City of BRADFORD METROPOLITAN DISTRICT COUNCIL

BRADFORD ADULT SOCIAL CARE

Internal Transfers Between Services

Guidance & Principles

NOVEMBER 2024

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The wording in this publication can be made available in other formats such as large print and Braille. Please call 01274 435400.

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Introduction

The purpose of this guidance is to support managers with the process and principles they need where they are assessing whether a person may be more appropriately supported by a different service with the Care Act Assessment and/or Care Act Review process; and therefore, will need to transfer between services within Adult Social Care.

This guidance is specifically for managers where a person with Care and Support needs has been referred to or supported by one service and it is determined either following further screening or a change in the persons needs or circumstances, that they may be more appropriately supported by an alternative service going forward. This guidance aims to support these considerations and provide the principles and process for safe transfers.

> **“The core purpose of Adult Care and Support is to help people to achieve the outcomes that matter to them in their life.”**
>
> (Care Act 2014, Statutory Guidance)

Bradford's Adult Social Care Services Criteria

Below are the criteria for each of Adult Social Care Service in Bradford. This should be referred to when considering the most appropriate service to support an adult who is referred into Adult Social Care. Past intervention from a team /service does not always indicate that they are the most appropriate team for future intervention for that person, nor does it necessarily make them responsible for meeting that person's care and support needs in the future. If a referral has been received and it has been indicated that the person's case is best placed with another team or service, and the referral does not require immediate intervention, the case can be transferred to the appropriate team as per this guidance. Where there is an immediate risk and it is not immediately clear which service would be best place to support, the individual should be supported by the service/team who knows the person best, and consideration of transfer should only take place once the immediate risks are addressed. In this instance services should work collaboratively to ensure that the persons needs are addressed using the resources available across ASC.

Adults with Disabilities (AWD) Service:

AWDs will generally work with individuals under the age of 25 - 65 who live in the Bradford District. The individuals this team are most appropriately able to support are:
·Adults with a Learning Disability. The UK Department of Health and Social Care (DHSC) defines a learning disability as 'A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood'.
·Those with a long-term physical disability. This includes conditions such as cerebral palsy, multiple sclerosis, fibromyalgia, and Downs syndrome, who are not currently open to another team.
·Adults moving to the Bradford district and have had a disability since childhood.
·Adults with have acquired a physical disability or injury, such as an acquired brain injury; (exceptions apply when this is in combination with multiple long-term conditions associated with older age, in which case this should be led by OP)
·Adults who have a neurodevelopmental condition, such as autism
·Adults who have needs associated with illness or recovering from injury, such as long-term symptoms associated with a virus or cancer.
AWD may also have management responsibility for individuals over the age of 65 but have a lifelong disability and are not experiencing other conditions relating to age. Consideration should be given to whether a person under the age of 65 presents with a condition that would be best managed by the Older People's Service.

Preparation for Adulthood Team:

The PfA / Front Door Team will support young people with specific support needs transition into adult social care. Joint working with children's social care may begin at age 16 and a transition care act assessment to assess likely needs under the Care Act 2014 will be undertaken and completed before the young person turns 18.

A referral to the PfA Team can be made through the Adults with Disabilities Front Door Team around the time of the young person's 16th birthday*. Consent must always be sought by the referrer and the young person should always be made aware that a referral is being made. Once the young person is allocated a PfA / Front Door social worker the focus of the work age

Bradford's Adult Social Care Services Criteria

16 to 18 years will be on preparation for adulthood. The children's social worker will remain the primary worker until the young person turns 18 and appropriate planning should take place to ensure a smooth handover between children's and adults' social workers.

Situations may occur in certain circumstances where young people who were previously unknown to services will need support and planning: for example, due to people moving house, or as a result of a young person moving into the area. The initial referral should be made to the adult social care Independent Advice Hub (IAH) for a young person over 18 or to Children's Services Integrated Front Door if the young person is under 18. If the person meets the criteria for the PfA / Front Door Team a worker from that team will be allocated to commence an assessment.

The PfA / Front Door Team will become the primary worker if they are already involved on the individual's 18th birthday and will carry out a Care Act assessment during this time prior to this. The PfA Team will remain involved until such time as the EHC Plan is ended (either at age 25, or when educational outcomes have been met and the individual no longer attends an education or training provider) and a social care support plan put into place. The PfA Team will remain involved until complex transition issues are resolved, and support plans formalised; the young person will then be transferred to the relevant adult social work team.

Older People's Service Criteria

The Older People's Service have a responsibility to work with individuals with organic mental health conditions, such as dementia and alcohol-related brain damage, regardless of age and will generally work with individuals over the age of 65 where:

- The Adult has needs that mainly result from conditions associated with ageing/frailty
- The Adult has a number of health conditions, of a nature usually associated with older age that contribute to their needs
- The Adult has needs associated with illness or recovering from injury.

Community Mental Health Team (CMHT)

The CMHT has the responsibility to work with people with complex and enduring mental health problems who require specialist support such as:

- People with "acute and or chronic" mental illness
- People who struggle to manage due to a decline in mental health
- People who have complex needs alongside a mental illness, such as, but not limited to, drug and alcohol use, people subject to sections under the MHA, such as detention in hospital or orders within the community.

How to decide which is the appropriate Service

Where it is unclear which service is the most appropriate to support a person and a decision needs to be made who takes responsibility for the referral, the below principles must be followed.

Guiding Principles

- All referrals should be looked at on an individual basis. Every person is unique and requires different support; teams should operate in a way that is best placed to meet the person's needs. Doubts around a service's responsibility to meet a person's needs should not cause unnecessary delay to their receipt of an assessment, information, advice, or support. On occasions where a team who may not consider themselves the most appropriate service and there is an immediate need/risk, they must carry out the initial assessment to avoid unnecessary delay. Decisions around which service is most appropriate to manage the referral long-term can be made following the initial assessment.
- The needs/risks to the person should continue to be met by the current service or team whilst this process is followed. This process should not compromise the person with care and support needs. No one will be denied access to, or experience long delays in receiving the support that best meets their needs due to any of their protected characteristics, including their age, diagnosis or type of disability.
- Individuals, their families and other professionals should be involved in discussions regarding a transfer between services and be informed of the transfer process. They should be kept updated and advised once the transfer has been completed, ensuring that all information on how to contact the responsible service is provided.
- People should not be transferred where there is an urgent need/crisis response required. The current responsible team/service should respond to this and then consider transferring the person once the immediate situation has been stabilised.
- People should only be transferred in a stable, safe position. For example, not mid-way through assessments, with urgent issues outstanding; or where support for assessed unmet care and support needs is not in place.
- People should not be transferred purely on an age/diagnosis basis. For example, when a person reaches 65 or a person receives a diagnosis of Schizophrenia etc. The primary reason for support of the person is the crucial factor to consider.
- People should only be transferred when their social care record is up to date, all assessments and support plans are finalised.
- If a person appears to have multiple conditions, requiring an assessment or review, all services should consider what appears to be the person's primary reason for care and support, and which service is best placed to address this.
- No person should be transferred without a Team Manager to Team Manager discussion and agreement. Where no agreement can be reached, this should be escalated to the relevant Service Managers for discussion and so on to Head of Service and Assistant Director should they remain unresolved.
- Only once a transfer has been agreed, the person should be transferred to the relevant service on the social care recording system, with a clear and concise case summary added to the progress notes, outlining the important elements of the person's situation.
- People with more complex needs or circumstances should have a worker-to-worker handover and potentially some joint work for an appropriate amount of time agreed between the Team Managers to ensure a safe transfer.
- It may be decided that it is appropriate for the person with care and support needs for the two services to remain involved, consideration should be given to whether joint working and/or responsibility for any commissioned support is shared.

How to decide which is the appropriate Service

Team Manager to Team Manager discussion

The Team Managers should consider each case individually. The individual's and where appropriate family/carers views and wishes should always remain central. The skills and resources of each service should be explored to determine which is best suited to meet the person's needs and desired outcomes, particularly when a person's primary need is not clearly defined. It is also appropriate to consider the progression of any condition and whether this influences the service most appropriate to manage their care and support in the long term. During this discussion, managers should also consider whether other services within ACS or partner agencies could meet the person's needs or support to meet these needs. It is advised that Team Managers make a record of their discussion and factors considered. Should the Team Managers be unable to reach agreement the notes from their discussion should be presented to their respective Service Managers who will then meet to try and reach agreement. In the rare event that Service Managers are not able to agree, this will be escalated to the appropriate Assistant Directors who will make the decision.

How to prepare a referral to move to another service one agreement has been reached.

Prior to a referral moving to another service, all referrals should have a clear and robust case summary outlining the person's current needs and any outstanding work (if applicable). The following requirements should be met before transfer:

- A review should be completed which reflects the person's needs around the time of transfer and should contain an up-to-date care and support plan and carer's assessment (if applicable), as well as any other required assessments
- The care and support plan is up-to-date and outlines how current needs are being met, as well as any strategies for addressing needs that are not yet met
- The person's contact details and demographics are completed and up-to-date
- Any relevant referrals, such as referrals for packages of care or accommodation, should be completed
- Any assessments or applications regarding mental capacity and Community Deprivation of Liberty (DoL) are completed (if applicable)
- There is clear evidence that conversations have been had with the individual and their families, including around how another service will be managing their referral
- An up-to-date risk assessment has been undertaken, where required
- Any risks to staff are recorded on the front page of a person's social care record (reminders) and any other issues for consideration are recorded. These should be reviewed regularly.
- A contingency plan is in place for instances such as the primary carer not being available.

Determination for Joint working

When it appears that a person's needs would be best met by more than one service, it is good practice to carry out a joint assessment or joint visit. However, in these circumstances, responsibility for the referral will remain with **the original holding team**. Generally, the service that will hold main responsibility for a person that requires joint working is the one that is best placed to support the person's primary need. This includes carers and which service is best placed to provide an assessment and support. Consideration should be given to the

How to decide which is the appropriate Service

complexity of the most prevalent need and anticipated duration of the support required. Even if a service has main management responsibility for an individual, colleagues from other services should still provide advice, support, and intervention. For people where short-term intervention is required from other services, the original holding team should maintain responsibility. It is essential that staff across services maintain effective communication with the person and professionals involved.

Case examples

John

John is a 64-year-old man with a diagnosis of a learning disability. He has had support from the learning disabilities team for most of his life. He lives independently with a few hours of support every week to prompt him with personal care and to support him to do his shopping. His sister also visited several times a week and they went out together, sometimes meeting in Leeds City Centre. John had a review of his care and support needs 10 months ago and it was established that his support plan continued to meet his needs and outcomes.
John's sister Carol has noticed in her recent visits over the last few months that John is appearing more and more confused. She supported him to visit his GP who did a test for a UTI, which was negative. He had further blood tests, but nothing really showed up. Carol was keeping an eye on it and thought John might just be getting a little forgetful however, over the course of the last 2 months Carol noticed that John was struggling with tasks that he had always been able to do, about a week ago she had a call from John's neighbour to say that there had been a small house fire at John's, he had put a metal bowl in the microwave.

Carol supported John to contact his GP again, who repeated the UTI and blood tests, both of which didn't show anything wrong with his health. The GP felt that John possibly has Dementia so made a referral and a few weeks later, following further tests, it was confirmed. Carol has been providing more support to John but is now struggling due to her own family commitments and has contacted Adult Social Care advising that she is now struggling with the amount of care her brother needs and it is becoming desperate for them. She said that she thinks John is struggling with his younger sister providing the support as he has always seen himself as the protective older brother, it is really affecting their relationship and Carol's wellbeing.
The Independence Advice Hub screens the referral. They consider the criteria for each team, noting that the Adults with Disabilities Team have been involved previously and fund his current package of care. As John's needs now relate to dementia and this is likely to continue to deteriorate, they consider passing this onto the Older People's Team as the most appropriate team however, as the referral has been determined as a priority, they pass it onto the Adults with Disabilities Team who know John well to ensure that John and Carol get support as soon as possible.

A Social Worker from the Adults with Disabilities Team, Amy, visits John with his sister present. They complete an initial assessment. John is very confused. They talked

How to decide which is the appropriate Service

about the recent small house fire and Carol said that John had always been independent with cooking, so this was a shock. The Social Worker, John and Carol agree on a plan which will meet John's immediate needs. His current support will be increased, and Carol will support with the rest, this will allow for a more thorough assessment to be completed. The Social Worker offered Carol a Carer's Assessment, but she declined stating that it was her brother, and she wanted to support him during this difficult time. She agreed she could continue for a short time with the extra support as long as this would be assessed longer term. Amy advises John and Carol that as his needs now relate to his dementia and not his learning disability that she will discuss with her Team Manager whether John would be best supported by the Older People's Team, as they have the most knowledge of services to meet the needs of an older adult with dementia, but reassured them that she would remain involved until any decision was made and would keep them updated.

Amy went back to the office and discussed the case with her manager. Although John is not yet 65, he has only just had his 64th birthday, his needs now relate to his dementia rather than his learning disability. Amy's manager agrees to have a conversation with the Team Manager in the Older People's Team and discuss it.

The Team Managers meet. They discuss and record their decision that John would be best supported by the Older People's Team as his needs are likely to increase and the Older Peoples Team have access to the most appropriate skills and services to meet his needs going forward. They agreed a transfer on Priority 1.

Amy writes up a transfer summary on John's record. She ensures the support plan is up to date with his current support, including the informal support provided by his sister. She updates all the contact information in his record and send this to her Team Manager who then passes the referral through the electronic system to the receiving team. Amy calls John and Carol to advise them that his Care Act assessment will be completed by the Older People's Team, she gave them the contact number for the team and advised that John will be assessed as a priority and she will ensure that all John's information is passed over to the new worker, including letting the new Social Worker know that he loves Leeds FC and that it has always been important to him to have the latest shirt and season ticket!


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