Prioritisation Tool Introduction, Principles and Guidance:

This guidance document is to support triage and decision making for new referrals, incoming work, and relevant **unallocated** work.

The guide should also be used when considering the people allocated to colleagues who are away from their post for an extended period. (Colleagues absent for 4 weeks or more).

- The tool is to provide consistency across all Prevention and Personalisation Teams, including Occupational Therapy, where it is not possible to immediately allocate to a colleague.
- The aim is to provide a risk assessment and evidence-based decision making to determine the priority in which a worker is allocated.
- It is recognised that all duty points operate slightly differently. It is expected that the duty worker reaches a decision of priority and (dependent on their grade and level of experience, competence, and confidence) should seek appropriate support for the decision in line with their usual practice arrangements.
- Senior Practitioners will support decision making using this tool.
- Service Managers are accountable for all service decisions and are expected to have oversight of the practice and decision making.
- All teams are to use the prioritisation tool for incoming work.
- This will be an additional task in the teams without current waiting lists (where all work can, and is, allocated immediately) it is important from a Departmental Management Team (DMT) risk assessment, demand and capacity perspective to have a line of sight to this.
- All **unallocated work** (that requires input) must be added to a standardised spreadsheet to reflect true demand, risk rating and capacity.
- A standardised spreadsheet will promote consistency and reflect business continuity and assurance. (Some specific work may need to take place between teams who share duty systems).
- The spreadsheet will enable Service Managers to evidence decision making and have access to information to understand demand, trends, patterns, and current numbers awaiting allocation.
- The spreadsheet is in line with current practice and can identify work which needs prioritising in accordance with recommended timescales. This will evidence and prioritise the timescale people are waiting allocation even if needs or risk remain unchanged.

- The spreadsheet is for unallocated work only **not a duty or allocation spreadsheet**.
- Work requiring allocation, which is not a new referral, will enable Service Managers to plan for existing work which may require intervention (e.g., unplanned reviews (unallocated work where there has been a change in need and therefore a review is needed, unallocated overdue planned reviews). Reviews will be on a separate tab for ease of access.
- Work should only be allocated to colleagues who are at work and who it is known have capacity, this will prevent hidden waiting lists on workloads.
- It may be possible to allocate discreet pieces of work when it is not possible to allocate more complex and time intensive work. Service Managers' and teams' judgement will not be queried where there is a clear rationale.
- DMT may ask for capacity to be created to prioritise a certain type of work (e.g., reviewing people in Community Support Beds (CSBs) etc). This tool will evidence the impact additional asks will have on the allocation of high priority work. Service Managers should escalate these concerns via the Group Manager.
- It is important for practitioners to have a balance between reactive and proactive work to manage demand effectively and offer a varied workload.
- Service Managers will have evidence to predict, plan, report and escalate to Group Managers as required.
- **The structure of the spreadsheet should not be changed at any time – this includes changing drop-down lists and adding or deleting columns.**

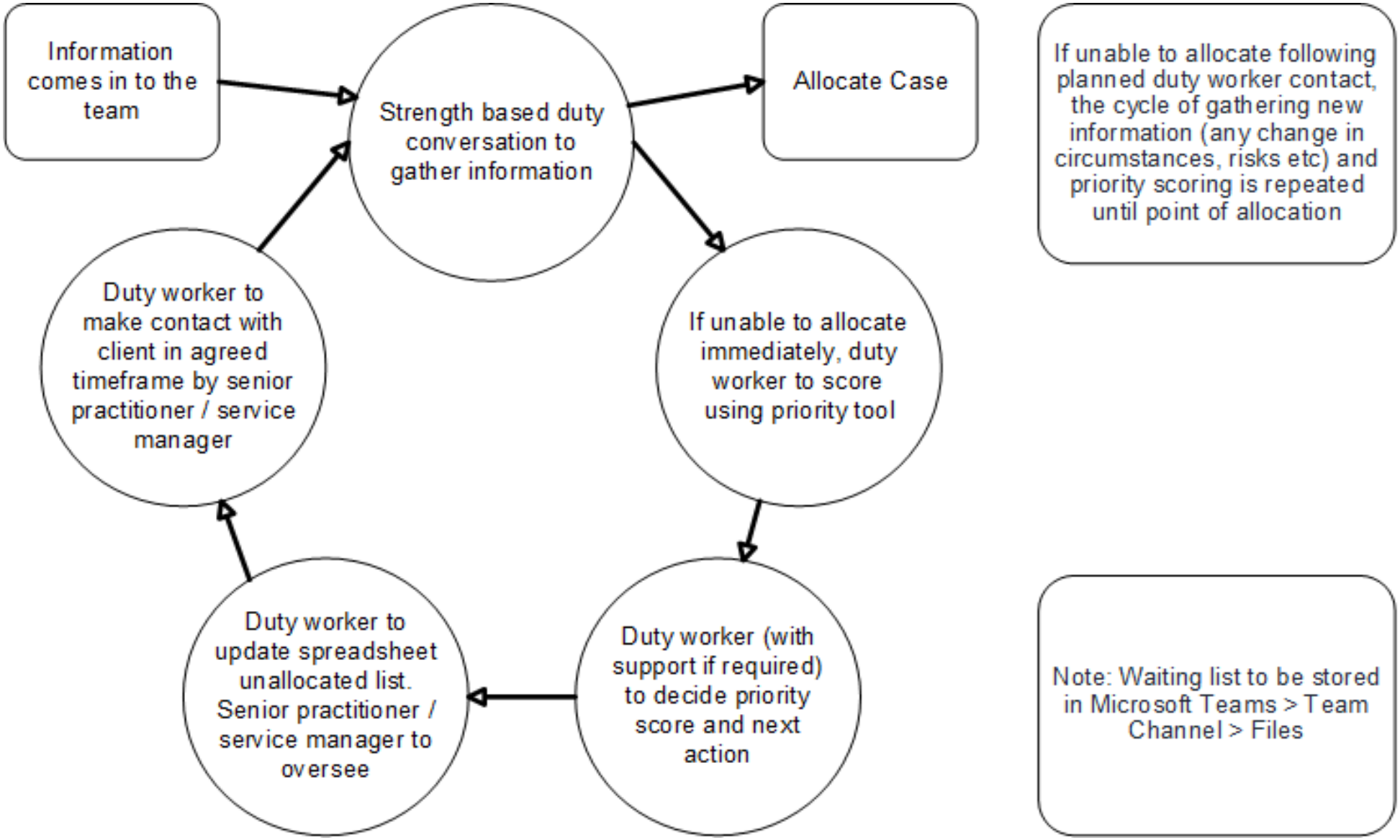
- There is an expectation that all colleagues use their professional judgement supported by the descriptors below:

	Very High	High	Medium	Low
Safeguarding	Life is or will be threatened and/or serious abuse, neglect or coercive control will occur/has allegedly occurred	Person feels unsafe in current environment – escalating concerns of being targeted in local community	Person feels unsafe in current environment – has been targeted on 1 or 2 isolated instances	Person feels unsafe in current environment – No indication of abuse
Activities of Daily Living	Inability to carry out vital activities of daily living and there is no formal or informal network, or there is an imminent breakdown of formal/informal support network. Inclusive of urgent moving and handling assessment, equipment breakdown	Inability to carry out the majority of activities of daily living and there is no formal or informal network, or there is an imminent breakdown of formal/informal support network. Inclusive of moving and handling assessment, equipment breakdown	Inability to carry out the majority of activities of daily living and there are reported difficulties in the informal network, but the formal network is supporting	Struggles with some activities of daily living (safe but takes a long time) and there are reported difficulties in the informal network continuing to provide support. Includes OT assessment for access to gardens.
Care of a child	Parent(s)/carer/guardian with a disability – Indication the parent is Care Act eligible and/or indication that there is risk to welfare of the children – Safeguarding and Children's not involved	Parent(s)/carer/guardian with a disability – Indication the parent is Care Act eligible and/or indication that there is risk to welfare of the children – Safeguarding and Children's actively involved	Parent/carer/guardian with a disability – Indication the parent is Care Act eligible and/or some impact on children – Children's actively involved	Parent/carer/guardian with a disability – informal support in place and/or other professionals involved
Person not Known to Local Authority (LA)	Person not known to LA: Unable despite making relevant enquiries on duty to establish level of risk (no identified formal/informal network)	Person not known to LA: Difficulty in confirming level of risk despite making relevant enquiries on duty (some limited monitoring by other professionals/agency)	Person not known to LA – level of risk identified e.g., self-funder	Person not known to LA – level of risk identified – needs can be met by signposting, advice and information
Accommodation	There is an indication the person is Care Act eligible and there is an immediate need for support to access accommodation, care and support	There is an indication the person is Care Act eligible and there is an urgent need for support to access accommodation, care and support	There is an indication the person is Care Act eligible, and accommodation, care and support appear unsatisfactory in the current accommodation (needs improvement)	There is an indication the person is Care Act eligible but is dissatisfied with present accommodation (based on preference). Also includes Disabled Parking Bays, Dropped Kerbs and Hardstandings.
Engagement	Person not engaging – With an indication that person may lack mental capacity and/or subject to coercion or control	Reluctant to engage/accept support – indication that person may lack mental capacity and/or subject to coercion or control. Imminent risk of lack of engagement	Intermittent lack of engagement with support reported by formal/informal network – indication that person may require further assessment of mental capacity	Person engaging – no concerns about mental capacity nor concerns that the person is subject to coercion or control
Adult Care MDT Contribution	Immediate attendance or input required	Urgent attendance or input required e.g., Community DOL, Decision Support Tool	Planned attendance or input required.	Future attendance being requested.
Transition – Follow PFA/Transition procedures	Child is looked after and approaching 18 with unsustainable or unstable support	Child is preparing for adulthood has an EHC plan and is age 16 years +	Child is preparing for adulthood has an EHC plan and is age 14 years +	Child, family and/or other support require advice, information and signposting
Carers	Person immediately unable to sustain their vital caring role	Person unable to sustain their vital caring role within a week or requires urgent planned break.	Persons caring role is unsustainable within the next month or planned break from caring role required (e.g., carer requires surgery)	Persons caring role is at risk of breakdown.

Note: Impact score x Frequency Score = Priority Score

Frequency → / Impact ↓	Isolated instances or unlikely to happen soon (1)	Infrequent occurrences or may happen soon (2)	Regular occurrence or likely to happen soon (3)	Very frequent and/or imminent (4)
Very High (4)	**(4)** Medium Acceptable Risk Requires Close Monitoring	**(8)**** Medium Acceptable Risk Requires Close Monitoring	**(12)** Very High Unacceptable Risk Immediate action required	**(16)** Very high Unacceptable Risk Immediate action required
High (3)	**(3)** Low Acceptable Risk Requires some monitoring	**(6)** Medium Acceptable Risk Requires close monitoring	**(9)** High Unacceptable Risk Immediate action required	**(12)** Very high Unacceptable Risk Immediate action required
Medium (2)	**(2)** Low Acceptable Risk Requires some monitoring	**(4)** Medium Acceptable Risk Requires Close Monitoring	**(6)** Medium Acceptable Risk Requires Close Monitoring	**(8)**** High Unacceptable Risk Requires Close Monitoring
Low (1)	**(1)** Low Acceptable Risk Requires some monitoring	**(2)** Low Acceptable Risk Requires some monitoring	**(3)** Low Acceptable Risk Requires some monitoring	**(4)** Medium Acceptable Risk Requires Close Monitoring

****Please note, a score of 8 could be either High or Medium Risk, dependant on the Frequency and the Impact risk score. Please ensure you mark the Prioritisation Label accordingly.**



Process for allocating a case:
Diagram begins with box "information comes into the team"
This goes to circle 1 "Strength based duty conversation to gather information"this goes to circle 2 "If unable to allocate immediately, duty worker to score using priority tool" this goes to circle 3 "Duty worker (with support if required) to decide priority score and next action" this goes to circle 4 "Duty worker to update spreadsheet unallocated list.
Senior practitioner / service manager to oversee" this goes to circle 5 "Duty worker to make contact with client in agreed timeframe by senior practitioner / service manager"
This goes back to circle 1.
There are notes to the right of the diagram "If unable to allocate following planned duty worker contact, the cycle of gathering new information (any change in circumstances, risks etc) and priority scoring is repeated until point of allocation"and "Note: Waiting list to be stored in Microsoft Teams > Team Channel > Files"

Anticipated timescales and expectations:

All situations scored as 'very high' priority are to be managed on duty or via immediate allocation.

Priority Level	Allocation Time	Contact Frequency (Minimum)*
Very high	managed on duty/direct allocation	Same day followed by frequency as agreed with the relevant person.
High	2 - 3 weeks	Once every week followed by frequency as agreed with the relevant person.
Medium	4 - 6 weeks	Once every 2 weeks followed by frequency as agreed with the relevant person.
Low	6 - 8 weeks	Once every 4 weeks followed by frequency as agreed with the relevant person.

** These are the minimum expectations of contact unless there are reasonable/mitigating circumstances, arrangements in place or an agreed contingency plan that prevent it (e.g., those receiving STS or awaiting Funded Nursing Care (FNC) review in settled care home placement).*

These expectations on what pertains to each risk category, allocation times, and frequency of contact, will provide teams a baseline to work towards, as well as a level of intelligence in our reporting.

Area Group Managers and Assistant Directors will be provided a position of strategic oversight and will be able to assure, corporately, that we are doing everything we can to manage risk and keep people safe.

Area Group Managers are expected to have an oversight of the allocation lists, working with their teams to ensure there is consistency in risk rating and improvement cycle activity.

FAQs

What is considered a "new referral"?

New referrals would be any of the following:

- A referral for someone not previously known, or not currently open/receiving a service from ASCH. This could come via an online professionals' referral form, ACATT or Call Derbyshire.
- A hospital discharge where the person has not had a previous service from ASCH but has been discharged with a **short-term** service that requires a review and does not have a personal budget.
- A referral for a young person under 18 who requires support and input through the transitions process from Children's to Adult care.

What is considered an "overdue review"?

An overdue review is relating to a person who is receiving a service from ASCH, who's review is overdue, and who does not have an allocated worker to complete this review.

What is considered an "unplanned review"?

An unplanned review is relating to a person who is receiving a service from ASCH, who's review is not due for some time, but due to a change in need or circumstance, requires their review to be bought forward. This could be the result of a call to duty to advise of a change in need, or a hospital discharge where a client has an established package of care which has been increased on discharge and that change requires review.

Do all reviews need to be on the risk prioritisation tool?

No – the tool is for all **unallocated work** that requires allocation. For stable future reviews that are not yet overdue, they do not need to be on the spreadsheet. In that instance, when the review becomes due, **if the review is not able to be allocated due to capacity of the team**, then the referral would go onto the spreadsheet as an **overdue review**.

If a worker is off long term (maternity leave or long-term sickness for example) or leaves the department, do all their cases go on the risk prioritisation tool spreadsheet?

No – not necessarily. As an example, say you have a worker with 30 cases who leaves the team. Of those 30 cases, 15 are stable reviews which are not yet due (so not overdue). Those 15 cases can remain unallocated and in the team future work until the review is due. Of the remaining 15 cases belonging to the departing worker, 10 are allocated immediately by the Service Manager due to the need for immediate input from ASCH. These cases would not go on the spreadsheet either, as they immediately are allocated. The remaining 5 cases are all reviews that are **overdue** but can not be allocated due to capacity in the team. In this instance, those 5 cases would be put on the spreadsheet, and a risk prioritisation label given to them based on their level or urgency.

Where do hospital discharges fall in relation to the spreadsheet?

Where a person has been discharged from hospital or a CSB (Community Support Bed) with a new service (this could be a package of care or residential or nursing placement), and they **do not already have a service via ASCH**, this would be considered a **new referral**.

Where a person has a previous placement or package of care, but this has been amended or changed on discharge, this would be an unplanned review. For example, a person has a previously package of care with 4 calls a day but has been discharged to a residential placement – this would be an unplanned review.

What should we do when the case has been allocated?

Once a case has been allocated, it can be deleted off the spreadsheet as it is no longer unallocated. You can do this by deleting the row of the spreadsheet.

How do we ensure that low and medium level cases are allocated and not left waiting? What happens if a case is not allocated by the allocation deadline?

The risk prioritisation tool is a tool to support with management of waiting lists. When allocating work, a Service Manager/Senior Practitioner is able to filter the unallocated cases by level of priority.

It may be that Service Managers focus on allocating the high and very high priority cases first. Following this, if there is capacity in the team to take on additional allocations, the spreadsheet can be filtered to show medium or low cases, allowing the Service Manager to allocate some of those cases, using date the referral is received to allow for allocation of cases that have been waiting longer first.

This should reduce the issue of low and medium risk cases being left waiting for longer because they are lower risk.

You do not need to change the prioritisation label based solely on the allocation deadline being missed. Risk prioritisation label should only be changed if there is a change in need/circumstances.

Where do tech aids, OT non-complex and OT Complex cases go? Do cases that are picked up by SCPs go on the OT spreadsheet?

ALL tech aids, OT non-complex and OT complex cases should go on the OT risk prioritisation spreadsheet, even if SCPs can/are picking up some of these cases.

If a social care worker is sending an "additional worker referral" via mosaic, this should be treated as a new OT referral and, if unable to allocate immediately, should be put on the OT prioritisation tool like any other referral.