**Integrated Localities Team**

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| Name of Manager | Kate Concannon  |
| Manager’s Contact Details | Email:Kate.concannon@iow.gov.uk | Telephone No:01983 821000Ext:6743 |

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| Key Activities | The Integrated Localities Team are an Island wide team; working in three integrated localities (South, Central & West, and North East). Each locality has their own uniqueness and strengths. The three localities are individually aligned with Health Localities and GP surgeries.We work together with health and community partners to achieve the best possible outcomes for people living within the community. Our ethos is to work in a person-centred way to bring professionals together to concentrate on personal outcomes of the individual to enable them to have the best possible life they can. Helping people to identify their strengths and support networks. We have also adopted an Asset Based Community Development (ABCD) approach and are continuingly working with are partners to build resilient communities. Each Locality operate an Open Case Duty System for unallocated cases, so that there is a point of contact for service users, family and providers.The review/assessment focuses on outcomes and whether the person has achieved what they wanted too over the last twelve months and establishes how far the services provided have achieved these outcomes set out in their Care Plan and we confirm or amend the current Care Plan at the time of the review.The team ensures that individuals are able to participate in their review/assessments. We apply The Mental Capacity Act 2005 and refer to Advocacy if an individual lacks capacity. With the individuals consent we involve family and friends and ensure providers of services provide feedback to inform the review.As part of the review/assessment process we identify those who may be eligible for Continuing Health Care Funding and support individuals and family members in understanding this process. We complete Checklists and Decision Support Tools. Our aim is to ensure individuals are safeguarded when required, whilst being fully enabled to take risks, safeguarding underpins all of these functions and encompasses Making Safeguarding Personal.By attending the regular Integrated Locality service meetings, the team support the multi-agency group with early help plans and interventions to promote independence and resilience. |
| Key Outcomes | We recognise the importance of robust and timely reviews, in:* Preventing crisis or breakdown of support.
* Ensuring the quality of the support provided
* Ensuring that support continues to meet the outcomes the individual has identified, and that the wellbeing principle is applied, and reviews are person centred.
* Ensuring carers are identified and supported.
* Ensuring that council resources are invested at an appropriate level to meet assessed and eligible need.
* Identify potential safeguarding concerns.

The Integrated Locality service (IL) support individuals to achieve their identified outcomes, building their resilience. Reducing the need for statutory involvement. The IL also work together aiming to build community resilience developing safer and inclusive communities across the island.  |
| Key Service Users | * The teams work with all adult service user groups, including young adults still in education receiving care and support.
* The team also works with carers, completing and reviewing carers assessments.
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1. Role of Consultant Practitioners in the Integrated Locality Team

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| Oversight of Practice | The Consultant Practitioners support the Group Manager in the day to day management of the team to enable the team to meet their statutory requirements.The Consultant Practitioners are responsible for:* Prioritising team workload and allocations.
* Cases transfer both into and out of the team.
* Read and authorise Assessments, Care Plans and reviews.
* Undertake 1:1 supervision. Identify learning outcomes and support reflective practice.
* Support staff through informal supervision, discussions and Team Meetings, building team resilience.
* Work with the Principle Social worker.
* Complete Personal Development Plans (PDPs).
* Understand data, record and use data to inform practice and monitor performance and ensure targets are met.
* Chair meetings for example Best Interest meetings, MARMs and Safeguarding meetings.
* Identify staff training needs.
* Support CHC and DST
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| Carrying Limited Caseload | The expectation is that the Consultant Practitioner will case hold for example where a case is complex and requires a higher level of oversight, however the case load is kept to a minimum to enable the consultant to complete oversight of practice. |
| Authorising Assessments etc | * The Consultant Practitioner will review and authorise assessments, care plans and reviews daily and keep up to date to enable cases to be transferred to the Scheduled Review System to be held until next annual review.
* The Consultant Practitioner will ensure quality in undertaking collaborative case audits.
* Assessments, Care Plans and Reviews must be person centred and the Consultant Practitioner will review and authorise, offering guidance and support to staff.
* The Consultant Practitioner will be responsible to authorising support packages up to a set amount. Packages beyond this amount will need to go to panel for verification and the case

worker will submit a panel form to the Consultant Practitioner for sign off before it is presented. |
| Supervision of Staff | The Consultant Practitioner will supervise qualified and unqualified staff and use reflection as a tool to inform practice and enhance knowledge and practice and follow the Isle of Wight Council Supervision Policy. |
| Key Competencies | * + Knowledge of current Social Care legislation and guidance (e.g. Care Act, Mental Capacity Act, Mental Health Act, DoLs and Continuing Healthcare).
	+ Good understanding of Adult Safeguarding, Making Safeguarding Personal and self-neglect.
	+ Ability to chair a range of meetings.
	+ Ability to work in a fast-paced team to meet targets.
	+ To be organised and ability to prioritise workload.
	+ Good report writing skills.
	+ To be able to motivate, support and enable colleagues and people we work alongside to reach their potential.
	+ To understand the need for data and ability to analyse.
	+ Ability to manage change and conflict and to challenge.
	+ To address issues such as sick leave and work with Human Resources.
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1. Role of Social Workers in the Integrated Locality Team

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| Key Activities | * To undertake, assessments, create care plans and undertaken both annual reviews and unscheduled reviews with people we work alongside, families and providers.
* To provide supervision to Social Care Officers using reflective practice and following the Isle of Wight Supervision Policy.
* To work alongside the principle Social Worker.
* To undertake complex case work, for example Court of Protection applications for Deputyship, Adult Safeguarding enquiries as directed by Adult Safeguarding team.
* To undertake Mental Capacity Assessment and Best Interest Meetings as required.
* To meet weekly targets for annual reviews.
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| Key Competencies | * Knowledge of current Social Care legislation and guidance (e.g. Care Act, Mental Capacity Act, Mental Health Act, DoLs and Continuing Healthcare).
* Good understanding of Adult Safeguarding, Making Safeguarding Personal and self-neglect.
* Ability to work in a fast-paced team and to meet targets.
* To be organised and ability to prioritise workload.
* Good report writing skills.
* To be able to motivate, support and enable staff and people we work alongside to reach their potential.
* To understand the need for data and ability to analyse.
* Ability to manage change and conflict and to challenge.
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| Key Outcomes | * To be able to work within an integrated team and be able to retain your social work ethics and values.
* To empower individuals to become an agent for change in their own lives.
* Work alongside multiagency partners to increase community resilience.
* To help people to maintain or improve their wellbeing and to live as independent as possible. Care Closer to Home Strategy.
* Provide or arrange for services, facilities or resources which will prevent, delay or reduce individuals’ needs for care and support or the need for the support of carers.
* Carry out an appropriate and proportionate assessment/reviews.
* Carry out capacity assessments if it is believed an individual may lack capacity keeping individual central in process and Best Interest Decisions.
* Involve an advocate (a family member, friend or independent advocate) to help the individual through the process if they have substantial difficulty understanding, retaining and using the relevant information.
* Carry out a safeguarding enquiry where a person may be at risk of abuse or neglect.
* Consider what else (other than the provision of care and support) might assist the person in meeting the outcomes they want to achieve.
* Ensure the care and support plan, or support plan, is, as far as possible, agreed by the adult or carer in question, that it promotes wellbeing and meets outcomes.
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1. Role of Social Care Officer in the Integrated Localities team

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| Key Activities | * To undertake, assessments, create care plans and undertaken both annual reviews and unscheduled reviews with people we work alongside, families and providers.
* To undertake Mental Capacity Assessment and Best Interest Meetings as required supported by Social Care practitioner.
* To meet weekly targets for annual reviews.
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| Key Competencies | * Knowledge of current Social Care legislation and guidance (e.g. Care Act, Mental Capacity Act, Mental Health Act, DoLs and Continuing Healthcare).
* Ability to work in a fast-paced team and to meet targets.
* To be organised and ability to prioritise workload.
* Good report writing skills.
* To be able to motivate, support and enable colleagues and people we work alongside to reach their potential.
* To understand the need for data and ability to analyse.
* Ability to manage change and conflict and to challenge.
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| Key Outcomes | * To be able to work within an integrated team and be able to retain your social work ethics and values.
* To empower individuals to become an agent for change in their own lives.
* To help people to maintain or improve their wellbeing and to live as independent as possible. Care Closer to Home Strategy.
* Provide or arrange for services, facilities or resources which will prevent, delay or reduce individuals’ needs for care and support or the need for the support of carers.
* Carry out an appropriate and proportionate assessment/reviews.
* Carry out capacity assessments if it is believed an individual may lack capacity keeping individual central in process and Best Interest Decisions.
* Involve an advocate (a family member, friend or independent advocate) to help the individual through the process if they have substantial difficulty understanding, retaining and using the relevant information.
* Support and be involved in a safeguarding enquiry where a person may be at risk of abuse or neglect.
* Consider what else (other than the provision of care and support) might assist the person in meeting the outcomes they want to achieve.
* Ensure the care and support plan, or support plan, is, as far as possible, agreed by the adult or carer in question, that it promotes wellbeing and meets outcomes.
* Social Care Officers are encouraged and supported to progress their careers
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