VERY SHELTERED HOUSING

A GUIDE FOR TEAM MANAGERS AND NAMED ASSESSORS

JANUARY 2003

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INTRODUCTION

The story of the development of Very Sheltered Housing Schemes in Suffolk is an exciting one. In the early 90's it was recognised that older people do not necessarily want to give up their homes to move into residential care when they need increasing amounts of support, and a housing-with-support option was called for. From 1995 onwards, Suffolk Social Care in partnership with Housing Departments and Housing Associations have worked together to develop very sheltered housing schemes across the county. Many of these have been newly built, with accommodation in one and two bedroomed flats to a very high standard. Others have been created by extensive refurbishment from existing sheltered housing schemes. The success of the schemes has been due to good partnership working and the willingness of Housing partners to invest in such resources.

A further innovation in the last two to three years has been the creation of 'extra care' parts of schemes, where people with considerable levels of disability through dementia or mental ill health can be supported, yet remain as householders.

Currently approximately four hundred and fifty people are accommodated in very sheltered housing schemes in Suffolk, and many more are in the pipeline. This service therefore makes a considerable contribution to the range of services available to older people who are frail or have disabilities. All the evidence shows that this is a highly-valued resource by tenants, their carers and those professionally involved with them.

Like most innovative good practice, very sheltered housing has developed in a somewhat piecemeal fashion. The 'Design and Management Guide' was the first document to try and lay down standards and good practice to be followed in the development of new schemes; and this was recently added to by "Extra Care Guidance." (Both for schemes with extra care for people with dementia and for other mental health difficulties)

An internal Social Care Working Group has been looking at consistency issues as regards our role in partnership, and this guide is a first attempt to make sure that named assessors and Social Care Managers understand the different aspects of the resource and work effectively to achieve the best outcomes for their customers.

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CHAPTER ONE – WHO IS VERY SHELTERED HOUSING FOR?

ONE: WHOSE NEEDS CAN BE MET IN VERY SHELTERED HOUSING

Very Sheltered Housing provides a long term home until the level of nursing needs is no longer able to be met by Community Services, physical or psychiatric. The eligibility criteria of 4 hours of personal care and support with no maximum enables a mixed community within any scheme. VSH provides more opportunity for 'couples' to stay together, the cared for to remain with their unpaid carer.

VSH provides more opportunity for unpaid and paid carers to share the caring role. The care provision within VSH is more flexible than that currently provided in the rest of the community, this therefore can meet supervisory needs and assists in the maintenance of independence.

When a couple are considering a move into VSH due to the care needs of one, arrangements in the event of the death of either person need to be clearly agreed at the time the tenancy is considered/signed up. This issue needs to be carefully considered in terms of tenancy rights etc.

Mainstream – VSH

Housing with care and support can provide flexibility for several short contacts with staff which can allay anxieties and offer frequent supervision. It has been seen that after moving in some people have reduced care needs due to their increased security or improved independence.

Application for VSH is made after exploration of other options within the present home have been explored. The factors that lead to an application range through:-

- Need for more flexible care and support than is available in present home.
- Present home is not suitable to meet present needs and is unsuitable for adaptation.
- Wish to live in own home environment but there are difficulties in meeting their needs at home.
- Where partner/unpaid carer is under considerable stress undertaking the caring role and needs flexibility in their support to alleviate stress.
- Enough life-skills remain to be enhanced in a supportive environment.
- Values independence, own space, does not wish for communal living.
- Night care availability.
- Anxious if no-one around, availability of staff gives confidence.

Extra Care

It is essential that there is good multi-disciplinary assessment and care planning.

People in extra care will have significant levels of disability due to functional or organic mental health conditions.

Indicators for successful placements are thought to be linked to one or more of the following:-

- People who need support (including night times) but who value some independence and privacy.
- People whose familiar belongings are essential cues for their functioning.
- Where safe physical boundaries are needed the building design aims to provide this.
- People who need a great deal of prompting to perform daily living tasks and need a lot of reminding and reassurance about where they are etc do well in these environments. Staff on duty can provide this support more economically and consistently to a group of tenants than to one person alone at home.
- To be successful, tenants need to have ability to benefit from very sheltered housing assets (independence, tenancy, own space, own life-style, care on domiciliary care model).
- Family carers are able and enabled to carry on caring if they wish.
- People who need to engage frequently with others in order to retain their orientation.

Management Tips for Extra Care VSH

1) Photos taken (with permission) of all new tenants so if they are missing and police help is sought a recent photo is available to give them.

2) All tenants have a card with their name and address in their purse/wallet when they go out, with their agreement.

3) Training and advice on diversion techniques and management strategies should be given to all staff.

4) Partnership working with CPN colleagues in assessment, care planning, guidance and support to staff.

5) Partnership working with family carers who need to be aware of health and safety issues that form part of the training of paid staff.

6) Comprehensive risk assessments and risk management strategies.

TWO: PEN PICTURES

1. Mrs. T. was diagnosed with Muscle Scoliosis in her early 60's. She was 78 years when she moved into Very Sheltered Housing following the death of her husband 2 years previously and the gradual deterioration of her MS symptoms over the previous 10 years.

   On admission to the VSH Scheme Mrs. T. had low muscle tone, was unable to move her legs, trunk or one arm, she had slight movement in the other arm and minimal neck movement. Mrs. T. was catheterised and needed assistance re bowel care. Mrs. T.'s speech and cognititive abilities were not affected.

   As time has progressed Mrs. T.'s speech has reduced and movement in her left arm is within her hand only, she needs assistance to eat and drink. Mrs. T. has a finger control panel to access t.v., light alarm and door entry.

   Current service provision is 4 visits during the day by two carers to assist with all personal care tasks including toiletting and feeding, 2 night visits are also available to turn Mrs. T. and attend to other needs as required. A daughter visits every day to assist with bowel care, shopping, laundry and social interactions.

   The success of Mrs. T. placement within VSH is due to her own motivation to stay 'at home,' her daughters' daily support and the flexibility of onsite carers and scheme manager support plus their commitment for people to retain independence.

2. Mr B. had become very isolated in the community following the loss of family carers. He became very anxious and low in mood and started to neglect himself, and his household. Because of his arthritis, he needs help getting dressed and 'started' for the day and support to carry out household tasks. Since being in a very sheltered housing scheme, his need for care and support has lessened, his anxiety is much reduced and he has become able to develop a lifestyle with which he is happy.

3. Mrs. G. was taken into a psychiatric unit when the level of her dementia became too much for her husband to cope with. He also had disabilities and it seemed unlikely they would be able to manage again at home. They would need a high level of care including during the night. Closely involved family members thought residential care for Mrs. G. was the only option. Both Mr. and Mrs. G. were able to take up tenancy of a two-bedroomed flat in the extra care part of a scheme. They are happy to be together again and carers support Mr. G. to continue to care for his wife. He can take respite in other facilities at the scheme he wishes. Mr. and Mrs. G. are being enabled to continue their lives together in a highly supportive environment.

THREE: ELIGIBILITY AND ALLOCATION CRITERIA

Eligibility Criteria

General Principles

a) Allocations policies and procedures for very sheltered housing schemes will be fair and equitable and access to schemes will be open to all older people whose needs for the service can be demonstrated. In exceptional circumstances, a place may be offered to someone under 60 years of age.

All applications will be considered by the Allocations Panel.

b) Eligibility for very sheltered housing schemes will be established by the completion of a Housing Needs Assessment and a Community Care Assessment. This will ensure that information is not only collected from the applicant, but also given on possible housing opportunities and other resources.

c) Applicants must be in housing need. The present living situation may no longer be suitable because care and other facilities cannot readily, practicably or economically be provided there.

d) A person will usually require assistance with their daily living tasks, and/or their personal care and support. This means that a person would require a minimum of four hours personal care and support each week. There are additional criteria to be met for a place in any 'extra care' part of a scheme. (See Section Two).

e) Care plans will be compiled with all older people allocated tenancies in very sheltered housing to reflect ways of meeting their needs in the scheme, in order to provide maximum independence, autonomy, dignity and choice for the individual.

f) Applicants will usually be living in the district council area of the very sheltered housing scheme. Alternatively, they must be able to demonstrate a strong connection to the area – immediate family member. (See County Allocations Policy – Appendix 1).

g) The needs of carers will be considered in assessment for very sheltered housing.

Allocations Criteria

a) Tenants living in very sheltered housing schemes will have care and support needs because of a range of difficulties, and disabilities including dementia, mental health problems and physical disability. The four hour personal care and support criteria (minimum) with no maximum enables a mixed community to be formed.

b) Allocations panels will endeavour to ensure that whenever possible tenants enter very sheltered housing at an optimum time for them, which may be in the early stages of dementia, during recovery from an episode of depression or when coming out of hospital after a long term illness.

c) Applicants for very sheltered housing may currently be living in a range of housing, including residential care or sheltered housing. For each tenant, very sheltered housing will provide a service or support not available in his or her current accommodation. A more independent lifestyle should be facilitated for as many tenants as possible, whereas the provision of regular night care or a continually supportive community will be key factors for others.

d) Applicants may have restricted mobility but will be able to cope in a supportive environment. Some people may need a variety of aids and equipment to enable them to function positively.

e) Applicants with a physical disability will be able to make a home for life in very sheltered housing unless health deteriorates to the point where longer term nursing care and/or specialist provision is necessary.

f) Tenants in very sheltered housing may be currently suffering from depression and/or the effects of isolation and/or may have suffered from mental health problems.

g) Applicants for very sheltered housing will not currently be suffering from mental health problems which lead to violent or severely challenging behaviour. Such people may however be considered for a tenancy in an extra care part of a vsh scheme, where a full risk assessment indicates suitability.

h) Applicants for very sheltered housing may be in the early stages of dementia, but will still be able to make relationships, function within a daily routine, have some knowledge of their surroundings and/or be in a supportive relationship within the scheme.

i) Existing tenants whose dementia worsens and those who develop symptoms of dementia will be able to be supported within the scheme. If behaviour is severely challenging or anti-social and/or people become a danger to themselves or others, then a risk assessment will be undertaken. They should be considered for a tenancy in an extra care part of a scheme.

j) It is recognised that tenants may need flexibility in the provision of care services and that tenants care needs will change over time.

CHAPTER TWO – ALLOCATION, ASSESSMENT & CARE MANAGEMENT

ONE: ASSESSMENTS AND THE ALLOCATION PANEL

1 Allocations should be in line with County Allocations Policy (Appendix One and available on public folders).

2 The representative on the allocations panel from Suffolk Social Care should be the local Team Manager or Senior Practitioner.

3 Housing register application form completed and eligibility for housing needs established.

Currently the Suffolk agreement requires that for very sheltered housing an applicant should have lived in the area either for 6 of the past 12 months or 3 of the last five years.

For a family connection the requirement is that a close family member should have lived in the area for a minimum of 3 in the past 5 years. Some Housing Authorities are prepared to consider cross-boundary placements for other reasons.

4 A comprehensive community care assessment, including where appropriate, a risk assessment, should be available to the panel through the Social Care Manager/Senior Practitioner. In the case of application for extra care an assessment including that of a consultant in Psychiatry of Old Age must also have been considered. An example of a risk assessment format is given at Appendix 3.

5 In completing the needs assessment, multi-disciplinary/specialist input may be useful in identifying all care needs.

6 As a minimum the detailed care plan/service package (current and/or proposed) should accompany the assessment.

7 Information to providers and panel should reflect what assistance/support is given by informal carers/family members and whether this is likely to be maintained in VSH setting. Links should be supported rather than displaced.

8 Assessments should reflect the preferences of the individual, needs of the carer and at all times reflect due regard for independence, autonomy, dignity and choice for the individual. This will include cultural, ethnic and religious needs.

9 In borderline cases identified in the allocation panel meeting Providers will be involved in the decision making process. This will include the Scheme Manager meeting the potential tenant either in the scheme or another setting. It must be recognised that the Housing Provider has the final word on an allocation.

TWO: GOOD PRACTICE FOR NAMED ASSESSORS

Information for Providers

1 As a minimum the detailed care plan/service package (current and proposed) should accompany the assessment.

2 In completing the needs based assessment, multi disciplinary/specialist input may be useful in identifying all care needs. A current assessment from a consultant in Psychiatry of Old Age is a requirement for extra care services.

3 Information should reflect what assistance/support is given by informal carers and/or family members, and whether this is likely to be maintained. The assessment should reflect the preferences of the individuals, the needs of the carer and at all times reflect due regard for independence, autonomy, dignity and choice for the individual.

Assessment information needs to include:

- Up-to-date information on person's personal care needs, as well as full information re: mental and physical health, social needs, family support, issues of lifestyle, culture, religion.
- Information about how needs are currently being met (information gained from hospital, paid and unpaid carers, other key professionals)
- Why this resource is being selected.
- Aims and objectives of placement (any independence or rehabilitative targets; the person's own aspirations and wishes for the placement).
- Risk assessment (manual handling and behaviour).
- Any equipment needs

NB: The person should always be involved in gathering this information and see and sign it before it goes to the Scheme Manager with their permission.

4 Where risk assessments have been part of the care management process these must also be made available for consideration in the allocation process and future management. The named assessor should evidence why a risk assessment is unavailable/inappropriate.

NB: Risk assessment forms are currently being piloted for later inclusion in the Assessment process. The current form is included at Appendix 3.

5 Where the customer is from a black or minority ethnic group extra care and sensitivity must be shown in the care planning process to ensure cultural / religious needs are met. This is the responsibility of the Named Assessor, working closely with the Scheme Manager. Further guidance ("Culturally Competent Care") to be issued shortly.

Introductory Process

- The prospective tenant and family (if appropriate) should visit the scheme, preferably before their application is considered by allocations panel. There should be the opportunity to see the binding and meet other tenants (if possible).

- Prior to commencing the tenancy, a meeting should be held involving the applicant, their family or friends (if requested), the Scheme Manager or delegated person and Named Assessor. If time is short, this may have to be done on the phone. However, a meeting should take place as soon as possible after the tenancy has been taken up.

  The meeting will :-

  - Ensure the applicant's questions are considered.
  - Establish how the accommodation is furnished, what to bring etc.
  - Discuss the tenancy agreement between Housing Association and applicant.
  - Confirm date to move.
  - Arrange review day.
  - Ensure financial issues including rent and charges are clarified.
  - Discuss the continuing role of family members/carers and supporting other networks.
  - Undertake preliminary discussion of care plan, and management of any identified risks.

Early Days to 6 Week Review

- The scheme staff will be spending time with the new tenant getting to know them and helping with introductions / settling into community and the environment.

- The role of the Named Assessor during this period may be minimal, needing to check with the tenant, Scheme Manager and other appropriate people that all is well. Alternatively, it may involve a lot of work if the person is not happy with their decision or staff have difficulty in meeting the tenant's needs.

- Care plan variations/flexibility will need to be discussed.

- Risk assessments and risk management strategies may need to be agreed.

Reviews

The initial review should take place within 6 weeks after commencement of the tenancy, but may need to be ongoing to reflect continuous changing needs and the dynamics of the settling in period. It is anticipated that the service package in the initial introductory period may need to be flexible and varied. A robust assessment should identify potential needs and responses to them, but close partnership working is a crucial part of the process, with the named assessor and Scheme Manager working closely together. The review should include the resident, family, named assessor and scheme manager. It is the responsibility of the named assessor to call the review. The review will:

- Confirm whether or not this is the right placement for the person. If there is doubt, there will need to be full discussion of the options.
- Review the care plan (personal care, support, rehab objective, lifestyle choices)
- Ensure financial arrangements are finalised
- Apply a problem-solving approach to any difficulties

Reviews should be annual, but can be called at any time by the tenant, care provider or assessor. The completion of the new (tenant) satisfaction survey should be part of the initial review and when appropriate thereafter.

Moving On

The Very Sheltered Service specification (available on the County Council website), is clear about triggers for moving on from Very Sheltered Housing and Extra Care Services. Decisions will only be made after multi-agency discussion and agreement.

When a tenant moves into a scheme it is likely to be for life except in exceptional circumstances. These are:-

i) need for nursing care is on-going and more than local Community Nursing Services will provide.

ii) when the landlord is no longer able to offer “reasonable peace and quiet” to other tenants, as required by the tenancy agreement;

iii) when the tenant, other tenants or staff are at risk of physical or mental abuse (the decision being reached jointly following a multi-disciplinary risk assessment).

No termination of tenancy should be given by the HA without full multi-disciplinary discussion.

Guidance will be offered shortly on how to proceed when one partner of a couple in the scheme dies, and the remaining partner has no care and support needs.

CHAPTER THREE – SETTING UP NEW SCHEMES

ONE: DEVELOPMENT PROCESS

The Role of the Purchasing Manager & the Project Team

When a Very Sheltered Housing Service goes into development, it should never be a surprise to local Social Care Services staff. It will have been funded on the basis of hard information about unmet housing and support need that will have been provided by the local team and housing department.

It has been clear from the review process of existing services that the most successful are those which have had local involvement from Social Care Services throughout the development process. Such involvement also enables local 'tuning' of the Design and Management Guide (which provides the specification) to ensure that identified needs are being met. This is especially the case when considering Extra Care Services. Design and Management Guides are available on Public Folders.

The Housing Register and Special Needs Register should also provide useful information about local need.

A multi-agency and disciplinary group, the Project Team, is responsible for delivering the new scheme within time and budget against the specification. It is also responsible for liaison with service users, ensuring that capital and revenue budgets are agreed and sufficient to deliver a high quality service. It has responsibility also for other matters including design and operational policy.

The Project Teams meet monthly and begin as soon as capital is agreed. Its job is generally finished after letting (which they also oversee) but they hold reviews at 3, 6 and 12 months after the new service starts to ensure that learning is looped into new services.

The Team Manager for the area where the new Scheme is to be built is expected to be a member of the Project Group throughout and fully participate in the multi-agency approach to the development. Specific responsibilities are:-

- Identifying local need and ensuring the scheme is developed to meet these needs
- Contributing to the identification/appointment of the care provider (who may or may not also be the landlord)
- Ensuring the ACM/CM responsible is aware of the timing of the project and that appropriate bids for revenue funding have been submitted
- Taking responsibility with partners for the development of the operation policy for the scheme, which includes care management and budget approval information
- At the appropriate time begin to identify tenants for the scheme and participate in allocation panel
- Work with ACM/CM to ensure an appropriate budget framework (eg core and flexi-funding) is put in place, fully agreed with care provider and that an appropriate contract is drawn up.

TWO: THE BUDGETS

1) The Capital Budget

This is likely to be funded from a number of sources. Primarily the responsibility of the District or Borough Council (who are the statutory housing authority) the capital budget operates within the guidelines of the Housing Corporation (a quango that funds and regulates registered social landlords (RSL/Housing Associations). All schemes must also meet the standards laid down in the Very Sheltered Design and Management Guide and the Extra Care documents relating to services for people with Dementia and Functional Mental Ill Health.

Sources for capital funding are numerous and include:-

- District/Borough Councils (who contribute grants known as Local Authority Social Housing Grant or LASHG
- The Housing Corporation (who on the recommendations of DCs/BCs and SCC fund Registered Social Landlords with Social Housing Grant or SHG)
- Suffolk County Council (who also can give LASHG in pursuance of their policies on resources to older people)
- Private Finance (which can be raised by RLSs in the form of mortgage repayable through the rents)
- Trusts or other charitable bodies (who on occasion contribute to schemes, albeit usually for the 'jam' rather than the 'bread and butter')
- The Tenants (through their rental payments, either direct or through Housing Benefit)

NB: Purchasing Managers will not be involved in issues relating to capital funding.

2) The Revenue Budget

Currently a number of systems for revenue budget calculation are in place. These gradually will become standardised. The revenue budget consists of three separate components:-

i) The Core Budget for personal care

Paid monthly or 4-weekly the core budget represents the level of service which tenants in a scheme will require irrespective of their individual needs.

It is calculated on the basis of two components:

- 4 hours personal care per tenant (not per flat) – this reflects the minimum care requirement identified in the eligibility criteria for very sheltered schemes)
- the cost of waking night services (may also include the cost of one sleeping night worker where required).
- Management costs.

ii) The Flexi-budget for personal care

The flexi-budget is held by the purchaser and paid 4-weekly on receipt of individualised invoices.

This reflects the assessed personal care needs of individual tenants over and above those funded in the core budget. It also enables the possibility of a quick response should an individual tenant need temporary adjustment to care levels.

iii) Supporting People budget

This new budget works alongside the core budget and funds housing support. Included in this grant is cleaning, handy-person services, activities organiser and support worker services to tenants.

Purchasing Managers are responsible for identifying the revenue budget and defining with the care providers how it will work.

THREE: DEPARTMENTAL OWNERSHIP

Councillors are aware that a need has been identified in their patch as they have access to the draft Three Year Rolling Programme and the Development Programme covering all proposed and developing supported housing services. These are also reported in the Annual Housing Report. There is also an agreement in place that the District/Borough and County Council Ward Councillor be contacted prior to a planning application being made. There is an agreed format for this.

If a scheme is creating concern among local people then extended briefing and information sessions will be required. This usually is undertaken by the Project Team.

Directorate are also aware of developing schemes because of their access to the draft Development Programme and Housing Annual Report.

FOUR: OPERATIONAL POLICY

Each scheme has an Operational Policy that is developed as part of the Project Team process.

Formats should be similar as an outline for the document has been agreed and is available on the County Council website under Housing matters or from Joint Commissioning Manager (Housing). It is included at Appendix 1.

Each Operational Policy represents a fusion of information including the “Heads of Terms” as agreed by the Project Team from the agreed outline and the policies of partner provider agencies.

The Operational Policy is a living document and as such should be reviewed annually by the Joint Advisory Group.

CHAPTER FOUR – FINANCIAL ISSUES

ONE: FUNDING THE CARE (CORE AND FLEXI)

1) Core and Flexi-funding - Objectives

- To ensure that personal and other agreed care, based on an assessment of need, is provided according to need.
- To provide flexibility so that the amount of care provided overall is tailored to meet the assessed needs of individuals and can therefore increase or decrease.
- To provide care and support, which is in line with a domiciliary care model rather than a residential model of staffing.
- To assure a basic amount of secured funding to ensure needs are met at the eligibility criteria level and that staff are available at all times.

2) Core Funding

Includes:-

- Proportion of cost of the Scheme Manager (other contributors – Housing landlord, Supporting People).
- Four hours of care and support per tenant. (In existing schemes it is envisaged that 25% of this will be funded via Supporting People - see note 1 on next page).
- In extra care the four hours per tenant will be made up to ensure at least one staff member is available at all times to that part of the scheme.
- Senior staff availability at all times.
- Overhead costs.
- Night care (sleeping and/or waking as agreed).

Core funding is usually paid in advance monthly or 3-monthly (as the Care Provider prefers).

In a new scheme, the Care Provider will be asked to submit a price to cover all the elements of the core funding. This will be agreed by the Assistant County Manager responsible.

3) Use of flexi-budget in Care Management

The core and flexi financial arrangement allows people to be supported in very sheltered housing no matter what their needs are (unless they need highly specialist or nursing care that cannot be provided by Community Nursing). The core funding allows for four hours of care and support for each person per week in the main part of the scheme as outlined above and at least one staff at all times in the extra care part of the scheme. The flexi-budget is held by the local Community Team Manager (normally as part of their normal purchasing budget), and is to be used to purchase care above four hours, and in exceptional cases in extra care.

Such hours of care must be considered necessary by the named assessor (in discussion with the Scheme Manager and Care Provider) and agreed by the Senior Practitioner or Team Manager. They will be contracted for in the same way as domiciliary care, and the Care Provider will invoice for them in the usual way. Obviously they will be incorporated into the updated care plan, following reassessment or review.

Care Providers have the power to increase care in an emergency, but should discuss this with the Named Assessor as soon as possible. The local Operational Policy should define this power.

The cost of flexi-hours will be no more than the current domiciliary care rate.

The amount of flexi-care rises and falls with the needs of the individual. Core funding is paid even when a flat is vacant, but clearly flexi-funding ceases when the tenant no longer needs it.

Notes :-

1) Existing schemes are at Levington Court, Swann House, Barons Meadow, Marjorie Girling, Peppercorn House, Paddy Geere, William Wood, Holm Court, Heathcote House, Searman Court and Childwick House. 25% of the core funding is apportioned to Supporting People.

2) In Schemes developed from the Residential Homes, the core funding is set at a slightly different level, (Cullum Road, Deben View, Ravenswood, Reydon and Stutton) and flexi-funding available at a different stage. Core funding is hours, and flexi-funding comes in when the aggregate of care hours exceeds this. 35% is adjudged to come from Supporting People. See separate contracts for each of these schemes.

3) Schemes where the care is provided by the in-house service is all funded on a flexi-basis at the current in-house rate. (William Wood, Josselyn Court, Sidney Brown Court). 25% of the first 4 hours will come from Supporting People.

4) Varying the Budget

The core funding comes from a central budget managed by an Assistant County Manager (OP/PD). There is very little flexibility in this budget and, apart from the annual inflationary increase, additional demand has to be requested in the Department's annual budget cycle.

Often a development is required in a scheme (e.g., more night care, additional supervisory staff, more day-care staff support etc). When Team Managers discuss such developments with Scheme Managers / Care Providers, they need to be cautious about agreeing further financial commitment, without first having a full discussion with the Assistant County Manager. If the need for such a development is urgent, we will decide how to finance it (perhaps from local budgets), until it can be taken into the overall budget in the following financial year. Sometimes a development may have to wait until funding can be found in the next financial year.

TWO: CHARGING ISSUES

Day - Tenants are charged for their hours of care and support in the same way as users of domiciliary care, following financial assessment. They will pay by the normal methods. As Supporting People funding is established there may be variations in charging (guidance to follow). New charging policies are also to be brought in. Where the charge for care to a full cost payer exceeds the amount payable for residential care, the procedure for reducing charges should be considered.

Night - Access to care and support at night is part of the very sheltered housing service, and there is no charge for occasional one-off calls, emergency needs or during brief periods of illness. However, if a tenant requires regular night-care on a planned basis (as part of their care plan), they should be charged in the same way as for their day-time needs.

THREE: "OUT-OF-COUNTY" TENANTS

Occasionally a person will be placed in a Suffolk very sheltered housing scheme from another county. This decision rests with the allocation panel. There is a regional agreement that such tenants should become the financial responsibility of Suffolk once their tenancy has been confirmed, just as other tenants moving into Suffolk do.

(Incidentally, this also applies to Suffolk customers moving into very sheltered housing schemes in other counties in the region).

FOUR: RECORDING ON CARE FIRST

1. Very Sheltered Housing Schemes need to be set up correctly on the Care First Resource Directory. If you are inputting a V.S.H. scheme for the first time, please contact the Contracts Administrator, who will be able to confirm if a scheme already exists correctly on Care First. If the scheme needs to be input onto the Resource Directory, he/she will need to know the name and address of the scheme, and the hourly cost charged for the flexible hours purchased.

2. Agreements should be added under the "Domiciliary Care" service provision.

3. The supplier chosen is the name of the Very Sheltered Unit, for example "Holm Court VSH", as opposed to the agency supplying the care.

4. Most of the Very Sheltered Housing Schemes provided 4 hours of care per person each week as part of the block grant, and are thus "free" to the local team's purchasing budget. These 4 hours need to be entered in the "Standard" care band on the timetable. These hours should be split against each day of the week as appropriate.

5. Any additional hours purchased at the flexible hourly rate are a commitment to the local team's purchasing budget. These hours need to be entered as "Band 1" hours, which will automatically cost the package correctly.

6. Further guidance is to be issued on recording on Care First for the tenants in the VSH Schemes developed from the residential strategy.

CHAPTER FIVE - MAINTENANCE AND DEVELOPMENT OF SCHEME

ONE: JOINT ADVISORY GROUP (JAG) OR COMMITTEE

This group is responsible for the smooth running of the service and for ensuring that it employs best practice. It meets not less than four times a year and is made up of all stakeholders to the scheme including tenants, staff, care managers, health workers, housing, social care and health purchasers and community representatives. Every scheme must have such a group.

The JAG also provides information to assist in matters of quality assurance and budget negotiation. It may recommend development to the scheme, good practice protocols etc. and should periodically review the Operational Policy in-line with the guidance.

The JAG does not involve itself in personnel matters.

County Guidelines are attached at Appendix 1.

TWO: LINK SOCIAL WORKER

Many of the day-to-day issues arising in very sheltered housing can be resolved by appointing a link Social Worker from the local Team to very sheltered housing schemes. To ensure advocacy for individual tenants and avoid over-identification with provider issues, the link Social Worker should not be the named assessor for all the tenants (but can be for some). It is recommended that each scheme have a link Social Worker.

The role of the link Social Worker is :-

1. A named contact for the provider with the Department.

2. To give general information about Departmental issues.

3. To give general advice about how Social Care and Health can support individuals in very sheltered housing.

4. To give feedback in a general way to the Community Team Manager about how the Care Provider is managing their role, and forewarn of issues arising.

5. To provide an information loop between named assessors and the care provider.

6. To attend Meetings as appropriate.

However, the link Social Worker should not be the Social Care representative on the allocations panel (this role falls to the Team Manager or Senior Practitioner), and whilst attending the JAG, if appropriate, should not be the departmental representative except when occasionally deputising for the Team Manager / Senior Practitioner.

It is necessary to also ensure a link CPN for every scheme.

THREE: LIAISON WITH MANAGER OF SCHEME / DEVELOPMENT OF SCHEME

Most issues will be resolved by the JAG, the allocations panel and the day-to-day contact between the Team Members and Scheme Manager. However, the Team Manager should feel free to have separate meetings with the Scheme Manager when issues arise, and should anyway have an annual meeting (preferably in Nov/Dec) to discuss any budget issues relevant to the effectiveness of the scheme, and prepare any requests for additional funding.

Where a new scheme begins, or there is a change of management it will be useful during the first year or so for the Team Manager to have more frequent meetings with the Scheme Manager to ensure implementation of the objectives for the scheme and iron out teething problems.

FOUR: VERY SHELTERED HOUSING DOCUMENTS

This document should be read in conjunction with:-

- Design and Management Guide
- Extra Care / Dementia
- Extra Care / Functional Mental Health
- Very Sheltered Housing Service Specification

Obtainable via website and Joint Commissioning Manager (Housing).