Bitesize video guide: Thresholds and Practice for Working with Adults, Carers & Families in Waltham Forest

Hello, my name is **Karlina** and I work at the Rough Sleeper Assessment Bed Project at YMCA Walthamstow. I'm really pleased to have this local guidance to help practitioners like myself understand how to effectively support adults, carers and their families to access the right care at the right time. Here are some key principles of the new Adult Thresholds Guidance, Right Conversation, Right Care, Right Time:

- Build a shared understanding of our Think Family vision, our theory of change and the role of different agencies in delivering good outcomes for all adults in Waltham Forest, so they can be independent, resilient, well and safe
- Support practitioners to use their professional skills to have a quality conversation that build relationships between professionals and between professionals and adults and their families which identify the strengths and needs of families in the context of their community, environment and of their own experience.
- Provide a number of potential indicators of need across a broad spectrum, that can be used to support understanding of risk and to information sharing between agencies to help improve adults' outcomes.
- Provides clear and simple information on how to respond with the right conversation, right care, at the right time.

I was working with Leon who had been rough sleeping for a year after the breakdown of his marriage due to their alcohol abuse. Rough Sleeping can be a dangerous and isolating experience. People end up rough sleeping for numerous reasons including experiencing a traumatic experience in their life; abuse as a child; relationship breakdown; alcohol / substance abuse; mental health issues; physical health issues.

Leon's physical health was very poor with incontinence problems, possible prostate cancer and other health concerns. Which was due to his struggle of over 20 years with alcohol abuse. Leon attended his GP a few times but didn't feel able to discuss all his health issues. Leon was self-neglecting. He felt very overwhelmed, and his living conditions quickly deteriorated. Leon needed support with independent living and wellbeing needs.

I read the self-neglect multi-agency guidance for some tips on starting conversations and reviewed the threshold guidance to support me having quality conversations with Leon and with other professionals.

I spoke with Leon about the best way to support him, he gave me permission to contact his GP to highlight all his health issues. This resulted in a referral to the Community Nurses team to support Leon with his incontinence and a referral to the hospital for investigation of his prostate. In time Leon also agreed to a referral to Care Grow Live for support with his alcohol use.

As the person with the best relationship with Leon, I saw myself as the Key Person. With Leon's consent I arranged a Team around the Person meeting and invited the GP, community nurse, and CGL worker and we all met together with Leon. We asked Leon what he was worried about and his top concerns. All the practitioners then said what they were worried about. We discussed and agreed the best way forward. We wrote a short action plan that outlined what Leon wanted and how we were going to work together to help him achieve it. The TAP meetings meant we all had the same information and really helped Leon to receive a seamless service.

When a client has multiple complex needs, they struggle to explain their circumstances with multiple organisations repeatedly. This is tiring and stressful for the client

Having short meetings with Leon meant as agencies we all saved time. We didn't duplicate our events; we were all clear about our roles and actions.

The TAP enabled the right conversation to happen for Leon which produced the right care at the right time for him.

Hello, my name is **John** and I work in the safeguarding adults' team

Priya is 75 years old, she lives on her own and has complex and long-term support needs. Priya has dementia and her main symptoms are short term memory loss and mild disorientation. Priya was first referred to social care by her friend and informal carer Brenda. Priya considers Brenda to be her family. Brenda was worried that Priya

couldn't manage her personal care and some other activities associated with daily living. A care package was put in place and with support from Brenda, Priya was managing much better.

At a review of the care plan Priya alleged that Brenda was stealing from her. Over the next 24 hours Priya repeated and then retracted the allegation on several occasions. The agency carer raised a safeguarding concern with the Multi-Agency Safeguarding Hub – known as the MASH.

The MASH screener contacted all the people working with Priya and through quality conversations they shared information about their views on Priya's finances, the informal carer and whether they had concerns about Priya 's ability to manage her finances.

The screener contacted Priya to discuss the allegation and assessed that Priya had communication difficulties. The screener was concerned about her mental capacity in relation to managing her finances.

The Care Agency did not have any concerns about her informal carer. They mentioned that Brenda had access to Priya 's money and sometimes provided them with money for Priya 's shopping. The community nurses did not have any concerns either.

The situation was also discussed with the Police who are part of MASH and it was agreed the most proportionate approach was to undertake a Section 42 safeguarding enquiry.

Following Making Safeguarding Personal principles it was important to understand what Priya wanted. A capacity assessment provided evidence that Priya lacked capacity in relation to some aspects of managing her finances. Brenda was her only close friend but was also the alleged abuser and Priya had no relatives, so an Independent Mental Capacity Advocate known as an IMCA was appointed in relation to the Safeguarding enquiry to ensure that Priya 's voice was heard.

The IMCA, and the social worker, used a strengths-based approach which meant that they were able to understand what decisions Priya was able to make. This included the wish to continue having contact with Brenda whose company she enjoyed, but Brenda should not manage her money.

The outcome of the enquiry was that there was no evidence to suggest that Brenda had been stealing from Priya and that Priya did not have the capacity to make decisions regarding the management of her finances or her care package. It was then agreed, in Priya 's best interests, that the local authority should make an application to the Court

of the Protection to be appointed as her Deputy to manage her finances. The IMCA would be involved for any future significant decisions to ensure these were taken in Priya ’s best interests. Through having the right conversation, involving the IMCA, Priya received the right care at the right time in line with Priya ’s own wishes.

Hello, my name is **Sharon**. I work in the Social prescribing team in Waltham Forest. Social Prescribing enables GPs and other health and social care professionals to refer patients to a link worker. We then provide a telephone guided conversation so they can learn and design their own personalised solutions, for example, 'co-produce' their 'social prescription'

We received a referral for emerging needs from a practice nurse for Geraldine, who lives with and is a carer for her older parents. As a family they had become isolated and were wary of services and “do gooders” interfering in their lives. Her mother had a low mood and felt lonely. Geraldine had been out of work for some years, was in debt and had very low self-esteem.

As the social prescriber I contacted Geraldine by telephone. Through quality conversations I was able to build a relationship with her which enabled us to identify together the strengths and needs of her family and her as a carer. Geraldine was able to say what she was most worried about, what she wanted to change about her life and think about a way to make it happen. We also made a referral for Geraldine to be contacted by Carers First to offer support to Geraldine as a carer, as she had not heard of this organisation.

Geraldine spoke with her mother about the things she used to enjoy, her mother said she missed the religious community she was a part of. Geraldine contacted the local mosque and her mother started attending a weekly lunch club on a Wednesday. Geraldine told me she was worried about her finances as she was not receiving benefits. We resolved this by booking an appointment for Geraldine to meet with the Citizen Advise Bureau welfare advisor at one of our GP Health centres where she was supported to tackle her debts and apply for benefits.

Geraldine had low self-esteem and felt deskilled from being out of work for several years. We discussed volunteering opportunities and in time Geraldine contacted her local food bank and started volunteering.

The issues that Geraldine and her family were facing felt overwhelming. Through taking a strengths and Think Family approach, having the right conversation about the right care at the right time, the family were able use the support of their community and

other relevant voluntary and community organisations to help them to resolve the issues for themselves.

Hello, my name is **Alexa**. I work in hospital discharge team at Whipps Cross Hospital. Sometimes people have a crisis and need extra support and intervention. It's important that people receive the right amount of help at the right time and are helped in the long term to be independent, resilient, well and safe.

Lucas came to the hospital following a fall at home. Lucas lives in the community with his son and has carers 3 times a day to support him with his daily living. He has diabetes and long-term depression and anxiety. When Lucas is feeling particularly low and anxious, he finds it harder to keep to a good diet for his diabetes. This has resulted in Lucas having pressure ulcers in the past. Lucas had a fall at home and his son phoned an ambulance. Lucas came to hospital but did not need to be admitted.

The day after, the carers noticed that Lucas's pressure ulcer on his sacrum had reopened, possibly due to his recent low mood, inactivity and the fall the day before. Lucas felt very upset as a result of the fall and became very agitated, anxious and verbally aggressive. Lucas refused to let the community nurses or the carers treat his pressure ulcer.

The nurses contacted her GP who referred Lucas to the North East London Foundation Trust crisis team for support with his mental health. The early help recovery and progression team were also contacted to provided physio support to Lucas to build his confidence following his fall.

The North East London Foundation Trust crisis team came to see Lucas the next day and provided one to one support to Lucas. They adjusted Lucas's medication temporarily to reduce his anxiety. North East London Foundation Trust visited daily and through quality conversations with both Lucas and the nurses, he became less anxious and slowly allowed the community nurses and agency carers to treat his pressure ulcers.

Taking a think family approach, we recognized that Lucas's son needed support himself as well as needing support to care for his dad. The GP referred him to social prescribing to support him going out and making new friends.

North East London Foundation Trust continued to support Lucas for another week and then handed him into the care of the GP to monitor. Lucas needed extra support for a period of time and received this because agencies had the right conversation to decide on the right care for Lucas at the right time.