SERVICE SPECIFICATION
SCHEDULE ONE (1)

Service specification and Associated Service Specification Schedules for the Provision of

CARE AND SUPPORT AT HOME IN BOURNEMOUTH CHRISTCHURCH AND POOLE

Service Specification Schedules

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1. The Journey Towards a New Model of Care Delivery

This Specification highlights the Journey and the level of commitment needed, not only to deliver a quality service for the immediate future, but for Providers, Commissioners and Service Users to commit to working together for the longer term to shape the future model of home care across Bournemouth Christchurch and Poole. This collaborative Journey supports the principles of coproduction and mutuality that will facilitate design of an evolving model of service delivery that seeks to improve the quality of life for the user.

Time will be needed to embed cultural changes, as well as new processes and procedures that will be associated with a new model of service delivery. Service Users will need to be supported to confidently engage and explore the ways their personalised outcomes can be achieved, in conjunction with their care provider. More widely, carers and families will, equally, need to be supported throughout the Journey to recognise the positive impact of any new approach with reassurance provided over the quality of any changed model of service delivery.

Over time, more diversity in service development will result, as Commissioning Partners and Providers co-develop other forms of support that increase choice and control for Service Users and demonstrate a shift away from the traditional 'time and task' activity. Service Users will then be able to purchase the service of their choice from a broad menu of options that not only include community providers, but include the third sector and, through the use of innovative technologies, they may opt for a council managed personal budget or take this as a Direct Payment.

Providers will be supported to explore and implement service developments, optimising the use of assistive and digital technology such as pendant alarms, medication dispensers, electronic MAR charts, and to make best use of a range of digital platforms and local community resources to Service Users with a Health or Council managed service.

In partnership, the Provider and Commissioning Partners may wish to develop a number of options for the future to promote increased flexibility and choice in the delivery of the service. The timings of care visits, for example may be one area for consideration and whether flexibility can be built in when in managing time, if key outcomes have been met. One option may be to explore whether spare hours may be 'banked' by the Service User, rather than being lost, but collaboration will be essential so that parameters are agreed and solutions are acceptable.

Other options, such as Individual Service funds (ISFs) have been adopted in some areas as a way of delivering personalised services, but locally providers will benefit from support to develop their ability to offer these. New systems and training will need to be established to expand, and consolidate, the skills of care staff to promote working in a consistently creative and person-centred way.

Part of the Journey includes a commitment to the evolution of the Proud to Care programme through which Commissioning Partners and Providers will recognise the hard work and valuable contribution that home care workers make to our community. Through Proud to Care, Providers and Commissioning Partners commit to work more closely to benefit from the combined economies of scale achievable by collaborating throughout the Journey.

Since the introduction of the Care Certificate in 2015, the Commissioning Partners have been keen to support implementation across the sector as it is a major step in linking up previously the two separate roles of the Health and Homecare Worker with a common set of standards. Although, not mandatory, care certification provides significant evidence that the health or social care worker has been trained and developed to a broad range of specific standards that must be completed, and assessed, before the worker can practice without direct supervision. By adopting this approach, Providers are demonstrating a high quality expectation from their workforce, characterised by a committed, caring and compassionate approach in the delivery of their service to vulnerable people.

The common values and consistencies shared by the care workers, undertaking the Care Certificate, will facilitate the development of a plethora of new roles and opportunities, within the caring workforce, to progress into specialist areas or to support career progression into the nursing and social work professions. In time, boundaries between the two roles will become increasingly blurred; an approach that reflects the prominence of the integration agenda between health and social care. This will ensure the new hybrid care workers of the future are adept, and proficient at responding to changing needs across health and social care.

Joining up processes for the individual is a key aim of the Commissioning Partners and, not least, at the acute hospital interface between health and social care where systems can appear to prevent rather than facilitate hospital discharge. Providers will be expected to communicate with clinical staff so that the patient's journey is improved and more cohesive at the point of hospital discharge so promoting a smooth transfer of care.

2. Introduction

The vision for people who use health and social care services is that they have access to quality care and support that will maximise their potential for independence through clearly identified personal outcomes that build on or maintain any reablement goals that may be outstanding.

2.1. Definitions and Interpretations

Any reference to Commissioning Partners and Providers includes employees of those organisations. Any reference to Providers includes voluntary and private sector organisations and individuals with designated responsibility under the Health and Social Care Act 2008 and the Care Act 2014.

2.1.1. Abuse

Describes a single action or repeated action or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to a person including physical, emotional, financial, sexual, racial abuse, neglect and abuse through the misapplication of drugs.

2.1.2. Adult at risk

Refers to any person aged 18 years and over who:

- May have need for care and support (S9 (1) Care Act 2014
- Or as a Carer may have need for care and support either now or in the future (S10 1(a)
- Is experiencing, or is at risk of, abuse and neglect and as a result of those needs cannot protect themselves.

2.1.3. Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework (ASCOF), measures performance against information on the outcomes for people using social care services and their carers. This information not only gives a national picture of the overall effectiveness of the sector but also shows how well individual council areas are meeting the needs of their populations. ASCOF is included in this specification because providers of care & support are a key element for commissioning partners to deliver the outcomes in this framework. (Dept. Health, November 2014).

2.1.4. Assistive Technology

An umbrella term that includes assistive, adaptive, and rehabilitative devices for older people or those with disabilities and includes the process used in selecting, locating, and using them.

2.1.5. **Business Continuity Plan**
A document that contains critical information on what the business needs to remain operational when faced with unexpected and adverse events including staff shortages.

2.1.6. **Care Act 2014**
The Care Act 2014 came into force in April 2015. Local Authorities and Clinical Commissioning Groups have a range of new duties and responsibilities under the Care Act. Some of these new duties will impact organisations that provide care and support services.

2.1.7. **Care and Support at Home**
This may include a mixture of personal care, enabling, domestic tasks and assistive technology. When these occur together, the service is always regarded as home care and support or domiciliary care.

2.1.8. **Care Diary**
This document is completed by the Social Worker/Care Manager, and is a daily record of the tasks to be carried out by the Provider. It should be read in conjunction with the Care and Support Plan, and used to develop the Provider's Delivery Plan in partnership with the Service-User**.**

2.1.9. **Care Line**
The term used for alarms and pendants specifically designed to be small, lightweight, discreet and comfortable for use by individuals who are at risk of falling or who are vulnerable but wish to retain independence at home. When Care Line wearers require assistance they use the alarm to contact a call centre. Depending on the situation the call centre will contact a named contact and/or the emergency services.

2.1.10. **Care Quality Commission (CQC)**
The organisation that is responsible for the registration and regulation of health and social care in England in accordance with the Care Act 2014.

2.1.11. **Care and Support Plan**
Following a social care assessment and a determination of eligibility the Care and Support Plan is agreed between the social care practitioner and the Service User. It highlights the outcomes that have been agreed that impact significantly on the Service User's well-being. The Plan will periodically be reviewed by the local authority. The Care and Support Plan provides the starting point for discussion between the Provider and the Service User in how these outcomes will actually be met by the care provided.

2.1.12. **Care and Support Worker**
Refers to the Provider's employees who provide the care and support service to Service Users in their own homes. This includes any staff employed by sub-contractors of the Provider who have been approved by the Commissioning Partners.

2.1.13. **Carer/Informal Carer**
A person of any age who provides or intends to provide on-going unpaid support to a partner, child, relative or friend. Without this help the health and wellbeing of the cared for person could deteriorate because of disability, a serious health condition, mental ill health or substance misuse. The carer may live with or apart from the cared for person. Services provided by the NHS may also be in place.

2.1.14. **Continuing Health Care**
Refers to a package of continuing care that is commissioned (arranged and funded) on behalf of the NHS. Continuing Care refers to care that is extended over a period to a person aged 18 or over to meet physical and/or mental health needs which have arisen because of disability, accident or illness.

2.1.15. **Commissioner**
The term Commissioner refers to the Commissioning Authority (Bournemouth, Christchurch and Poole Council [BCP Council]) or NHS Dorset Clinical Commissioning Group) purchasing/funding the individual care and support arrangement.

2.1.16. **Commissioned Health Outcome Plan/Health Care Plan**
The Agreed Commissioned Health Outcome Plan identifies the needs/outcomes of the patient, how these are to be met and the services required to meet those needs. This can be primary, secondary or commissioned care or family involvement.

2.1.17. **Commissioning Partners**
The Commissioning Partners are Bournemouth, Christchurch and Poole Council [BCP Council] and NHS Dorset Clinical Commissioning Group who are the Commissioners of the Care and Support at Home Service.

2.1.18. **Direct Payment**
A payment of part or all of a personal budget directly to a Service User or their representative in order for them to arrange their own care and support.

2.1.19. **Early Help**

Early help is intervening to prevent or reduce needs escalating later. This approach underpins the vision of the Care Act 2014 (S2) where local authorities have duties to prevent, reduce or delay the escalation of need and crises.

2.1.20. **End of Life Care**
This term refers to generalist care provided to people who are expected to die within the next twelve months, and includes those who are expected to die imminently. Any palliative care provided during this time is considered to be end of life care, although this is of a specialist nature and would be provided by the NHS.

2.1.21. **Frailty**
Diminished strength, endurance and function, with outcomes being poor for what might be considered a relatively minor ailment for more resilient individuals.

2.1.22. **Guidance**
Any health and social care guidance (including Cabinet Office guidance), direction or determination which the Commissioners and/or Provider have a duty to have regard to, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Provider by the Commissioners and/or Department of Health.

2.1.23. **I statements**
These express what people want to see and experience from services delivered in their own communities and homes, and what they expect to find if personalisation is really working well. The statements are used in this specification as a practical way to describe those expectations, and because they will be an element of the quality assurance framework for the service. Reference: “Making it Real”, National Co-production Advisory Group, Think Local Act Personal.

2.1.24. **Individual Service Fund (ISF)**
This is a more flexible type of 'managed' budget, as the Service User chooses the provider and decides when and how the care will be provided. The local authority pays the provider directly so the Service User is relieved of the responsibility of managing the budget.

2.1.25. **Infection Control**
This term relates to the policies and procedures that together provide guidelines to minimise the risk of spreading infection.

2.1.26. **Key Worker**
The Officer of the Commissioning Partners (for example Social Worker, Care Manager, Clinical Case Manager) responsible for ensuring that the assessed outcomes identified by the Service User that maintain or improve their wellbeing are met.

2.1.27. **Managed Budget**
When the local authority manages the Service User's personal budget, and commissions specific services and support for the person under a contract with a provider.

2.1.28. **Medication**
A Drug or other form of medicine that is used to treat or prevent disease.

2.1.29. **Moving and Handling Plan**
A document which is specific to a Service User who requires assistance with their transfers and/or walking. The document specifies the number of staff, any equipment and the procedures to be followed when care staff and /or carers are assisting the individual to move. This plan shall be completed following an assessment by a person with specialised knowledge of moving and handling techniques, for example an occupational therapist or back care advisor.

2.1.30. **Multi-disciplinary team**
A multi-agency team that spans both health and social care and typically will be made up of social workers, occupational therapists, physiotherapists, nurses and other clinicians who are all involved in the care of the Service-User.

2.1.31. **MUST (Malnutrition Universal Screening Tool)**
A five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition) or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

2.1.32. **National Framework for NHS CHC**
Sets out the principles and processes of the National Framework for NHS Continuing Health Care and NHS-funded nursing care.

2.1.33. **National Minimum Wage**
The minimum rate that an employee can earn in an hour.

2.1.34. **NHS Continuing Health Care**

Care that is arranged and funded solely by the NHS where it has been assessed that the Service User's primary need is a health need and eligibility determined against criteria as detailed in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care July 2009.

2.1.35. **Outcomes**
The end result of the service provided by a Provider, which can be used to measure the effectiveness of the service. An outcome may be a service outcome which is applicable to all Service Users, or an individual outcome which pertains to the individual Service User and is identified in the Service Users Care and Support Plan/Health Outcome Plan.

2.1.36. **Personal Budget (Social Care Direct Payment)**
An indicative amount of funding allocated to an individual following an assessment of needs to determine the way money is spent to meet his or her care needs. This can be taken as a commissioned service, Direct Payment or a combination of both.

2.1.37. **Personal Health Budget**
A personal health budget is an allocation of CCG resources that Service Users can use to meet their health and well-being goals in new and innovative ways that do not rely on commissioned services. It does not cover an individual's entire NHS care. (GP services, A&E, and inpatient care, are excluded).

2.1.38. **Personalisation**
The process by which state-provided services can be adapted to suit Service Users. This means everyone having choice and control over the shape of their support along with a greater emphasis on prevention and early intervention.

2.1.39. **Prevention**
Services that reduce needs for support among people and their carers in the local area, and contributes towards preventing or delaying the development of such needs.

2.1.40. **Provider**
The organisation providing the Care and Support at Home Service and includes employees, agents and volunteers of that organisation. This may include sub-contractors who are approved by the Commissioning Partners.

1.1.35 **Provider Review**

Review carried out as necessary by the Provider and the Service User to consider any aspect of the Service User's care and support and the delivery of the Service.

1.1.36 **Reablement**

A service that provides practical and emotional assistance enabling people, who are at risk of not being able to remain independently in their own homes because of frailty, disability or illness, to require less support.

The aim is to reduce the effect of a Service User's disability and to maximise their functional independence. It is the achievement of restoration of a Service User's previous level of ability taking into account the needs of the Service User and their Carer.

1.1.37 **Re-assessment**

Formal re-assessment of needs undertaken by the Commissioner.

1.1.38 **Recording and Reporting**

All aspects of recording, reporting and sharing of information for services provided under this specification. Information may be required in various formats including digital and on-line.

1.1.39 **SALT (Speech and Language Therapy)**

Treatment provided by allied health professionals to support and care for adults and children who have difficulties with communication, or with eating, drinking and swallowing.

1.1.40 **Service Delivery Plan**

The Service Delivery Plan, drawn up by the Provider in partnership with the Service User, states the tasks that will be undertaken to meet the Service Users' outcomes as defined in the Care and Support Plan/Health Outcome Plan.

1.1.41 **Service Review**

Arrangements made by the Commissioners and the Provider to consider any aspect of the Agreement or the performance of the service.

1.1.42 **Service User**

An individual receiving the care delivered by the Provider, in accordance with the Agreement, Service specification and related documents appended to the Agreement. Any reference to the Service User shall, where appropriate, include the Service User's duly authorised representative

1.1.43 **Service User Review**

A formal review undertaken by the Commissioners' social care practitioner/case coordinator with the Service User and the Provider to discuss and review the Service User's current needs and any aspect of the service provided. Following the Service User Review, the Service Delivery Plan will be updated.

1.1.44 **Self Directed Support (SDS)**
The social care system which operates to give Service Users the choice, control and power over their support that they receive. This process replaces care management.

1.1.45 **Self Funder**
Individuals who are paying the full cost of the services they receive, either to live independently at home or in a care home.

1.1.46 **Skills for Care**
A national organisation responsible for providing training to employees providing social care services.

1.1.47 **Sleep-In Night Care**
Is the service provided between the hours of 11:00pm and 6:00am where the Care and Support Worker sleeps in the Service User's home and will immediately respond to any request for assistance. The service may include personal care, enabling and domestic tasks. The sleep-in night Care and Support Worker may be disturbed up to twice per night before the service is regarded a "waking night". Care and Support Workers can expect to be provided with a bed in a separate room and to be able to go to bed by midnight.

1.1.48 **Supported Assessment**
A professional process undertaken by the Key Worker with the Service User to identify their needs and the outcomes they wish to achieve within the context of their situation.

1.1.49 **Social Care Commitment**
A commitment to the public that care and support services will always be supported by skilled people who treat them with dignity and respect. Employers commit to give their workers the development /training they need and staff commit to put social care values into practice within their daily work.

1.1.50 **Social Value**
Under the Social Value Act 2012 the Commissioning Partners must put social value at the heart of all services commissioned. Securing all opportunities to add economic, social or environmental benefits for their local area.

1.1.51 **Universal Services**

Refers to services that are available to all individuals across Dorset and which can be accessed directly without the involvement of the Commissioning Partners.

1.1.52 **Waking Night Care**

The service provided between the hours of 11.00 pm and 6.00 am where the Care and Support Worker must remain awake and vigilant throughout their shift to undertake any care needs that may arise including quiet domestic tasks.

2 Strategic Context

The Commissioning Partners (Bournemouth, Christchurch and Poole Council [BCP Council] and NHS Dorset Clinical Commissioning Group (CCG) are together committed to a changed approach that is co-produced with providers to support development of an effective care and support at home service that, as well as maximising independence, will support a reduction in inappropriate hospital admissions and join up services for the benefit of the Service User.

This Specification will identify a move towards an alternative model of service delivery but will, firstly, invest commissioning resources into stabilising the market by supporting the continuation of a framework model of care and support. It is critical that both quality and supply is sustained and, in the current climate of a national and local workforce shortage, the Commissioning Partners are committed to forging collaborative relationships with providers gained through a shared understanding of future challenges and opportunities.

By working in partnership, the Commissioning Partners support a whole system approach to maximise efficiencies and reduce duplication to better meet the rising demand. This will be crucial as the number of older people and people living with long-term conditions is predicted to rise significantly across Bournemouth, Christchurch and Poole. Many of these people will be on the frailty spectrum and, for them acute hospital admissions pose a particular risk. As people live longer, with increasingly complex conditions, this will add further strain on existing health and social care services.

During the life of this contract, there will be opportunity to ensure the infrastructure is in place to support the move to an alternative model, within quality and budgetary constraints and without compromising the needs of the Service User. In time, this will support more diversity in service development which will provide flexibility for Service Users and promote increased choice and control.

3 Service Strategy

This Specification has been co-produced with providers, informed by local and national consultation and is underpinned by the "I Statements" that users of services have highlighted as important in the delivery of care services ("Making it Real", Think Local Act Personal). The views and perceptions of the Service User will be held as a measure in determining how well services are performing (Adult Social Care Outcomes Framework DH 2016). Providers will be expected to assess, both the quality and effectiveness of their own services in the context of personalisation (UK Home Care Association Guidance).

The Commissioning Partners are committed to ensuring services are equitable and accessible and uphold and protect the Human Rights of those in receipt of services ("Close to Home", Equality and Human Rights Commission 2011). Services need to be more joined-up between health and social care to improve the Service Users' experience as well as facilitating more choice and flexibility in how care is delivered ("Where the Heart Is", a report by Healthwatch Dorset 2015).

4 Strategic Priorities

There is a focus on Service User outcomes to meet the well-being requirements of the Care Act (2014) by:

- Enhancing physical, mental and emotional well-being
- Delaying and reducing the need for long term care or a hospital admission
- Increasing choice and control in day to day life
- Supporting Service Users to do what is important for them through social contact, meaningful activity, in relationships and in contributing to society
- Maintaining dignity and respect by providing support that makes them feel better about themselves
- Protecting vulnerable individuals from abuse and harm
- Maintaining suitability of living accommodation.

Maintaining Service User independence and promoting their goals by ensuring:

- High quality services that promote a strengths based approach

- Accessible and understandable information that supports informed choice
- Respect for the role played by family and carers in supporting the Service User to achieve independence.

Strengthen the links between the Care and Support at Home Service and other services, including Health Care and the Third Sector by:

- Raising the profile of the Care and Support Worker role and their contribution to maintaining the well-being of the Service User
- Continuing and building on reablement goals
- Referring on where additional services might promote well-being
- Recognising that good quality health and social care services can impact strongly on emergency admissions, accident and emergency care as well as preventing delayed discharges.

Work with Commissioning Partners to support the supply of Care and Support services that will be required, both now and in the future by:

- Committing to the improved reputation of the care sector for employment
- Ensuring care staff achieve at least the national minimum wage, together with travel, direct costs and other associated expenses.

5 Service Model and Scope

This Specification aims to support vulnerable Service Users aged 18 years and above, to maintain their well-being and maximise their independence through the provision of high quality responsive care and support services to meet the outcomes identified in the Care and Support Plan/Health Outcome Plan, whether they are in receipt of either individual, or council managed budgets, or those receiving NHS Continuing Healthcare across Bournemouth, Christchurch and Poole.

The Care and Support at Home service will be delivered between the hours of 6am to 11pm for day services, and 11pm to 6am for night services 365 days per year (the service may be required over 24 hours for CHC) and is for all Service Users including older people, people with mental health conditions, people with physical disability including sensory loss or impairment, individuals with dementia, people in need of carers home based support or night care (waking and sleep in nights), live in care, end of life care, people leaving hospital and those living in extra care in Bournemouth and Christchurch. The Service does not include provision of support for people with a requirement for specialist Learning Disability care, except on occasions where the required support is not considered specialist in nature.

It is a holistic service which aims to maximise integrated partnerships between available community resources and the Provider so as to help each Service User achieve the outcomes that matter to them in their life.

6 Service Requirements

The aims of the service are to:

6.1.35 Address all aspects of the Service User's health and well-being which will include focusing on the functional independence at home plus proactively working in partnership with the wider community, including statutory partners to share information and signpost the Service User to resources so promoting an active life within their community.

6.1.36 Ensure systems of communication that are effective in supporting and empowering the Service User to retain control and be confident to disclose when they are feeling mistreated, abused or neglected (e.g. through poor nutrition, hydration or social isolation).

6.1.37 Develop a real understanding of the outcomes each Service User wishes to achieve to promote health and well-being, improved choice and control, prevent abuse and understand what 'feeling safe' means to each Service User and to agree, negotiate and record their aspirations and outcomes and how these can be realised.

6.1.38 Ensure care workers follow six key principles which underpin a personalised approach to safeguarding an individual: empowerment, prevention, proportionality, protection, partnership and accountability.

6.1.39 Ensure care workers are aware of and respect the wishes of the Service User/carers about the way the Care and Support Plan/Health Outcome Plan is delivered, taking into account the 'I' Statements referenced in Definitions, clause 1.1.20

6.1.40 Promote the experience of co-ordinated health and social care that supports Service Users in a joined-up manner.

6.1.41 Assist the Commissioning Partners in monitoring the Service User's well-being and in being alert to signs of change.

6.1.42 Encourage the utilisation and development of informal networks, universal services and community based organisations in order to ensure that Service Users have an active and stimulating life, social isolation is reduced and people are helped to participate in their Community.

6.1.43 Promote best use of advances in technology to ensure effective communication and recording methods and proactive engagement with Assistive Technology.

6.1.44 Make effective use of community resources – encouraging active involvement of the voluntary and community sector as contributors to Care and Support Plan/Health Outcome Plan and maximising the use of and involvement of 'universal' community resources including My Life My Care. www.mylifemycare

6.1.45 Eradicate waste in the delivery of care, e.g. by reducing the extent of travel for support staff and removing areas of duplication that exist from multiple providers.

6.1.46 Ensure that working practices and delivery of support aligns with local and nationally determined priorities for public health.

6.1.47 Ensure skilled, competent workers with the appropriate characteristics are available in the delivery of the service(s).

7 Service Provision and Principles

The Provider shall:

7.1 Recognise that everyone's needs and outcomes will be different and personal to them.

7.2 Work in partnership with Service Users to help them maintain and improve their independence to achieve realistic goals.

7.3 Promote a culture and commitment to fair access, fair exit, diversity and inclusion that ensuring Service Users are well-informed about their rights and responsibilities.

7.4 Commit to empowering Service Users, applying a reablement approach and building their confidence and supporting their independence.

7.5 Promote participation in decisions and ensure Service Users are provided with clear information and appropriate support that may be necessary to facilitate this. Care and support is personal to the recipient and Providers must take positive action to ensure Service Users are not excluded.

7.6 Promote effective communication and liaison with all relevant professionals to ensure Service Users are supported by joined-up services, including but not limited to Community Health Services, Secondary Health Services, Social Workers and Occupational Therapists.

7.7 The Provider will ensure that the Care and Support Worker will know in advance of service delivery what communication needs the Service User

has and, wherever possible, will match a worker with experience of specialist communication to the Service User. If an experienced worker is not available, then appropriate training must be provided to meet these needs.

7.8 To consider Service Users within the context of their families and wider support networks.

7.9 To monitor the Service User's health and general wellbeing.

7.10 All services shall be provided in a way that maintains the Service User's independence in as many aspects of daily living as possible. This may mean assisting someone to do something for themselves (self-care), rather than providing direct care, or may mean working alongside the Service User to enable them to maintain control of their own domestic environment.

8 Service Objectives

8.1 To ensure Service Users are able to remain in their own home for as long as they feel safe to do so.

8.2 Support Service Users to achieve and maintain their potential for independence in relation to physical, intellectual, emotional, cultural and social capacity and to be included within their chosen community.

8.3 Lead to a more personalised approach.

8.4 Give Providers greater flexibility in the way they work.

8.5 Create opportunities for innovation.

8.6 Enable Commissioning Partners and Providers to determine 'smarter' solutions

8.7 Enable the Commissioning Partners to deliver value for money solutions for those in need of care and support

8.8 Prevent inappropriate or premature admission to hospital or residential care by recognising the signs that a Service User may become unwell and taking early action.

8.9 Be proactive in supporting the Service User to address their health needs.

8.10 Prevent the need for increased levels of support or need for emergency services.

8.11 Advise the Commissioner if the Service User's needs change so that the Care and Support Plan/Health Outcome Plan is adjusted accordingly.

8.12 Providers will provide good quality services, which are delivered in a respectful and compassionate manner, and where Service Users and their carers feel secure and confident in the care and support provided to them.

8.13 Ensure that Service Users are at the centre of decisions about how they are cared for and their Service Delivery Plan shall be designed with them, be outcome-focused and should enhance what they can do for themselves.

8.14 The Service will provide personalised care and support delivered when and where it is needed.

8.15 The Service will be sufficient to meet the eligible needs and demands from vulnerable people requiring regulated care and support.

8.16 The Service facilitates timely and reliable access to personal care and support, particularly but not exclusively, in cases of hospital discharge

8.17 The Service will deliver sustainable capacity in the market that meets the needs of Service Users, characterised by reliability, quality and accountability.

8.18 The Provider will provide good or excellent quality services as determined by the Care Quality Commission and by the Commissioning Partners.

9 Service Description

9.1 **The Provider shall ensure that:**

9.1.1 Services they provide promote the principles that underpin the Care Act 2014, and the broad definition of promoting well-being in particular.

9.1.2 Services delivered prevent, reduce and delay the need for increased care and support or acute/residential care of Service Users and carers.

9.1.3 Services are personalised to the Service User by being outcome focused and build on the outcomes defined in the Service User's Care and Support Plan/Health Outcome Plan.

9.1.4 Services are provided in a way that maintains and upholds Service User choice in as many aspects of daily living as possible (known as maintenance outcomes). This may mean assisting and encouraging

Service Users to maintain healthy hygiene routines, promoting 'self-care' rather than providing direct care, or may mean working alongside the Service User to enable them to be in control of their own physical appearance or their personal care tasks, as an example.

9.1.5 In planning the delivery of the service, the starting point is the Care and Support Plan/Health Outcome Plan that will indicate the level of independence and the need for more assistance (known as improvement/change outcomes).

9.1.6 Services provided can meet the following needs and outcomes. Although the list is not exhaustive it does provide an indication of the range of tasks encompassed in providing care and support at home:

- Personal hygiene and care, including dressing tasks and the maximising of self-care
- Menstrual care
- Assistance with toileting needs
- Continence care (including catheter and colostomy emptying), and support to self-manage where appropriate
- Oral care including monitoring mouth and dental health and swallowing functions.
- Supporting people discharged from hospital
- Assistance with accessing community and universal services.
- Assistance with medication and/or administration
- Emotional and psychological support such as confidence building and motivation.
- Supporting and working with Service Users with dementia, and/ or complex behaviours
- Identifying carers, respecting and supporting their caring role.
- Applying a reablement approach to service delivery and maintaining reablement objectives
- Sensory loss / impairment requiring specialist communication skills
- Monitoring and recording progress in traditional and non-traditional support including the use of Assistive Technology/Health Technology

- Where a determination that the Service User is entitled to CHC services the tasks carried out are related to he treatment, control or prevention of a disease, illness, injury or disability and the care or aftercare of a person with these needs.

9.1.7 The Provider shall ensure services can meet the following needs and outcomes of the practical elements of care that will maintain a "habitable home environment" (Care Act 2014 Eligibility Regulations). These tasks will almost always be delivered in conjunction with other care and support. The list of practical support is not exhaustive but gives an indication of what may be required:

- Withdrawing money on a Service User's behalf (this task may be needed temporarily until formal arrangements can be made).
- Payment of bills,
- Assistance with household emergencies and consequences (fire, burst pipes, etc.).
- Social rehabilitation, including escorting Service Users to access facilities
- Domestic services, as part of an overall care arrangement only, such as cleaning, washing up, making/changing beds and laundry
- Helping with pet care
- Ensuring the home environment is safe, secure and comfortable (including signposting to other agencies, if necessary, e.g. fire service)
- Dealing with household refuse

9.2 **Nutrition and Hydration**

9.2.1 The Provider shall ensure that Care and Support Workers are trained to observe the signs that may indicate a Service User is dehydrated, including unusual dryness of the mouth and lips.

9.2.2 The Provider shall ensure that staff are trained to be observant to unusual weight loss or lack of appetite.

9.2.3 The Provider shall ensure care staff actively encourage a varied and nutritious diet supplemented with healthy, tasty snacks to encourage a small appetite.

9.2.4 The Provider shall ensure care staff are vigilant to other causes of reluctance to eat such as ill-fitting dentures causing problems with chewing. Swallowing difficulties may also impact and appropriate action shall be agreed with the Service User (or Social Worker/Case Coordinator acting in the best interests of the Service User) and progressed.

9.2.5 The Provider shall ensure that where concerns are observed about the level of food and fluid intake, or believes the Service User is nutritionally at risk, then appropriate action must be agreed with the Service User (or Social Worker/Case Coordinator acting in the best interests of the Service User) and taken forward with the GP or community nurse.

9.3 Supporting community integration

9.3.1 Facilitate and encourage friends and family relationships, where appropriate.

9.3.2 Support the maintenance of other social contact by signposting Service Users to community and other third sector services including but not limited to, Careline/Lifeline services, transport, recreational facilities or services.

9.3.3 The Provider shall work with the Service User to signpost on to other organisations through 'My Life, My Care' online resource: https://www.mylifemycare.com/ or through the Commissioners' Brokerage Service.

9.4 Services to be excluded are:

9.4.1 The moving of heavy items of furniture or equipment

9.4.2 The cleaning of the outsides of windows

9.4.3 Repairs to electrical or other domestic appliances

9.4.4 Repairs to the home or contents

9.4.5 Assistance with the making of wills or any other legal documentation

9.4.6 Assistance with decision-making on personal finance matters

9.4.7 Gardening

9.4.8 Situations where children would be present without an adult family member

10 Services for Carers

10.1 Included in this specification are the requirements to deliver a home based support service as set out in Service Specification Schedule Nine.

11 Service Delivery

11.1 **Developing & Delivering**

11.1.1 The Provider shall work with the Service User in developing and delivering the Care and Support Plan and Service Plan as agreed with the Service Commissioner.

11.1.2 The Provider is expected to make every effort to accept all referrals, in particular where a service has been restarted following a temporary cancellation e.g. where the Service User has been into respite or hospital admission.

11.1.3 The Provider shall liaise with the relevant Health or Social Care professionals, including hospital staff, if the Service User is an inpatient, once the start date of the service has been agreed and confirmed.

11.1.4 For NHS Continuing Health Care services, the Provider must send written confirmation to the Clinical CHC Team acknowledging that the Service User has transferred successfully to their care.

11.1.5 In circumstances where the Provider needs to implement immediate or urgent changes in order to maintain a Service User's safety the Provider must notify the Service Commissioner immediately. Any additional needs and/or care provision will then be reviewed.

11.1.6 The Provider shall be required to deploy two or more care staff where the health or social care assessment indicates this is needed as

detailed in the Care and Support/Health Care Plan, and payment will be made accordingly.

11.1.7 The Provider shall be required to provide the service to the Service User for varying periods of specified time, ranging from a single period of not less than 15 minutes to multiple episodes of varying duration.

11.1.8 The periods of time specified in the Care and Support/Health Care Plan and Referral are the periods of time the Provider is required to provide Services to the Service User, and does not include travelling time.

11.1.9 The Provider shall, under no circumstances, commence, terminate or suspend Services to a Service User without first consulting the Social Care/Health Care and/or Brokerage Team for instructions and obtaining its agreement on how to proceed.

11.1.10 The Provider shall notify the Commissioner immediately where the Provider's staff are believed to be at risk of actual, or possible, harm or injury.

11.1.11 The Provider shall inform the Service Commissioner immediately in the event of a Service User making an unreasonable request of the Staff, or behaving in an unacceptable manner.

11.1.12 The Provider shall ensure that competent and suitably skilled staff assess a Service User's environment on or before the first visit to ensure it is safe and comfortable and report any concerns or hazards to the Commissioner. The Risk and Health and Safety Assessment of the Service User's home environment which shall be reviewed on a regular basis.

11.1.13 The Provider shall ensure care staff remain vigilant to internal environment risk factors and seek to minimise any hazards wherever possible. This may include reducing risks of falls caused by ill-fitting footwear; burns, caused by faulty kitchen equipment or poisoning caused by trying to heat the home using kitchen appliances (carbon monoxide).

11.1.14 The Provider shall ensure that staff observe, notify and adequately record changes in the Service User's condition to the Commissioner.

11.1.15 The Provider shall ensure that their staff advise the Service Commissioners of any difficulties or conflicts that arise while performing the Services.

12 Provision of Services

12.1 The Provider shall ensure every Service User receives visits according to the frequency and duration recorded in the Care and Support/Health Care Plan, and the service shall be performed to the standard required by this Specification.

12.2 The Commissioning Partners reserve the right to withhold payment for any Services that are unrecorded in the Care and Support/ Health Care Plans.

12.3 The Provider's Staff shall arrive at the agreed time as specified in the Care and Support/Health Care Plan within 15 minutes of the time agreed with the Service User in the Care and Support/Health Care Plan. Persistent failures to arrive at the agreed time may give rise to adjustments in any payment due.

12.4 The Provider shall make every effort to contact the Service User to inform them where staff are going to be late, and the alternative arrangements where applicable. Where Care Workers are late and the Services are not provided for the contracted period of time an adjustment shall be made to the payment due.

12.5 Where the Care Worker is more than 15 minutes early, but the Service User is not ready for the visit, the Care Worker shall return at the appointed time. No additional payment shall be due for the additional time spent.

12.6 The Provider shall ensure that the Service User is notified in advance, where possible, if the regular Care Worker is unavailable or, if an emergency as soon possible. Every effort shall be made to promote consistency of carers, using substitute Care Workers that are trained to the agreed standards where necessary.

12.7 The Provider shall ensure the names of care staff who attend the Service User are recorded legibly in the delivery Care Plan.

12.8 The Provider shall ensure that care staff do not arrange substitute staff or changes in personnel to cover absences themselves.

12.9 The Provider shall ensure the Service User has adequate fluid (such as a glass of water) to hand and, where available Careline/Lifeline Crisis pendant, mobile/landline is within reach before leaving the Service User. This is critical where a Service User is unable to independently retrieve these items themselves.

12.10 The Provider staff shall not throw personal items away, with the exception of domestic refuse.

12.11 Where the Provider uses equipment belonging to the Service User they shall do so in a considerate and appropriate manner. They shall inform the Service User of any equipment that is damaged or unsafe and shall not be required to use such equipment.

12.12 The Provider shall promote the health and well-being of Service User in receipt of Services by upholding and implementing best practice in hygiene and in infection control procedures.

13 Visit to the Service User

13.1 **Service Commencement**

13.1.1 The Provider shall arrange for an appropriately qualified Supervisor or a Manager to visit the Service User before the agreed start date of the Service to discuss with the Service User and their Carer particular service arrangements including the agreed time for visits, complaints procedures and other relevant information as detailed in the Care and Support/Health Care Plan.

13.1.2 Relevant and comprehensive information and records concerning the service shall be provided in the most appropriate format for the Service User. The Provider shall as a minimum supply the Service User with:

- A Brochure or Fact sheet about the service(s) to be provided
- Provider Delivery Care Plan

- Details and contact numbers for the Provider, the Service Commissioner and any other emergency number.

13.1.3 The Provider shall notify the Commissioner of any exceptional factors that may affect their ability to meet the requirements of the Care and Support/Health Care Plan in order that the Social Worker/Care Manager/Clinical Case Manager at his/her discretion can consider any reasonable amendments to the Care and Support/ Health Care Plan.

13.2 **Medication**

13.2.1 The Provider will be responsible for ensuring that a trained person develops a Medication Care Plan and Medication Administration Record (MAR) of prescribed medications and creams where the Provider is involved with a Service User's medication needs.

13.2.2 The Provider shall ensure that Medication is administered in line with the requirements of the Care and Support Plan/Health Outcome Plan/Service Delivery Plan and the Commissioner's Medicines Guidance (Schedule Five).

13.2.3 The Provider shall ensure that all care staff have the necessary training, and regular update training, to use the MAR sheet and be fully compliant with the requirements of the Medicines Guidance (Service Specification Schedule Five).

13.2.4 The Provider shall have a clear written Medication policy, agreed by the Commissioner and shall ensure its entire Staff are trained to meet the Service User's medication needs in accordance with the Commissioner's Medicines Guidance (Service Specification Schedule Five).

13.2.5 The Provider's Medication policy must identify the parameters and circumstances for assisting and administering medication and health related tasks and identify the limits to assistance and tasks which may not be undertaken without specialist training.

13.3 **Provider Care Plans and Record Keeping**

13.3.1 The Provider shall maintain, at its own expense, a Provider Delivery Care Plan in a format approved by the Commissioner, within each home where services are provided. This will be laid out in such a

way that the following record can be made (for each visit where appropriate):

- The arrival and departure times of the Care Worker
- The name of the Care Worker
- The relevance of the Provider Care Plan/Health Care Plan to the Service User, and how this aligns with the Service User's wishes, aspirations and promotes optimal health and well-being. This is a living document and shall be updated regularly in partnership with the Service User to ensure that goals around self-care and independence; hopes for the future; keeping well, maintaining contact with friends and family; and strategies for keeping positive and emotionally well.
- A general description of the tasks completed
- Medication prescribed and administered
- Allergies, likes and dislikes, preferences, hobbies, preferred communication style and cultural needs
- Menus where food is prepared
- The effectiveness of the Care Diary/ Care Plan in meeting the Service User's needs
- Signs of change, observed by the Care Worker, which deviates from a Service User's 'usual' behaviour. Although not exhaustive, this will include alertness to changes in mood, ability, and mental/physical health. These changes should be discussed with the Service User and where consent and actions agreed, these shall be escalated to the relevant professional for action.
- Professional/carer/family involvement, and preferred other
- Financial arrangements where these are part of the care arrangement
- Documentation of individual Service User satisfaction with the care provided and how this directly links to their expressed goals, ambitions and aspirations to chart progress achieved in a meaningful and personalised way.

13.3.2 The Service User shall be requested to sign the Provider Delivery Care Plan and timesheets but shall not be put under any duress or pressure to do so. Where a Service User is unable to personally sign records or fails to do so the Provider shall notify the Social Worker/ Care Manager/Clinical Case Manager in writing.

13.3.3 The Provider shall immediately notify the Social Worker/Care Manager/Clinical Case Manager should the Delivery Care Plan be lost or misplaced, and the Provider must immediately provide a replacement

Plan. A temporary record must be kept until a replacement Provider Care Plan is available.

13.3.4 The Provider shall ensure that where the Service User, their relative or representative decline to have records kept in their home that a signed and dated statements, confirming their refusal, is kept on the Service User's file including the file at the registered office.

13.3.5 The Provider must be willing to work together with the Commissioner to shape the way that service delivery is recorded in the future, and be willing to participate in pilots or trials of technology that may support this.

13.3.6 Provider shall keep accurate records of the service and decisions made and shall be fully accountable to the Commissioner in respect of these.

13.3.7 The Provider shall maintain appropriate records for each Service User who is in receipt of a service.

13.3.8 Evidence of regular review and evaluation of outcomes shall be provided to the Commissioners upon request.

13.3.9 The Provider shall ensure that a record of communications with Service Users/Carers/Family or their representative is kept in relation to service provision.

13.4 Multi-disciplinary Working

13.4.1 The Provider shall be required, when requested, to attend, or contribute to, Multi-Disciplinary Case Conferences in cases of complex need or where relevant background information is needed to inform care arrangements and that information relating to the well-being of Service Users is made available to the multi-disciplinary team.

13.4.2 The Provider shall be required to attend a Multi-Disciplinary Case Conference when concerns are raised over continuing eligibility to NHS Continuing Healthcare funding. Where it has been determined that a Service User is no longer eligible, NHS funding will cease in accordance with the Payment Conditions

13.5 Nutrition and Hydration

13.5.1 The Provider shall ensure all Care Workers have the skills to observe that Service Users are being well-nourished and well-hydrated as a core component of maintaining good health.

13.5.2 The Provider shall ensure that all Care Workers are well informed, equipped and supported to provide good nutrition, hydration and effective nutritional care. This includes awareness that some groups, including older people are more vulnerable to food-related illnesses because of a weakened immune system.

13.5.3 Where service provision involves meal preparation or support to prepare meals, Care Workers shall be aware they have a responsibility to promote a Service User's access to a balanced, varied and healthy diet, and to ensure food is fresh and in date for healthy consumption.

13.5.4 The Provider shall ensure that where changes, or difficulties, are observed, then specialist assessments (e.g. MUST and SALT) are sought immediately through Community Health Services and that the Commissioner is informed of any referrals.

13.5.5 The Provider shall ensure that staff understand and receive training on the requirements of the Food Safety Act 1990 in how food is handled, stored, prepared and delivered.

13.6 Understanding Behaviour that Challenges Services

13.6.1 The Provider shall promote consistency of care worker to assist with understanding of: individual preferences; alterations in mood, heightened frustration and understand the underlying cause of any behaviour change.

13.6.2 The Provider shall ensure that Care Workers are aware of other factors that may impact on a Service User's behaviour including social isolation, reaction to change, diagnosis of an illness or condition, or incompatibility with the care worker.

13.6.3 The Provider shall ensure that Care Workers respond positively and pro-actively, and in a person-centred way, to changes in a Service User's behaviour in the expectation of a positive response and outcome and to deescalate the situation.

13.6.4 The Provider shall ensure that Care Workers are sensitive to the needs of Service Users who may have communication difficulties where frustration may be a trigger for changes in behaviour.

13.6.5 The Provider shall ensure that a risk assessment is undertaken for each Service User receiving a service which shall be regularly updated to reflect new hazards and changes in risk management to take into account that behaviour that is defined as “challenging” can put them, or those around them at risk and can lead to a poorer quality of life.

13.6.6 The Provider shall ensure that risk assessments reflect the risks to care worker, the Service User, and their environment and that these risks are taken into account in the delivery of the service. This shall be in addition to the Care and Support/ Health Care Plan completed by the Social Worker/Care Manager/Clinical Case Manager which will detail the involvement of specialised professionals or outside agencies, if appropriate.

13.6.7 The Provider shall recognise their duty of care to minimise risk to care staff, and others, by establishing policies, procedures and regular training to ensure that staff are as informed as possible of strategies to reduce these risks.

14 Access and Security

14.1 The Provider shall only access the Service User’s home as directed in the Care and Support/ Health Care Plan and will have a policy in place to this effect.

14.2 The recording of key safe entry codes shall be done in a secure manner to ensure that the codes cannot be traced to the Service User’s address, other than by relevant employees.

14.3 The Provider will notify the Commissioner if there are any difficulties accessing the Service User’s home, or if a key safe is damaged or faulty.

14.4 The Provider shall have a policy relating to failure to gain access in line with clause 17.2.

14.5 The Provider will have a robust Access and Security Policy including Key Management and procedures for when a worker leaves employment.

14.6 The Provider shall ensure all reasonable steps are taken to maintain the security of the Service User's home and check that doors and windows are secure, as reasonably required by the Service User.

15 Service User Care and Support Plan/Health Outcome Plan Review

15.1 The Provider shall ensure care worker involvement in Care and Support Plan/Health Outcome Plan Reviews undertaken by the Social Worker/Care Manager/Case Manager, with any changes to the service delivery, as a result, being confirmed in writing to all those involved. The Social Worker/Care Manager will coordinate involvement in the Review for Council Funded Service Users, generally within 6-12 weeks of the commencement of the Service with further Reviews undertaken annually.

15.2 The Provider, Service User/Carer/Family or the Commissioning Partner shall request a Care and Support Review Service User outside of the regular review timetable if it appears that significant changes have taken place which may require alteration to the Care and Support Plan/Health Outcome Plan/Care Diary.

15.3 The Provider shall ensure care staff are involved in reviews of Agreed Commissioned Health Outcome Plan, generally carried out within 14 days' commencement of the service, with a copy of the Review document forwarded to the Clinical CHC Team. Formal reviews will be carried out on a case by case basis; generally, at the first three months then every twelve months, but maybe generated at any time prompted by the Service Provider, Service User, Family/Carer.

16 Service Cancellation

16.1 Where an individual package of care has been made for a fixed period, the arrangement shall cease on the expiry of that period. The arrangement may be renewed for a further fixed period with the agreement of the Service User, the Commissioner and the Provider.

16.2 If the Service User dies during the period of the arrangement, the arrangement terminates on the day of death.

16.3 The Provider, or the Commissioning Partners shall give not less than four weeks' notice to terminate an individual package of care. Except when the Service Provider can no longer meet the Service User's needs (see clause 16.6) or where a change of Service Provider is due to the termination or expiry of this Agreement.

16.4 Where the package of care is no longer required following an assessment by the Commissioner, the Commissioner will give the Provider one week's notice to terminate the individual package of care.

16.5 The Provider is expected to make every effort to ensure there is sufficient staff to deliver the service at all times, which may include implementing business continuity arrangements with the agreement of the Commissioner.

16.6 The Provider shall not give Notice on an individual package of care due to staff shortage, but will instead alert the Commissioner that Business Continuity arrangements are being implemented. Where the Business Continuity arrangements are not predicted to be temporary, or where a Service User would be put at risk because of the Business Continuity arrangements, the Provider and Commissioner will work together to agree a way forward.

16.7 Where continuation of the placement would give rise to serious risk to the life, health and well- being of the Service User, or other Service Users the arrangement will be terminated immediately.

16.8 The Provider shall immediately inform the Commissioner's Brokerage Team when a Service User is admitted to hospital. The package of care will terminate 48 hours after the Service User is admitted to hospital unless the package of care is protected.

16.9 Where a Service User's package of care is protected while they are in hospital and the Provider is informed they will not be returning home the package of care shall terminate on the day that the Service Provider or Service Commissioner received notification from the hospital that the Service User will not be returning home.

16.10 The Provider shall provide appropriate care to meet the needs of all referred Service Users at home; however, exceptional circumstances may arise whereby the Provider is unable to meet the needs of a Service User. In this eventuality, the Provider must alert, and give notice to the Clinical Continuing Healthcare Team/Care Management Team as soon as possible

to facilitate the sourcing of alternative care and to mitigate any disruption in service to vulnerable Service Users.

17 Emergencies

17.1 The Provider shall notify the Social Worker/Care Manager/Clinical Case Manager immediately when a Service User is considered to be in need of urgent attention from other services, or is at immediate risk, after ensuring the relevant emergency service is summoned.

17.2 The Provider shall report any failure by care staff to gain access to the Service User to the Social Worker/Care Manager/Clinical Case Manager, or if outside normal office hours, by referral to the Emergency Out-of-Hours Service/Clinical Continuing Healthcare Team.

17.3 The Provider shall immediately report any changes/concerns in the Service User's circumstances or other concerns that the care staff may have about a Service User to the Continuing Healthcare Team/Care Management Team, or if outside normal office hours, to the Emergency Out-of-Hours Service.

17.4 The Provider shall allocate additional care time to ensure the Service User's health and safety where a Service User's needs have changed due to sudden illness or unforeseen circumstances. This extra care will be at the discretion of the Provider and must be in proportion to the nature of the emergency. The need for this additional care and the amount of care given must be discussed with the Commissioners on the same day, or the next working day if this is not possible.

18 Provider Staff

18.1 The Provider will have in place a staff code of conduct to be followed by staff at all times.

18.2 The Provider will ensure that all Care Workers receive appropriate training including relevant induction standards and professional development including the care certificate.

18.3 The Provider shall ensure that their staff understand they are guests in a Service User's home and shall act accordingly.

18.4 The Provider shall ensure their staff do not help themselves to food/tea/coffee, or other provisions, unless specifically invited to do so or use any facilities e.g. telephones unless this is agreed by the Service User (except in the case of an emergency).

18.5 The Provider shall ensure their staff demonstrate respect for the Service User's home, their possessions; routines and personal standards.

18.6 The Provider must have a Registered Manager in place. In the event that the Registered Manager's position becomes vacant, the Provider is required to take immediate steps to fill the vacancy and notify the Commissioner.

18.7 The Provider shall ensure that, in addition to their statutory duties, under the Care Standards Act 200 and any future legislation, pre-employment checks relating to care staff shall include the taking up of at least two satisfactory written references and a close scrutiny of their employment history.

18.8 The Provider must ensure that all Staff have identification in a form acceptable to the Provider which they must carry whenever providing the Service (and show the Service User or their Carer on demand), displaying an up-to-date photograph, name and signature of the Care Worker, the name of the Provider, and a telephone number which can be used to verify this information. This identification must be tamper proof and reviewed regularly.

18.9 The Provider shall ensure that their staff are required to wear a uniform so that they are identifiable to Service Users receiving the service.

18.10 The Provider shall require staff, as part of their Infection Control policy to have access to a 'spills kit'.

18.11 The Provider shall ensure their organisation has an Information Security Policy that staff are able to easily access following initial and comprehensive training. The Policy shall ensure that staff are fully aware of the policies surrounding information governance and how this is stored on a wireless or global network, i.e. iCloud.

18.12 The Provider shall have a Social Media policy to mitigate risks of breaches of Service User confidentiality by their staff in the course of their duties at work.

18.13 The Provider must have in place a recall system to guarantee the return of company property including identification when employment ceases.

18.14 Where the Service User has a requirement identified in the Care and Support/ Health Care Plan to be cared for by staff of a certain gender, ethnic or religious cultural group arising from recognised religious or cultural needs, this will be respected by the Provider. Wherever possible, appropriate staff with the necessary skills shall be allocated to provide the Services.

18.15 The Provider must ensure Care Workers have sufficient command of the English language to understand training and instructions. Care workers must be able to verbally communicate with Service Users in order to provide a person-centred Service demonstrating understanding of outcomes, goals, and aspirations. The obligation upon the Provider must be carried out with due regard to the law on equalities and the Provider's own equal opportunities policy.

18.16 The Provider shall ensure that their Care Workers are given clear guidance and advice on how to maintain a professional and comfortable working relationship with Service Users. If it is felt by the Service Commissioner that this professional relationship is in danger of, or has broken down, the Service Commissioner reserves the right to ask for the member of Staff to be removed from the Service User's care.

18.17 The Provider shall ensure their staff do not invite or allow other people, children or pets into the Service User's home.

18.18 The Provider shall ensure their staff ask permission from the Service User before touching personal possessions.

18.19 The Provider shall ensure their staff place all possessions back in position prior to finishing work; this task is essential where Service Users have visual loss.

19 Provider Obligations

19.1 The Provider shall provide suitable office facilities for the purposes of providing the service to Service Users who live within the administrative boundary of the service. The facility shall provide reasonable access for all demonstrated through compliance with the requirements of the Disability Discrimination Act 1995, Human Rights Act 1998 and the Equalities Act 2010.

19.2 The Provider shall ensure the office facility(ies) support the core service tasks/functions of the Care and Support at Home Service, including administration of the service.

19.3 Temporary and agency staff are considered to be directly employed by the Provider for the purposes of this Specification.

19.4 The Provider shall work in partnership with the Service User, Carer/Family/Representative and the Service Commissioners, at all times, to ensure the Service continues to meet the expressed needs of the person receiving the service.

19.5 The Commissioner shall be responsible for providing up to date information to the Provider and for ensuring that any amendments to the Service User's details are communicated to the Provider so that the details can be amended.

19.6 The Provider will have in place at least the following policies (not an exhaustive list):

19.6.1 Staff Recruitment and Retention
19.6.2 Staff Training and Development
19.6.3 Staff Supervision and Support
19.6.4 Staff Disciplinary and Grievance
19.6.5 Safeguarding Adults
19.6.6 Risk Assessment
19.6.7 Falls Management
19.6.8 No Response and Missed Calls
19.6.9 Medication Management and Administration
19.6.10 Use of Social Media
19.6.11 Uniforms
19.6.12 Infection Control
19.6.13 Restraint and Restriction
19.6.14 Medicines Policy
19.6.15 Whistleblowing
19.6.16 Equal Opportunities
19.6.17 Complaints and Compliments
19.6.18 Gifts, Wills, Donations and Bequests
19.6.19 First Aid
19.6.20 Record Keeping (inc. Document Retention)
19.6.21 Business Continuity/Contingency Plans

20 Partnership Working

20.1 The Provider shall be responsible for ensuring that Service Users are referred to the appropriate agencies for specialist assessment.

20.2 The Provider shall work collaboratively with other agencies to ensure that Service Users have access to information and assistive technology, to maximise their independence and well-being.

20.3 The Provider shall working collaboratively with the Commissioning Partnership in line with condition 23 of this Specification.

21 Complaints and Compliments Procedure

21.1 The Provider will comply with all Complaints Procedures as set out in the Agreement. In addition, the Provider will ensure that they comply with the following;

21.1.1 The Provider shall ensure that their policies and procedures remain current in line with the Care Quality Commission (CQC) by ensuring they have an effective and accessible system for identifying, receiving and handling complaints from people using the service, people acting on their behalf or other stakeholders. All complaints must be investigated thoroughly and any necessary action taken where failures have been identified (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16).

21.1.2 The Provider shall comply with the Duty of Candour (Care Act 2014) to be open and honest with Service Users, carers and their representatives when things go wrong, and comply with requests for the Care Quality Commission to provide a summary of complaints, responses and other related correspondence or information related to the provision of care to vulnerable people.

21.2 The Provider shall forward complaints, compliments or queries relating to the actions of the Commissioning Partners, or their delegated officers to ensure the appropriate agency is informed and the matter is dealt with according to local policy and procedures.

21.3 The Provider shall report any complaints or untoward incidents related to NHS Continuing Healthcare, within a 24-hour period to the Commissioning Partner. All complaints relating to this provision of care by the Provider will be investigated by the Provider in the first instance and a

full written report sent to the NHS Dorset CCG (Bournemouth and Poole's CHC Commissioning Manager and named Clinical Governance Lead) within fourteen days of the complaint and will then be shared with the Clinical Governance Team.

21.4 The Provider shall maintain a log of complaints relating to the Service, together with records of the responses to those complaints. Copies of any Complaints, Compliments and Comments received are to be forwarded to the relevant Commissioning Partner, with summary Complaints data to be presented at the joint review meetings, between Commissioning Partners and the Provider.

22 Provider Business Management

22.1 The Provider shall manage the service in a business- like manner, demonstrating a sound financial base and meeting all contractual obligations to the highest standard.

22.2 The Provider shall provide information to the Service Commissioner on the financial security of the business when requested.

22.3 The Provider shall ensure their staff in senior positions within the organisation have the knowledge, skills and competence to undertake this Specification to ensure high standards of care provision for Service Users and Carers.

22.4 The Provider must understand the nature and purpose of the Service it is providing, in particular the varying needs of Service Users, and that this is fully conveyed and understood by its employees.

22.5 The Provider shall ensure the Management Structure of the Service is robust, flexible, and responsive to changing needs, circumstances and demands. There will be a strong commitment to leadership within the organisation, business direction and oversight to keep abreast of national and local best practice initiatives in care.

22.6 The Provider shall ensure all staff, comply, uphold and maintain legislative requirements, employment practice, policies and procedures at all times.

22.7 The Provider must inform the Service Commissioner of any changes relevant to this Contract, including changes of personnel and/or address.

23 Service Development

23.1 The Provider shall improve choice and flexibility in service provision for Service Users through the development of a range of diverse services to meet the expressed outcomes of Service Users.

23.2 The Provider shall, in delivering new models of care and support, ensure that consideration is given to the personal character, adaptability, empathy and strong communication skills required for staff undertaking these changed roles.

23.3 The Provider shall demonstrate efficient use of staff and environmental resources.

23.4 The Provider shall work to develop supportive, responsive and flexible services for Service Users with range of needs arising from the complexity of their health or social care conditions. The complexity of those conditions may result in variations in the amount, or intensity, of care and support and the development of quality services shall operate to complement primary healthcare, including palliative care teams in promoting individual choice, comfort and care so reducing the need for unplanned admission to hospital.

23.5 The Provider shall innovate to improve the availability of effective and reliable responses to urgent care needs to improve outcomes in terms of provision

23.6 The Provider shall work to secure confidence in the quality of care being delivered that shall be capable of delivery at a fair cost, within budgetary constraints.

23.7 The Provider shall facilitate workforce development, including sustainable improvements around recruitment, retention and training and staff pay and conditions.

23.8 The Provider shall approach development of care services in a responsive, proactive and problem solving way to facilitate the co-design of sustainable solutions to the challenges faced by the market. Co-design, in this context, includes commissioners, providers, Service User, Carer and other stakeholders.

23.9 The Provider shall work to improve contract monitoring and opportunities for shared information systems that help commissioners to better understand the needs of people receiving support in Dorset.

23.10 The Provider shall develop innovative services to support the complex needs of people with forgetfulness, memory loss and dementia ensuring they are responsive to the personal needs of the Service User and carer. Development of quality person-centred services shall incorporate flexibility, reliability and continuity of care both for those living alone and with their carers.

23.11 The Provider shall develop innovative services which promote community integration for those with long-term conditions.

23.12 The Provider shall develop procedures to help identify opportunities where the use of Assistive Technology, Telecare or Tele-health may maximise independence for users of service.

23.13 The Provider shall develop coordinated pathways to promote seamless transitions, for the Service User potentially from a range of providers including Reablement and Intermediate Care Teams.

23.14 The Provider shall develop ways to pro-actively engage citizens and their carers in continuous service development.

23.15 The Provider shall commit to, and proactively engage in, service development by:

- Attendance at Communication and Engagement events
- Participation in innovative approaches with other providers as well as with commissioning partner
- Investing in system hardware and software to improve and maintain an efficient service delivery.

23.16 The Provider shall apply a continuous service improvement approach and a positive attitude to working with Commissioning Partners and other providers to promote best practices.

23.17 The Provider shall have a Business Continuity Plan in place which fully reflects their organisation and operating commitments. Such a plan shall be maintained and tested periodically and be reviewed at least annually and be available to the Commissioning partners upon request.

23.18 The Provider shall apply a Continuous Service Improvement approach and a positive attitude towards innovation and working with Commissioning Partners and other Providers, to include:

- Responding to Service User feedback
- Developing new services in collaboration with the Commissioner and providing feedback to Commissioning Partners about new services that may be required
- Being responsive to initiatives aimed at furthering recruitment and retention practices including planning for improvements where there is a deficiency in the volume of care staff
- Commitment to the Proud to Care campaign
- Investment in innovation and service development
- Commitment to joint working and coproduction of the Care and Support at Home Services going forward
- Workforce training and development and general workforce competency, where there is a deficiency of skills and knowledge or the need to develop new skills in the workforce
- Business Continuity Plans and testing procedures.

24 Service Provider Accessibility

24.1 The Provider shall ensure care staff appointed to manage and supervise the Service must be available during the working day by telephone, Email and facsimile, and a duty manager/responsible individual must be on-call for its Staff, Service Users and the Commissioner to contact outside normal office hours (for urgent matters).

24.2 For the purpose of this Contract office hours shall be from 9am to 5pm Monday to Friday.

25 Quality Assurance

25.1 The Provider shall comply with the requirements of this Specification to include Quality Standards, as determined by the Care Quality Commission's Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, together with any subsequent standards contained in Health and Social Care regulatory frameworks issued by the Care Quality Commission.

25.2 The Provider shall be committed to quality assurance and continuous service improvement.

25.3 The Provider shall be expected to have an internal quality assurance system, to include standard setting, monitoring, and information management and review processes, in order to ensure that the required service quality is maintained.

25.4 The Provider shall undertake customer satisfaction surveys and other quality initiatives as guided by Commissioning Partners.

25.5 The Provider shall submit quality assurance report to the Commissioning Partners as indicated in the Performance Framework and Service Monitoring Measures (Service Specification Schedule Three).

25.6 The Provider shall work collaboratively with other services, such as Health, Intermediate Care and Reablement to ensure functional gains are maximised for the Service User and their experience is one of a seamless service.

25.7 The Provider shall treat Service Users with respect, compassion, dignity and ensure their Human Rights are respected in every aspect of their daily life.

26 Effectiveness

26.1 The Provider shall ensure all individuals referred to the Service receive consistent, accurate and appropriate information and advice from the point of contact.

26.2 The Provider shall work to improve outcomes for Service Users that will reduce reliance on long-term, intensive and residential care.

26.3 The Provider shall promote an enabling approach to maximise independence maintain well-being and negate the need for acute admissions to hospital and reduce the risk of premature entry to institutional care.

26.4 The Provider shall deliver a flexible, consistent and reliable service developed in conjunction with the Service User, informed by their choice in how and when services are provided as far as possible.

26.5 The Provider shall commit to ensuring continuous professional development of staff to meet the changing needs of services as people are living longer with more complex and interrelated conditions.

26.6 The Provider shall work collaboratively with the Commissioning Partners to share and deliver a range of preventative services designed to manage risk and encourage healthy living.

27 Efficiency

27.1 The Provider shall ensure that there is a suitably qualitied person available during office hours to consider the outstanding care arrangements contained in the daily waiting list/available packages of care email from the Commissioner's Brokerage Team and respond as soon as possible to confirm their capacity to accept referrals.

27.2 The Provider shall be required to confirm with the Commissioner's Brokerage Team whether they are able to accept a referral within two hours of considering the daily waiting/available packages of care list and keep accurate records of circumstances for declining a referral including the reasons.

27.3 The Provider shall be required to provide the Service from 6 am to 11 pm Monday to Sunday (including Bank Holidays) 365 days a year. The Provider may also be requested to provide Services throughout the night.

27.4 The Provider shall provide a 24-hour service for NHS Continuing Healthcare Services, Monday to Sunday inclusive, including all national bank holidays, at times specified in the Care and Support/Health Care Plan, in order to meet an Service User's requirements.

27.5 The Provider shall facilitate specialist referrals for Service Users identified as having complex needs.

27.6 The Provider shall work collaboratively with other agencies to ensure that Service Users have access to information to maximise their independence and well- being.

27.7 The Provider shall operate an out of office Service provision which shall be available at all times outside normal office hours.

27.8 The Provider shall encourage positive links with other organisations and services in the service area to ensure that resources are used to maximum effect.

27.9 The Provider shall develop a range of services, in conjunction with the Commissioning Partners to meet the needs of the community and will include those of a preventative nature.

27.10 The Provider shall work co-operatively with all those providing care to Service Users in their own home, including carers and families as well as statutory and voluntary organisations to ensure that support is as comprehensive as possible and that existing resources are used to maximum effect.

27.11 The Provider shall promote effective communication with other services including Reablement, and Intermediate Care Services to ensure a smooth and timely transition for the Service User.

27.12 The Provider shall ensure that all care rounds are as efficient as possible in line with Environmental Policies and maximising use of resources.

27.13 Where community equipment is in place but no longer used, the Provider shall escalate this to the Commissioner in a timely way.

27.14 The Provider will develop and implement the use of electronic aids to include Assistive Technology, Telecare and Tele-health to support a Service User's assessed needs. Where the implementation of such technology presents a fundamental change to the way the service is delivered the Provider will seek prior agreement from the Commissioner.

28 Responsiveness

28.1 The Provider shall advise the Brokerage Teams within 24 hours of a Service User's admission to hospital, or if a week-end admission then on Monday.

28.2 The Provider shall access interpreters to facilitate the delivery of the Home Care Service where a communication need is identified.

28.3 The Provider shall identify and respond sensitively and flexibly to the Service User's changing needs as identified in their Care and Support/ Health Care Plan.

28.4 The Care and Support at Home Service shall be delivered within timescales that are agreed and are proportionate to the level of need identified in the Care and Support/Health Care Plan.

28.5 The Provider shall facilitate and promote independence at all times by supporting Service Users to participate in carrying out tasks wherever possible so that independence is maximised.

28.6 The Provider shall ensure a timely response to changing need and work collaboratively with Health and Social Care to seek to reduce the incidence of inappropriate acute hospital admissions.

28.7 The Provider shall respond within a maximum of two hours of referral to a request from the Brokerage or Clinical CHC Team confirming they are able to provide the required level of care.

28.8 The Provider shall notify the Clinical Continuing Health Care Team immediately if they consider that the Service User may no longer meet eligibility to NHS Continuing Healthcare, in order to facilitate an early Review and Reassessment by the Team.

28.9 The Provider shall facilitate collection of health and social care data, as required by the Commissioning Partners, including statistics for inclusion in PSS User Experience surveys.

29 Choice

29.1 The Provider shall encourage Service Users to remain as independent as possible in leading their chosen lifestyle.

29.2 The Provider shall ensure that appropriately qualified Care Workers facilitate the development of Care and Support Plans in conjunction with the Service User. Working in partnership, the emphasis shall be placed on identifying who and what is important to the Service User their personal strategies for keeping safe, the goals, aspirations, skills, abilities and choices a Service User wishes to make.

29.3 The Provider shall actively seek and act upon the views of the Service User in the delivery and development of the Services they receive. In order to maximise choice and control, up-to-date information about the Service is to be regularly provided to the Service User to encourage signposting to other services, or re-referral, where appropriate.

29.4 The Provider shall refer any difference of opinion/conflict or requests for change expressed by the Service User, Carer or their Representative to the Social Worker/Care Manager/Clinical Case Manager for review

29.5 The Provider and their Staff shall respect the Service User's right to choice and self-determination which shall be facilitated, wherever practicable.

29.6 The Provider shall ensure the Service User and/or their Carers are empowered to exercise the greatest possible choice and control over the way in which Services are provided and the order in which tasks are performed, as outlined in the Care and Support/ Health Care Plan.

29.7 The Provider shall be aware of the need to be responsive to the particular communication needs of some individuals such as visual, hearing, or speech loss and the language needs of Service Users where English is not their first language.

30 Reporting

30.1 In addition to the reports prescribed within this contract the Provider shall comply with all reasonable additional requests for information.

30.2 The Provider shall ensure the following data is collated and recorded:

- Referrals and reasons for refusal of referrals
- Care provision and staff deployment e.g. hours and numbers of staff deployed
- Written evidence of staff training and monitoring by the Provider's management team
- Such other information as the Commissioner may reasonably require from time to time.

30.3 The Provider shall provide the results of internal management audits that monitor service performance and standards.

31 Service Review and Monitoring Arrangements

31.1 Service Reviews and Service Monitoring shall be a joint responsibility of both the Commissioning Partners and the Provider and will be aligned to the Performance Framework and Service Monitoring Measures (Service Specification Schedule Three).

31.2 The Commissioning Partners shall be entitled to introduce, or change, any systems of contract monitoring. Any changes will be communicated to the Provider.

31.3 Monitoring and auditing will be at the frequency determined by the Commissioning Partners to include, but not be limited to, the Performance Framework and Service Monitoring Measures Service Specification Schedule Three.

31.4 The Provider shall at all times co-operate with the Commissioning Partners, their processes for inspection, monitoring, evaluation and quality audit as reasonably requested by them.

31.5 The Provider will commit to being involved in the process of revising monitoring and review processes where requested by the Commissioner.

31.6 The Commissioning Partners retain the right to take their own measures to satisfy themselves as to the quality of the Service they are purchasing. Such monitoring may include a visit to the Provider office (with or without prior notice), examination of records, interviews with the manager, supervisor or Staff, including the right to seek, in confidence, the views of those for whom the Service is provided and their Carer.

31.7 The Provider shall self-monitor their performance in relation to the required standards contained in the Contract and shall be responsible for ensuring compliance with the standards contained within this Specification, Care Quality Commission requirements and those contained in future legislation.

31.8 Monitoring methods may include but shall not be limited to:

31.8.1 Quality Assurance methods and frequencies, including at least annual satisfaction survey, telephone monitoring and regular reviews

31.8.2 Auditing of the delivery Care Plan with the outcomes contained in the Care and Support Plan/Health Outcome Plan, in conjunction with the Service User and Social Worker/Clinical CHC Manager.

31.8.3 Improvement plans based on feedback from Individual users of the service

31.8.4 Notification to the Commissioning Partners of any failure to apply standards, together with action taken

31.8.5 Care Quality Commission Inspection Report and/or other indicators of performance

31.8.6 Changes to clinical practice as a result of complaints which must be implemented within 14 days of the cause.

31.9 The Service Provider's own Quality Assurance shall mirror the requirements of this Specification and the Indicators set out in Service Specification Schedule Three.

31.10 The Commissioning Partners reserve the right to request reasonable changes to the Care and Support Performance Framework.

31.11 The Provider shall provide comprehensive financial reports upon request to the Commissioning Partners so that the financial health of the organisation can be monitored to ensure the sustainability of a service to vulnerable Service Users.

31.12 The Provider shall comply with requests from the Care Quality Commission to provide information relating to the financial stability of the organisation (Care Act 2014).

31.13 The Provider's ordering system shall support the Commissioning Partners' quality assurance requirements.

32 Provider Workforce

32.1 The Provider shall ensure that care workers are:

32.1.1 Fully competent to manage, supervise, co-ordinate and deliver the entirety of this specification. In order to identify and successfully deliver outcomes to Service Users with a range of needs, Providers will be required to ensure that they have staff who are skilled, competent and appropriately trained.

32.1.2 Fully understand their own role and responsibilities

32.1.3 Aware that there is an expectation that optimum continuity of care worker is maintained.

32.1.4 Are trained, updated and regularly tested on the requirement of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

32.1.5 Able to fully comprehend and understand application of the pan-Dorset Safeguarding Policy and their responsibilities.

32.1.6 Feel valued by having regular access to practical guidance, quality advice and support and training to develop their skills, competency and knowledge.

32.1.7 The Service must be provided (as set out in the Framework Agreement) in line with legislation, all good practice and standards, and must meet the legislative requirements set out in the Care Act 2014. For further detail see Service Specification Schedule Six for the full Protocol.

33 Fair Access, Diversity and Inclusion

33.1 The Provider shall demonstrate within their organisation a culture and commitment to fair access, fair exit, diversity and inclusion, and will ensure Service Users are made aware of their rights and responsibilities.

33.2 The Provider shall facilitate a circle of support services that means care and support is maintained where it might otherwise be disrupted or fail.

34 Business Continuity Plan

34.1 The Provider shall have a robust business continuity plan in place to reduce the risk of service disruption to vulnerable Service Users. As a minimum, this plan will record resources and risk, and consider:

- A risk assessment that identifies five levels of impact from an insignificant disruption to one of significance.
- The minimum number of people required to deliver the Service

- The critical times to deliver the Service
- The premises where the Service is delivered from
- Business Continuity and control measures in the event of an emergency or power failure

(This list is not exhaustive)

34.2 The Provider shall work collaboratively and positively with the Commissioning Partners to promote the status of the domiciliary care sector and so improve the retention and recruitment of care workers. This may involve working collectively with other Providers in the sector on joint projects to improve quality, address workforce issues, or develop services.

34.3 The Provider shall invest time and resources in proactively working to recruit and retain staff to meet the predicted increase in capacity requirements.

35 The Management of Potential Risks and Disruptions

35.1 The Provider shall receive information, from the Commissioning Partners, about measures required to manage the risk or hazard, including the involvement of carers and any other relevant people in the Service User's life. Actions shall be taken to mitigate risk and the Care and Support Planning process will record whether this will create a significant impact on the Service User's well-being. Where concerns remain the Provider shall work with the Service User to look for solutions and notify the relevant Commissioning Partner of any significant changes made to the service.