

# 4

## ADULT SOCIAL CARE TEAMS

This section describes which teams deal with which groups of service users.

### 4.1 Social Services Line

Deals with all enquiries about Adult Social Care.

### 4.2 Advice Information and Assessment team

Deals with all referrals to Adult Social Care which are not within the remit of specialist teams i.e. learning disability, mental health, sensory impairment, homelessness or substance misuse issues. Includes both social workers and occupational therapist.

### 4.3 Community Adults teams

The individual must be 18 - 64 years old and have a permanent physical disability or sensory impairment which has a substantial long-term adverse effect on their ability to manage their daily lives, and rely on others to provide personal care in order to undertake day to day activities

OR the individual must be 65 or more years old, and appears to be in need of community care services.

Note that those people who have a temporary physical disability or sensory impairment following illness, injury or a crisis in their lives can still be considered for reablement services.

### 4.4 Occupational Therapy teams

The individual must be “ordinarily resident” in the borough, 18 or over, and have a permanent and substantial physical disability, (it is likely that he/she has had the disability for six months or more), OR be experiencing difficulties due to the ageing process.

### 4.5 Hospitals team

The Adults Hospitals Team provides a service to any borough resident aged over 18 who may need community care services on discharge from hospital.

If the person is already in receipt of services the Hospitals team will monitor to ensure the appropriate level of care is set up for a safe discharge.

The team will take referrals from any hospital across the country as long as ordinary residence in the borough is established (see [Sn 105.1.1](#)).

## 4.6 Community Team for people with a Learning Disability

The Community Team for people with a Learning Disability (CTLD) when assessing eligibility for a person with Learning Disability and/ or Disability on behalf of the Royal Borough and CLCH provides services to individual adults over the age of 18 when needs arise from physical, sensory, learning or cognitive disabilities and impairments, or from associated mental health difficulties.

Below are two definitions, one for learning disability and the second for disability: these statements help to define the service user in a category which will determine the care pathway to be pursued.

### Learning Disability

For someone to be defined as having a learning disability, there needs to be a *“significant reduced ability to understand new or complex information, to learn new skills with a reduced ability to cope independently and which started before adulthood with a lasting effect on development”*. Department of Health, Valuing People (2001).

For people with a learning disability, an intelligence quotient of 70 or less has been required to determine whether an individual has a learning disability. More recently, it has been recognised that some adults can reach a much higher score than this, but due to their particular needs, still require services from the CTLD.

More appropriately, an assessment to establish adaptive/social functioning and communication should form the basis of an eligibility assessment. Usually adults with a learning disability receive services from the CTLD when they have an accompanied reduction in ability to cope independently which is attributable to the learning disability.

It is important to note that the definition is inclusive of adults with autism *and* a learning disability or significantly impaired social and adaptive behaviour functioning. This is an area where cases need to be assessed on their individual merit. For example, an individual may have a diagnosis of Asperger’s Syndrome and other features such as impaired intellectual, adaptive or social functioning, which mean that they would receive services from the CTLD. Another example may be that the individual has Asperger’s Syndrome and no other feature, which suggests they may be better served by another team, such as the Community Mental Health Team.

For the purpose of reaching the eligibility threshold, the following indicators should be used:

An adult should be regarded as learning disabled if he or she has a special need in the area of intellectual, emotional, social or adaptive behavioural development due to:

- a recognised genetic disorder which would result in a diagnosis of learning disability, e.g. Down’s Syndrome
- a recognised in-born metabolic disorder which would result in a diagnosis of learning disability, e.g. untreated phenylketonuria

- significant developmental delays, e.g. cannot demonstrate the ability to complete very basic tasks, with a measurable cognitive impairment
- significant social skill deprivation, or cannot interact with other adults in a safe or meaningful manner, e.g. unable to understand verbal communication at a basic level
- autism linked with a communication disorder and cognitive impairment.

Learning disabled adults are by definition, vulnerable. There is a Learning Disability Leaflet, 'Learning Disabled Adult Services: When we can help', which describes the services available to meet individual need, which can be requested.

The definition of a 'vulnerable adult' has the potential to include large numbers of adults, but not all adults will receive an assessment or direct casework intervention from the CTLD under the Social Services responsibility. It is important to note that different boroughs will have different criteria for assessing and providing services and that as a result the Royal Borough's threshold may result in the provision of a service whereas neighbouring boroughs would not provide the same level of service.

## Disability

The meaning of 'disability' within the Disability Discrimination Act 1995 is:

*"Subject to the provisions of Schedule 1, a person has a disability for the purposes of this Act if he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities"*<sup>1</sup>

There are further definitions more specifically broken down and categorised within the Act, and further amendments and inclusions have been made within the Disability Discrimination Act 2005. (See [Sn 105.2](#) for more details.)

## 4.7 Integrated Transition team

The Integrated Transition team was set up under a 12-month project from 1 Dec 2010. The team is located within Adult Social Care and based with Learning Disabilities Services, and works with young people from the age of 16 and on occasion 14, who meet the eligibility criteria for learning disability or physical disability defined above. The team works with people up to 25 years of age, though the intervention may end sooner. All functions associated with transition of young people with disabilities within this age range are carried out or commissioned by the team.

## 4.8 Sensory Impairment Service

## 4.9 Community Mental Health Teams (CMHTs)

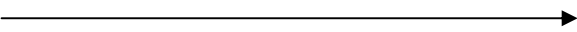
Deal with people:

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<sup>1</sup> Office of Public Sector Information

- who have a primary and or significant mental health need;
- who are on Care Programme Approach (CPA), which will include service users with long and enduring mental health issues;
- who have a high risk of mental health re-admission;
- who have been discharged from mental health in-patient services (and are automatically on CPA).

Adult CMHTs deal with adults aged 18 to 64 years old (inclusive), and Older Adults CMHTs deal with adults aged 65 years or more.

<b>Response Times for Older Adults CMHTs</b>		
<b>Non-Urgent (Moderate)</b>	<b>Urgent (Substantial)</b>	<b>Emergency (Critical)</b>
Seen within 48 hrs – 14 days	Seen within 24-48 hours	Up to 4 hours
Deteriorating Functioning 		
<b>Low Risk</b>	<b>High Risk</b>	<b>Immediate Risk</b>
Service users who: <ul style="list-style-type: none"> <li>• have complex mental health needs, but not requiring immediate intervention</li> <li>• have deteriorating functioning</li> <li>• have fragile carer relationships</li> <li>• require further diagnosis and assessment following advice from multi-disciplinary team.</li> <li>• require joint clarification of issues.</li> </ul>	Service users who: <ul style="list-style-type: none"> <li>• have urgent psychiatric intervention related to complex needs</li> <li>• are at serious risk of harm to self or others (including carers)</li> <li>• may require hospital admission for assessment and treatment</li> <li>• may require best interest / complex capacity assessment or assistance in this decision making process or AMHP to be consulted with.</li> <li>• are at risk of imminent carer breakdown</li> <li>• may be at risk of deterioration if urgent assessment not carried out to revise treatment.</li> </ul>	Service users who: <ul style="list-style-type: none"> <li>• have a need for <i>immediate</i> psychiatric intervention related to complex needs, or</li> <li>• are at serious and immediate risk of harm to self or others (including carers)</li> <li>• may require immediate hospital admission for assessment and treatment – HTT input</li> <li>• may need AMHP assessment</li> <li>• are at risk of immediate breakdown of support from a significant carer.</li> </ul>

AMHP = Approved Mental Health Practitioner

HTT = The Home Treatment Team is a crisis team for older adults, which is aimed at supporting older adults with complex mental health problems in a crisis in the community and to prevent admission to mental health hospital where possible.

#### 4.10 Young Onset Dementia Service

The Young Onset Dementia Service is a coordinated multidisciplinary service for referral, assessment and support of younger people with dementia and their carers

in Kensington and Chelsea and Westminster. Support includes: information and advice, pre/post diagnosis counselling, investigations and diagnosis, assistance with practical and social needs, specialist day hospital support and carer support. There is half a K&C social work post based within the team. The team apply care management procedures in the usual way to service users that they take on.

#### **4.11 Substance Use team**

The SUT works with drug and alcohol users who:

- are over 18 (16 and 17 year olds will be worked with where appropriate); and
- are resident in the borough: those with strong connections in the borough or those who are homeless and meet ordinary residence guidelines; and
- have a current or recent substance use problem which has impacted on their physical health and/or mental health and daily living skills; or
- have a substance use problem together with other complex needs such as health risks, physical disability, cognitive dysfunction; or
- are offenders with substance use problems who are part of the Drug Intervention Programme (DIP).

The SUT aims to:

- enable individuals to access specialist treatment to become drug/alcohol free by providing effective referral, assessment, care planning and care management service;
- provide harm minimisation service to those individuals with complex needs who wish to continue use of their substances;
- negotiate long term packages of care for those individuals in need of continuing care e.g. Korsakoff's syndrome;
- share expertise with non-substance use specialist services;
- offer assessments to carers, including friends and relatives who are concerned about someone they know with a substance use problem.

There is a duty and referral service 10.00am to 1pm Monday to Friday with a voicemail service outside these hours. The team can also be contacted through the Team Support Officer's phone during office hours.

#### **4.12 Joint Homelessness team**

To be added.

#### **4.13 Dual Diagnosis team**

To be added.

#### **4.14 Self-Directed Support (SDS) team**

Offers:

- a specialist support planning resource to help advise practitioners and service users on the elements of employing people through a direct payment - recruitment, employment checks, payroll tax and National Insurance and

financial monitoring support: this includes the writing of and setting up of support plans for service users;

- direct payment audit assessments and reviews to teams where any concerns or issues arise in service user direct payment management;
- advice, information and support to practitioners and service users on all things pertaining to personal budgets.

The team has responsibility for the management of support planning referrals to external providers and for tracking and monitoring the performance, both qualitative and quantitative, of this service.

The team currently supports ASC service users and some Mental Health service users but also has a role in supporting a small number of Families and Children service users.

#### **4.15 Emonitoring team (Home Care)**

To be added.

#### **4.16 Reablement Services**

Deal with all service users who have been assessed as likely to improve their independence through reablement, who are not within the remit of specialist teams. The Reablement Service also includes an occupational therapist who works with any service user of the Reablement Service who needs occupational therapy during their reablement period.

#### **4.17 Intermediate Care team**

The Intermediate Care Team is a new multidisciplinary team bringing together community health services, reablement services and social workers to facilitate hospital discharge and to reduce the likelihood of readmission. They will initially see all people discharged from hospital who initially need some level of social care input and have the potential to increase their independence. The team will include occupational therapists, nurses and physiotherapists and will be able to access speech and language therapists and dieticians. They will work in tandem with the Reablement Service. The service will later expand to include people who have not been in hospital but have the opportunity to avoid hospital admission with the help of a period of clinical and social care support.

#### **4.18 Financial Assessment team**

Carries out financial assessments for adults assessed as eligible for social care.