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 – COMMUNITY SUPPORT TEAM

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 To seek Cabinet Member approval to publish the revised Statement of Purpose for the Community Support Team on the council website.

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 Community Support Team 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 The Team is part of a registered Rehabilitation and Reablement service, providing time limited rehabilitation and reablement therapies and support in people's own homes.

2.4 The service works with individuals, and their friends and families, to develop a programme of intervention 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.

For example; following a lengthy stay in hospital a 77 year old gentleman was supported by this service to regain his confidence at home. He continues to live independently in his own home and with the help of this service attends the local Wellbeing Hub and has increased his circle of friends and contacts to prevent loneliness.

2.5 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.

2.6 The Statements of Purpose are also available to: -

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

3. OPTIONS FOR CONSIDERATION

3.1. **Option 1** - Approve the publication of the Statement of Purpose for the Community Support Team on the council website.

3.2. **Option 2** –The Statement of Purpose for the Community Support Team is submitted to CQC but not published on the council website.

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4. ANALYSIS OF OPTIONS

4.1. **Option 1** – Approve the publication of 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 the service to provide a detailed account of the aims and objectives of the Community Support Team 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 Community Support Team 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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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

Community Support Team

Contact Details:

North Lincolnshire Council
Community Support Team
Sir John Mason House
42 De Lacy Way
Winterton
Scunthorpe
North Lincolnshire
DN15 9XS

Tel: 01724 298190 (24hrs)

Service Manager – Kelly Wigham
Head of Service – Wendy Lawtey

Content

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 in the Community Support Team
- People provided with support and services by the Community Support Team.
- All carers or family members of people provided with support and services by the Community Support Team

The Community Support Team is a registered Rehabilitation and Reablement service, providing time limited rehabilitation and reablement therapies and support in people's own homes.

This document aims to provide a detailed account of the services provided by the Service 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 service users and their families and any other professional agency with a legitimate link or enquiry about the Community Support Team. 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 Community Support Team.

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 a person can remain at home and feel confident, safe and able to live independently, without the need for ongoing care support.

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 Community Support Team?

The Community Support Team is part of North Lincolnshire Council's Adult Social Care support offer. Staff work across the community providing rehabilitation and reablement services in an individual's home, or place of choice. The team 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 their own home.

The Community Support Team is part of the North Lincolnshire Council, Adult Services Intermediate Care Service, providing an integrated social care and health service to residents across the North Lincolnshire Region. A team of social care and health professionals from across Adult Services provides programmes of intense therapy and care in a person's own home.

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 to people who need support effectively and work as one team
- 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 social care 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 they:

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

The Community Support Team 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 remain living at home.

1.6. Service Description

- We arrange emergency placements out of hours, or at a time of crisis, and support appropriate early discharge from hospital and to ensure the discharge is safe to take place.

- We complete a 'needs assessment' in partnership with service users 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 and keep them at the centre of everything we do.

- 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.

- Documentation provided to individuals, for example, a 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 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 the individual and their circle of support, reducing services as appropriate to enable an individual to regain maximum independence.

- Our Roving Nights and Out of Hours teams work to keep our community safe by working with other agencies, including the health service and the police, in dealing with crises such as carer breakdown, homelessness, domestic violence, safeguarding concerns and home closures.

- Upon completion of services 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 them to regain/remain independent. We introduce people to wellbeing hubs to access activities in their local community, reducing social isolation.

- After completion of services 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.

- Where further eligible social care needs are identified, we refer to the appropriate network for full assessment of needs.

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 their own home 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 support by the Community Support Team are assessed using a multi-agency approach. This approach brings together both the health and social care 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 Community Support Team services 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 their circle of support is 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 service user'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 staff team work to ensure people's physical needs and emotional wellbeing are fully considered and supported during their recovery.

Support plans are continually reviewed in full partnership with the individual and their circle of support. A progress 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 inclusive of the 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, supported 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 carryout an assessment of contribution to the cost of support.

2.4. Return to independent living

The purpose of the Community Support Team is to support people in their own homes to regain the physical strength and daily living skills needed to remain living independently.

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

Upon completion of services 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 health and social care services which can assist a person remain independent. We introduce people to community wellbeing hubs and support them to access activities in their local community, promoting inclusion and reducing social isolation.

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 Community Support Team programme of rehabilitation and reablement. This involvement starts with their first assessment of care needs.

A plan for regaining independence is discussed, and what needs to be in place for this to happen, and this topic is returned to throughout a person's programme of support. This ensures the main goal of independent living remains a core goal. This 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 remain at home as independently 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. Reviews

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

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.

3.3. Feedback

Feedback and comments help inform and develop the service we deliver. Each person is informed of the formal complaints process when services start. 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 by telephone or in person,
- complete a complaints / compliments form either after or during the period of their support,
- or fill out the surveys and questionnaires that are sent to a person and their circle of support after the completion of their programme of rehabilitation and reablement.

- Discuss any issues at the ‘exit meeting’ where we can discuss the experiences of the individual throughout the rehabilitation and reablement process.

4. Health

4.1. Physical health

The Intermediate Care Service, Community Support Team, is an integrated service of health and social care professionals. 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 social care support and health therapies 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 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 supported by the Community Support Team they are encouraged to participate in the available social and wellbeing activities and opportunities in their local area. We encourage people to join their local Community Wellbeing Hubs and take part in the activities that are offered there. We will support a person to do this if required.

When a person's rehabilitation and reablement support is complete, 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 ensures everyone is fully informed and takes responsibility for the safe administration of medicine, including controlled drugs. 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.

The Community Support Team will support people to take any medicines that have been prescribed by a doctor, if required.

Risk assessments are completed to established if a person is able or wishes to self-medicate or if assistance is needed. This is reviewed regularly and adjustments made if necessary.

5. Safe

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 protection awareness.

5.3. Adult Protection

Safeguarding is embedded in the policies and procedures of the Community Support Team. 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 embedded in the policies and procedures of the Centre.

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.

5.4. Health and safety

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

We carry out risk assessments on any equipment we use to help support people in their home. If the equipment belongs to the individual the responsibility for maintaining the equipment to ensure its safety remains with them.

Infection control procedures are in place and regularly reviewed. The service will access 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 Community Support Team Sir John Mason House De Lacy Way Winterton North Lincolnshire DN15 9XS 01724 298190

6.1. Staffing of Community Support Team

The number of staff required on duty by day is determined by the number of people requiring support, any assessed risks and the time of day.

Number of care staff required on duty during the day, evenings and overnight	
Staff	**Hours**
Team Manager x 1	08:30 to 17:00
Community Support Coordinators x 1	6:45 to 15:15 14:45 to 23:15 23:00 to 07:00
Duty Officers x 1	06:45 to 3:15 08:30 to 17:00 14:45 to 23:15
Support Workers x 24 (including 2 duty support workers)	07:00 to 13:30
Support Workers x 16 (including 2 duty support workers)	16:00 to 22:30
Support workers x 2 (Duty)	10:00 to 16:30
Support worker nights x 4	23:00 to 07:00
Operational support staff = 2 full time equivalent, 1 part time	Monday – Friday 9-5

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 through the Employee Performance Review Model and annual appraisals. 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,
- MCA DoLs,
- Diversity
- Data protection

Mandatory medication training is provided for staff with annual updates

6.4. Resources

Total budget of £1,610,539

6.5. Organisational Structure

6.6. Internal Governance