A Common Knowledge & Skills Framework for Connecting Care+ Hubs

Approved:	**22nd March 2018**
Last Updated:	**3rd August 2021**
Version No.	**15**
Next Review Date:	**November 2021**

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Foreword

The Connecting Care+ Hubs are key components of the Wakefield New Model of Care, and are designed to improve the coordination and integration of care across the NHS, social care and the voluntary sector for people with health and / or social care needs. Covering the whole district, the hubs offer a wider health and social care service and focus on crisis intervention, to prevent avoidable hospital admission and support services to enable people to be discharged from hospital earlier. The hubs enable multiple agencies to work together more seamlessly, support patients with health and/ or social care needs who could otherwise receive fragmented care, with multiple referrals and handovers. By better coordination, the risk that patients could deteriorate to the point of A&E attendance and hospital admission will be reduced.

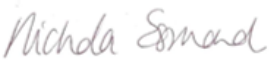
As a health and social care system this means that in line with the Five Year Forward View the vision and the transformation programmes we are implementing, are possible, due to the level of collaborative leadership and strong partnership working across the health and social care system.

The Connecting Care+ Hubs at Waterton and Bullenshaw consist of specialist workers from Community NHS health services, social care, Age UK Wakefield District, Carers Wakefield and District, WDH and SWYFT. This ensures that all service users referred into the Connecting Care+ Hubs get the right care, at the right time, in the right place and by the right person.

This model is designed to support citizens to achieve better health outcomes, closer to home, and at the same time generate the capacity required to enable acute hospital reconfiguration to be delivered.

Transforming services to meet the new model of care means we have to transform the workforce to be capable, confident and skilled to support the delivery of health and care support to residents in of Wakefield. Everyone working in the Connecting Care+ Hubs should be able to take part in learning and development so they can carry out their role effectively. This will help to develop the common core knowledge competencies required and a consistent approach so they can provide high quality care and support to delivering services and meet outcomes.

We look forward to seeing you make a real difference and to watch you progress.



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Contents

Common Knowledge & Skills Framework

Staff Name: _____

Introduction

This learning and development framework has been developed for staff working in the Connecting Care+ Hubs, and is intended to support effective staff development by focussing on common tasks related to roles, and the associated specific knowledge and skills needed by workers to support the delivery of seamless health, care and support to the residents of Wakefield.

The framework has been developed by Wakefield Council's Adults Integrated Care, Age UK Wakefield District, Carers Wakefield & District, Mid Yorkshire Hospital Trust – Community Services, WDH and South West Yorkshire Foundation Trust and identifies learning requirements of staff, and how these will be supported to ensure a capable, confident and skilled workforce.

The framework is not intended to replace existing learning and development requirements of each organisation, but to ensure consistency in the content and delivery of learning outcomes which are common across all partners. It is a ***mandatory*** requirement for managers to ensure their staff meet the learning outcomes as prescribed in this framework through discussion and observation of competencies.

The National Core Skills Education & Training Frameworks developed by Skills for Health, Health Education England and Skills for Care have determined learning and development requirements for Dementia, End of Life and Mental Health.

The Health & Safety at Work Act (1974) has determined the Health & Safety requirements and the National Competency Framework for Safeguarding Adults has identified learning and development requirements for Safeguarding training.

All National Frameworks have been mapped against job role requirements of staff.

This framework will be continually developed in parallel with the evolvement of the Connecting Care+ Hubs.

The framework is sub divided into two sections; common knowledge and skills and additional knowledge requirements.

Induction

It is a mandatory requirement for all staff working in the Connecting Care+ Hubs to attend the personalised technology training suite at WDH, for staff to familiarise themselves with technology and support available.

Please contact the Adult Workforce Team (01977 723527) to arrange attendance at WDH.

	Date	Manager Signature
WDH Personalised Technology attendance		

Further information regarding Connecting Care+ can be found on the system wide website:-

Connecting Care (wakefieldhealthandcareworkforcehub.co.uk)

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Common Knowledge & Skills

It is a requirement for **all Staff** working in the Connecting Care+ Hubs to have basic, practical knowledge about the functionality of the Hubs to enable staff to make informed decisions. This information is delivered in small bite-sized quick reference guides.

The Quick Reference Guides are listed in the below checklist. Managers should sign off each guide when they are confident that understanding and the application of knowledge has been demonstrated:-

Quick Reference Guide	Date Read	Manager Signature
Connecting Care+ Hubs		
Connecting Care+ Guiding Principles		
Access to Care		
Age UK Wakefield District		
Carers Wakefield & District		
Community Occupational Therapy		
Connecting Care+ Coordination Unit		
Connecting Care+ Communication & Engagement Framework		
Connecting Care+ Wakefield Council Assessment & Care Management		
Continuing Healthcare (CHC)		
Mental Health Navigators		
Mid Yorkshire Integrated Care Team (MY ICT)		
Personalised Technology		
Pharmacy Awareness		
Reablement		
Sensory Impairment		
The Prince of Wales Hospice		
WDH		
Wellbeing Offer		

Common Knowledge & Skills

Knowledge & Skill area	Date	Manager Signature
Building, Facilities & Fire Safety Awareness Each Connecting Care+ Hub has an introduction document which details all relevant facilities, hours, Health & Safety, Fire and parking information. These documents can be found on the Connecting Care+ Partners website or below:-  Introduction to Bullenshaw Connectir  Introduction to Waterton Hub 03 02 Wakefield Council nominated person who has management responsibilities for the building. This person is responsible for chairing the Building User Group and ensuring that all building users are adhering to the Wakefield Council's Health & Safety Building Policies. <u>Wakefield Council Employees</u> This information can be found in the Safety Improvement Programme (SIP) folder within your Team. Please ask your Line Manager where this is located. Your Line Manager will discuss any necessary information as part of your induction.		
Business Continuity & Emergency Planning It is a requirement for all Teams working in the Connecting Care+ Hubs to undertake their organisational Business Continuity & Emergency Planning arrangements. These documents can be found within each Team. Please ask your Line Manager where this is located. Your Line Manager will also go through any necessary information as part of your induction.		
Hub Systems Training (SystmOne) SystmOne 'Full' Training & 'Lite' Training (appropriate to your role) is required. Please discuss with your Manager which category of training you require. Your Manager should contact the Adult Workforce Team to reserve your place on the next available course.		

Knowledge & Skill area	Date	Manager Signature
Information Governance It is a requirement for all staff working in the Connecting Care+ Hubs to undertake *their organisational specific* Information Governance training requirements. It is a requirement for all staff working in the Connecting Care+ Hubs *to receive training* on the Information Sharing Agreement. All staff who triage within the Hubs (with exception of Wakefield Council), are also required to complete the *Third Party Information Security* document to access the Local Authority SystmOne platform (PIC File). Your Line Manager will go through any necessary information as part of your induction.		

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Connecting Care+ Quick Reference Guides

Connecting Care+ Hubs

Quick Reference Guide

What does Connecting Care+ mean?

Connecting Care+ is made up of local health, social care, voluntary and community sector organisations from across the Wakefield district. These organisations work together as partners to deliver health and social care integration to deliver innovative methods of care to local people.

The Connecting Care+ vision is to ensure that local people receive person-centred coordinated care, which is delivered at the right time, in the right place and by the right person. In order to achieve this vision, certain principles were outlined by partners. These principles are:

- Patients are practically managed at or close to their homes
- Care is co-ordinated and seamless
- Only those people that need to be in hospital are admitted
- Once admitted into hospital, people only stay for as clinically long as necessary
- People are supported and are in control of their condition and care, enjoying independence for longer
- Unpaid carers are prepared and supported to care for longer.

Our Connecting Care+ partners are:

- NHS Wakefield Clinical Commissioning Group
- Wakefield Council
- WDH
- South West Yorkshire Partnership NHS Foundation Trust
- Spectrum Community Health CIC
- The Mid Yorkshire Hospitals NHS Trust
- Age UK Wakefield District
- Nova
- Carers Wakefield and District
- Conexus Healthcare Limited (GP Federations)

What is a Connecting Care+ Hub?

The new Connecting Care model redesign across the Wakefield district was implemented on 4th December 2017. The new model will provide a wider Health and Social Care service, and focus on crisis intervention, to prevent avoidable hospital admission and support services to enable people to be discharged from hospital earlier.

The purpose of Connecting Care Hubs is to deliver person centred coordinated care, which achieves better outcomes for Wakefield people who need Health and Adult Social care.

The aim of the Connecting Care Hubs is to ensure that:

- Care is coordinated and seamless with health, care and support working together to share information, plan and join up care for people
- A clearer, faster access to Hub services for acute, primary, clinical and Adult Social Care providers is improved by having one single referral process through the establishment of a single point of access
- People are supported and in control of their condition and care, enjoying independence for longer
- Unpaid carers are prepared and supported to care for longer
- Care is cost effective and within available budgets
- All staff understand the system and work safely and effectively in it

Access & Support

The main referral pathway for most stakeholders is via Social Care Direct or MY Therapy Co-ordinators. GP's and Hub partner agencies can directly refer through to the Connecting Care+ Units bypassing Social Care Direct / MY Therapy Co-ordinators.
All referrals to the Hub are registered and accessed through the SystmOne Personal Integrated Care (PIC) File.

All Hub referrals are triaged by the Hub Triage Team, which is made up of Social Workers, Advanced Care Practitioners and Community Therapists, they are responsible for signposting referrals to the most appropriate partner in the Multi-Disciplinary Team (MDT) for Case Management.

All cases are monitored by the Coordination Unit which consists of Support Service staff.

The Hubs include a number of partner agencies; this includes, Social Workers, Care Coordinators, specialist staff from both Age UK Wakefield and Carers Wakefield and District, Mid Yorkshire Therapy Team staff including Occupational Therapists, Physiotherapists, Dieticians, and Pharmacists. Mental Health Navigators from SWYFT and Wellbeing Case Workers from WDH are also available.

Locations & Opening Hours

Bullenshaw Connecting Care Hub
Bullenshaw Road
Hemsworth, Pontefract
WF9 4LN
Opening hours: 8am – 6pm
Tel: 01977 727015
Email: carecoordinationuniteast@wakefield.gov.uk

Waterton Connecting Care Hub
Waterton Road
Wakefield
WF2 8HT
Opening hours: 8am – 6pm
Tel: 01924 307277
Email: carecoordinationunitwest@wakefield.gov.uk

Connecting Care+ Hub Guiding Principles – Workplace Values

Quick Reference Guide

What are Values?

Values are a set of beliefs or views that people hold about what is right or wrong and reflect a person's sense of what is good or bad.

They can have a strong influence on an individual's attitude and behaviours, acting as a set of guidelines or rules for how to behave in different situations.

Values help to maintain a consistent approach and staff know what is expected in the workplace.

Everyone is responsible for embedding values. Values can only work if they are seen as an integral part of the workplace.

Workplace Values

Workplace values are the guiding principles that are most important to the employer. These deeply held principles are used to define the right and wrong ways of working and help to inform important decisions and choices.

Workplace values are important as they help to create an identity, culture, belonging and loyalty from staff.

Values help to maintain a consistent approach and ensure everyone knows what is expected of them in their day to day role.

How should we behave and what should we expect from others?

The challenge to deliver high quality integrated services by adequately trained and developed staff is huge. From analysing skills and attributes of existing and future staff, to recruiting and retaining the right people with the right values, having adequately skilled and qualified staff at both professional and vocational levels, to working across traditional role boundaries.

To meet these workforce challenges, the following Guiding Principles will be adopted:

Work Together; don't undermine each other

- Staff should be professional and act with integrity at all times

Openness

- Staff should be open to learning from others and willing to share knowledge and best practice.

Respect and speak well of each other

- All staff should treat people with dignity and respect regardless of their culture, religion, age, race, sexual orientation or disability
- Accept and respect people's individuality

Be professional, especially when things go wrong

- Staff should be honest and transparent and not afraid to say when they have done something wrong

Do what we say we will do

- Staff should take personal responsibility for ensuring they contribute to the provision of excellent, safe, high quality care and support to others

Speak with candour and courage

- Workers should have the courage to speak up and appropriately challenge others where there are concerns
- The working environment should be such that workers feel safe and confident to raise questions, express concerns, talk about their experiences and make suggestions for service improvement.

Access to Care

Quick Reference Guide

What is Access to Care?

Access to Care, based at Wakefield One, includes Social Care Direct (SCD).

Social Care Direct is the initial point of contact for all new Adult Social Care referrals to Wakefield Council. The team consider any new referrals under the Care Act (2014). Most of the referrals include safeguarding adults who may struggle to protect themselves, assess people for any care and support needs, support carers and families, and provide people with advice and information.

Social Care Direct also covers out of hours so a Social Worker is usually available to talk to families to help them cope out of hours, and ensure that they respond to any urgent safeguarding concerns. The Social Worker works alongside an experienced Approved Mental Health Professional (AMHP) who is available to undertake assessments under the Mental Health Act (1983).

The team will try to support people as much as possible by ensuring they get the advice, assurances, and will put people in touch with partner organisations to get the help they need. If however someone needs a further assessment or safeguarding support then the team will refer onto one of the teams including the Connecting Care Hubs, Adult Safeguarding Team, Community Learning Disability Team, and Sensory Impairment Team.

Sometimes people contact Social Care Direct to seek support with their mental health, however these are usually redirected to Mental Health Services. The person must speak to their GP in the first instance who may refer to Secondary Mental Health Service via Single Point of Access (Tel: 01924 316900).

It is important to recognise the difference between an assessment of mental health and a Mental Health Act assessment. An AMHP will consider a Mental Health Act assessment and only make an application to psychiatric hospital once all community based options have been exhausted. The AMHP will usually make contact with families, GP's, SPOA, and crisis team to ensure they had done all they can help people manage at home.

All initial referrals are taken by Customer Service Advisors. The referral information is passed to a team of Social Workers and Care Coordinators. This information is then triaged to review how urgent it is, gather further information, offer advice and support to the referrer and signpost to the appropriate team or service. During the day there are up to 9 staff members available, including an Occupational Therapist available. On nights and weekends there are 1 to 2 staff members available. There are two managers who oversee the team and one of these managers is always on call at weekends and nights.

Access & Criteria / Referring to us

Social Care Direct can be accessed in several ways as this is a 24/7 service. You should contact Social Care Direct first if you, or someone you know, appears to need Adult Social Care services in Wakefield. If we don't think you need a Social Care assessment, we will give advice and information about what other agencies and support groups can offer.
If you are worried about the safety or wellbeing of an adult at risk or older person, please contact Social Care Direct. They will deal with your concerns and offer advice and support about what to do. See below for contact details:-

- Telephone: 0345 8 503 503
- Minicom: 01924 303450 (type talk welcome)
- Email: social_care_direct@wakefield.gov.uk or socialcare.direct@wakefield.gcsx.gov.uk (secure)
- Website: http://www.wakefield.gov.uk/health-care-and-advice/adults-and-older-people-services/social-care-direct

Locations & Opening Hours

Social Care Direct Day Team operates Monday to Friday, 8.30 – 5pm.

The Out of Hours team covers all other times.

Please note only urgent referrals will be dealt with during Out of Hours.

The day team is based at Wakefield One and the Out of Hours team is based at Pontefract Municipal Building.

Age UK Wakefield District

Who are Age UK Wakefield District?

Age UK Wakefield District is a local independent charity working with and for older people across Wakefield District.

We promote the well-being of all older people and aim to help make later life a fulfilling and enjoyable experience. We also aim to influence the way people think about ageing and the valuable contribution older people make to society.

As a local partner of Age UK, we aspire to work in local partnerships to deliver services appropriate to community needs.

Age UK Wakefield District has a:

- Staff team of 100 who deliver and support services to older people
- Volunteer team of 160+, in more than 200 volunteering roles, who work closely with staff to ensure that all services are effective, professional and friendly
- Board of Trustees who work closely with senior staff to offer support, expertise and guidance in the strategic and business planning of the organisation
- Membership who ensure that Age UK Wakefield District is promoted and supported throughout the District through their ongoing interest and affiliation

For more information see our website www.ageukwd.org.uk
For information about our assessment see www.leafoutcomes.uk

An Overview of our Services

- **Connecting Care++ Service** – Working with a team of professionals across the district providing assessments and addressing the needs of clients. Acts as a gateway (SPOC) into other Age UKWD services. Person Centred LEAF-7 assessment, Edmonton Frailty assessment and Falls assessment allow us to provide emotional and practical support to older people.
- **Information and Advice Service** – Providing independent information advice and support for older people and those who care for them. Examples include benefit checks for working age, retired and disability benefits. We support clients to make benefit application. We provide information and advice on a wide range of issues supported by national fact sheets and information guidance. Deliver national campaigns such as winter warmth.
- **Advocacy Service** – Independent support, enabling people to make the right choices. This includes money management, stabilising debt and personal budgeting. Appeals and tribunals. Independently supporting client with complaints. Supporting clients to make informed choice about family matters, housing and care.
- **Bereavement Service** – Advice and emotional and practical support at home and in groups following bereavement.
- **Staying Independent** – One to One support at times of sudden change or following illness. Supports clients to build confidence, to engage in, or access in social activities

- **Home Shopping Service** – Arranging shopping deliveries direct to client's homes.
- **Living with Dementia** - Providing support and advice.
- **Volunteering** – Providing volunteers across a range of services to support clients.
- **Befriending** – Providing friendly volunteers who visit and have time to listen and talk.
- **Supported Hospital Discharge** – A safe and secure transport service from hospital to home which also supports clients to settle at home and provides interventions or referrals to connecting care.
- **Home Support Service** – Bespoke paid for service to meet the social and domestic needs of clients.
- **Personal care** – A paid for service that assists with low level personal care such as washing and dressing as well as medication prompts.
- **Campaigns** – listening to clients and making changes.
- **Engaging for the future** – developing different ways of improving individual's lives.

Access & Criteria / Referring to us

Referral into any service can be made through the Connecting Care service in the Hubs. Generally the criteria is as follows:

- Over 50 years old for most services (exception Bereavement(18), staying independent & hospital to home (60)
- Registered with a Wakefield CCG GP
- A council tax payer to Wakefield Council

Referring to us:

- Via a PIC

Locations & Opening Hours

Age UK Wakefield District has staff located in both Waterton and Bullenshaw Connecting Care+ Hubs, as well as other support staff and services which are based across the Wakefield district.

The majority of our services operate a Monday to Friday 9am - 5pm service, however the Connecting Care+ Team and the Hospital to Home service operate a 365 day service.

The Connecting Care+ service operates between the following times:

- Monday to Friday 8.30am to 5pm

Carers Wakefield & District

Quick Reference Guide

Who are Carers Wakefield & District?

Carers Wakefield & District are a registered charity that gives support to unpaid adult carers from age 17 who care for a relative, child or friend who has an illness, disability, learning disability, is frail, elderly or has a mental health condition.

An Overview of our Services

We have support workers located in the Waterton & Bullenshaw Connecting care+ Hubs and Pinderfields Hospital. There are additional support workers based in our main office at King Street, Wakefield. Our services operate from Monday to Friday, 9.00am to 5.00pm.

We have specialised staff in the following areas:-

- Mental Health
- Dementia
- Learning Disabilities
- Autism
- Care Homes

Our Role is to:-

- Listen and talk things over to help the carer make decisions and choices
- Give advice and information about services available for the carer and/or the person cared for i.e. make referrals to Social Care Direct and/or other services
- Liaise with, and refer to, other professionals in the Hub and carry out joint visits if appropriate
- Check benefits eligibility
- Give support at meetings that are relevant to the caring role
- Provide information and support relevant to the complexities of the Care Home system
- Support carers through the process of discharge from hospital working closely with discharge teams across the Mid Yorkshire Trust
- Increase the number of carers identified by GP practices and to develop positive working relationships to support carers

Support Groups

We run general support groups across the district which is held on a monthly basis where carers can come for a coffee and a chat and speak to a support worker.

We also have the following specific support groups:

- Mental Health Carers' Support Group (for carers caring for someone with a mental health condition)
- Men's Group
- Working Carers' Group
- Walking Group
- Care Home & Supported Living Groups

Social Activities
From time to time we organise trips to places of interest, especially during Carers' Week in June.

Young Adult Carers
We organise social activities specifically for young adult carers from 17-25 yrs.

Volunteer Befriending Service
We have a number of volunteers who can visit carers who are feeling isolated. We give training and induction and carry out DBS checks on all our volunteers.

Courses
We run courses for carer's dependant on need and funding.

Newsletter
Details of all the above and anything else of interest to carers are in our newsletter which we send out four times per year.

Grants
My Time

- A grant of up to £100 in any one year for carers to take a break from their caring role. Application forms are available from carers support workers or the main King Street office in Wakefield.

Grants for Carers' Groups

- Available to groups who support carers caring for someone. This can be internal to our organisation or external groups.

Access & Criteria / Referring to us

Referral into any service can be made through:-

- The Connecting Care+ service in the Hubs
- Via the Personal Integrated Care (PIC) file
- Direct to our duty desk 01924 305544

The criteria is that we support anyone aged over 17 who provides care to a relative or loved one and is:

- Registered with a Wakefield GP
  And / or
- A Council Tax Payer to Wakefield Council

If in doubt please seek advice from a member of the Carers Wakefield & District team.

Locations & Opening Hours

The main office is located at 25 King Street, Wakefield, WF1 2SR where The Chief Executive, Managers, Specialised Support Staff and Administration Staff are based.

Services operate

Monday, Tuesday, Wednesday & Friday	9am to 5pm
Thursday	9am – 7pm

With an answer machine service outside these hours on 01924 305544.

Community Occupational Therapy (Wakefield Council)

Quick Reference Guide

Who are Community Occupational Therapists?

The Community Occupational Therapy team is part of Wakefield Adult Integrated Care Services and works closely with Social Workers and other Health professionals to maximise someone's abilities.

It serves the needs of the Wakefield population aged 18 years and upwards that need support with their day to day living activities. The goal is for individuals to be as independent as possible in their homes, wherever they may be and whatever tenure they live in, and to maintain their skills for a long as possible. The type of people seen varies from people with complex health needs, such as transitioning Young Adults or those funded by Continuing Health Care, Palliative Care, Elderly Frail people, and people with Learning Disabilities. The Service is not time limited and while some individuals are dealt with quickly, others may be ongoing cases for some time.

What is Community Occupational Therapy?

The Community Occupational Therapy team assesses Wakefield residents at home. The team look at how someone manages with daily living activities such as washing, bathing and generally how an individual is coping at home. The team will try to suggest ways or techniques to manage problems encountered. They may also supply equipment and refer for adaptations to make life easier to support living at home. The Team can also look at Moving and Handling techniques, giving support and advice to carers and care providers and request equipment to support the safety of both client and carer.

The team will also liaise with other professionals involved with the individual, or refer to other agencies, to ensure individuals achieve their potential e.g. Adaptations Team, Age UK, WDH, Live Well team , My Therapy or Continuing Health Care. The team also support carers who look after individuals in the Community, whether they are family or paid care staff.

Access & Support

The Community Occupational Therapy team has an eligibility criteria based on someone's needs as required by The Care Act 2014. Referrals to the team come through either Social Care Direct, where someone is not known to the service and only needs an Occupational Therapist assessment, or via the Connecting care+ Hubs, where the person is known and active to Adult Integrated Care services. Residents of Wakefield can self-refer via Social Care Direct.

The eligibility criteria for alterations to property is based on the Adaptations Team criteria, for both minor and major works. All standard equipment is issued on behalf of Wakefield Equipment Services. There is no charge for standard equipment.

The Community Occupational Therapy team has its own satellite store for immediate issue of smaller pieces of equipment.

There are three priority levels, Urgent, Critical and Substantial and the referral will be prioritised by an Occupational Therapist using the information supplied by the referrer

Locations & Opening Hours

Currently the Team is based at Civic Centre, Castleford on the First Floor and works:

Monday to Thursday	8.30am to 5.00pm
Friday	8.30am to 4.30pm

Telephone:	01977 723922 (team direct number)
Social Care Direct:	01924 303456
E mail:	communityot@wakefield.gov.uk

Connecting Care+ Coordination Unit

Quick Reference Guide

What does Connecting Care+ Coordination Unit mean?

The Connecting Care+ Co-ordination Units will support Triage Managers with the processing of urgent and non-urgent Personal Integrated Care (PIC) referrals for adults and older people within the Wakefield district.

The Units will have access to a range of Health and Social Care IT systems and will work alongside a range of multi-agency managers with access to other IT systems such as Age UK Wakefield & District, Carers Wakefield & District, and WDH.

In addition, the Units will have access to vital daily intelligence that the Connecting Care+ Hub will need to operate efficiently and effectively, and make better informed decisions.

This will mean that the citizens across the district will have a multi-agency holistic response to support their needs.

What is a Connecting Care+ Co-ordination Unit?

Each Unit is managed by a Support Services Co-ordinator who has management responsibility for Co-ordination Support Officers, who work 8am – 6pm Monday to Friday.

Working closely with Triage Managers, the role of the Unit is to:

- Signpost urgent and non-urgent referrals through to the most appropriate care pathway
- Provide real-time data to support the daily 'Stand Up' meetings within each Hub
- Record and monitor referral activity coming into the Unit on the Personal Integrated Care (PIC) File, and process appropriately
- Monitor and record Key Connecting care+ Hub Performance Indicators and other team measures

Access & Support

There are three referral pathways to the Care Co-ordination Units:

1) Access to Care (Social Care Direct and My Therapy)
2) GP Direct Referrals and other Internal Hub Referrals
3) Yorkshire Ambulance Service

The main referral pathway for most stakeholders is via Social Care Direct or MY Therapy Co-ordinators. However, GP's can directly refer through to the Units bypassing Social Care Direct / MY Therapy Co-ordinators. Hub agencies will be able to refer onward referrals to the Units in most cases, this will be dependent on the nature of the referral and whether this is deemed more appropriate for Access to Care to triage (i.e. Safeguarding).

All referrals received will be treated as urgent referrals to prevent hospital admission and support early discharge from hospital.

The Units will also provide Triage Managers with real-time data to support daily ‘Stand Up’ information which is distributed each morning to partners including critical information.

Locations & Opening Hours

There two are Care Coordination Units based at Bullenshaw Connecting Care+ Hub and Waterton Connecting Care+ Hub.

The Care Coordination Units are open Monday to Friday, 8am until 6pm.

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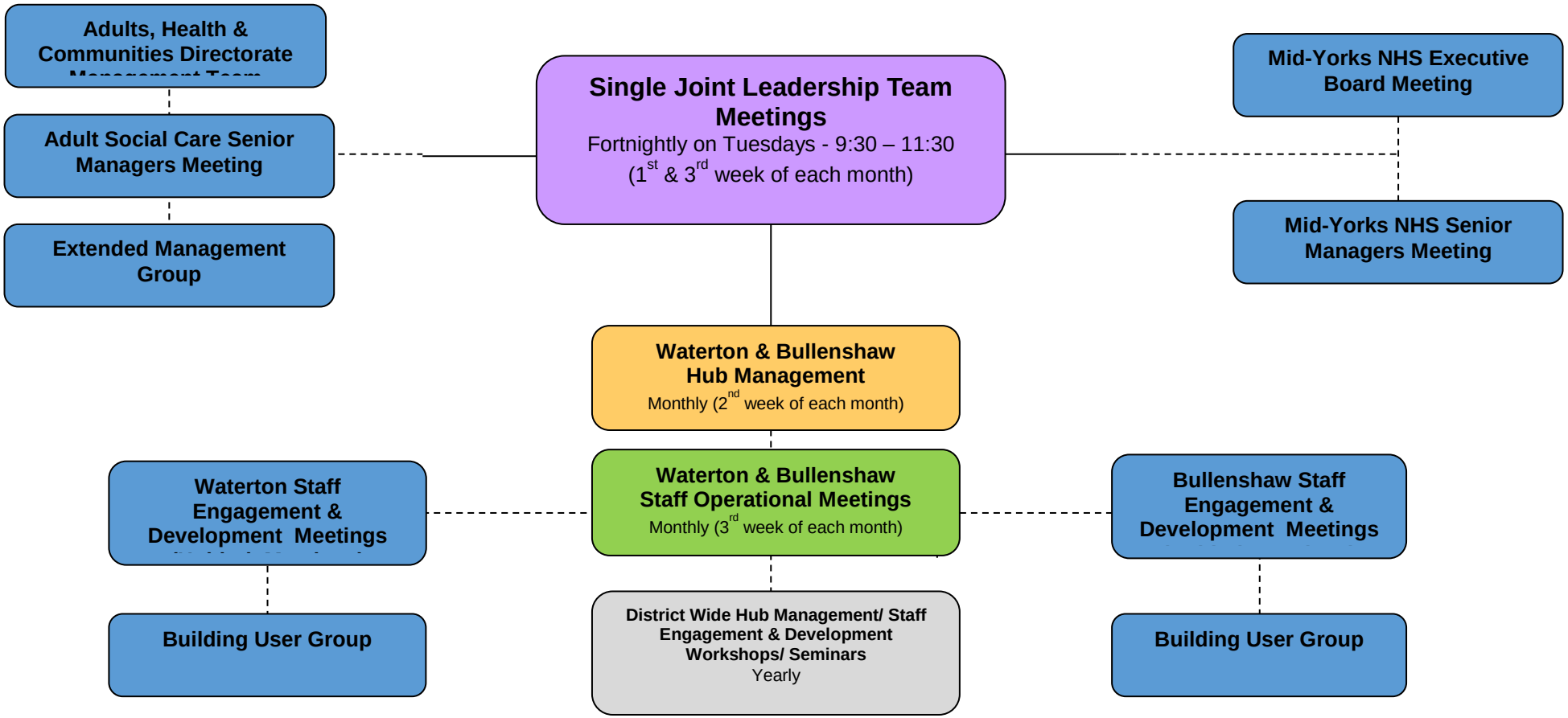
Connecting Care+ Hubs
Communication & Engagement Framework

Quick Reference Guide



Connecting Care+ Wakefield Council
Assessment and Care Management Teams

Quick Reference Guide

What does Assessment and Care Management mean?

Our team comprises of Care Coordinators, qualified and advanced Social Work Practitioners, to provide social work interventions to vulnerable adults within the community. The team is linked up to certain geographical GPs on the East and the West of the district.

We are committed to Safeguarding, enabling independence and meeting the health and wellbeing needs of vulnerable adults as a priority.

What is the Assessment and Care Management Service?

The Assessment and Care Management team commission care, support and advice to people who need it to manage their lives and be independent. We work with people aged 18 onwards, older people, people with a disability or long term illness, people with brain injuries or mental health problems and carers.

We undertake Social Work interventions both for carers and individuals who have an appearance of needs. We fulfil our statutory duties in regards to completing Care Act assessments to identify individuals social care needs and eligibility. The team also support plan how these needs can be met, via Reablement services, the wider community, technology, individual benefits and universal services. The ethos is to prevent, reduce and delay people from requiring care.

We provide Care Management for those who do need care and support, to be commissioned by the council. This includes supporting people to move into extra care settings or into residential care.

Our practice is underpinned by legislation, consisting of a range of statutory casework. This includes completing Mental Capacity Assessments, commissioning Advocacy services, making Best Interest Decisions and going to Court for Court of protection cases, as required. We also safeguard vulnerable people by effectively support planning to prevent or reduce people from abuse.

We support with Continuing Healthcare cases, by identifying individuals potentially eligible for NHS funding. We attend decision support tools to provide our professional opinion and multi-disciplinary input.

Access & Criteria / Referring to us

Assessment and Care Management teams work under the National Eligibility criteria set out by The Care Act 2014.

The Local Authority has a duty to complete an assessment if an individual has an appearance of care and support needs. The Local Authority have a duty to meet only identified eligible needs and do not require to put a service in place if it can be met by more cost effective services (such as telecare).

If the individuals needs do not meet the national eligibility criteria, the local authority still has to provide information and advice on what support might be available in the community to support them.

We do not have a responsibility for providing NHS services such as medication, patient transport or nursing care.

As part of the Connecting Care+ Hubs, internal referrals can now be made to Adult Social Care via a Personalised Integrated Care (PIC) referral on SystmOne.

If you are not part of the Connecting Care+ Hub, Social Care Direct is our gateway to care, if you require to make a referral please contact them on 0345 8 503 503.

Locations & Opening Hours

Our Hub locations are:
Waterton House, Waterton Road, Wakefield, WF2 8HT

Bullenshaw, Bullenshaw Road, Hemsworth, WF4 4LN

Opening hours:

08:30 – 19:00	Mon – Fri
08:30 – 17:00	Sat – Sun

If you require support out of hours please contact Social Care Direct on 0345 8 503 503.

They will deal with your concerns and offer advice and support about what to do if you are worried about the safety or wellbeing of an adult at risk or older person.

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Continuing Healthcare (CHC) (Wakefield Council)

Quick Reference Guide

What does Continuing Healthcare mean?

NHS Continuing Healthcare (NHS CHC) is the name given to a package of care which is arranged and funded solely by the NHS for people who have been found to have a 'primary health need'.

To qualify for NHS CHC the person must be aged 18 years or over and have needs that have arisen due to disability, accident or illness.

Primary Health needs are assessed using the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, October 2018 (Revised).

People eligible for NHS CHC funding are provided with all of their Health, Social and Nursing care, free of charge.

Eligibility for NHS CHC is not dependent on a diagnosis, condition or particular disease.

People can be eligible for NHS CHC regardless of the setting or who provides the care.
NHS CHC funding is not for life and is subject to regular review and reassessment of need.

Access & Support

NHS CHC should be considered for anyone in need of ongoing care and support from Health and Social Care services.

Wakefield Council employs 2 full time dedicated Continuing Healthcare Advisors who are available to offer individual support to Local Authority staff.

Training sessions are delivered throughout the year and both CHC Advisors can attend team meetings, as required.

Online training can be accessed via the intranet; factsheets are available to download and print off, as are a variety of NHS CHC documents.

Locations & Opening Hours

Paula Simpson & Donna Burnett (CHC Advisors) are currently based at Civic Centre, Castleford.

They can be contacted during normal office hours on either;

Tel: 01977 724079 or 01977 724270.

Email: psimpson@wakefield.gov.uk or dburnett@wakefield.gov.uk

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Infection, Prevention & Control

Quick Reference Guide

What is the Purpose of Infection Control?

Infection control is used to minimise the risk of spreading healthcare infections. The purpose of infection control is to reduce the occurrence and spread of infectious diseases.

Why is Infection Control important?

Infection control is important because, without it, people are at higher risk of infection. Pathogens spread very quickly particularly from one person to another without effective infection control.

The Basic Principles of Standard Precautions

There is a basic level of infection control precaution, which should be used as a minimum, when coming into contact with people. Hand hygiene is a major component of standard precautions and one of the most effective methods to prevent transmission of pathogens associated with health care.

"Standard Precautions" require that workers assume that the blood and body substances of all people are potential sources of infection, regardless of diagnosis or presumed infectious status.

The basic principles of standard precautions are:

Hand Hygiene
Hand washing and drying before and after each personal contact, before and after preparing meals (if applicable) etc. or use of hand sanitising products if hand washing is not available. Hand washing is the most important procedure in the prevention and minimisation of the spread of infection.

Personal Protective Equipment (PPE) *(if applicable to your role)*
Disposable gloves, disposable apron (one use only)

Respiratory Hygiene (Cough Etiquette)
Cover your mouth and nose with a tissue when coughing or sneezing, use the nearest waste receptacle to dispose of the used tissue, perform basic hand hygiene.

The above information provides a brief overview of Infection Prevention and Control. Please follow your own organisational specific requirements in relation to your role.

Mental Health Navigator (South West Yorkshire NHS Foundation Trust)

Quick Reference Guide

Who are the Mental Health Navigators?

There are 3 Registered Mental Health Nurses based within the three Connecting Care+ Hubs (Castleford Civic Centre, Waterton House and Bullenshaw)

What can the Mental Health Navigators offer?

Their function is three fold and underpinned by the philosophies of mental health promotion, empowerment and personal responsibility.

Function 1

- Conduct a holistic mental health assessment on those identified. These should be undertaken in a timely manner, and alongside partner agencies if appropriate
- Support patients to access appropriate support and advice
- Guide patients and their families/carers through the mental health care system, signposting to the most appropriate service and enabling patients to make informed choices
- Promote self-directed care and work collaboratively with patients/carers/families on personalised care plans
- Work collaboratively with partners and external service providers/agencies who may contribute to the above process
- Provide early interventions and support to patients to prevent presentation to hospital with an acute episode
- Focus on recovery and improve access for all patients – 'right person, right place, right service'

Function 2

- Provide mental health advice, education and support to team members
- Identify and develop educational sessions for those within the hub

Function 3

- Improve mental health knowledge within GP surgeries, acting as a source of support for surgeries in the management of patients presenting with mental health issues
- Share information with community anchors
- Share good practice and participate in research
- Improve the profile of mental health and wellbeing services
- Reduce the number of patients requiring ongoing support from health and social care

Access & Criteria / Referring to us

Mental Health Navigators will work with anyone over the age of 18 living in the community who is experiencing a mental health problem. We would not accept referrals for;

- Those exhibiting acute physical ill health, or in an acute phase of mental illness.
- Those who pose a high risk to themselves or others.
- Patients who are actively suicidal
- A pre-existing diagnosis of unstable severe mental illness
- Those with significant impairment of cognitive function e.g. dementia, autistic spectrum problems of learning difficulties. This also includes patients who need to be referred for forensic or neuropsychological assessment. Such individual's needs are best met via specialist or secondary community mental health teams
- WDH tenants requiring MH support require referral to the WDH Health and Wellbeing team who can provide MHN assessment
- Patients already receiving support from secondary care MH services, or with a referral for secondary care services in situ

If a patient is not suitable for support from the MHN, they will work proactively with other providers to ensure the right care is secured.

Locations & Opening Hours

There is one Mental Health Navigator based within each of the Connecting Care Hubs:

Waterton Hub Monday to Friday between the hours of 8am – 4pm

- Email – lesley.harris@swyt.nhs.uk
- Phone – 07979 532772
- Face to face at hub

Castleford Civic Centre Monday to Thursday between the hours of 8am – 4pm

- Email – emma.clough@swyt.nhs.uk
- Phone – 07879 602281
- Face to face at hub

Bullenshaw Monday to Friday between the hours of 8:30am – 4:30pm

- Email – richard.barratt@swyt.nhs.uk
- Phone – 07585 201476
- Face to Face at hub

The service is not currently available evenings, weekends, nights or bank holidays.

Mid Yorkshire Integrated Care Team (MY ICT)

Quick Reference Guide

Who are MY ICT?

MY Integrated Care Team is a team of qualified nurses and Health care support workers. We see patients in the community who:

- Are age 18 and over
- Registered with a Wakefield G.P.
- Have an ongoing health or rehabilitation need that can be managed safely in a patient's own home with a period of short term input
- Identified as having a Palliative/end of life diagnosis with a days to weeks prognosis
- Require Intravenous antibiotics administering in a community setting
- Provides out of hours district nursing service

What is MY ICT?

To provide holistic, patient centred care when supporting individuals who have been in hospital or in the prevention of unnecessary hospital admissions. Also to provide patient centred palliative care at home and support for patients who are medically unwell but do not require a hospital admission. Also to provide rehabilitative care for patients who require support to resume previous levels of independence. The team can also administer intravenous antibiotics in a patient's homes or residential home. Our ethos is a goal centred MDT approach to provide seamless and cohesive nursing and therapy to maximise health and function.

MY ICT as a service will:-

- Be patient centred in the delivery, development and organisation of our services
- Aim for excellence in the provision of high quality individually focused interventions in partnership with other appropriate agencies/services
- Positively influence the delivery and development of services through leadership and example
- Aim to be leaders in providing Nursing Services to the residents of Wakefield

Access & Support

Contact numbers and Referral Process are through the Single Point of Contact (SPOC)
Telephone Number: 01924 327591

Locations & Opening Hours

Based at The Bungalow, Castleford. MY ICT covers the whole of the Wakefield District as long as the patient has a Wakefield GP.
We are a 24 hour a day, seven day a week service.

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Mid Yorkshire Therapy (MY Therapy)

Quick Reference Guide

Who are MY Therapy?

MY Therapy is a team of Community Therapists and Support Workers. We see patients within the Wakefield district who require assessment, treatment and rehabilitation services. The team is made up of Physiotherapists, Occupational Therapists, Dietitians and support staff.

MY Therapy has teams based in the Connecting Care+ Hubs and Wakefield Intermediate Care Unit. Referrals are made to the service via telephone or e-referral, and there is a co-ordinator based within the hubs 8am – 6pm each weekday to triage referrals.

Referrals are prioritised by clinical staff, either Physiotherapists, Occupational Therapists or band 4 Technical Instructors. Patient information is triaged and visits booked into diaries based upon the urgency of the situation and the needs of the patient.

MY Therapy can respond quickly where a patient's circumstances and their requirements indicate a need for this. The referrals to MY Therapy are predominantly Therapy but the team work closely with the connecting care hub partners to ensure that other service requirements can be identified at the point of referral regardless of whether they are health, social care or voluntary sector workers.

An Overview of our Service

Rehabilitation can be provided in any community setting including patients own homes, residential Care homes, residential rehabilitation setting

The service specialises in the following areas:

- Dietetics
- Cardiac rehabilitation
- Respiratory
- Neurology
- Falls and Orthopaedics
- Generic Rehabilitation

Access & Criteria / Referring to Us

Criteria:

- 18 years and over
- Registered with a Wakefield District GP
- Medically manageable within primary care
- Rehabilitation potential (OT, PT, Dieticians)
- Urgent OT / PT related equipment / mobility aids to prevent admission
- Therapy and or Dietetic input to patients at home or in the bedded units
- Respiratory service including pulmonary rehab groups
- Generic rehabilitation and falls management

- Neuro service including Early Supported Discharge (ESD) and management of long term conditions
- Cardiac rehabilitation service
- Support to emergency department to prevent admission
- Assessment & intervention in a crisis to try to maintain someone in their own home and prevent admission
- Referring to MY Therapy Community Rehabilitation
- For all enquiries ring 01977 747471 or referrals; 01924 327591

Opening Hours

MY Therapy is a seven day a week service, 365 days a year.

Our hours of work are:

Monday to Friday	8am-6pm
Weekends	8am-4pm.

We also cover all Bank Holidays.

Personalised Technology (Wakefield Council)

Quick Reference Guide

What is Personalised Technology?

Personalised Technology/Telecare is support and assistance provided at a distance using information and communication technology. It is the continuous, automatic and remote monitoring of users by means of sensors to enable them to continue living in their own home, safely and more independently, minimising risks such as a falls, smoke, gas and flood detection and can be used for other real time emergencies and lifestyle changes over time such as a loss in short term memory, dementia, confusion and leaving the property at inappropriate times.

Equipment Guide

Community Alarms are monitored by call centres which are capable of receiving alerts from the devices listed below.

Pagers for onsite carers are also capable of receiving alerts from the following devices:

Wearable devices:	Neck or wrist worn personal pendants to detect falls
Environment monitoring:	Equipment that detects smoke, CO2, extreme heat, low temperatures, gas, floods
Movement monitoring:	Bed/chair leaving sensors, Passive Infrared Movement detectors (PIR's), door entry/leaving sensors
Personal Wellbeing:	Epilepsy monitors, incontinence monitoring (sheets), bogus caller alerts (pendants), medication dispensers/reminders.

Telecare is customisable to most individual's situations.

Apps and Downloads

Here are some examples of what is available, google and you'll find more:

https://www.greenalp.com/RealTimeTracker/
Real-Time GPS Tracker and *Real-Time GPS Tracker 2*. Greenalp belongs to the most popular real-time location tracking services available for Android. Individual users use this service to show their location to their family and friends in real-time.
http://www.bookofyou.co.uk/

Book of you is a fantastic interactive book that uses the benefits of reminiscence therapy to create a personal life story of someone living with dementia, by capturing the precious moments that make up their lives and who they are.
https://apps.beta.nhs.uk/?category=Mental%20Health

You can find digital tools to help you manage and improve your health for:

Cancer	COPD
Dementia	Dental
Diabetes	Healthy Living
Learning Disabilities	Mental Health

Access & Support

Technology can be accessed in different ways.

1. Through a Social Care assessment by a Social Worker, OT, Mental Health or Physiotherapist where an assessment is carried out to identify needs, and do they meet the National Eligibility Criteria. When receiving technology through Social Care a financial assessment is carried out to determine contributions towards the cost of the service

2. By self-referral direct to WDH Care Link. The costs are determined on types of technology package that is installed in the home. There is no eligibility criteria and no financial assessment carried for the service.

3. Thirdly there are many internet access sites that can provide equipment on a private purchase basis, this is a short example of what you can find when you google search:

   Direct referral to Care Link
   https://www.carelink24.org/?gclid=CIa2tvDj79UCFSux7QodLLsMtg

   At dementia
   https://www.atdementia.org.uk/

   Age Action Alliance
   http://ageactionalliance.org/

   The Helpful Things Company
   https://www.helpfulthings.co.uk/

   Tel Me Now - Technology for independent living
   https://www.telmenow.com/

   Spring Chicken - Making life easier & brighter as you get older
   https://www.springchicken.co.uk/

Locations & Opening Hours

Contact: telecare@wakefield.gov.uk or fthompson@wakefield.gov.uk

Pharmacy Awareness (Mid Yorkshire Hospital Trust)

Quick Reference Guide

Who are the Connecting Care+ Pharmacists?

The Connecting Care+ pharmacists are clinical pharmacists working in the community to provide safe and effective pharmaceutical care in a domiciliary setting. They are employed by Mid Yorkshire Hospitals NHS Trust

An Overview of our Service

Pharmacists will review referred patients and conduct clinical medicine reviews and carry out interventions where appropriate to improve pharmaceutical care. Pharmacists will provide medication education, assess adherence and follow up patients as appropriate to monitor outcomes.

Access & Criteria / Referring to us

Criteria

- Adult patients aged 18 years and over
- Registered with a Wakefield CCG member GP practice
- Have a rising risk of admission or readmission to hospital due to worsening clinical condition or when there is an opportunity to avoid hospitalisation

Patients requiring specific consideration include those:

- Taking 4 or more long term medications concurrently where changes to the regular medication regime have been made or there is a concern about adherence.
- Following a medication related admission e.g. hypotension, hypoglycaemia
- Following hospital admission, those identified at risk of medication related problems
- Having confusion with their medication or difficulty managing medicines
- Frequent GP attenders
- Large amounts of unused medications in the home or returned to pharmacy
- Taking high risk drugs e.g. opiates, benzodiazepines, methotrexate, insulin, antiplatelets/anticoagulants, Parkinson's medications
- Repeated falls

Other criteria may be considered appropriate for inclusion, but priority may be given to patients meeting the above criteria at the discretion of the pharmacist.

Referrals

- Internal referral via PIC on systmone,
- Connecting Care+ partners via Care coordination hubs
- Any other referrers via single point of contact (SPOC): 01924 327591

Locations & Opening Hours

There are 3 WTE pharmacists that cover the two CCT hubs:

- Bullenshaw, Hemsworth
- Waterton, Wakefield

The service is available Monday to Friday, 8.45am – 5.15pm.

Reablement (Wakefield Council)

Quick Reference Guide

What does Reablement mean?

Reablement is a short and intensive service, usually delivered in the service user's own home, which is offered to people with disabilities and those who are recovering from an illness or injury. It is one of the council's main tools to manage the cost of an ageing population and has proved an important asset as authorities face cuts in government funding.

The Reablement Service aims to work with individuals to encourage and motivate them to rebuild confidence, support the development of daily living skills and promote and retain as much independence as possible.

Reablement Services are provided by local authorities, and in some cases in partnership with Community Health Services.

Reablement is usually non chargeable which means it is free of charge even for people who usually pay for all or part of their care.

What is the Reablement Service?

The purpose of Reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home.

If a person is referred to the Reablement Service, a Reablement worker will visit them in their home, assess their abilities, needs and agree goals. Over the next few days and weeks the individual will be supported to regain physical function and relearn skills such as cooking meals, washing and getting about.

The workers who visit may be care workers who have been trained in Reablement, but they may also be assisted by Occupational Therapists or Physiotherapists who will give expert advice and support.

Instead of doing things for the person, Reablement workers will actively assist individuals in doing things for themselves. This approach takes longer than conventional home care, which is why visiting times tend to be longer.

There is also more of a focus on assessments, workers will regularly measure how the person is improving and will regularly assess them in order to record progress and plan ongoing support.

A Reablement worker may introduce equipment or modifications and this is where an Occupational Therapist will contribute. Modifications may be temporary or permanent to help keep the person safe and independent at home.

As part of a pilot project with WDH all service users receiving Reablement will be offered WDH's Care Link Telecare service free of charge for the period of Reablement. The service will consist of a Telecare alarm and 24/7 monitoring and response. At the end of the Reablement period, the service user will have the option to keep the alarm as a paid for service.

The Reablement Team can also offer a range of other responses including:

Hospital to home. This response is a free service designed to support a return to home after a period of time away for whatever reason. This can be to promote confidence, check that previous routines are still appropriate, check that heating is on and food is in the home etc. The service is very short term and hopefully results in the service users picking up where they left off and the outcome is hopefully that they will not require any ongoing services.

Bridging service. This is exactly what is says and is designed to bridge the new start or restart of a longer term service and this is a **chargeable service from day one**.

Emergencies are agreed on a case by case basis with the appropriate hub coordinator.

Access & Support

All referrals must be for adults age 18 years and above and they must be Wakefield residents. Referrals should be sent via Social Care Direct or through the connecting care hubs or hospital social work teams and an assessment must have been undertaken before Reablement Services are commissioned through a Social Worker, Care Coordinator of ward based discharge coordinator.

The service offers the following:

- Crisis intervention to prevent unnecessary admission to hospital, respite placements or support for breakdown in carer responsibility.
- Support as an interim measure until a longer term provider is found.
- Facilitates safe hospital discharge following acute admission.
- Prevents admission to acute wards by supporting safe discharge from A&E and assessment units.

Locations & Opening Hours

The Reablement Service has two hub bases, one on the East and one of the West of the district.

Waterton Hub, Waterton House, Wakefield
Telephone: 01924 303731

Hazel Garth Annexe, Knottingley
Telephone: 01977 723735

The Reablement Service is available from 6:30am to 11.00pm, 365 days a year.

Sensory Impairment (Wakefield Council)

Quick Reference Guide

Who are the Sensory Impairment Team?

The Sensory Impairment Team is a multi-disciplinary team consisting of Social Workers, a Care Coordinator and Rehabilitation Officers. The team also have funding agreements with Wakefield Deaf Society and Wakefield District Sight Aid to provide low level assessments for the provision of equipment, advice and support for people with sight, hearing or dual sensory loss. Eye Clinic Liaison Officers provided by Royal National Institute for the Blind (RNIB) are based at both Pinderfields and Pontefract hospital to ensure early intervention for people with a vision impairment.

What does the Sensory Impairment Team do?

The Sensory Impairment Team undertakes assessment and care management functions for people who have a sensory impairment as their primary need. Specialist assessments for people with a dual sensory loss, visual and hearing impairment are undertaken within the team or through referral to local agencies for low level equipment provision. Under The Care Act 2014, there is a specific requirement for individuals who meet the Department of Health deafblind criteria to be assessed by a person who is suitably qualified. Practitioners within the Sensory Impairment Team are able to undertake such assessments or refer onwards to a more qualified service/practitioner. The team is here to offer information/advice around sensory impairment and ways in which to ensure that service users can fully participate within their assessment (such as use of interpreters).

The Sensory Impairment Team delivers rehabilitation services (such as mobility, daily living and communications training) to people with a visual impairment and provides a range of equipment either directly or through local voluntary agencies acting on our behalf. The rehabilitation officers can train a person's carer to safely assist someone with a visual impairment when out and about in the community. Rehabilitation officers also undertake specialist assessments of a person's home and can provide advice, further rehabilitation and equipment to promote independence with daily living skills.

The Sensory Impairment Team also holds the registers of individuals who are sight impaired/severely sight impaired and Deaf/Hard of Hearing and identifies individuals with a dual sensory impairment.

The focus of the Sensory Impairment Team sits very firmly within the Prevent, Reduce and Delay agenda of The Care Act 2014. The rehabilitation officers explore the individual's daily life in detail including how they can improve their personal wellbeing by exploring and supporting to engage in their hobbies and interests, return to work or education and lead fulfilling lives.

Access & Support

Referrals to the team for individuals' resident within the Wakefield area can be made through a number of ways: Referrals made through the Hub Co-ordination Units will be screened and passed to the Sensory Impairment Team where appropriate. Individuals or professionals can refer directly through Social Care Direct, or professionals with access to CareDirector can click on the "refer to Sensory Impairment Team" within the Conversations Record (Forms section of the referral)) and complete the relevant questions for direct referral into the team. All referrals are triaged by a practitioner upon receipt to the team to identify the service required and urgency.

Referrals are also made directly into the team through the Eye Clinic Liaison Officers or through receipt of a Certificate of Visual Impairment completed by a Consultant Ophthalmologist.

The Sensory Impairment Team operates a duty system and a practitioner within the team is available every day during office hours to assist with enquiries and to support referrals into the team.

Locations & Opening Hours

The Sensory Impairment Team is based at the Civic Centre:

Monday to Thursday	8.30am to 5.00pm
Friday	8.30 am - 4.30pm
Team Telephone Number:	01977 723922
Social Care Direct:	01924 303456

The Prince of Wales Hospice

Quick Reference Guide

Who are The Prince of Wales Hospice?

The Prince of Wales Hospice has been providing care to people with a life-limiting illness since 1989. Our services are available to any adult from the Five Towns area of West Yorkshire.

We care for patients with any life-limiting illness, including cancer, motor neurone disease and chronic heart and lung disease. We care for anyone over the age of 18, either as a visiting out-patient, or on our ward where we offer 24-hour specialist care. Our Hospice helps people live better with their illness. Many choose the safety and dignity of our Hospice for care at the end of their life.

Our care also extends to the carers and families of our patients, who often need us just as much. As a healthcare service, we are regularly inspected by the Care Quality Commission.

We provide our care free of charge and entirely based on need, but only about a 25% of the cost is covered by the NHS. This means we have to raise over £3m a year through our shops, fundraising events, donations and fundraising initiatives in our communities. Of every £1 we raise, 86p is spent directly on patient care and 14p is invested in raising more funds.

An Overview of our Service

Incare - The Hospice has thirteen bedrooms for patients who need 24-hour specialist care. Patients who stay with us often need help managing their physical symptoms, such as pain or nausea. Others may be having distressing emotional or spiritual difficulties.

Outreach - Outreach is for people who have a life limiting condition and live relatively well at home, but could benefit from social support from others in a similar situation. It's a chance to get out of the house, make new friends and participate in crafts and other activities.

Lymphoedema Clinic – As well as a Lymphoedema Clinic at the hospice, we also offer two outreach lymphoedema services at Wakefield Hospice and the Rosewood Centre in the grounds of Dewsbury and District Hospital. Patients must be referred to the clinic by their Health Care Professional. Those referred will be invited to an assessment appointment lasting about two hours, which includes a thorough consultation.

Therapy services – The Hospice provides a range of therapeutic services that are available to all patients known to the Hospice as well as their carers and families. Complementary therapies have been shown to help make life more comfortable for patients by promoting relaxation and reducing anxiety. We offer a variety of treatments in our relaxing therapy rooms including: Reiki or light touch, massage, aromatherapy, relaxation, sound and touch and visualisation.

Family and carer support - We offer a confidential ear and practical support to help families and carers throughout our care for their loved one and beyond. Spiritual support is available and we have a quiet area available for reflection.

Bereavement support - Our bereavement support service can help families come to terms with the loss of a loved one. We provide a confidential opportunity to talk with someone other than family and friends, can suggest coping mechanisms and provide the chance to talk to others in a similar situation.

Access & Criteria / Referring to Us

Hospice services can be accessed via a referral from one of the following health care professionals; GPs, Hospital doctors (after assessment by the hospital palliative care team), District nurses, Specialist Palliative Care Team.

Opening Hours

The Prince of Wales Hospice is located on Halfpenny Lane, Pontefract, West Yorkshire, WF8 4BG. We offer 24-hour specialist care.

For further information on any of our services call: 01977 70868 or visit: www.pwh.org.uk.

Wakefield Wheelchair Service

About the Wakefield Wheelchair Service?

The Wakefield Wheelchair Service is delivered by the Wakefield Council on behalf of NHS. The aim of the service is to maximise the mobility and independence, improve the quality of life of the clients and their carer's through timely access to appropriate assessment, provision and maintenance of the equipment.

The team consists of Physiotherapists, Occupational therapists, Technical instructor, Rehabilitation engineer and administration staff.

What do the Wakefield Wheelchair Service do?

The service provide a range of equipment including manual wheelchairs, powered wheelchairs and special seating to people of all ages.

Clients will be assessed for the most suitable equipment to meet their needs in line with the eligibility criteria set by the NHS.

The majority of clients are seen at the Wheelchair Service but we may be able to offer home visits where appropriate. Carers and relatives are also encouraged to attend the appointments.

Equipment issued from the Wheelchair Service will also be maintained free of charge by our contracted repair service.

The service now offer Personal Wheelchair Budgets (PWB) to anyone who is eligible for an NHS Wheelchair. This may allow clients to choose a different wheelchair from our range and make a contribution towards this. Alternatively, if the client chooses to purchase a wheelchair outside our normal range they can receive some financial help towards this. We can give further details on request.

Access & Support / Referring to Us

The initial referral must come from a health care professional, such as a GP, Therapist or Nurse who can refer into the service, using the service specific referral form.

Existing clients can request a review if they feel it is necessary

Location & Opening Hours

Wakefield Wheelchair Service is based at:

Community Equipment and Wheelchair Services
Unit 10
Trinity Business Park
Turner Way
Wakefield
WF2 8EF

Opening Hours:

Monday to Thursday	8.30am – 5pm
Friday	8.30am – 4.30pm

Contact Details:

Telephone Number	01924 302448
Email:	wheelchairservice@wakefield.gov.uk

WDH

Quick Reference Guide

Who are WDH?

WDH was formed in March 2005 and is a housing association, regulated by the Homes and Communities Agency (HCA). The organisation is a charitable Community Benefit Society registered under the Co-operative and Community Benefit Societies Act 2014.

WDH is Wakefield's biggest housing provider, owning and managing over 31,000 properties within the Wakefield district and employing over 1,400 people.

The housing association provides a range of affordable housing as well as services that improve the social value for people. WDH offers value added services for older people, people with health challenges and supports people back into work.

What can WDH offer?

Mental Health Navigators
WDH's Mental Health Navigators work with tenants and families to ensure that people experiencing mental ill health can access the interventions and support they need to make positive changes to their situation.

Wellbeing Caseworkers
WDH's Wellbeing Caseworkers support tenants and families to better understand the actions they can take to manage their health and wellbeing by making and maintaining positive changes to their lifestyle.

Tenants are supported to address the underlying issues which prevent them from adopting healthy lifestyles and the emphasis is on supporting them to develop their skills.

Wellbeing Caseworkers complete an initial assessment and the areas which they cover include:

- General Health
- Mental Wellbeing
- Setting up a home
- Sustaining your tenancy
- Life skills
- Money matters
- Personal administration
- Children and parenting responsibilities
- Managing person safety
- Community networks
- Diet and healthy eating
- Exercise
- Use of alcohol, drugs and smoking
- Independent travel
- Motivation and engagement with support services
- Employment, training, education and hobbies
- Offending behaviour

Care Link Telecare
Care Link supports people of all ages, in any state of health, to live independently and with confidence in their own home.

The Care Link service offers a community alarm and a range of sensors linked to a 24/7 contact centre to support a number of different health issues or vulnerabilities for customers of any tenure.

Care Link Responder Service
The Care Link responder service operates on a 24/7 basis and will respond to issues such as falls in the home. Responders are able to lift customers using the latest lifting equipment reducing the need for an ambulance call.

The service is available to non WDH tenants.

Home Visiting Service
Home visiting is for anyone who feels they need a little more support at home, and caters for people with physical health problems, mental health problems, people with learning difficulties, those with low confidence, people suffering from social isolation and those who just want a little company through the week while their loved ones are at work.
Home visiting is a flexible service and is tailored to an individual's needs with the frequency and time of visits agreed with the customer.

The service supports people to improve their independence and confidence so they can stay in their own home and provides help with: physical or mental health issues; making new friends; finding out about local social activities; reading and explaining mail; and communication with relatives.

The service can be provided to non WDH tenants.

Independent Living Schemes
A WDH Independent Living Scheme offers support for an independent lifestyle. Residents have their own door key and can come and go as they please, while still living within a larger secure scheme, or a self-contained bungalow, that offers them safety and peace of mind.

WDH's Independent Living Schemes are located across the Wakefield district. All are within close proximity to local amenities, meaning residents are never far from shops and essential services.

Residents have a built-in support system, because each property is fitted with a WDH Care Link alarm providing a 24-hour emergency contact.

Each scheme has either a Community Support Worker or a Residential Scheme Manager who looks after each resident's welfare and liaises with relevant agencies where required. They also arrange and support social activities and events to encourage social interaction.

Extra Care
Extra Care is similar to WDH's Independent Living Schemes, but offers additional support. Residents are provided with a three course midday meal each day. Domestic assistants undertake light housekeeping duties within individual properties to support residents.

Adaptations
WDH's team of Occupational Therapists will assess and provide minor adaptations to tenants to help them continue living independently or support them to move to more suitable accommodation. They also work in partnership with Wakefield Council to provide major adaptations to tenant's homes.

Cash Wise
WDH's Cash Wise programme aims to equip tenants with the knowledge and skills to take control of their financial affairs and manage and sustain their tenancies. Cash Wise programme can support tenants with:

- Help with benefit problems
- Help managing money
- Cook healthy food on a budget
- Job advice

Locations & Opening Hours

For any of the above services contact OneCALL our 24 hour Customer Contact Centre on 0345 8 507 507 or e-mail onecall@wdh.co.uk

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Wellbeing Offer

Quick Reference Guide

What does Low Level Wellbeing mean?

To meet the challenges of the future, it is vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible.

The care and support system must work actively to promote wellbeing and independence and should not just wait to respond when people reach a crisis point.

For a self-care and strengths-based approach to care and support to work effectively, practitioners must be aware of what people are able to do with resources available to them, either by using their own skills or by using what's around them in their relationships or communities.

By knowing what's available in the community and by working collaboratively with people, will help the individual to deal with challenges in life in general and in meeting their needs and achieving their desired outcomes.

Access & Information

Access Bus/Travel
Access Bus is a dial-a-ride bus service providing door-to-door local transport, seven days a week between 9am and 5pm. It is of particular benefit to people who are unable to use standard bus services, as the driver assists passengers from door-to-door, including boarding and alighting. The buses are fully accessible, fitted with seatbelts and the most up-to-date wheelchair restraints. Most trips are for shopping purposes, such as to the local supermarket or shopping centre, but we also provide a limited number of journeys for social purposes, to locations such as local community centres, places of worship and visits to family and friends. www.wymetro.com/plan-a-journey/accessible-travel/accessbus/
Who is eligible?
Anyone of any age can register for Access Bus.
How do I register?
You can download/print an application form (pdf - opens in new window) to send, or telephone 0113 348 1903, Monday to Friday between 7.30am and 4pm.

Adults Education - Learning for life and for work.
Joining Adult Ed and taking a course is a great way of learning and developing new skills, picking up a new hobby or interest, improving your confidence and also making new friends. Many of the courses are free and they can offer financial help with fees, travel, equipment or childcare. They also offer a wide range of assistance throughout your journey if you are new to doing this.
To find out what's on -
www.wakefield.gov.uk/jobs-and-learning/adult-education

Age UK Wakefield
See Quick Reference guide for services offered.
If you need to know more about what other services are available to older people in the community, please contact Age UK Wakefield on: Tel 01977 522114 – Bank St office

Waterton hub email ageukcentral@ageukwd.org.uk
Bullenshaw email ageuksoutheast@ageukwd.org.uk

Alcohol and Drug Advice and Services
There are a number of local organisations working across Wakefield to offer support, advice and treatment.
www.wakefield.gov.uk/health-care-and-advice/public-health/alcohol-and-drugs

Autism Directory
Links to local and national information and advice websites and resources.
www.wakefield.gov.uk/Documents/health-care-advice/autism-directory.pdf

Carers Wakefield & District
See Quick Reference guide for services offered.
If you need to know more about what other services are available to carers in the community, please contact Carers Wakefield & District on 01924 305444.
Free Carers resource: Carer Digital Resource – www.carersdigital.org - register using code DGTL7298 includes jointly app.

Cinnamon Trust
The only specialist national charity for people in their last years and their much loved, much needed companion animals. A network of 15,000 volunteers "hold hands" with owners to provide vital loving care for their pets. We keep them together - for example, we'll walk a dog every day for a housebound owner, we'll foster pets when owners need hospital care, we'll fetch the cat food, or even clean out the bird cage, etc.

When staying at home is no longer an option, our Pet Friendly Care Home Register lists care homes and retirement housing happy to accept residents with pets, and providing previous arrangements have been made with us we will take on life time care of a bereaved pet.

More information: www.cinnamon.org.uk/home.php

Citizens Advice
Citizens Advice aim to provide the advice people need for the problems they face and improve the policies and practices that affect people's lives.
They provide free, independent, confidential and impartial advice to everyone on their rights and responsibilities. They value diversity, promote equality and challenge discrimination.
Find your local Citizens Advice office here https://www.citizensadvice.org.uk/about-us/how-we-provide-advice/advice/search-for-your-local-citizens-advice/

Connect to Support Wakefield
Connect to Support is a website for people who want support in the Wakefield district. You can find lots of information about the services available including local groups and activities people can get involved with. You can also find information and advice about a range of health and social care subjects. The website is available at
https://www.connecttosupport.org/s4s/WhereILive/Council?pageId=340

Connecting Care
The Connecting Care website provides information about council, health and voluntary sector services. The site has been specifically designed to look for information from Facebook, Meetup and many other sources on the web.

You can access information regarding:

- Information, Advice and Services: hospitals, GP's and health services, learning and education, local support groups and advice, money and legal advice, services, training and employment
- Health and Wellbeing: carers wellbeing, local respite care, personal care, recreational activities, sexual health and wellbeing
- Independent Living: finding support, housing support, local social groups, tackling isolation
- Support: Carers and homecare, local support groups, mental health support and your health

https://www.wakefield.gov.uk/health-care-and-advice/adults-and-older-people-services/older-people/closer-to-home

Events and Culture Wakefield
Wakefield has a host of cultural opportunities to visit and explore ranging from museums, castles, art galleries aswell as holding a number of festivals through the year. Most of these are free to visit but you may have to pay for parking. Toilets and cafes available at some sites. For more information: **www.wakefield.gov.uk/events-and-culture**

Experience Wakefield
You can find out about transport and bus routes, journey planner, what's on, shop mobility and lots of other things to do across the Wakefield District.
www.experiencewakefield.co.uk/travel-transport.aspx

Hospices
There are two hospices in the district.
The Prince of Wales Hospice provides care and support for patients with long term illness, life-limiting illnesses and support for their families. For more information regarding services provided for:

- Day therapy
- Dementia friendly
- Families and carers
- Getting referred
- Incare
- Lymphedema clinic
- Therapy services

Go to https://www.pwh.org.uk/our-care/for-patients or telephone 01977 708868

Wakefield Hospice is a registered charity, is committed to providing the highest level of symptom management and care for people who have advanced active, progressive and long term or life threatening illness. The Hospice endorses a holistic approach in promoting quality of life for patients as well as in the continuing support that is offered to families and carers throughout the period of illness and into bereavement. For more information regarding services provided for:

- In patients
- Day therapy
- Bereavement
- Education

Go to https://www.wakefieldhospice.org/Contact-Us or telephone 01924 331400

Libraries and Local History Wakefield
Your local library can offer more than books. They have film and music libraries to enjoy including free e-books and magazines and free computers available to use. They have reading sessions for all ages, run various classes, craft and chat sessions, Chess Tuesdays, job clubs, readers groups and many others. They also have a dementia friendly libraries at Sandal and Normanton library. They also run mobile libraries for people unable to get out and about and have services and facilities to help library users with a disability or impairment. They can also help you with finding out history of where you live or your family tree.
www.wakefield.gov.uk/libraries-and-local-history

Independent Age
Whatever happens as we get older, we all want to remain independent and live life on our own terms. That's why, as well as offering regular friendly contact and a strong campaigning voice, Independent Age can provide you and your family with clear, free and impartial advice on the issues that matter: care and support, money and benefits, health and mobility.
A charity founded over 150 years ago, we're independent so you can be. To access more information the website link is below:
https://www.independentage.org/

Live Well Wakefield
Live Well Advisors listen to what people might be finding difficult in their life and together will work through the options that may be available to help them. This could be anything from housing options, advice around maximising income, support around the health and social care system, accessing healthcare services to supporting people who need access to specialised services – such as mental health and substance/alcohol misuse and providing opportunities to people of all ages, including those who may feel isolated by society or want to embrace a new challenge.

The service is provided by the South West Yorkshire Partnership NHS Foundation Trust and you can contact them by phoning 01924 255363 or access the website:
http://www.livewellwakefield.nhs.uk/

NHS Choices
Helping you take control of your health and wellbeing including medication, health needs and living, NHS Services www.nhs.uk/

Nova Wakefield District
Is the support agency for voluntary and community groups in Wakefield district. Nova works alongside a number of expert organisations in Wakefield district to deliver support to their members and other voluntary organisations.

For a list of up to date Community Anchors (organisations running community facilities in the Wakefield district) contact 01924 367418 or access Nova's website https://www.nova-wd.org.uk/

Riverside
The preventing Rough Sleeping Model is an outreach and support service for people rough sleeping in the Wakefield District.

Call 01924 385722 (24 hours) or 07989 384172 or email mailto:RC%26S.Wakefield@riverside.org.uk

Sports and Leisure Wakefield
Everyone should have the opportunity to participate in sport and physical activity, whatever their ability. Wakefield Sports and Leisure provides a wide variety of high quality sports, activities and facilities for Wakefield residents and anyone who visits the city for all ages and abilities. Some of the facilities include gym, swimming pools, keep fit classes, golf, running tracks, badminton and football. Charges may apply.

To find out more: www.wakefield.gov.uk/sport-and-leisure

For disability sport and fitness: https://www.wakefield.gov.uk/sport-health-and-leisure/sport-and-activities/disability-sport-and-fitness

Or contact: Sport and Active Lifestyles, Wakefield One, PO Box 700, Burton Street, Wakefield WF1 2EB email sal@wakefield.gov.uk Tel no 01924 307820

To find out your nearest activity or sport club: www.yorkshiresport.org/get-active/

There are also a number of free parks and countryside walks, cycle routes and places to visit and to watch wildlife. www.wakefield.gov.uk/sport-and-leisure/parks-and-countryside

To find out about accessible venues: www.opencountry.org.uk/countryside-access-directories/ search Wakefield.

The Silver Line
The Silver Line operates the only confidential, free helpline for older people across the UK that's open 24 hours a day, seven days a week. The helpline number is 0800 4 70 80 90. It offers telephone and letter friendship schemes where they match volunteers with older people based on their interests, facilitated group calls, and help to connect people with local services in their area.

Volunteering
Volunteering can offer opportunities to meet new people, learn new skills and have fun. Find out about opportunities for volunteering
www.wakefield.gov.uk/community/volunteering

Wakefield Home Energy Grants and Schemes
Staying warm can help people to remain well and living independent. For information about the home energy grants and schemes on offer contact: Home Energy Team, Strategic Housing, Wakefield Council, Wakefield One, PO Box 700, Burton Street, Wakefield, WF1 2EB. Email eat@wakefield.gov.uk Telephone: 0344 902 0222
www.wakefield.gov.uk/housing/energy/help-with-home-energy-improvements

WDH
See Quick Reference guide for services offered.
If you need to know more about what other services are available to WDH tenants in the community, please contact OneCALL a 24 hour Customer Contact Centre on 0345 8 507 507 or e-mail onecall@wdh.co.uk
To understand housing choices see: https://www.wakefield.gov.uk/housing/housing-in-the-wakefield-district/our-priorities/about-housing-options

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Additional Knowledge & Skills

This section details additional knowledge and skills which is role specific. Managers should sign off each area when they are confident that understanding and appropriate application of knowledge has been demonstrated.

Knowledge & Skill Area	Date	Manager Signature
Continuing Healthcare (CHC) Please ensure that the CHC Factsheets are read and discussed with your Manager. Please contact the Adult Workforce Team (01977 723527) to arrange attendance at the next available CHC Workshop if this is applicable to your job role.		
Dementia It is a requirement for all staff working in the Connecting Care+ Hubs to adhere to the National Dementia Core Skills Education and Training Framework, under the following Tier breakdowns:- <u>Tier 1</u> *Relevant to all Health & Social Care staff, including those not providing direct care and support, such as catering, maintenance or administration staff.* • Staff to complete the Tier 1 Open Learning Pack <u>Tier 2</u> *Relevant to Health & Social Care staff directly providing care and support which would include care assistants working in residential or home care and also personal assistants.* • Staff to complete the Tier 1 and Tier 2 Open Learning Packs • Staff to undertake the NCFE Level 2 Certificate in Principles of Dementia Care The Open Learning Packs and NCFE can be accessed by contacting the Adult Workforce Team (01977 723527). It is a requirement for all staff working in the Connecting Care+ Hubs to have an awareness and understanding of the 3D's (Dementia, Delirium & Depression). Please access the below link:- https://www.lifestorynetwork.org.uk/resources/5-knowing-me-e-resource		

Knowledge & Skill Area	Date	Manager Signature
Diabetes It is a requirement for all staff working in the Connecting Care+ Hubs to read the information sheet on Diabetes Awareness.		
End of Life Care It is a requirement for all staff working in the Connecting Care+ Hubs to adhere to the National End of Life Core Skills Education and Training Framework, under the following Tier breakdowns:- <u>Tier 1</u> *Relevant to all Health & Social Care staff that require general end of life care awareness, focussing on a community development, asset based approach to care.* • Staff to complete the Tier 1 Open Learning Pack <u>Tier 2</u> *Relevant to Health & Social Care Professionals who require some knowledge of how to provide person-centred, high quality end of life care as they often encounter individuals who need such support within their working environment. However, they do not work in services that primality offer care and support for individuals approaching the end of life, their family and carers.* • Staff to complete the Tier 1 Open Learning Packs • Staff to undertake the NCFE Level 2 Certificate in End of Life Care The Open Learning Packs and NCFE can be accessed by contacting the Adult Workforce Team (01977 723527).		
First Aid / Basic Life Support <u>All Connecting Care+ staff working in the Community</u> should follow their own organisational specific requirements. <u>Wakefield Council staff</u> Designated First Aider – to complete the Emergency First Aid at Work 3 Day Course with a 2 Day Reaccreditation within 3 years Appointed Person – to complete the Emergency First Aid 1 Day Course every 3 years The 3, 2 and 1 day training can be accessed by contacting the Adult Workforce Team (01977 723527).		

Knowledge & Skill Area	Date	Manager Signature
Infection, Prevention & Control It is a requirement for all staff working in the Connecting Care+ Hubs to undertake the NCFE Level 2 Certificate in Infection, Prevention & Control. The NCFE can be accessed by contacting the Adult Workforce Team (01977 723527).		
Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) & Mental Health Awareness (MHA) It is a requirement for all staff working in the Connecting Care+ Hubs to adhere to the Mental Health Core Skills Education & Training Framework, under the following criteria:- <u>Local Authority Staff</u> It is a requirement for all staff working in the Connecting Care+ Hubs to attend a ½ day workshop 'Mental Health Awareness Session'. Please contact the Mental Health Team on 01924 303869 to reserve a place. <u>Staff who make decisions and anyone who supports staff who make decisions</u> It is a requirement for this staff group to attend a ½ day workshop 'MCA inc. DoLS'. Please contact the Mental Health Team on 01924 303869 to reserve a place. <u>Age UK Wakefield District and Carers Wakefield & District Staff</u> It is a requirement for staff working in the Connecting Care+ Hubs to attend a MCA inc. DoLS briefing session. Please contact the Mental Health Team on 01924 303869 to reserve a place. For staff who make decisions or support staff who make decisions, staff should attend a briefing session on MCA inc. DoLS. Please contact the Mental Health Team on 01924 303869 to reserve a place. <u>Mid Yorkshire Hospital Staff</u> It is a requirement for all Mid Yorkshire Hospital staff to undertake MCA training at Levels 1, 2 or 3. This will be determined by your manager, subject to your job role. This training will be delivered internally by Mid Yorkshire Hospital Trust.		

Knowledge & Skill Area	Date	Manager Signature
Safeguarding It is a requirement for all staff working in the Connecting Care+ Hubs to be compliant with the National Competency Framework for Safeguarding Adults. <u>Level 1</u> *Relevant to all staff working in the Connecting Care+ Hubs* • All staff to undertake the Safeguarding Adults Open Learning Pack • All staff to complete the Safeguarding Children (Level 1) e-Learning by accessing https://wakefieldlscb.safeguardingchildrenea.co.uk/ <u>Level 2</u> *Relevant to all staff that work in the Community* • All staff to undertake the Safeguarding Adults Open Learning Pack • Your Manager will contact the Adult Workforce Team to reserve a place on the Safeguarding Adults – VARM training • Your Manager will contact the Adult Workforce Team to reserve a place on the Safeguarding Adults – Partnership Enquiries training • All staff to complete the Safeguarding Children (Level 1) e-Learning by accessing https://wakefieldlscb.safeguardingchildrenea.co.uk/ • All staff to complete the Safeguarding Children (Level 2) The Open Learning Packs can be accessed by contacting the Adult Workforce Team (01977 723527).		
The Care Act 2014 • All staff should read The Care Act 2014 Factsheets and have a discussion with your Manager. • All staff to complete First Contact Identifying Needs Assessment & Eligibility Open Learning Pack • All staff to complete Advocacy Open Learning Pack The Open Learning Packs can be accessed by contacting the Adult Workforce Team (01977 723527). *<u>Additional – for Social Work Practitioners & Care Coordinators</u>* Your Manager will contact the Adult Workforce Team to reserve a place on The Care Act 2014 3 day programme.		

Continuing Healthcare (CHC)

The following table identifies learning and development requirements appropriate to your job role.

Access to Care Staff		
Role	**Factsheet**	**Workshop**
Mid Yorkshire – Nurse Coordinator	✓	✓
Mid Yorkshire – Therapy Coordinator	✓	✓
Wakefield Council – Social Care Direct – Social Work Staff	✓	✓
Wakefield Council – Social Care Direct – Non Social Work Staff	✓	✓
Connecting Care+ Hubs (Triage / Coordination Unit / MDT)		
Role	**Factsheet**	**Workshop**
Age UK Wakefield District – Senior Manager	✓	✓
Age UK Wakefield District – Senior Support Worker	✓	✓
Age UK Wakefield District– Support Worker	✓	✓
Carers Wakefield & District – Carers Support & Development Manager	✓	✓
Carers Wakefield & District – Carers Support Workers	✓	✓
Mid Yorkshire – Admin (Band 2)		
Mid Yorkshire – Admin (Band 3)		
Mid Yorkshire – Advanced Practitioner	✓	✓
Mid Yorkshire – Nurses (Band 5)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 5)		
Mid Yorkshire – Occupational Therapist (Band 6)		
Mid Yorkshire – Occupational Therapist (Band 7)		
Mid Yorkshire – Pharmacist (Band 8a)		
Mid Yorkshire – Physiotherapist (Band 5)		
Mid Yorkshire – Physiotherapist (Band 6)		
Mid Yorkshire – Physiotherapist (Band 7)		
Mid Yorkshire – Single Point of Contact (SPOC) staff	✓	✓
Mid Yorkshire – Technical Instructor (Band 3)		
Mid Yorkshire – Technical Instructor (Band 4)		
Mid Yorkshire – Therapy Lead	✓	✓
Mid Yorkshire – Therapy Team Leader		
South West Yorkshire Foundation Trust – Mental Health Navigator	✓	✓
Wakefield Council – Admin Coordinator, Coordination Unit	✓	✓
Wakefield Council – Care Coordinator	✓	✓
Wakefield Council – Coordination Support Officer, Coordination Unit	✓	✓
Wakefield Council – Coordination Support Officer, Teams	✓	✓
Wakefield Council – Locality Manager	✓	✓
Wakefield Council – Manager of Coordination Services	✓	✓
Wakefield Council – Social Worker (Level 1)	✓	✓
Wakefield Council – Social Worker (Level 2)	✓	✓
Wakefield Council – Support Services Coordinator	✓	✓
WDH – Team Leader for Independent Living	✓	✓
WDH – Wellbeing Case Worker	✓	✓

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Continuing Healthcare (CHC)

Factsheets

Factsheet 1

An Overview

- Continuing Healthcare (CHC) should be considered for individuals who ***may*** be in need of ongoing care and support from health and social care professionals ***as a result of disability, accident or illness***.

- National Guidance available since 2007 (revised in 2012), sets out a single, National Framework for determining eligibility for NHS Continuing Healthcare and for NHS-funded nursing care.

- The purpose of the National Framework is to provide for fair and consistent access to NHS funding across England, regardless of location, so that individuals with similar needs should have an equal likelihood of getting all of their health and nursing care provided ***free of charge***.

- NHS Continuing Healthcare is the name given to a package of care which is ***arranged and funded solely by the NHS*** for individuals outside of hospital who have ongoing health care needs.

- People can receive NHS Continuing Healthcare in any setting, including their own home or in a care home.

- NHS Continuing Healthcare is free, unlike support provided by local authorities for which a financial charge may be made depending on income and savings.

- Anyone over 18 years of age assessed as having a certain level of care needs may be entitled to NHS Continuing Healthcare.

- Entitlement to NHS Continuing Healthcare is ***not dependent on a particular disease, diagnosis or condition***, nor on who provides the care or where that care is provided.

- A ‘primary health need’ is assessed by looking at all of someone’s care needs and relating them to four key indicators: nature, complexity, intensity and unpredictability.

Factsheet 2

Continuing Healthcare Checklist

- This is a ***screening tool*** to help health and social care staff judge whether it is appropriate to undertake a full assessment for NHS Continuing Healthcare.
- The Checklist will usually be completed when there is an assessment or review of a person's health or social care needs.
- The Checklist does not indicate eligibility for NHS Continuing Healthcare, only that they require a further, full assessment of eligibility.
- If a completed Checklist indicates there is a need to carry out a full assessment of eligibility for NHS Continuing Healthcare, the person completing it then contacts the Clinical Commissioning Group (CCG), by email, and forwards a signed copy of the document.
- A copy of the completed checklist should also be sent to the CHC advisors (Paula Simpson & Donna Burnett) who will then scan it onto care Director and log the details so that the progress of the document can be tracked.
- The CCG will arrange for a multidisciplinary team to carry out an up-to-date assessment of need. They will coordinate and arrange for a Decision Support Tool (DST) to be completed.

Factsheet 3

The Decision Support Tool

- The multi-disciplinary team should be made up of two or more relevant, health or social care professionals.
- The MDT might ask for more detailed specialist assessments from other non-attending professionals.
- The purpose of the tool is to help decide on the nature, complexity, intensity and unpredictability of a person's needs over 11 different domains.
- The multi-disciplinary team will then make a ***recommendation*** to the CCG as to eligibility for NHS Continuing Healthcare.
- The CCG, by way of a ***verification panel***, should usually accept this recommendation in all but exceptional circumstances.
- Funding for someone found to be eligible for NHS Continuing Healthcare should be backdated to either 28 days after The CCG receives the checklist, or the date of The DST, whichever is soonest.
- Some cases might be deferred if there is a miss match of information or further details are required.

Factsheet 4

Fast Track Tool

- The Fast Track Tool may, in certain circumstances, be ***used instead of the Decision Support Tool*** to confirm eligibility for NHS Continuing Healthcare funding.

- The Fast Track Tool may be implemented where there is a ***rapidly deteriorating condition which may be entering a terminal phase***.

- The Fast Track Tool can only be completed by an appropriate clinician. On receipt of the completed document, the CCG will arrange for care to be provided as quickly as possible.

- The CCG will discuss options with people entitled to NHS Continuing Healthcare; about how their care and support needs will best be provided for and managed and their preferred setting in which to do that.

- Within 3 months, or after immediate support has been provided following the completion of a Fast Track Tool, the CCG will usually arrange for a review and completion of a Decision Support Tool.

- A decision might be made that the person is no longer eligible for NHS Continuing Healthcare funding.

- The CCG should send a written decision as to entitlement to NHS Continuing Healthcare together with reasons for the decision.

- Neither the NHS nor the Local Authority should withdraw from an existing care or funding arrangement without a joint review and reassessment of needs. Alternative funding or services must be in place before any proposed changes take place.

Factsheet 5

Reviews

- Reviews should be carried out after 3 months and then at least annually.

- Neither the NHS nor the Local Authority should withdraw from existing funding arrangements without a joint review and reassessment of that person's needs.

- If someone is not happy with the outcome, they can request an independent review via the CCG.

Continuing Healthcare (CHC)

Learning Solution Information

Continuing Healthcare (CHC) Workshop

Learning Aim:
To provide a clear understanding of the NHS Continuing Healthcare process.

Learning Outcomes:
On completion of the workshop, learners will:-

1. Know when to apply the checklist
2. Have a better understanding of what constitutes a primary health need
3. Consider what evidence might be required to support a recommendation for CHC funding
4. Know what resources are available to support CHC assessments
5. Recognise common errors
6. Recognise examples of good practice

Please contact the Adult Workforce Team (Wakefield Council) on 01977 723527 to arrange attendance at the next available CHC Workshop if this is applicable to your job role.

Dementia

It is a requirement for all staff working in the Connecting Care+ Hubs to adhere to the Dementia Core Skills Education and Training Framework, under the following breakdown:-

Access to Care Staff		
Role	**Tier 1**	**Tier 2**
Mid Yorkshire – Nurse Coordinator	✓	✓
Mid Yorkshire – Single Point of Contact (SPOC) staff	✓	
Mid Yorkshire – Therapy Coordinator	✓	✓
Wakefield Council – Social Care Direct – Social Work Staff	✓	✓
Wakefield Council – Social Care Direct – Non Social Work Staff	✓	
Connecting Care+ Hubs (Triage / Coordination Unit / MDT)		
Role	**Tier 1**	**Tier 2**
Age UK Wakefield – Senior Manager	✓	
Age UK Wakefield – Senior Support Worker	✓	✓
Age UK Wakefield – Support Worker	✓	✓
Carers Wakefield & District – Carers Support & Development Manager	✓	✓
Carers Wakefield & District – Carers Support Workers	✓	
Mid Yorkshire – Admin (Band 2)	✓	
Mid Yorkshire – Admin (Band 3)	✓	
Mid Yorkshire – Advanced Practitioner	✓	✓
Mid Yorkshire – Nurses (Band 5)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 5)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 6)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 7)	✓	✓
Mid Yorkshire – Pharmacist (Band 8a)	✓	✓
Mid Yorkshire – Physiotherapist (Band 5)	✓	✓
Mid Yorkshire – Physiotherapist (Band 6)	✓	✓
Mid Yorkshire – Physiotherapist (Band 7)	✓	✓
Mid Yorkshire – Technical Instructor (Band 3)	✓	
Mid Yorkshire – Technical Instructor (Band 4)	✓	
Mid Yorkshire – Therapy Lead	✓	✓
Mid Yorkshire – Therapy Team Leader	✓	✓
South West Yorkshire Foundation Trust – Mental Health Navigator	✓	
Wakefield Council – Admin Coordinator, Care Coordination Unit	✓	
Wakefield Council – Care Coordinator	✓	✓
Wakefield Council – Coordination Support Officer, Care Coordination Unit	✓	
Wakefield Council – Coordination Support Officer, Teams	✓	
Wakefield Council – Locality Manager	✓	✓
Wakefield Council – Manager of Coordination Services	✓	
Wakefield Council – Social Worker (Level 1)	✓	✓
Wakefield Council – Social Worker (Level 2)	✓	✓
Wakefield Council – Support Services Coordinator	✓	
WDH – Team Leader for Independent Living	✓	
WDH – Wellbeing Case Worker	✓	

Dementia

Learning Solution Information

Dementia – Open Learning Pack (Tier 1)

Learning Aim:
Individual awareness of dementia will be raised, in terms of knowledge, skills and attitudes. This is based on the Dementia Core Skills Education and Training Framework Tier One.

Learning Outcomes:
On completion, learners will:-

1. Recognise what is meant by the term Dementia
2. Identify the prevalence of dementia in the UK population
3. Recognise signs of dementia and also be aware that these signs may be associated with other conditions or circumstances
4. Describe what actions individuals can take to reduce the risk of dementia, or to delay onset
5. Explain why early diagnosis of dementia is important
6. Describe the actions that people affected by dementia can take in order to live as well as possible after diagnosis
7. Discuss the importance of recognising a person with dementia as a unique individual
8. Describe the impact of dementia on individuals, families and society
9. Explain ways to communicate effectively and compassionately with individuals who have dementia
10. Recognise reasons why a person with dementia may exhibit signs of distress and how behaviours seen in people with dementia may be a means for communicating unmet needs
11. Identify how to signpost individuals, families and carers to dementia advice, support and information

Dementia – Certificate in Principles of Dementia (Tier 2)

Learning Aim:
Learners will develop skills in the principles of dementia care
To develop and formally recognise their knowledge in the Principles of Dementia Care whilst supporting the care of service users, friends and families at this sensitive time of life.

Learning Outcomes:
On completion, learners will be able to:-

1. Apply their knowledge of dementia awareness
2. Describe and apply a person centred approach to the care and support of individuals with dementia
3. Identify the factors that can influence communication and interaction with individuals who have dementia and how to address these
4. Discuss the importance of equality, diversity and inclusion in dementia care
5. Explain the administration of medication to an individual with dementia and how to do this using a person centred approach
6. Recognise different behaviours in the context of dementia

Diabetes Awareness

It is a requirement for all staff working in the Connecting Care+ Hubs to read the following information sheet about Diabetes Awareness:-

Role	Information Sheet
Mid Yorkshire – Nurse Coordinator	✓
Mid Yorkshire – Single Point of Contact (SPOC) staff	✓
Mid Yorkshire – Therapy Coordinator	✓
Wakefield Council – Social Care Direct – Social Work Staff	✓
Wakefield Council – Social Care Direct – Non Social Work Staff	✓
Role	**Information Sheet**
Age UK Wakefield District – Senior Manager	✓
Age UK Wakefield District – Senior Support Worker	✓
Age UK Wakefield District – Support Worker	✓
Carers Wakefield & District – Carers Support & Development Manager	✓
Carers Wakefield & District – Carers Support Workers	✓
Mid Yorkshire – Admin (Band 2)	✓
Mid Yorkshire – Admin (Band 3)	✓
Mid Yorkshire – Advanced Practitioner	✓
Mid Yorkshire – Nurses (Band 5)	✓
Mid Yorkshire – Occupational Therapist (Band 5)	✓
Mid Yorkshire – Occupational Therapist (Band 6)	✓
Mid Yorkshire – Occupational Therapist (Band 7)	✓
Mid Yorkshire – Pharmacist (Band 8a)	✓
Mid Yorkshire – Physiotherapist (Band 5)	✓
Mid Yorkshire – Physiotherapist (Band 6)	✓
Mid Yorkshire – Physiotherapist (Band 7)	✓
Mid Yorkshire – Technical Instructor (Band 3)	✓
Mid Yorkshire – Technical Instructor (Band 4)	✓
Mid Yorkshire – Therapy Lead	✓
Mid Yorkshire – Therapy Team Leader	✓
South West Yorkshire Foundation Trust – Mental Health Navigator	✓
Wakefield Council – Locality Manager	✓
Wakefield Council – Social Worker (Level 2)	✓
Wakefield Council – Social Worker (Level 1)	✓
Wakefield Council – Care Coordinator	✓
Wakefield Council – Manager of Coordination Services	✓
Wakefield Council – Support Services Coordinator	✓
Wakefield Council – Coordination Support Officer, Care Coordination Unit	✓
Wakefield Council – Coordination Support Officer, Teams	✓
Wakefield Council – Admin Coordinator, Care Coordination Unit	✓
WDH – Team Leader for Independent Living	✓
WDH – Wellbeing Case Worker	✓

Diabetes Awareness

What is Diabetes?

Type 1 Diabetes is a serious, lifelong condition where your blood glucose level is too high because your body can't make a hormone called insulin.

Around 10 per cent of people living with diabetes in the UK have Type 1 diabetes. It's the most common type of diabetes in childhood but it can develop at any age.

Type 2 Diabetes is a serious, lifelong condition where blood glucose level is too high. This is because the body doesn't make enough of a hormone called insulin, or the insulin doesn't work properly.

Around 90 per cent of people living with diabetes in the UK have Type 2 diabetes. Type 2 diabetes starts gradually, usually later in life, although people are being diagnosed at a younger age. It is the most common type of diabetes in adults.

What are the signs of Diabetes?

The common symptoms of diabetes are:

- Going to the toilet a lot, especially at night.
- Being really thirsty.
- Feeling more tired than usual.
- Losing weight without trying to.
- Genital itching or thrush.
- Cuts and wounds take longer to heal.
- Blurred vision.

Why do the symptoms of Diabetes occur?

These symptoms occur because some or all of the glucose stays in the blood, and isn't being used as fuel for energy. The body tries to reduce blood glucose levels by flushing the excess glucose out of the body in the urine. High levels of glucose being passed in the urine are a perfect breeding ground for the fungal infection which causes thrush.

Early Diagnosis of Diabetes

Early diagnosis, treatment and good control are vital for good health and reduce the chances of developing serious complications.

If someone has the symptoms of Diabetes it is important to get checked by their GP.

What happens if you Ignore the signs of Diabetes?

It’s hard to ignore the signs of Type 1 diabetes because symptoms can often appear quite quickly. But leaving it untreated can lead to serious health problems, including diabetic ketoacidosis, which can result in a potentially fatal coma.
Although the majority of people with Type 1 diabetes are diagnosed in childhood and early adulthood, the symptoms are the same at any age. Adults with Type 1 Diabetes may not recognise their symptoms as quickly as children, which could mean their diagnosis and treatment may be delayed.

Type 2 Diabetes can be easier to miss as it develops more slowly, especially in the early stages when it can be harder to spot the symptoms. But untreated diabetes affects many major organs, including your heart, blood vessels, nerves, eyes and kidneys. Being diagnosed early and controlling your blood sugar levels can help prevent these complications.

End of Life Care

It is a requirement for all staff working in the Connecting Care+ Hubs to adhere to the End of Life Core Skills Education and Training Framework, under the following breakdown:-

Access to Care Staff		
Role	**Tier 1**	**Tier 2**
Mid Yorkshire – Nurse Coordinator	✓	✓
Mid Yorkshire – Single Point of Contact (SPOC) staff	✓	
Mid Yorkshire – Therapy Coordinator	✓	✓
Wakefield Council – Social Care Direct – Social Work Staff	✓	
Wakefield Council – Social Care Direct – Non Social Work Staff	✓	
Connecting Care+ Hubs (Triage / Coordination Unit / MDT)		
Role	**Tier 1**	**Tier 2**
Age UK Wakefield District – Senior Manager	✓	
Age UK Wakefield District – Senior Support Worker	✓	
Age UK Wakefield District – Support Worker	✓	
Carers Wakefield & District – Carers Support & Development Manager	✓	
Carers Wakefield & District – Carers Support Workers	✓	
Mid Yorkshire – Admin (Band 2)	✓	
Mid Yorkshire – Admin (Band 3)	✓	
Mid Yorkshire – Advanced Practitioner	✓	✓
Mid Yorkshire – Nurses (Band 5)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 5)	✓	
Mid Yorkshire – Occupational Therapist (Band 6)	✓	
Mid Yorkshire – Occupational Therapist (Band 7)	✓	
Mid Yorkshire – Pharmacist (Band 8a)	✓	
Mid Yorkshire – Physiotherapist (Band 5)	✓	
Mid Yorkshire – Physiotherapist (Band 6)	✓	
Mid Yorkshire – Physiotherapist (Band 7)	✓	
Mid Yorkshire – Technical Instructor (Band 3)	✓	
Mid Yorkshire – Technical Instructor (Band 4)	✓	
Mid Yorkshire – Therapy Lead	✓	✓
Mid Yorkshire – Therapy Team Leader	✓	
South West Yorkshire Foundation Trust – Mental Health Navigator	✓	
Wakefield Council – Locality Manager	✓	✓
Wakefield Council – Social Worker (Level 2)	✓	✓
Wakefield Council – Social Worker (Level 1)	✓	✓
Wakefield Council – Care Coordinator	✓	✓
Wakefield Council – Manager of Coordination Services	✓	
Wakefield Council – Support Services Coordinator	✓	
Wakefield Council – Coordination Support Officer, Care Coordination Unit	✓	
Wakefield Council – Coordination Support Officer, Teams	✓	
Wakefield Council – Admin Coordinator, Care Coordination Unit	✓	
WDH – Team Leader for Independent Living	✓	✓
WDH – Wellbeing Case Worker	✓	✓

End of Life Care

Learning Solution Information

End of Life Care – Open Learning Pack (Tier 1)

Learning Aim:

To provide learners with the opportunity to explore and understand end of life care and to develop knowledge and skills for working with people who are approaching the end of their life.

Learning Outcomes:

On completion, learners will:-

1. Describe what End of Life Care is – the basic principles and components
2. Identify the many endings that people experience during their life course and the different ways that people deal with endings
3. Demonstrate good communication skills relating to End of Life Care
4. Explain the differences between death and dying and the different courses that the end of life process might take
5. Describe some of the common fears experienced by people facing the end of their life
6. Identify some of the key components of good care for people approaching the end of their life
7. Describe the emotional, social and spiritual care you need to give an individual who is approaching the end of their life and their loved ones
8. Recognise what to expect when someone reaches the end of their life
9. Recognise the importance of following an individual's wishes and beliefs in terms of "Rites of Passage" and after care immediately after they have died, including any cultural observances

End of Life Care – Certificate in End of Life Care (Tier 2)

Learning Aim:
To develop and formally recognise their knowledge in the Principles of End of Life Care whilst supporting the care of patients, service users, friends and families at this sensitive time of life.

Learning Outcomes:
On completion, learners will be able to:-

1. Recognise different perspectives on death and dying
2. Identify the aims, principles and policies of end of life care
3. Describe factors regarding communication in end of life care
4. Explain how to access the range of support services available to individuals and others.
5. Discuss approaches to managing pain and discomfort
6. Explain how to assist in minimising an individual's pain or discomfort
7. Describe how to monitor, record and report on the management of an individual's pain or discomfort
8. Recognise how an individual's dementia can affect their end of life care
9. Describe how to support the individual
10. Explain how to support family, significant others and friends
11. Describe how to support an individual as they are approaching death
12. Explain how to care for the deceased
13. Identify the support that may be needed by family, significant others and friends
14. Identify the relevant legislation and policies
15. Describe the process of loss and grief
16. Describe loss in the context of end of life care
17. Explain how to support the bereaved
18. Recognise how to manage your own feelings

First Aid

Role	3 Day Course	1 Day Course	Basic Life Support	Own Organisation Requirements
Mid Yorkshire Staff			✓	
All other Partners				✓
Wakefield Council Staff – Designated Person	✓			
Wakefield Council Staff – Appointed Person		✓		

First Aid

Learning Solution Information

3 Day Emergency First Aid at Work (Wakefield Council – Designated Person)

The learner will understand the roles and responsibilities of a first aider to be able:

- Assess an incident
- Manage an unresponsive casualty who is both breathing/not breathing normally
- Recognise and assist a casualty who is choking
- Manage a casualty with external bleeding
- Manage a casualty who is in shock
- Manage a casualty with a minor injury
- Conduct a secondary survey

The learner will learn how to administer first aid to a casualty with:

- Injuries to bones, joints and muscles
- Suspected head and spinal injuries
- Chest injuries
- Burns and scalds
- Eye injuries
- Sudden poisoning
- Anaphylaxis
- Suspected major illnesses

Refresher – 2 Day Reaccreditation within 3 years of certification

1 Day Emergency First Aid (Wakefield Council – Appointed Person)

This course gives learners the skills to help someone who is:

- Unresponsive and breathing
- Unresponsive and not breathing (including the use of an automated external defibrillator/AED)
- Having a seizure, Choking, Bleeding Heavily, Suffering from Shock and Burns

It also includes information on:

- Dealing with an emergency, Assessing a Casualty, Monitoring a Casualty, where to get help
- Electrical incidents, Accident Recording and Reporting
- Control of substances hazardous to health (COSHH)

Basic Life Support (Mid Yorkshire Hospital Trust Staff Only)

This course gives learners the skills to:

- Understand and be able to apply the principles of resuscitation.
- Demonstrate the skills taught in simulated scenarios.
- Understand the process for restocking crash trolleys
- Apply assessment principles to detect early signs of patient deterioration and help prevent cardiac arrest-depends on session.
- Safely operate a manual/automated defibrillator –depends on session.
- Understand policy and guidelines relating to resuscitation and withholding of resuscitation – Do Not Attempt Cardiopulmonary Resuscitation orders – DNACPR

Mental Health Awareness, Mental Capacity Act & Deprivation of Liberty Safeguards

Access to Care Staff		
Role	**MH Awareness**	**MCA inc. DoLS or MY equivalent**
Mid Yorkshire – Nurse Coordinator	✓	✓
Mid Yorkshire – Single Point of Contact (SPOC) staff	✓	
Mid Yorkshire – Therapy Coordinator	✓	✓
Wakefield Council – Social Care Direct – Social Work Staff	✓	✓
Wakefield Council – Social Care Direct – Non Social Work Staff	✓	
Connecting Care+ Hubs (Triage / Coordination Unit / MDT)		
Role	**MH Awareness**	**MCA inc. DoLS or MY equivalent**
Age UK Wakefield District – Senior Manager	✓	✓
Age UK Wakefield District – Senior Support Worker	✓	✓
Age UK Wakefield District – Support Worker	✓	✓
Carers Wakefield & District – Carers Support & Development Manager	✓	✓
Carers Wakefield & District – Carers Support Workers	✓	✓
Mid Yorkshire – Admin (Band 2)	✓	
Mid Yorkshire – Admin (Band 3)	✓	
Mid Yorkshire – Advanced Practitioner	✓	✓
Mid Yorkshire – Nurses (Band 5)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 5)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 6)	✓	✓
Mid Yorkshire – Occupational Therapist (Band 7)	✓	✓
Mid Yorkshire – Pharmacist (Band 8a)	✓	✓
Mid Yorkshire – Physiotherapist (Band 5)	✓	✓
Mid Yorkshire – Physiotherapist (Band 6)	✓	✓
Mid Yorkshire – Physiotherapist (Band 7)	✓	✓
Mid Yorkshire – Technical Instructor (Band 3)	✓	
Mid Yorkshire – Technical Instructor (Band 4)	✓	
Mid Yorkshire – Therapy Lead	✓	✓
Mid Yorkshire – Therapy Team Leader	✓	✓
South West Yorkshire Foundation Trust – Mental Health Navigator	✓	✓
Wakefield Council – Locality Manager	✓	✓
Wakefield Council – Social Worker (Level 2)	✓	✓
Wakefield Council – Social Worker (Level 1)	✓	✓
Wakefield Council – Care Coordinator	✓	✓
Wakefield Council – Manager of Coordination Services	✓	
Wakefield Council – Support Services Coordinator	✓	
Wakefield Council – Coordination Support Officer, Care Coordination Unit	✓	
Wakefield Council – Coordination Support Officer, Teams	✓	
Wakefield Council – Admin Coordinator, Care Coordination Unit	✓	
WDH – Team Leader for Independent Living	✓	✓
WDH – Wellbeing Case Worker	✓	✓

Mental Health Awareness, Mental Capacity Act & Deprivation of Liberty Safeguards

Learning Solution Information

Wakefield Council Staff

Mental Health Act (MHA) Awareness Workshop

Learning Aim:
Participants to gain a working knowledge of the Mental Health Act including the principles and its application in practice.

Participants to gain a working knowledge of mental illness and its impact on service users and families.

Learning Outcomes:
On completion, learners will be able to:-

1. Participants to be more confident in using the Mental Health Act in practice.
2. To understand how this relates to people who use our services.

Staff who make decisions and anyone who supports staff who make decisions

Age UK Wakefield District, Carers Wakefield & District Staff and WDH

Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) Workshop

Learning Aim:
Using practical examples the Participants will gain a working knowledge of the Mental Capacity Act including the core principles and the 2 stage test of capacity.

Understand the impact of Sec 5 and 6 of the MCA.

Participants will be able to assess capacity and record this appropriately, and will develop an understanding of the Human Rights act

Participants will be given a brief introduction to the Deprivation of Liberty Safeguards, and the “acid Test” and some guidance about its application in the practice.

Learning Outcomes:
On completion, learners will be able to:-

1. Participants to be more confident in using the Mental Capacity Act in practice
2. To understand how this relates to people who use our services
3. Understand how this affects human Rights
4. Have a basic understanding of the Deprivation of liberty safeguards and how these apply in practice.

Mid Yorkshire Hospital Staff

Mental Capacity Act (MCA) Prompt Cards

- MCA in practice
- Applying the 5 principles that underpin the MCA
- Making capacity assessments
- Best Interests Decisions
- MCA decision-making flowchart
- Best Interests decision-making flowchart
- Deprivation of Liberty (DoLS) Safeguards
- DoLS Flowchart
- Restriction versus deprivation of liberty
- Resources

Mid Yorkshire Hospital Staff

Mental Capacity Act (MCA) Level 1 & 2

Level 1 training is aimed at ALL staff and can be completed by:

- Attending Staff Induction & reading the NHS England prompt cards and informing organisational Development the date the cards were read.

Level 1 is automatically completed when level 2 and 3 have been completed.

Level 2 training can be completed by:

- Completing eLearning. Access/completion instructions can be found on the organisational Development Intranet page under NLMS
- Attending the MCA level 2 session on the Safeguarding Adults Level 2 Workshop.

Session Objective:

- To explore the contents of the Mental Capacity Act 2005
- To consider the effect of the act on consent and decision making
- To understand the process of assessing capacity and determining best interests
- To consider the implication of using the act in practice
- To consider what amounts to a deprivation of liberty and how authorisation for this is sought

Content:

- Legal duties
- Helping people make decisions
- Assessment of capacity
- How to determine best interests
- Independent Mental Capacity Advocacy
- Introduction to Deprivation of Liberty Safeguards

On completion of this programme you will be able to:

- Understand what mental capacity is and how to assess if a person is able to make a decision
- Understand the statutory checklist for determining best interests
- Understand the new legal duties placed on those who work in health and social care
- Understand the role of the Independent Mental Capacity Advocacy Service
- Understand the framework for Deprivation of Liberty Safeguards.

Suitable for staff who are likely to participate in decision making and have face to face contact with patients.

Safeguarding

It is a requirement for all staff working in the Connecting Care+ Hubs to adhere to the National Competency Framework for Safeguarding Adults, under the following breakdowns:-

Access to Care Staff		
Role	**Tier 1**	**Tier 2**
Mid Yorkshire – Nurse Coordinator	✓	✓
Mid Yorkshire – Single Point of Contact (SPOC) staff	✓	
Mid Yorkshire – Therapy Coordinator	✓	✓
Wakefield Council – Social Care Direct – Social Work Staff	✓	✓
Wakefield Council – Social Care Direct – Non Social Work Staff	✓	
Connecting Care+ Hubs (Triage / Coordination Unit / MDT)		
Role	**Tier 1**	**Tier 2**
Age UK Wakefield District– Senior Manager	✓	
Age UK Wakefield District – Senior Support Worker	✓	
Age UK Wakefield District – Support Worker	✓	
Carers Wakefield & District – Carers Support & Development Manager	✓	
Carers Wakefield & District – Carers Support Workers	✓	
Mid Yorkshire – Admin (Band 2)	✓	
Mid Yorkshire – Admin (Band 3)	✓	
Mid Yorkshire – Advanced Practitioner	✓	
Mid Yorkshire – Nurses (Band 5)	✓	
Mid Yorkshire – Occupational Therapist (Band 5)	✓	
Mid Yorkshire – Occupational Therapist (Band 6)	✓	
Mid Yorkshire – Occupational Therapist (Band 7)	✓	
Mid Yorkshire – Pharmacist (Band 8a)	✓	
Mid Yorkshire – Physiotherapist (Band 5)	✓	
Mid Yorkshire – Physiotherapist (Band 6)	✓	
Mid Yorkshire – Physiotherapist (Band 7)	✓	
Mid Yorkshire – Technical Instructor (Band 3)	✓	
Mid Yorkshire – Technical Instructor (Band 4)	✓	
Mid Yorkshire – Therapy Lead	✓	
Mid Yorkshire – Therapy Team Leader	✓	
South West Yorkshire Foundation Trust – Mental Health Navigator	✓	✓
Wakefield Council – Locality Manager	✓	✓
Wakefield Council – Social Worker (Level 2)	✓	✓
Wakefield Council – Social Worker (Level 1)	✓	✓
Wakefield Council – Care Coordinator	✓	✓
Wakefield Council – Manager of Coordination Services	✓	
Wakefield Council – Support Services Coordinator	✓	
Wakefield Council – Coordination Support Officer, Care Coordination Unit	✓	
Wakefield Council – Coordination Support Officer, Teams	✓	
Wakefield Council – Admin Coordinator, Care Coordination Unit	✓	
WDH – Team Leader for Independent Living	✓	
WDH – Wellbeing Case Worker	✓	

Safeguarding

Learning Solution Information

Compliant with the National Competency Framework for Safeguarding Adults

LEVEL 1 – All Staff

Safeguarding Adults – Open Learning Pack

Learning Aim:
To ensure that all employees work within the Care Act 2014 and the Combined Area Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire and North Yorkshire and York (2018)

To enable employees in Adults, Health & Communities and the Private, Voluntary and Independent Sectors to develop knowledge and skills based on the Learn to Care National Competency Framework for Safeguarding Adults. **Staff Group A Level 1 Alerters** (Third edition).

Learning Outcomes:
On completion, learners will:-

1. Explain the context, principles and values of adult safeguarding
2. Describe what safeguarding is and your role in safeguarding adults
3. Explain what to do if you suspect a child is being abused
4. Describe the different categories of abuse; significant harm or self-neglect and the linked agendas
5. Recognise an adult potentially in need of safeguarding and the action you need to take
6. Explain the procedures for raising a safeguarding concern
7. Describe the process of whistleblowing
8. Identify the policies, procedures and legislation that support adult safeguarding

Safeguarding Children – eLearning (Level 1)

To access use the following link:-
https://wakefieldlscb.safeguardingchildrenea.co.uk/

Learning Outcomes:

1. Identify the potential indicators of abuse, including the four categories – physical, emotional, sexual and neglect.
2. Know what to do if you're worried or suspect a child is being or is at risk of being abused.
3. Recognise the potential impact of parent /carers physical and mental health on the wellbeing of a child.
4. Understand your responsibilities in sharing information.
5. Know who to contact for advice and support.
6. Know how to access the Trust and interagency safeguarding children policies and procedures.

LEVEL 2 – Staff working in the Community

Safeguarding Adults – Self-Neglect & Hoarding (1 Day Training Course)

Learning Outcomes:

On attending the course, delegates will be able to:-

1. Identify a self-neglecting individual
2. Discuss how to empower the individual, as far as possible, to understand the implications of their actions
3. Describe how to promote a person-centred approach which supports the right of the individual to be treated with respect and dignity, to be in control of, and as far as possible, to lead an independent life
4. Identify the role of key principles from government policy on adult safeguarding in empowerment, protection, proportionality, partnership and accountability
5. Describe the risk factors associated with self-neglect
6. Identify when a self-neglecting individual is at significant risk of significant harm
7. Identify the lead coordinating agency and any other agencies who need to engage within the process and work within Wakefield's multi-agency guidance in an appropriate way to respond to the risk including multi-agency meetings, comprehensive risk assessment, determining outcomes
8. Demonstrate the ability to maintain case records, including summary record of defensible decisions and efforts and actions taken by all agencies involved

Safeguarding Adults – Partnership Enquiries (1 Day Training Course)

Learning Outcomes:

On attending the course, delegates will be able to:-

1. Identify the definition of 'Safeguarding'
2. Recognise the meaning and importance of Making Safeguarding Personal (MSP)
3. Explain their role and responsibilities and those of partners under the multi-agency policy and procedures
4. Describe the investigative processes regarding a safeguarding concern, consent issues and the S42 enquiry process. This will include both the risk management and formal S42 enquiry approaches including responsibilities and the importance of partnership working to achieve desired outcomes.
5. Demonstrate an understanding of the Mental Capacity Act and its critical role in adult safeguarding
6. Discuss ways of interviewing an adult, including: planning, explanation and engaging, listening skills, questioning techniques and best evidence practice
7. Discuss different types of evidence and how to preserve using 'best evidence' techniques
8. Recognise the need to go to a case conference even when there has been a police investigation

Safeguarding Children – Level 2

Learning Outcomes:

1. To allow participants to describe what constitutes abuse and the potential impact of abuse on a child's life
2. To enable participants to identify factors which contribute to vulnerability and gain an understanding of early help where additional needs are identified
3. To ensure that staff are aware of safeguarding thresholds for intervention where there is a risk of significant harm
4. To enable participants to recognise their own personal and professional responsibilities in relation to safeguarding and promoting the welfare of children and young people
5. To promote effective interagency working
6. To ensure participants understand their duty to share information where a child may be at risk
7. To promote effective communication and engagement with children and families who are vulnerable
8. To raise awareness of Prevent (WRAP) Training

The Care Act 2014

Access to Care Staff		
Role	**Factsheets & Open Learning Packs**	**3 Day Training Programme**
Mid Yorkshire – Nurse Coordinator	✓	
Mid Yorkshire – Single Point of Contact (SPOC) staff	✓	
Mid Yorkshire – Therapy Coordinator	✓	
Wakefield Council – Social Care Direct – Social Work Staff	✓	
Wakefield Council – Social Care Direct – Non Social Work Staff	✓	
Connecting Care+ Hubs (Triage / Coordination Unit / MDT)		
Role	**Tier 1**	**Tier 2**
Age UK Wakefield District – Senior Manager	✓	
Age UK Wakefield District – Senior Support Worker	✓	
Age UK Wakefield District – Support Worker	✓	
Carers Wakefield & District – Carers Support & Development Manager	✓	
Carers Wakefield & District – Carers Support Workers	✓	
Mid Yorkshire – Admin (Band 2)	✓	
Mid Yorkshire – Admin (Band 3)	✓	
Mid Yorkshire – Advanced Practitioner	✓	
Mid Yorkshire – Dietitian (Band 5)	✓	
Mid Yorkshire – Dietitian (Band 6)	✓	
Mid Yorkshire – Dietitian (Band 7)	✓	
Mid Yorkshire – Nurses (Band 5)	✓	
Mid Yorkshire – Occupational Therapist (Band 5)	✓	
Mid Yorkshire – Occupational Therapist (Band 6)	✓	
Mid Yorkshire – Occupational Therapist (Band 7)	✓	
Mid Yorkshire – Pharmacist (Band 8a)	✓	
Mid Yorkshire – Physiotherapist (Band 5)	✓	
Mid Yorkshire – Physiotherapist (Band 6)	✓	
Mid Yorkshire – Physiotherapist (Band 7)	✓	
Mid Yorkshire – Technical Instructor (Band 3)	✓	
Mid Yorkshire – Technical Instructor (Band 4)	✓	
Mid Yorkshire – Therapy Lead	✓	
Mid Yorkshire – Therapy Team Leader	✓	
South West Yorkshire Foundation Trust – Mental Health Navigator	✓	
Wakefield Council – Locality Manager	✓	✓
Wakefield Council – Social Worker (Level 2)	✓	✓
Wakefield Council – Social Worker (Level 1)	✓	✓
Wakefield Council – Care Coordinator	✓	✓
Wakefield Council – Manager of Coordination Services	✓	
Wakefield Council – Support Services Coordinator	✓	
Wakefield Council – Coordination Support Officer, Care Coordination Unit	✓	
Wakefield Council – Coordination Support Officer, Teams	✓	
Wakefield Council – Admin Coordinator, Care Coordination Unit	✓	
WDH – Team Leader for Independent Living	✓	
WDH – Wellbeing Case Worker	✓	

The Care Act 2014

Factsheets

Factsheet 1

Wellbeing

This factsheet aims to give you a brief introduction to the Principle of Wellbeing. The Care Act introduces a new statutory duty that all Local Authority workers must promote an individual's well-being when carrying out social care/social work functions. The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. Underpinning all individual care and support functions (that is any process, activity or broader responsibility that you perform on behalf of the local authority) is the need to ensure that doing so focuses on the needs and goals of the person concerned.

You must promote wellbeing when carrying out any care and support functions in respect of a person. This may sometimes be referred to as "the wellbeing principle" because it is the guiding principle that puts wellbeing at the heart of care and support.

The wellbeing principle applies in all cases where you are carrying out a care and support function, or making a decision, in relation to a person. It applies equally to adults with care and support needs and their carer's. In some specific circumstances, it also applies to children, their carer's and to young carers when they are subject to transition assessments (see Factsheet 8).

Wellbeing is a broad concept, and the statutory guidance defines it as relating to the following nine areas in particular:

1. Personal dignity (including treatment of the individual with respect)
2. Physical and mental health and emotional wellbeing
3. Protection from abuse and neglect
4. Control by the individual over day-to-day life (including care and support provided and the way it is provided)
5. Participation in work, education, training or recreation
6. Social and economic wellbeing
7. Domestic, family and personal relationships
8. Suitability of living accommodation
9. The individuals contribution to society

Promoting Wellbeing

You can promote a person's wellbeing in many ways. How this happens will depend on the circumstances, including the person's needs, goals and wishes, and how these impact on their wellbeing. There is no set approach, each case should be considered on its own merits. Consider what the person wants to achieve, and how the action which is being taking may affect the wellbeing of the individual in relation to the nine areas listed in the definition above. During the assessment process, for instance, you should explicitly consider the most relevant aspects of wellbeing to the individual concerned, and assess how their needs impact on them.

It is likely that some aspects of wellbeing will be more relevant to one person than another. You should adopt a flexible approach that allows for a focus on which aspects of wellbeing matter most to the individual concerned. Although the wellbeing principle applies specifically when you perform an activity or task, or makes a decision, in relation to the person, the principle should also be considered when undertaking broader, strategic functions, such as planning and review.

Role of the Principle Social Worker in Adults Integrated Care Services

The Principle Social Worker (PSW) who is a qualified registered social worker professional practice lead and will:

- Support and develop arrangements for excellent practice
- Lead and oversee excellent social work practice
- Lead the development of excellent social workers
- Support effective social work supervision and decision making
- Oversee quality assurance and improvement of social work practice
- Advise the director of adult social services (DASS) and/or Wakefield wider council in complex or controversial cases on developing case or other law relating to social work practice
- Function at a strategic level of the Professional Capabilities Framework

Wakefield Council support of the Principle Social Worker

Wakefield Council will ensure that the PSW is given the credibility, authority and capacity to provide effective leadership and challenge, both at managerial and practitioner level and are given sufficient time to carry out their role. The PSW will be visible across Wakefield, from elected members and senior management, through to frontline social workers, people who use services and carers.

They will maintain close links with the DASS and frontline practitioners, engaging in some direct practice, which can take different forms such as casework, co-working, undertaking practice development sessions, mentoring etc.

Integration of health and care support will increasingly require social workers to lead, both in their teams and across professional boundaries, particularly in the context of safeguarding, mental health and mental capacity. Through their direct link to practice the PSW can 'bridge the gap' between professional and managerial responsibility, to influence the delivery and development of social work.

Principle Social Workers role in Safeguarding

The Care Act 2014 makes "Making Safeguarding Personal" a legal requirement. As professional lead for the work the Principle Social Worker will:

- Develop a broad knowledge base on safeguarding and Making Safeguarding Personal and its application in their own and others work.
- Play a lead role to ensure the quality and consistency of social work practice in fulfilling safeguarding responsibilities.

Have extensive knowledge of the legal and social work options to both general and specific cases

Factsheet 2

Prevention, Reducing or Delaying Needs

This factsheet aims to give you a brief introduction into prevention and reducing or delaying needs. One of the biggest changes and critical to the vision of the Care Act is that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point.

To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible.

Your role and responsibility for prevention applies to **all** adults, including:

- People who do not have any current needs for care and support
- Adults with needs for care and support, whether their needs are eligible and/or met by the local authority or not
- Carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for support which are not being met by the local authority or other organisation

The term “prevention” or “preventative” measures can cover many different types of support, services, facilities and resources. There is no one definition for what constitutes preventative activity and this can range from wide-scale whole-population measures aimed at promoting health, to more targeted, individual interventions aimed at improving skills or functioning for one person or a particular group or lessening the impact of caring on a carer’s health and wellbeing. You should consider **all** options available to support people in the community not just social care services which can be purchased.

Prevention is often broken down into three general approaches:

Prevent: **primary prevention/promoting wellbeing** should be targeted at individuals who have no particular health or care and support needs. These are services, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing.

Reduce: secondary prevention/early intervention: more targeted interventions should be aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down or reduce any further deterioration or prevent other needs from developing. Sometimes early support can help stop a person’s life tipping into crisis.

This could also include a falls assessment, housing adaptations, handyman services, assistive technology/telecare services. Targeted interventions should also include approaches to identifying carers as they can also benefit from support.

Delay: tertiary prevention: interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions (including progressive conditions such as dementia), supporting people to regain skills and manage or reduce need where possible. This could also include rehabilitation / reablement services.

In summary, the focus of prevention is to promote wellbeing, considering any care and support needs in the context of the person's skills, ambitions and priorities. Including consideration of the role a person's family or friends can play in helping them to meet their goals.

Whilst developing and delivering preventative approaches you should ensure that individuals are not seen as passive recipients of services, but are able to participate in the design of care and support based around achievement of their goals.

Factsheet 3

Advice and Information

This factsheet aims to give you a brief introduction to the provision of information and advice as required by the Care Act. One of the key changes is that we (the Local Authority) have a duty to establish and maintain an Information and Advice Service relating to care and support for adults and support for carers in the Wakefield district. This information will be available for staff through Connect 2 Support Wakefield.

This service will be really useful tool for you as it will provide information and advice on:

- How Wakefield's information and advice system operates
- The choice and types of care and support and the choice of providers available
- How to access the care and support available within universal/local services
- How to access independent financial advice on matters relevant to the meeting of needs for care and support
- How to raise concerns about the safety and wellbeing of an adult who has needs for care and support

In providing information and advice you must:

- Seek to ensure that what is provided is sufficient to enable the adult/s to:

  a) identify matters that are or might be relevant to their personal financial position that could be affected by the system e.g. universal deferred payments scheme
  b) make plans for meeting needs for care and support that might arise
  c) understand the different ways in which they may access independent financial advice on matters relevant to the meeting of needs for care and support

The Information and Advice service will go much further than it ever has done before, embracing the community and the support networks available within it. If you decide that someone is not eligible for support, you will still need to record this and also provide them with the reason for your decision, with information and advice to help them address their eligible needs.

Factsheet 4

Independent Advocacy

This factsheet aims to give you a brief introduction to Independent Advocacy. Although you will have always ensured that you involved people in decisions about them and their care, the Care Act introduces the provision of an Independent Advocate whenever you identify a person who has substantial difficulty in being fully engaged in the decision making process including carers. This means you will not be able to progress assessment, reviews, safeguarding etc. in these cases without having arranged for someone to assist them in being involved in the process.

The Care Act defines four areas where an individual may have substantial difficulty "in being involved" within their assessment:

1. Understanding relevant information
2. Retaining information
3. Using or weighing up the information
4. Communicating their views, wishes and feelings

If any one of those applies, they will need someone to assist them.

In general, a person who has substantial difficulty in being involved in their assessment, plan or review, will only become eligible for an Independent Advocate when you identify that there is no one else willing and suitable to support their involvement. You will need to consider whether a family member or friend is suitable, particularly where there may be safeguarding concerns.

There may be some people who require Independent Advocacy to access information and advice prior to their assessment. Initial contact services and community teams need to consider such needs, to ensure that information and advice services are accessible.

Independent advocates have two main functions:

1. to support the person to make their own decisions and be as involved as possible; and
2. to represent them, which may involve speaking on their behalf.

The independent advocate must 'advocate' on the person's behalf:

- to put their case
- to scrutinise the options
- to question the plans if they do not appear to meet all eligible needs or do not meet them in a way that fits with the person's wishes and feelings
- or are not the least restrictive of people's lives
- and to challenge your decisions where necessary.

The ultimate goal of having advocacy is to secure a person's rights, promote the person's wellbeing and ensure that their wishes are taken fully into account.

You will be expected to recognise that an advocate's role includes challenging professionals on behalf of the person, and must take into account any representations made by an advocate. You should take reasonable steps to assist the independent advocate in carrying out their role.

Guidance on advocacy rights and working with independent advocates:

1. **Know when there is legal duty to instruct or offer access an advocate.** There are legal duties on local and health authorities to provide and promote access to advocacy, that you must make yourself familiar with. Remember the right to access statutory advocacy is not just best practice, but places legally binding duties onto professionals to refer.

2. **Explain advocacy to people who could benefit.** You are an essential part of making advocacy accessible and are often working with people who could really benefit from advocacy support. By explaining advocacy and the role of an advocate you can ensure people don't miss out on advocacy.

3. **Refer…early.** Advocates need time to build up rapport with a person, establish their role and work out how best to work with a person to meaningfully support them through decision making processes. By referring early you are more likely to get better advocacy and therefore better decision making.

4. **Don't take it personally!** Good advocates are trained not to make challenges personal, however part of their role is to support people to raise concerns and make challenges – regardless of whether the concern or challenge is legitimate, fair or valid. The primary goal of the advocate is to help a person express their views no matter what these views are. When advocacy works well it is often because the health or social care professional can listen to these concerns and respond positively.

5. **Don't invite the advocate to offer an opinion or make decision**. It is natural for health and social care professionals who are used to working within multi-disciplinary teams to seek consensus from people involved in a person's life when it comes to making decisions. However advocates do not make decisions: advocates are there to make sure the person at the centre of the decision participates in the decision. To avoid confusion it's simply best not to ask the advocate to contribute to decision making.

6. **When sharing information, treat the advocate as if they were the person**. An important principle underpinning advocacy is that of a rebalance of power – the advocate has equal power with the person they are supporting and cannot make decisions about their life or advise them what to do. This means that advocates should not hold information about the person that they do not know themselves. So assume if you share any information with the advocate, they are going to share it with their advocacy partner. The only instance an advocate would withhold information from their partner would be in extreme cases of risk.

Together for Mental Wellbeing
WAKEFIELD ADVOCACY TOGETHER HUB

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Factsheet 5

Eligibility and Assessment

This factsheet aims to give you a brief introduction into Eligibility and Assessment in relation to the Care Act. The Care Act 2014 introduces a national eligibility threshold, which consists of three criteria, all of which must be met for a person's needs to be eligible. This replaces the current FACS criteria for care.

The eligibility threshold you will work to is based on identifying:

- Whether a person's needs are due to a physical or mental impairment or illness
- To what extent a person's needs affect their ability to achieve at least two or more specified outcomes
- Whether and to what extent this impacts on their wellbeing

If you decide that someone is not eligible for support, you will still need to record this and also provide them with the reason for your decision with information and advice to help them address their eligible needs.

Involvement in the Assessment process

It is vital to ensure that you work in a person centred way, keeping the individual at the forefront of the process. If the person appears to have substantial difficulty in engaging with the process, you will need to ensure that they have to assist them in engaging (see Factsheet 3).

National Eligibility Threshold

Firstly in considering whether a person's needs are eligible for care and support, you must consider whether the person's needs are due to a physical or mental impairment or illness. This includes conditions such as physical, mental, sensory, learning or cognitive disabilities or illnesses, brain injuries and substance misuse.

If they do have needs caused by any of the above conditions you must consider whether the effect of the adult's needs means they are unable to achieve two or more of the following specified outcomes:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of their home safely
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education or volunteering

- Making use of necessary facilities or services in the local community including public transport and recreational services
- Carrying out any caring responsibilities the adult has for a child

The regulations provide that 'being unable to achieve' specified outcomes means the person:

- is unable to achieve the outcome without assistance. This includes where the person may need prompting or
- is able to achieve the outcome without assistance but doing so causes the adult significant pain, distress or anxiety or
- is able to achieve the outcome without assistance, but doing so endangers or is likely to endanger the health and safety of the adult, or of others or
- is able to achieve the outcome without assistance but takes significantly longer than would normally be expected

Finally and crucially, as a consequence of the person being unable to achieve two or more of the specified outcomes there is, or is likely to be, a significant impact on the person's wellbeing. You should consider how the adult's needs impact on the following nine areas of wellbeing

1. Personal dignity (including treatment of the individual with respect)
2. Physical and mental health and emotional wellbeing
3. Protection from abuse and neglect
4. Control by the individual over day-to-day life (including over care and support provided and the way it is provided)
5. Participation in work, education, training or recreation
6. Social and economic wellbeing
7. Domestic, family and personal relationships
8. Suitability of living accommodation
9. The individuals contribution to society

In making this judgement you should look to understand the adult's needs in context of what is important to him or her. The needs or condition of the person may fluctuate and this should be considered as part of the assessment.

Assessment

If a person appears to have any level of needs for care and support, the local authority must carry out a needs assessment, or a carer's assessment for a carer. This is regardless of a person's financial situation. Therefore, assessments are available to self-funders.

Your assessment should identify:

1. Care and support needs
2. What outcomes the individual is looking to achieve to maintain or improve their wellbeing
3. How care and support might help in achieving these outcomes

Assessment should be seen not as a gateway to services, but in a much wider way - as a **critical** intervention in its own right. It is a crucial means of helping the person to understand their needs, how they can be met, and how they can achieve their outcomes. This might not necessarily be through enabling access to care services, but by involving networks of support, universal/local services, or the person's own strengths. It is important to take the opportunity and assessment to connect people with wider information and advice and preventative services.

Factsheet 6

Carer's Eligibility and Assessment

This factsheet aims to give you a brief introduction to Carer's Eligibility and Assessment.

Carer's Assessment

For the first time Carers have rights to assessment and support planning, placing them on an equal footing as the adult they care for. Although in practice you already identify carers, carers no longer have to show that they provide 'regular and substantial' care to receive care and support. Nor do they have to be caring for someone eligible for social care services.

All identified carers are entitled to a carer's assessment. As part of the carer's assessment you must explore the carers need for support and the sustainability of their caring role. You must also consider the impact on the carer's activities beyond the caring role, including the carer's desire and ability to work and their ability to participate in external activities.

You should inform the carer that they are being assessed and the information should be shared about what they might expect from the assessment process – its format, timescales, rights to complain, and the ways in which they can be involved.

The assessment must follow core statutory obligations, but the process should be flexible and adaptable and the format could include for instance:

- a face-to face assessment
- an online or phone assessment
- a combined assessment e.g. of a person needing care and their carer or with a child (where both people agree, and the consent condition is met in relation to the child)

Involvement in the Assessment process

It is vital to ensure that you work in a person centred way, keeping the individual at the forefront of the process. If the person appears to have substantial difficulty in engaging with the process, you will need to ensure that they have someone to assist them in engaging (see Factsheet 3).

Eligibility

The Care Act 2014 introduces for the first time, a national eligibility threshold for carers, which consists of three criteria, all of which must be met for a carer's needs to be eligible.

The Carer's Eligibility threshold is based on you identifying:

1. Whether a carer's needs are a consequence of providing necessary care for an adult
2. To what extent the carer's needs affect their ability to achieve specified outcomes, or puts their health at risk, and
3. Whether and to what extent this impacts on their wellbeing

Carer's can be eligible for support **whether or not** the adult for whom they care has eligible needs. The eligibility determination must be based on the carer's needs and how these impact on their wellbeing.

If you decide that someone is not eligible for support, you will still need to record this and also provide them with the reason for your decision with information and advice to help them address their eligible needs.

The needs or conditions of the person cared for may fluctuate, and in a similar way, the needs of carers are likely to fluctuate over time. This should therefore be considered within the assessment process.

When considering whether a carer's needs are eligible, you must consider whether the carer's needs for support arise as a consequence of **providing necessary care** for an adult**.** The carer's need for support must be because they are providing care and that care must be deemed to be '**necessary'**.

If the carer has needs caused by providing necessary care, you must consider whether:

- The carer's physical or mental health is, or is at risk of, deteriorating; or
- Because of their caring role is unable to achieve any one or more of the following specified outcomes:
    1. Carrying out any caring responsibilities the carer has for a child
    2. Providing care to other persons for whom the carer provides care
    3. Maintaining a habitable home environment in the carer's home
    4. Managing and maintaining nutrition
    5. Developing and maintaining family or other personal relationships
    6. Engaging in work, training, education or volunteering
    7. Making use of necessary facilities or services in the local community including recreational facilities or services
    8. Engaging in recreational activities

The Care Act regulations provide that 'being **unable to achieve'** specified outcomes includes circumstances when the carer:

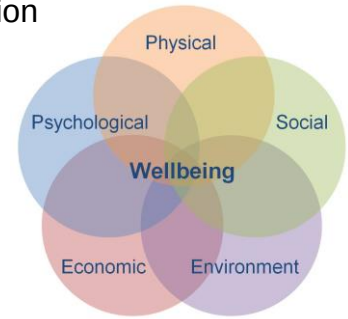
- Is unable to achieve the outcome without assistance
- Is able to achieve the outcome without assistance but doing so is likely to cause the carer significant pain, distress or anxiety
- Is able to achieve the outcome without assistance, but in doing so endangers or is likely to endanger the health and safety of the carer or any adults or children for who they provide care

Finally you must consider whether, as a consequence there is or is likely to be, a significant impact on the carer's wellbeing. You should determine this if:

- the carer's needs impact on an area of wellbeing in a significant way, or
- the cumulative effect of the needs impact on a number of the areas of wellbeing to such an extent that they have a significant impact on the carer's overall wellbeing

To do this you should consider how the carer's needs impact on the nine areas of wellbeing:

1. Personal dignity (including treatment of the individual with respect)
2. Physical and mental health and emotional wellbeing
3. Protection from abuse and neglect
4. Control by the individual over day-to day life (including over care and support provided and the way it is provided)
5. Participation in work, education, training or recreation
6. Social and economic wellbeing
7. Domestic, family and personal relationships
8. Suitability of living accommodation
9. The individuals contribution to society



In making this judgement, you should look to understand the carer's needs in context of what is important to him or her.

Factsheet 7

Support Planning

This factsheet aims to give you a brief introduction into support planning. Person centered care and support planning refocuses the priority from services to ensuring better lives for people. It offers them the opportunity to take choice and control over their care and support.

You will, already in practice, complete comprehensive support plans. However, the Act requires support plans to now evidence:

1. The eligible needs the person has
2. Which needs the local authority will meet
3. Consideration of any needs being met by a carer
4. It must include a tailored package of information and advice on how to delay and/or prevent the needs the local authority is not meeting
5. You must ensure that the content of the plan is finalised with the person and any other people that the person requests
6. This must be compiled in a format that makes sense to them

To ensure that the planning process takes a holistic approach, which takes into account people's wishes, feelings, strengths, needs, values and aspirations, (irrespective of the extent to which they choose or are able to actively direct the process), you must ensure that the person is actively involved and influential throughout. Genuine involvement and ownership can both aid the development of the plan and increase the likelihood that the person may achieve the outcomes that matter to them. To facilitate genuine involvement, you must ensure that information about the choices and options available, are provided in an accessible format to help the person make informed decisions about their care e.g. enlarged print.

There may be cases where a person wishes to have a greater involvement in the care planning process, but has no family or friends who can help, and therefore requires an Independent Advocate to understand the relevant information provided by you, and to be able to use it to effectively plan for their care and support (see Factsheet 3).

Production of the Plan

Where a person with specific expertise or training in a particular condition has carried out the assessment, someone with similar knowledge should also be involved in the production of the plan.

There is a need to focus upon peoples' strengths and assets rather than the deficits. This should include the support and strengths that they have in their communities as well as their own personal capabilities. This includes the support that they need to enhance their wellbeing and improve their connections to family, friends and the community.

If the Local Authority has a duty to meet a person's needs, you must help the person decide how their needs are to be met, through the preparation of a care and support plan. This includes needs being met without local authority resources, The local authority still has a duty to record this on a support plan, and review to ensure that this external support still remains sufficient.

'Meeting needs' is an important concept under the Act and moves away from the previous terminology of '**providing services'**. *"The Act aims to encourage diversity and innovation in the way in which a person's needs are met, rather than prescribing a service that may be neither what is best nor what the person wants".*

When developing the plan, there are certain elements that you **must** always ensure are incorporated in to the final plan:

1. The **needs** identified by the assessment
2. The outcomes the individual is looking to achieve to maintain or improve their **wellbeing**
3. The person's own capabilities, assets and strengths and the potential for improving their skills, as well as the role of any support from family, friends or others that could help them to achieve what they wish for from day-to-day life
4. Whether, and to what extent, the needs meet the **eligibility criteria**
5. The needs that **the authority** is going to meet, and how it intends to do so
6. For a person needing care, for which of the **desired outcomes** care and support could be relevant
7. For a carer, the outcomes the carer wishes to achieve, and their wishes around providing care, work, education and recreation where support could be relevant
8. **The personal budget, direct payments** and the amount which the person must pay towards the cost of meeting the needs
9. Information and advice on what can be done to reduce the needs in question, and to prevent or delay the development of needs in the future
10. Where needs are being met via a direct payment, the needs to be met via the direct payment and the amount and frequency of the payments
11. You should also ensure that you record where you will not be meeting the eligible needs, so that you are able to respond to any changes in circumstances more effectively

Factsheet 8

Transitions

This factsheet aims to give you a brief introduction to Transitions into adulthood and the role that you will play within this. The Care Act 2014 and related reforms aims to underpin and promote the extension of best practice in transition arrangements. The Care Act introduces new entitlements to transition assessment for young people, young carers and carers of young people and looks to underpin continuity in provision from children's to adult services.

At the same time, changes introduced by the Children and Families Act 2014 and Special Educational Needs (SEN) reform introduce a system of support extending from birth to twenty-five years of age. This means there will be a group of young people who will be entitled to support through both pieces of legislation. The Mental Capacity Act 2005 also applies to all young people from the age of 16yrs, and needs to be considered throughout the transition process.

Transition is an essential part of human life and experience. Here the term is used to refer to the process of change for young people, and those around them, as they progress from childhood to adulthood. This movement can be a time of celebration, change and also challenge for all young people. It is a time when they are considering and making decisions about their continuing education, work and careers, their social life and where and how they will live.

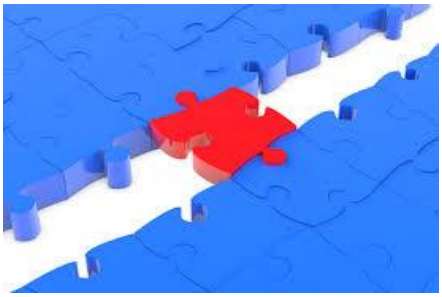
The vital importance of a successful transition to adulthood for young people has long been recognised. There is now a considerable body of evidence to suggest that too many young people entering adult services are at greater risk of marginalisation and poorer outcomes as a result of the transition process and its conclusion. We need to ensure that arrangements are in place to ensure that young people with complex needs have every opportunity to lead as independent lives as possible and are not disadvantaged by the move from children's to adult services.

Challenges combine both organisational and attitudinal issues. For example, the process can be managed very badly and transition to adult services has been described as being like "falling off a cliff". There is no reason in law why this should be the case; the fundamental duties for disabled young people as adults are to assess their needs and provide services to meet these needs. Some of the obstacles that young people in transition and adults face are also rooted in their own lack of expectation and aspiration about their adult lives, often as a result of negative messages from those around them or simply a lack of understanding.

Alongside the availability of appropriate provision, a successful transition to adulthood depends on early and effective planning, putting the young person at the centre of the process so that you can help them to transfer to adult services. In Wakefield currently, the process of transition starts whilst the young person is still in contact with children's services, with joint working by a social worker from the adults team from the age of 16yrs until the young person is 18yrs and transfers to the adult team. If the young person is still in education at this time, the Complex Care Needs team will undertake the transitions process.

An adult assessment is usually completed at age 17yrs, eligible needs identified, and a support plan agreed with the young person and family. Consideration is also given at this stage to any health needs and a Continuing Healthcare assessment is completed if appropriate. The young person will be offered an individual budget which may be taken in the form of a direct payment, a personal health budget, a managed account or a mixture of these. Transition may, subject to the needs of the young person, continue for a number of years before and after the transfer to adult services. It is important to ensure that the overall focus is on outcomes and activities rather than services.

The Care Act and related reforms aims to underpin and promote the extension of best practice in transition arrangements. The Care Act introduces new entitlements to transition arrangements for young people, young carer's and carers of young people and looks to underpin continuity in provision until a plan for adult services is in place. In order to ensure best practice in transition arrangements Wakefield is currently reviewing the transition pathway which will lead to changes in the way the children's and adult's teams work together to avoid the description of transition to adult services being like "falling off a cliff". This means that there will be more emphasis on a streamlined process which provides continuity of care for the young person.



Factsheet 9

Safeguarding

This factsheet aims to give you a brief introduction to the changes to Safeguarding Adults within the Care Act. The Care Act puts adult safeguarding on a legal footing and from April 2015 where you must:

- **Make enquiries**, or ensure others do so, if you believe an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so by whom(Note the term investigation is no longer used and has been replaced by enquiries)
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them (see Factsheet 3)
- You also need to be aware that the Local Authority has a statutory duty to have a Safeguarding Adults Board in place

An adult at risk of harm is **defined** as someone who has needs for care and support, is experiencing, or at risk of, abuse or neglect and is unable to protect themselves against the abuse or neglect or the risk of it. This means that **regardless of whether you are providing any services or not,** you must follow up any concerns about either actual or suspected adult abuse or neglect.

Safeguarding Adults Boards will be strengthened and have more powers than the current arrangements set up by "No Secrets" but they will also be more transparent and subject to greater scrutiny.

The Act signals a major change in practice, a move away from the process-led, tick box culture to a **person-centred** social work approach which achieves the outcomes that people want. You must be flexible and work with the adult all the way through the enquiry and beyond where necessary. **Practice must focus on the person,** which accounts for the possibility that individuals can change their minds on what outcomes they want through the course of the intervention. The West Yorkshire policy and procedures are currently being updated to reflect the changes from the Care Act.

The Statutory Guidance Enshrines the Six Principles of Safeguarding

1. **Empowerment -** presumption of person led decisions and informed consent
2. **Prevention -** it is better to take action before harm occurs
3. **Proportionality -** proportionate and least intrusive response appropriate to the risk presented
4. **Protection -** support and representation for those in greatest need
5. **Partnerships -** local solutions through services working with their communities
6. **Accountability -** accountability and transparency in delivering safeguarding

The Act includes new duties for **agencies to work more closely together** and **share information.** Fears of sharing information must not stand in the way of protecting people.

Agencies that support adults at risk can prevent and detect harm but they must **act swiftly and competently** when abuse is suspected or reported. There must also be sufficient support, specialist expertise, independent advocacy and access to criminal justice within each area.

The advances in **personalisation** of social care go hand-in-hand with the new approach to safeguarding; empowering people to speak out, make informed choices, with support where necessary, and encouraging communities to look out for one another. The two concepts are also inseparable from **quality of life and dignity.** There is still a need for specialist ongoing training to keep up the **legal literacy** of specialist practitioners and all training has been reviewed to ensure that this is maintained.

You must make sure you use the least restrictive options and comply with the Human Rights Act and the Mental Capacity Act. The emphasis must be on a **sensible risk appraisal,** not risk avoidance, which takes into account individuals' preferences, histories, circumstances and lifestyles to achieve a proportionate tolerance of acceptable risks. In the words of Lord Justice Munby:

"What good is it making someone safer if it merely makes them miserable?"

The Care Act also makes "Making Safeguarding Personal" (MSP) a legal requirement, meaning safeguarding should be person-led and outcome focussed. Wakefield Council has signed up to implementing MSP at Bronze level and are currently piloting this and then MSP will be rolled out across all teams. Further information regarding MSP implementation will be available in due course.

MSP means it should be person-led and outcome focused. It engages the person in the conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Safeguarding Adults Board

Safeguarding is everyone's business, and it is important that organisations work together to protect people who need help and support. To overcome this challenge each Local Authority is required to set up a Safeguarding Adults Board (**SAB)**, with core membership from the local authority, Police and the NHS (specifically the local Clinical Commissioning Group/s) and it also has the power to include other relevant bodies.

Wakefield already has an established SAB. The SAB will be strengthened and have more powers than the current arrangements set up by "No Secrets" but they will also be more transparent and subject to greater scrutiny.

The board requires to:

1. Develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations

2. Publish the safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.

Factsheet 10

Reviews

This factsheet aims to give you a brief introduction to Reviews of Care and Support plans. This review is an essential part of the customer journey, to ensure the person has the opportunity to reflect on what is working, what is not working and what might need to change. It ensures that your plans are kept up to date and relevant to the person's needs and aspirations, provides confidence in the system, and mitigate the risk of people entering a crisis situation.

As already established in Wakefield, you are under an ongoing duty to keep the person's plan under review generally, and to ensure that their needs continue to be met; you will review the plan periodically, involving the person and agreeing any necessary changes. The review will help to identify if the person's needs have changed and can lead to a reassessment and a revision of the plan, including the personal budget, if changes are required. The review process will be person-centred, outcome-focused, accessible and proportionate, and must involve the person.

Keeping plans under review is an **essential** element of the planning process. Without a system of regular reviews, plans could become quickly out of date meaning that people are not obtaining the care and support required to meet their needs. Plans may also identify outcomes that the person wants to achieve which are progressive or time limited, so a periodic review is vital to **ensure** that the plan remains relevant to their goals and aspirations.

Reviews must also include support plans whereby some ones eligible needs are being met without local authority resources. The local authority still has a duty to review and update these support plans to ensure that the external support still remains sufficient.

There are several different routes to reviewing a care and support plan, which are already in place in practice. These include:

1. a planned review
2. an unplanned review,
3. a requested review.

A review can be requested at any time by a service user, their representatives, care provider or any other appropriate individual or agency. You have a duty to consider conducting a review if a request for one is made by the person receiving the care, or someone acting on their behalf. You should provide information and advice to people at the planning stage about how to make a request for a review, and this process should be accessible and include multiple routes to make a request (e.g via e-mail or telephone). The information given to people should also set out what happens after a request is made, and the timescales involved in the process. You should also identify the need for an Independent Advocate.

The first planned review should be an initial **'light-touch'** review of the planning arrangements **6-8 weeks** after sign-off of the personal budget and plan. It should be combined with an initial review of direct payment arrangements, where relevant. This will provide reassurance to all parties that the plan is working as intended, and will help to identify any teething problems.

In the absence of any request for a review, or any indication that circumstances may have changed, you should conduct a review of the plan **no later than every 12 months** after the agreement and sign-off of the plan and personal budget.

You should establish systems that allow the proportionate monitoring of care and support plans, (e.g telephone reviews), to ensure that needs are continuing to be met. This system should also include cooperation with other health and care professionals.

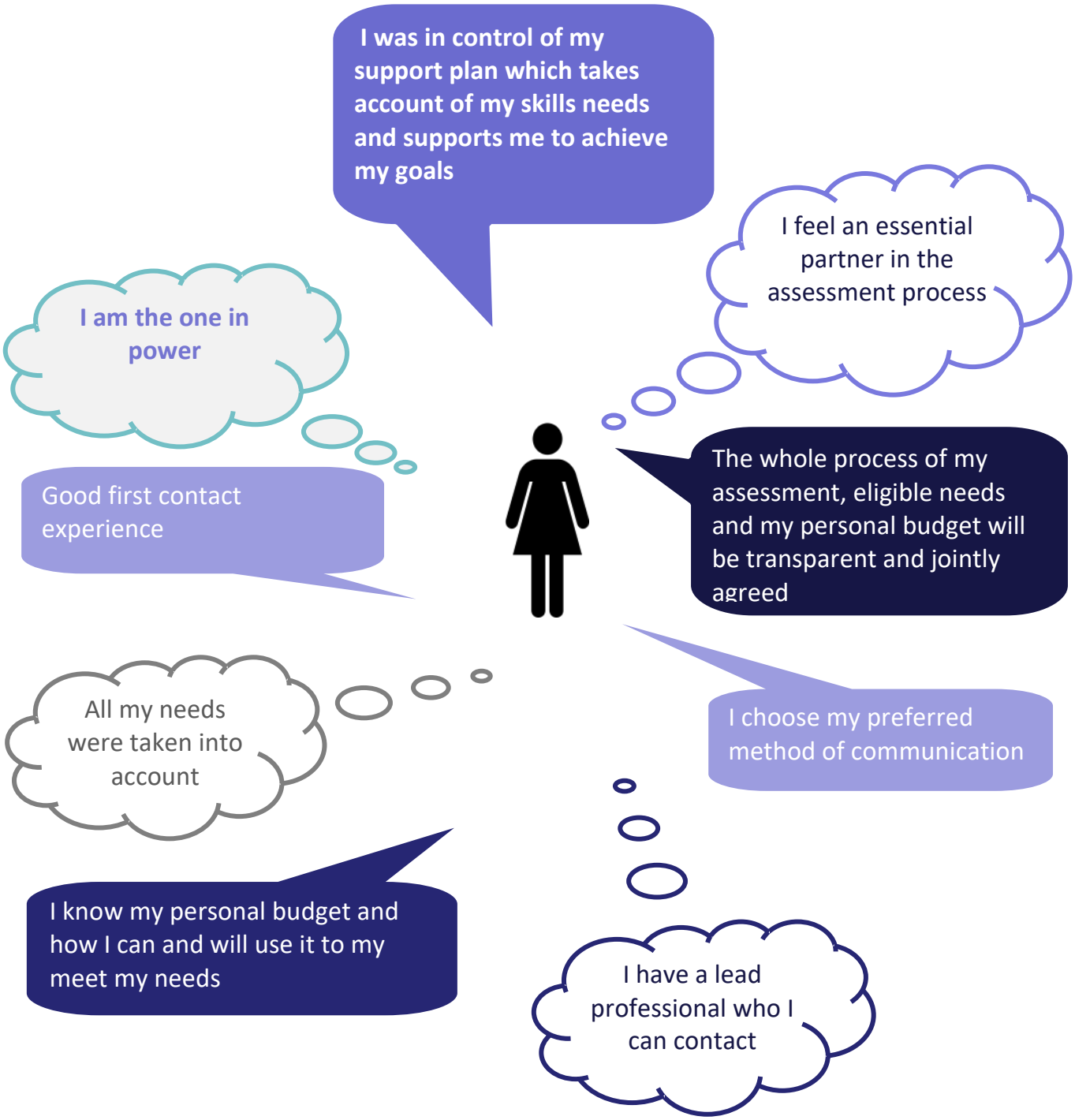
The review process you conduct should cover these broad core elements:

- Have the person's circumstances and/or care and support or support needs changed?
- What is working in the plan, what is not working, and what might need to change?
- Have the outcomes identified in the plan been achieved or not?
- Does the person have new outcomes they want to meet?
- Could improvements be made to achieve better outcomes?
- Is the person's personal budget enabling them to meet their needs and the outcomes identified in their plan and is the current method of managing it still the best one for what they want to achieve, e.g. should direct payments be considered?
- Is the personal budget still sufficient to meet the person's care and support needs?
- Is the person at risk of abuse or neglect?
- Are there any changes in the person's informal and community support networks which might impact negatively or positively on the plan?
- Are the person, carer and independent advocate satisfied with the plan?

Where a decision has been made following a review that a revision of their plan is necessary, you should inform the person, or a person acting on their behalf of the decision and what this will involve. You will also provide them with a written record of the review and any decisions made.

Factsheet 11

Ideal Assessment Experience



Factsheet 12

Definitions & Descriptors

The generally accepted definition of Deafblindness is that persons are regarded as Deafblind "if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss" (*Think Dual Sensory,* Department of Health, 1995). Deafblindness can be found in all age groups, including children and young people, but the incidence is greatest in older adults.

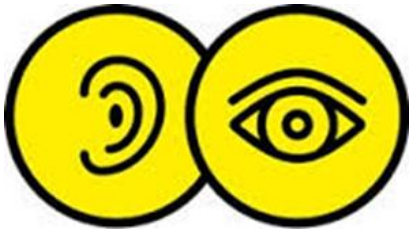
The term 'dual sensory loss' can be used interchangeably with Deafblindness denoting the fact that combined losses of sight and hearing are significant for the individual even where they are not profoundly deaf and totally blind. It is the way in which one sensory impairment impacts upon, or compounds the second impairment, which causes the difficulties, even if, taken separately, each single sensory impairment appears relatively mild. Similarly the term 'multi-sensory impairment' can be used interchangeably with Deafblindness but is usually used in relation to children.

Many people do not define themselves as Deafblind or having dual sensory loss. They may use such phrases as "I don't see too well or hear too well". However, they do describe their vision and hearing loss in terms of which indicate that they have significant difficulties in their day-to-day functioning and may need support to live independently. These people could be described as having a combined sight and hearing loss if the deterioration or progressive loss of their sight and/or hearing causes a significant functional impact on one or more of the following:

- Communication
- Access to information
- Mobility

Four basic groups of people experiencing Deafblindness have been identified:

1. Those who are hearing and sight impaired from birth or early childhood
2. Those blind from birth or early childhood who subsequently acquire a hearing loss that has a significant functional impact
3. Those who are deaf from birth or early childhood who subsequently acquire a significant visual loss
4. Those who acquire a hearing and sight impairment later in life that has a significant functional impact



Descriptors for Congenital & Acquired Deafblindness

Congenital Deafblindness
People who are born with hearing and sight impairment may display any of the following characteristics:

- No response to sound and/or light or little/poor response
- Tactile selective – avoiding touch (children – especially younger children)
- Problems with eye contact / social participation at an early age
- Slowness in developing and generalising skills (children)
- Adopting an unusual posture for undertaking tasks – using residual hearing or sight Eccentrically (children)
- Difficulty making sense of the world around them
- Developmental delay
- Personalised methods of communication
- Repetitive behaviour
- Behaviour likely to harm themselves or others
- Withdrawal / isolation
- Use of smell, taste, touch to gain information

Acquired Deafblindness
People who acquire a hearing and sight impairment later in life may display any combination of the following characteristics:

Hearing:

- Non-response when you speak from behind
- Need for the television/radio/stereo to be louder than is comfortable for others
- Difficulty following speech with unfamiliar people or accent
- Difficulty following changes of speaker during conversation
- Lack of awareness of noises outside immediate environment e.g. building works, traffic noise etc.
- Tendency to withdraw from social interaction
- Use of hearing aids, loop system etc.
- Complaints that everyone mumbles or speaks too quickly

Vision:

- Need for additional lighting
- Lack of awareness that you have changed position
- Inability to find things when placed in unfamiliar position
- Clumsiness
- Unusual use of touch to support mobility or task
- Difficulties caused by changes in light levels
- Difficulties with unfamiliar routes of places
- Difficulty recognising someone they know until they introduc
- Difficulties with television and newspapers
- Unusual eye contact

Legislative Information

Local Authorities are required to identify, make contact with, and keep a record of Deafblind people in their catchment area. In doing so they should be aware that many of those who are known to Local Authorities as having learning disabilities, multiple disabilities or problems associated with age, may also have dual sensory impairment.

The purpose of keeping the records is to ensure that Local Authorities can make contact with Deafblind people and have access to information to inform the local Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and the Local Authority's market shaping duties under the Care Act.

Assessment & Eligibility

Local Authorities **must** undertake an assessment for any Adult who appears to have needs for care and support, regardless of whether or not the Local Authority thinks the Adult has eligible needs or of their financial situation. An assessment begins when the Local Authority starts to collect information about the Adult. Any person carrying out an assessment – at any stage during the assessment – must be appropriately trained. This includes those at the first point of contact, who may need to ask appropriate questions in order to identify whether someone is Deafblind and refer the person to a specialist assessor accordingly.

The Care Act 2014

Learning Solutions

The Care Act – Assessment & Eligibility – Open Learning Pack

Learning Aim:
To enable you to develop specialist knowledge in the Care Act in relation to: First Contact, Identifying Needs, Assessment and Eligibility.

Learning Outcomes:
On completion, learners will be able to:-

1. Recognise the importance of the role of prevention within social work
2. Demonstrate knowledge of the assessment and eligibility process
3. Identify the range of assessment methods for both service users and carers and ensure that appropriate and proportionate assessment methods are used, including when integrated assessment is required
4. Explain the changes in the Care Act in relation to new responsibilities for carers
5. Identify when safeguarding might come into the assessment process
6. Describe the definition of wellbeing
7. Discuss the process to follow when a person refuses an assessment
8. Demonstrate understanding of the National Eligibility Framework and the National Carers Eligibility Framework and how to apply these to assessments carried out
9. Maintain accurate records and ensure that those being assessed are given copies of their assessments including a written record of their eligibility determination
10. Analyse when Independent Advocacy duties apply

The Care Act – Advocacy – Open Learning Pack

Learning Aim:
To enable you to develop knowledge, experience and skills about Independent Advocacy.

To help you reflect on the implications of the Act for your role, so that you will know what you must do differently and what you may need to do differently.

Learning Outcomes:
On completion, learners will be able to:-

1. Identify when a person needs an Independent Advocate
2. Organise for an Independent Advocate to facilitate the involvement of a person
3. Identify Independent Advocacy under the Care Act
4. Define the four areas of substantial difficulty in the Care Act
5. Describe the different people employed as Independent Advocates (Including Independent Mental Capacity Advocates)
6. Discuss the role/s of an Independent Advocate
7. Recognise the interface with the Mental Capacity Act 2005
8. Analyse when Independent Advocacy duties apply

The Care Act – 3 Day Culture Change Programme

Culture Change

Learning Aims:
To increase staff knowledge and understanding of the context and principles of The Care Act 2014.

To raise awareness of the key principles underpinning The Care Act requirements changes.

To promote a strength-based, outcome focussed and holistic approach in interventions with individuals, and to give staff the confidence and capability in applying these in their interventions with individuals.

Learning Outcomes:

1. Demonstrate their understanding of The Care Act 2014, and the 3 tiered approach:
    - mental / physical disorder or impairment
    - outcomes
    - significant impact on wellbeing
2. Describe the wellbeing principle by:
    - Reviewing Significant Impact (Department of Health)
    - Discussing evidencing and analysing information
3. Identify the service user's journey in the reformed system
4. Explain a strengths based approach and identify the following key areas:
    - Identify what a service user can / cannot do
    - Demonstrate a real reflection of the situation
    - Appropriately evidence an assessment and demonstrate the impact on what a service user would or wouldn't have as a result
    - Discuss appropriate questions
5. Discuss the appropriateness and proportionality in interventions, liking this into wellbeing
6. Demonstrate an assessment of eligibility that is fair, based on evidence and individual needs
7. Identify an outcomes focussed approach, discussing desired outcomes and eligibility outcomes
8. Define the whole family approach, holistic and joint/combined approach (Children & Family Act)
9. Demonstrate professional accountability
10. Identify how to have creative conversations, and the art of delivery
11. Review and discuss assessments and The Care Act 2014 Legal duties
12. Identify the Prevention Agenda

Assessment & Eligibility (Inc. Carer's)

Learning Aims:
To increase staff knowledge and understanding of the context and principles of The Care Act 2014 and the Children and Families Act 2014 in relation to Carers (including young / parent carers)

To increase staff knowledge and understanding of assessment and eligibility within The Care Act 2014, including in relation to Carers.

To improve staff confidence in how to apply principles and practice in assessment and eligibility, including in relation to Carers.

Learning Outcomes:

1. Identify The Care Act 2014 principles in the individual (adult & carer) journey: from first contact to review including support planning:
    - Wellbeing
    - Prevent, delay and reduce
    - Integration, co-operation and partnership
2. Discuss ways in ensuring that assessment is appropriate and proportionate:
    - Identify how to prepare for an assessment (consideration of Advocacy services should also be discussed)
    - Discuss supported self-assessment
    - Review holistic, combined and joint assessments
    - Discuss strengths based approaches in assessments
    - Describe fluctuating needs in assessments
    - Demonstrate professional responsibility and creative conversations in assessments
3. Explain how to make an eligibility determination: for adults and for carers
4. Describe the next steps after and within assessment
5. Participate in open discussions and exercises on the above, including the use of practice examples to illustrate application of the key elements (Wakefield Council to provide bespoke examples)

Carer's Assessment & Eligibility

Learning Outcomes:

1. Identify The Care Act 2014 principles, duties and rights for and in relation to carers
2. Discuss Young Carers and Parent/Carers rights and duties in relation to:
    - Children & Families Act 2014
    - The Care Act 2014
3. Demonstrate ways in ensuring that assessment is appropriate and proportionate by utilising creative conversations and taking professional responsibility
4. Explain how to use combined assessments and a whole family approach: Carer and cared for person different scenarios (e.g. Cared for person not known to LA, Carer and cared for person known to LA, conflict of interests between Carer and cared for person etc.)
5. Identify how to make an eligibility determination for Carers different scenarios (e.g. Cared for person not known to LA, Carer and cared for person known to LA, conflict of interests between Carer and cared for person etc.)

6. Discuss the next steps after and within the assessment:
    - Eligibility determination
    - Provision of information and advice in writing
    - Support Plan

Person Centred Care

Learning Aims:
To enable staff to have a person centred approach to care of individuals.

To enhance the skills and knowledge of staff in the new ways of working.

Learning Outcomes:

1. Explain the Legislation for the person centred approach to providing care and support by reviewing person centred approaches in The Care Act 2014 – putting good practice into Law
2. Discuss a brief overview of the development of person centred approaches
3. Explain what person centred care is and what it means to and for staff working in the Adult Social Care sector and their working practice.
4. Identify what person centred practice looks like in:-
    - Assessment, Care & Support Planning, and Review
    - Ongoing Casework
    - Safeguarding
    - Support to Carers
5. Identify the benefits for staff, and more importantly, Service Users, Carers and their families by discussing how person centred approaches link to better outcomes for
    - People with care and support needs
    - Carers
    - Staff
6. Discuss the challenges of person centred working, and possible ways to tackle these
7. Recognise working towards a person centred system and language
8. Discuss risk assessment and analysis
9. Recognise the need to identify socially isolated people
10. Describe and discuss case studies which will draw conclusions from 2 & 3 above

Version Control

Version Number	Purpose / Change	Author	Date
V2	Updates from consultation	S Hyde	24.01.18
V3	Update of The Care Act Factsheets	S Hyde	31.01.18
V4	Updates from Partner final consultation	S Hyde	05.03.18
V5	All signatures added	S Hyde	20.04.18
V6	Update of Advocacy services - factsheet (page 92)	S Hyde	16.05.18
V7	Update of Connecting Care logo to Connecting Care+ & Connecting Care+ Hub Factsheet update (page 13)	S Hyde	24.09.18
V8	Update of Age UK and WDH Quick Reference Guides	S Hyde	11.10.18
V9	Embedding of Introduction to Hub specific Guides (page 10)	S Hyde	18.10.18
V10	Update of Carers Wakefield & District Quick Reference Guide (page 21) Update of link (page 56)	S Hyde	23.11.18
V11	Full review & Update of content	S Hyde	22.1.19
V12	Update of Quick Reference Guides Addition of Quick Reference Guides: The Prince of Wales Hospice Wakefield Wheelchair Services	S Hyde	16.12.19
V13	Update of Adult Workforce Team address	S Hyde	17.06.2020
V14	Update of signature page Review & update of Quick Reference Guides	S Hyde	12.03.2021
V15	Update of Carers Wakefield & District Quick Reference Guide	S Hyde	03.08.2021

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