1. Pen picture of Team

<table>
<thead>
<tr>
<th>Key Activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adult First Response is the ‘front door’ to Adult Social Care. It is a single point of access for all social care referrals.</td>
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</tr>
<tr>
<td>• At present Adult First Response and Self-Directed Support are undergoing change development to support a multi-team Duty/Triage system.</td>
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</tr>
<tr>
<td>• Key day to day activities, include Care Act Assessments, Mental Capacity Assessments. Best Interest meetings and Safeguarding.</td>
<td></td>
</tr>
<tr>
<td>• The team will also work with Direct Payments, Court of Protection and complex issues whilst reviewing any existing care input. Focusing on equality and self-determination for service users and their carers. Ensuring that carers needs are acknowledged and assessed.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Outcomes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• To promote Think Local, Act Personal and work with the community and multi-agency colleagues to ensure that Adult Social Care always respond in a person-centred way.</td>
<td></td>
</tr>
<tr>
<td>• To maximise information and data for Adult Social care in terms of commissioning services and responding to Community needs.</td>
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</table>

<table>
<thead>
<tr>
<th>Key Service Users</th>
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</thead>
<tbody>
<tr>
<td>• 18 plus – Adult First Response is the initial responder for the Local Authority, so key service users will be anyone with a presenting social care need.</td>
<td></td>
</tr>
<tr>
<td>• Once referrals have been screened they may be referred on to other Adult Social care teams.</td>
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</tr>
</tbody>
</table>
## 2. Role of Consultant Practitioners in Team

| Experience of Risk Assessments | • Adult First Response Consultant Practitioners are operational managers.  
• They oversee daily the workflow of referrals into Adults Social Care. They need to be able to direct and advise on risk taking and evidence this in their decision making. |
| Experience of Complexity | • Adult First Response and Self-Directed Support Consultant Practitioners will deal with complex situations and need to be able to liaise with multiple professionals and co-ordinate support. This will include safeguarding and Best Interest. They need to be at ease under pressure and stressful situations and give clear operational leadership to the teams. They also need to be able to articulate their rationale and proportionate response.  
• This will mainly be around consent versus unwise decision making and can be very challenging.  
• They will need to demonstrate the Adult Safeguarding policy is adhered to be clear re accountability and responsibility, escalating any concerns as soon as possible to senior management. |
| Oversight of Practice | • Quality assurance and ensuring effective working practices are in place, on the spot case supervision and quality individual reflective supervision.  
• Monitoring and designing inductions for new staff, tailored to the individual and following through Probation programme and setting achievable SMART goals with the worker.  
• Consultant practitioners are mentors and coaches in terms of practice and assist in ensuring that operational standards are upheld. They need to be clear about policies and legal frameworks in terms of practice as staff performance is part of their remit.  
• To maximise effective and efficient use of resources in line with outcome focused assessments. |
| Carrying Limited Caseload | • Consultant Practitioners may hold a few very complex or high profile referrals or co-work these with other team members. |
| Authorising Assessments etc | • To promote a model of self-directed support for individuals and carers.  
• Positively challenging practice and promoting effective use of resources.  
• Ensure compliance with all legal frameworks and localised policies and guidelines. |
| Supervision of Staff | • To promote and facilitate the expertise and knowledge with colleagues positively and assist with team and
individual development. Highlighting training needs and change in service delivery.

### 3. Role of Social Workers in Team

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>To facilitate and support individuals to complete a strength-based approach care needs assessment. To ensure early intervention and signposting through universal community services to encourage independence and wellbeing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Competencies</td>
<td>Knowledge of and competency in Social Work Theory, practice and values, the Care Act, Mental Capacity Act and Best interest legislation. Being aware of and acting under any other current, relevant legal frameworks or guidelines. Show clear understanding of Safeguarding and Making Safeguarding personal. Identifying and working with Continuing Health care. Proficient IT skills.</td>
</tr>
<tr>
<td>Key Outcomes</td>
<td>To promote person centred working and support autonomy in decision making when the individual has capacity. To ensure that all decisions are made in the persons best interest when they do not have capacity. Clearly identify and evidence this thought process and communication re how this was established. To hold a case load to a level of complexity and provide case management guidance support to social care staff and students when required. Ability to work effectively under pressure. To be able to thrive in a complex and demanding environment. Apply policies, procedures, code of conduct and good practice emphasising professionalism at all times.</td>
</tr>
</tbody>
</table>

### 4. Role of Social Care Officer in Team

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>To facilitate and support individuals to complete a strength-based approach care needs assessment. To ensure early intervention and signposting through universal community services to encourage independence and wellbeing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Competencies</td>
<td>To undertake a holistic needs assessment including risk assessment in line with Care Act. Knowledge and understanding of Adult Social Care legislation. To ensure robust reviews of care after six weeks to assist in promoting independence.</td>
</tr>
<tr>
<td>Should be able to communicate with a range of individuals with a variety of needs. Maintain and promote communication with partner agencies. Practice in a way that safeguards adults Computer literate and able to write concise reports/case notes.</td>
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</tr>
<tr>
<td><strong>Key Outcomes</strong> EXTENDED COLUMNS</td>
<td></td>
</tr>
<tr>
<td>Able to prioritise, manage their own case load and be accountable for the work they undertake. Ability to work effectively under pressure To be able to thrive in a complex and demanding environment Ensuring appropriate and effective use of resources.</td>
<td></td>
</tr>
</tbody>
</table>

*Adult Safeguarding Team*
<table>
<thead>
<tr>
<th>Name of Manager</th>
<th>Maria Blazeckova</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager's Contact Details</td>
<td>Email: <a href="mailto:Maria.Blazeckova@iow.gov.uk">Maria.Blazeckova@iow.gov.uk</a></td>
</tr>
</tbody>
</table>

1. **Pen picture of Team**

**Key Activities**
- Living a life that is free from harm and abuse is a fundamental right of every person. When abuse or neglect does occur, it needs to be dealt with swiftly, effectively and in ways that are proportionate to the concerns raised. In addition, the person must be at the centre of any safeguarding response and must stay as much in control of decision making as possible. The right of the individual to be heard throughout the process is a critical element in the drive to ensure personalised care and support.

- The team works in a multi-agency way to provide a positive and empowering experience for the adult at risk and concentrates on their Making Safeguarding Personal (MSP) outcomes. All members of the team display professional curiosity and team work.

**Key Outcomes**
- Working together to prevent and stop both the risks and experience of abuse or neglect. Safeguarding balances the right to be safe with the right to make informed choices, while at the same time making sure that the person’s wellbeing is promoted, taking into consideration their views, wishes, feelings and beliefs when deciding on any action.

**Key Service Users**
- People who may be in need of care and support services; and who are or may be unable to take care of themselves or are unable to protect themselves against significant harm or exploitation.

2. **Role of Consultant Practitioners in Team**
| Oversight of Practice                                                                 | • Provide support to all practitioners, ensure high quality reflective practice and evidence the safeguarding principals of making safeguarding personal.  
|                                                                                     | • Ensure best practice is followed and evidenced in recording.  
|                                                                                     | • Provide reflective supervision.  
|                                                                                     | • Facilitate and shape multi-agency working with partner agencies and providers.  
|                                                                                     | • Improve processes.  
|                                                                                     | • Participate in MAST/MASH, MARM, MAPPA, and MARAC.  
|                                                                                     | • Oversee decision making of duty social worker and support helpdesk officers.  
|                                                                                     | • Ensure effective communication with community and professionals.  
|                                                                                     | • Support carers, friends and family members throughout contact with the Safeguarding team.  
|                                                                                     | • Provide regular feedback to the person at risk, their advocate and other relevant people.  |
| Carrying Limited Caseload                                                         | • Hold small caseload of complex S42 enquiries.  
|                                                                                     | • Chair Safeguarding meetings.  
|                                                                                     | • Coordinate and chair multi-agency risk management meetings.  
|                                                                                     | • Ensure continuous learning and improvement of practice.  
|                                                                                     | • Facilitate training and reflective group sessions.  
|                                                                                     | • Oversee high risk domestic abuse incidents in relation to adults at risk and ensure policies are followed.  |
| Authorising Assessments etc                                                       | • Quality assure safeguarding enquiry work completed by practitioners and providers to ensure appropriate practice.  
|                                                                                     | • Oversee completion of risk assessments, safeguarding plans, protection plans and MSP outcomes of the adult at risk.  
|                                                                                     | • Ensure safe practice.  |
| Supervision of Staff                                                              | • Provide regular supervision.  
|                                                                                     | • Facilitate reflective practise using a holistic approach and to enable the practitioners to enhance their practice and maintain their wellbeing within a frontline area of social work/social care practice.  
|                                                                                     | • Ensure continuous personal development.  
|                                                                                     | • Develop and support resilience.  |

3. Role of Social Workers in Team
<table>
<thead>
<tr>
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</thead>
</table>
| • Facilitate face to face and telephone contact with members of the community and professionals.  
• Take part as a duty social worker and work closely with Helpdesk officers to triage new referrals.  
• Carry caseload of S42 enquiries.  
• Coordinate S42 enquiries.  
• Complete risk assessments and safeguarding/protection plans.  
• Complete capacity assessments in line with the MCA.  
• Facilitate advocacy and Making Safeguarding Personal  
• Work closely with partner agencies.  
• Provide regular updates to the adult at risk and other involved professionals and family members.  
• Ensure proportionality and positive communication with all involved parties. |
<table>
<thead>
<tr>
<th>Key Competencies</th>
</tr>
</thead>
</table>
| • Confident and enthusiastic with good interpersonal skills.  
• Excellent communication skills.  
• High quality, strength-based assessment and recording skills and outcome focussed recording.  
• Multi-agency working. |
<table>
<thead>
<tr>
<th>Key Outcomes</th>
</tr>
</thead>
</table>
| • Help to develop the learning and confidence of others in the team.  
• Deliver a safe, professional and effective safeguarding service.  
• Ensure MSP and safeguarding principals are the centre of team practice.  
• Deliver best practice.  
• Empower the adult at risk in their own decision making. |
The Review & Quality Assurance Team and Long-Term Condition Team

<table>
<thead>
<tr>
<th>Name of Manager</th>
<th>Julie Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager's Contact Details</td>
<td>Email: <a href="mailto:Julie.green@iow.gov.uk">Julie.green@iow.gov.uk</a></td>
</tr>
</tbody>
</table>

1. Pen picture of Team

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>• The Review &amp; Quality Assurance Team and Long-Term Condition Team work closely together and staff in these teams undertake scheduled/unscheduled annual reviews and longer-term work.</td>
</tr>
<tr>
<td>• The Review &amp; Quality Assurance Team and Long-Term Condition Team is a mix of Social Care Practitioners, Social Care Officers and Consultant Practitioners and overseen by a Group Manager.</td>
</tr>
<tr>
<td>• As a result of a large number of people receiving support via Adult Social Care, approximately 1700 cases remain open, but are managed within the review system as they are stable cases that do not actively require a named worker.</td>
</tr>
<tr>
<td>• The Long-Term Condition Team hold a small number of case that require longer intervention, however once settled transfer into the review system.</td>
</tr>
<tr>
<td>• We recognise the importance of robust and timely reviews, in:</td>
</tr>
<tr>
<td>- Preventing crisis or breakdown of support.</td>
</tr>
<tr>
<td>- Ensuring the quality of the support provided</td>
</tr>
<tr>
<td>- Ensuring that support continues to meet the outcomes the individual has identified, and that the wellbeing principle is applied, and reviews are person centred.</td>
</tr>
<tr>
<td>- Ensuring carers are identified and supported.</td>
</tr>
<tr>
<td>- Ensuring that council resources are invested at an appropriate level to meet assessed and eligible need.</td>
</tr>
<tr>
<td>- Identifying potential safeguarding concerns.</td>
</tr>
<tr>
<td>• As a dedicated team we complete annual reviews of Personal Budgets, Traditional Managed Services as well as Residential and Nursing Home reviews, both here on the Isle of Wight and to those we support on the mainland.</td>
</tr>
<tr>
<td>• The team operate an Open Case Duty System for unallocated cases, so that there is a point of contact for service users, family and providers.</td>
</tr>
</tbody>
</table>
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 and completed Checklists and Social Care Reports.

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.

The Review & Quality Assurance Team and Long-Term Condition Team is an exciting team to work in, the team have a wealth of knowledge and skills and welcome new staff.

Key Outcomes

- 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.
- Carry out a safeguarding inquiry 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.

### 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.

### 2. Role of Consultant Practitioners in Team

#### 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 supervisions.
- Support, staff through informal supervision, discussions and Team Meetings.
- Work with the Principle Social worker.
- Complete Personal Development Reviews (PDRs).
- 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.

#### 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.
- 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.

<table>
<thead>
<tr>
<th>Supervision of Staff</th>
<th>• 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.</th>
</tr>
</thead>
</table>
| 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 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 services users 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. |

3. Role of Social Workers in Team

| Key Activities | • To undertake, assessments, create care plans and undertaken both annual reviews and unscheduled reviews with service users, families and providers.  
• To provide supervision to Social Care Officers using reflective practice and follow 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. |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 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 services users to reach their potential. |
- To understand the need for data and ability to analyse.
- Ability to manage change and conflict and to challenge.

### Key Outcomes

- 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.
- Carry out a safeguarding inquiry 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.

### 4. Role of Social Care Officer in Team

#### Key Activities

- To undertake, assessments, create care plans and undertaken both annual reviews and unscheduled reviews with service users, 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.

#### 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 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 services users to reach their potential.
- To understand the need for data and ability to analyse.
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<td>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.</td>
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</tbody>
</table>
**Adult Transition Team**

<table>
<thead>
<tr>
<th>Name of Manager</th>
<th>Daron Perkins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager's Contact Details</td>
<td>Email: <a href="mailto:daron.perkins@iow.gov.uk">daron.perkins@iow.gov.uk</a>  Telephone No: 019083 821000 ext 6582</td>
</tr>
</tbody>
</table>

1. **Pen picture of Team**

**Key Activities**
- Completion of Strengths based Care Act Assessment and Support Plans for eligible young people under the age of 18 who require ongoing support into adulthood in preparation for transition to adult social care at age 18.
- Implementation of departmental Safeguarding procedures.
- Ongoing review of support plans until transition arrangements are settled at which point support will transfer for ongoing review.

**Key Outcomes**
- Promotion of departmental Care Close to Home programme so that maximising independence and living as independent a life as possible are the cornerstone to all decisions.
- Young people are supported to lead independent, fulfilling lives that reflect the aspirations and desires of other young people of a similar age.
- The young people we serve plan and direct the support they require and remain autonomous. Where this is not feasible all possible steps are taken to ensure that the young person remains at the centre of all decision making.
- Provision of creative support arrangements that underpin the development of independence through access to a personal budget and the use of Personal Assistants.
- Utilisation of smart technology that supports the promotion of independence.
- Increase uptake of individual tenancies and other personalised living arrangements including access to Shared Lives arrangement.
- Young people develop a range of independent living skills becoming increasingly autonomous as the support provided reduces as independence increases.
- Ongoing reduction in the over reliance of residential provision to meet need.

**Key Service Users**
- Young people aged 16-18 with eligible needs who require transitional planning in preparation for receiving social care support from their 18th birthday.
2. Role of Consultant Practitioners in Team

| Oversight of Practice | - Provision of practice oversight to promote the highest standards of service delivery through formal supervision, informal day to day case discussions and via case review and audit.  
| | - Lead and where appropriate coordinate MARM, Safeguarding, Blue Light and other multi-agency meetings.  
| | - Joint case work to assist staff development.  
| | - Referral management and case allocation.  
| | - Attendance at weekly funding verification panel.  
| | - Oversight and action to improve team performance, data collection and data cleansing.  
| | - Assistance in management of complaints.  
| | - Implementing lessons learned from serious case reviews.  
| | - Lead in development of reflective practice.  
| | - Development of specific project work.  
| | - Deputise in managers absence.  
| | - Joint work with partner agencies in developing transition related practice and documentation.  
| | - Ensure team members consider all possible funding streams including Continuing Health Care.  

| Carrying Limited Caseload | - Consultant Practitioner will hold a limited caseload of the most complex and challenging cases where reputational risk is an issue or high risk is present.  

| Authorising Assessments etc | - Quality control and authorisation of assessments and support plans.  

| Supervision of Staff | - Supervision will be cascaded through the team with the Consultant Practitioner supervising an agreed number of staff.  

3. Role of Social Workers in Team

| Key Activities | - Completion of timely strengths based, Care Act Assessments in preparation for the delivery of support to the young person to start on their 18th birthday.  
| | - Support plans will focus on creatively promoting the development of independence regardless of the young person’s abilities.  
| | - Completion of regular quality reviews that ensure support is targeted and new goals set that continue to enhance independence.  
| | - Implementation and promotion of departmental
safeguarding procedures.
- Requirement to develop and adhere to ongoing development as required by practitioners registering body.
- Attendance at all relevant meetings in relation to the individual i.e. school reviews, safeguarding meetings etc.
- Adherence to departmental recording policy.
- Promotion of Personal Budgets to provide the individual with more control over the support they require.
- Ensure that all relevant support and funding streams have been explored i.e. Continuing Health Care.

### Key Competencies

- Knowledge of key legislation and best practice guidance, understanding practice implications and delivery of highest standards i.e. Care Act, Mental Capacity Act.
- Ability to practice safely and effectively within scope of practice.
- Excellent communication skills and the ability to develop positive relationships with all concerned to facilitate that ensure the best outcome for the individual.
- Ability to challenge and manage potential conflict.
- Timely and accurate recording.
- Ability to manage priorities effectively.
- Clear understanding of Safeguarding procedures and requirement to take proportionate action.
- Understanding of data protection requirements.
- Demonstration of reflective practice that informs ongoing development.
- Awareness of cultural, equality and diversity and disability issues.

### Key Outcomes

- Promotion of departmental Care Close to Home programme so that maximising independence and living as independent a life as possible are the cornerstone to all decisions.
- Young people are supported to lead independent, fulfilling lives that reflect the aspirations and desires of other young people of a similar age.
- The young people we serve plan and direct the support they require and remain autonomous. Where this is not feasible all possible steps are taken to ensure that the young person remains at the centre of all decision making.
- Provision of creative support arrangements that underpin the development of independence through access to a personal budget and the use of Personal Assistants.
- Utilisation of smart technology that supports the promotion of independence.
- Increase uptake of individual tenancies and other
personalised living arrangements including access to 
Shared Lives arrangement.
- Young people develop a range of independent living 
skills becoming increasingly autonomous as the support 
provided reduces as independence increases.
- Ongoing reduction in the over reliance of residential 
provision to meet need.
- Young people remain safe whilst recognising that those 
with capacity have the right to take risks.

<table>
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<th>4. Role of Social Care Officer in Team</th>
</tr>
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- Completion of regular quality reviews that ensure support 
  is targeted and new goals set that continue to enhance 
  independence. 
- Understanding departmental safeguarding procedures 
  and scope and role within this. 
- Requirement to develop and adhere to ongoing 
  development as required by practitioners registering 
  body. 
- Attendance at all relevant meetings in relation to the 
  individual i.e. school reviews, safeguarding meetings etc. 
- Adherence to departmental recording policy. 
- Promotion of Personal Budgets to provide the individual 
  with more control over the support they require. 
- Ensure that all relevant support and funding streams 
  have been explored i.e. Continuing Health Care. |

| **Key Competencies**                  |
| - Knowledge of key legislation and best practice guidance, 
  understanding practice implications and delivery of 
  highest standards i.e. Care Act, Mental Capacity Act etc. 
- Ability to practice safely and effectively within scope of 
  practice. 
- Excellent communication skills and the ability to develop 
  positive relationships with all concerned to facilitate that 
  ensure the best outcome for the individual. 
- Ability to challenge and manage potential conflict. 
- Timely and accurate recording. 
- Ability to manage priorities effectively. 
- Clear understanding of Safeguarding procedures and 
  requirement to take proportionate action. 
- Understanding of data protection requirements. |
| Key Outcomes | Demonstration of reflective practice that informs ongoing development.
|             | Awareness of cultural, equality and diversity and disability issues.
|             | Promotion of departmental Care Close to Home programme so that maximising independence and living as independent a life as possible are the cornerstone to all decisions.
|             | Young people are supported to lead independent, fulfilling lives that reflect the aspirations and desires of other young people of a similar age.
|             | The young people we serve plan and direct the support they require and remain autonomous. Where this is not feasible all possible steps are taken to ensure that the young person remains at the centre of all decision making.
|             | Provision of creative support arrangements that underpin the development of independence through access to a personal budget and the use of Personal Assistants.
|             | Utilisation of smart technology that supports the promotion of independence.
|             | Increase uptake of individual tenancies and other personalised living arrangements including access to Shared Lives arrangement.
|             | Young people develop a range of independent living skills becoming increasingly autonomous as the support provided reduces as independence increases.
|             | Ongoing reduction in the over reliance of residential provision to meet need.
|             | Young people remain safe whilst recognising that those with capacity have the right to take risks.
Adult Community Mental Health Team

<table>
<thead>
<tr>
<th>Name of Group Manager</th>
<th>Charles Mlambo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager's Contact Details</td>
<td>Email: <a href="mailto:charles.mlambo@iow.gov.uk">charles.mlambo@iow.gov.uk</a></td>
</tr>
</tbody>
</table>

1. Pen picture of Teams

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>General Mental Health Social Work’s Key Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Completing &amp; reviewing all the Care Assessments.</td>
</tr>
<tr>
<td></td>
<td>• Setting up care packages.</td>
</tr>
<tr>
<td></td>
<td>• Attending &amp; contributing to the care planning through the MDT forums.</td>
</tr>
<tr>
<td></td>
<td>• Hospital discharge planning meetings.</td>
</tr>
<tr>
<td></td>
<td>• CTO renewals, and production of social circumstances reports and presenting these reports to hospital and Tribunal Meetings.</td>
</tr>
<tr>
<td></td>
<td>• Contributing to section 117 after care arrangements &amp; reviews.</td>
</tr>
<tr>
<td></td>
<td>• Production of MOJ reports.</td>
</tr>
<tr>
<td></td>
<td>• Contributing to the general ASCD duty rota – at least one day a week.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMHP Specific Key Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Applications for compulsory admission to hospital under Sec.2,3 or Sec.4.</td>
</tr>
<tr>
<td>• To interview patients “in a suitable manner” (Sec 13(2)</td>
</tr>
<tr>
<td>• To inform patient’s Nearest Relative when detaining under Sec.2 &amp; Sec 3.</td>
</tr>
<tr>
<td>• To interview a person removed to a &quot;place of safety&quot; by police under S.136.</td>
</tr>
<tr>
<td>• To consider applications for a patient to be made subject to Supervised Community treatment under Sec.17A.</td>
</tr>
<tr>
<td>• To consider applications for warrants S135(1).</td>
</tr>
<tr>
<td>• To support or make arrangements or authorise others to convey patients to hospital.</td>
</tr>
<tr>
<td>• To contribute to AMHP duty rota at one day a week.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To support mentally disordered persons to maximise their independence in the community, in line with Isle of Wight key care delivery policy, ‘Care Close at Home’, so as to prevent or reduce hospital admissions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Service Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Service users with severe and enduring mental illness who are in the community – this could be people living in their</td>
</tr>
</tbody>
</table>
own accommodation, supported, hostels, residential, nursing homes or patients in hospital at the point of their discharge.

### 2. Role of Consultant Practitioners in Team

<table>
<thead>
<tr>
<th>Oversight of Practice</th>
<th>• In conjunction with the Group Manager, to be responsible for the operational and performance management of the service, working with staff on day to day resolving of all operational issues as required.</th>
</tr>
</thead>
</table>
| Carrying Limited Caseload | • To support and facilitate staff induction and ongoing professional supervision, appraisal, involving fellow practitioners as appropriate.  
• To ensure all staff within the team receives support and guidance in accordance with the individual's professional code of conduct and registration requirements.  
• To undertake investigations into complaints received about the service and be proactive in trying to resolve issues for individuals.  
• To undertake complex safeguarding enquiries.  
• To provide emotional and practical support and advice to other staff working in the various areas of a multi-professional service.  
• To ensure risk management systems are in place, regularly evaluated and appropriate actions taken to mitigate presenting risks. |
| Authorising Assessments etc | • To authorise all assessments timely and ensuring that all assessments are evidence based and indicative of defensible decision making applications / processes. |
| Supervision of Staff | • To have regular case discussions with all staff at least once a month.  
• To lead in reflective case discussions in monthly meetings.  
• To ensure and encourage all staff to have regular relevant trainings.  
• To oversee the allocation of case work and supervise ongoing social care intervention for individuals and carers, across the locality (ensuring professional and specialist skills are used appropriately).  
• To use IT systems to enable monitoring quality issues and evaluation outcomes, reporting regularly to the Group Manager on Performance Management and Quality Assurance. |

### 3. Role of Social Workers in Team
### Key Activities
- You will manage a caseload of service users with severe and enduring mental illness using the Care Act / Care Programme Approach as a basis for your intervention liaising with other professionals and our partners in the community to meet care plan goals and empower to recover.

### Key Competencies
- Ideally you will be an AMHP or keen to undertake this training and develop your career. You will have a clear understanding of the MHA, CA and MCA. You will be joining and helping to build on the existing team of competent staff who work together in an anti-discriminatory collaborative way alongside people to achieve maximum independence, recovery and wellness.
- You will also be fluent at Safeguarding vulnerable individuals using advocacy when required and be able to understand and utilise Care Act Roles. You will take part in the duty rota and AMHP rota.
- Major tasks will include holistic assessments, care planning and reviews meeting the requirements of the Care Act, CPA and S117s.
- Demonstrate Ethical and Professional Behaviour.
- Be able to understand and be able to engage Diversity and how diversity and difference characterize and shape the human experience and are critical to the formation of identity.
- Be able to engage with Individuals, Families, Groups, Organizations, and Communities.
- Be knowledgeable about evidence-informed interventions to achieve the goals of clients, carers and families.
- Skilled to a Social work degree.
- Be able to assess and manage risks.
- Be able to effectively work within the confines of the Care Act, Mental Health Act and the Mental Capacity Act.
- Ability to understand the impact of ill mental health and how to respond to their needs empathetically.
- Good communication skills.
- Being able to undertake risk assessments.
- Being conversant with the safeguarding processes.
- Good IT skills.
- Being resilient and being able to be calm under pressure.
- To be able to work effectively independently and as part of a team.
- To be able to undertake regular training in order to keep abreast with current mental health issues.

### Key Outcomes
- To use IT systems to enable monitoring quality issues and evaluation outcomes, reporting regularly to the Group Manager on Performance Management and
Quality Assurance.

- To also ensure throughput of work is achieved and that the team works efficiently in achieving optimal outcomes for individuals and carers by providing advice and direction within the service area.

### 4. Role of Social Care Officer in Team

| Key Activities | To undertake the general ASCD duty rota.  
|                | Complete standard care act assessments and if during their involvement the assessments becomes complex, cases are passed on to qualified social workers.  
|                | Undertake reviews.  
|                | To liaise with deputy-ship on cases that are open to deputy-ship team. |

| Key Competencies | Ability to understand the impact of ill mental health.  
|                 | Good communication skills.  
|                 | Being able to undertake risk assessments.  
|                 | Being able to be aware of safeguarding processes.  
|                 | Good IT skills.  
|                 | To be able to be calm under pressure.  
|                 | To be able to work effectively independently and as part of a team.  
|                 | To be able to undertake regular training in order to keep abreast with current mental health issues. |

| Key Outcomes | To support in ensuring throughput of work is achieved and that the team works efficiently in achieving optimal outcomes for individuals and carers by providing advice and direction within the service area. |
# Adult Hospital Team

<table>
<thead>
<tr>
<th>Name of Manager</th>
<th>Daron Perkins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager's Contact Details</td>
<td>Email: <a href="mailto:daron.perkins@iow.gov.uk">daron.perkins@iow.gov.uk</a></td>
</tr>
</tbody>
</table>

## 1. Pen picture of Teams

| Key Activities | Completion of holistic strengths-based Care Act assessments for eligible vulnerable adults requiring social care support upon hospital discharge.  
| | Alert and Implementation of safeguarding procedures.  
| | Attendance at Discharge Planning Meetings and other multi-agency meetings to promote and facilitate the earliest possible safe discharge.  
| | Best Interest and mental capacity work to ensure capacity issues are at the forefront of all decisions so that the person can wherever practicable direct their care and support needs.  
| | Ensure that a whole systems approach is adopted that includes family and community support so that paid for care is only utilised when other options are unavailable.  
| | Advice and support to people who self-fund their support upon discharge to ensure timely discharge.  
| | Advice, support and sign-posting to people who decline social care support. |

| Key Outcomes | Promotion of Care Close to Home programme so that the first option is always a safe return home.  
| | Maximising reablement opportunities so that people regain and develop their independence skills to enable them to remain independent.  
| | The people we serve wherever possible plan and direct the support they require and remain autonomous.  
| | Provision of creative support arrangements through access to a personal budget.  
| | Assisting the Council to deliver high quality support arrangements to those eligible and in need of ongoing support. |

| Key Service Users | Eligible vulnerable adults over the age of 18 requiring social care support at the point of discharge. |
### 2. Role of Consultant Practitioners in Teams

| Oversight of Practice | • Provision of practice oversight through formal supervision of professionally qualified staff, informal day to day case discussions and via case review and audit.  
• Attendance at weekly Patient Discharge Meeting to facilitate early discharges.  
• Attendance at designated multi-disciplinary meetings, forums, discharge planning meetings etc.  
• Joint case work to assist staff development.  
• File audits.  
• Safeguarding lead for Team.  
• Case allocation.  
• Oversight of team performance and data collection along with team manager.  
• Assistance in management of complaints.  
• Implementing lessons learned from serious case reviews etc.  
• Lead in development of reflective practice. |
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<tr>
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<tbody>
<tr>
<td>Carrying Limited Caseload</td>
<td>• Consultant Practitioners hold a limited caseload of the most complex and challenging cases where discharge is problematic or high risk.</td>
</tr>
<tr>
<td>Authorising Assessments etc</td>
<td>• Quality control and authorisation of assessments and support plans.</td>
</tr>
<tr>
<td>Supervision of Staff</td>
<td>• Supervision is cascaded throughout the team with Consultant Practitioners supervising a number of the qualified social workers and nurses within the team.</td>
</tr>
</tbody>
</table>

### 3. Role of Social Workers in Teams

| Key Activities | • Completion of timely strengths based, Care Act Assessments and plans that promote the maintenance and promotion of independence, choice and autonomy.  
• Implementation and promotion of departmental safeguarding procedures.  
• Requirement to develop and adhere to ongoing development as required by practitioners registering body.  
• Attendance at multi-agency discharge planning meetings to ensure timely discharges.  
• Adherence to departmental recording policy. |
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(DTOC).
- Where ever possible people return to live in their own home.
- Promotion of independence and autonomy whilst accepting that individuals with capacity have the right to take risks.
- Reduction in the use of residential and nursing placements.
- Everyone who would benefit from Reablement support is identified and supported through a Reablement arrangement.
- Individuals are at the centre of all decisions and direct their support wherever possible.
- Delivery of an outstanding, cost effective service.

### 4. Role of Social Care Officer in Teams

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<th><strong>Completion of timely strengths based, Care Act Assessments and plans that promote the maintenance and promotion of independence, choice and autonomy.</strong></th>
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<tbody>
<tr>
<td></td>
<td><strong>Implementation and promotion of departmental safeguarding procedures.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Ongoing development of professional practice that supports role.</strong></td>
</tr>
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<td><strong>Attendance at multi-agency discharge planning meetings to ensure timely discharges.</strong></td>
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