SCHEDULE 2 - THE SERVICES

Schedule 2 Part 1: Service Specification

SERVICE SPECIFICATION

Service	**“Warm Home, Better Health" Home Visiting Scheme**
Commissioner Lead	**Lakhwinder Gill**
Provider Lead	
Period	01/10/2019-31/05/2020

1. Purpose

1.1 Aims

The procurement aims to provide 300 home visits to vulnerable residents over 65, those with a long term health condition and households on a low income with children under 5 and make their homes warmer and alleviate fuel poverty. The procurement will pilot an enhanced service for 40 people at risk of falls.The project will also make referrals to preventative health improvement services

The main components of the project are:

1. 300 home visits to vulnerable people over 65, people with long term health conditions and low income households with children aged under 5 by energy efficiency professionals to provide energy advice and make referrals to energy efficiency installation schemes. These home visits will be one off visits. Repeat visits can be made but should only account for 5-10% of the home visits. Follow up work should be carried out via phone calls and referrals where possible.

2. A breakdown of home visits should target areas of high fuel poverty prevalence :

- Old Malden, St James and Alexandra wards, Norbiton and Canbury (40% of home visits).
- Over 75’s at risk of fuel poverty: (50% of home visits)
- Those with long term health conditions, at risk of fuel poverty : (30% of home visits).
- Low income households with children aged under 5- (20% of home visits)

3. Reduce energy bills by providing energy saving devices to people during home visits, where appropriate, including high visibility low wattage CFL bulbs, water saving devices and radiator reflector panels
4. Improve and promote energy efficiency within targeted households through the provision of energy efficiency advice during home visits, referrals to energy efficiency installation schemes, assistance to switch energy supplier and improve residents behaviour in terms of energy efficiency
5. Increase household income through referrals to income maximisation services, assistance to save money on water bills and increase awareness of the winter fuel payment
6. Make referrals and increase the numbers of people benefitting from energy efficiency installation schemes
7. Increase numbers of people who successfully access the GLA Warm Homes Fund
8. Make referrals to the priority register scheme
9. Undertake health screening with criteria and questions agreed in collaboration with the commissioner (including physical and mental wellbeing) while conducting home visits, conduct brief health interventions using MECC principles.
10. Increase referrals to healthy lifestyle services in Kingston to households at risk of fuel poverty including smoking cessation, weight management, Get Active, NHS Health Checks, immunisation, alcohol advice, Better Bones Services and services that tackle social isolation.
11. Increase referrals using the Connected Kingston to Services to health and wellbeing services such as Staywell, iCope, income maximisation services, dementia services, falls prevention, Better Bones and Fire Service, Carer services, mental health services) on behalf of their clients where appropriate.
12. Provide an enhanced service to 40 homes where residents have fallen in the last 12 months or are worried about falling and provide an assessment on potential hazards and recommend repairs to improve safety in the homes
13. Provide remedial action to prevent falls and accidents such as securing loose carpets, putting up grab rails and changing light bulbs
14. Undertake targeted promotion in line with a communication and marketing plan in areas with people most at risk of fuel poverty via GP letters (if required) sent to at risk patients, door to lettering campaigns in areas where people are most at risk of fuel poverty and targeted mailshots to low income groups who receive council tax benefit relief.
15. Maintain links with GP surgeries in target areas to support referral of vulnerable patients for an energy efficiency home visit though flu clinic attendance and flu correspondence.
16. Maintain referral network of health and social care professionals working with target groups such as Older People's Vulnerable People's Project, Children's Centres, BME groups and Staywell to support them to refer their patients for an energy efficiency home visit

17. Maintain links with local community organisations by providing energy efficiency presentations and workshops, attending events, and and/or providing promotional materials at community venues.
18. Provide fuel poverty training to local health and social care providers in the borough, and identify fuel poverty champions in the borough to increase awareness of fuel poverty, and referrals to the service.
19. Collect and provide data (a combination of a quantitative minimum data set as well as qualitative data) about the service to the commissioner.
20. To undertake work through data collection and analysis, and drawing on best practice and local/national policy directions to support the development of the project.

1.2 Evidence Base –

A household is currently judged to be in 'fuel poverty' based on how it scores using the "low income / high cost" methodology[1]. Households in fuel poverty face the choice of spending their resources on basics such as food and lighting or heating their homes.

2.28 million households in the United Kingdom are thought to be in fuel poverty. In Kingston this equates to 6,020 households (9.3% of the total housing in Kingston). Through its effects on residents and the people around them fuel poverty can lead to poor health and a decreased quality of life. Nationally it has been highlighted as an area of importance with several key documents including, "Building Better Lives", "The Marmot Review", and "The Cold Weather Plan" highlighting aspects of fuel poverty. Unlike many other diseases and problems, those suffering from fuel poverty are often not the most deprived. In fact, those in social housing in Kingston are less likely to be a household suffering from fuel poverty. Fuel poverty affects unique niches such as older people living in large private homes or individuals that privately rent.

Fuel poverty has been estimated [1] to affect 9.3% of total housing in Kingston, this compares with previous figures from 2010 (9.9%) and 2012 (8.9%). In comparison, London had a rate of 8.9% and England 10.4% in 2012.

[1] *Under the 'Low income, High cost' measure, households are considered to be fuel poor where:

1. They have required fuel costs that are above average (the national median level)

2. Were they to spend that amount, they would be left with a residual income below the official fuel poverty line.

3. The key elements in determining whether a household is fuel poor or not are:

Income, Fuel prices, Fuel consumption(which is dependent on the dwelling characteristics and the lifestyle of the household)
Source: Public Health Outcomes Framework (derived from data from the Department of Energy and Climate Change).
http://www.phoutcomes.info/public-health-outcomes-framework

Using population mapping techniques it was estimated that Kingston's vulnerable individuals in fuel poverty were as follows[1]:

- Over 75s: 869
- Under 5s: 1,314
- Limiting long term illness: 1,917

The local Kingston housing stock is primarily private (88%) with the majority owner occupied (74.2%). Social housing comprises 12% of the total Kingston housing stock (compared with London at 24.3% and England at 18.3%)[1]

Low indoor temperatures of people's homes are associated with increased vulnerability due to cardiovascular disease. Studies have shown that a lowering of temperature by just 1 degree can result in a rise of blood pressure of 1.3 mm Hg, increasing risk of strokes and heart attacks. Cold air also affects the normal protective function of the respiratory tract, leading to increased vulnerability to respiratory infections. Dampness in the home can also increase mould growth, which can cause asthma and respiratory infections. Falls and injuries, particularly in the elderly through worsened symptoms of arthritis and decreased dexterity, are also found to increase in cold homes. Increased mental health problems are also linked to cold, damp housing[2]. Studies have shown that mental health improves when the heat inside a home is increased by improving insulation of the building. In an extreme cold snap, people in poor housing or without adequate heating may also be at risk of hypothermia. In summary, the following health benefits of an adequately heated house may be realised:

- Reduction in strokes and heart attacks
- Improvements in mental health and perceived well being
- Reduction in falls and associated ill-health and mortality
- Reduction in excess winter mortality.

Cold homes have been linked with a range of health problems in children including mental health problems and respiratory problems[3]. Research has found an association between cold homes and poor educational performance among children, partly due to higher rates of sickness and absence from school[4].

The annual cost to society of private sector home fall hazards associated with older people is estimated at £1.6 million but, a saving of £1.5 million is estimated as being possible if these hazards were mitigated. The cost benefit scenarios show that the best value initiatives will look to small-scale repair or improvement works to stairs, trip

[2] NHS. Keep Warm Keep Well. Supporting Vulnerable People during Cold Weather: Advice for health and social care professionals. September 2008. Available at: www.dh.gov.uk/publications

[3]Public Health England. Health equity briefing. Fuel Poverty and Cold Related health problems (September 2014)

[4] Somerville M, Mackenzie I, Owen P, Miles D. Housing and health: does installing heating in their homes improve
the health of children with asthma? The Society of Public Health. 2000;114(6):434-9

hazards within the home and to uneven paths. Targeting initiatives towards dwellings occupied by persons over 60 will bring the greatest benefit[5].

1.3 General Overview

Households suffering fuel poverty can be assisted by: improving the energy efficiency of their homes/ and or using their existing fuel systems more efficiently or receiving increased income to purchase more fuel. In Kingston and some other boroughs there are a number of grants available to improve the energy efficiency of homes for older people/ older people receiving certain benefits or other people receiving other benefits. However, it has been found that some of the most vulnerable older people do not access these grants. The Royal Borough of Kingston (RBK), in association with a number of other nearby boroughs, has been working to increase awareness of available home energy efficiency interventions (e.g provision of free loft insulation, boiler related equipment) and help target groups access such grants.

Kingston Public Health have had a longstanding commitment to addressing fuel poverty since an initial pilot project in 2009, followed by annual commissioning of the project. There are 6,020 households in Kingston estimated to be in fuel poverty. Since the pilot project, almost 3000 home visits have taken place. In 2018/19. It continues to be a high priority for Kingston as demonstrated by the recent JSNA which identified many recommendations. A Joint Strategic Needs Assessment on Fuel Poverty was undertaken in 2015 to support a better understanding of the range of need within the Borough.

Expected Outcomes

1. Identify people at risk of fuel poverty and provide 300 home visits
- Over 75's at risk of fuel poverty: (50% of home visits)
- Those with long term health conditions, at risk of fuel poverty : (30% of home visits).
- Low income households with children aged under 5- (20% of home visits)

2. Reduce energy bills and support targeted households by providing energ saving devices to people during home visits, where appropriate, such as radiator reflectors, light bulbs and water saving devices
3. Improve energy efficiency within targeted households through the provision of energy efficiency advice during home visits, referrals to energy efficiency installation schemes and advice on energy switching
4. Increase numbers of people who successfully access the GLA Warm Homes Fund through enhanced support

[5] BRE January 2015, BRE Client Report: A quantitative Health Impact Assessment: The cost of private sector housing and prospective housing intervention in the Royal Borough of Kingston-Upon-Thames

5. Increase household income through referrals to income maximisation services, assistance to save money on water bills (30% of home visits) and raise awareness of the winter fuel payment
6. Increase awareness and access of healthy lifestyle services and social inclusion projects in Kingston to households at risk of fuel poverty by signposting and referring people during home visits (30% of home visits).
7. Increase referrals to health and wellbeing services in the borough using the Connected Kingston Website
8. Increased referrals from voluntary sector and local authority workers providing home care/support to people at risk of fuel poverty
9. Reduce CO2 emissions from people's homes
10. Reduce fall hazards in the home and improve safety

2. Scope

2.1 Service Description

2.1.1 Home visits by energy efficiency professionals

300 Home visits will be carried out in 2019/20 with vulnerable older residents experiencing fuel poverty throughout Kingston. The free and impartial home visit will be provided by one of the providers fully trained and DBS checked advisors. These advisors will have a knowledge of local safeguarding procedures, mental health awareness, dementia awareness, social isolation and loneliness awareness, cultural awareness, sensory loss awareness, Connected Kingston training, MECC training and brief health intervention training.

Home visitors should have a Domestic Energy Assessor (DEA) or NVQ Level 3 (6049-03) Provide Energy Efficiency Services or equivalent, or City and Guilds Energy Awareness (6281-01).During the home visits, the Home Visitors provide a comprehensive package of advice and assistance depending on the needs of the client. This includes general energy advice, information on specific energy efficiency measures, referral to energy efficiency grants and demonstrations on using equipment as well as complementary assistance such as benefit entitlement checks, security measures and fire safety provision. There are a variety of national, regional and local schemes aimed at improving energy efficiency. The home visitors can identify the most suitable and cost-effective scheme for each household and refer them to those schemes. The services offered during the home visits:

- Inspection of the home including the loft, walls and individual rooms
- Demonstration of heating controls and how to read their meters

- Verbal advice on heating, lighting, insulation, combating draughts and condensation, winter fuel payment, changing fuel supplier, tariff and payment options, understanding their utility bills and fuel debt advice as appropriate
- Grant and discount scheme referrals and post home visit support to increase the success of grant applications
- Factsheets and leaflets
- Referral to a benefits health check service where appropriate
- A direct referral for Fire Safety Check and Smoke Alarms where appropriate
- Referral to other services (HIA, handy person, security measures, Priority Register Scheme) as appropriate
- Schedule a handyperson visit to people at risk of falls and provide an assessment of potential hazards, recommend repairs and provide remedial action to reduce fall hazards such as securing loose carpet, putting up grab rails and changing lightbulbs.

In addition to this the home visit will include a health element that will constitute

- A Bones and Falls Screen, and a direct referral to the falls service where appropriate.
- Making Every Contact Count: An opportunity to identify and access information relating to promoting health and well-being (including smoking cessation, alcohol, Better Bones personal safety, activity and healthy lifestyles, getting out and about and immunisation, mental health services, dementia), and provide brief intervention and/or signposting where relevant.
- Referrals to social inclusion projects and services for carers using the Connected Kingston website

All of these are offered free of charge to residents and all advice is impartial.

The provider will be responsible for producing and distributing literature to promote the service and for securing information to signpost to other relevant services as appropriate where required.

A comprehensive risk assessment framework should be utilised by the service provider to assess the risk of the home visits, and whom employees should flag risks to. Appropriate risk management solutions should be utilised by the provider to mitigate the risk. Lone working policies should also be in place for employees and include arrangements for procedures for evening home visits.

2.1.2 Support GP Practices in target areas to refer patients for an energy efficiency home visit

The provider will identify GP surgeries in areas where there is an increased risk of fuel poverty and promote the Warm Home, Better Health project and encourage take up of home visits, with a focus on the wards that have the highest fuel poverty. This will include collaboration with GPs, practice nurses, and patient participation groups in addition to promoting self-referrals to maximise appropriate referrals. Training will be provided for referral, in addition to articles included in newsletters and marketing material provided wherever possible.

The provider, if required, will arrange to send a personally addressed letter to relevant GP patients to promote the service based on a successful pilot last year which indicated that this is an effective way of engaging older people at risk.

Flu clinics will also be attended to target older people at risk to encourage them to sign up for a home visit.

2.1.3 Maintain referral network of health professionals and community organisations to support referral of their clients for an energy efficiency home visit

The energy efficiency home visiting project will provide an opportunity for health professionals to 'prescribe' a home visit. This offers a sustainable and preventative approach that will reduce the likelihood of re-occurrence of cold-related illness. All health professionals across the borough will be provided with a free phone number and encouraged to refer via the Connected Kingston Website to allow them to arrange visits for the service.

The provider will continue to build on work carried previously to support health and social care professionals across the sectors to refer to the project. The provider will support the professional network by identifying barriers to referrals, and working with professionals to overcome these barriers.

The energy efficiency advisors will provide workshops and talks at community organisations and events. These will be provided in areas identified as having a high population of private tenants at risk of experiencing fuel poverty and any identified through monitoring as showing low referral numbers.

The provider will train housing staff, information and advice staff, local faith and community groups and social care staff to effectively support those with heating issues, and increase awareness of support available.

The provider will also deliver energy efficiency workshops to residents of the borough.

2.1.4. To signpost people to a range of services to improve health and well-being

The provider will undertake a health screen to identify individuals at risk of falling, bone health, alcohol consumption, and social isolation through a health screening provider by the commissioner, and will seek consent to make a referral for individuals at risk into health and wellbeing services in RBK.

The provider will identify homes that require a Fire Safety Check and/or Smoke Alarms and will seek consent to make a referral for individuals at risk to the Fire Service.

The provider will offer brief intervention and provide an opportunity to access information about accessing a range of services to improve health and well-being (including smoking cessation, Better Bones Service, healthy lifestyles and activity, NHS checks, isolation, mental health and personal safety)

The provider will schedule a handyperson visit to people at risk of falls and provide an assessment of potential hazards, recommend repairs and provide remedial action to reduce fall hazards such as securing loose carpet, putting up grab rails and changing lightbulbs.

2.1.5 To undertake work to support Public Health with the development of the fuel poverty project

The provider will work with Public Health to provide data, undertake pieces of work and provide advice to support planning to develop the fuel poverty project to target people at risk of cold related hospital admissions with sign-posting, referrals and prevention advice.

2.1.6 Data and information requirements for commissioner

To provide monthly output monitoring data on project plans, marketing, the number of referrals completed, aggregated demographic information of older people visited, a breakdown of interventions offered and referrals made during home visit. To provide a comprehensive mid-way evaluation report in January 2020, and a full evaluation on or before the 31st May 2020.

Data Protection and Information Governance requirements will be outlined in the contract with RBK, and these measures have to be adhered to while on home visits, and within the office. Standard and legal obligations in regards to information governance should be adhered to at all stages of the service development. The provider will have a sound governance framework in place covering the following areas: information governance and security, information quality, consent and records management.

2.2 Accessibility/acceptability

Referrals are made through a single free telephone number and can be made by anyone including; GPs, health and social care professionals, friends, carers or the older persons themselves. All visits are carried out in resident's homes by a fully DBS checked professional. Supported visits can be arranged if an individual is particularly vulnerable.

2.3 Whole System Relationships

The organisation works with a range of statutory, health and social care, voluntary and community sector organisations across Kingston. The provider will develop relationships with the voluntary sector organisation, advice services, local authority teams, GP's, churches, community groups and hospital staff to expand the range of referrals to the project.

2.4 Inter-dependencies
The organisation works closely with the Local Authority and the CCG to improve home energy efficiency and to reduce fuel poverty in the borough.

2.5 Role and Accountability
The provider must have clear lines of accountability and responsibility for all services carried out under this specification. The provider is responsible for the recruitment, appointment and training of personnel to meet the requirements of the service and the provision of local IT support to maintain continuity of service. The Provider will ensure that robust business continuity plans are in place and that all critical functions have been clearly mapped and have contingencies in place.

2.5 Relevant Clinical Networks and Screening Programmes
n/a

2.6 Sub-contractors
n/a

3. Service Delivery

3.1 Service Model
See Service Specification 2.1

3.2 Pathways

4. Referral, Access and Acceptance Criteria

Geographic coverage/boundaries

Borough of Kingston

4.1 Location(s) of Service Delivery

Homes of residents in Borough of Kingston vulnerable to fuel poverty

4.2 Days/Hours of operation

9am-5pm Monday - Friday

4.3 Referral criteria & sources

Any household in Kingston Borough where a person is vulnerable to fuel poverty is eligible for a visit although priority will be given to those at greatest risk of fuel poverty as defined by the provider. Older people, families with young children and people with long term conditions are most vulnerable to the effects of fuel poverty. 50% of home visits should be for those aged 75 and over 30% of visits can be delivered to those with long term health conditions and 20% to low income households with children under 5.

40% of home visits booked should be within the wards where fuel poverty is highest, or more than 40% if achievable.
These wards are: Old Malden, St James and Alexandra wards, Norbiton and Canbury.

Referrals are generated through several routes:

- Referrals from Primary Care: GP surgeries in high risk areas will be targeted by Thinking Works to support GPs, practice managers and PPGs to encourage residents to participate. Flu clinics will be targeted in consenting GP practices.
- Referrals from health professionals: During year one of the project health and social care teams, GPs and hospital staff will be trained in the referral process. Regular updates will be sent to teams to remind them and to encourage them to refer.
- Targeted mailings : The provider will send out promotional information in flu clinic invites sent by GPs, targeted mailshots to people receiving council tax support or those on a low income
- Local events: Local resident events that were relevant will be attended to inform people about the service and provide them with an opportunity to sign up for a visit.
- Local Authority public health events and team meetings will be attended by the provider to increase referrals.

4.4 Referral route

All referrals are made through a free phone number to a call centre where the referral is logged and home visitors contact older person to arrange a meeting

Alternatively referrals can be made at an event held by the provider for the purpose of getting residents to sign-up

4.5 Exclusion Criteria

Only people who can be considered at risk of fuel poverty within Kingston can access the service, and fall within the client groups mentioned.
Repeat visits should only be made in extenuating circumstances.

4.6 Response time and prioritisation

Home visitors will contact referrals within 48 hrs to arrange a visit. Referrals are not prioritised however efforts will be made to support professionals and carers who are assisting an individual at high risk.

5. Discharge Criteria & Planning

The project consists of a single home visit – however, for individuals with complex needs and/or issues a follow-up contact (telephone/visit) may be necessary to resolve an issue identified at the first visit (ie. a visit might reveal a need to apply for certain benefits before the individual can be assessed for some grants) or if an individual's circumstances change significantly. Where appropriate the provider will make onward referrals using the Connected Kingston Website to additional support services including benefit advice, handyperson services etc. Follow-up support will be available on request.

In event of safeguarding concerns, referrals should be made to the safeguarding team at RBK.

6. Self-Care and Patient and Carer Information

The home visit can be organised and attended by a carer where appropriate. Information is provided about all recommended grants, services etc. The project will aim more broadly to increase awareness of resources and to promote information available to professionals and individuals to take appropriate action themselves where a visit is not appropriate / available.

7. Quality and Performance Indicators	*Quality and Performance Indicator(s)*	*Threshold*	*Method of Measurement*	*Consequence of Breach*
HCAI Control	N/A			
Service User Experience	Feedback Questionnaire		Summary report	
Improving Service Users & Carers Experience	Feedback Questionnaire		Summary report	
Unplanned admissions	N/A			
Reducing Inequalities	Minimum data set will be provided by Public Health Kingston, along with Making Every Contact Count Toolkit. Referral data on: ● Age ● Gender ● Ethnicity ● Postcode area ● Referrals to other services		Monitoring Report	
Reducing Barriers	Referral data		Monitoring Report	
Improving Productivity	N/A			
Access	Referral Data		Monitoring Report	
Personalised Care Planning	N/A			
Outcomes	Referral Data		Monitoring Report	

8. Activity			
Activity Performance Indicators	*Threshold*	*Method of measurement*	*Consequence of breach*
300 home visits by source	*300*	*Monitoring Report*	*Final payment adjustment on performance:*
Visits to targeted groups	*50% over 75s* *20% low income families with under 5s* *30% people with long term health conditions* *40% visits in* Old Malden, St James and Alexandra, Norbiton and Canbury wards.	*Monitoring Report*	*Final payment adjustment on performance:*
Number of follow-up contacts (telephone / visits)	*Follow up calls - up to 100. Repeat home visits 5-10% of 300*	*Monitoring Report* *The provider will need to assess whether fuel poverty visits have been made by previous provider during referral process.*	*Final payment adjustment on performance:*
Number of referrals to Falls Service and Better Bones Service made		*Monitoring Report*	*Final payment adjustment on performance:*

Number of referrals made to Fire Service		*Monitoring Report*	*Final payment adjustment on performance:*
Number of referrals to healthy lifestyle services and social inclusion projects and (by Type)		*Monitoring Report*	*Final payment adjustment on performance:*
Number of MECC assessments and referrals for identified support?		*Monitoring Report*	
Numbers referred to income maximisation services and assessment of numbers of people who receive winter fuel payment			
Number of home hazard assessments taken place and remedial action taken	40 people	*Monitoring Report*	
Number of local support service staff trained and energy efficiency awareness outreach events in the community events attended	*60 local support staff trained on fuel poverty (social care teams, advice teams, older people services providing home care, surgeries).*	*Monitoring Report*	

	6 identified champions 5 outreach events		
Project support	*Quarterly Meeting*	*Monitoring Report*	*Final payment adjustment on performance:*

Monitoring Requirements

The organisation will submit monthly email reports and a summary report in May 2020. Minimum data sets and template service outcome questionnaires will be provided by the commissioner, and the provider will need to use and provide reports using these data sets. Health screening templates will also be provided by the commissioner.

Activity Plan

Milestone (1): The provider to market the programme via GP mail outs, mail outs to low income households and flu clinics
Milestone (2): Train local providers on fuel poverty (at least 4 sessions, training 60 staff in year) and 5 community outreach events. Fuel Poverty champions identified from these organisations to identify and refer those at risk of fuel poverty.
Milestone (3): 300 home visits
Milestone (4): Distribute energy/water saving devices
Milestone (5) 40 home hazard assessments and remedial action completed
Milestone (6): Summary report

9. Continual Service Improvement Plan

Monitoring reports will be submitted to the Public Health Older People Programme Lead on or before 6th of each month, consisting of an activity and outcome report for the month before. Quarterly meetings will be attended to ensure that the project is meeting its targets. In addition a summary report will be produced by 31st May 2020.

10. Prices & Costs

Activity	Cost	Notes
Home visitor time		This covers 300 energy efficiency survey and advice visits and any technical surveys for loft/cavity

Marketing and paper-based materials		All materials including fact sheets and forms
GP mailings and targeted mailshots to people on a low income		To cover part funding of 3000 letters to go out from GP surgeries in conjunction with flu vaccination letters and mailshots to people on a low income
Expenses, travel, parking etc.		
Surgery training, relationship management and meeting days		Allows for 2 days a month for 6 months of engagement, meetings and training with the surgeries
Project set up and management		Includes preparation of all survey forms, management of bookings, referrals and visits and collating and reporting on data
Handyperson time		To cover time to carry out remedial action to reduce falls hazards and improve safety
Total		38,300

10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block Arrangement	**Payment based on performance: reconciled at last payment**	**38, 300**		
Total		**38, 300**		

Contract total to be paid in two invoices of on or after the following dates:

1. October 1st £19,150
2. March 16th £19,150 (adjusted based on performance)