Report of the Director of Adults and Community Wellbeing

Decision to be taken after: 20 April 2017

NORTH LINCOLNSHIRE COUNCIL

ADULT'S AND FAMILIES CABINET MEMBER

STATEMENT OF PURPOSE – INTERMEDIATE CARE CENTRE

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 To seek the Cabinet Member approval to publish the revised Statement of Purpose for the Intermediate Care Centre.

2. BACKGROUND INFORMATION

2.1. The council is legally required to produce a Statement of Purpose for any registered services it provides in accordance with Care Quality Commission (Registration) Regulations 2009.

2.2 The Intermediate Care Centre is a registered service provided by the Council Adult Services and as such is required to regularly review and submit a Statement of Purpose for inspection purposes.

2.3 Sir John Mason House, is a registered Intermediate Care Centre, providing time-limited rehabilitation and reablement therapies and support in a purpose built residential setting.

2.4 The centre opened in May 2015 following £3.3 million investment from the Council and prevents people who are medically fit for discharge being delayed in Hospital.

2.5 The Service is provided by a team of social and health care staff, who work together to provide a programme of support and therapies to achieve a person's goals to get home and live as independently as possible.

2.6 The service works with individuals, and their friends and families, to improve mobility and health needs, help with daily living activities, practical tasks and develop the confidence, strength and skills to carry

out these activities independently to enable people to continue to live at home.

2.7 A statement of purpose is a legally required document that includes a standard set of information about a provider's service. Statements must describe:

- The provider's aims and objectives in providing the service.
- Details of the services provided
- The health or care needs the service sets out to meet.
- The provider's and any registered managers' full name(s), business addresses, telephone numbers and email addresses.
- Details about the legal status of the provider (for example, whether they are an individual, company, charity, or partnership).
- The address CQC must use to send formal documents to registered providers and managers.

2.8 The Statements of Purpose are also available to: -

- Each person who works within the Intermediate Care Centre, both social care and health staff.
- People provided with support and services by the Intermediate Care Centre.
- All carers or family members of people provided with support and services by the Intermediate Care Centre.

3. OPTIONS FOR CONSIDERATION

3.1. **Option 1** - Approve the publication of the Statement of Purpose for the Intermediate Care Centre based at Sir John Mason on the Council website.

3.2. **Option 2** –The Statement of Purpose for the Intermediate Care Centre based at Sir John Mason House is submitted to CQC but not published on the website.

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4. ANALYSIS OF OPTIONS

4.1. **Option 1** – Approve the Statement of Purpose - This option will ensure we meet our legal requirements under the Care Quality Commission

(Registration) Regulations 2009. It will also enable us to provide a detailed account of the aims and objectives of the Intermediate Care Centre to social care and health staff, people who use the service and their circle of support.

4.2. **Option 2** – This will mean that the information we provide to those who work in, or use, the Intermediate Care Centre is retained within the service.

5. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY, IT)

5.1. No implications.

6. OUTCOMES OF INTEGRATED IMPACTASSESSMENT (IF APPLICABLE)

6.1. Statutory Implications - Adult Services is responding to the Care Quality Commission (Registration) Regulations 2009 that every registered care facility provides a Statement of Purpose.

6.2. Environmental implications – None

6.3. Diversity implications – None

6.4. Section 17 – Crime and Disorder implications – None

6.5. Risk and other implications – None

7. OUTCOMES OF CONSULTATION AND CONLICTS OF INTERESTS DECLARED

7.1. Consultation with staff members across the Intermediate Care Service, took place and the information provided influenced the content of the Statement of Purpose.

7.2. The views of the Diversity Officer and other professionals were also obtained and contributed to the development of the Statement of Purpose

8. RECOMMENDATIONS

8.1. The Cabinet Member supports the publication of, the Statement of Purpose for the Intermediate Care Centre on to the Council website.

Director of Adults and Community Wellbeing
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Ashby Road
SCUNTHORPE
North Lincolnshire
DN16 1AB
Author: Karen Pavey
Date: 13 January 2017

Background Papers used in the preparation of this report:

People Directorate

NORTH LINCOLNSHIRE COUNCIL
www.northlincs.gov.uk

Vision – Safe Supported Transformed

Adult Social Services Statement of Purpose

Intermediate Care Service

Intermediate Care Centre, Sir John Mason House

Contact Details:

North Lincolnshire Council
Intermediate Care Centre
Sir John Mason House
42 De Lacy Way
Winterton
Scunthorpe
North Lincolnshire
DN15 9XS

Tel: 01724 298444 (24hrs)

Service Manager – Marian Davison
Head of Service – Wendy Lawtey

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1. Quality and purpose of care

1.1. Introduction

This Statement of Purpose is written in accordance with Care Quality Commission (Registration) Regulations 2009.

The statement is produced by the Registered Manager on behalf of North Lincolnshire Council People's Directorate.

Reference is also made within the document to a series of North Lincolnshire Council, Adult Services policy documents, which can be read in conjunction with this statement. These documents are all available in full at www.northlincs.gov.uk

This document is created for submission to the Care Quality Commission as part of North Lincolnshire Adult Services' legal responsibility to produce a Statement of Purpose for any registered services it provides, in accordance with Care Quality Commission (Registration) Regulations 2009. We are also aware that other people would find this document useful and therefore we also make it available to: -

- Each person who works at the Intermediate Care Centre, Sir John Mason House.
- People provided with support and services at the Intermediate Care Centre, Sir John Mason House.
- All carers or family members of people provided with support and services at the Intermediate Care Centre, Sir John Mason House

The Intermediate Care Centre, Sir John Mason House is a registered Rehabilitation and Reablement Centre, providing time-limited rehabilitation and reablement therapies and support in a purpose built, 30 bed, residential setting.

This document aims to provide a detailed account of the services provided at the Centre in line with Care Quality Commission (Registration) Regulations 2009.

This document will provide a clear picture as to our overall aims and objectives in terms of providing the optimum standards of care support to achieve a person's goals to live as independently as possible.

This document is available to people who use the service and their families and any other professional agency with a legitimate link or enquiry about the Intermediate Care Centre. It is a requirement that every member of staff remains fully conversant and up to date with the contents and meaning of this document.

The Registered Manager regularly reviews the Statement of Purpose and associated policies in relation to the Intermediate Care Centre, Sir John Mason House.

1.2. Ethos and Philosophy

We strive to deliver support that puts people at the centre of our services. We will ensure that we keep the person at the heart of our service and take their whole wellbeing into account. We aim to ensure that when a person returns home, they feel confident, safe and ready to return to independent living.

We will enable people to feel confident and supported when taking managed risks, enabling them to develop the strength and skills to maximise their ability to live independently.

We will treat everyone as an individual and encourage them to maximise their intellectual, social and physical potential.

We will strive to preserve and maintain dignity, individuality, privacy and remain sensitive to a person's ever-changing needs.

We will, at all times, treat people with care and compassion and respond to people in a courteous, caring and respectful way.

We will offer services that ensure everyone has equal access to care and support and equality is demonstrated in the behaviours of all staff working in the integrated service. Staff from across health, social care and other partner agencies, work together to promote and develop care and support that is personal, fair and diverse.

We will work with a person to identify and achieve their potential through identifying the outcomes and goals that are important to them to maximise their independence. This will form the basis of their care and support plan, and will be reviewed with them on a regular basis, to assess and adjust the support they need to achieve their goals.

We identify a person's 'Circle of Support' as families, friends, carers, loved ones or others that provide care and support to an individual. We encourage a person to appropriately involve their Circle of Support in decisions made during their recovery process. We work inclusively to ensure all views, goals and circumstances are taken into account and they feel fully supported and empowered during their rehabilitation programme.

We believe that being part of a community and having a network of support can empower people to live healthy and fulfilling lives, supporting their health and emotional well-being. We work to ensure that when a person leaves the Intermediate Care Centre they have a network of support in place. Opportunities to develop that network further through the Community Wellbeing Hubs and other community activities and services, and where appropriate we will work with individuals and their Circle of Support to confidently access these services.

1.3. What is the Intermediate Care Centre?

The Intermediate Care Centre, is part of North Lincolnshire Council's Adult Social Care support offer, and is located within Sir John Mason House in Winterton. The Centre provides time-limited, rehabilitation and reablement support.

A person may need support after a stay in hospital, or a period of illness, to regain the physical strength and daily living skills needed to restore their independence, enabling them to remain living in their own home.

The service can also be accessed by individuals who are unwell and live in the community but would benefit from rehabilitative support in the Intermediate Care Centre.

The Centre is an integrated social care and health service, where a team of professionals from across Adult Services and the Health Service, provide programmes of intensive therapy and care in a purpose built, 30 bed, residential setting.

The team includes social care staff, occupational therapists, physiotherapists, district nurses and general practitioners from social care and health. By working in an integrated way we are able to:

- deliver support plans that bring together services to achieve the outcomes important to each individual
- improve transition between health and social care services
- communicate effectively to people accessing support services
- ensure effective, timely and inclusive decision making between social care and health

1.4. Core Functions

We work with people and their Circle of Support to develop a programme of support to improve mobility, meet health needs, help with daily living activities, practical tasks and develop the confidence, strength and skills to carry out these activities independently to enable people to continue to live at home.

We work in partnership with other social care and health professionals to prevent avoidable admission to hospital and facilitate appropriate early discharge.

1.5. Aims and objectives

Our goal is to provide a service that is fully person-centred, supporting people's physical, emotional and social needs to improve and develop their whole wellbeing.

We ensure that everyone has equitable opportunities to live the best lives they can with the fewest restrictions, irrespective of their individual backgrounds or circumstances. We use our values, influence and responsibility to engender high ambitions for vulnerable adults across our partner agencies - so that all adults

achieve excellent outcomes. We aim to ensure that all adults have the opportunity to reach their maximum independence after a period of illness or injury.

We are striving to ensure that at every stage of the journey individuals:

- feel safe and are safe
- enjoy good health and emotional wellbeing
- recognise and achieve their potential

The Intermediate Care Centre is a multi-disciplinary service that focuses on maximising long-term independence, choice and quality of life, simultaneously attempting to minimise on-going support.

We aim to:

- improve health and well-being outcomes
- promote independence
- increase and sustain daily living skills
- support carers to continue to care

We aim to enable independence, ensuring individuals are supported actively to take managed risks to build confidence and increase independence. We want individuals to live and thrive within their communities and will support them to regain the skills and support networks they need to live at home.

1.6. Service Description

Private Facilities

- The Intermediate Care Centre is modern care facility equipped to support and enable our guests to get back to independent living.

- We have 30 bedrooms all with en-suite bathrooms, TV and furnished to a high standard to ensure comfort and safety.

- Each room has a lockable cupboard for personal items and medication.

- Each guest can have a key to their own room (unless a risk assessment states otherwise).

- Hoists are available to assist with bathing and a “whirlpool” type bath is available.

- Toilets are fitted with grab rails and raised toilet seats are available to enable people to use the facilities independently. Commodes are available if people are assessed as requiring one.

Communal Facilities

- We have a communal lounge with TV, radio, CD player, books and board games.
- There is a private garden to sit and relax in.
- There is a large dining room where our team offer home cooked meals.
- A smaller dining room where people can take their meals in a quieter environment
- A kitchen where a person and/or their visitors can make their own snacks and refreshments and where kitchen assessments will take place
- There is a cordless phone for people to receive calls
- We provide laundry facilities and people are encouraged to do their own laundry or allow family or friends to help them
- We have a supply of library books, talking CDs and mp3 players that are refreshed by the council's library service every few months
- There is a free WiFi service available for all to use.
- We have several IPads and IPods that can be used to listen to music, entertainment, emails and access the internet
- There is a mobile scooter for guests to try to see if this might be the type of equipment that could help them when they return home.
- Guests can take part in a variety of recreational and physical activities. The activities may include book clubs, 'knit and natter' groups, dominoes, music sessions, concerts and plays put on by visiting schools and colleges and other theatre groups, various talks and presentations.

Services

- We complete a 'needs assessments' in partnership with individuals and their families, to plan what services would help a person retain or regain their physical health and social care needs. Assessments ensure they are responsive to people's preferences, aspirations and choices.
- Needs assessments are carried out with the purpose of exploring support which will enable people to remain independent using the The Care and Support (Eligibility Criteria) Regulations 2014 - The Care Act 2014.

- We arrange emergency placements to support early discharge from hospital and to ensure the discharge is safe to take place. Following emergency placements an assessment is completed to ensure a rehabilitation and reablement placement is appropriate.

- Documentation provided to individuals, for example, a Residency Contract and Welcome Guide, is discussed and manages the person's expectations of the service provided and how they will contribute to their rehabilitation.

- Individual support plans, which include programmes of care and therapy plans are completed in partnership with individuals and their family / carers (circle of support) to ensure the support and therapies we provide are personalised, effective at an individual level to achieve good outcomes and maximise independence.

- We monitor and review support packages on a weekly basis. We work in partnership with our multidisciplinary team, the individual and their circle of support, reducing services as appropriate to enable an individual to regain maximum independence.

- Upon discharge we provide advice and information to enable people to have choice and control over their own lives and to make good decisions about care and support.

- Where necessary we make referrals to other health and social care services, enabling individuals to regain/ maintain independence. We introduce people to wellbeing hubs to access activities in their local community, reducing social isolation.

- After discharge we share information about alternative private and voluntary services and support organisations that may also meet people's needs, and which could prevent them from becoming more dependent on services and delay the need for longer term support.

2. Care planning

2.1. Admission criteria

This service is available to people who are:

- Over 18 and live in North Lincolnshire or are registered with a North Lincolnshire GP
- Are willing and able to take part in a social care programme of support to improve daily living skills; and
- Are willing and able to take part in a therapy care programme to improve mobility and physical health
- Are in hospital and medically fit for discharge
- Are able to be supported in the Intermediate Care Centre and could therefore avoid an admission to hospital
- Meet the Care and Support (Eligibility Criteria) Regulations 2014 (see below).

The Care and Support (Eligibility Criteria) Regulations 2014 within the Care Act 2014 states the eligibility criteria for adults who need care and support are:

An adult’s needs meet the eligibility criteria if—

- the adult’s needs arise from or are related to a physical or mental impairment or illness;
- as a result of the adult’s needs the adult is unable to achieve two or more of the outcomes specified below, and
- as a consequence, there is, or is likely to be, a significant impact on the adult’s well-being.

The specified outcomes are:-

- managing and maintaining nutrition;
- maintaining personal hygiene;
- managing toilet needs;
- being appropriately clothed;
- being able to make use of the adult’s home safely;
- maintaining a habitable home environment;
- developing and maintaining family or other personal relationships;

For the purposes of this regulation an adult is to be regarded as being unable to achieve an outcome if the adult:-

- is unable to achieve it without assistance;
- is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety;
- is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or
- is able to achieve it without assistance but takes significantly longer than would normally be expected.

2.2. Assessment

Requests for admission to the Intermediate Care Centre are assessed using a multi-agency approach. This approach brings together both the social care and health needs of a person allowing an assessment to consider the whole of a person's needs and ability to benefit from rehabilitation and reablement therapies and support. As shown in the Care and Support (Eligibility Criteria) Regulations 2014, a need for rehabilitation and reablement may not always arise from a medical condition. Therefore, the final decision to offer services at the Centre remains with Adult Social Care to ensure support is given to all who meet the regulations and would benefit from a period of rehabilitation and reablement.

The person is fully involved in their assessment and family, loved ones and carers are also included to allow all views, goals and circumstances to inform the assessment process.

2.3. Care and support plan

Individual support plans are co-produced with each person to ensure their views, personal goals and desired outcomes are included and implemented. The plan will include how they wish to be spoken to, how cultural needs can be met and their preferences and dislikes. This empowers people to have choice and control over the support they receive and enables staff to work with empathy and compassion, have a deeper understanding of the people they support and provide a service that is caring, person-centred and culturally appropriate.

We appreciate the valuable input families, friends and carers can provide in a person's recovery, and always encourage their opinions and support when developing a support plan and reviewing a person's individual needs. The plan will remain person-led.

Our multiagency approach allows people's health and social care needs to be fully supported. Our integrated staff team work to ensure people's physical needs and emotional wellbeing are fully considered and supported during their recovery.

Support plans are continually assessed in full partnership with the individual and their circle of support. A multiagency meeting once a week, or more frequently if required, gives time to reflect on the goals and outcomes set and consider if they are being achieved and any adjustments made.

If the service is unable to meet an individual's needs, a multidisciplinary meeting will be held with the individual and their circle of support to find an alternative solution.

There is no charge for rehabilitation and reablement support for the first six weeks of a programme. A programme may be provided partly from the Intermediate Care Centre or, for a proportion of those six weeks, provided at home by the Community Support Team. Together they cannot exceed six weeks. After this period, if further

support is required, we will discuss with the individual, and their circle of support, fees payable and carry out an assessment of contribution to the cost of support.

2.4. Return to independent living

The purpose of the Intermediate Care Centre is to support people to regain the physical strength and daily living skills needed to return to independent living.

We work as a multidisciplinary team with the individual and their circle of support, adjusting support as appropriate to enable an individual to regain maximum independence.

Upon discharge, we provide advice and information to enable people to make informed decisions about care and support and help prevent them from becoming more dependent on services or delay the need for longer term support.

We make referrals to other social care and health services which can assist a person remain independent. We introduce people to community wellbeing hubs to access activities in their local community, promoting inclusion and reducing social isolation.

Home visits are arranged to support safe transition home and links established with universal services, to ensure people remain safe and risks are minimised in and around the home.

3. Views and wishes

3.1. Involvement of individual, family and carers (Circle of Support)

We encourage the complete involvement of a person throughout their care and support at the Intermediate Care Centre. This involvement starts with their first assessment of care needs.

Involvement continues when a person first arrives at their 'welcome meeting' which helps them, and their circle of support, understand the services, environment and care objectives of the Intermediate Care Centre in more depth. A plan for returning home, and what needs to be in place for this to happen, is first discussed at the 'welcome meeting' and this topic is returned to throughout a person's stay. This ensures independent living remains a core goal. This meeting also helps us to develop our understanding of each person as an individual, and their wishes and goals for regaining their independence.

We develop the support plan in partnership with the individual and their circle of support to ensure they are fully involved in identifying the outcomes required and adjustments needed to enable them to get back to health and therefore back home as quickly and safely as possible.

Records and support plans are available to the person receiving support, and are always open to scrutiny and comment.

3.2. Feedback

As part of our quality assurance we send a questionnaire to individuals and their family and carers during their stay. This enables us to understand what their experience of the service is like for them, if their outcomes and goals are being achieved and if they have suggestions for changes or improvements to the service.

Questionnaires are also sent to a random selection of individuals after they leave the Centre to establish impact on people in the longer term.

We use these views and comments to evaluate the service to ensure it is achieving its aims and objectives. They inform and influence any improvements and development of services to enhance our offer to the people of North Lincolnshire.

Feedback and comments help inform and develop the service we deliver. Each person is informed of the formal complaints process at the welcome meeting. People are encouraged to make comments, suggestions and complaints through a variety of means.

- They can raise a concern with a member of staff verbally as the issue arises,
- use a feedback form placed in their room at any point in their stay with us,
- complete a complaints / compliments form either after or during their stay,
- or fill out the surveys and questionnaires that are sent to a person and their family / loved ones after they have left the Centre.

4. Health

4.1. Physical health

Our multi-agency approach provides both social care support and health therapies to support a person to return to physical independence.

Our social and health care professionals support people to regain skills they may have lost through illness. They will provide a mixture of health therapies and social care support to help them achieve their goals to live as independently as possible. These may include:

- support to improve mobility and health needs
- help with daily living activities and practical tasks
- building confidence to carry out these activities
- working with health professionals to maximise therapy plans.

We have a contract with a general health practitioner service to provide support for general health needs of people staying with us.

We support people to make arrangements to see specialist practitioners, such as a dentist, chiropodist, optician or audiologist.

4.2. Social and wellbeing

All support plans consider the social and wellbeing health of a person. Views and suggestions given by an individual's Circle of Support are always valued.

Whilst a person is resident at the Centre they are encouraged to participate in the available social and wellbeing activities and opportunities.

People are encouraged to take their meals in one of the two dining rooms, giving opportunity to interact with other people who are receiving support at the Centre.

There are group activities to encourage physical exercise and social interaction, for example, chair based exercises, concerts and craft activities to build independence and improve wellbeing.

We encourage people to join in the activities that are taking place in the adjoining Community Wellbeing Hub, and will support a person to do this.

When a person leaves the Centre, we provide information and advice on community activities within their area and will link with other services that can support them to feel confident accessing these services.

We discuss the person's Circles of Support and explore how these networks might help to keep people healthy and included in their community.

Where a person has no personal network of support we will work with them to put in place a support network, which may include support to attend their local Community Wellbeing Hub, reducing social isolation.

4.3. Medication

Our Medication policy is kept live and up to date by our Medication Champion. This ensures everyone takes responsibility for the safe administration of medicines in the centre. The policy ensures audits are carried out regularly and in the event that an error occurs a learning review is quickly undertaken to immediately record and rectify the situation.

Controlled drug audits are also completed and our Medication Champion liaises with the local Clinical Commissioning Group Intelligence Officers.

Risk assessments are completed and establish whether someone is an administer assist or can self-medicate. This is reviewed regularly and adjustments made if necessary.

5. Safe Safeguarding Champion

5.1. Managed risks

We work to ensure people feel safe and are safe and are supported in taking managed risks and building confidence to return safely home.

We achieve this through our person-centred approach to a person's recovery, ensuring they are completely involved and consulted on their Support Plan, they have choice and control over what goals they would like to set and achieve, and are continually encouraged to take up new opportunities that will improve outcomes and general wellbeing.

5.2. Safer Recruitment

The service is well supported by the council's Human Resources Department. The Council's Safer Recruitment policies and processes ensure all staff have DBS clearances, which are reviewed and updated every three years. References for all employees are taken and any gaps in employment thoroughly explored.
The Adult Services Workforce Team provides mandatory and statutory training and all staff are trained in adult protection as well as child protections awareness.

5.3. Adult Protection

Safeguarding is embedded in the policies and procedures of the Centre. Our policies reflect the local Safeguarding Adults policies and procedures. This is a multi-agency document endorsed by the North Lincolnshire Safeguarding Adults Board. It describes how all partners work together to safeguard vulnerable adults in North Lincolnshire. It is

The Safeguarding Adults Board promotes and audits effective partnership working across North Lincolnshire and is made up of representatives from key partners who are responsible for the health and wellbeing of the public, for example, health, police and social care organisations.

We have implemented the principles of 'Making Safeguarding Personal', which enables adults at risk of harm to be encouraged to identify desired outcomes and what steps they can take to change their situation and to be safe and involved throughout the safeguarding process.

The centre is a 'space of safety' for anyone to feels unsafe to call and seek help or advice.

The Herbert protocol is used to capture personal details for all our guests in the event anyone gets lost in the area. The protocol includes a photograph being taken within four hours of arrival and staff are trained in its importance in helping to keep people safe. The protocol is shared with individuals and loved ones at the welcome meeting.

5.4. Health and safety

We are well supported by the Council's Health and Safety Team and Procedures for building and personal awareness. Training is given and updated regularly for all members of staff. Accident recording systems are in place for guests, visitors and staff members.

Individuals, visitors and staff have a responsibility to keep themselves and others safe when using the facilities provided.

Infection control procedures are in place and regularly reviewed. The service accesses specialist support if necessary.

Business continuity plans are in place and mandatory exercises occur every three years.

6. Leadership and management

Registered Provider
North Lincolnshire Council. Civic Centre. Ashby Road. Scunthorpe. North Lincolnshire. DN16 1AB
Responsible Individual
Marian Davison Hewson House. Station Road. Brigg. North Lincolnshire DN20 8YE
Registered Manager
Jackie Campbell Intermediate Care Centre Sir John Mason House De Lacy Way Winterton North Lincolnshire DN15 9XS

6.1. Staffing of Intermediate Care Centre

The number of staff required on duty by day is determined by the occupancy of the building, any assessed risks and the time of day.

Number of care staff required on duty during the day and evenings	
Number of care staff on duty during the day 8am – 11pm	4/5 care staff
Number of care staff on duty during Night 10-45pm – 8am	3 care staff
Number of ancillary staff 8am – 6pm	1 fte staff member
Number of catering staff	1.5 fte staff members

The table above shows the number of social care staff on duty. In addition to this a number of health care professionals are present at the Centre delivering health therapies. This staff group will consist of:

- Physiotherapists
- District Nurses
- Occupational Therapists
- General Practitioners – contracted to the Centre 'as needs arise'

6.2. Supervision

North Lincolnshire Adult Services requires the regular and meaningful supervision of all staff. Regular supervisions give the opportunity to address issues, promote a positive culture and improve the overall quality of service delivery. Staff receive regular reflective supervision. The performance review model encompasses how and individual can have an impact on the priorities of the service and wider council by demonstrating working towards the following priorities:

- ENABLE communities to thrive and live active and healthy lives
- SUPPORT safeguard and protect the vulnerable
- SHAPE the area into a prosperous place to live, work, invest and play
- COMMISSION to improve outcomes for individuals and communities
- TRANSFORM and refocus, ensuring we remain a dynamic and innovative council

The Council's Code of Conduct on employment is given to, and discussed with, all members of staff.

Supervision and Whistle Blowing procedures ensure staff can raise any concerns.

6.3. Induction and training

Staff receive an initial induction including safety training:

- Adult protection responsibilities
- Safeguarding awareness
- Mental Capacity Act and Deprivation of Liberty basic awareness
- Health and Safety Awareness

Annual training plans include:

- Health & safety risk assessments/IOSH training
- Safeguarding
- Medication
- MCA DoLs
- Moving and handling
- Diversity
- Data protection

Mandatory medication training is provided for staff with annual updates. A Medication Champion advises staff members, monitors training attendance and identifies areas for training.

Moving & Handling Champions carry out risk assessments, advise staff and monitor training. They receive and disseminate updates.

6.4. Resources

£1.2m budget

6.5. Organisational Structures

North Lincolnshire Adult Social Services

Team Manager

Registered Care Coordinators

- Care Workers (Day)
- Care Workers (Night)
- Care Assistants (Day)
- Care Assistants (Night)
- Housekeeping
- Admin Assistant

North Lincolnshire and Goole NHS Foundation Trust

NHS Managers

- District Nurses
- Occupational Therapists
- Physiotherapists
- GP Practice

6.6. Internal Governance Framework