support a person, carer or their family to prevent problems from occurring and/or at the first sign of a problem to prevent that problem from getting worse. Prevention is everybody's responsibility and we work collectively so that people, carers and families get support at the earliest opportunity.

Key person: any person who agrees to take the lead in coordinating the risk management plan for an individual on behalf of the adult services system. This person will generally be nominated at a practitioners' meeting or Team Around the Person. The Key Person does not have to be a practitioner.

Resilience: this term is used often in the guidance and is a key concept in our approach to providing services for people, carers and families. Resilience is what helps someone to prevent, reduce or overcome the damaging effects of difficult experiences. It is the ability to bounce back and successfully adapt to situations in spite of the challenges of everyday life.

Wellbeing: This is a broad concept, and it is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- Participation in work, education, training or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual's contribution to society.

Person centred: focusing care and support on the needs of the individual. Ensuring that people's preferences, needs and values guide our decisions so that care and support provided is respectful of and responsive to them. People should have the opportunity to make informed decisions about their care and support in collaboration with social care and/or health partners.

Safeguarding: is defined in Statutory Guidance as "protecting a person's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the person's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action."

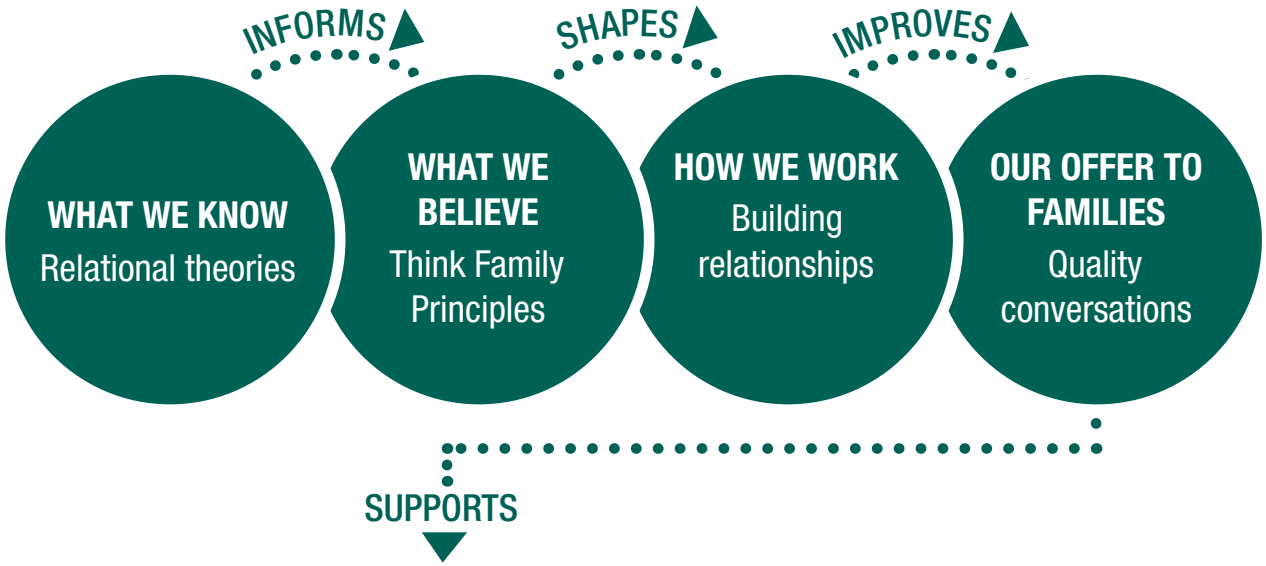
Practitioner: this means any member of staff who works with people, carers and families. This includes staff and volunteers who have only occasional contact with people, carers and their families, those whose main role is to work with people and their families and managers and leaders in agencies who have responsibility for work with people, carers and their families.

PART ONE
THINK FAMILY: AN OVERVIEW

Think Family

Our theory of change

Building relationships is at the heart of our theory of change, which is set out in this model to show how our knowledge and principles inform how we work in partnership with the individual, their families in their communities to improve outcomes for adults and carers.



Think Family Vision

Ambitious goals

The Think Family vision is for all individuals and families in Waltham Forest to be safe, well, independent, and resilient. This means helping people to help themselves and each other by developing skills and building relationships.

Independent: We want more of our residents to be leading independent lives, realising their own ambitions without the need for intervention from agencies and going further, to give something back to those who may be more vulnerable.

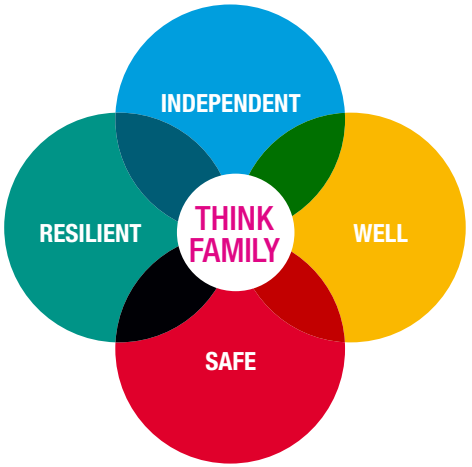
Resilient: We want our residents to have the skills, knowledge and capacity to cope with, manage and reduce problems that may arise in their lives, and restore their wellbeing for themselves using the resources they have in their communities and social networks.

Well: We know that achieving a good level of wellbeing enables our residents to enjoy a high quality of life. We want all individuals, families and members of our communities to be mentally, emotionally and physically healthy, and enjoy a positive and fulfilling experience of life in our borough. There is a real opportunity to improve the wider influences which will improve health and wellbeing.

Safe: Being safe is a fundamental right for all people and is an essential foundation for people to enjoy a good quality of life. We want all individuals, families and everyone in our communities to be safe from harm – be that abuse, neglect, exploitation, or the harmful effects of crime, violence, substance misuse or extremism.

Of course, these four goals are closely interrelated: only when an individual is safe, can they be well, and it is resilience which enables a person and their family to be independent. These are the goals which give shape to our **Think Family** approach and which will drive our services in future.

Our ambitious goals require new principles and commitments that are based in a **strengths-based approach** to working with families: building their skills and capacity to help themselves and each other.



Think Family vision

Ambitious goals

Right Conversation, Right Care, Right Time: identifying needs and risks

1. The person's wellbeing and safety are paramount. We will use clear, systematic methods to identify strengths, needs and risks and proactively work with vulnerable people and carers that are most likely to have poor outcomes in the future and engage them in new and different approaches to understand their wishes, outcomes, build their skills, capacity and relationships, potentially diverting them from more intensive intervention at a later stage.

Working with people and their whole families in their networks & communities

2. We work as change agents with the person and their whole family in a joined-up way. We use our professional skills to draw on an individual's strength, those of the family and support family members to help each other. This means thinking about the family in the widest sense, including the influences of child carers, siblings, friends, neighbours, and communities, and this also means understanding the impact of family dynamics, relationships and local networks on individual and family wellbeing.

Quality conversations

3. The starting point for anyone concerned about a vulnerable person and carer should be a quality conversation with them and if appropriate relevant family members, advocates and others. We see everyone who works with people, carers and their families as change agents that use their specialist skills to build relationships and abilities that improve outcomes for people.

Early Intervention is a commitment to collaboration: it's everyone's responsibility

4. We are committed to early interventions including collaboration with other partners and agencies. Promoting the wellbeing of people and carers who may have or may develop care and support needs is everyone's responsibility. We will work together across agencies so people and carers with emerging and/or established needs can reach their potential and achieve good outcomes.

Helping individuals and families to help themselves and each other

5. All interventions – whether big structured programmes or individual conversations with individuals and their families – must be focused on using our skills to develop individual and family skills, capacity and relationships. This is how we will judge our success both at the macro (borough-wide) and micro (individual/family) levels.

Clear offer in response to identified needs

6. We will be clear about the offer that we are making to individuals, carers and their families, so that people understand what their rights and entitlements are to care and support. This will include a full description of our offer and what it looks and feels like from the person's perspective.

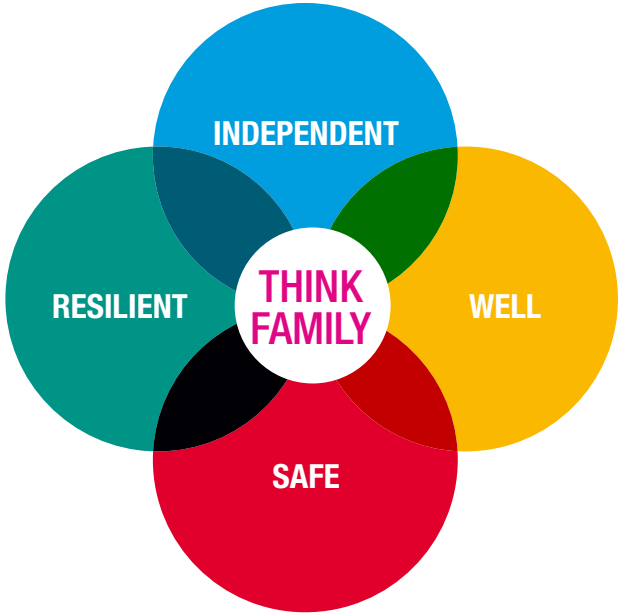
Evidence-based prevention and action

7. The offer must be informed by evidence. We will plan and commission services based on a sound understanding of data and will use verified prevention and early intervention methods to transform the adult services system, upskilling staff and changing our practice across the board.

Our Think Family commitments to people, carers and families

We will:

- Recognise that the person and their family are experts in their own lives and are best placed to determine and meet their own needs with support from their networks, communities and universal services.
- Recognise that dealing with emerging social care needs sometimes at a time of crisis is challenging and that with the right support, at the right time, for the right length of time people can develop their own skills and capacity and find the right support to meet their need and to achieve good outcomes.
- Make every contact count.
- Not pass the buck.
- Where appropriate offer one main point of contact, called a key person, who will act as a change agent in working with them and their family.
- Make assessments uncomplicated and robust.
- Provide services that are easy to access, safe, practical and useful.
- Recognise that each person's needs and circumstances are varied and offer variety in response.
- Work in partnership with individuals and families (not 'do to' them) to improve their outcomes, build resilience and sustain improvements. The quality of the relationship within and between the person, family and practitioner has a direct impact on the effectiveness of the help that is offered.
- Make necessary judgements in balancing the rights of the person to sometimes make unwise decisions and the legal duty to ensure they are protected from abuse and neglect.
- Reduce unnecessary intrusion and duplication in the lives of vulnerable people, carers and their families whenever possible, through outcome-based interventions and integrated working.
- Recognise the person's expertise by experience, including their right to participate in decisions about them in line with their capacity to do so.
- Seek the voice of the person when considering their needs, the outcomes important to them in their life.
- Involve families in decisions where appropriate to do so about how to improve outcomes for the person and carer.
- Accept that uncertainty and risk are features of safeguarding work: risk management may only reduce risks, not eliminate them.
- Measure the success of our safeguarding and early interventions by Making Safeguarding Personal and checking with people that their outcomes were met.



PART TWO
UNDERSTANDING THE THINK FAMILY THRESHOLDS

A framework for identifying outcomes, strengths, needs and risks

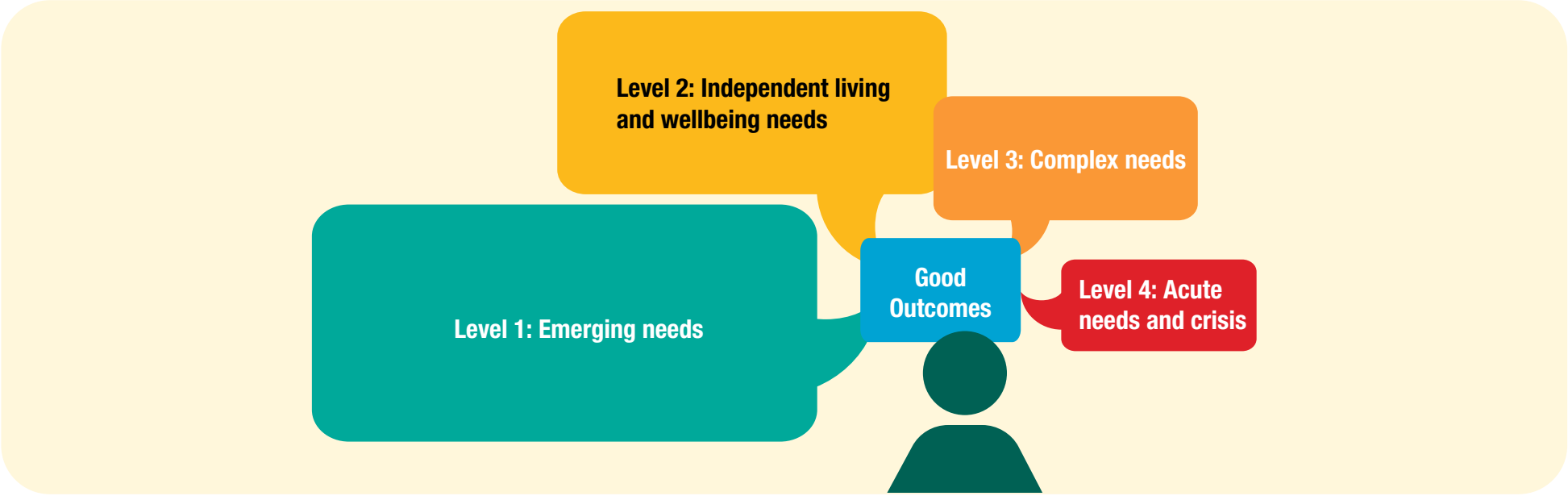
It's vital that everyone who works with people, carers and their families develops a good understanding of how to use their skills to identify and assess the strengths and needs, and how agencies can work together to ensure that individuals get the right action and care, at the right level and at the right time and place.

This guidance will provide a foundation of knowledge for anyone working with people, carers and families, but it is the quality conversations that will build relationships and make a difference to people's outcomes and lives.

These include conversations between people, carers, families and practitioners, between practitioners and their line managers, or with the MASH and other colleagues when they have concerns about specific people.

If we don't develop an understanding of strengths, needs and risks through quality conversations with colleagues and with people and their families, we can make unnecessary referrals that clog up the system and divert resources away from people who need them most. This can also create frustration between agencies, practitioners and families.

The adult services system Levels of Need follow the levels of care and support set out in the Care Act 2014 guidance and are directly linked to our Think Family vision. Although the strengths, needs and risks of people, carers and their families rarely fit into neat levels – for example, a husband and wife may have different levels of need and their individual needs may change over time – the levels help us to consider the key issues for a person and their family and what the right action and care might be.



Levels of need for the adult services system

Good Outcomes

At all levels, people are:

- Feeling safe
- Having things to do
- Seeing people
- Staying as well as they can
- Living where/as they want
- Free from stigma and discrimination

At all levels, people are:

- Listened to
- Having their say
- Treated with respect
- Responded to
- Offered reliable care and support

At all levels, people can:

- Eat properly and maintain proper nutrition
- Maintain personal hygiene
- Manage toilet needs
- Dress appropriately
- Able to use and move about the home safely
- Maintain their home in a fit and proper state
- Maintain and develop relationships with family and friends
- Take part in any work, education, training or volunteering they may wish to
- Participate in social activities, hobbies and use of public transport/local services
- Look after any children or family members they have responsibilities for

Level	What's happening for the person, carer and their family?	What is the offer of services available in Waltham Forest to improve outcomes at this level?	What difference does that make for people?
LEVEL 1: EMERGING NEEDS	People, carers and their families are broadly able to achieve good outcomes, but sometimes need some additional help to access community support or universal services. We want all people, carers and families to be able to access these services as their first port of call when they need any help, support or advice.	**SELF-HELP & PREVENTION OFFER** Support from family, community and network Voluntary and community sector organisations Connecting Communities programme Waltham Forest Library Services Leisure centres and services Primary Care from general practice (GPs) Housing services Carers support FOR MORE INFO ON THE OFFER AT LEVEL 1, SEE PAGES 37-38	• Able to self-help • Increased choice & control • Informed decision making • Personal/family resilience

Level	What's happening for the person, carer and their family?	What is the offer of services available in Waltham Forest to improve outcomes at this level?	What difference does that make for people?
LEVEL 2: INDEPENDENT LIVING & WELLBEING NEEDS	The person, carer and their family may need assistance to achieve one or more desired outcomes. They may be able to achieve the outcome unaided but: • Experience significant pain, distress or anxiety • Doing so endangers, or may endanger their or another person's health and safety • It takes significantly longer than would normally be expected	INDEPENDENT LIVING & WELLBEING OFFER The offer at LEVEL 1 and: Managed Network of Care Adult social care urgent & short-term responses Equipment and assistive technology NELFT falls prevention Waltham Forest talking therapies Drugs & alcohol support: Change Grow Live agency Support for victims of domestic abuse Reablement, recovery & progression Disabled Facilities Grant Sheltered housing FOR MORE INFO ON THE OFFER AT LEVEL 2, SEE PAGES 39-41	• Improved wellbeing • Delay and reduction in need • Early Intervention – increased independence • Improved life chances • Increased safety • Building resilience
LEVEL 3: COMPLEX & LONG-TERM SUPPORT NEEDS	The person, carer and their family have high level health or care needs that are complex, and need care and support to achieve good outcomes, including support from practitioners in the adult services system. These needs may include functional limitations, frailty in older people, behavioural health conditions, and social needs.	COMPLEX NEEDS & LONG-TERM SUPPORT OFFER The offer at LEVELS 1,2 and: Mental Health single point of access (SPA) NELFT rapid response NELFT rehabilitation Adult social care response: risk management and care management Secondary health care Memory clinic Complex psychological therapy Medication management Specialist mental health teams e.g. Perinatal, eating disorder service, personality disorder, older people Community nursing and therapy via the SPA including: wound management, general nursing care End of life care	• Person-centred care • Right support at the right level • Choice & control • Increased independence • Improved wellbeing • Improved safety • Improved life chances

		Specialist nursing e.g. respiratory, diabetes, tissue viability, continence, sickle cell, MS and Parkinson's Podiatry Nutrition and dietetics Supported home discharge Learning Disability Services Direct payment support service Community Rehabilitation Services Day opportunities Domiciliary support (home care); supported living, extra care; residential or nursing care; medical intervention FOR MORE INFO ON THE OFFER AT LEVEL 3, SEE PAGES 42-46	• Person-centred care • Right support at the right level • Choice & control • Increased independence • Improved wellbeing • Improved safety • Improved life chances
LEVEL 4: ACUTE NEED AND CRISIS	The person, carer and their family have very serious and/or urgent needs and may be in crisis. These needs may include serious abuse with long-lasting negative impact, including risk of serious injury and/or death.	**MULTI-AGENCY RESPONSE** Services at LEVELS 1,2, 3 and: Deprivation of Liberty Safeguards (DoLS) Adult Safeguarding Service Specialist social work services AMHP assessment Psychiatric liaison service AMHP service Mental Health home treatment team Mental Health inpatient beds Rapid Response High intensity user programme Urgent centre at Whipps Cross hospital Neuro navigation service Ainslie rehabilitation unit Continuing Health Care assessment FOR MORE INFO ON THE OFFER AT LEVEL 4, SEE PAGE 47	• Protection from abuse/neglect • Making Safeguarding Personal • Improving care quality • Human rights upheld • Least restrictive provision is in place

Good outcomes for carers

The good outcomes for people listed on page 15 do not fully reflect the priorities of all carers. In Waltham Forest, we are committed to understanding the needs and outcomes of carers and set out three principles:

1. Fair and equitable provision

Carers will be treated fairly and equitably alongside the individuals who they care for. Their access to services and support will reflect their individual circumstances and needs and the circumstances of those they are caring for. Their support will account fully for how their age, cultural background, socio-economic status, gender and sexuality impact on their roles as carers.

2. Ease of access to support

Carers have repeatedly told us that is has been difficult to identify what support is available to them and how to access support. We will ensure that there are clear points of access into assessment and support for carers and that these routes of access do not unintentionally discriminate against carers due to age, language and other cultural barriers.

3. Think Family outcomes and principles

The carer outcomes framework below is based on four areas, including:

- Quality of life of the cared for person
- Quality of life for the carer
- Managing the caring role
- Service and process-based outcomes

Quality of life for a cared for person: safe, well, resilient and independent

Quality of life for the carer

Well: maintaining their health and wellbeing as well as that of the person they care for

Independent: carers are central to decisions and have the tools they need for good outcomes for themselves and those they care for

Safe: positive relationships with the cared for person, family, friends and community

Resilient: with knowledge, skills and resources to sustain their caring role for as long as they are able to

Managing the caring role

Satisfaction in caring

Choices in caring, including the limits of caring

Feeling informed, skilled and equipped to support the cared for person

Partnership with services who help to address the needs of the cared for person

Service-based outcomes

Valued and respected with expertise recognised

Having a say in services

Flexible and responsive to changing needs

Positive relationship with a key person and/or with practitioners from any level and discipline

Accessible, available and free at the point of need

What to do if you are worried about an adult

It is everyone's responsibility to help people to live free from neglect, harm and abuse. You play an important role identifying the needs and risks. Where a need or risk is identified, everyone can respond early by holding conversations with practitioners and community members who are in contact with the person, carer and their family. Conversations are held to identify how those needs can be met collectively by family, community and services.

If you have urgent concerns that you or someone you know, is being abused or neglected, you can contact the Safeguarding Adults Team at Waltham Forest Direct:

Email:
safeguarding.adults@walthamforest.gov.uk

Telephone:
020 8496 3000
Your call will be treated in the strictest confidence.

Otherwise, please complete our online referral form to raise a safeguarding concern.

If you are unable to do this online then you can visit a Library Plus branch where you can use a self-service computer to log your request or report. Staff are available to support you if you need it.

For further information visit
walthamforest.gov.uk/safeguardingadults

If you believe someone is in immediate danger please call 999.

If not, and you want to report a crime call 101 or visit met.police.uk/ro/report/ocr/af/how-to-report-a-crime

Should you have concerns regarding the lack of response to practitioners' opinions and judgements expressed by your staff about safeguarding matters, including concerns that social care is not taking appropriate actions regarding the well-being of a person with care and support needs, or are not responding in a timely fashion to your concerns you can escalate this by visiting walthamforest.gov.uk/strategicpartnerships

When in doubt, always hold a conversation with your line manager or agency safeguarding lead.

Understanding risks of abuse and neglect for people, carers and their families

Everyone who works with people, carers and families must be aware of the risks of the following forms of abuse:

- **Physical abuse** including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
- **Domestic violence** including psychological, physical, sexual, financial, emotional abuse; so-called 'honour'-based violence.
- **Sexual abuse and/or exploitation** including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the person has not consented or was pressured into consenting.
- **Psychological abuse** including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
- **Neglect and acts of omission** including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
- **Self-neglect** covers a wide range of behaviours such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.
- **Financial or material abuse** including theft, fraud, internet scamming, coercion in relation to an person's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- **Modern slavery** encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
- **Criminal exploitation** including the exploitation that involves vulnerable people in criminal activity such as cuckooing.
- **Discriminatory abuse** including forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.
- **Organisational abuse** including neglect and poor care practice within an institution or specific setting such as a hospital or care home, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

The following risks should be considered:

- Abuse by one adult at risk by another within a service setting should be addressed as an Adult Safeguarding issue.
- If a child or children is/are causing harm to an adult, action should be taken with a referral to the MASH and close working with children's services.

Where there are on-going safeguarding issues for a young person and it is anticipated that on reaching 18 years of age, they are likely to require ongoing support, arrangements should be discussed as part of **transitional safeguarding planning and protection**.

- A carer may experience intentional or unintentional harm from the person they are trying to support or from practitioners and organisations they are in contact with; or, a carer may unintentionally or intentionally harm or neglect the person they support on their own or with others.

- If a person doesn't meet the statutory test for Safeguarding Adults, the Local Authority will still act i.e. information and advice, or signposting is provided. Where parts of the statutory test are met and the risks are high, a non-statutory enquiry can be carried out.

What do we mean by abuse and neglect?

Pan-London Multi-agency Safeguarding Adults Policies and Procedures outline the following additional types of abuse:

- **Disability Hate Crime** – A crime motivated by a person's Disability or perceived Disability
- **Female genital mutilation (FGM)** – Procedures that intentionally alter or injure female genital organs for non-medical reasons
- **Forced marriage** – A marriage in which one or both of the parties are married without their consent or against their will
- **Hate Crime** – A crime motivated by Disability; Race; Religion; Sexual orientation; Transgender
- **Honour Based Violence** – It has or may have been committed when families feel that dishonour has been brought to them
- **Human trafficking** – The movement of people and services for the purposes of exploitation
- **Mate Crime** – When vulnerable people are befriended by people who then exploit them
- **Restraint** – Unlawful or inappropriate use of restraint or physical interventions
- **Sexual Exploitation** – Involves exploitative situations where a person receives something as a result of them performing, and/or another or others performing on them, sexual activities
- **Radicalisation** – The aim of radicalisation is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause

Who could be the person responsible for abuse or neglect?

- The person who is responsible for the abuse is often well known to the person abused and could be:
- Relatives and family members
- Practitioners staff
- Paid care workers
- Volunteers
- Other service users
- Neighbours
- Friends and associates, and
- Strangers

What are indicators of abuse or neglect?

Here are some indicators to look out for (this is not an exhaustive list):

- Multiple bruising or finger marks
- Seeking attention/ protection, often from numerous sources
- Excluded from outside social contacts
- Injuries the person cannot give a good reason for
- Deterioration of health for no apparent reason
- Loss of weight
- Inappropriate or inadequate clothing
- Lack of eye contact – looking at the floor during discussions or looking to others to answer questions even when directed to the individual
- Withdrawal or mood changes
- Practitioners and other visitors may have difficultly gaining access to the person or may find confidential interaction inhibited
- A carer who is unwilling to allow access to the person
- An individual who is unwilling to be alone with a carer
- Unexplained shortage of money

PART THREE
OUR PARTNERSHIP PRACTICE MODEL

The importance of quality conversations with people, carers, and families

A quality conversation is a starting point for everyone who works with people and carers to improve outcomes. We use this term to describe the phone calls and meetings that take place with people, and between practitioners working at every level of need across the adult services system.

Our conversations need to be meaningful and actively help people find the solutions they need in a straightforward way. Using a checklist approach to need can tend to highlight family weaknesses. By contrast, a quality conversation can take into consideration the complexity of the person, carer and family situations and can place more emphasis on their strengths and assets.

When a person's needs cannot be met by family, community and universal services alone, a quality conversation will strengthen and improve joint planning, decision making, collaborative working and a partnership approach to having the right conversation to provide the right care at the right time.

If we don't develop a good shared understanding of strengths, needs and risks through quality conversations with families and colleagues, we may not be able to meet needs and improve outcomes in a timely way. We may also end up making unnecessary referrals, diverting resources away from the people who need them most.

This can create frustration and resentment between people, carers, families and the agencies across the adult services system. That's why this part of the guidance is critical.

Finding solutions together

In the first instance, unless this is likely to increase the risk of harm, the first step for anyone who is concerned about the wellbeing of an person, carer or their family should be to start a conversation with the person, carer and family to gain an understanding of their experiences, wishes, feelings, wellbeing, environment and of any other agencies involved with them.

Once there is a shared understanding of what the issues are, the professional should try to help to explore possible solutions. The default option should not be to suggest a source of support external to the person and their family. It should be to identify what the person, carer and family can do themselves to address any needs and/or stop problems from developing.

If external support is needed, it is important to explore what capacity there is in the wider extended family or community, for example from friends, neighbours, and community organisations. Practitioners should also reflect on what they or their colleagues can do to help and make sure this is communicated clearly.

The importance of this conversation with the person, carer and family cannot be underestimated. In many cases, conversations will happen repeatedly over time and the relationship that is formed will be critical to enabling change. Through this relationship, it is possible to explore issues, set expectations, develop individual and family skills, provide advice and challenge individuals and families to make changes where necessary.

Building relationships

This move towards quality conversation as the key to addressing concerns about vulnerable people, carers and families represents a critical shift in the way we understand our roles and responsibilities for working together to meet needs. Seeking advice and support from other agencies must not be about passing a case on but about bringing in additional sources of support to help meet identified needs. In this way, we place building relationships at the heart of what we do, because this will form a strong basis for sustainable change in the lives of people, carers and families.

Helping people, carers, and families to help themselves and each other

Quality conversations between people, carers, families and the people working with them can help an individual to:

- Stay healthy, well, resilient and independent
- Identify strengths, interests, and resources
- See positives, notice opportunities and find solutions
- Build relationships between people, carers, family members and the people who support them
- Access the support available in communities and to make use of local resources
- Address issues and problems – such as social isolation, falls and the breakdown of relationships with carers – before they get worse
- Avoid entering health and care systems at a higher level

Quality conversations also help establish:

- What people want to achieve in life
- The strengths, interests, abilities and resources they and others bring that can help them achieve this
- The contribution that services and outside support can add to help them achieve this
- The extent to which outcomes are achieved, what has helped before and what has prevented outcomes before

By starting a conversation with the person around the outcomes important to them, agencies can work towards sustainable changes that build on the person's own capacity, tailored to their needs, aspirations and circumstances. While the approach requires significant time investment in the short term, longer term savings are achieved by avoiding wasteful use of services that either don't make a difference to the person required or reduce their independence and wellbeing.

Quality conversations help to record information on outcomes. People supporting individuals can add to the information that they gather from conversations with a person by drawing on information from others close to the person and from their own observations.

Information is recorded qualitatively, and always in language that is meaningful to the person. Information is also recorded about a person's outcomes to inform decision making within health and care organisations. This includes decisions about:

- Individual packages of care and support
- Service delivery and improvement
- Planning and commissioning of services

There is more information on a structured approach to quality conversations and recording information about people, carers and families on page 25.

Remember…

If a conversation leads anyone to feel concerned that a person or carer is at risk of harm, neglect or abuse, then they should have a conversation with their line manager and/or the Adult Safeguarding Lead within their agency.

If it's an emergency and an adult is at risk, contact MASH or the Police (see page 19).

Quality conversations at each level of need

The diagram below outlines conversations at each level of need based on a person's preferred outcomes, their strengths and needs and the risks that might be present in their lives:

LEVEL 2: CONVERSATION ABOUT INDEPENDENCE AND SAFETY
to assess levels of risk and develop and implement an emergency plan, working intensively with the person to address these

What needs to change to make you safe and regain control?

How do I help to make that happen? I will stick to the person like glue to help make the most important things happen

What offers do I have available to support you?

Can I access small amounts of money?

Can I use my knowledge of the community to support you?

How can I pull these things together in a plan and work alongside you to make sure it makes a difference to you?

LEVEL 1 CONVERSATION ABOUT WELLBEING IN THE COMMUNITY
to explore people's preferred outcomes and connect them to personal, family and community sources of support so that they can get on with their life independently

What really matters to you? What is your preferred outcome?

How can I connect you to things that will help you get on with your life?

How can we draw on your assets, strengths, family, and community?

What do you want to do?

What can I connect you to?

Good Outcomes:
Safe Well Resilient
Independent

LEVEL 3: CONVERSATION ABOUT OUTCOMES FOR PEOPLE WITH COMPLEX NEEDS
to explore and plan long-term outcomes, built around what a good life looks like to the person, and how best to mobilise the resources needed, and the personal and community assets available.

What does a good life look like to you?

How can I help you use your resources to support your chosen life?

Who do you want to be involved in good support planning?

What is a fair personal budget and where does the money come from?

LEVEL 4: CONVERSATION ABOUT A CRISIS OR URGENT SAFEGUARDING NEEDS
to respond immediately to the risk of neglect and/or abuse

How can we protect you from abuse and/or neglect?

What does it mean to Make Safeguarding Personal for you?

How can we improve the quality of your care?

How can we uphold your human rights?

Is the least restrictive provision in place?

Safeguarding

THE INGREDIENTS OF EVERY QUALITY CONVERSATION

1. **Active Listening**: giving time and space, picking the right environment, really listening and not just waiting to speak.
2. **Identifying Assets and Strengths:** finding out what matters to the person, what their desired outcomes are, their personal strengths and the assets around them which may include family members, friends, and activities they enjoy or community groups they are part of.
3. **Enabling the person, carer and family to take the lead:** resisting the urge to "solve the problem" and helping them to reflect and set out their outcomes.

Working with people, carers and families in their networks and communities

Think Family means thinking community. We know that isolation is a key issue in our community and a key reason why people, carers and families turn to the Council and statutory partners like the specialist health services and the Police for help. We know that many residents would welcome the opportunity to give something back. The evidence is clear that people who are proactively engaged in their communities are happier and healthier.

Working with people, carers and their families in their networks is about sharing our knowledge and experience and empowering our residents, voluntary, faith and community groups, libraries, GPs, pharmacists, housing and other agencies to provide support without having to refer for specialist advice.

We want to change the culture of the borough, working together to share positive messages about how people can stay safe, well, resilient and independent so that specialist services are not the first port of call when things go wrong. This involves maintaining and sharing up to date information about the resources, opportunities and activities that are available across the borough. Everyone working with people has a responsibility to update their own knowledge about local communities and to know how to help people, carers and families to access sources of information, advice and support.

This involves having quality conversations with residents across Waltham Forest that build relationships, build confidence and add to our shared knowledge of what works for people, carers and their families.

Connecting Communities

The Connecting Communities Strategy is linked to Think Family and aims to improve the life chances of all residents in Waltham Forest by helping our communities feel safer and more connected. The strategy aims to reduce inequality, create opportunities, and make Waltham Forest a better place to live. We want people to be proud of their different backgrounds, cultures and faiths, while feeling part of the bigger community. We believe that a shared sense of identity helps people to overcome differences, learn from each other, and get to know their neighbours.

The aims of Connecting Communities are to:

- Raise awareness of good work already happening locally, so more people can support, join and benefit from it
- Inspire people to get involved through ‘small acts’ like mentoring or simply saying ‘hello’
- Make it easy for residents to lead change that helps make Waltham Forest a better place to live
- Tackle discriminatory attitudes
- Highlight that everyone here is linked to one another because they have Waltham Forest in common

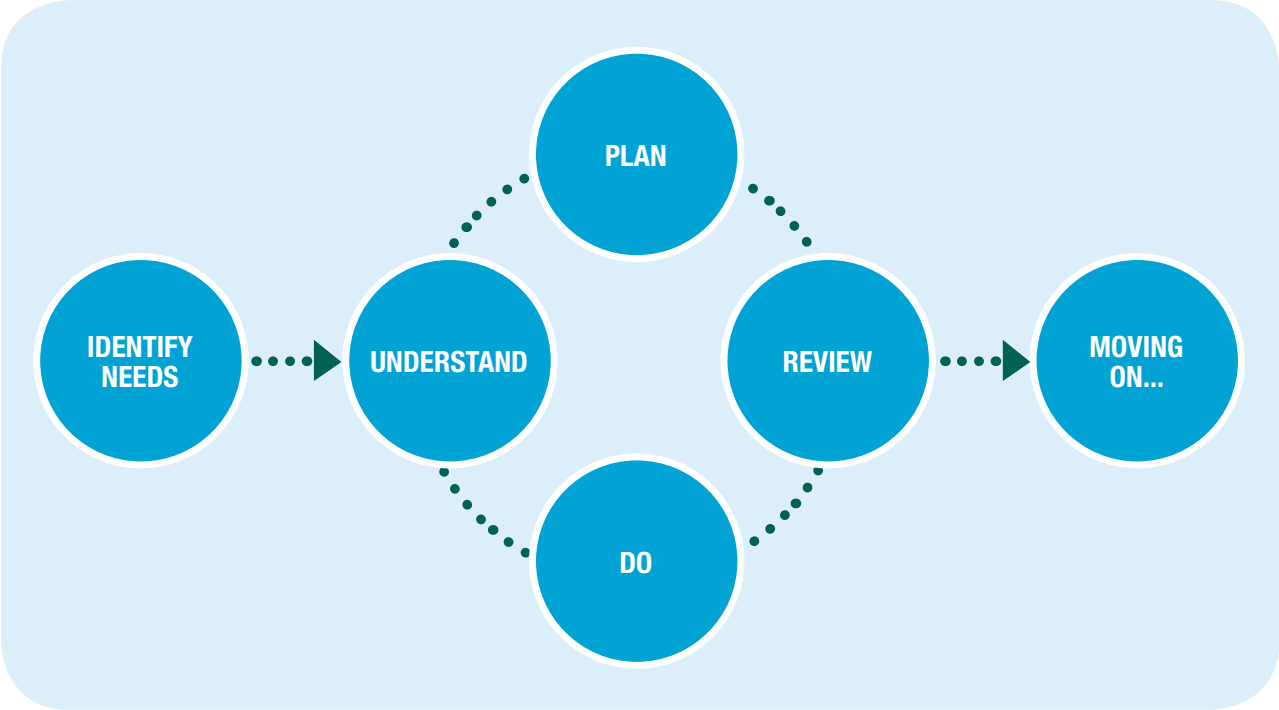
Connecting Communities will foster connections and encourage positive interactions between community groups and will focus on ways that people, carers and families can get the most out of living in Waltham Forest.

A structured approach to good outcomes

Following a clear and structured approach will help you to make sure that the work you do together with people, carers and families leads to effective actions that will bring about and sustain changes, resulting in good outcomes.

This process will support anyone in any setting to build and maintain professional and constructive relationships with people, carers and families and to produce evidence of the work. For example, you can use this evidence to share information with other agencies, like the MASH.

This structured approach is designed so that your work maintains clear intentions, professional boundaries and a focus on outcomes. The following diagram highlights the basic steps of the structured approach for providing support at **any level of need**:



A structured approach to good outcomes

Three principles should inform every stage of this structured approach:

- Record the strengths, needs and risks factors of the individual person, their carer and family that you identify through conversation and information sharing
- Have the right conversation, to provide the right care and action, at the right level, at the right time
- Follow the safeguarding procedures for your agency if you have any concerns that a person or their carer may be at risk of significant harm

How each agency follows these principles will vary in practice, however the outcomes should always be the same: notice and record where people and carers are not making expected progress towards good outcomes

- Individuals and families are identified for and receive support from other services when and where it is needed
- MASH is contacted at the right time if there are concerns that a person is suffering or at risk of significant harm, abuse or neglect

There is no one way to record the steps of the structured approach. Different agencies use different methods to record effectively the needs of people and carers. An important step – that is often missed out – is to prepare for work with a person, carer and family, including:

- Making space in your timetable
- Checking records for work that has been done previously by your agency
- Planning how you will gather information including conversations with colleagues
- Consider whether there is information held by other agencies

When you record presenting strengths, needs and risks statements they should be in simple, straightforward language that makes sense to the person, carer and family without minimising the seriousness. Often the experience of discussing strengths and needs in a straightforward manner will bring the situation into perspective and can help people to better assess their own situation. Recording conversations will help people, carers and families to plan and review together, and provide evidence of progress made along the way toward good outcomes.

Always consider the following guidelines for information sharing:

1. The Data Protection Act provides a framework to ensure that personal information is shared appropriately. It is not a barrier.
2. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
3. Be open and honest with the person from the outset about why, what, how and with whom the information will, or could, be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
4. Seek advice if you are in doubt, without disclosing the identity of the person where possible.
5. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest.
6. Consider safety and well-being: Base your information sharing decisions on considerations on the safety and well-being of the person and others who may be affected by their actions.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

If at any time you think at adult is at risk of immediate harm or abuse, you must raise a safeguarding concern immediately **see page 19.**

Work out when to share information by asking themselves the following questions:

1. Is there a clear and legitimate purpose for information sharing?
2. Does the information enable a living person to be identified?
3. Is the information confidential?
4. Do you have appropriate consent?
5. Is there sufficient public interest?
6. Are you sharing appropriately and securely?
7. Have you recorded your decision properly?

Identifying needs and making a referral: what's the difference?

A referral is a formal process used to log a concern or issue and to inform others that some action needs to be taken. For some settings, there is a formal referral route: either make a written request for support or a care package to be provided, or sometimes a person, carer or family self-refers using a written request. The referral route must be known and understood by everyone in your agency or setting, so that concerns and needs can be noticed by anyone.

What if there isn't a formal referral process within my organisation?

Where there is no formal referral process – for example, where initial contact with a person, carer or their family is their attendance at an informal activity – it is good practice to record the contact. No matter what size of organisation, all agencies should have a clear process that staff can use to indicate concerns about a person's needs. It is good practice to have a clear recording process in place for staff to use to log any concerns.

What goes into a referral? The referral can include any valid and relevant information or previous assessments that have been carried out by the person making the referral. A referral that logs concerns or identifies a need should also give the reason for the referral and the outcomes that are expected.

Remember: right conversation, right action and care, at the right time. The quality of service and the improved outcomes are the most important aspects of recording. Although it is important to follow a process and to record your work, these two aspects should not take priority over making sure that people get the right action and care at the right time.

When working with people and with other practitioners to identify needs, it remains vital that you always consider the views and perceptions of people, carers and families about their own circumstances.

Many people who have support needs can have their needs met in the context of their family and the community with minimal support from other agencies. When we identify and record issues and problems early, we can prevent needs from worsening and maintain the wellbeing and independence of people and carers.

Comparing Good Outcomes with emerging needs, and with independent living & wellbeing needs

Good Outcomes

Safe Well Resilient Independent

Our standards for work with people, carers and their families:

I will treat everyone with dignity and respect.

I will ensure your care and support is safe and I will work with you to identify risks and put in place plans and actions to mitigate these so they don't turn into an incident.

I will work to ensure you are protected from abuse and neglect, appropriately supported to make decisions or have someone else who can support you where you don't have capacity and make sure the service you receive is the least restrictive.

I will ensure I am professional, registered where I need to be, well trained so I can offer you the best person-centred care and support.

I will provide honest information that is easy to understand and in an accessible format or language.

I will support you to be as resilient and independent as possible.

I will work in a "person-centred" way and treat you and everyone like an individual recognising your preferences, your nutritional and hydration needs and building on the strengths and assets of you and those around you including carers, family and communities.

I will listen to your views and those close to you and deal with any complaints you have, ensuring I act on them so we will continually evaluate and improve our service to meet the highest standards.

Level 1: Emerging needs

- Isolated incident exposes person to a minor risk of harm without any injury
- Person lacks stimulation or leisure opportunities in day to day life
- Person has an ongoing minor physical health condition
- Person feels emotionally low for short periods and does not feel able to access support
- Person neglects self-care from time to time
- Person refuses to leave the house for significant periods of time

Level 2: Independent living and wellbeing needs

- Person does not maintain good nutrition and healthy weight
- Person is not able to manage toilet needs
- Inadequacy of care leads to some personal discomfort
- Taunting or hateful language undermines the person's dignity
- Poor physical health leads to deteriorating quality of life
- Person is withdrawn and rarely speaks to anyone
- Person's significant substance use prevents them from self-care and social activities
- Person experiences significant loneliness which may relate to abuse experienced as a child
- Care is rigid and inflexible, and the person has no privacy

Comparing Good Outcomes with complex needs, and with crisis or acute needs

Good Outcomes

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I will listen to your views and those close to you and deal with any complaints you have, ensuring I act on them so we will continually evaluate and improve our service to meet the highest standards.

Level 3: Complex needs

- Person has substantial and complex physical health needs that are life limiting and reduce functional ability
- Person has significant mental health difficulties and complex social issues
- Person has chronic substance misuse that impairs functional ability
- Person has a learning disability that affects their functional ability
- Person has autism that affects their functional ability

Level 4: Crisis or acute needs

- Person has ongoing complex health conditions and needs urgent/immediate intervention due to life threatening symptoms or circumstances
- Person's mental health disorder leads to suicidal or other extreme behaviour and needs urgent/immediate intervention
- Person is subjected to abuse or neglect and needs immediate protection
- Person has complex physical and/or mental health issues, is without care and in need of urgent/immediate response
- Person is involved in criminal exploitation of their needs and vulnerability

Developing clear plans in collaboration with people, carers and families

Action plans are most effective when they are written simply and clearly. Here are ten tips on how to make an action plan that works:

1. Collaborate

The process of creating and agreeing a plan together can be a powerful experience for a person, carer and their family, so the plan should be made together.

2. Define small steps

The plan will work best if the change required is clearly defined and should include small steps to take to make change and sustain it.

3. Networks and community

Always consider support and advice that might be available within the family, the local network and from within the community.

4. Not too difficult…

Don't set actions or goals that are very difficult and have a poor chance of success. This will likely demoralise the people, carers, and families you work with and can move them further away from putting a plan in place. Agree actions that you know can be achieved and that bring people steps closer to addressing issues and improving outcomes.

5. …but not too easy either!

A plan where the steps are too easy to achieve will not result in significant change. Don't be tempted to write down steps and actions that you know people already do on a day-to-day basis. Make sure there is some challenge in the agreed plan.

6. Agreements are always two-way

Including action that you will take as well as action that the person, carer and family will take is a way to gain and maintain trust. For example, you might go to an appointment about housing with the person and their carer, or you might agree to contact an agency on behalf of them if there is conflict or they need support. However, avoid the temptation to try and solve the person's problems for them. The person must be a part of the solution, recognise their abilities, and build their skills and confidence to sustain the change.

7. When and who?

Give each step a time or day and record who will carry out that step. The plan might have actions for more than one person because it is collaborative.

For example, there may be different steps for an person, their carer, for family members, people in their network, agreed actions for you, and for other partners. Always remember to include the date and the person responsible.

8. Guide and demonstrate

There may be some tasks that need to be done that people, carers or family members don't know how to perform, have never done before or that they find difficult to do. This might be the use of equipment to maintain independence and wellbeing, advice on managing money, or helping a person with new nutrition requirements. Be prepared to guide a person and their carer through the actions on the plan, and to demonstrate, explain or even teach certain tasks and include this in the plan you make together.

9. Add reward…

Include the benefits or positive consequences of carrying out the tasks in the action plan. People, carers and their families will feel motivated by many different things. It's a good idea while you're getting to know the person, carer and family members to learn their motivators. If you know what rewards people respond to, you are more likely to agree a plan that will result in successful changes.

10. Sign up

Plans help to gain agreement on actions and it's a good idea for you, the person, the carer and family members who have actions to sign up to the plan to symbolise your commitment to outcomes.

Team Around the Person approach

What is a Team Around the Person?

This approach brings together the different people who provide support and care for a person so that they experience a more seamless service.

Team Around the Person approach can create opportunities for a group of people to work together effectively to understand and manage risk for a person, carer and their family, and to provide support that promotes and maintains good outcomes in a community context.

What is a key person?

The term key person refers to someone who will coordinate the plan of support and care for a person. This key person supports collective responsibility and will work with others to co-create a plan of care and support.

The **key person** does not have to be a professional. For example, it could be a family member, carer, or a neighbour.

Where the key person is a professional, they could be from any agency or discipline. For example, they could be a housing officer, a GP, a community nurse, or a support worker from a community organisation.

What if the needs of the person, carer or their family change? What if there is a new risk or safeguarding concern?

The roles and responsibilities around safeguarding people, carers and their families do not change in the context of the team around the person.

If at any time you think at adult is at risk of immediate harm or abuse, you must raise a safeguarding concern immediately as set out on page 19.

What does the Team Around the Person do?

The team collaborates to:

- Get away from a checklist approach to understanding needs, and moves toward listening to people to understand their strengths and to finding solutions while also recognising the practical limits of support and care
- Identify needs, risks and the desired outcomes of the person
- Agree the clear roles, responsibilities, actions and timescales, including mitigation plans
- Share responsibility for the de-escalation of risks and the promotion of wellbeing the person, carer and family, working with different levels of need at the same time
- Include discussion of the response to any mental health issues and negative social consequences e.g. chaotic lifestyle or challenging behaviour and how to prevent escalation to homelessness or other negative outcomes
- Prevent – where possible – case closure when person refuses consent/access
- Use a persistent and proactive approach and positive risk taking
- Avoid the tendency to back away when there is a risk of negative outcomes e.g. self-neglect
- Avoid ‘revolving door’ where the person keeps being referred to the same agency
- Avoid agency ‘ping pong’ where the person is referred to different agencies

Safe Well Resilient Independent

PART FOUR
THE OFFER AT EACH LEVEL OF NEED

A clear offer to people, carers and families in response to levels of need

LEVEL 1: SELF-HELP & PREVENTION OFFER

Digital wellbeing platform and wellbeing planner

Waltham Forest Directory

Integrated contact centre for customer enquiries: information, advice and guidance and requests e.g. Blue Badge

Self-assessment

Equipment and living aids marketplace

Universal Services: Housing, Education, Libraries, Leisure Services, Benefits, Police

Voluntary, Faith and Community Sector

Adult Hubs – drop-in centres

Children & Family Centres

LEVEL 2: INDEPENDENT LIVING & WELLBEING OFFER

Services at LEVEL 1 and:

Wellbeing Local Area Coordination, Social Prescribing, Living Well Waltham Forest

Rough sleeping coordinator & homelessness outreach team

Drugs and alcohol services

Equipment, adaptations, telecare & assistive technology

Integrated Care Management & Rapid Response

Prevention & Wellbeing Team: carer breakdown; immediate crisis; chaotic lifestyles,

Mental Health below CPA threshold, recovery & progression

Community Health Services – Care Coordination, Rehabilitation

Hospital social work and discharge planning

LEVEL 3: COMPLEX NEEDS & LONG-TERM SUPPORT

Services at LEVEL 1, 2 and:

Adults Care Management Team

Adults & Older Peoples' Mental Health Services

Learning Disability Service

Good Outcomes:
Safe Well Resilient Independent

LEVEL 4: SAFEGUARDING ADULTS & HIGH-RISK CRISIS RESPONSE

Services at LEVEL 1,2, 3 and:

MASH

Safeguarding

Waltham Forest MASH: multi-agency safeguarding hub

Waltham Forest has developed a single front door for safeguarding concerns regarding people, carers and their families, based within the MASH.

- All safeguarding concerns must go to the MASH.
- Requests should have the consent of the person wherever possible. Follow up of Concerns and Enquiries must include the person or involve a an advocate as required.

The MASH acts as a single front door for all children and adult safeguarding concerns in Waltham Forest and protects children, adults, carers and families from harm, neglect and abuse. It is made up of practitioners across the public sector to deliver a true multi-agency approach when dealing with safeguarding.

Representatives from…	Help to deal with referrals…
Health	Related to health by liaising with other health practitioners from the community and hospitals
NELFT	Related to people who have social care needs primarily arising from their mental health issues
Met Police	Related to criminal activity
National Probation Service and Community Rehabilitation Company	Related to reoffending and high-risk offenders released into the community
Waltham Forest Council Adult Social Care	Concerning vulnerable people, carers and their families
Waltham Forest Council Children's Social Care	Concerning safeguarding of children, young people and their families
Waltham Forest Council Housing	Related to safeguarding issues in Council residential properties across the borough
IDVA (Victim Support)	Related to domestic abuse
Gangs Bronze multi-agency panel	Where interventions are required for those involved with, or at risk from, or victims of gang activity

Level 1: self-help & prevention: community support & universal services

An offer of self-help and prevention is available within community support and universal services. This offer meets the emerging needs of most people, carers and their families so that they can achieve good outcomes.

These services are:

- Available to all people, carers and families
- Fundamental to improving outcomes for people, carers and families
- A foundation of support for families and available at every level of need
- Vital in identifying emerging needs and risks at the earliest opportunity
- Best placed to build relationships between people, carers, families and practitioners on a regular basis
- An integral part of the delivery of Think Family, Independent Living and Wellbeing, and Specialist Services, wherever this does not put a person at risk of abuse or neglect

We support all people, carers and their families to help themselves and each other. Community support and universal services help people to access information and advice via digital platforms and tools that all people, carers and families can use to get the help that they need.

These services include information, advice and guidance from:

- Citizen's Advice Waltham Forest
- Housing Services and advice – matching suitable accommodation to need
- NHS services in Waltham Forest including Primary Care
- Carers First in Waltham Forest
- Public Health campaigns e.g. smoking cessation services
- Drug and Alcohol support services https://www.changegrowlive.org/content/cgl-waltham-forest
- Waltham Forest libraries
- Waltham Forest leisure facilities
- Community Alarms

There are also a range of community-led initiatives and services provided by charities, voluntary groups, faith groups and community groups that help and support people with care and support needs e.g.

- Alzheimer's Society
- Carers UK
- Age UK

More information – including many more voluntary, community and faith sector organisations can be found at Waltham Forest Directory: https://directory.walthamforest.gov.uk/

My wellbeing plan

My Wellbeing Plan is an easy to use online tool which allows people to create a plan of action to boost their wellbeing and make positive changes in their lives. Plans can be as long or short as people prefer and contain any goal from being healthier to getting out and about and meeting people. The tool also provides information and advice to support people in meeting goals.
walthamforest.gov.uk/wellbeing

Equipment and living aids marketplace

Waltham Forest Equipment and Living Aids online marketplace is where people can browse and purchase a range of products that can assist them in all areas of the home. The products listed have been taken from external provider's websites. When making a purchase, links redirect to the provider websites for direct purchase. Users can create a shortlist to bookmark and compare products.
walthamforest.gov.uk/equipment

Self-assessment tool

By answering some quick questions about the current situation, the tool can direct people, carers and their families towards information, advice and services that could help them to live independently and improve their wellbeing. The tool can be used to find out if a person is likely to be eligible for care and support and whether they would have to pay for some or all of the care and support that they need.
walthamforest.gov.uk/selfassessment

Contact Resolution Centre and Financial Assessment Unit
Help people, carers and families to:

- Access information, advice and guidance on how to access services, support to resolve issues, and financial assessments
- Make transactions (e.g. order a Blue Badge) and receive information, advice and guidance on how to access services
- Make a referral through the contact resolution centre.

Wellbeing, Prevention & Independence helps people, carers and families to:

- Access the right level of support by screening referrals and requests for care and support
- Get the right response and right care at the right time
- Access teams, workers and agencies who provide care and support
- Update their information about wellbeing and safety at a welfare visits.

Email:
wfdirect@walthamforest.gov.uk
or
Telephone:
020 8496 3000

Website:
walthamforest.gov.uk/service-categories/adult-social-care

NELFT Mental Health and Community Services at Level 1

The Single Point of Access (SPA) team helps people, carers and families access information, advice, screening, and referrals for mental health services. The single telephone number is for anyone enquiring about mental health services in Waltham Forest, urgent mental health assessment where needed and management of referrals to other specialist mental health services. The number is: 0300 300 1570

The access and assessment service is for people aged 18 and over who need community mental health services in Waltham Forest. We provide an initial mental health assessment. Following assessment, we help people, carers and families at this level by:

- Referring or signposting to other mental health services or organisations
- Signposting to other services (e.g. social services)
- Providing brief intervention by the team for up to six months.

If needed, we can offer:

- Full assessment of mental health and social care needs
- Access to a psychiatrist talking therapies and other psychological help
- Advice and information
- Crisis intervention
- Psychiatric medication review
- If appropriate, self-guided support
- Support with social problems
- Recovery and wellbeing approaches.

Our team is made up of psychiatrists, community mental health nurses, mental health social workers, support time and recovery workers and occupational therapists.

Wood House/Forest House, Thorpe Coombe Hospital, 714 Forest Road, Walthamstow, E17 3HP.
Opening times:
9am – 5pm, Monday to Friday

Tel:
0300 300 1570 – Opt. 4

Email:
WFAA.Team@nhs.net

Referrals will be accepted from GPs or other health professionals. Self referrals or from family, carers or friends and via walk-in centres.

Whipps Cross Hospital pathway

- Red Cross Support,
- Supported Home Discharge Team for non-complex discharges

Level 2: independent living & wellbeing offer

Managed Network of Care and Support

Waltham Forest Council, local Health services, community organisations and other service providers are collaborating on Better Care Together to connect community and partner services to deliver a managed network of care and support. We work with a wide range of organisations to develop a 'connected care' community that can support people to access self-care and support, and to find solutions themselves that help them to meet their needs and achieve the outcomes that are important to them.

This includes initiatives such as:

Wellbeing at Home

Wellbeing at Home supports residents to maintain and improve their wellbeing, independence and quality of life. The service will support people for up to 12 weeks to achieve the goals that people set for themselves. This might be help to find clubs and activities, find services that can offer support or supplying a volunteer to get people out and about again.

Local Area Coordination

This service is for older people, carers, or people with a disability or mental health needs. Coordinators can help people to stay safe, well, resilient and independent. They work with individuals and communities to create resilience and strength. Coordinators take the time to get to know people, carers and families, so they can learn about their needs and interests. Coordinators help to identify and develop strengths, skills, talents and abilities and find the solutions that are right for people, carers and their families. They help people to:

- Access information, advice and support
- Build their own local network
- Find practical ways to resolve problems
- Be part of the community
- Identify strengths, goals and needs

Social Prescribing helps people, carers and their families to:

- Get advice about entitlement to benefits or what to do about debt
- Become more active or increase healthy eating
- Join in with local groups like art classes or gardening groups and connect to local befriending or volunteering schemes
- Gain training to help build confidence or move into work
- Receive assistance with a cold home or other housing issues

This service also provides a link between residents and further support in order to improve their health and prevent the deterioration of illness.

Adult Social Care response at Level 2

Screening & Triage helps people, carers and families to:

- Access a review of their needs and risks that have not been addressed
- Receive the right response at the right level
- Access support from teams or workers.

Urgent Response helps people, carers and families to:

- Have their strengths, needs and risks urgently assessed
- Receive unplanned review visits to review outcomes, needs and risks
- Receive updated care and support plans
- Purchase or amend existing services
- Have immediate risks addressed and managed, including support to prevent carer breakdown
- Receive support or care from other teams/ workers if needed.

Trusted Assessor identifies the needs of people, carers and families for small aids to daily living and for minor adaptations.

Wellbeing planning helps people, carers and families with emerging needs through a combination of products and services that will promote wellbeing and independence.

Recovery & Progression helps people, carers and families to recover and progress towards greater independence following an episode of ill-health or a significant life event. The team provides intensive early interventions and can also arrange access to long-term support and specialist social work services, where these are needed to improve outcomes.

Occupational Therapy Team supports people through occupational therapy assessments and manual handling risk assessments, which help to identify the need for equipment or other support. The team help people, carers and families with care and support plans, and to access training and advice.

Hospital Social Work and Discharge Planning supports people, carers and families through conversations that identify the needs of people to support them during and after discharge from hospital including Accident and Emergency. The team helps with requests to purchase, amend or start services, such as reablement, rehabilitation, step down from acute beds to community beds and long-term care and support.

Community Mental Health response at Level 2

NELFT Waltham Forest Falls Prevention Services is part of the Waltham Forest adult community health service and helps people to access treatment when they have falls, have fear of falling or poor balance/mobility or when they are considered to be at risk of falls. The service helps people to reduce the risk of falls, slips and trips within the community. Follow the link for more information about this service. https://www.nelft.nhs.uk/services-waltham-forest-falls-prevention

NELFT Waltham Forest Talking Therapies help people with a range of mental health problems such as depression, anxiety, and stress.

Tel:
0300 300 1554

Email:
wf.talkingtherapies@nhs.net

NELFT Waltham Forest Rehabilitation Service provides a range of Occupational Therapy and Physiotherapy services that help people:

- Who have undergone a recent change in clinical condition, mobility or functionality.
- Whose medical needs could not be met by their own GP or other Health professional in the community.
- Whose clinical conditions are safe and have suitable environment for care at home.

This service can be described as a 'bridge' between hospital and home. It is a service that aims to help people regain the best possible level of independence following a recent deterioration in function. It can be seen as aiding recovery following hospitalisation or to avoid hospital admissions.

NELFT Waltham Forest Rehabilitation Service – Inpatient Services unit includes 32 rehabilitation beds for people:

- Who live in Waltham Forest aged 18 and over
- Those are medically fit for transfer
- Who have agreed transfer to a rehabilitation bed
- Who would benefit from a short period of rehabilitation and need 24-hour support by nursing/care staff.

The aim is to provide short term inpatient rehabilitation services for those who are medically well enough to leave hospital and receive care in a nurse and therapy led unit. The team will meet people's needs in a timely and appropriate way, within a community bed setting. On discharge from the Unit, people will be expected to return to their usual place of residence.

NELFT Memory clinic is a team doctors, nurses, psychologists, occupational therapists and other healthcare practitioners who help people with memory difficulties. People can access assessment, diagnosis and treatment for memory difficulties. The service provides support for people with memory problems, their carers and their families and have links with many other services working within the local community. People are referred by GPs, other doctors and healthcare practitioners.

Housing and Homelessness Services

Information about sheltered housing can be found at the Waltham Forest Directory: https://directory.walthamforest.gov.uk/

The Waltham Forest Directory has details of organisations offering emergency accommodation in the borough. The following charities and agencies help people who are homeless, or at risk of becoming homeless:

- St Mungo's Waltham Forest Single Homeless Housing and Support Hub – provides support for people who are homeless, insecurely housed, or have received an eviction notice. You can email, phone, or visit in person at the Forest YMCA. See their contact details and download their leaflet
- Shelter – provides advice, support and legal services
- Homeless UK – gives support and advice on accommodation and finding support services
- No Second Night Out – focuses on helping people who are rough-sleeping for the first time
- Fountain Day Centre – has a drop-in service offering breakfast, lunch, plus bathing and toilet facilities for homeless people: Fountain Day Centre, 3 Staffa Road, Leyton, London E10 7PY.

Other services at Level 2

Drugs & Alcohol support from the Change, Grow Live Service helps people, carers and family members who use any kind of drug and/or alcohol and who want to recover or change. The service works at all levels, from prevention and early engagement, through to recovery.

Information about support for victims of domestic abuse can be found at Waltham Forest Directory: https://directory.walthamforest.gov.uk/

These services include:

- Waltham Forest Solace Women's Aid – 07340 683382
- Ashiana Network (South Asian, Turkish and Iranian women) – 020 8539 0427
- Haven the Survivors of Abuse Network (historic and current sexual abuse) – 020 8520 0755
- Kiran Project (women and children from BAMER communities) – 020 8558 1986
- Stay Safe East (Disabled people service) – 020 8519 7241 text phone 07587 134 122
- IMECE (Turkish, Kurdish and Turkish Cypriot women) – 020 7354 1359
- Rise Mutual – 07535 651784

Level 3: complex needs & long-term support

The offer at this level aims to support people with long-term care and support needs to achieve good outcomes, maximising independence, safety, resilience, and wellbeing. This is the threshold for formal assessment and care management under the Care Act, Mental Health Act, Mental Capacity Act or other related legislation e.g. Human Rights assessment.

Residents may be 18 to over 100 years old and may have a wide range of disabilities or impairments including physical disabilities, sensory impairment, learning disabilities and/or mental health concerns.

People with serious and/or enduring mental health problems are supported through **dynamic care management**, which means that when needs arise they are responded to promptly. This involves re-assessment of any new strengths, needs or risks rather than waiting for a scheduled review.

The offer at this level includes:

- Social work and care management interventions
- Long-term packages of care at home
- Care and support in residential or nursing care placements
- Medical interventions from primary, secondary or tertiary health services.

Specialist services work closely with other statutory services and partners to help people achieve the outcomes important to them and may nominate a lead practitioner for a coordinated approach to the provision of support.

Community Learning Disabilities Team (CLDT)

The team helps for people with a learning disability and carers with social care needs to access support that promotes independence and wellbeing.

This team helps people, carers and families with:

- Information, advice and services
- Short-term targeted support that promotes improved wellbeing and prevents needs and risks from getting worse
- Assessments to determine needs and capacity
- Care and support planning, resource allocation and attending care and support panels
- Protection from abuse and neglect.

Community Health and Mental Health Teams

Adult Social Care and North East London NHS Foundation Trust (NELFT) work together to improve outcomes for people with health and mental health needs. The offer to people, carers and their families at this level may include:

- Complex psychological therapy
- Medication management
- Specialist mental health teams e.g. perinatal, eating disorder service, personality disorder, older people
- Community nursing and therapy via the single point of access including: wound management, general nursing care
- End of Life care
- Specialist nursing e.g. respiratory, diabetes, Tissue Viability, continence, sickle cell, MS and Parkinson's
- Podiatry
- Nutrition and dietetics

NELFT Rapid Response provides assessment, treatment and support to people who are experiencing a crisis and who might otherwise be admitted to hospital. The team provides an urgent assessment service for worsening health problems, minor injuries and minor illnesses and works closely with GPs, social and community services including care homes, to ensure people are supported in a home environment wherever possible. The team offers a range of enhanced diagnostic and treatment

options to support other health and care providers in managing people's needs at home during a crisis. These include full assessment within two hours of referral, support visits, IV antibiotics, ECG, unscheduled and urgent venepuncture, sub-cut fluids for hydration support.

Community Recovery Team

This team provides specialist mental health services for people aged 18 to 65 with serious and/or enduring mental health problems. This includes multi-disciplinary assessments to identify the needs of people, carers and their family. The team coordinates a range of community interventions and services through a care plan. The team works with people, carers and other agencies to promote recovery and will support access to:

- Interventions that address severe mental health problems based on recovery and social inclusion
- Medication management
- Depot injection clinic
- Physical health screenings and focus on maintaining physical health (e.g. smoking cessation and substance misuse)
- Psycho-educational interventions
- Psychological therapies discharge group (focusing on relapse prevention) focus on employment and education
- Assertive outreach with people who have a documented history of non-engagement with services, non-compliance with medication and also have a significant risk of damaging behaviour to themselves or the public
- In-reach support for people in hospital.

Further information and referrals: the link below goes to the main site; referrals can be made via clinicians tab: https://www.nelft.nhs.uk/services-waltham-forest-community-recovery

Older Adults Mental Health Team

This team provides community mental health services to people aged 65 and over with serious and/or enduring mental health problems such as depression, anxiety, schizophrenia. The older adult mental health team also provides community mental health services to people aged 18 and over with complex cognitive disorders.

The service includes:

- Single point of access for all referrals
- Assessment and diagnosis
- Psychological intervention
- Medication management
- Risk management, including safeguarding support, advice and health information for people and their carers
- Support and education for primary care teams, social and community services, outpatient clinics and other statutory, voluntary and private organisations providing care to older people with mental health needs.

Group and individual therapies include:

- Medication management
- Talking therapies
- Cognitive behavioural therapy (CBT)
- Cognitive stimulation therapy
- Rehabilitation programmes
- Support to engage in community social, leisure and recreational pursuits
- Occupational Therapy
- Provision of environmental adaptations and assistive technologies.

Further information and referrals: https://www.nelft.nhs.uk/services-waltham-forest-older-adult-mental-health

Adults Care Management Team

This team helps working age people who have a physical impairment or older people who have long-term care and support needs. This team helps to improve outcomes for people, carers and families through access to:

- Dynamic care management long-term care and support in both community and placement settings
- A full range of assessments such as: Mental Capacity Assessment, Best Interest Assessments
- Information, advice and signposting to support resolution of additional issues affecting the care and support of individuals
- Practical support to connect them to local community activities, services and initiatives to improve outcomes, maintain a family life and access educational, vocational and employment opportunities
- Manage complex cases, including dealing with fluctuating and episodic behaviours and complex family and caring circumstances
- Review progress against care and support plans on a regular basis with service users and relevant others
- Working together with hospital discharge planning to people with existing packages of care and support
- Care package variations including step-up and step-down arrangements
- Protection from abuse and neglect.

Social workers in this team lead on safeguarding concerns and provide support to people, carers and families and/or colleagues with:

- Determining the capacity and best interest of the person
- Advice on the protection of property
- Understanding eligibility decisions
- Planning and review of care and support.

Eligibility threshold for adult social care at Level 3

A person's needs are eligible where they meet these three conditions:

1. Needs

Adult's needs are related to a physical or mental impairment or illness.

2. Outcomes

The adult is unable to achieve two or more of:

a) Managing and maintaining nutrition;
b) Maintaining personal hygiene;
c) Managing toilet needs;
d) Being appropriately clothed;
e) Maintaining a habitable home environment;
f) Being able to make use of the home safely;
g) Developing and maintaining family or other personal relationships;
h) Accessing and engaging in work, training, education or volunteering;
i) Making use of necessary facilities or services in the local community including public transport and recreational facilities or services;
j) Carrying out any caring responsibilities the adult has for a child.

3. Wellbeing

There is or is likely to be a significant impact on the adult's wellbeing, including:

a) Personal dignity including treatment of the individual with respect;
b) Physical and mental health and emotional wellbeing;
c) Protection from abuse and neglect;
d) Control by the individual over day-to-day life including over care and support provided and the way it is provided;
e) Participation in work, education, training or recreation;
f) Social and economic wellbeing;
g) Domestic, family and personal relationships;
h) Suitability of living accommodation;
i) The individual's contribution to society.

The Social Care Institute for Excellence has clear guidance around the thresholds and criteria for both individuals and carers:

https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/

Charging and financial assessment:

The Care Act provides a single legal framework for charging for care and support under sections 14 and 17. It enables a local authority to decide whether or not to charge a person when it is arranging to meet a person's care and support needs or a carer's support needs.

Where a local authority arranges care and support to meet a person's needs, it may charge the person, except where the local authority is required to arrange care and support free of charge. The framework is intended to make charging fairer and more clearly understood by everyone.

The overarching principle is that people should only be required to pay what they can afford. People will be entitled to financial support based on a means-test and some will be entitled to free care.

Moving between local areas:

It is critical that local authorities understand which people they are responsible for and that people know who to contact when they need care and support.

Most of a local authority's care and support responsibilities relate to the entire local population for example in relation to information and advice or preventive services.

However, when it comes to determining which people have needs which a local authority is required to meet, the local authority is only required to meet needs in respect of a person who is 'ordinarily resident' in their area, or is present there but has no settled residence.

Ordinary residence is crucial in deciding which local authority is required to meet the care and support needs of people and their carers. Whether the person is 'ordinarily resident' in the area of the local authority is a key test in determining where responsibilities lie between local authorities for the funding and provision of care and support.

Level 4: safeguarding adults & high-risk crisis response

For information on what to do if there are concerns about an adult, please read page 19 to 21.

Everyone who works with people, carers and families must safeguard them from abuse and neglect. Safeguarding concerns can be identified at any level of need from emerging needs to complex needs.

High Risk Situations

Where people are at immediate risk, then Adult Social Care will provide a response – urgent if necessary – and follow up with a plan to mitigate and manage the risk, using the pan-London safeguarding adults procedures.

Safeguarding duties apply to any adult who:

- Is 18 years or over
- Has needs for care and support
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

People in custodial settings i.e. prisons and approved premises are not in scope for these procedures: Prison Governors and National Offender Management Services have responsibility for these arrangements.

Adults Safeguarding team helps people over the age of 18 to protect them from abuse. This includes:

- Daily Risk Management Forum
- Safeguarding Concerns
- Best Interest Assessments
- Deprivation of Liberty Safeguards (DoLS) requests & authorisations.

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards (DoLS) exist to provide suitable protection to all people who have a mental disorder or disability of the mind, including dementia or a profound learning disability, and lack capacity to consent to their care and treatment.

DOLS is concerned with ensuring that the restrictions applied to a person who lacks such capacity, in order to keep them safe, are:

1. In their best interests
2. The least restrictive option available

Adult Mental Health Response at this Level includes all the NELFT community health and mental health and services at Level 3, and:

- Rapid Response: short term, intensive urgent nursing care in the community to prevent a hospital admission
- Urgent Mental Health assessment and intervention
- Mental Health Crisis support and risk management
- NELFT Home Treatment Team provide hospital at home for people in acute mental health crisis
- Psychiatric Liaison Service: Emergency Mental health assessment
- High Intensity User Programme: Intervention with frequent attenders to hospital to support safe management in the community
- Urgent Centre at Whipps Cross Hospital: access to emergency medical assessment
- Mental health inpatient beds provide inpatient care for people with mental health problems
- Neuro navigation service ensures people with complex needs after stroke are managed in the most appropriate setting
- Ainslie rehabilitation unit: Short term inpatient multi-disciplinary rehabilitation
- Continuing Health Care (CHC) assessments
- Dual treatment pathway for mental health and substance use.

What is a Safeguarding Adult Concern and what is a Quality in Care Concern? What action will be taken?

Incidences of abuse may be one off or multiple and may affect one person or multiple people. Repeated incidents of poor care may be an indication of more serious problems and in order to see these patterns it is important that information is recorded appropriately and shared with relevant teams/organisations. The Waltham Forest Safeguarding Adult Operational Procedures outlines our local recording process.

Adult Social Care teams work closely with Clinical Commissioning Group, LBWF Contract Management and the Care Quality Commission to ensure quality in care and Safeguarding Adults data is shared, to prevent quality in care issues escalating to Safeguarding Adult concerns, and to ensure when Safeguarding Adult concerns or provider concerns do occur, there is a coordinated, effective and proportionate response.

The nature, context and frequency of each concern will impact on the level of risk and the overall decision made on the action required.

Pan-London guidance outlines the following causes of concern:

- A one-off medication error that could have serious consequences
- A series of medication errors
- An incident of under-staffing, resulting in a person's incontinence pad not being unchanged all day
- Poor quality, unappetising food
- Missed visits by Care Workers from a Home Care Agency
- An increase in the number of visits to A&E, especially if the same injuries happen more than once
- Changes in the behaviour and demeanor of people with care and support needs
- Nutritionally inadequate food
- Signs of neglect such as clothes being dirty
- Repeated missed visits by a Home Care Agency
- An increase in the number of complaints received about the service
- An increase in the use of agency or bank staff
- A pattern of missed GP or dental appointments
- An unusually high or unusually low number of safeguarding alerts.

Health and Safety concerns related to the environment/ setting

Inadequate flooring i.e. uneven carpets, poor standards of food hygiene, not storing hazardous fluids etc. in a safe place.

This is addressed through commissioners and if there are repeated or numerous concerns, the provider concern process is followed.

Concerns related to abuse or neglect where there is one victim

This can be any of the types of abuse or neglect listed in section 3.

If this concern relates to a commissioned service, the nature of the concern and the agreed outcome are shared with the commissioner so a collaborative approach to manage the risk and improve the quality of care is adopted. When a category/grade 3 and 4 or multiple category/grade 2 damage pressure ulcer is observed – this results in a Safeguarding Adult concern being raised.

These concerns will progress to a Safeguarding Adults Enquiry and progressed under our Safeguarding Adult Procedures. Please note that under the principles of Making Safeguarding Personal, the views of the person are central to establishing if further action will be taken, taking into account the principles of the Mental Capacity Act 2005 and public interest.

Concerns related to abuse or neglect where there are multiple victims within or out with an organisation

Institutional abuse is defined as repeated incidents of poor care of individuals, or groups of individuals. It can be through neglect or poor professional practice as a result of structures, policies, processes and practices within the organisation. It can occur in a care home, a hospital or in a person's home.

If this concern relates to commissioned service, the nature of concern and the agreed outcome are shared with the commissioner so a collaborative approach to manage the risk and improve the quality of care is adopted. It can be through neglect or poor professional practice as a result of structures, policies, processes and practices within the organisation. There should be careful analysis to understand what intentional and unintentional harm is. However, where there is unintentional harm due to lack of guidance for staff this may constitute organisational abuse. In these instances, the provider concern process is followed.

For concerns where the person alleged to be responsible for the abuse or neglect is not a volunteer or employee of an organisation and there are multiple people at risk, a large-scale Safeguarding Enquiry will be undertaken.

Adult Social Care is the lead agency

- If there is concern that an adult is at risk of being abused or neglected or self-neglecting, a referral must be made to Adult Social Care immediately – Adult Social Care is the lead agency and all concerns must be reported to Adult Social Care.
- If the concern is raised in or relates to a Hospital Trust or partner agency, this agencies' Safeguarding Adults Team will be informed and may be part of the Safeguarding Adult Enquiry. In these cases, all Safeguarding Adult concerns must be reported to Adult Social Care.
- Where a concern (not considered by a Safeguarding Adult Concern) is not referred to Adult Social Care, the individual agency MUST make a record of the concern and action taken. Concerns should be recorded in such a way that repeated, low level harm incidents are easily identified and subsequently referred. Not referring under Safeguarding Adult procedures does not negate the need to report internally and to regulators/commissioners as appropriate. If a concern does not require a Safeguarding Adult response, the identifying agency MUST demonstrate what action has been taken and involve other relevant agencies to support the individual(s) affected or at risk.

Once a safeguarding adult concern is raised, who might lead on the action to improve outcomes?

Type of Enquiry	Who might lead
Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or wilful neglect	Police
Domestic violence (serious risk of harm)	Police coordinate the Multi-Agency Risk Assessment Conference (MARAC) process
Anti-social behaviour (e.g. harassment, nuisance by neighbours)	Community safety services/local Policing (e.g. Safer Neighbourhood Teams)
Breach of tenancy agreement (e.g. harassment, nuisance by neighbours)	Landlord/registered social landlord/housing trust/community safety services
Bogus callers or rogue traders	Trading Standards/Police
Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Manager/proprietor of service/complaints department OR Ombudsman (if unresolved through complaints procedure)
Breach of contract to provide care and support	Service commissioner (e.g. Local Authority, NHS CCG)
Fitness of registered service provider	Care Quality Commission (CQC)
Serious Incident in NHS settings	Root cause analysis investigation by relevant NHS Provider
Unresolved serious complaint in health care setting	CQC, Health Service Ombudsman
Breach of rights of person detained under the MCA 2007 Deprivation of Liberty Safeguards (DoLs)	CQC, Local Authority, OPG/Court of Protection
Breach of terms of employment/disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body
Breach of health and safety legislation and regulations	HSE/CQC/Local Authority
Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy	Office of Public Guardian (OPG)
Inappropriate person making decisions about the care and wellbeing of an adult who does not have mental capacity to make decisions about their safety and which are not in their best interests	OPG/Court of Protection
Misuse of Appointeeship or agency	Department of Work and Pensions (DWP)
Safeguarding Adults Review (Care Act Section 44liv)	Local Safeguarding Adults Boards

What happens after contact with us? What may be the outcome of a referral?

- We will update the referrer on the outcome. This includes all Police Merlins
- If referrer does not receive an update on the outcome of their referral, they should contact Adult Social Care to establish this
- If referrer does not agree with the outcome, the referrer should share their view in writing with Adult Social Care, clearly explaining their concerns, the associated risks and personal outcomes of the adult (if established)
- If an agreed decision cannot be reached, the referrer should escalate the concern to the staff member's Team Manager and use the escalation process follow link to walthamforest.gov.uk/strategicpartnerships
- If there is a Police investigation, the Local Authority will work collaboratively with the Police. Other investigation processes may run concurrently with the Safeguarding Adults procedures i.e. Health Investigations – Serious Incidents, Root Cause Analysis or HR processes
- The Local Authority is always the lead agency for Safeguarding Adults.

What happens after submission of a Safeguarding Adults Concern?

- A referral will be reviewed by a member of staff within 24 hours – urgent matters will be reviewed immediately
- Any urgent action will be taken by the allocated worker
- The referrer may be contacted to discuss the referral and to gather/clarify information
- The referrer will be informed of the outcome and if further action is being taken, the referrer will be advised which member of LBWF staff is progressing this work and how to contact them.
- A manager and the staff member will work together to decide if the referral requires further action under our Safeguarding Adult Procedures. If the referral progresses to a Safeguarding Adults Enquiry (often referred to as a Section 42 Enquiry as it is Section 42 of The Care Act 2014), the Enquiry will progress in accordance with the London Multi Agency Safeguarding Adults Policies and Procedures and LBWF Local operational procedures and the referrer may be asked to undertake tasks to help those involved understand the risks and actions needed to safeguard the adult.
- Once the enquiry is complete, the referrer will be informed of the outcome
- Referrers have a responsibility to follow up a referral where they have not been informed of the outcome.

Not every referral will progress to a Safeguarding Adult Enquiry. The response must be proportionate to the level of risk and be in accordance with the principles of MSP. Examples of other outcomes are as follows:

- Information and advice given
- Referral to another agency e.g. Citizen's Advice, Police, Ind. Domestic Violence Advocate, MARAC, The Channel Panel
- Care and support assessment is completed with the adult
- Carer assessment completed with the carer
- No further action is taken as the adult does not want any action taken (undue pressure, the principles of mental capacity and public interest are considered)
- Concerns are passed to commissioners to progress as quality in care concerns.

LBWF is committed to Making Safeguarding Personal (MSP):

- We engage with the adult straight away (when it is safe to do so), establish their views and work towards achieving what is important to them, taking undue pressure, the principles of mental capacity and public interest into account at all times
- We ensure the adult understands what is happening at all times, leads on any decisions being made and knows who to contact if they have any queries
- We provide advocacy support to the adult if this is required
- Once the Safeguarding Plan is in place, the worker will ask the adult their view about what has happened and if they feel anything could have been done differently –this information is used to improve policies and procedures.

PART FIVE
OWNERSHIP AND GOVERNANCE

Waltham Forest Safeguarding Adults Board

Safeguarding is everyone's business, and it's important that organisations work together to protect people who need help and support. The Care Act 2014 requires local authorities to set up a Safeguarding Adults Board (SAB) in their area, giving these boards a clear basis in law for the first time.

The Act says that the SAB must:

- include the local authority, the NHS and the police, who should meet regularly to discuss and act upon local safeguarding issues
- develop shared plans for safeguarding, working with local people to decide how best to protect people in vulnerable situations
- report to the public annually on its progress, so that different organisations can make sure they're working together in the best way

Better Care Together Board

The joint vision of NHS Waltham Forest Clinical Commissioning Group and London Borough of Waltham Forest is to create a simplified and easy-to-access system of care and support for Waltham Forest residents, where care is personalised and individuals are supported to be as independent as possible. Integrating health and social care and working together is paramount to this.

To make this happen, local health and social care systems are being brought together to work in a seamless way, so that people receive coordinated support close to home, only going into hospital when they really need to, and staying no longer than necessary.

Both organisations have pooled 'health money' and 'social care money' into a single fund, called the Better Care Fund (BCF). This enables the organisations to get best value for the money collectively spent. The Council and the CCG jointly lead the health and social care integration agenda and this includes a pooled budget of £25m for 2017/18.

The Better Care Together Programme coordinates and supports a wide range of integration projects across the borough. It works closely with other change management programmes to share resources and plan strategically for the future.

Health and Wellbeing Board

Waltham Forest Health and Wellbeing Board was set up in 2013 and is a partnership between leaders from the health and care system, democratically elected members and patient representatives. The HWBB works with the Waltham Forest Clinical Commissioning Group and Public Health team to help provide the right health services for you, working with to provide the right health services in the borough. The Board meets quarterly in public.

Duties of the Health and Wellbeing Board include:

- Creation of a strategy – the Health and Wellbeing Strategy 2016-20 to reflect needs and influence what health, social care and public health services are commissioned
- To assess the needs of the population through the Joint Strategic Needs Assessment (JSNA)
- To promote joint commissioning and integrated provision, joining up social care, public health and NHS services with wider local authority services.

Glossary

Advocate	The role of an advocate in health and social care is to support a vulnerable person and ensure that their rights and views are being upheld in a health and social care context.
BAMER	Black, Asian, Minority Ethnic and Refugee
Best Interest Assessments	Information to help you assess whether a deprivation of liberty is in the person's best interests.
CCG	Clinical Commissioning Group
Complex Cognitive Disorder	Also known as neurocognitive disorders (NCDs), are a category of mental health disorders that primarily affect cognitive abilities including learning, memory, perception, and problem solving.
Complex Needs Team	From 1 November will be known as the Adults Care Management Team
CQC	Care Quality Commission
DoLs	Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005.
ECG	An electrocardiogram (ECG) is a test that can be used to check the heart's rhythm and electrical activity.
Extra Care	Extra care housing is housing with care primarily for older people who occupy self-contained dwellings and have agreements that cover the provision of care, support, domestic, social, community or other services.
HSE	Health and Safety Executive
IDVA	Independent Domestic Violence Advisor
IV	Intravenous therapy (IV) is a therapy that delivers fluids directly into a vein.
MARAC	Multi-Agency Risk Assessment Conference (MARAC) A meeting where information is shared on the highest risk domestic abuse cases.
MCA 2007	Mental Capacity Act 2007
Mental Capacity Assessment	An assessment to determine whether a person has the ability to make a particular decision at a particular time.

NELFT	North East London Foundation Trust
Perinatal mental health	Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child.
Personality Disorder	Personality disorders (PD) are a class of mental disorders. A person with a personality disorder has trouble perceiving and relating to situations and people.
Police Merlins	Merlin is a database run by the Metropolitan Police that stores information on children that have come to the attention of police and adults who may be in need of safeguarding. Merlins should be shared with Children and/or Adult social care.
Primary Health Services	Primary healthcare is generally provided by GPs and other services based in the community that diagnose and treat health conditions, and support management of long-term and chronic health conditions
Reablement	Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.
Rehabilitation	Restoring someone to health or normal life through training and therapy after imprisonment, addiction, or illness.
Safeguarding Adults Review	The Care Act 2014 requires the Safeguarding Adult Board (SAB) to undertake a Safeguarding Adult Review (SAR) when an adult in its area with care and support needs experiences abuse or neglect. The purpose of the reviews is about learning lessons so we can improve future practice.
Secondary Health Services	Secondary Healthcare refers to a second tier of health system, in which patients from primary health care are referred to specialists in hospitals for treatment.
Strengths-Based Approach	A social work practice theory that emphasises people's self-determination and strengths. It is a way of viewing a person as resourceful and resilient in the face of adversity.
Subcut Fluids	When people are unable to take fluids orally those fluids can be administered artificially either intravenously or by infusion into the subcutaneous tissues.
Supported Living	A range of services and community living designed to support individuals with disabilities and their families to attain or retain their independence.
Tertiary Health Services	Tertiary care is healthcare provided in specialist centres.
The Channel Panel	A multi-agency panel where information about vulnerable people at risk of radicalisation is shared.
Venepuncture	The puncture of a vein as part of a medical procedure, typically to withdraw a blood sample or for an intravenous injection.

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