Falkirk Council

Falkirk Council Social Work Services

Review of Community Care Locality & Integrated Teams

MODEL B

1. SUMMARY

This model is significantly different to the current arrangement. The proposal is to provide a focused intake/duty service at the first point of contact for new people referring themselves or being referred to the Service. The intake service will undertake assessment functions and when required, will work with service Users for up to 12 weeks. When service users require more lengthy or more complex intervention, they will be referred to the most appropriate care specific team.

2. DESCRIPTION OF MODEL

This proposal is for a 2 tier service model that makes separate provision for the assessment and short term assistance of service users, from the provision of long term assistance. It is recognised that within the Falkirk partnership we are at different stages with integrated teams, and the proposal is to continue to have locally based social work staffed teams alongside the integrated teams.

Assessment services and short-term work would be delivered through an Intake service dealing with all adults aged 18+ years, within 3 locality teams, co-terminous with health boundaries covering the following areas:

- Central – Grahamston and Camelon
- East – Meadowbank, Grangemouth and Bo'ness
- West – Denny and Stenhousemuir

The provision of longer term assistance and more complex packages of care, including care management, would be dealt with through 3 locally based long term teams, in the geographical areas outlined above and through the existing integrated teams for mental health, learning disability and sensory impairment. Where a service user has a primary diagnosis of learning disability, mental health or sensory impairment which requires social work intervention this will be provided by social work members of the integrated teams. The locality and integrated teams will deal with all service users aged 18+ years. The FDRI team would remain as is. These teams will be responsible for devolved budgets.

The Home Care Intake service would encompass the current 24/7 team responsibilities i.e. Out of Hours service, Re-hab at Home service and the Crisis Care service.

The Home Care Intake service would take all new referrals for the home care service with their function being to assess and review service users care needs, taking them through appropriate types/levels of care packages with a view to reaching the most appropriate level of care either for continued short term support (which they may or may not continue to care manage for up to the 16 week period) or for long term support in the community.

In considering work bases for the intake and locally based teams, it is proposed that the offices currently based in the central, east and west sectors are identified as work bases for either intake or locality teams. Further analysis of the footfall figures to the respective teams is required to confirm the most appropriate bases for intake and locality teams.

3. DEFINITIONS USED

Intake service
This would be an initial reception service which would provide an immediate intake assessment and short-term work in certain circumstances. This would be provided to anyone with community care needs, regardless of diagnosis and aged 18+ years at the point of contact.

The intake service would respond to:

- emergency assessments (Priority 1), high risk, palliative care, duty Mental Health Officer and adults at risk of harm situations (where these individuals are not allocated to a locality or integrated team).

- initial assessment to determine need and priority

- provision of equipment and adaptation, including sensory impairment equipment (to be identified), where these are not complex and it is anticipated can be concluded within a 12 – 16 week period, which would be flexible depending on circumstances

- all new referrals for adults with community care needs, where it is anticipated that work can be concluded within a 12 week period

- referrals for known service users whose cases have subsequently been closed

- referrals for new service users who are awaiting allocation to locality and integrated teams

- requests for information re services, policies, eligibility etc

The intake service could be provided through one centralised team, with a dedicated phone number, or through three locality based intake teams. The intake service would work within existing referral routes to avoid the potential for duplication in assessments and to maintain faster access to services through established direct routes, eg blind registration clinic, statutory Mental Health Officer service, learning disability and mental health referrals and transition from Children and Families.

Where social work services are required, these would be funded by the intake service up to 12 weeks, which builds in an automatic review process. If it is identified social work services are required on a longer-term basis, these would be funded and care managed by the locally based and integrated teams.

Locally based teams
The locally based teams would respond to:

- service users who have been assessed as requiring more complex interventions, or interventions likely to take longer than 12 weeks.

- All adults with a physical disability, older people with mental health issues including dementia, frail older people, all adults with drug and alcohol issues

At this stage it is envisioned that staffing in locally based teams will remain social work staff. The benefits of further integration should be explored to ensure the development of locality and integrated teams that will support the delivery of partnership ambitions with respect to community care and primary care priorities.

Integrated Teams
The integrated teams will be joint health and social work teams with clear protocols agreed in relation to accountability, responsibilities and operational management.

The descriptions as follows relate to the social work functions of the integrated teams.

Mental Health Teams
The three teams will continue to work with all adults up to 65 years with mental health difficulties plus severe and enduring mental illness.

Social Work staff will provide assessment and care management services, including Adult Support and Protection activities where required.

The team would have its own budget.

Learning Disability team
The team will continue to work with adults with a primary diagnosis of a learning disability from 18+ years for social work services.

Further work is required to identify the business case to create more than one learning disability team from the redesign of existing teams. It is proposed that this model will result in a transfer of care management responsibilities for adults with complex learning disability needs from existing Community Care teams.

Social Work staff will provide assessment and care management services, including Adult Support and Protection activities where required.

The team would have its own budget.

Sensory Impairment Team
The team will continue to work with children, young people and adults with a primary diagnosis of a sensory impairment that requires a need for social work intervention.
Social Work staff will provide assessment and care management services, including Adult Support and Protection activities where required.

The team would have its own budget.

Addiction services
We are aware that there are significant challenges in terms of service links within and between community care, criminal justice and addiction services. The review would welcome staff views on this area, to inform further developments and links within and between services.

4. BENEFITS AND CHALLENGES

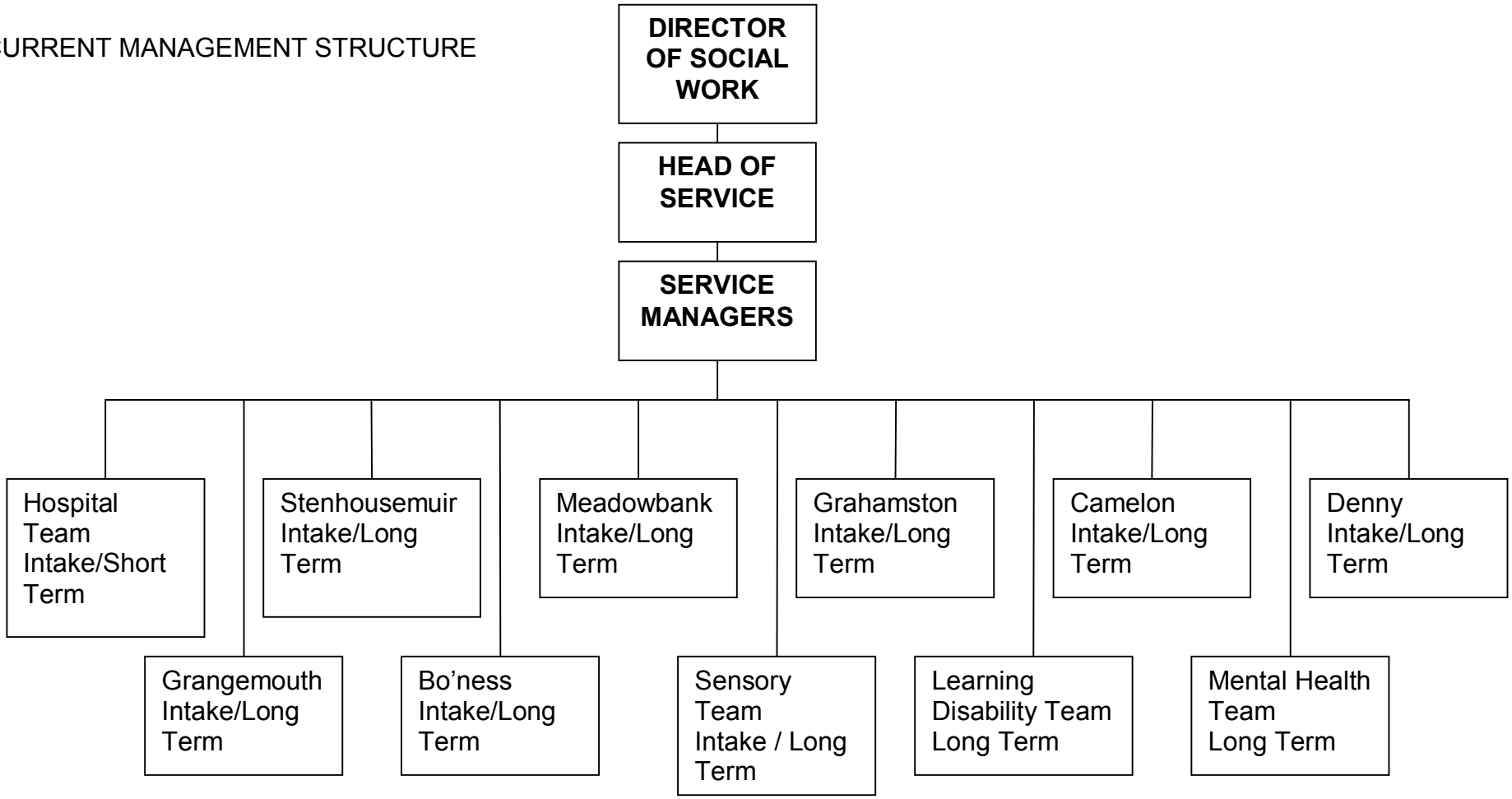
Benefits
- service users should have quicker access to assessment which results in the provision of non-complex pieces of equipment/adaptations
- one point of contact for all new referrals
- clear assessment and prioritisation for all referrals
- more consistent and effectively organised and managed service for short-term work
- retains locally based teams and links with communities
- co-terminous with GP practices, in-house Care and Support at Home services, consultant psychiatrists
- recognises the skills and expertise of in-take workers with opportunities for Continued Professional Development and shared learning
- locally based teams will be able to develop more skill and knowledge in working with the client groups and improve current joint working (possibly leading to a more integrated approach)
- Best Value approach to service provision – minimises duplication, streamlines management arrangements
- provides potentially greater transparency about referral and care management activity
- separates work activities and will lead to improved quality of care planning, monitoring and reviewing
- budgets will be devolved to all teams
- potential to support other agendas eg managing transition and national drivers to provide cohesive and integrated services
- strengthening specialist knowledge across all client groups

Challenges
- need to ensure correct balance between short and longer term work requirements
- including partners eg children and family staff, health, housing
- accessibility for service users and carers who will attend social work offices to access services
- need to develop pathways between all services, to avoid individuals being passed between services.

- to ensure consistency we need to have transparent policies which encompass all teams
- need to develop clear statements regarding what is expected of all teams.
- identifying appropriate bases for teams
- need for clarity about how we determine appropriate service for individual with multiple disabilities
- need for willingness to share expertise and help each other out.
- retention of all existing links with Primary Care
- budgets will be spread out thinly across teams
- need to develop a clarity about which services we purchase, making central decisions about new services to meet ever changing needs
- how to ensure that teams are resourced to meet the demands of an increasing and wider base within each client group
- joint IT systems

COMMUNITY CARE MANAGEMENT

CURRENT MANAGEMENT STRUCTURE



COMMUNITY CARE MANAGEMENT

PROPOSED MODEL B