**SERVICE SPECIFICATION FOR THE PROVISION OF SUPPORTED LIVING SERVICES FOR LEARNING DISABILITIES AND COMPLEX BEHAVIOURS**

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1. **The Vision and Strategy for Adult Social Care**

1.1 The provision of Supported Living for people with learning disabilities and complex needs in Oldham supports the vision for adult social care and the strategy for delivering care. Oldham’s strategy for adult care and support is focused on delivering:

* an improved universal offer to all adult residents via engagement with communities and key partners
* early intervention and prevention
* more help to live independently
* a focus on reablement and recovery
* providing alternatives to a reliance on residential care
* safe, good quality long-term care
* protection and safeguarding of vulnerable adults
* a targeted integration of services with the NHS.

1.2 The overall aim is to ensure as many people as possible are enabled to stay healthy and actively involved in their communities for longer and delay or avoid the need for targeted services.

1.3 This vision is represented in the diagram below:

1.4 The vision for adult care services in Oldham has been developed to align with Oldham’s ambition to developing a co-operative future; one where citizens, partners and staff work together to improve the borough and create a confident and ambitious place. Put simply, becoming a co-operative borough is about everybody doing their bit and everybody benefitting.

1.5 Key partners in developing and delivering the future model of adult care in Oldham include:

* Citizens
* Oldham Clinical Commissioning Group
* Housing Providers
* Health and Care Providers
* Carers
* Voluntary sector
* Volunteers.

1.6 **Vision for People with Learning Disabilities living in Oldham**

Oldham’s Draft Joint Commissioning Learning Disability Strategy aims to transform the design and delivery of services in Oldham so that people with learning disabilities:

* are supported to be fully included in our community
* are treated with dignity and respect
* have choice and control in their lives that enhances independence and promotes health and positive wellbeing.

1.7 When people with learning disabilities get care and support, we will ensure they will:

* receive the right care and support at the right time, by people who have values at the heart of what they do
* receive care and support at or closer to home, where that is the right place for them
* be cared for or supported by the most appropriate person, whether that is a professional, family member, carer or friend.

1.8 We need to provide opportunities to explore how organisations can do things radically differently and enable people with learning disabilities can be more involved in helping themselves and their communities.

1.9 What we need to do:

* Reduce reliance on institutional care through intervening and preventing more intensive interventions
* Ensure the right balance of services across the whole spectrum of need to support people as they age – this will include developing excellence in care for people with dementia
* Promote the integration of services which is no longer just about joint working but is radically changing the way services and agencies operate, including pooling budgets and sharing resources and skills.
* Work together in a fundamentally different way to make the significant shift required to move the emphasis away from institutional and acute care and towards community and home-based care and support, independent living, and recovery-focused services.
* Challenge who is best placed to provide services, who pays for them and how.
* Provide a range of innovative services and support for carers to enable them to continue caring for as long as they want to and are able to do so.
* Understand inequality in access to and outcomes from service provision and plan to reduce such inequality.

1. **The Service**

2.1 The service provides for one or more individual supported living package(s) purchased on a cost per case contract basis from the Provider by the Commissioner. Details of current packages are included at Appendix #.

* 1. The Service must:
  + Meet the housing, care and support needs of eligible Service Users in Oldham.
  + Maximise Service Users’ potential for sustainable independent living. This will be evidenced by:
* facilitating a safe and effective transition from hospital/residential care etc.
* creating move on plans at the point of admission so care pathway planning is robust and transparent.
* enabling Service Users to achieve more independent living, (e.g. facilitating a move to less intensive/restrictive supported living arrangements).
* enabling Service Users to require lower packages of care/support within timescales set out in the Care and Support plan.
  + Maintain optimum levels of independence of Service Users by measuring existing skills and abilities, goal setting, regular reassessment (e.g. three monthly) of skills and abilities preventing deterioration of abilities.
  + Complete as a minimum an annual review.

2.3 Key aims of the Service are to make a positive difference to the lives of Service Users by maintaining a clear focus on promoting people’s quality of life and enhancing their experience of care and support, and by providing care and support that is both personalised, preventative and reables skills and abilities.

* 1. The Commissioner therefore requires services where personalisation and person-centred planning are robustly embedded, putting the Service User and where appropriate, their Carers, at the heart of all decision making. We would expect that the provider uses the MCA 2005 at all times for guidance.
  2. The Service must be staffed by appropriately qualified/trained staff at all times to ensure it is managed safely and that desired outcomes/ needs of the supported individuals are met.
  3. Services are expected to address a range of individual care and support needs associated with learning disability, physical disabilities, mental health issues, offending etc., but may include other needs.
  4. The provider will support and record tenant forums which will acknowledge and act on any outlined issues, reporting on progress of any issues identified.

Resources

2.8 The services will be delivered as attached as Appendix 2.

2.9 The contract value will be as set out in the **Pricing Schedule** below**.**

**The contract price for the service is fixed. The rates are as follows:**

|  |  |
| --- | --- |
| **PRICING SCHEDULE** | |
| **Details of Rates** | **Rate (£)** |
| **Non Complex** | **£11.80 per hour** |
| **Complex** | **£13.50 per hour** |
| **Sleep-In** | **£35.00 per night** |

Contract prices and hourly rates are currently under review in light of imminent national implementation of the national living rate and recent judgements of sleep-ins and travel time.

1. **Regulatory/Legal Framework**

3.1 The services provided under this Contract must be provided in accordance with the requirements of:

1. The Care Act 2014 (including any amendments, modifications or re-enactments).
2. The Care Standards Act 2000 (including any amendments, modifications or re-enactments).
3. The Health & Social Care Act 2008 (including any amendments, modifications or re-enactments).
4. The Care Quality Commission (Registration) Regulations 2009.
5. The Mental Capacity Act 2005.
6. Department of Health’s Guidance on Deprivation of Liberty Safeguards: Supreme Court Judgments.
7. Equality Act 2010.
8. Disability Discrimination Act 1995.
9. Human Rights Act 1998.
10. The standards and Service Specification defined in this Contract.
11. Service Users’ individual assessed needs and identified outcomes, and any subsequent assessment, support plan or review documentation.
12. Any future legislative changes or changes to regulations that determine the standard of care to be delivered
    1. Supported Living provides care and support and is independently regulated by the Care Quality Commission (CQC) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.
    2. The CQC *‘Essential Standards of Quality and Safety’* underpin the requirements and quality standards within this specification. The Commissioner requires the Provider to deliver services in accordance with the registration requirements of the CQC, complying with all relevant regulations and best practice guidelines as updated from time to time.
    3. It is a requirement that all providers will be registered with the Care Quality Commission (CQC), and its successor bodies, and will maintain relevant registration throughout the duration of this contract therefore the regulations required for registration (and their associated standards) and the monitoring of the achievement of those regulations and standards are not duplicated in this specification. It is the Providers responsibility to ensure that they comply with current guidance. See current guidance at:

[CQC Regulations for service providers and managers](http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf)



* 1. The Provider will make available to the Commissioner, upon receipt, copies of any Regulatory reports, reviews or audits including those that have not yet been released to the public.
  2. The Commissioner expects all Providers to meet each of the standards that the government says service users have a right to expect and which are inspected by the Care Quality Commission (CQC). Where the Provider does not meet these standards, they must inform the Commissioner within 5 working days of receipt of notification from CQC. Providers must provide the Commissioner with copies of any action plans submitted to CQC. Non-compliance with CQC standards may trigger the requirements for contract review and an agreed action plan for improvement.

1. **Outcomes and outputs required**
   1. The Provider will be required to work with the Council and other stakeholders to develop the services specified within this Agreement to reflect a personalised care system based upon individual choice and individual budgets. Services will be expected to change and develop in order to offer a wide range of opportunities in the community to support individual objectives and outcomes of Service Users.

4.2 The Provider will be required to work with the Council to agree and implement changes during the life of the Contract so that service provision meets the needs of the locality and delivers what Service Users require.

4.3 By providing supported living for people with learning disabilities the Provider will deliver a service that supports the following outcomes **(please find the Supported Living Outcomes Framework attached at Appendix 3)**:

* + - 1. **QUALITY OF LIFE**

**Person-centred outcome**

*I have as much social contact as I want with people I like, and I am in control of my care and support.*

Service users will:

* Have access to leisure/social/lifelong learning activities and may include access to volunteering or employment opportunities.
* Be supported and have the confidence to participate in the above
* Feel part of decision-making processes through person-centred planning by:
  + Shaping own support plan
  + Deciding own group activities
  + Influencing the running of the service and the role staff play
  + Being encouraged to run activities themselves.
    - 1. **PREVENTION AND INDEPENDENCE**

**Person-centred outcome**

*I am supported to maintain my independence for as long as possible.*

Service users will be:

* able to make informed choices including managing risk in personal life
* able to express preferences/choices that are listened to/respected/acted upon and considered
* enabled to meet their own objectives as far as possible
* supported through relevant advice and information to maximise their health
* able to access and benefit from engagement with the community
* enabled to address other personal objectives by encouraging Service Users to contact the relevant services e.g. advocacy, health and wellbeing etc., and obtain support to access and use ‘direct payments’
* supported to access a range of employment opportunities based on their individual needs and aspirations.
  + - 1. **POSITIVE EXPERIENCE OF CARE**

**Person-centred outcome**

*I understand how care and support works and what my entitlements are.*

Service users will:

* have their privacy and dignity valued and respected at all times
* be valued as individuals and feel confident to be who they are
* be supported to meet their own personal objectives appropriately
* not be excluded or maginalised from services for any discriminatory reason.
  + - 1. **SAFETY**

**Person-centred outcome**

*I feel safe and secure.*

Service users will:

* be empowered to feel safe
* be protected from abuse and neglect.
  + - 1. **HIGH QUALITY MANAGEMENT**

**Person-centred outcome**

*I am happy with the quality of my care and support and I know that the person giving me care and support will treat me with dignity and respect.*

Service users will:

* have confidence in the way services are managed and led
* experience high quality services through their support staff
* suitable accommodation.

4.4 The service should support the delivery of Oldham’s Corporate Plan, including the ambition ‘to deliver a co-operative future where everyone does their bit to create a confident and ambitious borough’. This may involve evidencing the service’s contribution to achieving key corporate objectives relating to: health and wellbeing, levels of offending, worklessness, homelessness and substance misuse issues.

4.5 The desired outcomes for each Service User shall be defined in their individual, personalised Care and Support Plans. The Provider must ensure that the service:

* + meets the eligible assessed/identified needs of Service Users and fulfils the objectives set out in their individual care and support plan
  + promotes and supports the attainment of sustained independent living within the community, for as long as possible, by adopting an ‘enabling’ rather than a ‘doing for’ approach to service delivery.

4.5 Where appropriate, and in collaboration with the Commissioner, to support service users to identify and secure access to more independent permanent housing, and where necessary, to support service users to address any barriers to access (such as rent arrears from previous tenancies, etc.).

* 1. To support service users to regain, maintain or develop the skills, confidence and local community links needed to build successful lives, and to access other relevant services and opportunities including health and leisure services, education, training, and access to work.
  2. The Commissioner intends care and support services to be provided in line with current government guidance and best practice. The promotion of self-assessment and personal budgets for Service Users is the intended outcome for most users of social care services, and the Provider must facilitate this where directed by the Commissioner.
  3. To develop accessible service standards that clearly set out what Service Users can expect from the Service in terms of service delivery.

1. **Eligibility for the Service**
   1. The Service will be provided to adults from the borough of Oldham aged 18 and above who meet the Commissioner’s requirement thresholds. On occasion there may be the need to facilitate transition planning for those service users moving from Children’s to Adults Services, and some individuals may fall below the age of 18.
   2. The Commissioner will commission services via The Vacancy Panel.
   3. The Provider will develop accessible promotional material outlining eligibility for the service to assist The Vacancy Panel, Care Managers, potential Service Users and families to determine if the service is an appropriate option.
   4. The Provider will notify The Vacancy Panel via email on a monthly basis of any vacancies; providing information, on the services available, the vacancy mix of other tenants and photos of property using a proforma the Council supplies.
   5. The Provider will (as appropriate to the Service) deliver care and support for the following Care Categories in accordance with the registration status of the Provider with the CQC*,* meeting relevant regulatory requirements and/or having appropriate accreditation being recognised by the Commissioner:
      * + Learning Disability
        + Mental Health
        + Physical Disability
        + Dementia Care
        + Older People
        + End of Life
2. **Access, review and exit arrangements**
   1. Access to the Supported Living Service will be via the Commissioners nominations, for the purpose of this agreement this will be The Vacancy Panel as outlined in 4.2 above.
   2. Where stipulated/required, the Provider will facilitate occasional emergency access to services.
   3. The Provider may refuse a referral if:

* the Service User does not meet the eligibility criteria for the service
  1. The Provider will be responsible for providing a written explanation to the Vacancy Panel for any referrals which are refused and will include information about the Provider’s appeals process.
  2. The Provider will work closely with the Vacancy Panel to ensure that there is equality of access for all relevant service user groups.
  3. When all parties agree to the placement being made, The Vacancy Panel, Care Manager and Provider roles in access, review and exit arrangements are detailed below:

The Vacancy Panel is responsible for:

* Nominating applicants to fill vacancies at the Service
* Providing all relevant information about applicants to the Provider. This will include a Support/Care Plan and relevant risk assessments. The support plan/care plan will include:
  + Key Contacts
  + GP Details
  + Medication Needs
  + Risk factors
  + Capacity in relation to finances and tenancy.

Care Managers are responsible for:

* Exploring the vacancy panel options and working with individuals, their families, advocates and the Provider to determine the appropriateness of applying for a potential tenancy;
* Completing assessments, including capacity assessments, Best Interest Assessments and any subsequent applications to the COP;
* Undertaking Supported Needs assessment, securing of an individual budget that is appropriate to meet needs/outcomes within Best Value, providing a Support Plan which outlines the needs to be supported, with a care grid that identifies where and when support is to be provided. Develop risk assessments in consultation with health care professionals for all areas related to identified need and future review assessments;
* Review the Care Plan usually within12 to16 weeks of service commencement;
* Work with the Provider to identify and obtain appropriate move on accommodation / services for service users.
* Develop an exit strategy where it has been identified that the service user is moving into a reablement service.

The Provider is responsible for:

* Alerting the Vacancy Panel about any forthcoming vacancies as soon as they become aware of this
* Providing details about the vacancy mix of other tenants and photos of property
* Developing the Personalised Care Delivery Plan with the Service User detailing how the outcomes set out in the Care Plan will be achieved. This will include relevant service level risk assessments and must be completed within 7 days of service commencement and copies provided to the Care Manager
* Ensuring that all staff have read and understood their roles and responsibilities in the delivery of Care Delivery Plans and risk assessments: signature sheets should be available to evidence this
* Ensuring the Care Delivery Plan is signed by Service Users and a copy provided in accessible format when required
* Calling a review of the Care Delivery Plan at least every 6 months and/or after any significant change
* Involving the Care Manager in all reviews
* Informing Care Managers as soon as a service user’s continued use of the service becomes inappropriate (e.g. service user does not need such high levels of support)
* Seeking advice from the Vacancy Panel (or other relevant panels) where there is a substantial / serious unresolved / newly identified risk for advice and guidance.

All parties:

* the Care Manager, Provider or Service User may call a review at any time.

1. **Service delivery arrangements**

Care and Support Planning

* 1. The Provider will have robust needs and risk assessment and care/support planning tools in place to ensure that:
* Service Users are safe
* When Service Users’ needs change, a review is triggered to identify appropriate next steps
* Service Users are working towards greater independence
* The Provider informs the Commissioner at the earliest opportunity if the needs are such that the Supported Living Service is not sufficient to meet individual Service Users’ needs.
  1. The Provider will have a SMART person-centred and outcome focussed Care Delivery Plan for Service Users to meet desired outcomes. The Outcomes must be measurable and the service users must have been consulted on and agreed the outcomes.
  2. The Care Delivery Plan will include all key areas affecting the Service User and be focused around reablement. It must state clear goals, with reviewable, measurable steps that outline how to achieve these goals within timescales set out in the Care and Support plan. Progress/delivery against goals must be measured, evidence recorded and shared with Service Users
  3. Service exit to more independent accommodation, where appropriate, will be considered as part of support planning and will be addressed from the commencement of support and an exit strategy agreed.
  4. All areas of health needs of Service Users should be recorded along with contact with health professionals. For people with Learning Disabilities this will be via a Health Action Plan (HAP), hospital traffic light documentation, an annual health check with their G.P.
  5. Where Service Users may present behaviour that challenges, including self-harm the Servicethe Provider shall:
* have policies and procedures in place covering challenging behaviour, ensure that staff are made aware of these policies as part of their induction, and are complied with by all staff
* ensure Behaviour Management Plans are in place and being followed.
* ensure that a risk assessment is undertaken, which forms part of the Care/Support Delivery Plan, to evaluate the potential for harm to Service Users, staff, and members of the public. This will be done in partnership with the Commissioner, health partners and other relevant agencies.
* ensure case-by-case training where required for certain Service Users (such as, but not exhaustive; infection control, first aid, physical intervention training, CITRIS)
* record, analyse and report when required information and data that relates to the frequency, intensity and complexity of challenging incidents, as this helps inform Commissioners around service and funding needs.

7.7 Care and Support will be provided in a creative and flexible manner that is responsive to the needs of individual Service Users, promotes positive risk taking and the use of interventions such as Assistive Technology where this can support independence and mitigate risks

7.8 The Commissioner requires the Provider to ensure that:

* delivery of care and support is integrated and joined up around the needs of Service Users, not the needs of services and their staff
* the service actively engages and works collaboratively with key stakeholders such as landlords, social care and health professionals and with specialist services, including mental health, substance misuse services, probation, etc.
* promotes joint working and in-reach support as required to ensure a person-centred approach to delivering quality services.

7.9 The Commissioner requires the Provider to work within, contribute to and help develop protocols with relevant partners.

7.10 The Commissioner requires the Provider to be proactive in service planning to meet changing legislative requirements and evolving client needs, and to help improve standards by encouraging an evidence-based approach.

Staffing

7.11 The Provider will ensure that the Service will be available every day of the year, 7 days per week operating from 00.00 to 24.00 hours; a waking or sleeping night service between the hours of 23.00 and 07.00, etc). This amounts to 112 core hours per week.

7.12 The Provider will have mechanisms in place to ensure that staffing levels are sufficient and that staff on duty are appropriately qualified/ trained to ensure safe service delivery and to meet Service Users’ needs at all times.

7.13 The Provider shall ensure there is continuity in relation to the Staff who provide the Service and that a staff rota is available on site at all times and is available in a format accessible to all service users e.g. pictorial.

7.14 The Provider will ensure that all staff are issued with a Code of Conduct which describes the standards of professional conduct and practice required of them.

Living environment

7.15 In addition to supporting the Service User to maintain and keep clean their home the Provider will also be responsible for the up keep of areas where their Staff have sole or majority access (i.e. Staff bedrooms and bathrooms). This will include, but not limited to: cleaning, washing kitchen utensils, removal of rubbish and household waste, ensuring items are stored and stowed correctly. Where appropriate and in consultation with service users care managers, service charges can be used to employ a periodic deep clean service.

7.16 The Provider will support Service Users in the reporting of maintenance issues to   
 their Landlord and to ensure satisfactory resolution of maintenance issues within adequate time frames.

7.17 Where the Provider has concerns regarding the landlords resolution of maintenance issue, such issues should be brought to the attention of the Vacancy Panel.

7.18 The Provider will ensure (in liaison with the landlord where required) that regular maintenance checks are carried out, to include but not limited to: gas safety checks, smoke alarm tests, ensuring maintenance of the home to a safe and good standard. The provider will ensure that fire evacuations plans are in place for the property and each individual. Where inspections are carried out by the landlord and action plans implemented the provider shall comply with the H&S requirement’s.

7.19 The Provider, where appropriate will assist service users with their Housing Benefit Claims, acknowledging correct professional bodies and/or notifying the court appointed deputy when applicable.

7.20 The Provider will facilitate and assist Service Users to hold tenant’s forums and to record these meetings. The provider may wish to consult with a wider audience for representation via families, carers and or advocates for those that have communication difficulties. Copies of these meetings may be requested by the commissioner.

Records

* 1. The following records, to include, but not limited to the below, will be kept and   
      maintained by the Provider for each property and Service User, and be available   
      to the Commissioner if requested:
* Appointment/Activity Diary
* Antecedent Behaviour Charts (ABCs)
* Daily Log
* Communication Book
* Medication Administration Record (MAR)
* Financial Transaction Records
* Time Sheets
* Receipts
* Review Forms
* Staff Rotas
* Health Action Plan
* Traffic Light Assessment
* Record of Accidents and Incidents
* Risk Assessments
* Care Plans
* Care Delivery Plans
* Skill based assessments
* Mental Capacity Assessments
* Any documents relevant to MCA and/or DoLS
* Health professional visits

7.22 The Service will be delivered in ways that are consistent with the principles and practice outlined in: Think Local Act Personal, Making it Real, Valuing People, and, as outlined below, from The White Paper “Our Health, Our Care, Our Say”:

* Services will promote and facilitate the health and emotional well-being of Service Users who will use the service;
  + Service Users, and their carers, have access to choice and control of high quality services, which are responsive to individual needs and preferences;
  + Services will promote independence, and support Service Users to live a fulfilled life making the most of their capacity and potential;
  + Service Users have equal access to services without hindrance from discrimination or prejudice; they feel safe and are safeguarded from harm;
  + Services will be sensitive to personal beliefs and preferences and will respect confidentiality, and will promote and preserve dignity at all times;
  + Service Users are encouraged to participate fully in their community and feel that their contribution is valued equally with other people;
  + Service Users are not disadvantaged financially and have access to economic opportunity and appropriate resources to achieve this.

1. **Specialist staff knowledge and experience**

8.1 The Provider must:

* comply with training requirements in accordance with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010
* identify mandatory training and the frequency of such training
* implement relevant policies, practices and training programmes to ensure the Service is able to meet the needs of Service Users
* ensure that the Providers Staff have the necessary knowledge, skills, training and experience of providing care and support to meet the needs of individuals in the service
* maintain a current and up to date training matrix for all staff.

8.3 The Provider upon request will provide evidence of meeting the above requirements to the Commissioner

8.4 The Provider will ensure that there are robust procedures in place that safeguard vulnerable adults in compliance with Oldham’s Multi Agency Safeguarding policy.

* 1. The Provider must operate a policy on confidential reporting and whistleblowing.
  2. The Provider will maintain an update date management and staffing structure chart.

**9 Performance and contract management**

9.1 Success will be measured against the Outcome and Outputs outline and performance standards and targets set out within this contract and specifically as set out in **Schedule 7**.

9.2 The Commissioner will regularly monitor the performance of this Contract and the Provider will be required to provide all reasonable assistance to the Officer(s) of the Commissioner during the monitoring process.

9.3 The Commissioner reserves the right to:

* + - carry out unannounced visits at the properties where the Service is delivered, and at the Provider’s offices
    - directly obtain the views of Service Users and Carers regarding the performance of the Provider
* directly obtain the views of Provider staff and to observe the Service provided at the point of delivery without giving notice
* publish any reports of quality and performance audits it undertakes.

9.4 The Provider shall maintain an internal quality assurance system to ensure that the Service is of the required standard and quality. The system shall include standard setting, monitoring, management and review processes. The Provider shall give the Commissioner clear evidence of its quality assurance system upon request.

* 1. The Provider must compile, maintain and submit to us, such information or data as we may reasonably require to evaluate and monitor the service.
  2. The Provider must retain and make available for inspection and validation any information used to complete performance and quality returns to the council.
  3. The Provider shall carry out periodic surveys of Service User levels of satisfaction. This will be done at least annually and results are to be shared with the Commissioner as part of the quality monitoring process.
  4. The provider must report to us any Notifiable Incidents in line with: Notifiable Incident Form. Urgent notifications should be made to the Commissioner at the same time as to CQC.
  5. Complaints: the Provider must deal with any complaints received in a prompt, courteous and efficient manner. The Provider shall keep a written record of all complaints received in connection with the service provided under this contract, and of the outcome and action taken in relation to such complaints. Such records should also note whether the complainant was satisfied with the outcome. The Provider will retain records for inspection by the purchaser at all reasonable times upon request. The Commissioner may request details of all complaints and compliments at quarterly intervals.
  6. Where the commissioner receives a complaint directly from a Service User or Stakeholder about the Provider or Service, the Commissioner will inform the Provider as soon as is practicable (subject to consent by the complainant). The Provider will respond to the complaint as though the Provider had received the complaint directly.
  7. If a Service Users’ complaint is not, or cannot be resolved by the Provider then the Provider must assist the Service User in accessing the commissioner’s complaints procedure. The Provider will assist the Commissioner with any investigations of complaints being undertaken under its complaints procedure.
  8. Anticipated methods of performance measurement (these may be altered by the Commissioner during the period of the contract) include, but are not limited to:
  + Performance/ quality audits
  + Contract monitoring and performance criteria as detailed in **Schedule 7**
  + Consultation with Service Users, Staff and Stakeholders
  + Contract management and appraisal meetings
  + Care Management Reviews
  + CQC reports.

Contract monitoring/appraisal

* 1. Contract Monitoring is the regular process undertaken by the Commissioner to ensure that the Provider complies with the requirements of the contract and is performing effectively. It is anticipated that:
* contract monitoring returns will be submitted quarterly
* contract appraisal meetings will take place annually.

9.14 The Provider will submit contract monitoring and management information, by the 2nd week of months 4,7,10 & 1 of the financial year. The dates for the monitoring forms to be returned can be found in the table below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Contract year** | **Quarter 1 return date** | **Quarter 2 return date** | **Quarter 3 return date** | **Quarter 4 return date** |
| Year 1:  2016 – 2017 | Not applicable due to the start date of the contract | 14 October 2016 | 13 January 2017 | 14 April 2017 |
| Year 2:  2017 – 2018 | 14 July 2017 | 13 October 2017 | 12 January 2018 | 13 April 2018 |
| Year 3:  2018 – 2019 | 13 July 2018 | 12 October 2018 | 11 January 2019 | 12 April 2019 |