London Borough of Southwark

Additional Adults

Care at Home Tender

Service Specification

Southwark Good Practice Schedule

Appendix 2

Introduction

This schedule describes the elements of good practice which is expected from provider organisations and their staff in delivering the new service. It underpins the approach to outcomes which is central to the new service and the 'I Statements' given in the high level specification. The performance management arrangements are outlined in a separate schedule, but draw heavily on the assumptions about good practice made here. Similarly this schedule should be read in conjunction with the schedule on the new role of Community Support Worker.

It should be read in conjuncture with the schedules relating to:

1) The Vision for Care at Home
2) The Southwark Ethical Care Charter
3) The role of the Work force Schedule
4) Performance management, Monitoring and Review
5) Data Protection and Information sharing arrangements.
6) Medication Management Protocol
7) About me and my home care statement

All the providers will be expected to comply with the relevant mandatory regulations. The requirements of good practice listed below all draw on the requirements of the Social Care Act and Care Quality Commission Standards as well as the National Institute of Clinical Excellence Guideline 21[2].

This document and other relevant guidance are listed at the end of this schedule.

1. Ensuring Care is Person Centred

- Providers must meet the aspirations goals and priorities of each person and avoid a 'one size fits all' approach.
- The focus of work should be on what individuals using this service can or would like to do in a reabling manner rather than simply on what they cannot do.
- Particular care is to be taken over those who have cognitive impairment and those living alone as they are at higher risk of having unmet needs both physically and psychologically.
- It is expected that relevant family members be involved in all discussions about care and support and should always be treated with dignity and respect. In a diverse borough like Southwark both managers and workers will need to ensure that they have sufficient understanding of cultural qualities, distinctions and expectations and ensure that they are respected.
- Confidentiality and privacy must always be respected - but the new Community Support Worker role will demand more close working with other professionals, so workers will have access to more information and will also be expected to share information proactively as well on order to aid early identification of problems for nursing staff, for example. This means that all agencies will need to ensure their staffs fully understand how to work collaboratively but observe confidentiality.
- People should have whenever possible the same worker or workers to ensure continuity and consistency. Where there is an unavoidable change the person receiving he service should always be told in advance in whichever way they find most convenient- the approach to communication from the agency should be agreed with each person at the outset.
- In complex cases, and where high levels of care are required, as with for example individuals with dementia, good practice may be to have a team of 4 or 5 workers who know the person - one can act as lead, and the others can support, and be available to cover both planned and unplanned absence. Given the expectation within the specification of 7 day per week, 52 weeks per year working arrangements of this kind will be necessary, and it will be very important that the standard of provision at weekends is not inferior to that during the week-
- As care is to be personalised and based on an outcome based care plan agencies need to ensure in allocating workers that they have the correct skills and briefing to deliver the care successfully- certain lifting tasks for example. This also needs to apply whenever a replacement worker has to be used.
- All agencies need to ensure that there is a regular feedback process which fully involves the person receiving care and any other people significantly involved- family carers for example.
- Needs change and it is important that care plans evolve as well. This should be done in conjunction with other agencies but within the new service the Community Support Worker, who is likely to be the most frequently involved professional, need to watch carefully for change, talk about it with the person and

then proactively discuss developments and options with the other professionals involved. Recording practice needs to support these activities.

The implementation of a person centred and outcome-based approach in Care at Home will require changes of practice from other professionals in social care, community health and acute teams. The two main areas where changes will be made are as follows:

- Assessment and brokerage - ensuring that assessments and care plans are fully consistent with an outcome approach and recorded and communicated clearly as such both to the service user, their family and the provider.
- On-going care - social care and health workers will need to be briefed on the new scheme and be expected by managers to work with and communicate closely with Community Support Workers.

2. Providing information to people and their family carers about Care at Home

- Agencies should ensure that individuals receiving service are clear on what their allocated funding can cover.
- Since the new service is not based on 'time and task' more flexibility will be needed and this must also be explained carefully - together with arrangements for 'time banking' If, for example, a person has begun to cope with more food preparation on their own, it should be possible to agree a different use of the extra time for other personal objectives, and with a different time pattern.
- Services should provide good readable information, in the form of a welcome pack at the beginning of service.
- Good communication should be based in allowing people enough time to understand and this will require patience and an awareness of the person's particular circumstances - this is crucial for those with cognitive impairment, or high levels of anxiety.
- When the person cannot communicate in English, ways will need to be found to communicate in their own language. It must be remembered also that respecting culture and communicating effectively is about behaviour as well as language.
- People need to be given very clear plain information about how to make suggestions or complain and how complaints will be handled - again cultural differences need to be respected, as well as the tendency of people receiving care to be anxious about complaining because of fear about the consequences.
- Agencies must ensure that workers have good information and understanding of other local organisations and services which could assist the person being cared for. In Care at Home, agencies will be operating from one of the Local Care Networks and the focus should be on facilities within that area. This may cover everything from support groups to social and sporting clubs. Agencies should ensure that they have a well-maintained list, which can be added to and is also shareable with other partners.
- A care diary and the care plan will be kept in the person's home. This will be in a standard format across the borough and will log attendance, activities and other relevant information. It should be available to the person being cared for. Workers

should always complete it during the visit and should ensure that they have read and responded to new messages from others. While the log is essential it does not alter the need for workers to proactively communicate with other professionals and their own agency when they have concerns or wish for guidance.

- This specification and the accompanying schedules have all been developed with the close involvement of service users. The 'I statements' they have developed and refined are backed up by some specific issues and questions called **'About me and who I am"** which will be on each person's care plan. This means that any replacement carer who comes to their home would look first at these. The statements, questions and instructions which must be followed by all workers are as follows:

1. I need all care staff to show ID and tell me their name before they start giving any care
2. Be clear about what we call each other when we meet and anything else which is important about introducing ourselves
3. Care At Home staff should read the practical information provided, for example where I keep things or like things to be put
4. They should read what my core beliefs are
5. What I like and don't like to eat and drink
6. Things you will need to know to communicate effectively with me - language, hearing and sight issues
7. Who are the most import people to know about and contact if necessary- family; friends; key neighbours and the other professionals involved such as GP, District Nurse and any others.
8. What I like to talk about and my hobbies and interests
9. What worries, upsets or annoys me e.g. mobile phones being kept off, putting away things properly, speaking my language.
10. And anything else you need to know to give me good personal care.

Care at Home may well be important in the transition from hospital to home, and good liaison with hospital discharge planning will be important, especially where there is no input by the reablement service. Where Care at Home follows a period of reablement it will be important for the handover process to ensure that the Community Support Worker can sustain and reinforce the work which has been done, and for this reason agencies will need to ensure that workers have a good understanding of the nature of reablement work and how their role connects with it.

3. Core skills and working with other agencies to ensure an integrated approach

- Coordination arrangements will be agreed at the Care Planning stage, and while the Care At Home will not normally be the coordinator they will have a key role in the sharing of information. They will need to know and understand the different roles and individuals involved, together with how to make contact. A key development area for providers will be to participate in planning the processes and procedures to be used.

- Workers will need to be able to communicate clearly both orally and in writing, with other workers and with people using the service.
- Workers will need to have a reasonable understanding of the main conditions affecting people receiving care, notably dementia, diabetes, mental health conditions, neurological conditions, physical and learning disabilities, and sensory loss.
- Workers will need to have an understanding of basic well being matters and how to respond within their role - skin care, hydration, the impact of social isolation and their role in relation to medicines are key elements. These issues are addressed in the schedule on the role of the Community Support Worker.
- Agencies need to ensure that all workers understand their responsibilities in safeguarding and have the necessary understanding of key people to contact if a safeguarding crisis occurs. Within the agency there should be regular reviewing of performance in safeguarding and experience should also be shared with the relevant local authority and health professionals.
- It may well be that agencies consider having a staff group focused around particular client groups, or skill levels. The United Kingdom Health Care Association and the South West Dementia Partnership have suggested for example dementia champions:

'In order to support managers and care workers, many providers have identified and nominated a person within their organization to develop a specialist dementia knowledge base (i.e. appointing dementia mentors or 'champions', link workers or dementia managers). When an expert knowledge base is developed providers report that care workers and managers feel better equipped and supported to undertake and deliver care.'

4. Managing and supporting Care at Home Workforce.

- Workers need to be inducted properly with sufficient support and observed practice within the early months. Any initial identified training deficits should be addressed within this initial period.
- Supervisions, Appraisals and Team meetings should be regularly held for all staff as stipulated within the workforce schedule.
- Workers will be supported and enabled to attend training and agencies will need to plan carefully to ensure that care work is covered in their absence in a planned way. Training may be available in a number of forms - ranging from shadowing experience of another role - for example spending time on visits with a nurse, telelearning or a traditional short course.
- Workers should not be asked to undertake tasks which is above the level of competency and training .
- Mangers should spot check on a regular basis to ensure that they know workers are performing effectively and within the requirements.
- Successful agencies recognise and reward good practice - recognition is very important in sustaining moral, confidence and performance.
- Developing an appropriate staffing structure which allows people to make a career will be an important developmental issue which providers will share with the Council and the CCG, but there is much that agencies can do to recognise different skills

levels and enable people to take increasing responsibility. As the Cavendish Report notes:

'*The public image of this workforce is outdated. Looking after the frail and vulnerable with intelligent kindness can rarely be described as "basic" care. And as the landscape of health and social care has become more complex and challenging, so too have the tasks carried out by many support workers – whether it is domiciliary care staff asked to do work that used to be the preserve of district nurses, or hospital workers stepping up to carry out invasive procedures.'*

5. Developmental role of the provider agency in Care at Home

Successful providers chosen to deliver Care at Home services will be expected to work in a new way with the council and NHS partners, both strategically and operationally within the context of the Local Care Networks. This will be necessary because the overall service will be expected to develop over time, with a joint approach to problem solving, and an expectation that progress will be best achieved by sharing results, honest feedback and a willingness to be flexible in achieving the outcomes required. This is to be a very different way of partnership working, but is seen as worth the significant investment involved because of the potential to have real impact on hospital admissions, care home admissions and a generally enhanced quality of independent living for those receiving care.

This will call for significant contributions from agencies, notably:

- A commitment to working collaboratively with other providers in the Local Care Network and possibly beyond - this may mean help with staffing as necessary and certainly a shared approach to training.
- Full and consistent participation in Care at Home Forums will be expected from all providers.
- Management time will need to be available for other developmental meetings and activities - these will focus not only development tasks but on the analysis and action planning to support performance management.
- A commitment to good communication between management and staff throughout the organisation so that workers can see the bigger picture about performance and good practice.

It is recognised that these demands may have a significant impact on management time, but these responsibilities are part of the specified service and commitment to them will be regarded as crucial throughout the life of the contract.

6. Regulation and guidance

Agencies will be expected to comply with all required regulations and guidelines applicable to the activities outlined in this schedule, or to their own from of legal entity.

The notable relevant forms of regulation are covered in the following:

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Part 3 (as amended) and Care Quality Commission (Registration) Regulations 2009 (Part 4)
(As amended)

http://www.cqc.org.uk/content/regulations-service-providers-and-managers

Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse, Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board, published 2011 and reviewed 2014

http://www.scie.org.uk/publications/reports/report39.pdf

Home Care - Delivering Personal Care and Practical Support to Older People Living in Their Own Homes, NICE Guideline 21 published September 2015.
https://www.nice.org.uk/guidance/ng21

Providers should also take account of the following additional NICE guidelines, which are all available on:

http://www.nice.org.uk/Guidance

NICE Guidelines 23 Older people with social care needs and multiple long term conditions- November 2015

NICE Guidelines 16 Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset- October 2015

NICE Guidelines 42 Dementia: supporting people with dementia and their carers in health and social care- published in 2006 and currently being reviewed

NICE Guidelines 27 on Transition between inpatient hospital settings and community or care home settings for adults with social care needs, published December 2015

NICE Guidelines 161 Falls in older people: assessing risk and prevention published June 2013

NICE Guidelines 22 Older people with social care needs and multiple long-term conditions, published November 2015

NICE Guidelines 32 Older people: independence and mental wellbeing, published December 2015

Providers should also take into account for any packages that are funded by the the NHS the Department of health Outcomes Framework:

https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017

The Workforce and Medication schedules also contain links to various best practice sites