Appendix B

Bracknell Forest Council

Community Based Support Service

- for Older People and People with Long Term Conditions Framework

Specification

Contents

1. Introduction

1.1. The Council's Adult Social Care, Health and Housing Department requires Community Based Support services to support Individuals aged 18 and over who have long term conditions, live within the Bracknell Forest and meet the eligibility threshold for care and support as set out in the Care and Support (Eligibility Criteria) Regulations 2014 relevant to the Care Act 2014 as amended from time to time.

1.2. The Provider will be required to provide a personalised and outcomes driven service that promotes wellbeing, reablement, choice and flexibility to enable Individuals to remain at home wherever possible and where appropriate.

1.3. The aims of the Service are to:

1.3.1. delay an increase in need for paid support

1.3.2. reduce dependency on paid support and

1.3.3. help Individuals to make more use of community facilities with a focus on the outcomes that have been achieved as a result of the support delivered, rather than simply on activity levels.

1.4. The Provider shall maintain connections and working relationships with partners to identify opportunities to support people to access community services and activities. Providers shall gain access to support for Individuals through partnering with the voluntary and community sector. This is a critical factor in nurturing the resources to identify, develop and activate creative support solutions.

1.5. Providers shall adopt a variety of approaches depending on the Individual's changing level of functioning to support personal choice, achieve optimal functioning and support their informal carers to maintain their caring role through reliable and effective care. The Provider shall be aware of the developments and benefits of promoting the use of Assistive Technology, online support tools and facilitating access to these where appropriate for the Individuals.

1.6. The Council recognises the value of Providers in providing care but also working more creatively and flexibly with Individuals to help them live independently. There shall be a shared focus on results and a joint commitment to reducing the need for formal paid care and support. This will be achieved through having fewer contracted providers, which will provide an opportunity for strategic relationships, and a gain share model (see section 12).

1.7. While this document provides guidance and includes specific requirements, the Council encourages innovation. This Specification gives scope and flexibility for the Provider to organise care and support delivery in a range of ways to achieve the required Outcomes. This will include innovative approaches to the use of community activities, organisations, services and partnerships.

2. Background

2.1. Demand for social care is increasing; information from the Bracknell Forest Joint Strategic Needs Assessment shows that around 6,000 people aged 65 and over living in the Borough are estimated to be unable to manage at least one or two domestic tasks on their own, with this figure estimated to increase to around 7,000 by 2020. The challenge is to meet these needs without making the Individual dependent on the need for paid services.

2.2. Creating a solution that maximises independence is a central part of the Council's strategy in service provision, with Individuals being enabled to do as much as possible for themselves as far as they are able, and helped to reconnect back with their community wherever possible to alleviate their social isolation.

2.3. Community Support Services are an integral part of the Council's service provision in helping older Individuals and Individuals with long term conditions to remain in their homes with dignity and independence. Without the provision of Community Support Services many Individuals would not be able to continue to live in their own homes. It delivers practical help with personal care and activities which can be provided in someone's own home and in the community and a clear alternative to residential care giving Individuals a choice.

2.4. The Council recognises Providers have the knowledge and operational experience to help deliver personalised Wellbeing Plans. This approach of commissioning services will give Providers autonomy to develop Wellbeing Plans with Individuals that meets the Individuals needs and supports the delivery of the Service to be more responsive and cost effective.

3. Service description

3.1. The Provider must establish what Outcomes are important to Individuals and to work collaboratively with them to devise cost effective Wellbeing Plans to achieve them.

3.2. The Council recognises the use of Community Based Support is critical in prevention and delaying increases in need and also to help Individuals to remain at home for as long as possible where appropriate. The use of the voluntary and community sector also plays a key role in supporting Individuals to maintain their independence and contact with their community.

3.3. Through this model, Individuals with an identified need for care and support shall:

- be enabled to live independent lives as defined by them, with informed choice and control through access to appropriate services and as much involvement in decisions about their care and support as possible
- meet their identified goals resulting in a positive impact on their lives (or well-being)

- be able to respond flexibly to their changing needs
- have their care needs met in partnership with their family carers
- experience an enhanced quality of life, through support which helps them do things they find difficult, whilst preserving and developing abilities and skills
- have opportunities to participate in community life, access resources, engage with social, vocational and recreational activities that match their interests, skills and abilities
- maintain relationships with friends, family and partners in the ways that they choose and develop friendships and social networks should they wish to
- feel safe, secure and empowered because their rights are safeguarded while they are supported to manage risks
- have a positive experience of care and support provided through relationships based on mutual respect and consideration, where care is designed around their needs and is consistent and coordinated
- have access to Assistive Technology, telecare and on-line support tools to maximise their independence. See appendix 3

3.4. Gain Share Model

3.5. There will be a gain share element to this Contract. This shall be funded from the budget not utilised as a result of commissioned support decreasing as a direct result of the Provider achieving these with the Individual. See separate word document Appendix G for details.

3.6. Delivery of Community Based Support model

3.7. The Provider shall ensure that the Service is offered in an individualised and personalised way which is cost effective and use all available resources including use of Telecare Assistive Technology and on-line support tools. The Provider shall support flexibility and choice by planning care within a flexible time frame rather than allocating set times for care and support to be delivered. Wellbeing Plans for Individuals with ongoing needs shall be outcome-focused, with the emphasis on the Provider to work with the Individual to utilise the Individual's own resources and community assets to the fullest extent.

3.8. The Provider shall develop personalised, cost effective Wellbeing Plans which are Individual centred through discussing hopes and goals with the Individual, to help to identify their own desired goals and potential challenges. The Provider shall support Individuals to shape the kind of support they need and to exercise choice and control whilst encouraging and supporting the Individual's ability to self care. The Provider shall enable the Individual to access community and voluntary organisations, social and leisure activities and other services in line with the Wellbeing Plan. Where there are associated costs e.g. to attend a day centre or club, or for Assistive Technology, the Provider shall be responsible for paying for these services from the Individual's personal budget.

3.9. The Provider shall work to sustain Individuals' support contacts with family carers, family, friends and their local communities, value differences, and ensure the social, cultural and religious needs of Individuals are acknowledged and addressed.

3.10. There shall be a skilled, knowledgeable and competent workforce fit for purpose in place to meet the requirements of Individuals receiving the Service.

3.11. The Provider shall have clear procedures, that are regularly reviewed and which meet the requirements of Mental Capacity Act (2005), to assess Individuals' capacity, to support Individuals with decision making and to obtain appropriate and valid consent for Individuals who do not have capacity, or whose capacity is variable.

3.12. The Provider shall have appropriate mechanisms for effective monitoring to measure the impact the Service has on Individuals. This shall include quantifiable data on how far Individuals have achieved each of the Service and Individual Outcomes and Individuals' experience and satisfaction level.

3.13. The Provider must ensure that the Individual is aware of local community resources, activities and events in order to support access and address isolation and increase confidence. The Wellbeing Plan shall be sent to the Council's brokerage team for placing on the Individual's records. A copy of the Wellbeing Plan must be provided to the Individual. Whilst Wellbeing Plans do not require approval by the Council, the Council reserves the right to review the Wellbeing Plans at its sole discretion.

3.14. The Provider shall be expected to provide support to meet the Outcomes both at contract level and at an Individual level as identified in the Individual's Wellbeing Plan. The Provider shall be a joint partner in the care review process and contribute to reviews by providing information and fully participating in the review. The reviews will be co-ordinated by the Practioner. Furthermore the Provider shall also facilitate a person centred review independent of the Council at a frequency in accordance with the Providers own procedures.

3.15. The expectation is that there shall be a reduction in the reliance of paid care and a reconnection with the community for support. Where a reduction is achieved the Provider shall submit an amended Wellbeing Plan to the Council for approval. If approved, the Individuals personal budget shall be reduced accordingly.

3.16. It is essential that the Provider and all staff are familiar with the local voluntary sector community to signpost the Individual to non paid community based opportunities.

3.17. See Appendix 4, Navigating the Model diagram.

4. Scope of Service

4.1. Current volumes of domiciliary care

4.2. In December 2016 Bracknell Forest Council provided approximately 4315 hours of support per week to 327 individuals with packages of support ranging from 1 hour per week up to 56 hours. On average 5 new packages were requested weekly for an average package of 13.25 hours weekly. This information is given for guidance purposes only.

4.3. Services are provided to adults with a range of support needs, which includes (but is not limited to), people with mental health needs, learning disabilities, dementia as well as people with a physical disability, long term conditions or people requiring extra support following reablement from hospital. Services include (but not limited to) support with personal care, domestic support, meal preparation, medication support and attending appointments and arranging social activities and opportunities in the community.

4.4. The number and geography of provider

4.5. Providers shall be divided into groups, group A shall provide an “indicative” 800-1000 hours per week and group B shall provide an “indicative” 300-500 hours per week. The actual hours allocated to each group will be determined by a number of factors, which will include: the number of Providers awarded a Contract, the total number of hours being purchased by the Council on the Commencement Date, and the number of people who may opt for a Direct Payment in order to make their own arrangements. There is no guarantee of any specific number of hours.

4.6. Providers shall schedule their work to ensure Workers do not have unreasonable travel time between visits.

4.7. Throughout the Term of the Contract, the hours provided by each Provider may vary, depending on a number of factors, which include: pick up of new Referrals, number of Individuals who may chose to move to a direct payment and purchase their own services, quality of service, recruitment.

4.8. Services shall be provided between 0700 and 2200, 7 days per week inclusive of bank holidays. Providers shall pick up new Referrals and restarts at weekends and on a Friday to prevent delayed discharges from hospital or avoidable admissions to hospital.

4.9. Service Outcomes

4.10. The Provider shall be proactive and work with the Council to maintain and develop the Service Outcomes in order to ensure that the Service is progressively developed to meet changing needs and demands.

4.11. An Outcome can be described as the impact a Service has on the Individual. The following principles for Community Based Support have been developed:-

- Quality Services that focus on an Outcome based approach with a strong emphasis on enabling Individuals to live as independently as possible.
- Services that focus on the promotion of wellbeing.
- Services that allow more choice and control for Individuals.

4.12. The following outcomes are expected:

- Management of decline in independence, health and Wellbeing.
- Avoidance of unnecessary hospital admissions.
- Promotion of independence and support for Individuals to take control of their lives to make the choices that they consider best for them and also addressing risk in the least restrictive manner available to them.
- Decrease social isolation.
- Increase range of social networks.
- Increase in the knowledge of local community facilities and the confidence to access them.
- Facilitation of timely discharges from hospital.

4.13. General Outcomes to be demonstrated for Individuals;

- Outcome 1 – Improving health and emotional well-being
- To stay healthy and recover quickly from illness

- Outcome 2 – Improved quality of life
- To have the best possible quality of life, including life with other family members supported in a caring role

- Outcome 3 – Making a positive contribution
- To participate as an active citizen, increasing independence where possible

- Outcome 4 – Increased choice and control
- To have maximum choice and control

- Outcome 5 - Freedom from discrimination or harassment
- To live safely, free from discrimination or harassment

- Outcome 6 – Economic well-being
- To achieve economic well being and to have access to work and / or benefits as appropriate

- Outcome 7 – Maintaining personal dignity and respect
- To keep personal dignity and be respected by others.

4.14. Individual Outcomes

4.15. From these Service Outcomes people shall identify their Individual Outcomes, specific to them as Individuals, and record them in their Wellbeing Plan. The Provider shall work with the Individual to help them to identify their strengths, coping mechanisms, self management skills and to develop goals for the future. Individuals will be encouraged to focus on their strengths and their own capacity along with those of their family, friends and family carers to resolve problems themselves, delivering their own solutions. The specific Outcomes to be achieved for the Individual shall be agreed between the Individual and Provider and recorded within the Wellbeing Plan. For Individuals, the level and range of benefits demonstrated will vary considerably.

4.16. As a direct result of the Service more Individuals shall:

- Be supported to optimise their independence and manage their long term conditions
- Connect to their communities and feel less lonely and socially isolated.

4.17. Meeting the overall objectives

4.18. The Provider shall adapt their Service to deliver flexible options and tailored support which is cost effective to promote the Wellbeing of Individuals and shall contribute to the prevention, reduction or delay of the development of Individuals' needs, providing a person-centred approach with joined-up care and support including the Outcomes Individuals aim to achieve through working collaboratively with other Services.

4.19. The Provider shall partner with the community and voluntary sector and build relationships to provide access to resources to support Individuals to address their identified needs, enhance their quality of life and reduce the need for paid care.

4.20. The benefits this has for the Individual are making choices which make a difference through being given access to options, feeling of being connected and valued as a member of their community.

4.21. Working Together

4.22. The importance of closer partnership working and collaboration between the Council and the Provider is crucial to providing holistic efficient effective Services which meet the needs of Individuals to enable Individuals to remain in their own home, and the aim to seek continuous improvement to get the most out of the resources available by finding better, more efficient ways of working which are cost effective.

4.23. The Provider is encouraged to share with the Council ideas on practices, innovation or initiatives which improve quality and outcomes for Individuals. The Council is committed to allowing the Service to evolve going forward to ensure it continues to meet the needs of the individuals and reduces the need for paid support.

4.24. The Council recognises that the management of community support involves particular skills in managing a dispersed workforce able to deliver Services to a range of Individuals with a variety of need. The Council will promote a partnership approach through joint induction or training initiatives where possible. However whilst training opportunities will be offered by the Council at a reduced or no cost, Providers are expected to routinely deliver training in their own organisation.

4.25. **Health Integration**

4.26. The Provider shall collaborate with local Clinical Commissioning Group and health providers in accessing and making best use of services and resources thus providing better Outcomes for Individuals in addressing their health needs.

4.27. The Provider shall remain abreast of local services and information to support positive outcomes for the Individuals.

4.28. **Transition and mobilisation of Service**

4.29. There will be a 3 month's lead in time from the awarding of the Contract to commencement in order to TUPE staff (if applicable), for recruitment, and training.

4.30. Providers will be free to work in any area of Bracknell, however, for the purposes of enabling a smooth transfer on the Commencement Date, it is the Councils intention to transfer services based on zones. The Council anticipates that the transfers will take place over a period of up to six weeks from the Commencement Date. See PDF appendix F for details of the zones. Please note that the information in appendix F is based on information as at October 2016. This information is given for guidance purposes only and may vary.

4.31. The zones shall be divided to ensure Individuals living in less urban areas within the borough are catered for.

4.32. The Provider shall move Individuals who transfer to their Service on the Commencement Date to the Community Support model in accordance with their transfer plan detailed in their Invitation To Tender.

4.33. **Allocation of Services**

4.34. New Referrals will be offered to all Providers on the Framework via an initial email subject to the following exclusions:

- Providers must meet the requirements of the Contract and specification
- In the event that the Provider is flagged in accordance with the Councils Care Governance Boards procedures, see details at attachment E Providers Guide to Care Governance in the terms and conditions.
- Providers have not placed an embargo or exclusion on their own service, for example, if they are experiencing staffing difficulties
- This list is not exhaustive and the Council's decision as to whether or not to exclude a Provider shall be final and conclusive.

4.35. In the event that more than one Provider is able to offer a Service the Individual's care manager will be informed. Where appropriate, the Individual will be given the opportunity to choose which Provider they would prefer. Where this is not appropriate e.g. the Individual lacks capacity, the care manager will make the decision.

4.36. The care manager's decision process will be as follows, listed in order of priority-

1) lowest price -the care manager will look at the Provider with the lowest price quoted
2) quality issues – the care manager will take into consideration any known quality or care governance issues
2) 'best fit' i.e. which Provider can more closely match the Individuals needs or where a Provider is already based within the area
3) If the above did not apply, the care manager would chose at random.

4.37. The care manager's decision shall be final and conclusive.

4.38. The Referral will contain anonymised information, which will indicate the area where the Individual lives and give an indication of the needs of the Individual based loosely upon time and task. This information will give the Provider an opportunity to determine whether or not they can accommodate the Individual's needs. The Provider shall then work with the Individual to create a Wellbeing Plan and develop Outcomes to work towards moving forward. The Wellbeing Plan shall be completed within 2 weeks of the Service commencement unless there are exceptional circumstances.

4.39. Use of Electronic Time Management Systems (ETMS)

4.40. The Provider shall be required to operate an ETMS that records and collects the times that Workers start and finish their support tasks with Individuals. The Provider may use an ETMS of their choice. The Council shall request sight of the ETMS recordings at their discretion.

4.41. The Provider shall:-

- Ensure that its Workers are fully trained and competent in the operation of the system
- Maintain its ETMS systems

- Have in place a contingency plan that can be implemented to ensure the accurate recording and submission to the Council of actual times of Service delivery should there be a systems failure with the ETMS
- Notify the Council of any irregularity or misuse of the system by its staff.

5. Policy Context

5.1. The Service direction is supported by a number of national directives, including the Care Act 2014, giving a framework of social care legislation which sets out the principle that the core purpose of adult care and support is to help Individuals to achieve their Outcomes (what matters to them) and to improve their well being. It seeks to rebalance the focus of care and support towards promoting wellbeing and preventing or delaying needs, putting Individuals at the heart of the system. In addition the Services should:

- Promote integration of care and support with health services
- Provide information and advice
- Promote diversity and quality in provision of Services.

5.2. Reablement

5.3. The Council has an intermediate care service which is provided for up to a maximum of 6 weeks. It is a short term rehabilitation service which is in essence a preventative service. Where an Individual has been supported by the intermediate care service the Provider will be expected to continue the reablement approach within each Wellbeing Plan to help Individuals to proactively self-manage their needs, through rebuilding their skills and self-confidence, which they may have lost, and to restore their physical and mental capabilities to the optimum level possible. A key aspect to this process will be the facilitation of local community resources to develop and maintain connections to the community and natural support networks.

5.4. Regulatory Requirement

5.5. The Provider shall be registered with the Care Quality Commission (CQC), or statutory successor organisation, and shall provide as a minimum, care and support in accordance with the national minimum care standards. Registration must be maintained throughout the term of the Contract.

5.6. The Provider and all sub contracted organisations must comply with the fundamental standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

5.7. Information Governance and Security

5.8. The Provider shall ensure and demonstrate

- High standards of governance
- High standards of financial management and independent financial audit
- That there is a suitably skilled, safe and responsive workforce
- Full compliance with CQC regulations.

5.9. The Provider shall ensure that staff are appropriately trained and skilled with the necessary functional skills and competencies to meet the needs of Individual's including medical needs where appropriate, in line with the Individual's Wellbeing Plan and subject to appropriate training and have access to training in safeguarding protocols.

5.10. All staff shall have been subject to Enhanced Disclosure and Barring Service checks and receive regular supervision and an annual performance review which shall include identifying training needs specific to the Worker.

5.11. The Provider must have in place adequate disciplinary procedures to protect adults against any form of improper conduct by staff. Such conduct may include without limitation: neglect, discriminatory abuse, emotional abuse, physical abuse financial abuse and sexual abuse.

5.12. The Provider must immediately report any such incident to the Council's Adult Safeguarding team who shall consider the necessity of taking action in accordance with the Statutory guidance (Chapter 14) relating to the Care Act (2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

6. Quality Assurance

6.1. Access and Diversity

6.2. The Provider shall provide Services in an anti-discriminatory manner and practice, with due regard to a persons race age culture religion preferred language gender sexual orientation and disability.

6.3. The Service shall take account of needs arising from the following factors:

- Language & communication
- Religion & culture
- Learning ability
- Cognitive functioning
- Physical health & sensory functioning
- Age related issues
- Gender
- Sexual orientation.

7. Performance Management and Data Collection

7.1. The Provider shall comply with the monitoring arrangements set out in the Monitoring Schedule including, but not limited to, providing such data and information as the Provider may be required to produce under the Contract. The Provider shall submit 4 weekly and quarterly reports in terms of outputs, outcomes and quality and to ensure there is management oversight of the policy and operational issues. The reports shall include graphical and tabular analysis where requested by the Council. See appendix 1.

7.2. Monitoring meetings shall take place as a minimum quarterly in the first year and thereafter at a frequency to be reviewed.

7.3. The Contract will be monitored in the spirit of partnership to ensure best practice is at the heart of Service delivery and is central to continuous improvement of Services to Individuals.

7.4. Monitoring Aims

7.5. The aims of Contract monitoring are:

- to ensure that Individuals receive a consistent and reliable standard of Service
- to support Providers in the development of Service provision
- to ensure there is a quality assured, affordable market for Services in Bracknell Forest
- to ensure a joined up approach with a clear pathway is implemented between paid support and unpaid community services promoting opportunities to reduce the risk of loneliness.

7.6. Service Level Monitoring

7.7. Service Level Monitoring will take place quarterly and shall be used to measure the Service under Contract and shall include:

- Delivery of Outcomes for Individuals as evidenced at reviews
- Rates of recruitment and retention of staff
- Management and staff training qualifications
- CQC reports
- Collaborative working with community services and organisations
- Evidence of promotion of, and involvement with, the local community activities
- Examples of innovative and solution focused approaches to meeting Individuals Outcomes
- Quality assurance reports and Service improvements
- Contract management – accuracy, responsiveness, record keeping
- Responsiveness and capacity to deliver
- Number of Workers delivering support (Consistency and Continuity)
- Service outcome measures (Outcomes being achieved)

7.8. Other forms of Service Level Monitoring may be agreed between the Provider and Council and reviewed after the first quarter of the Service commencing.

7.9. Methods of Monitoring

7.10. The Contract shall be monitored on the basis of real Outcomes for those who receive care, with wellbeing as well as health and care outcomes at the core of Contract management.

7.11. Methods of monitoring shall include

- Monitoring of Individuals reviews
- Office visits and spot checks, including reasonable access to staff and Individuals files and ETMS in order to ensure compliance with the Contract
- CQC reports
- Implementation of action plans
- Contract reviews
- Quarterly monitoring return completed by the Provider, see appendix 1, monitoring template and 4 weekly monitoring reports.
- Feedback from Individuals, other Local Authorities, Family Carers and local intelligence.

7.12. Roles and Responsibilities

7.13. Council's Responsibilities

7.14. The Council shall ensure a clear monitoring mechanism with regards to Service delivery.

7.15. The Council's social care or health workers shall monitor and review with regard to Individual Outcomes.

7.16. Provider Responsibilities

7.17. The Provider is responsible for the day to day delivery of Services and shall continually review the Service delivery and alert the Council to significant changes in need or Service provision.

7.18. In the event that the Provider is flagged under the Councils Care Governance Procedures which would include a CQC inspection report below a 'Good' rating the Provider shall develop an action plan to address any issues identified which will be shared with the Council. The Provider shall also follow procedures as detailed in the Providers Guide to Care Governance and the Berkshire Multi-Agency Policy & Procedures at http://www.sabberkshirewest.co.uk/practitioners/berkshire-safeguarding-adults-policy-and-procedures/

8. Appendix 1

8.1. Monitoring

8.2. See below the monitoring requirements for the Contract.

8.3. The Provider shall provide the following:

Frequency	Data required
4 weekly – to be submitted within 14 days of the end of each 4 week period in accordance with the 4 weekly payment schedule at attachment C	• Analysis of activity per individual • Hours used per individual • Number of visits • Breakdown of spend for the period, spend to date balance of personal budget • Details of any sub contractors used during the 4 week period for support to an Individual, including the name of the Individual/s, start and end dates, as applicable • Details of any subcontractors used during the 4 week period to cover staff absences or vacancies, including dates and reason
Quarterly (quarterly reports shall be submitted electronically a week before the review meeting)	• Feedback from stakeholders, including complaints, compliments and actions taken to resolve issues • Good practice and areas requiring attention • Monitoring form appendix 1 completed

8.4. The Provider shall complete the following on a quarterly basis:

Demographics:
Individuals aged 18 and over who have long term conditions, living within the Bracknell Forest.

Desired outcomes:

- Quality services that focus on an outcome based approach with a strong emphasis on enabling Individuals to live as independently as possible.
- Services that focus on the promotion of well-being.
- Choice and control for Individuals.
- Promotion of independence and provision of re-enablement.
- Support for Individuals to regain or attain independence where possible.

Please circle which period monitoring information relates to:

Q1	Q2	Q3	Q4

Provider:

Service type:
The Service is for the provision of Community Based Support Services.

Service-specific outcomes:

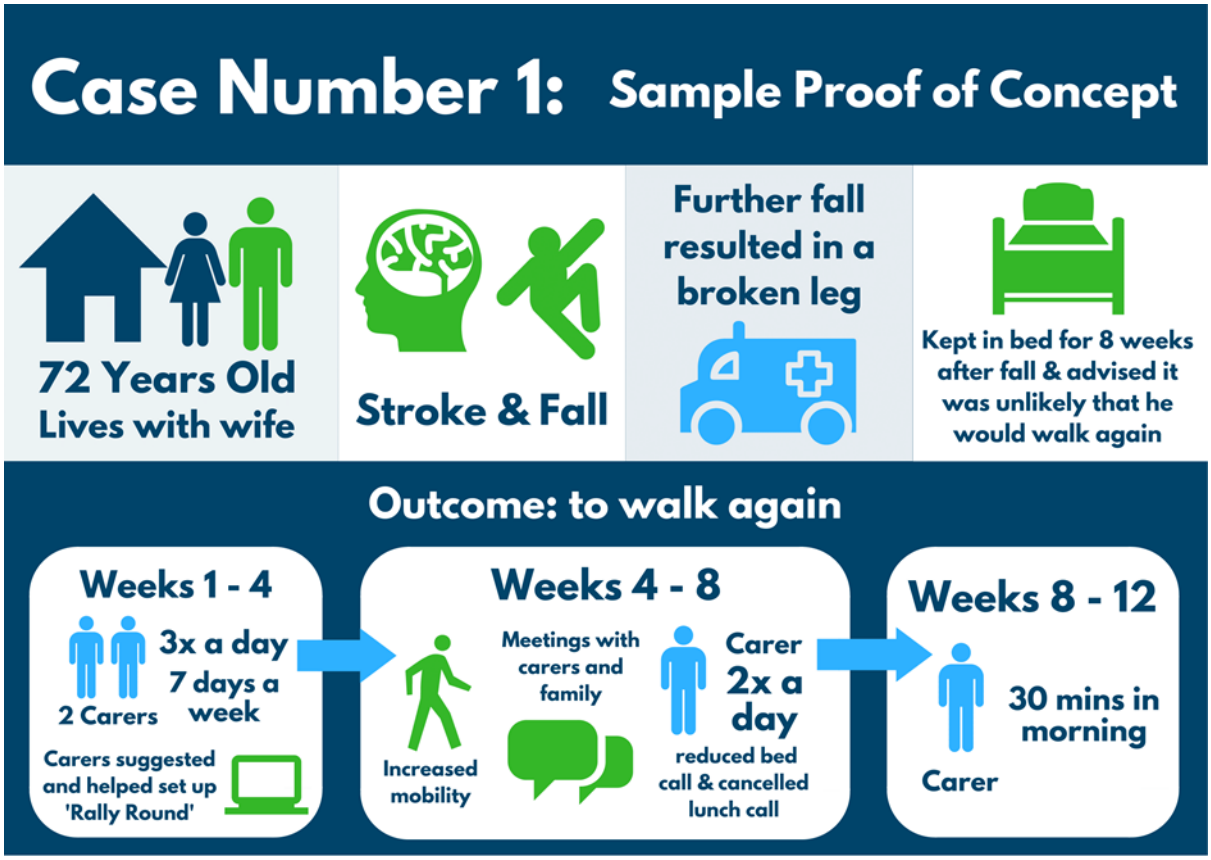
Managing decline in independence, health and Well-being.	
Avoidance of unnecessary hospital admissions.	
Individuals taking control of their lives to make the choices that they consider best for them	
Promotion of independence and support	
Decrease social isolation for the Individuals supported	
Increase range of social networks for the Individuals supported	
Increase in the knowledge of local community facilities and the confidence to access them	

Additional monitoring information:
A list of community services the Provider has been working in partnership with and case studies of any partnership working and examples of successful pathways to unpaid community support:
An overview of how the Service has met the Outcomes of Individuals and examples where Assistive Technology has been used to increase independence and decrease the need for paid support
An overview of feedback from the quarter, and the actions taken as a result of this feedback
Overview of any issues with Service delivery, irregularity or misuse of the ETMS, issues with ETMS or critical issues impacting on Service delivery
What have the challenges been this quarter and the actions taken to address these going forward
Overview of subcontracting for the quarter

9. Appendix 2

9.1. Examples of the Proof of Concept

9.2. Case Number 1: Sample Proof of Concept



9.3. Situation:

9.4. Mr Z is age 72. He is married and lives with his wife. Mr Z had a stroke and a fall, which resulted in poor grip in his hands and left side weakness. The couple managed between them very well, with Mrs Z being her husband's Carer. However, Mr Z was later admitted to hospital following a further fall which resulted in a broken leg. As a result, Mr Z was kept in bed for a number of weeks. He was transferring using a rotunda and the assistance of two Workers. He was advised that it was unlikely that he would walk again. The Provider was commissioned by the Council to supply a package of care. Mr Z set the Outcome that he would like to achieve. This was to be supported to get up and walk again; the Provider supported him to achieve this over time. Once the Council had done their assessment they referred to the Occupational Therapist.

9.5. Process/Timelines:

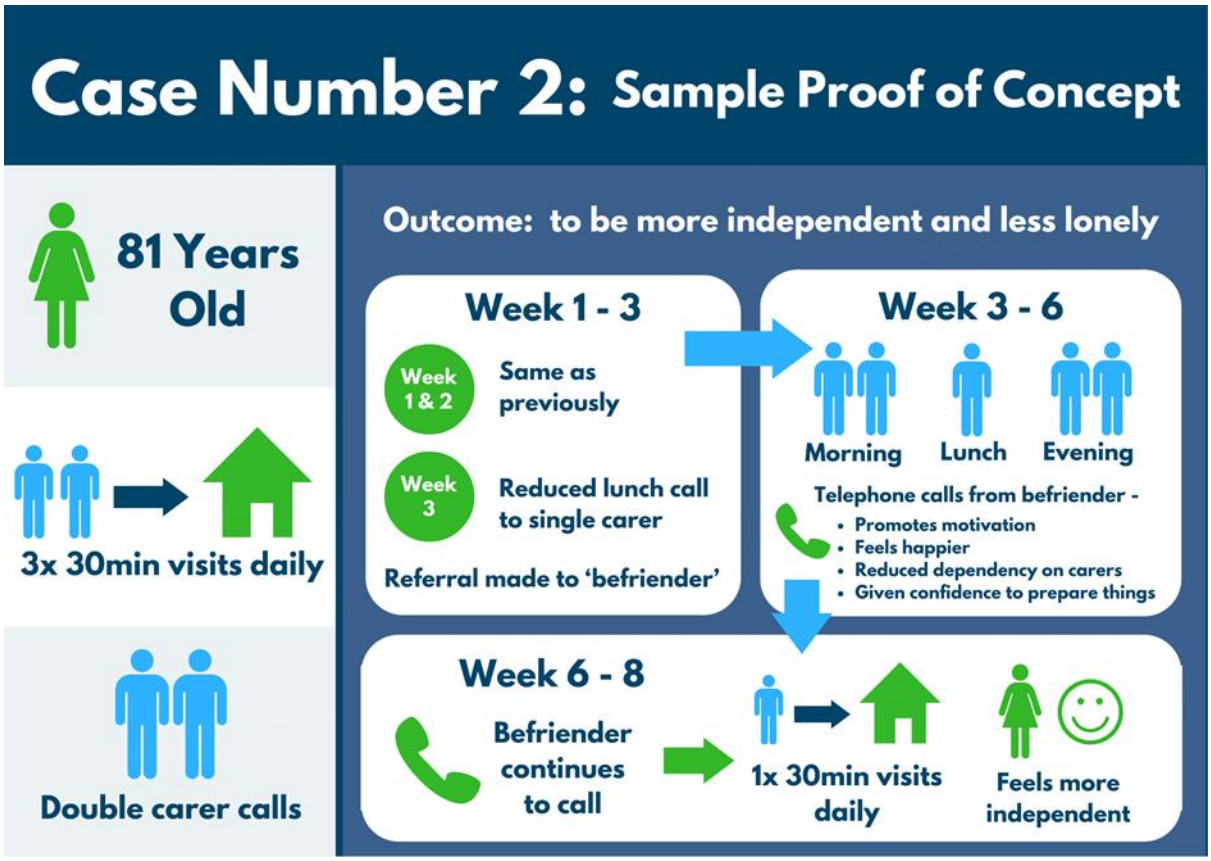
9.6. Care commenced. Mr Z was determined to walk again, so worked with the Workers to take steps and slow exercise. Mr Z did as much of his personal care as he could with encouragement from the Workers. The Workers were briefed on the specific Outcomes that Mr Z and family were hoping to achieve.

9.7. Weeks 1 – 4:
Mr Z started with two Workers, 3 times a day, 7 days per week. After 2 weeks he had reduced his bed call to 30 minutes and cancelled the lunch call altogether. Workers suggested Mr Z and his wife signed up to 'Rally Round' and helped set this up.

9.8. Weeks 4 – 8:
In the following weeks, Mr Z gradually improved his mobility. Regular meetings were held with the Workers and family members to discuss and agree actions.

9.9. Weeks 8 – 12:
After 6 weeks the Provider reduced the package to 1 Worker, 2 times per day. A further 2 weeks in and the package was reduced further to 1 worker a day for just 30 minutes in the morning, to assist with a strip wash. The family are delighted that Mr Z is now transferring using a frame. It means they can go back to their old routines and Mr Z's wife is able to support him during the day. Mr Z is ecstatic that he is now transferring and has nothing but praise for all the Workers that helped with his rehab. Mr Z is thankful that the Provider took the time to work with him and his family to regain his confidence and independence. From week 14 onward, Mr Z calls are reduced to just 2 X 30 minute calls per week.

9.10. **Case Number 2: Sample Proof of Concept**



9.11. **Situation:**

9.12. Mrs T is age 81. Following assessment, it was felt by Council staff that Mrs T might benefit from a revised approach to her care. Mrs T was in receipt of 3X 30 minute visits per day, double-Worker calls, 7 days a week.

9.13. **Process/Timelines:**

9.14. Following initial assessment, Council ascertained that Mrs T had relatively good transfer ability and that she had the potential, and willingness, to work with Workers to achieve greater independence.

9.15. **Weeks 1-3**

9.16. In the first 2 weeks, the Provider maintained the same call patterns and resource, but worked up to achieving more independent movement and transfers. In week 3, the Provider reduced the lunch call to single Worker. This worked well. It was positioned as a "trial" to avoid any stress. A referral was made to a befriender service by the Provider.

9.17. **Weeks 3 – 6**

9.18. The Provider maintained the double-Worker AM/Eve calls, and single Worker lunch. The befriender initiated telephone calls to Mrs T. This had the effect of engaging Mrs T, motivating her to become more independent and reducing the length of visits/number of tasks required. It directly enabled a reduction in dependency. Mrs T enjoyed and was motivated by the process. She found the telephone calls fun and looked forward to them.

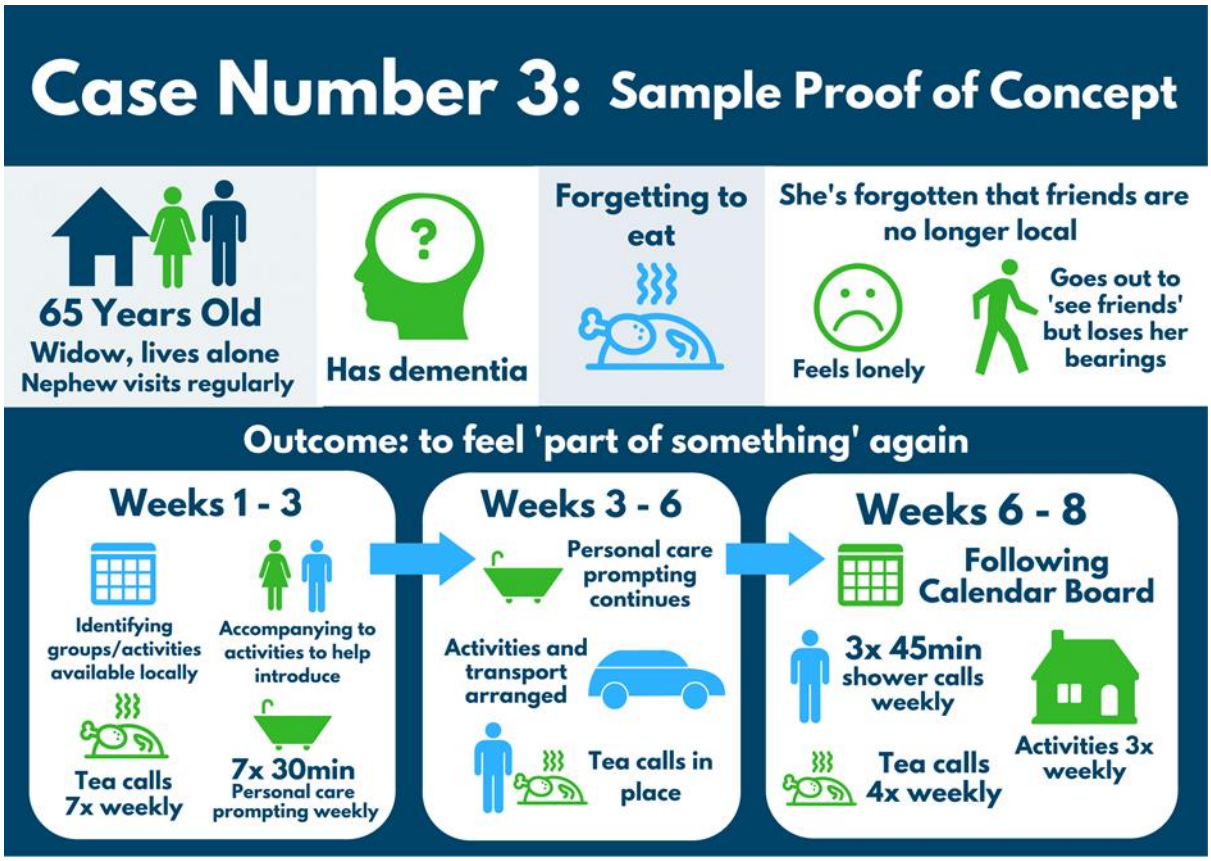
9.19. **Weeks 6 – 8**

9.20. Mrs T's independency levels increased. In week 6, the Provider was able to reduce all calls to single Worker 3 X daily for 30 minutes. This was done with the caveat that they could always revert back to double-ups if needed.

9.21. Mrs T was keen to keep calls as single Worker. It enables better, more personal, engagement with care staff and is less intrusive.

9.22. Mrs T now requires less support and feels far more independent. The outlook on outcomes is very encouraging, both health-wise and financially.

9.23. **Case Number 3: Sample Proof of Concept**



9.24. **Situation:**

9.25. Mrs K is 65. She is a widow and lives alone. Mrs K's husband died a year ago. Mrs K has no children but has one nephew that lives locally. He visits regularly but works full time, is married and has young children.

9.26. Mrs K has dementia. Her nephew has noticed that over the last few months she has gone out on many occasions and forgotten where she was going. He is now concerned that she may not be managing at home as well as he thought. He has noticed that there is little washing in the laundry basket and food is not being eaten. Mrs K feels lonely and says she goes out with the intention 'of seeing friends' but her dementia causes her to lose her bearings and she has forgotten that many of friends no longer live nearby. A package of care has been put in place. The nephew and Mrs K stressed that she wanted to feel 'part of something' again. The Provider was briefed on the Outcomes that Mrs K and her nephew wanted to achieve.

9.27. **Process/Timelines:**

9.28. Care commenced and Mrs K was found to be able to manage her personal care on a daily basis with encouragement from the Workers. The Workers alongside Mrs K, identified local groups and activities that would provide social stimulation for the Mrs K. A calendar board was created and put in the kitchen.

9.29. **Weeks 1-3:**

9.30. Worker encouraged personal care each morning. The Worker spent time each day with Mrs K identifying what groups/activities were locally available. A list was made of Mrs K's preferences. A Worker went in at teatime everyday to check that Mrs K had eaten. A Worker then accompanied Mrs K to activities to introduce her to them.

9.31. **Weeks 3-6:**

9.32. In following weeks, personal care prompting was still going ahead. The activities were joined and transport etc. was arranged for Mrs K to get to them. Tea calls were in place.

9.33. **Weeks 6-8:**

9.34. Personal care was reduced to 3x 45min shower calls weekly as it was assessed by the Provider that Mrs K was managing this well.

9.35. Mrs K was following her calendar board and knew what activities were on what day. The Provider had arranged for day centre on 2 days (transport included), a weekly tea dance at the community centre and a volunteer was arranged to pick up and take Mrs K home. Mrs K would get herself tea when she returned from these activities so the tea visit was cancelled on these days.

9.36. Mrs K seems happier that she has things to look forward to in the week. Having regular activities and her calendar board has allowed her to get into a routine and regain some independent.

9.37. From week 14 the tea calls at weekends were cancelled as Mrs K's nephew visited.

10. Appendix 3

10.1. Assistive Technologies

10.2. Telecare

10.3. A range of telecare technology is available in Bracknell Forest, some of which are detailed below for information. Unless specified otherwise, charges would apply to the Individual

10.4. Rally Round is a free online support tool contracted for by the Council which enables the co-ordination of informal help and support for an Individual from family and friends who are willing and able to participate, without the onus on the Individual to ask for that support, which many Individuals may find difficult. https://rallyroundme.com/bracknellandascot/

10.5. Pocket Pal is a wearable personal device with mobile technology. It can be used to communicate with vulnerable family members either in the home or when they are out and about. http://www.bracknell-forest.gov.uk/pocketpal

10.6. Lifeline is a personal alarm system that provides a link to a dedicated control centre, 24 hours a day, 7 days a week, 365 days a year. http://www.bracknell-forest.gov.uk/forestcarelifelinealarms

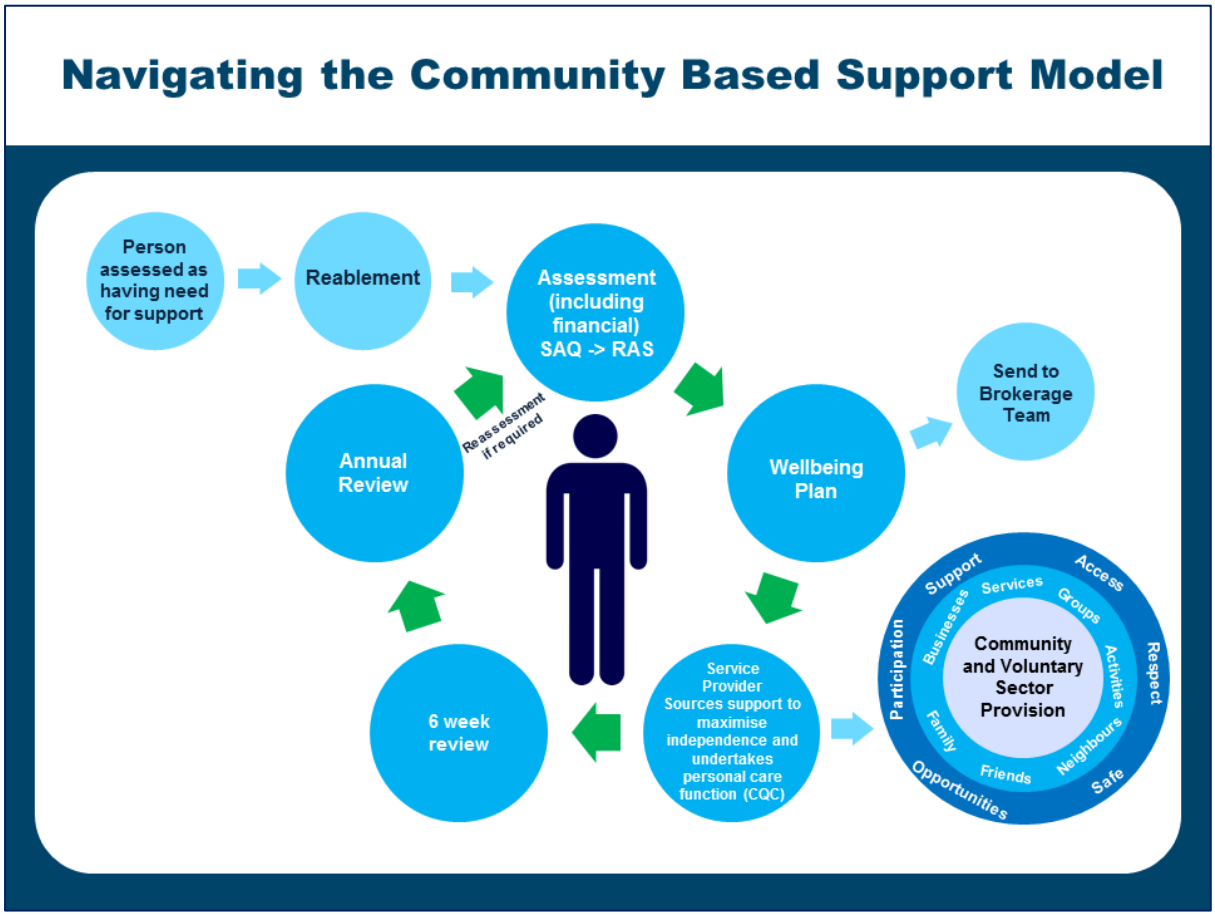
10.7. Telecare sensors, connected to the Lifeline alarm, comprise of a range of sensors can be installed and connected to the lifeline alarm. http://www.bracknell-forest.gov.uk/sensors

10.8. By accessing technology in this way the expectation is for Providers to identify and activate solutions for Individuals with a need resulting in reduction in the reliance on paid support and or for paid Services to be reduced, and for independence to be increased. There is an expectation for Providers to identify and activate solutions for Individuals, by accessing available technology, resulting in the reduction in the reliance on paid support or for paid Services to be reduced, and for independence to be increased.

10.9. Providers shall remain abreast of advances in technologies in the market and ensure staff are trained and able to promote the use of Assistive Technology with the Individuals they support.

11. Appendix 4

11.1. Navigating the model



12. Appendix 5

12.1. Community Based Support Model diagram