SAFE WELL PROSPEROUS CONNECTED

North Lincolnshire Council
Home First Community
Statement of Purpose 2021

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Author	Tammy Marshall, Registered Manager, Home First Community
On behalf of	
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Home First Community
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North Lincolnshire
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CQC provider ID:1-101668016

North Lincolnshire Council
www.northlincs.gov.uk

The information below is for manager number: ID	1-101668016	of a total of:	1	Managers working for the provider shown in part 1

1. Manager's full name	Tammy Margaret Marshall

2. Manager's contact details	
Business address	**8-9 Billet Lane** **Normanby Enterprise park**
Town/city	**Scunthorpe**
County	**North Lincolnshire**
Post code	**DN15 9YH**
Business telephone	01724 298190
Manager's email address[1]	
Tammy.marshall@northlincs.gov.uk	

Responsible Person – Marian Davison

Statement of purpose, Part 1

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	Home First Community Support						
CQC provider ID	1-101668016						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☐	

2. Provider's address, including for service of notices and other documents	
Business address[2]	North Lincolnshire Council Home First Community Support 8-9 Billet Lane Normanby Enterprise Park
Town/city	Scunthorpe
County	North Lincolnshire
Post code	DN159YH
Business telephone	01724 298190
Electronic mail (email)[3]	Tammy.marshall@northlincs.gov.uk
Updated	30/06/2021

By submitting this statement of purpose, you are confirming your willingness for CQC to use the email address supplied at Section 2 above for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email, please check or tick the box below. We will not share this email address with anyone else.

I/we do NOT wish to receive notices and other documents from CQC by email	☐

Where the provider is a partnership, please fill in the partnership's name at 'Full name' in Section 1 above. Where the partnership does not have a name, please fill in the names of all the partners at Section 3 below.

Where you do not agree to service of notices and other documents by email, they will be sent by post to the business address shown in Section 2. This includes draft and final inspection reports. This postal business address will be included on the CQC website.
Where you agree to service of notices and other documents by email your copies will be sent to the email address shown in Section 2. This includes draft and final inspection reports.

Please note: CQC can deem notices sent to the email or postal address for service you supply in your statement of purpose as having been served as described in Sections 93 and 94 of the Health and Social Care Act, 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents.

Content;

1. Quality and Purpose of Care

1.1. Introduction

This ***statement of purpose*** is written in accordance with the Care Quality Commission (Registration) Regulations 2009.

The statement is produced by the Registered Manager on behalf of North Lincolnshire Council.

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.
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 Home First Community Support team.
- People provided with support and services by the Home First Community Support team.
- All carers or family members of people provided with support and services by the Home First Community team.

Home First Community Support is a registered Rehabilitation and Reablement service, providing time limited rehabilitation and reablement therapies and support in a person's own home.

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 is available to service users and their families and any other professional agency with a legitimate link or enquiry about the Home First Community Support Service. 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 Home First Community Service.

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

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

We will offer services that are inclusive and assume potential, ensuring everyone has equal access to care and support. We will also ensure equality is demonstrated in the behaviours of all staff working in the integrated service.

We will work with a person to 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 and will be reviewed with them on a regular basis to assess and adjust the support they need to achieve their goals.

We will identify the person's circle of support' - families, friends, carers, loved ones or others that provide care and support to an individual and actively encourage them 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 considered and they feel fully supported and empowered during their rehabilitation journey.

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 Home First services, they have a network of support in place. There are opportunities to develop that network further through community activities and services. Where appropriate we will work with individuals and their circle of support to confidently access these services and as required through the additional support of our sister provision Home first community reablement.

1.2. What is the Home First Community Service?

The Home First Community service is part of North Lincolnshire Council's Adult Social Care support offer. Staff work across the community in an individual's home or place of choice providing services underpinned with an ethos of rehabilitation and reablement. The team provides time limited support following the Discharge to Assess process. This includes Rehabilitation and Reablement, agency shortfall and transition to long term care services as well as our Roving Night service.

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 via our access team, when deemed they would benefit from rehabilitative support in their own home.

The Home First Community Service provides an integrated Social Care and Health service to residents across North Lincolnshire, whereby health and social care professionals provide programmes of intense therapy and care in a person's own home. The team includes social care staff working directly with Occupational Therapists, Physiotherapists, District Nurses and General Practitioners.
By working in an integrated way, we are able to:

- Deliver support that brings together services to achieve the outcomes important to everyone
- Improve transition between health and social care services
- Communicate effectively with people who need support and work as one team
- Ensure effective, timely and inclusive decision making between social care and health care staff.

1.3. Core Functions

Our rehabilitation and reablement support seek to maximise people's independence in the short term by regaining skills and abilities or learning new ways of managing. This then ultimately helps people to help themselves, keeping people safe and well for longer, which helps reduce reliance on statutory services in the long term. This will include improving mobility, meeting social care needs, helping with daily living activities, identifying assistive technology and other practical tasks.

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

Once individuals have reached their optimum level of rehabilitation and reablement where there is evidence of long-term need, we will continue to provide support through our transition service and where appropriate, social work colleagues operating within the Home First arena will then ensure individuals are supported to access a personal budget and source a provider that can support them to meet their ongoing care needs. We ensure that a person's care and support is safe and effective and meets their needs by working with the individual and new care provider where agreed/appropriate to offer a robust handover period.

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. We also actively promote and signpost to services such as the Fire safety service and Handy man service. In addition, we consider assistive technology and how this can be utilised to enhance wellbeing and promote independence in creatively meeting support needs.

1.4. Aims and objectives

We use our values, influence, and responsibility to engender high ambitions for vulnerable adults across North Lincolnshire together with our partner agencies - so that all adults achieve excellent outcomes. We aim to ensure that all adults can reach their maximum independence after a period of illness or injury.

We are committed to achieving improvements for the people of North Lincolnshire as set out in the Council's four strategic outcomes. These are:

- Safe
- Well
- Prosperous
- Connected

We aim to:

- Improve health and well-being outcomes
- Promote independence
- Increase and regain daily living skills
- Support carers to continue to care

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

Home First Vision:

1.5. Service Description

- We arrange emergency placements out of hours, or at a time of crisis, and support safe and appropriate early discharges from hospital.

- Adult service practitioners complete discharge to assess/trusted assessment in partnership with service users and their families, to plan which services would help a person retain or regain their physical health and social care needs. Assessments ensure they are responsive to each person's preferences, aspirations and choices and keep them at the centre of everything we do.

- Documentation provided to individuals for example, a "Welcome Guide Booklet" is discussed. This informs the person's expectations of the service to be provided, and how the individual will contribute to their rehabilitation.

- Individual support plans identify outcomes and therapy where appropriate. They are completed in partnership with individuals and their circle of support to ensure the support and therapies we provide are personalised and effective to achieve good outcomes and maximise independence where possible.

- While in receipt of active rehabilitation we monitor support daily and review progress on a weekly basis. We work in partnership with the individual and their circle of support, reducing services as appropriate to enable an individual to regain maximum independence.

- We undertake initial contact reviews to identify as soon as possible any likely long term and or unmet need. In cases where the individual has reached their optimal level of functionality and still has unmet needs, this then triggers the social work colleagues from within Home first to complete a holistic assessment of needs 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.

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

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

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

- We undertake follow up visits after the end of our provision at various stages namely 3-day, 3-week and 3-months to check the following points:

How is the person managing?

If they are maintaining the level of independence, they achieved upon leaving Home first?

If an agency is supporting with ongoing care if they feel enabled to do continue to do things for themselves?

Where appropriate if they have accessed activities in their local community? If not, would they like/need any support to do so now?

If they have any new needs or they are experiencing any difficulties?

Ensure they have the appropriate information/contact details to escalate any future concerns?

*Please note during COVID-19 Home First Community have worked with the adult support team and adults with complex learning and physical disabilities to become as independent as possible, have a place to meet peers, and get support to access the community.

Providing personal care and medication administration as part of this support, normally working from dedicated bases.

They also support carers to have a break from their caring role. As part of contingency planning, they will carry out this support in the community and in people's own homes if the community venues have to close*.

Description of the location - Office facilities

The Duty function has been moved to reduce the risk of spread of infection from the previous base to Billet Lane that also offers access to showers.
This has also given us the opportunity to work with our colleagues in the community to respond more effectively to people's needs in a joined-up way. However, being a North Lincolnshire Council Building the functions of the building below remain the same.

Home First Community Support Office facilities.

- There are various offices that are used for both managers and staff with facilities available to hold meetings and training sessions

- The office facilities have lockable cupboards in which any confidential paper files can be stored safely

- The building is secured and alarmed during the times that the office is closed, and anyone entering the first floor requires access via a code and keypad

- The office is accessible for anyone having a disability and there are also adequate facilities with disabled access

- There is a communal kitchen and staff are encouraged to use this and the outside area during breaks

- The service has access to all technology needed to support the delivery of the service

- Staff have access to a resource library where books relating to Health and Social care topics are stored.

- There is a free Wi-Fi service available for all to use

- As part of North Lincolnshire agile working policy staff can access the Council premises within the specific locality to which they are delivering care. All laptop and paperwork are accessible and secure.

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.
- 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).

Please note during COVID -19 pandemic there has been an amendment to the criteria to allow Children's services to support Children and Adults with Complex disabilities within their own home through utilising those staff that are trained and skilled that would usually work with the service users in a setting outside of the home that is now closed due to COVID-19.

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 meets 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 needs the adult is unable to achieve two or more of the outcomes specified below
- 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
- Can achieve it without assistance but doing so causes the adult significant pain, distress, or anxiety
- Can achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others.

CQC service user bands The people that will use this location ('The whole population' means everyone).					
Adults aged 18-65	x	Adults aged 65+		x	
Mental health	x	Sensory impairment		x	
Physical disability	x	People detained under the Mental Health Act		☐	
Dementia	x	People who misuse drugs or alcohol?		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		x	
Children aged 0 – 3 years	☐	Children aged 4-12		Children aged 13-18	
The whole population	☐	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☐
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☐
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐

Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☐
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☐
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	x
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location	
Personal care	x
Registered Manager(s) for this regulated activity: Tammy Marshall	

2.2. Proportionate Assessment

Requests for support to the Home First Service are assessed using a multi-agency Discharge to Assess (Hospital Discharge Service: Policy and Operating Model 2020). 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 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 the decisions around their care and their circle of support is included to allow all views, goals, and circumstances to inform the 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 key information and details around their routine's preferences and dislikes. Our 'This is Me' support planning document empowers people to have choice and control over the support they receive and enables staff to have a deeper understanding of the people they support and to 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 when reviewing a person's individual needs.

Our multi-agency 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 is continually monitored in full partnership with the individual and their circle of support. A progress report is produced each week or more frequently if required, this gives time to reflect on the goals and outcomes set, and/or consider new goals.

If the service is unable to meet an individual's needs, a multi-disciplinary 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 by Home First short stay for a proportion of those six weeks, followed by the Home First Community Support Team. Together should they exceed six weeks a charge will being triggered. Where this is the case and continued support is required, we will discuss with the individual and their circle of support that fees that may be payable and will signpost to the online financial assessment form so that they can see what contribution they may need to pay for the cost of ongoing care and support.

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 journey of rehabilitation and reablement. This involvement starts with their proportionate assessment of needs and continues through the 'This is Me' document.

A plan for regaining independence is discussed, and what needs to be in place for this to happen, this topic is returned to throughout a person's journey through services. The plan ensures the aim 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 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 of outcomes identified 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 ask all individuals, their family and carers who have received our service to complete the 'Your experience and the 6Cs questionnaire'. While we encourage service users to complete these themselves at their leisure, we also make sure staff have time at the final visit to support individuals to complete them should they prefer assistance. Staff are also able to complete the questionnaire electrically from their mobile devises which allows us to upload directly via a link to MS forms. The surveys enable us to understand what the 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, by email or use of the Local Authorities online complaints form
- Fill out the 'Your experience and the 6Cs' questionnaire that are kept in the individuals IP for them to complete at the end of their programme of rehabilitation and reablement
- At any point during their journey through Home First Community Support through attending workers or our 24/7 duty line
- At observation visits where seniors attend to observe practice
- At the initial contact review – where we ask if the service is meeting need/expectations and ensure individuals are aware of how to make a complaint should they wish to
- At the courtesy follow up visits 3 days, 3 weeks and 3 months after the service has ended.

4. Health

4.1. Physical health

The Home First Community Support 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 or injury. They provide a mixture of social care support and health therapies to help people 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 considers 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 Home First Community Support 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. Community reablement colleagues help to ensure we best capture opportunities to maximise social inclusion and bolster people's networks and resilience, preventing loneliness and social isolation. We will also explore the possibility of assistive technology to enhance their day-to-day living.

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 circle 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, with a view to 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. If an error occurs this is identified and recorded on the medication incident form to immediately record, rectify and learn from the situation.

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

Risk assessments are completed to establish if a person is able or wishes to self-medicate or if assistance or full administration support 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 safely supported when taking managed risks and building confidence to return and remain safely at home. Home first community support has a comprehensive suite of risk assessment documents that allows to practice safely and in the least restrictive ways, these include

- Medication risk assessment
- Individual and environmental risk assessment
- 'Moving with Dignity' risk assessment
- Accident forms

- Body maps

We also discuss the use of assistive technology to support people in feeling safe within their own home.

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 Disclosure and Barring Service clearances, which are reviewed and updated every three years. References for all employees are taken and any gaps in employment history are 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.

Mandatory and statutory training is monitored within the service through regular supervisions and Employee appraisals, and well as regular updates within the Adult Social Care Data Records (was NMDS).

5.3. Adult Protection

Safeguarding is embedded in the policies and procedures of the Home First Community Service. 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 Home First Community Support.

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, these include 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.

As a provider within the Local Authority, we feel it is important to take a leading role in ensuring a robust safeguarding system that seeks to prevent abuse and neglect and is quick to respond and stop it where it occurs. As part of our continued commitment to learning from those cases that require our support we produce a quarterly report, which has a focus on learning rather than blaming. The report also allows checks and balances against the Care Act Safeguarding principles, internal procedures as well as reporting and risk reduction mechanisms.

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 as and when necessary.

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

As part of our induction all staff are provided with a Home First Community Support 'Health and Safety' handbook.

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

6. Leadership and management

Registered Provider
North Lincolnshire Council. Church Square House High Street Scunthorpe North Lincs DN15 6NL
Responsible Individual
Marian Davison Church Square House High Street Scunthorpe North Lincs DN15 6NL
Registered Manager
Tammy Margaret Marshall Home First – Community Support Team 8-9 Billet Lane Normanby Enterprise Park North Lincolnshire DN15 9YH 01724 298190

Locations managed by the registered manager at 1 above (Please see part 3 of this statement of purpose for full details of the location(s))	
Name(s) of location(s) (list)	Percentage of time spent at this location
North Lincolnshire Council Intermediate Care Centre – 8-9 Billet Lane	80%

Regulated activity(ies) managed by this manager		
Personal care	x	
Accommodation for persons who require nursing or personal care	☐	
Accommodation for persons who require treatment for substance abuse	☐	
Accommodation and nursing or personal care in the further education sector	☐	
Treatment of disease, disorder or injury	☐	
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Surgical procedures	☐	
Diagnostic and screening procedures	☐	
Management of supply of blood and blood derived products etc.	☐	
Transport services, triage and medical advice provided remotely	☐	
Maternity and midwifery services	☐	
Termination of pregnancies	☐	
Services in slimming clinics	☐	
Nursing care	☐	
Family planning service	☐	

6.1. Staffing of Home First - Community

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**
Registered Team Manager	08:30 to 17:00 Mon-Fri (plus on call)
Team Leader x 1	08:30 to 17:00

	Mon-Fri
Senior Community Rehabilitation Officers (x 1 AM x1 PM x1 Integrated Discharge Lounge IDT)	6:45 to 15:15 14:45 to 23:15 08:30-17:00 IDT
Duty Officers(x 1 AM x1 Mid x 1 PM)	06:45 to 3:15 10:00 to 16:00 15:00 to 23:15
Community Rehabilitation Workers (x 15 AM and x15 PM)	07:00 to 14:30 15:30 to 23:00
Transition Workers (x 7 AM and x 7 PM)	07:00 to 13:35 15:55 to 22:30
Community Officers (x 1 AM x1 PM)	07:00 to15:00 15:00 to 23:00
Community Officers IDT (x 1 AM x1 PM)	08:00 to 16:00 12:00 to 20:00
Roving nights and admin now under 'MYOS House' Registration but still form part of the North Lincolnshire Council 'Home First' 'Duty' services	From 01.07.2021

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. All staff members 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 and child protection responsibilities
- Diversity awareness
- Information Governance
- Safeguarding awareness
- Health and Safety Awareness
- Medication and Moving with Dignity training also required before unsupervised practise

Mandatory medication and Moving with Dignity training is provided for staff with annual updates

Other required training includes

Communication

Privacy and Dignity

Fire Safety

Care Act part 1&2

Fluids and Nutrition

Domestic violence

Dementia Friends

End of Life Care training

Best practice in recording

GDPR

Caldicott

Infection control and continence care

First Aid at Work

Food Safety

As a service we view ourselves as a learning organisation that seeks to expand the skills sets of workers beyond mandatory requirement to improve outcomes for service users.

As part of our New Kind of Worker project then we have been able to source training that equips us to be more safe, responsive, and effective:

SBAR

MUST

Sepsis

REACT to Red

Stoma Care

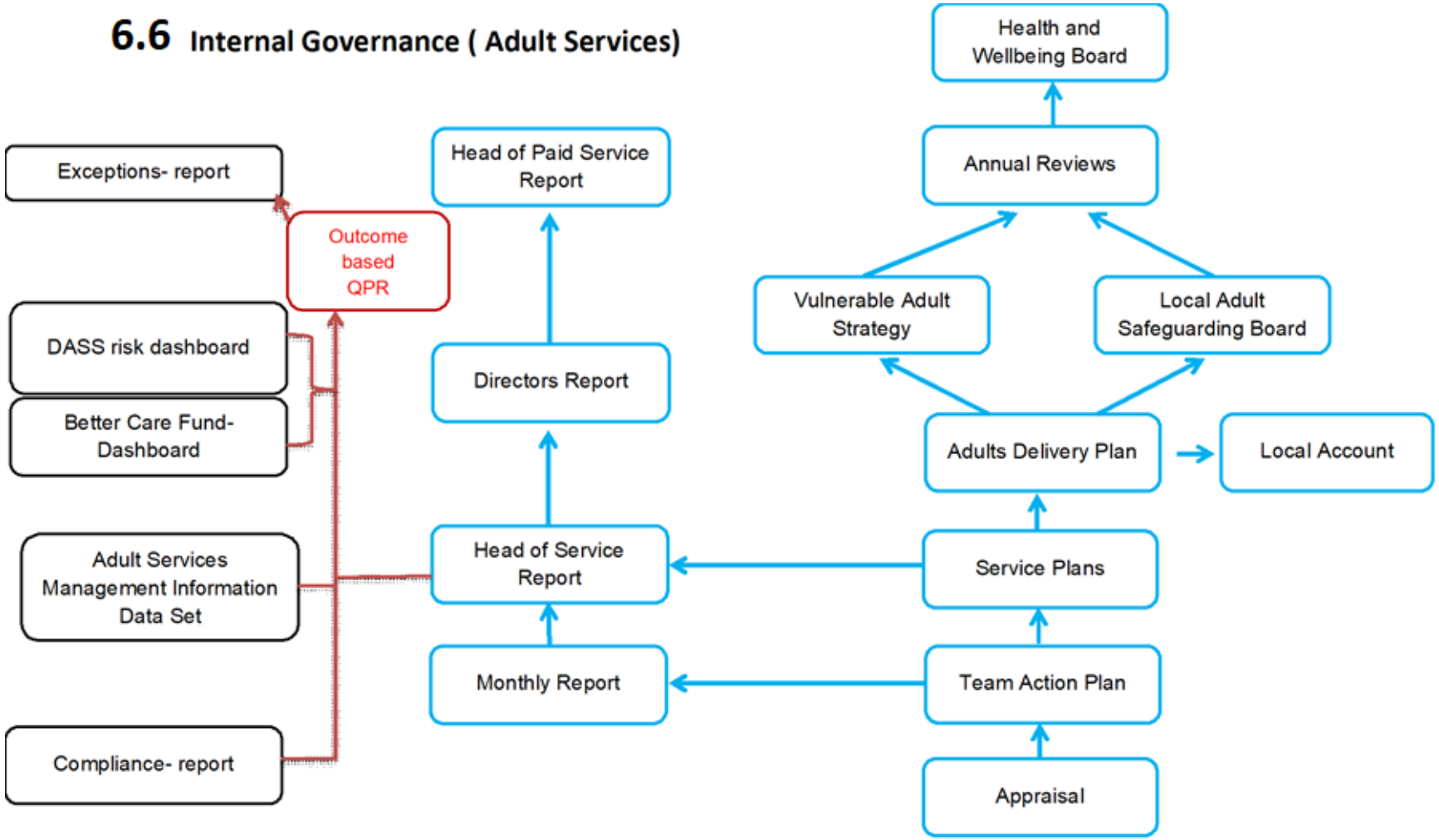
6.4. Resources

Total budget of £4,042,000

6.5. Organisational Structure

North Lincolnshire Adults and Community Wellbeing services

6.6 Internal Governance (Adult Services)



6.7. Performance and compliance measures

Compliance Measures	Best Practice Timescales	Statutory or Best Practice	Performance Target	Reporting Timelines
Completion of controlled drugs Audit	Quarterly	Statutory	100%	Quarterly
Number of people remaining at home 91 days after discharge from hospital	Quarterly	Statutory	Actuals	Monthly
Staffing and Management				
DBS Clearance	3 Yearly	Statutory	100%	Monthly
No of Complaints	monthly	Statutory	actuals	Monthly
How many responded to within timescale	20 working days	Statutory	95%	Monthly
Mandatory Training requirements	12 months	Statutory	100%	Monthly

ACTIVITY

Activity Measures	Best Practice Timescales	Statutory or Best Practice	Performance Target	Reporting Timelines
Progress meetings	Weekly	Best Practice	actuals	Weekly
Update Care first records	Daily	Best Practice	actuals	Weekly
Mar sheet Audits	Monthly	Best Practice	actuals	Monthly
Service Users discharged	Monthly	Best Practice	Actuals	Monthly
people signposted to universal services	Monthly	Best Practice	actuals	Monthly
Quality Assurance Surveys sent and returned	Quarterly	Best Practice	actuals	Monthly
Case File Audits	Monthly	Best Practice	100%	Monthly
admissions into Home First Community Support Team	Monthly	Best Practice	Actuals	Monthly
referrals from Home First Community Support Team to Localities for full assessment or further social work interventions	Monthly	Best Practice	Actuals	Monthly

Staffing and Management

Staffing and Management Measures	Best Practice Timescales	Statutory or Best Practice	Performance Target	Reporting Timelines
sickness recorded on system	monthly	Best Practice	100%	Monthly
sickness return to work interviews	monthly	Best Practice	100%	Monthly
appraisals	annual	Best Practice	100%	Monthly
appraisal audits completed	annual	Best Practice	actuals	Monthly
Staffing and Management Measures	**Best Practice Timescales**	**Statutory or Best Practice**	**Performance Target**	**Reporting Timelines**
6 monthly appraisal reviews (new starters)	6 months	Best Practice	100%	Monthly
Supervisions	4 a year (Regulated Services)	Best Practice	90%	Monthly
No of Compliments	Bi annual	Best Practice	actuals	Monthly
Fitness to practice - driving licence	annual	Best Practice	100%	Annual
Fitness to Practice - Risk assessments	annual	Best Practice	100%	Annual
National Minimum Data Set	Monthly report (internally)	Best Practice	100%	Monthly