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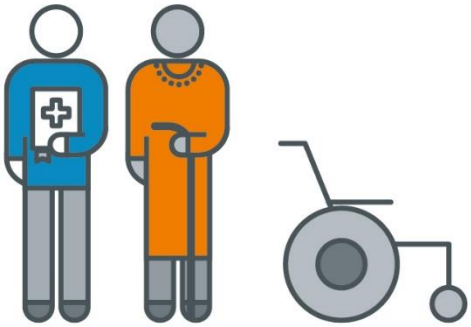

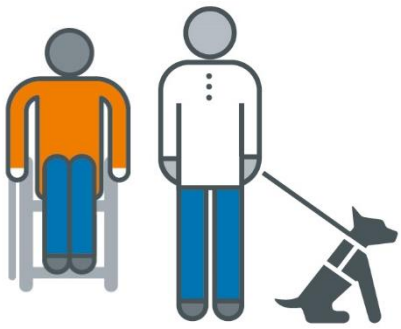

Adult Social Care: Transferring Between Services and Settings

CITY OF LONDON CORPORATION

DEPARTMENT OF COMMUNITY AND CHILDREN'S SERVICES

Contents

Introduction

Our aim is to ensure that transferring between services is a smooth, person centred and positive experience for our residents.

We do this by,

- practising person centred generic adult social work within a single service to minimise the need for transfers.
- operating as part of a 'cradle to grave' People directorate service
- ensuring systems are in place to promote and oversee timely transfers of care with internal and external agencies.
- Ensuring effective communication with the person, family and between professionals, internal and external agencies.

How we work

Adult Social Care is a single generic service comprising of Social Workers, Occupational Therapists, Strengths-based practitioners, and a dedicated full-time principal Social Worker. We work with adults who have physical disability, learning disability, mental health, substance misuse, dementia, including older people and those who sleep rough in the City.

Within the one service we provide Care Act Assessments, Carer Assessments, Reviews, Safeguarding, Mobility Assessments, Trusted Assessors, Telecare, Reablement, Direct payments, Homecare and Transitions.

We focus on providing a strengths-based approach and relationship-based practice, with the adult and carers at the heart of our work.

We have a single point of access for adults, carers and partners to all areas of the service.

The People Directorate

Adult Social Care sits within the People Directorate which also comprises of Homelessness services including Tenancy Support, Virtual Head Tacher, Children's Social Care and Quality Assurance including Workforce Development.

All these services are collocated on the same floor with Heads of Service sharing a physical office. All services attend a quarterly People Directorate meeting to learn together from each other, and to foster close working relationships.

Communication

Effective and timey communication is vital in achieving the best possible outcome for the resident.

Four key Principals of Good Communication

1. Communication should be person centred

2. A named professional should be identified in relation to every transfer of care from one care setting to another

3. In every case professionals should communicate with: a) the person being transferred, b) their carer / family and c) the individuals providing health and social care services, also adhering to the law on confidentiality

4. Gaining consent from the person at the earliest opportunity to facilitate information sharing across care providers is essential

Transitions to Adulthood

Transitions cases are discussed at the Quarterly Transitions Forum, which a representative from Adult Social Care attends. ASC have a dedicated Transitions Social Worker who takes all transitions cases and attends SEND panels and the Transitions Forum meeting. This is to ensure continuity of approach for both the young person and their parents, and support development of the service.

In addition to the transitions social work lead, there is a named manager to support the worker and oversee the work. Referrals come via the Transitions Forum and are allocated by the manager.

Leaving Hospital

Leaving hospital can be a difficult time for adults and their informal carers and is often a time of significant change in terms of their independence, care and support, and sometimes their accommodation. In recognition of this he City of London commission a Care Navigator from Age UK to provide information and advice to the resident (and their carer or family) on discharge practices, to assist understanding of our pathways and what to expect. This can include information on Reablement, Deprivation of Liberty Safeguards, financial assessment along with the identification and support of carers.

The Care navigator liaises with wards and hubs to attain relevant up to date case information and share information with GPs and the ASC team. The Care Navigator uses the ASC Mosaic system for recording, attends ASC team meetings, training, and away days.

There is an Adult Social Care leaflet, A guide to leaving Hospital along with an easy read version available to download on our website or distributed in hospitals by the Care Navigator and ASC practitioners.

Moving into Alternative Accommodation

There are times when an adult with care and support needs may, for a variety of reasons, need to move into alternative accommodation.

Care Homes and Supported Living

While there are no are no residential or nursing homes with the City of London, the adult social care team will discuss individual needs with adults and their family or carer to find a suitable care home in a suitable location. We currently have adults in care homes across the country to be near friends, family, or just to be in an area of preference. We aim to ensure that the adult has the things that are most important to them and that their accommodation and experience is as personalised as possible. The allocated social worker will visit to review this within 6 to 8 weeks and support with any adjustments to enhance the adult's experience.

The same approach is adopted to adults moving into supported living placements, although there may be more scope for scope for visits prior to moving in as part of a planned transition. This could involves spending the day or a night there to get used to new surroundings before properly moving in.

City Housing Stock outside the Square Mile

In addition to housing within the Local Authority area the City of London also has social housing stock based within neighbouring local authorities. When an adult moves from the City into housing in another local authority area they will become ordinarily resident in that area, meaning that Care Act duties for care and support will move to the new local authority. ASC will work with the adult, liaise with the host local authority and, where appropriate, provided short term support to ensure a smooth transition.

ASC will also liaise with Housing colleagues to ensure the property is suitable for the adult's needs.

Homeless Accommodation

Where there is a homeless person in the City with care and support needs who is moving into temporary or hostel type accommodation they will be supported by the Homelessness and Rough Sleeping (HRS) Social Worker and/or the HRS Strengths-based Practitioner. The HRS Strengths-based Practitioner is also able to offer intensive support and practical interventions to support the adult and help ensure they have all the things they need to live in their new accommodation.

Where the accommodation is outside the City there are complexities in determining who will be responsible for meeting their ongoing care and support needs. This can be due to specific arrangements between the City and the host Local authority, or the legal status of the homeless adult. The City will work with the adult, liaise with the host local authority and, where appropriate, meet the care and support needs of the adult.

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