

PARTNERSHIP SERVICE PROTOCOL

THE DELIVERY OF CARE AND SUPPORT SERVICES WITHIN EXTRA CARE HOUSING IN NORTH YORKSHIRE

Extra Care Housing provides safe and secure self-contained accommodation for vulnerable adults who require varying levels of care and support to enable them to live independently in a home environment

CONTENTS

PAGE

Section 1	Introduction	3
Section 2	Ethos of Extra Care Housing	4
Section 3	Service Outcomes and Objectives	6
Section 4	Definition of Care and Support Model	9
Section 5	Range of Services	12
Section 6	Service Philosophy	20
Section 7	Outcomes and Key Performance Indicators	22
Section 8	Access to Services	32
Section 9	Complaints and Protection	33
Section 10	Management and Administration	34
Section 11	Staffing	37
Section 12	Checklist for Skills and Experience for Scheme Managers and Staff	38
Section 13	Performance Monitoring and Evaluation	40
Section 14	References	41
Appendix 1		42

Glossary of Terms

Housing Provider	The Registered Social Landlord
Care Provider	Any domiciliary care agency providing care and support in the scheme
<i>flexi</i> Care Provider	24/7 background support service (will usually be provided by the Housing Provider)

This Guide is not designed to be considered in isolation: it is intended to be read alongside North Yorkshire County Council's Accommodation with Care Design and Ethos Guide, North Yorkshire County Council's Dementia Care Good Practice Guide: *Dementia Care and Support in Extra Care Housing* and North Yorkshire County Council's Market Position Statement for the care of older people and adults with physical, mental and learning disabilities. These Guides set out the expected minimum standards for the delivery of care and housing support services in extra care housing in North Yorkshire and are available on the website www.northyorks.gov.uk/extracare. The Protocol will be subject to regular review and subsequent updating. This will occur as a result of changes in legislation and standards and feedback from providers and developer partners as well as people who live in the schemes and people who come in to use the facilities and services.

1.0 INTRODUCTION

North Yorkshire County Council (NYCC) is engaged in an ambitious project to facilitate the delivery of accommodation with care to meet the needs of our current and future communities.

This includes working with housing providers to enable the provision of extra care housing (ECH) schemes; core and cluster accommodation; specialist housing and supported accommodation to meet the needs of vulnerable people in the county, including:-

- Older people
- People with a learning disability
- People with mental wellness requirements
- Long-term conditions including physical disability
- Complex needs including people living with dementia
- Cognitive impairment
- Sensory impairment

In North Yorkshire's extra care housing developments built before 2014, care and support was primarily provided by the NYCC "in-house" service. This ensures that a member of the domiciliary care team is on the premises at all times of the day and night (sometimes referred to as the 168 hours model). In addition, planned care for individual residents is generally provided by NYCC staff but increasingly there is some extra provision for which the independent sector is utilised.

Considerable work has been undertaken to look at how care and support should be working in extra care schemes in the future. This has looked at two aspects of care and support. The first is the background support that ensures that in an emergency situation a domiciliary care staff member is available to respond. On top of this, people will need some limited assistance (*flexi*Care/background support) with tasks on a general basis, whilst others will require planned support as part of a care package.

As a result of the research, negotiations with housing providers and the necessity to achieve the most flexible outcomes for the residents living in extra care housing in North Yorkshire, the introduction of a *flexi*Care or background support model was introduced and the first Scheme adopted this model in August 2014.

This document forms the basis of what is expected of the *flexi*Care support as well as the planned care and support provision.

The *flexi*Care background support will be provided to all residents regardless of their tenure status or dependency level. The use of Personal Budgets (PBs) will be promoted to residents and where available Individual Service Funds (ISFs) will be utilised. By doing so, the residents, with the help of the Care Provider, will be able to use their budgets more flexibly.

The Registered Providers of care and support services in extra care housing schemes will be responsible for providing the service either on their own or with a partner.

North Yorkshire County Council would support the use of staff mutuals to provide the care and support service in extra care.

2.0 ETHOS OF THE EXTRA CARE HOUSING SCHEME

- 2.1 North Yorkshire County Council's Care and Support Where I Live Strategy aims to reshape the countywide provision of care accommodation options and services in order to offer residents¹ increased choice and independence.
- 2.2 Extra care housing should provide safe and secure self-contained accommodation for vulnerable adults who require varying levels of care and support to enable them to live independently in a home environment.
- 2.3 Residents who have been assessed and meet the criteria for extra care housing may live as assured tenants or leaseholders with security of tenure in their own self-contained apartments.

Extra care should:-

- Contribute to the initial reduction of the levels of care and/or support previously received by the resident before entering the scheme
 - Support the on-going care and support needs of its residents and reduce the likelihood of admission to long-term care
 - Contribute to the prevention of hospital admission, re-admission and enable early discharge
 - Contribute to supporting people to live independently, stay healthy and recover quicker from illness or accident
 - Enable people to be supported to remain in their home and be supported to die at home if that is their wish
 - Enable people living with dementia to live independent, active and healthy lives without the need to move to more restrictive accommodation
 - Promote independence, prevention and wellbeing
 - Improve outcomes for residents and their carers
 - Enable two-way community interaction to provide activities, lifelong learning and social interaction
 - Give people choice and control over their care and support needs via the personalised care arrangement
 - Give people control over their personal finance arrangements including having access to welfare benefits with a view to maximising their income
 - Provide housing, care and support solutions to all vulnerable adults of all ages and across all needs
 - Be mixed tenure and tenure blind
 - Involve and consult with people of all ages and need, who are likely to live in or use the facilities and services provided at the scheme
 - Include a specialism where identified as a need such as a Memory Clinic or Learning Disability Day Service
 - Offer choice and control with a wide range of innovative, high quality and flexible care options that are joined up and seamless
- 2.4 The overall objective is to ensure that adults in North Yorkshire benefit from services in their own home and, where appropriate, are able to access alternative accommodation to meet their care and support needs, whether as a tenant, homeowner, or in shared ownership.

¹ We are using the term 'residents' in its true sense; as a resident of a housing model rather than a residential institution

2.5 The Care Provider will ensure there are staff available to provide residents with appropriate practical, emotional, personal and social care in their own home by promoting their independence, health and well-being in accordance with any on-going assessment of needs and through the on-going improvement, maintenance or minimised deterioration of:-

- Daily living functions
- Ability to self-care
- Mobility
- Confidence and independence in own home
- Physical and mental health

In addition staff will support residents to maintain and develop opportunities for social inclusion and lifelong learning as appropriate.

2.6 It is anticipated that residents will meet the criteria of three distinct dependency categories as follows:-

1. Low - 0-5 contact hours average per week - 30%
2. Medium - 5-10 contact hours average per week – 40%
3. High – 10 plus contact hours average per week – 30%

NB. Please note that the actual mix of needs will be subject to change in line with Allocations Panel recommendations and is likely to be scheme-based.

3.0 SERVICE OUTCOMES AND OBJECTIVES

The overall purpose of any extra care housing scheme is to provide safe and secure self-contained accommodation for vulnerable adults who require varying levels of care and support to enable them to live independently in a home environment.

3.1 Service Provision that:-

- Contributes to the initial reduction of the levels of care and/or support previously received by the resident before entering the scheme
- Supports the on-going care and support needs of its residents and reduces the likelihood of admission to long-term care
- Contributes to the prevention of hospital admission, re-admission and enables early discharge
- Contributes to supporting people to live independently, stay healthier and recover quicker from illness or accident
- Enables people to be supported to remain in their own home and supported to die in their own home if that is their wish
- Enables people living with dementia to live independent and active lives without the need to move to more restrictive accommodation

3.2 CARE SPECIFICATION

Care Services

3.2.1 It is anticipated that care services provided within ECH will be designed to:-

- Enable residents to live independently by providing a different range of services and approaches to the traditional home care model, which maximises the choice and control of the residents
- Consider and take into account the physical, psychological, social, emotional and spiritual needs of the resident as well as consideration to a resident's race, age, culture, religion, language, gender, sexual orientation and disability and other lifestyle choices, which will require care provider staff to gain an understanding of a resident's life history, personality, mental and physical health, relationships, preferences, attitudes and aspirations. This information will be used to plan and subsequently provide services that take into account the resident's wishes
- Achieve the maximum rehabilitative and re-enabling effect by:-
 - Appropriate assistance with physical rehabilitation and re-ablement
 - Identifying where aids and equipment are required and linking to rehabilitative and re-ablement services as appropriate/required

- Giving appropriate assistance in the learning and re-learning of skills and techniques necessary for independent living
- Giving encouragement and support to rebuild confidence/self-motivation and self-esteem
- Providing a range of preventative services to enable residents to promote and maintain their own health and wellbeing including information and advice on healthy living/safe practice and opportunities to maintain physical fitness, good nutrition and a positive attitude and approach to ageing
- Provide flexible and responsive services tailored to the needs and wants of each resident in order to fully promote and maintain their independence and dignity through the choice and control of all services, particularly those that cannot be provided by the resident themselves, eg personal care, domestic tasks etc
- It is anticipated that low-level nursing care needs will be met by Community Health Care professionals as appropriate, except where there is provision within the Care Provider's medication procedure to allow resource workers to carry out low-level nursing tasks and where a qualified nurse has assessed competence, or where nursing care has been commissioned by the Care Provider

3.3 Personal and Domiciliary Care Services

3.3.1 It is anticipated that Care and Support Services provided within ECH will be designed to:-

- Provide a waking background support or *flexiCare* model, as described in section 4.0 ensuring the care staff, including management, are available 24 hours a day, 7 days a week, 52 weeks per annum within the ECH scheme to ensure the presence of care and support around the clock to meet any additional needs of residents outside of those identified through a person-centred assessment of need
- Give people choice and control over their care and support needs via personalised care arrangements which includes Self-Directed Support
- Identify personal care and support targets and outcomes through assessment. These will then be met through a flexible plan agreed in conjunction with the resident and their representatives through the use of individual budgets and the personalised care arrangements
- Ensure appropriate support by reviewing of the resident's Care and Support Plan every month by the Care Provider with an initial review after 6 weeks and any changes made in agreement with the resident, their representative and Care Provider

3.3.2 Promote and maintain the independence of the resident by ensuring:-

- Day to day changes in capacity and need are monitored and responded to in agreement with the resident, their representatives and care staff
- A 'shared care' approach is adopted and implemented, ie care staff and management liaise with the resident and their representatives and any other

relevant organisations to ensure agreed tasks are provided

- Assistive Technology is fully available throughout the ECH scheme, including an emergency call system in place for the resident to summon help 24 hours a day, 7 days a week, 52 weeks per annum from the **flexiCare** staff team in the event that the resident's 'personal' carer/assistant is not available on site – subject to the **flexiCare** Care Provider's Charging Policy
- Appropriate facilities and equipment are available to meet the full range of care needs of the resident according to their individual assessment and to fully promote and maintain the independence and dignity of the resident, eg hoists, assisted bathing facilities, incontinence laundry management etc
- Residents have control over their personal financial arrangements including having access to welfare benefits where entitled

4.0 DEFINITION OF CARE AND SUPPORT MODEL

4.1 *flexi*Care or Background Support Model

North Yorkshire County Council Health and Adult Services' Directorate has undertaken work to develop a care model that can be used in all future extra care housing schemes.

Provision of a *flexi*Care background support service is essential to:-

- Achieve and sustain a tenancy in an independent living environment
- Ensure effective emergency response and evacuation as required
- Deliver a scalable and flexible service
- Realise and optimise re-ablement / enablement outcomes
- Support complex and multiple care needs within the community
- Prevent crisis and improve the quality of crisis intervention
- Promote and sustain resident inclusion in an active community
- Provide peace of mind for residents, their friends and families

4.1.1 The *flexi*Care background support service allows for greater flexibility and response, effectively putting the 'extra' into extra care. It is the availability of on-site waking staff 24/7 that is evidenced to enable people with significant care requirements to access extra care and to remain in their homes even with complex and multiple care needs.

4.1.2 Each scheme will need to have a provision of *flexi*Care or background support. There will also need to be planned support for people with on-going care requirements. It is proposed that this element would usually be funded via Individual Service Funds (ISFs) which would be managed by the Care Provider or via direct payments.

4.1.3 An extra care service is made up of several component parts:-

- Estate Management: Provided by the Scheme Manager
- *flexi*Care Support Service: Flexible background housing and care related support provided by support workers. Not allocated to individuals on a permanent basis
- Planned Support: Flexible housing, care and support time defined through individual support plans with resources allocated for individual use to meet personalised outcomes

4.1.4 This Partnership Service Protocol breaks with the 'tradition' that the background support service is wholly funded from the care budget and / or from the resident. Instead it outlines a more equitable distribution of cost and therefore references service charge as a partial funding mechanism. This aligns cost recovery to the activities and outcomes delivered through the background support service.

(See appendix 1 for breakdown of background support charges)

4.2 Supporting People Living with Dementia

4.2.1 With good quality design and flexible care and support services, the aim of extra care housing will be to enable a person living with dementia to live in their ECH

property for life, where it is practicable, safe and it is their wish to do so and not to move someone into residential or nursing homes because their support becomes difficult or expensive. The ethos is about finding a solution to support that person appropriately, safely and within their wishes.

4.2.2 The preventative role of extra care housing is recognised for its increasing use as a site for the delivery of community health services to people with complex needs, both to residents within extra care and the local community. The benefits of extra care housing are recognised by relatives of people living with dementia. In some cases, family relationships are said to improve when people with dementia move to extra care housing. Residents and relatives are reassured that there is someone on site to keep an eye on things and relationships revert to the personal rather than carer and cared for.

4.2.3 Extra care housing also provides potential benefits and improvements for carers looking after relatives living with dementia (eg partners and family). The nature of the environment, the specialist design features incorporated into the scheme and the fact that care and support is on site, reassures the carers and families that their relative will be cared for appropriately. An example of this is that couples can carry on living together, and where one of them is living with dementia, the other can continue to support their partner with the knowledge that should they need some help or a break from their caring role, it will be available.

4.2.4 People living with dementia require a high level of dedicated support and meaningful occupation. There are a number of success stories of people moving into specialist extra care housing late on in their condition where design features support them to orientate quickly and where support is tailored to meet their social and emotional needs as well as their physical needs. Some of the recognised benefits of providing meaningful activities for people living with dementia are:-

- Remaining physically and mentally active can have a significant impact on a person's wellbeing. It can provide a welcome distraction from the stresses of the illness and can help the person focus on the positive and fun aspects of life
- Carrying out simple everyday tasks can help the person living with dementia feel better about themselves by providing a structure to the day and a sense of achievement
- Some types of activity can help the person living with dementia to express their feelings - for example listening to music or writing something down

4.3 There is a lot of information available and many examples of different methods to support people living with dementia, for example the SPECAL method (Specialised Early Care for Alzheimers) and Dementia Care Matters (DCM). Both of these methods particularly focus on providing person-centred care and support to people living with dementia and are simple and easy to put into practice. The *flexi*Care background support model has also been designed to incorporate an element of flexible support for people living with dementia, which will enable the staff team to provide ad-hoc support to people at times suitable to them, which may not be in-line with their planned care and support package. The adoption of tested models will support the management and staff team to provide the best possible care and support to people living with dementia in extra care housing.

4.4 Services will be designed to achieve the maximum rehabilitative effect, utilising the support provided by NYCC's Short Term Assessment and Re-ablement Team (START) who will

maximise a person's ability to maintain their independence. It is important that where they have the ability, residents are supported to carry out tasks for themselves, even though it would be quicker for staff to undertake tasks directly. As well as assistance with hands-on physical rehabilitation, appropriate aids and equipment will be available, assisting in the learning or re-learning of skills and techniques necessary for independent living, the provision of encouragement and support to rebuild confidence or self-motivation.

- 4.5 A range of preventative services should be available to residents to assist and to preserve or promote their own health and wellbeing. These should include support and advice and opportunities for maintaining physical fitness, good nutrition and a positive attitude towards ageing. Services could include other therapeutic activities including complementary therapies.
- 4.6 Services provided will be flexible and responsive to the wishes of the individual residents. Loss of control over the person's order of day to day activities has been found to increase dependency. As far as is practicable, residents or their representative will be able to exercise control over the timing and type of assistance they receive with tasks that they cannot do for themselves.
- 4.7 In all aspects of service delivery the needs of the whole person (ie physical, psychological, social, emotional and spiritual) will be considered and taken into account, building on the original assessment information. This will require scheme staff to spend time gaining an understanding of the individual's life history, personality, mental and physical health, relationships, attitudes and aspirations. The planning or provision of the care and support service will always be approached from the resident's perspective and maintain a person's normal behaviour, in line with their personality and characteristics before they developed dementia.
- 4.8 Residents will have the support and assistance they need to access everyday opportunities and facilities. Every resident will have access to an advocate if required.
- 4.9 Residents, their family and/or their representatives/advocates will be provided with full information about the services and choices available to them.

5.0 RANGE OF SERVICES

5.1 Range of Services

- 5.1.1 All activities carried out should be as a result of an individual needs assessment and in line with personally identified outcomes through individual support plans or in response to ad hoc/emergency need.
- 5.1.2 Provision of care and support with the following living activities within the ECH scheme and with the additional provision of on-site communal facilities and activities:-
- Personal Care
 - Social Care and support including social inclusion, ie participation within the wider community
 - Meals and beverages
 - Assistive Technology
 - Household maintenance
 - Shopping and financial management support
 - Facilitating transport and mobility
 - Advocacy and befriending

These aims will be achieved by the joint working of the Housing Provider and the Care Provider to ensure that the residents, community and the scheme are fully integrated. Under the personalised care arrangements, the Care Provider should ensure each individual's support plan needs are met including social inclusion and assisting people to attend events and activities.

5.2 Personal Care

The department of Health Domiciliary Care National Minimum Standards Regulations suggest that personal care, in its established ordinary meaning, includes four main types of care which are:-

- Assistance with bodily functions such as feeding, bathing and toileting
- Care falling just short of assistance with bodily functions, but still involving physical and intimate touching, including activities such as helping a person get out of a bath and helping them to get dressed
- Non-physical care, such as advice, encouragement and supervision relating to the foregoing such as prompting a person to take a bath and supervising them during this
- Emotional and psychological support, including the promotion of social functioning, behaviour management, and assistance with cognitive functions

Personal Care as defined by CQC states that “The regulated activity of personal care consists of the provision of personal care for people who are unable to provide it for themselves, because of old age, illness or disability, and which is provided to them in the place where those people are living at the time when the care is provided”.

Personal care may include assistance with any or all of the following activities in line with Care Provider policies and will be provided in a re-enabling manner:-

- Bathing, washing, showering, shaving and oral hygiene
- Toilet and continence requirements and management
- Manual Handling in line with Care Provider policies
- Medication management and administration in line with Care Provider policies and CQC Medication Guidelines
- Medication requirements and any health-related tasks including catheter and stoma care that are not defined as nursing care in line with Care Provider policies and CQC Medication Guidelines
- Supporting and enabling residents to maintain a healthy and balanced diet
- Identify environmental and falls risks, provide appropriate advice and information and refer to appropriate person where necessary

5.2.2 Care and support services will be available 24 hours a day, 7 days a week, 52 weeks per annum.

5.2.3 *flexiCare* care staff and management are required to respond to emergency calls within 3 minutes, irrespective of the resident's care provider of choice.

5.2.4 At the point of care delivery, every opportunity should be taken to maximise the resident's capacity and ability to carry out the tasks themselves in a manner consistent with their physical and mental health.

5.2.5 In conjunction and liaison with health care professionals, care delivery should also include the improvement of continence, the management of incontinence and address any medication problems and remedial physical and mental difficulties and disabilities and must be undertaken in a manner that is sensitive to the resident and with their full involvement.

5.2.6 There must be sufficiently trained staff to meet the needs of residents with regard to the administration of medication, with clear procedures for obtaining prescriptions and dispensed medicines. Support must be available to residents to ensure that regular health assessments can be obtained from GPs and Community Health Services. The Care Providers shall ensure that all residents have access to relevant NHS services via a GP of choice according to need. These shall include occupational therapy, speech therapy, physiotherapy, dentistry, chiropody, optometry and dietetics.

5.2.7 The Care Providers shall not obstruct the formation or conduct of relationships unless the reasonable expectations of privacy of other residents are offended or exploited in line with Care Provider policies. It is, however, the duty of all staff working in an extra care scheme to alert North Yorkshire County Council to any matters that may equate to safeguarding of residents.

5.2.8 Residents will have a review of their needs undertaken monthly, with an initial review 6 weeks after moving in. The review will be the responsibility of the Care Provider, in conjunction with the NYCC Assessment Team to organise and will consider all the areas of the support plan and how effectively the needs of the resident are being met.

5.2.9 Initial and subsequent meetings will be conducted in the resident's first language and in circumstances where English is insufficiently understood; a helper from the same ethnic group or an interpreter must be available to assist.

5.2.10 The Care Providers shall ensure that the resident has access to appropriate advocacy services as required.

5.2.11 The **flexi**Care Provider will strive to assist in avoiding unnecessary hospital admissions but, when hospital admission is needed, the Care Provider shall ensure that the resident's next of kin and any other person nominated by the resident, is/are informed in accordance with the support plan, along with the NYCC local assessment team/allocated worker. The Care Providers will also ensure that the Scheme Manager is made aware at the first available opportunity; this is applicable to all care providers delivering care and support services in the scheme.

5.2.12 The resident's family and friends should be involved (if requested by the resident) in planning for and dealing with increasing infirmity, terminal illness and death.

5.2.13 The **flexi**Care Provider, in the absence of the Scheme Manager who has first responsibility for these measures - must ensure that the death of a resident is handled with dignity and propriety, with the following minimum requirements:-

- A doctor should be informed and requested to certify the death
- As far as practicable, all appropriate procedures will be in place to ensure that residents are treated in accordance with their wishes and customs on the event of death
- The next of kin and other individuals nominated in advance by the resident must be informed in a sensitive manner
- The relevant NYCC local assessment team/allocated worker must be informed

The deceased resident's relatives/carers shall be responsible for making funeral arrangements. In the absence of this, the death should be referred to the Care Assessor.

5.3 Social Care and Support including Social Inclusion

5.3.1 Social Care and Support carried out in an enabling manner is defined as assistance with any or all of the following activities:-

- Provision of a range of daytime, night, weekend and evening activities, which will be drawn up and agreed with the full involvement of residents and/or their representatives
- Listening and support with social or emotional needs
- Encouragement of practical skills and motivation
- Escorting residents as required on trips for shopping, hairdressing, recreation and social inclusion
- Liaising with health care professionals on behalf of residents to make and confirm arrangements, including escorting for healthcare appointments, eg dentist, hospital appointments
- Liaising with residents' representatives, eg family members, advocates etc
- Liaising with other care providers and/or professionals to ensure that effective, efficient services are provided throughout the ECH scheme
- Providing people who are living with dementia with emotional support

- 5.3.2 A full range of activities and facilities should be made available both within the ECH scheme and the wider community aimed at the promotion and development of physical wellbeing, fitness, mental stimulation, social inclusion, social engagement, relaxation, enjoyment, skills development and healthy living, with a focus on building and maintaining self-esteem along with a sense of achievement.
- 5.3.3 Organisations and residents from the local and wider community, eg libraries and places of worship, should be actively encouraged to become involved in the provision of activities within the ECH scheme.
- 5.3.4 Involvement with the local and wider community should be developed in order to enable the scheme's residents to contribute to community life as well as receiving support from others and to continue residents' normal relationship and behaviour patterns.
- 5.3.5 Residents should be able to receive visitors when desired. Visitors will be able to socialise and share food/drink with residents in communal areas or as invited guests in their apartments.
- 5.3.6 The personal choice of residents should also be reflected in the range of daily activities provided, including social and recreational interests. Reading material will be available eg newspapers and periodicals, talking books etc and a link to local library services maintained and residents must be supported to gain benefit from these services and equipment.
- 5.3.7 These aims will be achieved by the joint working of the Housing Provider and the Care Provider working together to ensure that the residents, community and the scheme are fully integrated. Under the personalised care arrangements, the Care Provider should ensure each individual's support plan needs are met including social inclusion and assisting people to attend events and activities.
- 5.3.8 The scheme will give consideration to enabling and supporting residents to bring their pets to the ECH scheme and the Housing Provider will ensure that identified support as appropriate is incorporated into residents' support plans.

5.4 Meals and Beverages

- 5.4.1 Catering and kitchen facilities will be the responsibility of the Housing Provider who will own and manage the scheme. A service will be provided which will be available for residents, their guests and members of the local community to purchase a meal in a restaurant setting.
- 5.4.2 The Care Provider, with an emphasis on enabling residents to maintain a healthy and balanced diet and in an enabling manner will provide any or all of the following services:-
 - Assistance with preparation and cooking of simple hot and cold meals and snacks
 - Assistance with the preparation of hot and cold drinks
 - Assist residents with meal preparation to be cooked at a later time, eg peeling of vegetables in line with assessed needs
 - Ensuring the safe reheating of previously prepared food, including frozen meals, in accordance with current legislation and in accordance with manufacturers' instructions
 - Provision within the resident's apartment of a hot or cold meal purchased from the restaurant should the resident either be unwell, unable to access the restaurant or

for any other reason as either specified as a matter of resident choice or in the resident's support plan

- Assistance with the preparation and cooking of simple hot and cold meals and snacks or provision of meals that caters for special diets, eg diabetic or potassium-free
- Escorting residents to and from the restaurant if they are unable to access it on their own
- Encouraging residents to eat and hydrate appropriately thereby avoiding malnutrition and dehydration especially prevalent in people living with dementia

5.4.3 If required, assistance with preparation and consumption of food should be given discreetly and with care and sensitivity. Taking into account the preferences of each resident by referring to their life history eg not giving a loaded plate to a resident with a small appetite who will be distressed by leaving food to waste, not patronising a resident who needs support with eating their meal and using appropriate interventions and tools to assist a resident to feed themselves as much as they are able to.

5.4.4 Food should only be liquidised following consultation with the resident or their representative and in discussion with the Care Provider and health care professional. The food should be liquidised in separate food item portions and presented in an attractive manner.

5.5 Assistive Technology

5.5.1 *flexi*Care staff are required to respond to emergency calls and Telecare alarm calls within 3 minutes, irrespective of the resident's care provider of choice.

5.5.2 The Housing Provider will work in partnership to ensure that the use of assistive technology as assessed for each individual is maximised to assist with independence, is enabling and brings benefit to the quality of life for the resident.

5.5.3 In some schemes, it may be that the Clinical Commissioning Group (CCG) has invested in Telehealth. The Housing Provider must work in partnership to enable access to users of the Telehealth system as directed by practice-based commissioning staff. This will include people from the community as well as people who live at the scheme and access arrangements must be in place at reasonable times, where these facilities have been provided.

5.5.4 North Yorkshire County Council will support the use of innovative assistive technology solutions that enable residents to live more independently, for as long as possible in their own homes.

5.6 Household Maintenance

5.6.1 The Care Provider – unless this service is made available to residents by the Housing Provider, will place an emphasis on enabling residents to maintain a safe, comfortable, warm and clean home and in an enabling manner will provide any or all of the following services or activities which will be funded via personal budgets:-

- General light cleaning or tidying of the home
- Cleaning of the kitchen area in order to maintain a hygienic environment
- Cleaning of bathroom and toilet areas
- Washing, drying and airing of laundry
- Essential ironing
- Operation of heating and ventilation systems
- Disposal of household rubbish as appropriate, ie in line with Local District/Borough Council Policy

5.6.2 Each resident or their representative will be responsible for providing suitable cleaning materials and equipment required by care/housing staff to perform any cleaning or household tasks.

5.6.3 All cleaning materials and equipment required by care/housing staff to perform any cleaning or household tasks will be used as economically and efficiently as possible and be environmentally-friendly wherever possible.

5.6.4 Assistance for residents to access dry cleaning facilities or services from within the community if required. Residents and/or their representative shall meet the full costs of dry cleaning.

5.7 Shopping and Finance

5.7.1 The Care Provider, with an emphasis on an enabling manner, may carry out or support any or all of the following activities:-

- Purchase of groceries or household goods from the most appropriate source, eg local supermarket or internet shopping, with due regard to cost and time, which will include any escorting as appropriate
- Collection of pensions and welfare benefits in line with appropriate guidelines
- Collection of dispensed prescriptions in line with appropriate guidelines
- Payment of bills and services
- Money Management and Welfare Benefits Advice

5.7.2 When providing assistance with activities, care staff will assist residents:-

- To promote their choice of branded goods
- To meet their special dietary and cultural needs
- To ensure the safe delivery of shopping in fresh and good condition
- To store goods appropriately and safely, eg frozen food, in line with manufacturer or supplier guidelines

5.8 Facilitating Transport and Mobility

5.8.1 Residents should be supported to access appropriate transport solutions and maximise their mobility wherever possible.

5.8.2 The Care Provider should assist residents and their families to access transition services eg admission and discharge to and from hospital etc.

5.9 Advocacy Befriending Services

- 5.9.1 Advocacy offers practical assistance to help people to secure their rights and to access services when they don't feel able to do this for themselves. It may be a family member, a friend or someone from an organisation such as Age UK.
- 5.9.2 Advocacy also assists when someone is deemed to lack mental capacity. If a person is deemed to lack mental capacity it means they lack the capacity to make a particular decision for themselves at the time the decision needs to be taken. Thus, mental capacity is time and decision specific. A person may, for example, have the capacity for small decisions such as what to eat for breakfast but lack the mental capacity to make complex decisions about finances or deciding where to live. However, the assumption must be that people have mental capacity until proven otherwise.
- 5.9.3 The Care Provider must ensure that where lack of mental capacity is suspected or confirmed, they notify the Social Care Assessor/Co-ordinator. The Care Provider should also work in partnership with Adult Services, the resident and their family to sign-post to advocacy services where required.
- 5.9.4 There are a range of organisations who offer volunteer befriending services. The volunteers visit isolated, frail and lonely people which can be a significant benefit to residents who may not have any family or friends to visit them.
- 5.9.5 The Care/Housing Provider must ensure that where a need is identified for a befriending or visiting service is confirmed; they notify the Social Care Assessor/Co-ordinator. The Care/Housing Provider should work in partnership with Adult Services, and the resident to sign-post to appropriate befriending and visiting services where required.

5.10 Development, Improvement and Maintenance of Quality of Life

- 5.10.1 A wide and varied range of flexible daytime activities and opportunities must be readily available to promote and encourage two-way interaction with the wider community which will enable both residents within the ECH scheme and residents from the local community to maintain and improve existing skills and interests and to acquire and develop new skills and interests including opportunities for lifelong learning.
- 5.10.2 Support and assistance should be readily available to enable residents within the ECH scheme to access a wide range of local community facilities. This will be funded via personal budgets.
- 5.10.3 Residents will be encouraged and supported in maintaining their network of relationships with family and friends and offered a range of opportunities to develop new social contacts both within the scheme and the wider community as appropriate.
- 5.10.4 Residents will be actively encouraged and supported to assist each other, family members and friends and be offered opportunities to contribute their skills and experience to life in the ECH scheme and to the wider community as appropriate.
- 5.10.5 Residents will be actively encouraged to organise and participate in discussions, eg residents' groups, concerning the operation and service standards of the ECH scheme and in the range of activities, opportunities and events.

5.10.6 A resident's right to choose when, how and if to participate in the range of activities, opportunities and events offered must be fully respected at all times.

5.11 Involvement and Interface with the Wider Community

5.11.1 The ECH scheme will develop, maintain and strengthen any links, formal or informal networks that residents may have within the wider community.

This will be achieved through:-

- The recruitment, support and input of local volunteers to assist in the range of activities and events available within the ECH scheme
- The development of joint projects and activities involving residents, the wider community, local schools, youth clubs, Older People's Forum and the wider voluntary, community and faith sector
- The active engagement of the ECH scheme and its residents in local community events
- Scheme facilities, eg restaurant, café, library being made available to the wider community
- Under the personalised care arrangements, the Care Provider should ensure each individual's support plan needs are met including social inclusion and assisting people to attend events and activities

These aims will be achieved by the Housing Provider, Care Provider and North Yorkshire County Council working in partnership together to ensure that the residents of North Yorkshire, their local community and the scheme are fully integrated.

6.0 SERVICE PHILOSOPHY

Service Philosophy

The principles outlined in the Partnership Service Protocol aspire to present a standardised partnership approach to service delivery in extra care housing. The protocol is intended for use by everyone involved in the development of extra care housing. It is therefore an expectation that North Yorkshire County Council staff are included in the resolution of issues that arise.

- 6.1 Services must promote and actively encourage the independence and wellbeing of the resident in their own home environment, taking into account the resident's particular circumstances in order that the ability to exercise choice, control and personal fulfilment and life satisfaction is maximised.
- 6.2 All services provided must treat every resident as an individual with their own specific needs and right to choose and control their lifestyle. The right of the resident to make their own choices, including calculated risks, which have been subject to a joint risk assessment, should be fully supported and respected through the delivery of a service with maximum flexibility.
- 6.3 All services must maintain the resident's independence, wellbeing, dignity, privacy and confidentiality – unless judged not safe to do so. This is in line with North Yorkshire County Council's Dignity in Care Charter and within the legislation of the Human Rights Act.
- 6.4 Any decision with regard to the services that are being provided to a resident should only be made with the full participation and agreement of that resident or their advocate/representative.
- 6.5 Residents or their representatives should be given full information on the services and choices available to them in a format that meets their needs.
- 6.6 Residents or their advocate/representative should be fully consulted on the planning and delivery of any services they receive, with provision made for their views on services and their delivery to be taken into consideration on an on-going basis outside any formal review of services.
- 6.7 All residents must have access to an advocate to either represent or assist in presenting their views on service delivery if they wish or if they don't have capacity themselves. Everyone must be deemed to have capacity until it is known that they don't have capacity and all decisions made on their behalf must consider any issues around deprivation of their liberty and ensure that services put in place are in the best interest of the resident.
- 6.8 All services will be provided in an anti-discriminatory manner with due regard and respect to race, age, culture, religion, language, gender, sexual orientation and disability.
- 6.9 All services provided must be flexible, consistent and reliable and in line with the needs of each resident and ensure delivery of outcomes across the key themes:-

- **Safeguarding**

Acting in a manner which contributes to the safeguarding of all vulnerable adults at all

times. Staff must be appropriately trained and able to confidently and competently manage situations and alert the appropriate person where potential abuse is identified. Please refer to North Yorkshire County Council's Safeguarding Policy

- **Quality**

The delivery of any services in an ECH scheme must strive to be of the highest quality. This will be judged by the project's extra Care Team Evaluation Model, CQC judgement framework and North Yorkshire County Council's Contract requirements

- **Personalisation**

Putting people in control of their own services, giving them choice and a stronger voice about how services are delivered to them

- **Efficiency**

Services should be delivered in a manner which is both effective and efficient in meeting residents' desired outcomes thereby maximising resources available to residents through Personalisation and hence delivering an efficient service

- **Prevention and Early Intervention**

Commissioning more services that promote wellbeing and prevent people from needing more intensive health and social care services as assessed and relevant, in partnership with the appropriate agency

In addition services will include the following principles:-

- **Services that are joined up**

Ensuring people experience seamless services from housing, health and social care

- **More Community-Based Services**

Services provided will support the promotion of people's independence and support carers with an emphasis on enabling them to remain active in the local community

- **Promoting Independence**

Services will be provided to promote and maximise independence with a focus on rehabilitation and re-ablement

6.10 All services provided within the ECH scheme will be measured against the following 5 assessment criteria principles (the 5A's model):-

- Affordability
- Availability
- Accessibility
- Acceptability
- Achievability

Services must also comply with:-

- Care Quality Commission Essential Standard of Quality & Safety
- North Yorkshire County Council's Quality Assurance Framework

7.0 OUTCOMES AND KEY PERFORMANCE INDICATORS

- 7.1 The care and support must be provided in a manner which offers confidentiality, respect, dignity and privacy and does not erode the resident's capacity for self-care or the contribution made by family carers. Key to providing the best possible support is the assessment, care and support planning and review process.
- 7.2 Each resident living in an extra care housing scheme will be respected as a unique individual, with recognition being given to his/her particular physical, psychological, social, emotional, cultural and spiritual needs.
- 7.3 Assessment, care and support planning and reviewing are key aspects of best practice and documenting the service received by individuals is vital. The way in which care and support services are documented will evidence what is occurring for the individual as well as demonstrating whether person-centred care is integral to the service provided.

Key indicators of best practice suggest that:-

- A full assessment is undertaken prior to a service being provided
- Evaluation and re-assessment is on-going
- All relevant documentation used by the organisation demonstrates that the individual is fully involved
- Cultural needs are appropriately considered
- Wellbeing for the individual is actively promoted
- The language used will be acceptable to the person receiving care
- Care and support plans are used as communication tools (evaluation is meaningless in the absence of well-documented care and support)
- A key worker system matches individuals and staff
- Relatives (and significant others) feel involved and supported

7.4 Objectives

- 7.4.1 To maintain the independence and safety of residents by providing support, encouragement, access to information and advice to residents in order to maintain their own physical and mental wellbeing, dignity and independence within their own home environment.
- 7.4.2 To ensure residents have choice and control over their own lives by involving them in decision-making processes both as a resident and in the wider community, and to adapt services to meet changing needs.
- 7.4.3 To provide care and support in a Home for Life environment, including Assistive Technology as required.

- 7.4.4 To maximise the physical and mental health and wellbeing of residents by providing Individual Needs Assessments and Support Plans in order to provide a full range of care and support services to meet these needs.
- 7.4.5 To fully support the individual reviews of residents' Support Plans to evaluate the outcomes of the service provision and to set new outcomes as appropriate.
- 7.4.6 To integrate the ECH scheme with the local and wider community in order to create a culture of everyday life within a stimulating, safe, secure and accessible environment.
- 7.4.7 To work in partnership with a range of stakeholders, including Local Commissioners, Borough and District Councils, the CCG, Housing Association and Care Provider, and the Voluntary Sector, in order to provide support, care and health to provide an affordable home for life with a range of services tailored to the needs of the resident.
- 7.4.8 To promote a representative community, eg residents' group and their support networks, by maintaining the balance and levels of need within the ECH scheme.
- 7.4.9 To ensure and maintain equality and provide a range of services that meet diverse needs.
- 7.4.10 To enhance dignity and choice in End of Life Care by enabling residents to die at home if this meets their choice and to put in place processes to ascertain and meet residents' wishes and preferences.
- 7.4.11 To strengthen the relationship between housing, health and care services via the improved delivery of joined up assessment, service provision and commissioning in order to deliver better outcomes for vulnerable adults (Decent Homes and Lifetime Neighbourhoods).

7.5 Service Outcomes

The Service Outcomes are based on access, independence and avoidance of admission to institutional care accommodation:-

Service Level Outcomes

A service that can:-

- 1. Contribute to the initial reduction of the levels of care and/or support previously received by the resident before commencement of the Service**
- 2. Support the on-going care and support needs of residents and reduce the likelihood of admission to long-term care**
- 3. Contribute to the prevention of hospital admission, re-admission and enable early discharge**
- 4. Contribute to supporting people to live independently, stay healthier and recover quicker from illness or accident**

Measurement Framework for Outcome One

A service that can contribute to the initial reduction of the levels of care and/or support previously received by the resident before commencement of the Service

Individual Outcome	Measures	Methodology
a) Improvement in being able to undertake daily living function	<ul style="list-style-type: none"> • % of residents who perceive that their ability to undertake a daily living function has improved since receiving the Service, eg cooking, caring for their own home • % reduction in the number of hours/visits attending to residents' daily living outcomes 	<p>Self-assessment/assisted assessment via discussion and/or questionnaires as appropriate</p> <p>Care Provider records, residents' files</p>
b) Improvement in undertaking the ability to self-care	<ul style="list-style-type: none"> • % of residents who perceive that their ability to undertake self-care has improved since receiving the Service, eg personal washing, toileting, self-medicate • % reduction in the number of hours/visits attending to the personal care outcomes 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>
c) Improvement in mobility function	<ul style="list-style-type: none"> • % of residents who perceive that their mobility has improved since receiving the Service, eg mobility around and outside their own home • % reduction in the number of hours/visits attending to mobility 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>
d) Improvement in confidence and independence in own home	<ul style="list-style-type: none"> • % of residents who perceive that their confidence has improved since receiving the Service, eg to undertake tasks with less support, self-medication, reduced isolation, interaction with other residents etc • % reduction in the number of hours/visits attending to residents' confidence and independence outcomes 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>

<p>e) Improvement in health or the capacity to sustain health – both their mental health and physical health</p>	<ul style="list-style-type: none"> • % of residents who perceive that they have seen an improvement in their overall health since receiving the Service, eg less tired, ability to concentrate, make decisions etc • % reduction in the number of hours/visits attending to overall health outcomes 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>
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Measurement Framework for Outcome Two
A service that can support the on-going care and support needs of its residents and reduce the likelihood of admission to long-term care

Individual Outcome	Measures	Methodology
<p>a) On-going improvement, maintenance or minimised deterioration in ability to undertake daily living functions</p>	<ul style="list-style-type: none"> • % of residents who perceive that their ability to undertake a daily living function has continued to improve since receiving the service, eg cooking, caring for their own home • % reduction in the number of hours/visits attending to residents' daily living outcomes • % of residents who perceive that their ability to undertake a daily living function has been maintained since receiving the Service, eg cooking, caring for their own home • % of residents for whom their number of hours/visits attending to their daily living outcomes has been maintained • % of residents who perceive that their ability to undertake a daily living function has deteriorated since receiving the Service, eg cooking, caring for their own home • % of residents for whom their number of 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>

	hours/visits attending to their daily living outcomes has increased.	
b) On-going improvement, maintenance or minimised deterioration in ability to self-care	<ul style="list-style-type: none"> • % of residents who perceive that their ability to self-care has continued to improve since receiving the Service, eg personal washing, toileting, self-medicate • % reduction in the number of hours/visits attending to residents' self-care outcomes • % of residents who perceive that their ability to undertake self-care has been maintained since receiving the Service. • % of residents for whom their number of hours/visits attending to their self-care outcomes has been maintained • % of residents who perceive that their ability to undertake self-care has deteriorated since receiving the Service. • % of residents for whom their number of hours/visits attending to self-care outcomes has increased 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>
c) On-going improvement, maintenance or minimised deterioration in mobility function	<ul style="list-style-type: none"> • % of residents who perceive that their mobility care has continued to improve since receiving the Service. • % reduction in the number of hours/visits attending to residents' mobility outcomes • % of residents who perceive that their mobility has been maintained since receiving the Service • % of residents for whom their number of 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>

	<p>hours/visits attending to mobility outcomes has been maintained</p> <ul style="list-style-type: none"> • % of residents who perceive that their mobility has deteriorated since receiving the Service. • % of residents for whom their number of hours/visits attending to mobility outcomes has increased 	
<p>d) On-going improvement, maintenance or minimised deterioration in confidence and independence in own home</p>	<ul style="list-style-type: none"> • % of residents who perceive that their confidence and independence has continued to improve since receiving the Service. • % reduction in the number of hours/visits attending to residents' confidence and independence outcomes • % of residents who perceive that their confidence and independence has been maintained since receiving the Service. • % of residents for whom their number of hours/visits attending to confidence and independence outcomes has been maintained • % of residents who perceive that their confidence and independence has deteriorated since receiving the Service. • % of residents for whom their number of hours/visits attending to confidence and independence outcomes has increased 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>

<p>e) On-going improvement, maintenance or minimised deterioration in health – both physical and mental health</p>	<ul style="list-style-type: none"> • % of residents who perceive that their health – both physical and mental health has continued to improve since receiving the Service • % reduction in the number of hours/visits attending to residents' health – both physical and mental health outcomes • % of residents who perceive that their health – both physical and mental health has been maintained since receiving the Service. • % of residents for whom their number of hours/visits attending to health – both physical and mental health outcomes has been maintained • % of residents who perceive that their health – both physical and mental health has deteriorated since receiving the Service. • % of residents for whom their number of hours/visits attending to health – both physical and mental health outcomes has increased 	<p>Self-assessment/assisted assessment via discussion</p> <p>Care Provider records, residents' files</p>
<p>f) Continued involvement and support for family and carers</p>	<ul style="list-style-type: none"> • % of residents who perceive that there are suitable opportunities and support for family and carers to be involved or contribute to their care. • % of family/carers who undertake or contribute to the care of their family member who feel that they have been offered 	<p>Self-assessment/assisted assessment via discussion</p> <p>Questionnaire/discussion</p>

	or given suitable support to care	
g) Reduced anxiety about ill health by individual and their families	<ul style="list-style-type: none"> • % of residents who feel less anxious about their ill health • % of family/carers who feel that the service has contributed to feeling less anxious about the ill health of their family member 	<p>Self-assessment/assisted assessment via discussion</p> <p>Questionnaire/discussion</p>
h) Ability to remain in own home for as long as possible	<ul style="list-style-type: none"> • % of residents who perceive and have demonstrated their ability to remain in their own home for as long as possible • % of residents who have moved to a long term residential environment 	<p>Self-assessment/assisted assessment via discussion</p> <p>Questionnaire/discussion</p> <p>Risk assessment</p> <p>Residents' files</p>

Measurement Framework for Outcome Three

A service that can contribute to the prevention of hospital admission, re-admission and enable early discharge

Individual Outcome	Measures	Methodology
a) Prevention of ill health	<ul style="list-style-type: none"> • No. of residents receiving annual flu vaccination • No. of residents receiving regular dental checks • No. of residents receiving regular health checks • No. of residents registered with GP • Increase in perception of improvements in own health of residents 	Quantitative data collection
b) On-going improvement, maintenance or minimised deterioration in health – both physical and mental health	<ul style="list-style-type: none"> • % of residents who perceive that their health – both physical and mental health - has continued to improve since receiving the 	<p>Quantitative data collection</p> <p>Residents' files</p> <p>Views of GP, consultant, resident, relative /carer</p>

	<p>Service</p> <ul style="list-style-type: none"> • % reduction in the number of hours/visits attending to residents' health – both physical and mental health outcomes • % of residents who perceive that their health – both physical and mental health has been maintained since receiving the Service • % of residents for whom their number of hours/visits attending to health – both physical and mental health outcomes - has been maintained • % of residents who perceive that their health – both physical and mental health - has deteriorated since receiving the Service • % of residents for whom their number of hours/visits attending to health – both physical and mental health outcomes - has increased 	
c) Prevention of hospital admissions and readmission	<ul style="list-style-type: none"> • % of residents who have required hospital admission • % of residents who have required hospital re-admission 	Residents' files
d) Reduced stay in hospital	<ul style="list-style-type: none"> • % of residents who have been maintained in their home longer before entering hospital 	Views of GP, consultant, resident, relative/carer
e) Ability to return to a suitable home environment following hospital discharge	<ul style="list-style-type: none"> • % of residents who have been discharged from hospital earlier than they may have been if returning to their own home 	Views of consultant, GPs discharge nurse etc

Measurement Framework Outcome Four**A service that can contribute to supporting people to live independently, stay healthier and recover quicker from illness or accident.**

Individual Outcome	Measures	Methodology
a) Enabling self-help to live independently, stay healthier and recover quickly from illness or accident	<ul style="list-style-type: none">• % of residents who perceive that information, advice and guidance has contributed to enabling their self-help to live independently, stay healthy and recover quickly from illness or accident• % of residents of the wider community who perceive that information, advice and guidance has contributed to enabling their self-help to live independently, stay healthy and recover quickly from illness or accident• Number of residents of the wider community who have been provided with information, advice and guidance• Number of residents and residents of the wider community attending peer support programmes• Number of facilitated health screening appointments	Residents' survey when appropriate Analysis of comments, commendation and complaints

8.0 ACCESS TO SERVICES

- 8.1 Potential residents will have a range of needs resulting from physical ill health, social isolation, sensory impairment, general frailty due to ageing and/or low to moderate levels of dementia, learning disability or mental health condition. Typically, these residents would have otherwise required accommodation in a care home.
- 8.2 A Social Care Assessor/Co-ordinator from the NYCC local assessment team will make an initial assessment and referral based on eligibility criteria.
- 8.3 The Care Provider will work with residents to ensure that their identified needs and outcomes are met in line with the Personal Support Plan.
- 8.4 The Provider of the **flexiCare** background support within the ECH must agree and demonstrate a willingness to work in partnership with other care providers who may work in the scheme and will establish a policy which gives access to and shows clear communications with other carers.
- 8.5 The **flexiCare** Provider must agree and establish and make available to all residents and NYCC a charging policy for residents in the event that they are called upon in an emergency to respond to residents' needs. The policy should clearly state if and when the **flexiCare** Provider will charge for any ad-hoc requests for support and what the level of charge will be.

9.0 COMPLAINTS AND PROTECTION

- 9.1 The Care/Housing Provider will have a written procedure and must operate a comments, compliments and complaints system for residents, their families and friends, from which lessons learnt can inform continuous improvements in the service. The procedure must be made available to residents, their families and friends.
- 9.2 The Care/Housing Provider will explain the procedure to the residents and ensure that where a complaint is made, they shall not be prejudiced in any way. The Provider shall take all reasonable steps to inform and co-operate with the Council in investigating any complaints.
- 9.3 The Care/Housing Provider must ensure that policies and procedures are enforced that protect residents eg disclosure of all forms of abuse and bad practice, health and safety, assisting with medication, confidentiality of information and dealing with violence and aggression.
- 9.4 In all circumstances where it is believed that there is any form of inappropriate contact between a resident and a member of staff, the Care/Housing Provider shall take immediate action to ensure the wellbeing of the resident and to investigate the circumstances. All such matters will be reported immediately to the NYCC local assessment team and contracting representative and follow the Council's Safeguarding Adults Multi Agency Policy and Procedures and Safeguard and Protect Operational Guidance which in the wider sense refers to the work with vulnerable adults to both prevent abuse and provide protection from abuse and to ensure their wellbeing.

10.0 MANAGEMENT AND ADMINISTRATION

- 10.1 The Housing Provider will be required to have a person registered with the Care Quality Commission as the 'fit person' who has overall responsibility for the Domiciliary Care Agency/Service where applicable. This person may be the owner or the most senior manager of the Service. Where the registered person is not responsible for the day-to-day management of the Service, they must appoint an experienced and qualified manager (who must also be registered) to be responsible for managing the office day-to-day operational issues. This should be in line with CQC Guidelines.
- 10.2 The Housing/Care Provider must implement a clear set of policies and procedures to support practice and meet the requirements of legislation, which are dated and monitored as part of the service's quality assurance process. The Housing/Care Provider must demonstrate that they not only have up-to-date policies and procedures available to the County Council at all times, but also that these documents are fully implemented in practice.
- 10.3 These policies and procedures will need to encompass the following areas:-
- Statement of purpose and aims and objectives of the Housing/Care Provider
 - Standards for quality assurance
 - Provision of non-discriminatory practice
 - Equalities and Diversity/Equal opportunities
 - Health and safety (including risk assessments, food hygiene and emergency procedures)
 - Moving and handling
 - Assisting with medication
 - Dealing with accidents and emergencies
 - Comments, compliments and complaints
 - Confidentiality of information/information sharing
 - Data protection and access to residents' own records
 - Recruitment and selection of staff including screening procedures
 - Staff contracts and job descriptions for all posts
 - Range of activities undertaken and limits of responsibility
 - Personal safety whilst at work
 - Dealing with violence and aggression
 - Discipline and grievance (including protection for 'whistle-blowers')
 - Training and staff development (including induction programme, NVQ qualifications and specialist training eg dementia)
 - Proper and appropriate maintenance of all records
 - Safe keeping of keys
 - Handling money and financial matters on behalf of a resident
 - Acceptance of gifts and legacies
 - Safeguarding Procedures
 - Scheme-based Partnership Protocol
- 10.4 The Housing/Care Provider will need to ensure that the rights and best interests of residents are safeguarded by keeping accurate and up-to-date records which must encompass the following areas:-
- Financial records detailing all transactions
 - Personal file on each resident

- Personnel files on each member of staff
- Interviews of applicants for posts who are subsequently employed
- Accident reports
- Incidents of Abuse or suspected Abuse (including use of restraint) and action taken
- Comments, compliments and complaints and action taken
- Disciplinary and grievance procedures
- Records kept in the home of residents

10.5 The service will be promoted positively by the Housing/Care Provider, particularly to members of black and ethnic minority communities, as well as to other professionals in health and social care agencies.

10.6 The Housing Provider will ensure that regular Management Liaison Group (MLG) meetings are held, usually on a quarterly basis, with representatives from all partners attending. The scheme manager will be responsible for ensuring that the minutes of these meetings are recorded and distributed to the respective representatives. The Terms of Reference for the MLG meeting will incorporate the following areas:-

10.6.1 Purpose:-

The Management Liaison Group is the vehicle that will ensure that providers of these services and key partners/stakeholders meet on a regular basis to achieve the aims and objectives below:-

- Operational agreements:-
 - The appropriate joint operational agreements must be in place between all providers of the housing management (including the landlord), housing support and care providers that clearly define the responsibilities and expectations in relation to the day to day management of the scheme
 - These operational agreements will act as the key reference document in dealing with any operational/management issues that require clarity/resolution
- Philosophy:-
 - Relationships between the providers of services and partners/stakeholders are pivotal to the success of the scheme and must be planned and managed effectively
 - A successful interface between these organisations is one that will include:-
 - A shared understanding and commitment to the philosophy of the scheme by all parties with the delivery of a quality cohesive service to residents being the common uniting goal
 - A strong commitment to joint working by all parties
 - An open and trusting relationship characterised by respect of specialisms and a willingness to learn and tackle problems together
 - Good working relationships at all levels and effective team working
 - Close co-operation and good communication between all parties

- A focus on delivering better outcomes for residents rather than being bound by internal processes
- Aims and Objectives:-

The main aims and objectives of the Management Liaison Group are to ensure that:-

- The various elements of the extra care service operate in harmony to achieve positive outcomes for residents through the delivery of a flexible and responsive seamless service
 - The early identification and resolution of management/operational issues with the agreement of appropriate actions where necessary
- The key areas of service provision that will need to be monitored are:
- Care Provision
 - Housing Support Provision
 - Housing Management (including items such as general housekeeping, repairs and maintenance, allocations, voids and health and safety issues)
 - Social and community activities
 - Catering
 - Training
 - Consultation with and feedback from residents/residents' forums
 - Lessons learnt for future projects

- Membership:-

- The following organisations and individuals will be members of the Management Liaison Group:-
 - Scheme/Service Manager
 - Care Provider Manager/s
 - Locality Housing Manager
 - North Yorkshire Care Service Manager or representative
 - Representative from other on-site services
- The group will invite other individuals/organisations to attend meetings as appropriate

11.0 STAFFING

- 11.1 The Housing/Care Provider will be required to ensure that it has sufficient staff to deliver the Service Specification, supported by clear lines of accountability and communication both within the scheme and with any external management.
- 11.2 The Housing/Care Provider must demonstrate that its recruitment procedures promote as far as possible the employment of people from the local community. As part of that recruitment procedure housing/care providers will promote initiatives such as walk or cycle to work which will support the employment of local people. Staffing numbers and skill mix of qualified/unqualified staff must be appropriate to the assessed needs of the residents and the purpose of the ECH scheme at all times, with a comprehensive induction, supervision, training and development programme maintained for all staff.
- 11.3 The Housing/Care Provider shall operate a rigorous and systematic approach to obtaining references on job applicants, including Enhanced Disclosure and Barring Service (DBS) checks in accordance with statutory guidance. Job applicants are required to declare previous criminal offences and occupational health screening shall take place prior to appointment. For the recruitment of management staff, if and where appropriate, procedures laid down in the guidance made under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009 shall be followed.
- 11.4 All staff must be provided with a written job description, person specification, identifying their responsibilities and accountabilities and with copies of the staff handbook, grievance and disciplinary procedures, General Social Care Council (GSCC) Code of Conduct.
- 11.5 Housing/Care Provider staff shall not be permitted to smoke within the grounds or building of the ECH scheme, which is required to operate a No Smoking policy throughout. If a resident chooses to smoke in their own apartments, a risk assessment will be carried out to ensure that any risks are mitigated.

12.0 CHECKLIST FOR SKILLS AND EXPERIENCE FOR SCHEME MANAGERS AND STAFF

Example Person Specification as recommended by the Care Services Improvement Partnership (CSIP) Extra Care Housing Toolkit:-

12.1 Scheme Management:-

- Experience of housing/estates management and lettings, licence or tenancy agreements
- Experience of managing expression of interest lists and referral systems
- Setting up contracts with tenants, leaseholders or owners
- Skills in negotiating with other professionals eg architect
- Knowledge of Health and Safety/fire regulations
- Basic knowledge of designing for all groups of older people
- Knowledge of Assistive Technology, its availability, methods of assessment and the ethical issues surrounding it
- Understanding the contribution of aids and adaptations to independent living
- Experience of managing and planning repairs and maintenance
- Skills in promoting and explaining a scheme to visitors

12.2 Providing Care and Support:-

- A focus on improving the quality of life for older people
- Undertakes a person-centred approach to working with people
- Recognises when older people do/do not need additional support and help
- Promotes care by families and friends
- Works in partnership with other agencies on behalf of tenants/owners
- Basic understanding of medication for the management of particular conditions, eg, dementia, stroke and diabetes
- Understands eligibility criteria, allocation, assessment, care and support planning
- Knowledge of safeguarding issues and the duty of care
- Understanding of relevant legislation, registration and accreditation
- Understands the causes of dependency
- Knowledge or experience of providing advocacy
- Knowledge or experience of bereavement counselling
- Understanding of anxiety and depression in older and vulnerable adults
- Risk analysis and management
- Experience of rehabilitation and re-ablement – encouraging residents to adopt and discover new skills
- Understands the role of prevention in the care of older people
- Including the role of dental and podiatry services
- Experience in the provision of activity-based care
- Understands the role and potential of intermediate care
- Understanding of welfare benefits
- Understands the physical, psychological, social, emotional, cultural and spiritual needs of residents
- Understanding of how Supporting People, Individual Budgets, and Outcome-focused Support (Care) Plans and Fairer Charging policies and practices work

There is an expectation that management and staff have basic training and a good understanding of supporting and caring for people living with dementia. Where a scheme has been identified as a specialist scheme, the expectation would be that training for that specialism is enhanced.

12.3 Facilities and Maintenance Management:-

- Experience of managing budgets
- Experience in managing catering facilities
- Experience in managing and maintaining communal facilities for the benefit of tenants/owners and the local community
- Experience of managing and maintaining communal laundries and bathing arrangements
- Engaging and communicating
- Experience in community liaison and development
- Experience of managing anti-social and challenging behaviours
- Promotes equality and diversity of employment
- Experience of managing relationships with neighbours and the wider community
- Understanding of community consultation and empowerment – encouraging, listening to and responding to the views of older people
- Knowledge of using different forms of communication with individuals and groups.
- Skills relating to intergenerational work and reminiscence therapy
- Understands community transport systems and supporting residents in accessing the wider community
- Experience of working with statutory, voluntary and independent sector organisations that provide leisure activities to older people in order to increase the range of activities available
- Experience of supporting residents' involvement in their social networks and local community
- Promoting the principles of lifelong learning

12.4 Staff Management:-

- Understands the ethos of ECH
- Interpersonal/communication skills
- Good planning and organisational skills
- Skills which help in influencing and negotiating with others
- Experience of managing under pressure/problem solving
- Promoting professional development, identifying training needs and accessing training
- Experience of managing budgets/financial awareness
- Experience in recruiting and retaining staff
- Exercises leadership and facilitates team building
- Appraisal and presentation skills
- Understands roles and responsibilities of other professionals and partnership working
- Understands the complaints policy and accident reporting mechanism
- Knowledge of business planning
- Experience of managing care staff/liasing with care providers/managing contracts
- Creating a safe working environment
- Understands confidentiality and data protection
- Experience of working with volunteers
- Understands personnel and payroll issues
- Experience of managing the allocation of staff

13.0 PERFORMANCE MONITORING AND EVALUATION

- 13.1.1 The most important factor in measuring the success of the Housing/Care Provider in meeting the aims, objectives and statement of purpose of the scheme and care deliver will be the views of the residents and/or their representatives.
- 13.2 The Housing/Care Provider must maintain effective systems of quality assurance and monitoring, based on seeking the views of residents, in order to demonstrate continuous service improvement.
- 13.3 The overall performance monitoring of the service will be determined by a combination of the following:-
- Housing/Care Provider's quality assurance systems – performance monitoring feedback from the Housing/Care Provider's own quality assurance systems eg based on resident feedback
 - Inspection - the ability of the service to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. The demonstrated ability to maintain and improve outcomes as defined including reference to formal inspection feedback and reports
 - The County Council's Extra Care Team will undertake a formal review and evaluation of the extra care scheme, in partnership with the Registered Social Landlord, of which care provision will be an integral part
 - County Council's contract monitoring systems – The contracting, procurement and quality unit will through its usual quality assurance methods monitor care and support contracts.

The underlying principles of this Protocol are entrenched in the general ethos for extra care housing, which is one of independent living with an enabling focus. This means that residents are encouraged and assisted to retain the skills they have for as long as possible and, for people moving in from residential care, to regain lost skills. This will be different for each person but the 'use it or lose it' cliché is particularly applicable to older people and it's important to agree with each individual what they wish for themselves and to assist them to achieve their own personal goals.

It is the duty of all partners to ensure that the principles outlined in this protocol are adhered to, in order to promote a positive approach to the delivery of housing, care and support services in extra care housing in North Yorkshire.

14.0 REFERENCES

North Yorkshire County Council's Accommodation with Care, Design and Ethos Guide for extra care housing:-

Download from www.northyorks.gov.uk/extracare - Information for Professionals

North Yorkshire County Council's Dementia Care Good Practice Guide: Dementia Care and Support in Extra Care Housing:-

Download from www.northyorks.gov.uk/extracare - Information for Professionals

North Yorkshire County Council's Market Position Statement for the care of older people and adults with physical, mental and learning disabilities:-

[http://www.northyorks.gov.uk/media/26456/Market-positionstatement/pdf/Market_position_statement_\(Oct_2013\).pdf](http://www.northyorks.gov.uk/media/26456/Market-positionstatement/pdf/Market_position_statement_(Oct_2013).pdf)

CQC – regulated activity definition of personal care:-

http://www.cqc.org.uk/sites/default/files/documents/ra_1_personal_care.pdf

Breakdown of Background Support Charges

The on-site domiciliary service will provide one waking person on site 24/7. This resource will not be allocated to planned support but will be used peripatetically and flexibly as required.

Between the hours of 22.00 and 06.59 the **flexiCare** support service will include at least one waking night staff. This is a total provision of 63 waking night hours per week. Where a scheme provides a specialist service ie supporting people with complex needs including people living with dementia, a higher level of **flexiCare** support service may be required.

The cost of running the service will be recovered as both a housing related support charge and a care support charge proportionate to the actual service delivered and the outcomes achieved. Experience suggests that a 30:70 housing to care ratio is reasonable.

The total cost of the service at the site is £..... per annum

At *insert scheme name* (XX units) this equates to £..... per unit per week and this will be recovered as follows:

- £..... charged to residents in service charge (Housing)
- £..... charged to residents as a background support service charge (Care)

The charge will be compulsory for all residents and will be charged as a unit rate per flat and not per person. The resident is responsible for payment and must ensure that this is met from one or a combination of the following:-

- Housing Benefit
- Other Benefits
- Personal Budgets
- Direct Contributions

North Yorkshire County Council will not enter into a contract with the housing partner to provide this service.

The Housing Provider will ensure that a background support service agreement is signed by each resident prior to moving into the scheme. This will set out rights, roles and responsibilities for all parties to the agreement. Attached to the agreement will be a simple overarching support plan stating the need for that resident to access the background support service. Documents will be signed by the Housing Provider and the resident thereby creating a binding contract for provision and payment.

The Housing Provider's default position will be to bill the resident directly but this can be varied as required, for example, where residents' Individual Budgets are being managed by the **flexiCare** Provider through an Individual Service Fund, the **flexiCare** Provider will deduct the cost of the **flexiCare** service at source.

Unlike some models elsewhere in the Country the need to pay for the background support service will not be linked to receipt of Attendance Allowance. All residents will work with the Housing Provider and North Yorkshire County Council to maximise their income to cover the cost.

As an indicator of affordability the total weekly charge:-

At *Insert name of scheme* the contribution towards the cost of the **flexiCare** services is £..... and equates to% of lower rate Attendance Allowance or% of the higher rate. This is within the limit of affordability.

Based on negotiations with North Yorkshire County Council the Housing Provider has included elements of home care provision in the model. The Care Provider is an accredited Provider for *<insert area>*. The extra care and home care charge rate per hour for planned care hours at the scheme will be £..... per hour. (Subject to review *<insert timescales>*) The on-site Care Provider will be offered as the default on-site service at the scheme.

4.1.14 The Housing Provider takes no view on whether North Yorkshire County Council will include a sum per week in the personal budgets allocated to residents with care needs to fund the essential background support service. The assumption will be that the service is accessible to people with limited means to guarantee that extra care housing is affordable to those who need it.