Appendix 2

DRAFT SERVICE SPECIFICATION

Extra Care Service at REARDON COURT

Autumn 2022

Contents

.

1. Introduction

1.1 In line with the Care Act 2014, government policy and the wishes of older people, Enfield Council has been steadily increasing support to assist older people to continue to live independently in their own homes. The overall objective of extra care linked to national policy is to address the issues of moving away from institutional provision towards supporting older people in houses in their communities. As older people become more frail housing issues become more crucial, such as physical location; characteristics of the person's living situation coupled with the interface with care support, health transport and community access. The provision and service design of extra care seeks to address these challenges to allow the individual to maintain feelings of safety, security and quality of life.

1.2 This draft document sets out the Agreement service specification for high-quality Care Quality Commission (CQC) registered adult social care for the range of residents at Reardon Court Extra Care housing (ECH). This document describes the key features of the service to be provided.

1.3 The services outline within this specification describes the holistic and personalised arrangements for providing domiciliary-based care to all Service Users, working alongside the housing provider.

1.6 Over the lifetime of the Agreement, the Provider will be expected to work flexibly with the London Borough of Enfield ("the Council") to develop the Services. This will be subject to regular Agreement monitoring and review and will have its focus on evidenced outcomes, including Service User satisfaction, quality assurance & organisational capacity and cost effectiveness & efficiency detailed in this contract and agreed between the parties.

2. Enfield Council Strategic Objectives

2.1 The Agreement is an opportunity for the Provider to establish or maintain a reputation for effective partnership and development working with a Local Authority.

2.2 The key strategic objectives relevant to this service specification are:

2.2.1 Good homes in well-connected neighbourhood.

To increase housing choice for adults with support and care needs living in the London Borough of Enfield, by developing an appropriate supply of good quality, specialist accommodation

options to meet the changing needs of existing and emerging communities.

2.2.2 Sustain strong and Healthy Communities

To ensure adults and their families/carers, including hard-to-reach groups have good access to clear and consistent information about specialist accommodation options in the London Borough of Enfield, so they are empowered to make informed decisions about where and how they are supported to live.

To enable adults with support and care needs to live as fulfilling, independent, healthy and well lives as possible and contribute to the prevention and early intervention agenda by development of specialist accommodation options.

To support the re-ablement of older people and contribute to the prevention and early intervention agenda through the development of short stay specialist accommodation options for older people with care needs.

2.2.3 To Build our local economy to create a thriving place

Maximise opportunities for independent living by improving the quality, design and accessibility of specialist accommodation for older people.

Better understand the changing aspirations of older people in Enfield with regard to specialist accommodation services.

Support the development of modern, innovative accommodation models that extend choice and empower vulnerable adults to take control of the services they receive in line with the Personalisation agenda and policy direction.

Ensure the availability of culturally accessible and socially inclusive specialist accommodation services to support Enfield's diverse population of older people and facilitate community cohesion.

Ensure the availability of accommodation services for older people in the borough that effectively meet the specialist or acute needs of those with long-term conditions, including dementia and stroke, and to appropriately support end-of-life care.

Work in partnership with the external provider market to raise quality standards in specialist accommodation services for adults at risk of abuse or neglect.

2.3 The Service will be underpinned by the Care Act 2014 and the Council's Dignity Strategy for Adult Social Care, Principles of Adult Social Care Enablement Policy and the Council's service promise.

3. The Premises

3.1 Reardon Court offers 70 units of ECH, comprising of

61 one-bedroom
5 two-bedroom
3 flexi flat one bedroom utilised as stepdown beds by Adult Social Care
1 flexi flat two bedroom utilised as a stepdown bed by Adult Social Care

3.2 The service is located at: 26 Cosgrove Court, Winchmore Hill London N21 3BH.

3.3 All flats are available under social rent though Enfield Council Housing.

3.4 It is planned that office accommodation would be made available however this may be shared with the Council's Housing Team. Cost of renting office space from the Landlords London Borough of Enfield is approximately £12,000 to £15,000 per annum (estimated) with a 1% annual uplift per year. This sum is not included within the contract price and is payable by the Provider to the London Borough of Enfield.

4. Needs of Service Users

4.1 This section provides an overall picture of the needs of a potential future Service Users in the facility. It is an aggregated view and not intended to prescribe individual Service User's needs fully. Service Users at Reardon Court will have differing needs and preferences which will be outlined in their individual Service User Care & Support Plans, which are regularly reviewed. The service users who will be placed at Reardon Court can be categorised into four broad groups described below. The information below contains a brief summary of the metrics associated with the needs of each Service User group.

4.2 *Group 1: Older Service Users who currently have eligible social care needs and have less significant problems in daily living* but may benefit from some degree of support (not long-term care) in communal living. Occasionally, such individuals may need one-off or short-term care, e.g. following a hospital episode, or as part of a short-term NHS or Council Service. If the care represents a defined episode of short-term NHS it should be noted that this service is outside the scope of this Specification. The Service Users in Group 1 will have the assistance of the Provider to support their care needs.

4.3 *Group 2: Older residents who have more substantial problems in daily living* and who are eligible for long-term care under the Care Act 2014, but who nonetheless also benefit from fixed care and support in the facility in the same way as Group 1 . All users in Group 2 will have their care provided by the successful Provider and the Provider should facilitate them to have as much choice & control over choosing & managing their care.

4.4 As part of a well-established care pathway in Extra Care, Service Users with less significant problems in daily living who choose to move into the Extra Care scheme may develop long-term, more complex problems in the future due to ill-health and frailty as they get older. This means the balance of numbers of Service Users in Groups 1, 2 & 3 will change over time, although the intention is to ensure the proportions of Service Users in these two groups reflect a "balanced community" living in the Extra Care facility (see Section 8 of this specification).

Group 3 *Older residents who have high care needs i.e. more than 14 hours per week* and who are eligible for long-term care under the Care Act 2014, but who nonetheless also benefit from fixed care and support in the facility in the same way as Group 1 and 2 Service Users. These individuals should be facilitated to have as much choice & control over choosing & managing their care. These Service Users will have assistance from the Provider to support their care needs

4.5 Group 4: Service User who form part of the Council's Integrated locality Team Service programme to support independence for a fixed period to regain function which will enable them to continue living safely and return back to their home. This is further explained below.

Service Users in the flexi flats will be supported by the Services Provider on request from the Council

4.6 The principle purpose of the flexi flats is to support the Council's enablement policy and all referrals will come through the Integrated Locality Team Service within the Council's Adult Social Care function. This is a time limited, up to 6-week period of treatment designed to maximise people's long-term independence and minimise or otherwise delay the requirement for ongoing care and referral to more acute care accommodation.

4.7 Where the flexi flats are not being used for a client directly placed by the Integrated Locality Team Service, the Council may also use the flexi flats to support trial placements / assessment periods to determine whether a potential Service User's needs can be effectively met in the extra care housing environment within the service levels provided.

4.8 The Provider may not be required to work directly with clients referred from the Integrated Locality Team Service. Flexi flat Service Users may

also be supported by the Council's Integrated Locality Team service or another provider on an agreed short-term package of support & care.

However: -

4.8.1 The Provider will still need to maintain an effective liaison with the Integrated Locality Team Service and any other support or care agency that may be working with the client.

4.8.2 Any "trial placements" made via the Integrated Locality Team Service or extra care housing panel will be with the Provider.

4.8.3 If a flexi-flat client (including one placed directly by the Integrated locality Team Service is suitable for and expresses an interest in, a longer-term vacancy at Reardon Court, then the Provider would be expected to take on a more direct involvement.

4.9 The Provider will be required to include flexi flat outcomes and move on as part of key performance indicator monitoring arrangements.

4.10 The service delivery model will be available to provide care to all households at Reardon Court, and when necessary, the Service Users who form part of the Integrated Locality Team Service within the Flexi Flats. The successful Provider is encouraged to consider ways in which the contract Services staff can be deployed flexibly to maximise the amount of care outcomes able to be delivered within the service model.

5. Aims and Outcomes

5.1 The overarching aim is for the Provider, including the housing provider, to work together (along with the Service User) in a coordinated way to provide high-quality adult social care services tailored and flexed to meet the agreed needs and outcomes of individual Service Users.

5.2 In providing this Model, a number of outcomes for Service Users should be achieved, under-pinned through the Council's ethos of Extra Care, which is *"providing well-designed housing that enables people to self-care for longer and gives them access to care of their choosing as unobtrusively as possible to help them retain independence."* The outcomes associated with this Model are therefore:

- *Enabling Independence:* Service Users will maintain as much independence as possible by adopting an enabling approach to supporting them in daily living and hence improving their quality of life;
- *Feeling Safe & Secure:* However, there will be an appropriate balance between managing risk, choice & safeguarding for individuals and for others; and Service Users should feel that support is provided as safely & securely as they need;
- *Being Healthy, Clean & Comfortable:* Service Users will be facilitated and supported to be as healthy and well as they can and

be clean and comfortable in the delivery of care at all times; This aim also includes the provision of a meal at least once a day as an assessed need.

- *Treated with Dignity & Respect in a Person-Centred Way:* Service Users will always be treated with dignity in a way that respects their individual social, cultural, ethnic, religious etc. needs and be at the centre of planning, choosing, managing and financing the care & support that's right for them;
- *Having Company & Contact and Feeling Engaged:* Service Users will be facilitated to have as much company & contact with others as they feel they need and are facilitated to take part in activities and interests that are important to them, including in the wider community.

5.3 As a result of achieving these outcomes for individual Service Users, it is expected there will be wider health & social care outcomes including:

- Working with service users in an enabling way that helps them to regain functions for a period of six weeks or longer if further enablement will support move on
- To reducing the risk of hospitalisation admission
- To reduce the need for a residential or nursing care placement

5.4 The personalised response to a wide range of individuals' needs and the intensity of these needs facilitated via this model will mean Extra Care facilities and services will support a 'balanced community'.

5.5 The Provider is expected to support the delivery of health and social care for individual in line with the relevant NICE guidance and related standards specifically relating to older people, people with severe and enduring mental health issues and learning and physical disabilities. This includes (but it is not limited to) Older people with social care needs and multiple long-term conditions (NG22), Older people: independence and mental wellbeing (NG32) or Falls in older people: assessing risk and prevention (NG161)

6. Description of Care Model

6.1 The Model relates to delivery of well-coordinated, consistent and high-quality care & support needed to deliver Service User outcomes on a day-to-day and longer-term basis:

- The model includes personal care for Group1, Group 2 and Group 3 Service Users who have been assessed as in need of this support.
- Social Activities to engage Service Users in meaningful activities
- Service Users' outcomes will be delivered through a collaborative, person-centred approach taking account their expressed wishes and choice.
- There is a requirement for the Provider of this specification to act as a coordinating agency amongst all stakeholders involved in the care

& support of individuals ensuring expectations in the Service User's Care & Support Plans and their outcomes are met satisfactorily, both on a daily basis and in the longer-term. This includes health and specialist agencies. There will be a requirement to ensure care and support is well co-ordinated and well governed to meet individual Service Users stated needs and outcomes

- The model includes the provision of 4 Flexi Flats that support the enablement Service Users for a period of 6 weeks or more. The period of enablement needed will be determined by the Integrated Locality Team Service

7. Service Provision

7.1 The overriding approach to service provision must be to deliver the aims and outcomes of the service model described in Section 5, of this specification particularly those relating to a caring and enabling approach. The onus of the Provider is to provide seamless service to Service Users on the basis of their Care & Support plans, Care Plans and Service User risk assessments.

7.2 Annex 1 of this Specification provides a summary of the care needs of potential Service Users at Reardon Court. This is meant to be an indicative 'snapshot' analysis of the support needed, as individual Service Users' needs may vary on a day-to-day and longer-term basis.

7.3 Delivery of this service model is based on the successful Provider delivering on their areas of responsibility which includes:

- Responsibilities for the planning and delivery with others, including the Service User, for individual Service User's Care & Support Plan;

- Non-night time care arrangements to deliver the care functions included, but not limited to, those described in Annex 1 Non-night time" is defined as the period 7 am – 10 pm;

- Night time personal care arrangements: "Night time" is defined as the period 10 pm to 7.00 am. Night time provision will be available to all service users.

- In addition to the Non- night time hours and the night time hours the Provider will be expected to engage service users in meaningful social activities to enhance their lives and wellbeing. Examples to be considered but not exclusive include

    - Coffee morning sessions
    - Exercise for therapeutic and social needs
    - Day and annual outings
    - Games and quizzes

- External speakers and befriending organisations supporting social inclusion

- Responsibilities for the managerial oversight and administration of the Service to fulfil the above functions. This extends to ensuring that the identity and purpose of visitors to the scheme e.g., health workers and family is ascertained and recorded to mitigate risks of unauthorised entry.

7.4 The Provider must seek to operate a culture where the approach to services is caring, collaborative and flexible, rather than being solely concerned with the completion of a set pattern of care tasks. It will do so through engendering good relationships among the community at Reardon Court and other health providers, including the housing provider. In doing so, the Provider must recognise Service Users' daily requirements may vary (and respond flexibly and accordingly), with some people requiring more assistance one week, then potentially less the next, and so on.

7.5 There may be occasions when individual Service Users may call upon the Provider to provide (particularly) personal care however, the long-term or continuing need for such a Service User to call upon the Provider care should trigger the need to assess or review that Service User's Care & Support Plan with other relevant parties. Such cases should be raised to the Council at the earliest practical opportunity.

7.6 There is expected to be a staff presence on site 24 hours per day. At the commencement of the Agreement, the Provider will operate the agreed staffing structure in place to support a straightforward transition for Service Users.

7.7 The non-night time for individuals will relate to the requirements of the Care & Support Plans for individual Service Users. However:

- There should be staff members available at all times to be able to respond to service users care and emergencies outside of planned care
- The Provider is expected to provide flexible support during the peak hours in the morning and evening of the non-night time, which will mean additional staff members, if needed, should be available to meet needs
- There is and expectation that the Provider will support service users if required to report emergency repairs outside of normal working hours

7.8 Night care workers are expected to be supported by an on-call service from within the Provider's organisation that should give them access to advice, support and intervention from managers as appropriate.

7.9 It is anticipated the night time provision will be supported, as a contingency, Assistive Technology will be available to provides an unplanned mobile response service. if triggered through the use of assistive technology (Section 11 of this specification). It is expected that the assistive technology service will be available to Service Users and staff during the non-night time. It should be noted, however, that accessing this Service during the non-night time and/or night time will be a contingency and that any longer-term and regular requirement to support a Service User via assistive technology should lead to a review of the individual's care and support needs.

7.10 The service model is funded on the basis it reflects:

- Service Users requiring housing related support or benefit advice will link into Housing Management arrangements outside of this specification. For advice and support with benefits or any benefit maximisation requirements, contact should be made with the Adult Social Care Finance and Assessment Team.

- It will have the capacity to provide support to all 70 households in Reardon Court during the lifetime of the contract working in partnership with relevant ASC staff and NHS staff including Hospitals, the Care Home Assessment Team (CHAT), GPs, District Nurses, Physiotherapists and Occupational Therapist

7.11 The Provider will not be obliged to account for every portion of the total number of hours in the service Model required for every Service Users but will be accountable for the delivery of long-term outcomes for Service Users that are included within individual social services care plans.

7.12 It should be noted that following successful implementation of the new Agreement, the Council wishes to work with the Provider in investigating possibilities for greater flexibility and efficiencies in the staffing model

7.13 **Care & Support Plans and Service User Risk Assessments**

The Provider must have:

7.14 The requirement at the commencement date of this Agreement is to continue to meet the terms of Service Users' Care & Support plans and Service User risk assessments in their existing form, the Provider must have:

- Reviewed all Care & Support plans and Service User risk assessments in conjunction with all relevant parties, including Service Users themselves;

- Transferred these relevant Service Users onto the Provider's Care & Support plan format, containing an up-to-date view of Service Users' care and support needs and their desired outcomes in the context of the aims and outcomes framework in Section 5 of this specification, and which are agreed with Service Users. Where necessary for individual Service Users, this will be coordinated with other Providers including the housing provider;

- Agreed with Service Users, how the Provider can best support them to meet their needs & goals and manage & reduce risks, including the role of any other Providers for that Service User;

- Record and deliver Services detailed within Service Users' Care & Support Plans and risk assessments, which should be signed by Service Users or their representatives.

7.15 The Provider will work with Service Users in an enabling way to support independence and regain functions and/or skills. Coinciding with the intention of ECH to promote and prolong independence, the Provider must contribute to a culture that fosters an approach of risk awareness over risk aversion; encourages all Service Users to retain independence, and which appropriately balances risk, choice and control and safeguarding in their lives and their care and support.

7.16 Care & Support Plans and Service User Risk Assessments should have a minimum review frequency of 6 months but must also be reviewed after one of the following:

- A request by the Service User (who must be informed by the Provider they have this opportunity);
- An incident or a significant change in the Service User's personal circumstances, including a change to their health status or level of independence;
- A material change to the Service User's Council Support Plan, if relevant.

7.17 For the relevant Service Users discussed in Section 7.14, of this specification responsibility for developing, recording, storing, implementing (in a timely fashion) and reviewing Care & Support Plans and Service User Risk Assessments lies with the Provider, including where there is a need to coordinate the care and support across other Provider(s), including the housing provider.

7.18 Each relevant Service User in Groups 1, 2 & 3 must have a nominated key worker employed within the Provider who will be their primary point of contact from the Provider for day-to-day queries and on the longer-term delivery of their (potentially coordinated) Care & Support plans and Council Care Plans. The key worker is therefore expected to coordinate the care & support with all other relevant Parties.

7.19 The Provider is expected to reduced staffing cost by making use of specialist equipment and assistive technology for those Service Users in Groups 1,2, 3 & 4 to reduce the need for double handed care.

7.20 ***Joint working and Liaison***

7.21 As part of the delivery of an individual's Care & Support Plan and the findings of its Risk Assessment, the Provider is expected to take a pro-active role (as directed by Service Users) in liaising with key agencies to meet the needs and outcomes in such Plans as outlined in Annex 1 of this specification. These agencies include (but are not exclusive to), the housing provider, London Borough of Enfield (including social services), health & emergency services and other care & support providers, community services transport, benefits, financial and leisure. As part of an enabling approach, the Provider should encourage the Service User to be fully involved in this liaison.

7.22 An exception to the responsibilities for the Provider laid out in 7.2 of this specification will occur where Service Users have capacity and have expressed their desire to conduct this liaison directly, through a named representative such as a family member or appointed advocate,

7.23 As directed by Service Users, the Provider will be required to work with families and advocates to assist in the delivery of the Service User's Care & Support Plan.

8. Nominations & Admission to Reardon Court

8.1 Applications of new residents to Reardon Court will be made by the Extra Care Housing Panel chaired by the Sheltered Housing Services Manager.

Applicants must:

- Have Care Act 2014 assessed adult care needs of a minimum of 7 hours consistent with provisions of the principle of a "balanced community" at Reardon Court.
- Be aged 60 years or over (or aged 55+ if there is a diagnosis of dementia or the applicant has a learning difficulty or physical disability);
- Be a resident in the London Borough of Enfield or have a local connection with the area or a strong social need to live in the area. This would usually be part of the local authority housing department's eligibility criteria;
- Have a housing need and be eligible for Sheltered Housing in the Borough, including having a local connection with the area;
- Have a positive desire to remain independent within the community;
- Have assessed adult care needs consistent with provisions of the principle of a "balanced community" at Reardon Court.

8.5 The principle of a “balanced community” at Reardon Court will be adhered to as much as possible, although a degree of flexibility will be needed in considering new applications, including those individuals’ potential future care needs. Applications will be made with consideration to the promotion of a “balanced community” as follows

- 30% of the residents with low dependency care needs; i.e. those requiring less than 7 hours of care per week
- 30% with moderate dependency care needs; i.e. those requiring between 8 and 14 hours per week
- 40% with high dependency care needs) i.e. those requiring 14 and 30 hours per week.

It should be noted that should a Service User’s health within any of the above categories change, this should trigger a review of the care through the London Borough of Enfield’s Integrated Locality Team Service.

8.7 The final decision about nomination will be made by the Extra Care Housing Panel, taking account of the individual application and the principle of a “balanced community”. The Panel will make this decision in consultation with the relevant Provider. Part of this consultation will be if there is sufficient capacity to provide care to the applicant within the Model.

The Provider will accept the Council’s nomination unless:

- there are no available units
- the provider is unable to meet the health and/or social care needs of the prospective service user as agreed with adult social care

8.10 The care needs of each applicant will be assessed with the Service User and their representatives, relevant Council professionals and the housing provider, to determine the outcomes that might be needed in the context of the as detailed in the Aims and Outcomes Section in Section 5 of this specification.

9. Move-on, Temporary Absence and End-of-Life & Death

9.1 Move on

Every effort should be made to accommodate service user’s needs within Reardon Court. It is however recognised there are times when the care needs of a Service User are deemed to be sufficiently intensive to be no longer be most effectively met at Reardon Court.

9.2 The possibility of a Service User needing to move on should be part of the review of their Care & Support Plan and Risk Assessment, which will be undertaken by relevant parties with the Service User or their

representatives. If all parties, including the Service User or their representatives, agree the Service User's needs and outcomes can no longer be met, the Council will be responsible for identifying a suitable alternative provision

9.3 It is expected the Provider, together with all relevant parties, including the housing provider, should be able to continue to support the Service User's care until a suitable alternative provision for the Service User is found. The Provider, together with the above relevant parties, should actively support the transfer of the Service User to the alternative provision to ensure move-on is as smooth as possible during the period of transition, as directed by the Council.

9.4 Temporary Absences

Service Users who have been in hospital will be supported to settle back into Reardon Court. In the case the service user who have received inpatient care in a psychiatric setting this may include a period of home leave before formal discharge. This will involve liaising closely with hospital staff, the person's GP, and relevant community services. The Provider will, where appropriate, be involved in discharge planning arrangements.

9.5 If service user is admitted to hospital or prevented from receiving the service due to sickness or incapacity during the contract period, the Provider will report this to relevant officers in the Council.

9.6 The provider will contact the police on the occasions where a service user has failed to return from community visits and as soon as they become aware when the service user has cognitive impairment.

9.7 End-of-Life Care

9.8 Every effort should be made to accommodate care and support needs of all Service Users within this specification The Provider is expected to support the needs and wishes of those who need end-of-life care including to live their last few days of life at Reardon Court, as part of the policy direction to support people to die in their own homes rather than in hospital.

9.9 In situations relating to the end-of-life for a Service User, the Provider is expected:

- In preparing for end-of-life, to be part of the planning and/or delivery of any agreed Advanced Care Planning arrangements for the Service User, as relevant to the Provider's role for that Service User
- To manage end-of-life with the Service User and their representatives with empathy, sensitivity, dignity and respect at all times;

- To work effectively with other specialist services (e.g. Palliative Care Nurses) for any Service User for whom it is providing care or assure any other Provider is doing so for any relevant Service User who has chosen to use their direct payment
- To liaise with the Council - including on the overall sustainability of the staffing model at times of sustained peak need;
- To liaise with and address the concerns of the Service Users and their family/advocates in conjunction with other relevant parties

10. Housing Management

10.1 The landlord (housing provider, London Borough of Enfield) retains an onsite housing management function. A key responsibility of the Provider will be to liaise with the landlord on Service Users' behalf as requested regarding:

10.1.1 Repairs
10.1.2 Rent and Service charges
10.1.3 Other issues related to the building or are otherwise the landlord's responsibility
10.1.4 When a death has occurred, or a service user has moved on to another accommodation
10.1.5 Business Continuity Plans

10.2 However, it is anticipated the Provider should work closely with the housing provider in the delivery of all Service User's Care & Support Plans. The housing provider should therefore be seen an integral party in delivery of support in the framework of the outcomes in Section 5 of this specification in particular in engendering an enabling and flexible approach to the delivery of these outcomes. To support this quarterly joint meeting with the housing provider should be scheduled

10.3 The Provider must maintain records of their assistance and advocacy with the landlord; including in Service Users' files where appropriate.

11 Use of Assistive Technology: Alarm & Alert Systems

11.1 Reardon Court will be equipped with an emergency call system; with maintenance provided for the system. There will be a pull chord in each flat and corridor. Service User calls will come through to the onsite care staff.

11.2 The Provider will embrace the use of assistive technology to assist in the efficiency of care provision. This would be a combination of assistive technology purchased and or fitted by the Council as well as the Provider own provision

12. Contract and Performance Management

12.1 The Provider will have a quality assurance system that is capable of monitoring and assessing provision of the service. The Provider will be required to collect data to demonstrate compliance to the required Outcomes and Key Performance Indicators and report their performance on a quarterly basis

12.2 The Council is responsible for ensuring the needs of service users and outcomes set out in this specification and any that are subsequently added under variation arrangements are met. To this end, the Council will work with stakeholders, including the Provider, to assure:

- Service Users, their representatives and the Council are satisfied with the quality, appropriateness, consistency, reliability and range of service they are receiving, including nursing care;

- Individual Service Users' outcomes as agreed and outlined in their person-centred Care & Support plans are met consistently on a day-to-day basis and as longer-term objectives.

- The Provider is delivering an appropriate, effective, efficient and sustainable service in terms of governance and staffing requirements,

12.3 Monitoring Approach

The Council has a robust monitoring process; which includes a quarterly self-assessment form to be completed by the provider. Review of these self-assessments will be part of quarterly meetings between the Provider and the Council of the core monitoring data and outcome measures in Section 5 of this specification.

12.4 The Council reserves the right to arrange a formal *ad hoc* Service Review and contract meeting with the Provider in addition to those scheduled in monitoring programme, if it believes it has sufficient grounds for concern about Provider performance in respect of this specification and contract.

13 Contract Hours

The available budget per year is unknow at this point

The hours to be delivered at this point is estimated to be up to 960 per week. The Provider is to notify the Council so existing residents can be reviewed and a joint discussions had around future demand that maybe required.

14 Contract Period

The contract will be for an initial term of 5 years, with the option to extend up to 2 further years from the commencement date.

15 Health and Safety

15.1 The Provider must ensure that the service has regularly checked and updated systems and procedures in place to comply with the relevant legislation governing the provision of extra care housing, e.g. health and safety, whistleblowing, staff training / induction / supervision / appraisal.

15.2 The provider shall ensure all staff have the appropriate Personal Protective Equipment (PPE) to undertake their work within a safe environment and effectively manage any potential hazards, infections and pest control

16.0 Delivering social value, sustainability and ethical practice

16.1 The Provider shall be required to use the contract as an opportunity to implement the Council's Sustainable and Ethical Procurement Policy covering all the scopes consisted within the policy as appropriate.

16.2 This shall include but not limited to employing systems and processes to manage the Provider's impacts on society and the environment where they will be required to provide data to demonstrate their social economic and environmental improvements throughout the duration of the contract.

17.0 Safeguarding

17.1 The Provider shall follow the Council's Safeguarding policy and procedures if abuse is identified or if the provider has grounds to believe that abuse may have taken place. The Provider will liaise with the Council immediately if there are safeguarding concerns.

17.2 The provider shall prepare its own internal guidelines to protect adults from abuse taking into account any multi-agency agreements.

17.3 The provider shall immediately bring to the attention of the Authorised Officer any allegation, complaint or suspicion of abuse by or regarding any Service User, whether the suspected abuser is employed by the Provider, by the Council or by any other person.

18.0 Risk of Accidents and Harm to Service Users and Staff

18.1 The Provider ensures that an assessment is undertaken of the potential risks to Service Users and staff associated with delivering the Service

and a risk management plan put in place. This should be updated annually or more frequently if necessary.

19.0 Staffing

19.1 The Provider will ensure that there is a staff development and training programme within the organisation, reviewed and updated annually, which ensures staff are able to fulfil the aims of the organisation and meet the changing needs of Service Users, their relatives and representatives.

19.2 The Provider will ensure that 100% of care workers are either trained to a minimum of NVQ level 2 or are working towards it or its successor Health and Social Care Diploma L2. Supervisors will be trained to a minimum of NVQ level 3, or successor Health and Social Care Diploma L3 and Managers to NVQ level 4 or successor L5 Diploma in Leadership. RM would have or be working towards a level 5 any staff that do not have a level 3 will be enrolled on the care certificate

19.3 Skillset of workforce to have a good understanding of physical disability, mental health needs, learning disability, dementia, frailty and end of life care.

19.4 The Provider will obtain an enhanced Disclosure and Barring Service (DBS) check for each member of staff, including staff who may be re-employed after a period of absence. The Council expects the Provider to renew these checks after a period of 3 years. The Provider will also make the appropriate checks against the Safeguarding Adults and Child Protection Registers. While awaiting the return of the DBS check, staff may start work once clearance from the appropriate registers has been received but must not work alone with service users until a clear DBS report has been received.

20 Working with the Voluntary and Community and Independent Sector

20.1 The Provider will liaise with local voluntary organisations as well as the independent sector to support service user's wellbeing and prevent social isolation. The provider will also be expected to work to promote intergenerational partnership arrangement with schools' colleges and sporting facilities

21.0 Record Keeping

21.1 Procedures will be in place to ensure that any significant safeguarding concerns identified by a staff member on a visit will be shared.

21.2 Personal information about service users will be held on the secure case management system.

21.3 Records and plans relating to service users are written in clear, concise, factual and non-judgemental language and include daily recording of services delivered, and recording of information relating to changes in need and risk

22.0 Policies and Procedures

22.1 The Provider will implement a clear set of policies and procedures to support practice and meet the requirements of legislation, which are dated, and monitored, as part of the quality assurance process. The policies and procedures are reviewed and amended every three years at a minimum, with core policies reviewed at earlier intervals and all polices having reviews triggered by change of law, by relevant incident or issue arising, or by a gap being identified through inspection or contract review.

22.2 The Provider will ensure that at least 2 members of the management team are registered Dignity Champions and that they take active steps to promote the Dignity in Care agenda across the Provider workforce. The Provider will ensure that in each operational year of the contract period at least 50% of the workforce are active, registered Dignity Champions.

22.3 The Provider is expected to enter into a Service Level Agreement with the Housing Management Provider to establish roles and responsibilities of the efficient management and operation of the scheme

23 Complaints, Compliments & Feedback

23.1 The Provider ensures that there is an easily understood, well publicised and accessible procedure to enable Service Users, their relatives or representative to make a complaint or compliment and for complaints to be investigated.

23.2 Every Service User should be made aware of their right of access to the Provider's Complaints and Compliments Procedures.

23.3 The Provider will maintain an up-to-date register of all complaints received, the action taken and the outcome of any investigation. These will be reported quarterly.

23.4 A complaints procedure will be given to every service user and representative by the extra care provider.

ANNEX 1
Care & Support Provision within the Model

Please note:
The successful provider is encouraged as part of the mobilisation & implementation period to consider this Annex alongside current job descriptions of onsite staff for a fuller understanding of how care services are currently delivered in practice.

Annex 1 is indicative only and not intended to be exhaustive or restrictive. It is likely that Service Users may present needs that warrant outcomes or activities not included.

1 Care & Support Plan

Each Service User in Groups 1, 2 & 3 will have an agreed needs and risk-based Care & Support Plan which is developed, assessed and reviewed with Service Users and others in the way described in the main body of this Specification. This process should clearly detail Service Users' aspirations, goals and expected outcomes within the principles set out in the outcomes framework in this Specification. The scope and detail of individual Plans should reflect the underpinning needs of individual Service Users for example, Service Users in Group 1 (who do not need routine personal care needs) expected to have less complex Plans than those individuals with "high" care needs in Group 3.

Items 2–5 below are those most likely to be part of the "care" offered to Group some of Group 1 and all of Group 2 and 3, Service Users.

2 Personal Care

To assist the Service User with:

1. Getting-up or going to bed.
2. Washing, bathing, hair care, denture and mouth care, hand and fingernail care, foot care (but not toe-nail cutting or any other aspect of foot care which requires a state registered chiropodist). Request for gender specific key worker staff should be taken into consideration
3. Catheter care (external).
4. Assisting Service User with dressing and undressing.
5. Toileting, including necessary cleaning and safe disposal of waste.
6. Food preparation, taking account specific cultural and dietary needs assisting, Service User with eating and drinking, including associated kitchen & domestic cleaning and hygiene.
7. Accompanying Service Users in attending day care, hospital appointments etc.

8. Taking medication prescribed to them in accordance with agreed protocols.
9. Responding to alarm calls and out of hours call monitoring.
10. Rehabilitation following hospital discharges.
11. Organising access to Services/liaises with relatives, health services etc.
12. Prompting/assisting Resident to undertake activities.
13. Supervising general health and well-being.
14. Operating and enabling Service Users to make use of Assisted Technology.

3 Cleaning and House-care

Assist the Service User with cleaning the home, which may include vacuuming, sweeping, washing-up, polishing, cleaning floors and windows, bathrooms, kitchens, toilets etc. and general tidying, using appropriate domestic equipment and appliances as available; including:

- Making beds and changing linen.
- Disposing of household and personal rubbish.
- Cleaning areas used or fouled by pets.
- Assisting with the consequences of household emergencies including liaison with local

4 Social activities will be provided on a daily basis