**Part B**

**Lot 1: Provision of Care and Support in Extra Care Housing Scheme**

**General Information and Specification**

**Please Note: This Part B document will only be issued once, but is relevant for all phases of the procurement process.**

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1. **Introduction and Background Information**

## 

## Procurement Procedure

The Authority is conducting this procurement process in accordance with the Public Contracts Regulations 2015. This opportunity falls within Schedule 3 of the Regulations (Social and Other Specific Services) and is therefore being run under the Light Touch Regime.

The Authority requires the information sought in this Selection Questionnaire from Applicants in response to the OJEU contract notice identification number **2018/S 007-011597** dated **11 January 2018**.

The Selection Questionnaire sets out the information required by the Authority in order to assess the Applicant’s suitability in terms of their technical knowledge, experience, capability/capacity, organisational and financial standing to meet the requirements.

The Selection Questionnaire will be available to every Applicant responding to the OJEU notice, and will be used in the first step of selecting Applicants to Tender. Selected Applicants will be notified in writing that they have been invited to participate further in the procurement. Unsuccessful Applicants will also be notified of the outcome of their first-stage application in writing.

At the conclusion of this first stage, the intention is to arrive at a short list of five (5) Applicants to take forward to the next stage. Where there is more than one (1) Applicant in fifth (5th) place, then all such Applicants will be invited to Tender. However, in the event that the short list of five (5) Applicants includes two (2) or more Applicants with joint scores, the shortlist will not be increased to include any Applicants beyond fifth (5th) place.

The Authority reserves the right to down select the lowest scoring Applicant if their score differs from that of the next Applicant by more than thirty per cent (30%), so long as there is an appropriate number of Applicants to provide genuine competition during the second (2nd) stage.

In the event that five (5) or fewer than five (5) submissions are received, the Council will take into account the above and therefore, may result in less than five (5) Applicants being taken forward to the second (2nd) stage.

To further illustrate this point please see refer to the following examples. In both Example 1 and 2 the intention is to arrive at a shortlist of five (5) Applicants. Examples 3 and 4 demonstrate where fewer than five (5) submissions were shortlisted.

Example 1

|  |  |  |
| --- | --- | --- |
| **Supplier** | **Score** | **Status** |
| One | 84% | Invited to Tender |
| Two | 83% | Invited to Tender |
| Three | 83% | Invited to Tender |
| Four | 72% | Invited to Tender |
| Five | 71% | Invited to Tender |
| Six | 65% | Down Selected |
| Seven | 60% | Down Selected |
| Eight | 52% | Down Selected |

Example 2

|  |  |  |
| --- | --- | --- |
| **Supplier** | **Score** | **Status** |
| One | 84% | Invited to Tender |
| Two | 83% | Invited to Tender |
| Three | 81% | Invited to Tender |
| Four | 72% | Invited to Tender |
| Five | 70% | Invited to Tender |
| Six | 70% | Invited to Tender |
| Seven | 64% | Down Selected |
| Eight | 52% | Down Selected |

Example 3

|  |  |  |
| --- | --- | --- |
| **Supplier** | **Score** | **Status** |
| One | 90% | Invited to Tender |
| Two | 81% | Invited to Tender |
| Three | 74% | Invited to Tender |
| Four | 69% | Invited to Tender |
| Five | 48% | Down Selected |
| Six | 45% | Down Selected |
| Seven | 41% | Down Selected |
| Eight | 33% | Down Selected |

Example 4

|  |  |  |
| --- | --- | --- |
| **Supplier** | **Score** | **Status** |
| One | 91% | Invited to Tender |
| Two | 87% | Invited to Tender |
| Three | 81% | Invited to Tender |
| Four | 56% | Down Selected |

Following the receipt and evaluation of those Tenders, it is anticipated that the Contract will be awarded to a maximum of one (1)Service Provider per Lot**.**

## Lots

This procurement opportunity is divided into two (2) lots as specified below:

|  |  |  |
| --- | --- | --- |
| **Lot Number** | **Area** | **Title** |
| 1 | Taunton, Somerset | Care and Support in Extra Care Housing Scheme |
| 2 | Taunton, Somerset | Care and Support in Learning Disability Supported Living Accommodation |

## Contract Period

The Contract being offered is due to commence on:

01 June 2018 to 31 May 2023

with the option to extend for: two (2) further periods of up to twelve (12) months.

For avoidance of doubt, the maximum duration of this contract, including permitted extensions will be until 31 May 2025.

## Eligible Users of the Contract

Not Used

## Procurement Timetable

The key dates for this procurement process are currently anticipated to be as follows:

|  |  |
| --- | --- |
| **Procurement Stage** | **Dates** |
| Publication of advertisement | 11/01/18 |
| Selection Questionnaire distributed to Applicants | 12/01/18 |
| Clarification questions to be submitted by | 22/01/18 |
| Clarification responses to be issued by | 23/01/18 |
| SQ deadline | 12:00 on 29/01/18 |
| Evaluation | 29/01/18 – 06/02/18 |
| Applicants notified of SQ decision | 07/02/18 |
| Procurement documents distributed to Applicants | 12/02/18 |
| Clarification questions to be submitted by | 26/02/18 |
| Clarification responses to be issued by | 27/02/18 |
| Bid Deadline | 12:00 on 05/03/18 |
| Evaluation | 05/03/18 – 23/03/18 |
| Intention to award | 05/04/18 |
| Standstill period | 05/04/18 – 16/04/18 |
| Contract start | 01/05/18 |

Please note that the above timescales are indicative; the Authority reserves the right to change the above timetable at any time, taking in to account the complexity of the Contract and the time for drawing up Competition Documents, subject always to the minimum timescales in the Regulations. In particular SCC may in its absolute discretion extend the deadline for the receipt of Bids and in such circumstances SCC will notify all Applicants of any change.

## Authority Representatives

No person in the Authority’s employ or other agent, except as so authorised by the Authority Authorised Officer or Procurement Representative, has any authority to make any representation or explanation to Applicants as to the meaning of the Contract or any other document or as to anything to be done or not to be done by Applicants or the successful Applicant or as to these instructions or as to any other matter or thing so as to bind the Authority.

|  |  |
| --- | --- |
| **Authority Authorised**  **Representative contact details:** | **Procurement Representative**  **contact details:** |
| Name: Steve Veevers  Address:  Somerset County Council  County Hall  Taunton  e-mail: sveevers@somerset.gov.uk | Name: Leanne Le Moucheux  Address:  Somerset County Council  County Hall  Taunton  e-mail: llemoucheux@somerset.gov.uk |

1. **Specification**

# Tennyson Court Specification

**Introduction**

Tennyson Court is the collective name of the development of a 64 unit, purpose built Extra Care Housing scheme and a 10 unit, purpose built Learning Disability Supported Living accommodation scheme on the same site.

It is a joint development between Knightstone Housing Association, Somerset County Council, Taunton Deane Borough Council, Homes and Communities Agency and NHS England. It is located in Parmin Close, just off Parmin Way in Taunton. It is very well located on the edge of the county town, with good links to transport, shopping, leisure and recreational activities.

**The Accommodation**

The flats in both units are of good size (50-55m2), with wet rooms in all flats, open plan living-kitchen-dining spaces and bedrooms, flooring is provided and it is probable that white goods will be provided in the kitchens (TBC).

10 of the ECH flats will be outside the scope of the contract and sold for shared ownership by the landlord. It is possible that the people living in these flats may choose to access the on-site care provider for private care arrangements, although this is not a condition of the sale.

A full size flat is given over the staff accommodation (office and rest areas) in both scheme and will be offered at Nil Rent, although a service level agreement will be put into place with care providers.

Both schemes have ample communal facilities inside and out, with the ECH scheme having a fully equipped commercial kitchen/restaurant, therapy & treatment room, accessible bathroom and breakout areas throughout.

Both schemes have a Tunstall Communicall assistive technology system built in, with call systems, door entry and hubs in each flat, ready for any specific sensors, alerts or add on’s that are needed. There is a small fund of money that might be used to support these assistive technology pieces, as well as the usual minor adaptation and Disability Facilities Grant process for any adaptions that might be needed. It is expected that assistive technology and adaptations should be used to promote good care delivery and to promote people’s independence.

**Care and Support**

The ethos and aim of both schemes is along the lines of the promotion of independence, progression within the areas that people are able to do so and the expectation that providers will be key partners in doing so. Somerset County Council is changing the way that it delivers services and can clearly see the strength of ECH and Supported Accommodation in being able to support people to make good choices about how they choose their care and it is delivered. Somerset County Council wishes to increase the range and breadth of options available to people and support them to stay well and healthy for as long as possible.

Somerset County Council consider that a good, healthy life can stem from a good, healthy community and relationships and wish for providers to be instrumental in developing and fostering this community feeling within schemes, either directly or through the use of other organisations.

The care and support for each scheme is broken down into three separate components; Core (or background staffing) which could also make up part of peoples complete package, Assessed (or individual hours) which make up the remainder of individual’s care packages and Night Support (which could be waking, sleep in or a combination of both). The core hours block will be for 105 hours of care and support, as well as night support to be confirmed once the final mix of needs is known. It is expected that final hours will be in the range of 300 to 450 hours in both schemes.

There is an expectation that the core provider will be responsible for picking up the bulk of the assessed care, although people will be given the opportunity to choose their provider or providers for their hours, to meet their specific outcomes. (Other schemes that have been commissioned in this way have seen a uptake of 95% of the assessed care buy the core provider)

**Allocation**

Allocation to both schemes will be via a joint allocation process; between landlord, commissioner and once appointed care and support provider. SCC would want the care provider to be part of the decision making at the earliest possible opportunity to have a say and some control over the balance and make up of the scheme. SCC expects that all people moving in will have care needs and ideally the final mix of people (in both schemes) will be a balance of low needs, medium and high comparatively. All resets of flats will be via a joint decision process. The process of moving in will be phased from the start of the contract for a period of up to 12 weeks (6-8 for the LD scheme) with people moving in flexibly over that time and providers recruiting and ramping up delivery over the same period. The expectation that a jointly agreed mobilisation plan will be in place and worked to over the pre contract and phased opening period.

It is expected that the people that are moving into the schemes may be identified as those at risk of entering residential care, already in residential care, in other housing with care needs and looking at ECH / Supported Accommodation as a good long term option. Ideally people will have a local connection to Taunton Deane, but this can be extended to the whole of Somerset or in the case of people with a learning disability, people returning to the area after being placed outside of the county.

**Working Together**

Over the duration of the contract, commissioners will seek to work with provider(s) to move from a time based commissioning model of hours and minutes to a personalised, outcomes based system in partnership and at a pace that works for all organisation. Some of this development may mean working in different ways and working with some trust between parties and people that receive care, possibly through new funding methods, i.e. pooled budgets, individual service funds or payments by outcomes.



**Care and Support in Tennyson Court Extra Care Housing Scheme**

**Taunton, Somerset**

# Integrated model

**December 2017**

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# Introduction

* 1. The care and support service will enable people living in Tennyson Court Extra Care Housing (ECH) Scheme in Taunton, Somerset to maintain and often improve their independence and wellbeing whilst maintaining their tenancy, and preventing admission into more acute social care and health services.
  2. This document sets out the service specification and standards which apply to the provision of the integrated care and support services in ECH in Somerset. Services include:
* Housing related support services
* Care and support for tenants living in ECH
* A crisis and urgent response service
* Delivering packages of assessed care and night time support (waking night)
* Maintaining a 24/7 on-site presence
  1. ECH is specialist housing for adults with health and social care needs. It is targeted mainly at older people, but is also used to meet the needs of younger adults with physical disabilities, learning disabilities or mental health problems. ECH is strongly promoted by the Department of Health, the National Housing Federation and other influential policy making bodies as a cost effective alternative to residential care. It can offer choice and continuing independence to people who might otherwise need a higher level of care long term or be admitted to a care home.

# Service developments

2.1 The Service Provider will be expected to work with the Housing Provider to identify efficiencies through improved ways of joint working and making best use of staff time to deliver the outcomes of the service. This could include looking at ways that the night covering staff can carry out other tasks and activities whilst maintaining the outcomes of the service and responding in an emergency to deliver care to those that need it. The delivery of any additional activities/tasks outside of the service specification will need to be agreed with the Housing Provider e.g. any other service that could be provided by the landlord such as cleaning communal areas or delivery of a meal service.

2.2 Outcome based commissioning will design the delivery of care and support in a way that will assist a Service User to maximise their potential for independence. The intention is that all services will become outcomes based recognising that this will need to be introduced throughout the duration of the contract.

2.3 The Service Purchaser and Service Provider will work collaboratively to jointly design and develop the outcomes based service model across all services. This will be informed by the evidence from actual service delivery which will show how reablement influences outcomes. This may require changes to the delivery model throughout the period of the contract.

2.4 The Service Provider will work with the Service Purchaser and the Housing Provider to continuously improve delivery and respond to service efficiencies.

# Working in partnership

3.1 It is acknowledged that many people who may be eligible to receive support from the Service will have complex needs and in many cases other significant care needs. It is the responsibility of the Service Provider to proactively develop and maintain robust working arrangements with other services and organisations that may be involved in providing care and support to the Service User and / or could be of future benefit to the Service User and their carers and families. These include, but are not limited to:

* Adult Social Care Teams
* Community Mental Health Teams
* CAMHS
* Drug and Alcohol Services
* Safeguarding
* Court of Protection
* CTALD
* District nursing service
* Health Care Assistants
* Health rehabilitation service
* GPs

3.2 The primary aims of a partnership working approach are to ensure that Service Users do not fall between services and that they receive the maximum level of support to which they are entitled. It ensures joined up working and “one support plan” for the tenant. The Service Provider will take a proactive role in helping with the development of joint protocols, pathways and assessment.

3.3 The Service Provider will identify and report innovations and new ideas with the Service Purchaser that can bring added value through enhancements in service delivery, information technology, individuals’ experience of the Service and cost efficiencies.

3.4 The Service Purchaser and Service Provider will work together to maximise opportunities for joint training including training on the use of equipment through the Equipment Assessment Centre.

3.5 The Service Provider will work with the Service Purchaser to develop and test new ideas and services in addition to the strategic development work required to achieve the overarching vision during the term of the contract.

3.6 The Service Provider will undertake a financial open book process with the Service Purchaser that ensures transparency in all financial transactions and funding issues.

3.7 The Service Provider will be proactive in joint problem solving with the Service Purchaser with regard to any challenges, whether in relation to service delivery, finance or service development and with a shared focus on benefit to the Service User.

3.8 The Service Provider will work with other organisations both within this service and with others delivering services in Somerset.

3.9 The Service Provider will be expected to work in partnership with the Housing Provider to ensure that the ECH tenants receive a seamless service. It is expected that the Service Provider will meet regularly with the Housing Provider to ensure that local partnership arrangements set out within a Service Level Agreement are in place and working effectively.

3.10 The Service Provider will regularly consult with the on-site staff teams through regular meetings and other methods to monitor the on-site arrangements to ensure that individual’s needs are being met and are in line with the service specification.

3.11 The Service Provider will have a Service Level Agreement with the Housing Provider to ensure that the ECH schemes have an on-site care and support presence 24/7.

3.12 The Service Provider will work flexibly with the Housing Provider so that in periods of “down time” they can support the delivery of other activities that deliver direct outcomes for the tenants. This will include working with the Housing Provider to deliver tasks on scheme but will not include tasks and activities where staff do not have suitable training or the necessary skills/qualifications.

3.13 As part of its own continuous improvement and development, the Service Provider will establish mechanisms to ensure on-going feedback and insight are gathered from tenants. This could be through an established group or regular engagement sessions. The Service Purchaser will have access to such user groups and the intelligence gathered as a result of their engagement. All associated costs will be borne by the Service Provider.

3.14 The Service Purchaser and the Service Provider will work together to find constructive ways of accommodating difficult cases where Somerset County Council is endeavouring to meet its statutory obligations.

3.15 The Service Provider will agree to take on all orders for packages of assessed care on the scheme. Where the Service Provider is unable to resource a package, the Service Provider will either sub-contract to another organisation or recruit Agency staff.

3.16 The Service Provider will work with the Service Purchaser to provide advice and support as and when needed to assist where other services or providers are struggling or failing. Whilst recognising that this is a responsive service, Somerset County Council undertakes to give as much advance notice as possible where it is anticipated that help is needed.

# Delivering Services in Somerset

**The County Plan for Somerset 2016 – 2020: Councils Vision and Priorities**

* 1. Somerset County Council is working towards a general ground breaking joint integrated arrangement between health and social services delivering better results for residents to become more efficient and making public funding go further.
  2. Somerset County Council is working towards closer working partnerships across the public, voluntary and private sectors.
  3. The County Plan is available through this link:

<http://somersetcountyplan.org.uk/wp-content/uploads/2016/01/County-Plan-high-res-12.01.16.pdf>

**Adults Social Care Services in Somerset: Our Vision**



4.4 Service Users in Somerset will remain independent for as long as possible with access to the right information and advice when needed to help families and communities by giving them the support they need to reduce the risk of them losing their independence.

4.5 When Service Users do need care or support this will be through high quality, joined up health and social care services. These will, where possible, enhance rather than replace existing informal support networks. Service Users will be in control of the care and support services they need. They can arrange them so that they are delivered where, when, and by the Service Providers they want, to achieve the things that are important for them.

**Care and support at Home Services for Adults in Somerset: Our Vision**

4.6 In Somerset we want a vibrant care market where Service Users can access care and support that is local, reliable, responsive, high quality, personal and practical, and delivered with dignity.

4.7 We want to:

* help Service Users to become more independent and maintain independence (delaying the need for further care and support / healthcare) and achieve their optimum wellbeing and full potential.
* allow Service Users to live well in the community where they have choice and control about how their needs are met.
* help to prevent inappropriate hospital admissions.
* be responsive and flexible to changing need.
* help Service Users with care and support needs to be involved in their local community.
* work in partnership with Service Users and Service Providers to promote the highest sustainable quality of life and reduce duplication.
* meet important outcomes in the care and support plan.
* have services that are based upon the social model of disability, social inclusion and enablement.

4.8 In addition, the services outlined within this specification will comply with, and support delivery of the following local policies, procedures and strategies (and any modifications and / or replacements):

**Health & Wellbeing Strategy for Somerset**



**Better Care Fund Strategy and Plan**



**Positive Mental Health: A joint strategy for Somerset 2014 – 2019**



**Crisis Concordat – Somerset declaration statement and action plan**

<http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/02/Crisis-Concordat-Draft-Somerset-Declaration-v9-30-1-15-TG-signed.pdf>



**Somerset Dementia Strategy – 2013 – 2016**



**Somerset Autism Strategy**



# Legislation

5.1 All services set out in this specification and associated appendices must be delivered in line with all legislation relevant to the delivery of the services. This includes all Acts and Regulations, and associated Codes of Practice and Statutory Guidance that cover the provision of care and support services and includes but is not limited to:

* The Mental Health Act 1983 (amended 2007)
* The Mental Capacity Act 2005
* Public Interest Disclosure Act 1998
* Equality Act 2010
* Autism Act (2009)
* Data Protection Act 1998
* Care Act 2014
* Public Services (Social Value Act) 2012

# Vision for Care and Support in Extra Care Housing Schemes

6.1 People in Somerset will have a range of options that offer a specialist housing provision for adults who need on-going daily and night time support in addition to their assessed care needs. The service enables people to remain independent in their own home for as long as possible, with access to the right type of support and information when they need it.

# Scope

7.1 A list of the ECH schemes is shown in Appendix 1.

7.2 There is an expectation that there will be a designated on-site team that will deliver integrated care and support services to people living in Tennyson Court and the following services are included:

7.2.1 Housing Related Support Service

Housing related support services will be provided to assist people to develop or maintain their independence within the community, thus preventing loss of their home or tenancy, and/or the otherwise unnecessary use of more acute health and social care services. The housing related support element of the integrated service will be available for all ECH tenants.

A key objective of ECH is to provide security and a sense of permanency to tenants, by responding to changes in the level and nature of their needs, without requiring that they move to alternative accommodation. Whilst it is recognised that this will not be achievable in all cases, the expectation is that it will serve as a general principle.

It is important that individual tenants are enabled to maintain and develop links with the broader community in which the scheme is located and beyond. These activities will be part of the broader package of housing related support aimed at maintaining and/or developing independence through prevention and enablement.

The Service Provider will:

* ensure as a minimum that all tenants have access to a daily welfare check to ensure the wellbeing of a tenant.
* help the tenant to understand and keep to the terms of their tenancy.
* attend promptly to any call via the community alarm equipment to give assistance to the tenant.
* ensure that all tenants have access to a suitably trained member of the designated team of staff to work with them in a flexible and holistic way to meet their goals and aspirations. These must be clearly written within an individual outcome focussed Housing Related Support Plan which will be available for each tenant and reviewed at least annually, or when a tenants circumstances change.
* promote independence and choice including accommodation and move on options.
* offer all tenants advice on maintaining their independence within their accommodation, with respect to money management, catering and managing the home.
* assist tenants with correspondence; reading and writing of letters and support tenants making telephone calls that are necessary to the wellbeing of the tenant.
* act as an Advocate for the tenant where gaining access to other key services is necessary to the wellbeing of the tenant.
* provide advice to tenants in relation to ensuring privacy within their accommodation.
* ensure the safety and security of all tenants particularly where there is a change of circumstances / health / falls / bereavement / hospital discharge or other critical events to maximise independence and reduce the need for move-on to more acute care services. e.g. Hospitals and Residential Care.
* be prepared to ensure for short periods, as the need arises, that a tenant who is temporarily unwell receives adequate support and has access to the crisis and urgent response service, or other medical services.
* arrange aids and adaptations to the property as required to support them in their personal safety, home security and living independently.
* provide advice and support where needed on reporting any defects or faults within the tenants property to the maintenance section or the Housing Provider.
* promote and facilitate the provision of suitable social and health and wellbeing activities on site in line with tenant’s expressed wishes
* help tenants to access opportunities locally such as leisure, cultural, faith, volunteering, education, training and employment. This will include facilitating and assisting residents in social activities on scheme as well as in the community.
* help tenants to access healthcare and receive advice in relation to promoting healthy living (such as district nursing teams, physiotherapists and community mental health teams).
* help tenants to access other specialist services when appropriate including a referral via Adult Social Care or health professionals.
* encourage tenants to build or sustain effective social and familial relationships, thereby reducing social isolation.
* record significant events/information regarding tenants and the scheme in general in a journal/log that is accessible by all scheme cover staff delivering housing related support.
* immediately inform Somerset County Council’s Adult Social Care Teams when a property becomes vacant.

If sickness or other events prevent the usual support worker from carrying out these tasks, it is the responsibility of the Service Provider to make appropriate alternative arrangements and to notify tenants of the cover arrangements.

7.2.2 The Crisis and urgent response service

The crisis and urgent responsive service will be available 24/7, 365/366 days per year. The Service Provider will respond to the needs of an individual in an emergency within 30 minutes. The Service Provider will ensure that tenants ‘in need’ will receive care and/or support in an emergency/random situation any time of the week day or night. The care provider can flex or add a maximum of five hours of care per week for each scheme as part of the crisis and urgent response service, any further increase will require authorisation from the Service Purchaser.

7.2.3 Assistance to dine where lunch is provided

Where a lunch time service is available in a the dining area the Service Provider will assist tenants to and from the dining room if needed and will support the tenants to take a meal service in a social environment if possible. This service will be provided for two hours on each day that a communal lunch service is available and where tenants require assistance to dine. This, two hours will be reviewed as part of the service development and amended if the demand is apparent and needs of the tenants increases e.g. large numbers of people taking a meal need more lunch time assistance.

7.2.4 Delivering assessed packages of care & night time care and support

The Service Provider will deliver personal care and support for tenants who meet the eligibility criteria for Somerset County Council funded support. The service will be commissioned in units of time initially but this may change towards an outcome based delivery model during the contract period. The Service provider will be required to respond to care for tenants who have additional needs during the night.

Following an Assessment of need, tenants will receive a Financial and Benefits check to determine their contribution to this service. All tenants will be expected to sign a charging agreement for the care and support services (Appendix 15). The Service Provider will be required to collect any tenant contribution for this service. All tenants eligible for assessed care will receive a Personal Budget which will enable them to choose how they would like their care to be managed. This can be paid via a Direct Payment or a managed budget. The provider will be required to work to the key service principles and operational requirements for assessed care which are set out in Schedule 1 of this service specification.

The schedule covers the following areas;

1. Assessment and referral
2. Care and support planning and delivery
3. Arranging care
4. Review and monitoring of Service User needs
5. Temporary Suspension, Re-Start and ceasing of care packages
6. Record keeping
7. Using the local community for facilities and services
8. Keeping safe: data protection
9. Keeping safe: management of medicines and mental capacity
10. Keeping safe: safeguarding,
11. Property
12. Disaster Recovery Plan
13. Risk assessment,
14. Communication and culture,
15. Meeting the needs of Service Users with specific conditions
16. Workforce: recruitment, training and supervision of staff, workforce planning

7.2.5 Scheme cover

The Service provider is required to ensure that scheme cover is maintained 24 hours per day, 7 days per week, 365/366 per year.

# Eligibility criteria

8.1 The ECH service is available to any adult with a need for on-going and regular 24-hour support. The applicant does not have to have an assessed care need. The aim of ECH in Somerset is to offer a home for life with care and support available when needed. All ECH tenants should have access to these integrated care and support services.

8.2 To receive a package of care, the tenants must have assessed eligible needs that meet the Care Act eligibility criteria for care and support.

8.3 Tenants who arrange their own assessed care using a Direct Payment will do so as private citizens independently of this service specification and associated schedules

8.5 The criteria for eligibility for assessed care is based on identifying how a tenant’s needs affect their wellbeing. A tenant will be eligible for social care and support if their care needs are due to a physical impairment or mental impairment or illness and as a result of their care needs they are unable to achieve two or more of the things in the list below and as a result of not being able to achieve these things it has a significant impact on the adult’s wellbeing:

* + - managing and maintaining nutrition
    - maintaining personal hygiene
    - managing toilet needs
    - being appropriately clothed
    - being able to make use of your home safely
    - maintaining a habitable environment
    - developing and maintaining family or other personal relationships
    - accessing and engaging in work, training, education or volunteering
    - making use of necessary facilities or services in the local community including public transport and recreational facilities or services
    - carrying out any caring responsibilities an adult has for a child.

8.6 A major element in the Care Act 2014 is a requirement to promote a tenant’s wellbeing in relation to their disability or impairment. “Wellbeing” is a broad concept and relates to a person’s:

* + - personal dignity (including being treated with respect)
    - physical and mental health and emotional wellbeing
    - protection from abuse and neglect
    - control over day-to-day life (including how care and support is provided)
    - participation in work, education, training or recreation
    - social and economic wellbeing
    - domestic, family and personal life
    - suitability of living accommodation
    - contribution to society.

# Independent Advocacy in Somerset

9.1 The Service Purchaser must involve tenants in decisions made about them and their care and support. No matter how complex a tenant’s needs, the Service Purchaser is required to help tenants express their wishes and feelings, support them in weighing up their options and assist them in making their own decisions.

**When does the advocacy duty apply?**

9.2 The advocacy duty will apply from the point of first contact with the Service Purchaser and at any subsequent stage of the Assessment, planning, care review, safeguarding enquiry or safeguarding adult review.

9.3 If it appears to the Service Purchaser that a tenant has care and support needs, then a judgement must be made as to whether that tenant has substantial difficulty in being involved and if there is an appropriate individual to support them. An independent Advocate must be appointed to support and represent the tenant for the purpose of assisting their involvement if these two conditions are met and if the individual is required to take part in one or more of the following processes described in the Care Act 2014:

* + - a needs assessment
    - a carer’s assessment
    - the preparation of a care and support or support plan
    - a review of a care and support or support plan
    - a safeguarding enquiry
    - a safeguarding adult review
    - an appeal against a local authority decision under Part 1 of the Care Act (subject to further consultation).

9.4 In Somerset the independent advocacy service is currently provided by Swan Advocacy.

Swan Advocacy

Somerset office

Hi-point, Thomas Street, Taunton, TA2 6HB

Phone 03333 44 7928

Email [Somerset@swanadvocacy.org.uk](mailto:Somerset@swanadvocacy.org.uk)

Website [www.somerset-ias.org.uk](http://www.somerset-ias.org.uk)

# Social and Added Value

10.1 The Public Services (Social Value) Act 2012 requires that all contracts should deliver some further benefit back into the community above and beyond the goods or services being paid for under the contract.

10.2 The Service Purchaser recognises that social value is about maximising the impact of public expenditure. Social value is defined as ‘the additional benefit to the community from a commissioning / procurement process over and above the direct purchasing of goods, services and outcomes’ (Social Enterprise UK: the Social Value Guide 2012).

10.3 The Service Provider is required to introduce innovative ideas to promote social value over the lifetime of the contract which may be based on social, environmental or economic sustainability.

10.4 The priority areas for Somerset as set out in the Somerset County Council Social Value Policy Statement are:

* + - Developing employment, skills and training opportunities
    - Improving the health and wellbeing of local residents, employees and reducing health inequalities.
    - Helping build community capacity and playing an active role in the local community.
    - Creating opportunities for micro-Service Providers / small and medium enterprises to be part of supply chains.



10.5 The Service Provider is also expected to introduce ideas for added value through improvements or additional services.

# Service aims, standards and outcomes

Tenants with assessed care needs

11.1Tenants with assessed care needs can expect the Service Provider to:

* meet the assessed eligible outcomes agreed within the What Matters To Me care and support plan (92)
* focus on the care and support needs of a tenant in every aspect of their life and give the right level of support wherever possible.
* plan support that enables tenants to take more responsibility for increasing their independence and reducing dependency on care and support over time.
* focus support on what tenants can or would like to do to regain and or maintain their independence and not only on what they cannot do.
* deliver continuity of care by staff the tenant knows.
* ensure that tenants who need an Advocate have one.
* develop a daily care and support plan that empowers the person as much as possible by recognising what they want to do.
* undertake an on-going review of the agreed outcomes, and make small changes that may increase or decrease the support a tenants needs following an agreed process.
* provide tenants with information about their care and support and tell them how they can give feedback.
* promote confidence in the provision of high quality care and support at home.
* apply a personalised approach to how and when care and support is arranged in agreement with the tenant.
* promote choice, control and inclusion with access to services which enable the tenant to remain living independently in their own home to meet their individual requirements.
* work in a joined up way with other care and support, health, voluntary and community sectors.
* take a proactive approach to positive risk taking.

For the Service Provider

11.2 The Service Provider will be responsible for assessing the needs of all tenants and monitoring any risks associated with this Assessment, which will be reviewed at least annually or more frequently as required and whenever there are any significant changes. There will be an expectation that the designated on-site team will respond to changing needs flexibly, and where necessary, arrange for Adult Social Care staff to review a tenants assessed needs. This is essential to meet the needs of any ECH tenant

11.3 The Housing Provider and Service Provider will comply with the governance arrangements set out in Appendix 3, ECH governance arrangements.

* attend allocation meetings with Adult Social Care staff and Housing Provider staff
* arrange for on-site staff to have monthly or bi-monthly team meetings
* managers must meet weekly to discuss care/support and on-site arrangements
* arrange monthly or bi monthly meetings of senior managers to ensure local partnership arrangements for the scheme are being met.

11.4 Tennyson Court ECH scheme will have a designated on-site team that will respond to assessed care needs. In addition the team will provide a housing related support and a crisis and urgent response service that can respond in an emergency at any time of the day or night. The CQC registered provider of the integrated care and support service will be required to have a formal agreement with the Housing Provider to ensure that a 24/7 presence is maintained.

11.5 The Service Provider will be required to have appropriate registration with the Care Quality Commission (CQC) for the delivery of care including incidental care.

11.6 The Service Provider will ensure that appropriate numbers of staff with the correct training, skills, ability, knowledge or experience are available to deliver the service 24/7 that meets the assessed needs of all tenants.

11.7 The Service Provider will be responsible for ensuring that all staff working on the scheme will be trained to the standards set by the Housing Provider for the delivery of housing related support services and scheme cover. The Housing Provider of the ECH scheme(s) will be responsible for ensuring that the covering staff have access to emergency/contingency planning arrangements in the event of, for example, a fire or lack of electricity, and appropriate cover arrangements are in place in the event of sickness or other absence. All staff who are employed to deliver the service will complete a scheme induction and tour of the building which will include the following as a minimum standard:

* security of the building
* fire and evacuation procedures
* use of fire equipment
* on call alarm system
* accident reporting
* safeguarding

Standards for all tenants of Extra Care Housing

11.8 The following standards are for the Service Provider and they set out what tenants can expect.

*Care and support workers will:*

* introduce themselves when they arrive
* understand what the tenants want to achieve
* know the tenant and their integrated Care and Support plan
* be trained to deliver the complete support needed
* always deliver care and support to a high standard with a focus on supporting independence and choice.

*When care and support workers visit they will:*

* focus their attention on the tenant
* remember and be respectful that they are in the tenant’s home
* check the daily integrated Care and Support plan and medicines administration records
* be pleasant and treat tenants with dignity and respect
* aim to arrive on time and will always call to say if they are going to be late or early
* always knock/ring doorbell waiting for a response to gain entry, as with any individual’s home in the community, unless by prior written agreement for those who cannot easily answer the door
* report any changes needed to a supervisor
* say when they are leaving
* make sure at the start of each visit that they will agree what support they are assisting with and record it in the care and support plan
* make sure tenants are comfortable at all times
* talk to the tenant in an appropriate and respectful manner
* check that the tenant is happy with the support given and share anything that needs to improve
* be aware of and respect other household members, family and carers
* ensure that appliances that have been used are turned off after use and prior to leaving.
* be aware and respect a tenant’s property for example: covering footware to avoid leaving mud on the carpet

*The following checklist is for the Service Provider to complete with tenants*

* I have agreed a clear plan that tells me how and when I will be supported with clear outcomes for the period of support.
* I know the name of the Service Provider supporting me and I know how to contact them when I need to.
* I know what to expect from the Service Provider supporting me and they have given me clear standards that tell me what I can expect.
* I review my integrated Care and Support Plan regularly with the Service Provider who supports me.
* I am clear that this support will help me do more myself.

11.9 The following outcomes apply to all services covered by this specification. It is expected that the Service Provider will incorporate these outcomes into their approach to quality assurance and monitoring as part of the service development approach:

* I am able to choose what care and support I need. It is delivered consistently by someone who I know and understands me.
* All the people involved in my integrated care talk to each other: I know what to expect and that I will only have to tell my story once.
* I know who to talk to when I am unhappy with my integrated care and I know that I will be heard when I do.
* I can change my integrated Care and Support Plan arrangements when they are not working for me and I know what I am paying for.
* I feel safe. I know that my care is high quality and that it meets my needs.
* My wider support network is well integrated with care and community support.
* I am treated with dignity, respect and compassion and those that are close to me are effectively supported.
* I know that I won’t be admitted to hospital or kept in hospital unless it is absolutely necessary.
* My Service Provider helps me regain, improve and maintain my independence and control.
* My emotional, intellectual, social, mental and physical wellbeing are treated as equally important.
* I can do most things for myself and I am able to take risks.
* My carer can continue to care for and support me whilst the care worker is also supporting me, and my integrated care arrangements will complement my carer and my existing support arrangements.

# Allocation

12.1 Placements into ECH will be determined by a Countywide Allocation Panel which will consist of the Housing Provider, the Service Provider and a Team Manager or named Advanced Practitioner from Adult Social Care. Panel meetings will be monthly or as and when required. Please refer to Appendix 2 ECH pathway.

12.2 The Housing Provider will assess the individual’s needs for this type of supported accommodation. Adult Social Care will assess an individual’s needs for social care services. This may be a joint visit or one provider following up the first contact made by the other. The Assessment will involve Somerset Partnership where appropriate. Documentation will be shared between panel members.

12.3 The Service Provider at the request of the Service Purchaser can carry out initial needs assessment for the scheme under a Trusted Assessor role. These assessments will be requested by the Service Purchaser and will support the What Matters To Me assessment (Appendix 10).

12.4 Waiting lists will be monitored by the countywide ECH Allocations Panel through Homefinder Somerset.

12.5 Applicants should be encouraged to visit the scheme before committing themselves to an application or being considered for a tenancy.

12.6 ECH should be a housing option based on the needs assessment of an individual and should include home owners.

12.7 Housing providers must notify Adult Social Care when a void occurs or notice of a vacancy is received and put this onto Homefinder Somerset.

12.8 The allocation of the tenancy in ECH should be agreed by the countywide ECH Allocations Panel prior to the offer of a tenancy being made.

12.9 If the Allocation Panel members are unable to allocate to a void property within four weeks the Housing Provider can source a suitable tenant to enable the rental of the property to avoid the loss of income.

12.10 The Housing Provider will inform prospective tenants of panel decisions. If a prospective tenant is refused a property, they have the right to request information on the reasons why. The Housing Provider will be responsible for responding to this request.

**13. Contract management and performance**

13.1 The Service Purchaser will monitor overall performance of the Service Provider against the contract and specification and implementation plan. This will involve a focus on performance and quality as well as operational issues.

13.2 The Service Provider shall manage financial and operational arrangements to optimum capacity, best value and development to ensure that Service Users receive the best service possible. The Service Provider is encouraged to be innovative and develop services to meet local demand in a way that keeps them sustainable. The Service Provider shall pro-actively seek to add value and expand services by seeking external funding opportunities to develop new service approaches based on identified Service User needs.

13.3 The Service Provider must comply with the Contract, risk management and quality policy, Appendix 4, and its associated processes, in addition to the requirements stated within this specification.

13.4 Any organisation legally able to review service quality, including those commissioned to do so on the Purchaser’s behalf (for example, Healthwatch), must be given every support to talk to Service Users individually about the services they receive as well as staff and any sub-contractors.

13.5 Information will be made available by the Service Provider, including quality ratings, inspection reports, action plans and other documents produced by CQC in the operation of their regulatory function, together with the Service Provider’s own quality assurance procedures and measures, which will be provided to the Service Purchaser on request.

13.6 The Service Provider will have the necessary administrative systems in place to ensure good support services are provided.

13.7 The Service Provider will be required to provide specific monitoring information as requested through the self-assessment form to demonstrate the following:

General

* The number of tenants on the scheme
* The age and sex of tenants on the scheme
* The number of tenants that moved in
* The number of tenant that have moved on
* The number of tenants receiving support
* The number of tenants receiving assessed care
* The number of tenants privately purchasing care
* The number of tenants who have used the crisis and

emergency response service

* Evidence of social value and added value
* Service satisfaction data e.g. tenant surveys and actions

Assessed care

The requirements are set out in Appendix 4, Contract, risk management and quality policy.

13.8 Periodically the Service Purchaser will require examples through case studies that demonstrate how the service is meeting tenant’s needs.

SCHEDULE 1 - KEY SERVICE PRINCIPLES AND OPERATIONAL REQUIREMENTS FOR THE PROVISION OF CARE AND SUPPORT

# Assessment and referrals

**Key Principle 1: The needs of Service Users (and their carers where appropriate) are individually assessed by the Service Provider to help their planning and delivery of care**

**Operational Requirements:**

* 1. The Service Provider will carry out their own Assessment with the

Service User to aid their planning of the delivery of care and/or support, proportionate to the type of service being considered to agree details with the Service User of how to achieve outcomes, and, where applicable, in context with any other services that the Service User may already be in receipt of and/or proposed.

* 1. Details of the assessment and referral process are specified within the

associated service specification and the Service Provider will have a prompt and efficient system for responding to referrals including emergency referrals.

1.3 The Service Provider will ensure that any previous support by another

Service Provider or service will comply with any agreed transition plans.

1.4 The Service Provider will set out standards and overall outcomes, use

checklists to ensure Service Users are clear what to expect. These standards, outcomes and the checklist will meet or exceed those in section 11 of this specification.

1.5

Before a referral is made to the service provider by the referrer, the needs of each individual adult along with their potential outcomes will be identified by a social care professional and documented as clearly achievable outcomes within the What Matters To Me. (Appendix 10)

1.6 Referrals to the Service Provider will be in accordance with the pathway detailed in Appendix 2, ECH pathway.

1.7 The Service Provider will work in partnership with Adult Social Care.

1.8 The Service Purchaser, or an organisation authorised to act on its behalf (‘the Referrer’) will make the initial referral to the Service Provider.

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1.9 The start date for each individual will be agreed with the Service User and/or their representative(s) and the Referrer based on the individual needs and the urgency of the service.

1.10 The Service Provider will develop the agreed outcomes within the Care and Support Plan into a programme of support with clear tasks to support the Service User, based on a reablement approach where appropriate. There should be clear timescales within the plan that evidence the achievement of outcomes over the duration of the service.

1.11 The Service Provider will arrange an introductory assessment visit for each Service User. What Matters to Me (Appendix 10) will underpin the provider programme. This will be agreed by the Service User or with their consent, their carer and/or their representative(s).

1.12 The individual Care and Support plan will be focused on maintaining care and support and where possible, supporting self- management and the developing potential for independent living.

1.13 The provision of assessed care will deliver the outcomes agreed by Adult Social Care staff with the Service User (and their representative if appropriate) in their care and support plan.

1.14 If the Service User has been in hospital and has a pre-existing care package and this continues to meet their longer-term needs it should continue with the existing provider and any assessed charge must continue to be paid.

1.15 Where the Service User has completed an intense reablement service, through Re Able Somerset and a long term care and support service is required, the two providers will work together to ensure a smooth handover. What Matters To Me (Appendix 10) will be developed by the Re Able Somerset provider and agreed by Adult Social Care.

# Care and support planning and delivery

**Key principle 2: Service Users have the information they need to remain independent**

**Operational requirements:**

2.1

* + 1. Where Service Users have chosen to manage their Personal Budget either through a Direct Payment or Individual Service Fund (ISF), they have the information they need that supports them to make informed choices about their care and support arrangements.

2.2 Service Users know what to expect from the care and support service and have a clear plan that they have developed with the Service Provider built on the outcomes set out in the Care and Support plan.

2.3 Service Users have the time they need to understand the information they are given. Sometimes Service Users may need an Advocate to help them**.**

2.4 All information is accessible and understandable:

* + Easy to read and in plain English and in a suitable format
  + Available in the Service Users language
  + Available in different formats (paper, electronic, telephone)

2.5

* 1. The Service User has clear information about how their care and support is delivered (Welcome Pack).

2.6 Service Users have the time to understand the information within the Welcome Packs and this will also hold key information and guidance including:

* + - the registered manager or Service Provider
    - Somerset Direct and emergency duty details
    - Healthwatch Somerset
    - the core service values, including expected standards and the overarching Service User outcomes.as outlined in the What Matters To Me (Appendix 10)

2.7 Service Users know what they should do if they would like to give feedback, including making formal complaints, compliments and comments and how it will be followed up.

2.8

* 1. Service Users know how to request a review of their care and support.

2.9 Information is updated and reviewed regularly and any changes are clearly documented.

2.10 The Service Provider will consider the need for an independent Advocate, if a Service User lives alone or lacks capacity or has difficulty in expressing their views and aspirations and has no one else to support them.

**Key principle 3: Service Users have choice and control about how their**

**needs are met with a well-planned and positive experience when they**

**start with their Service Purchaser**

**Operational requirements:**

2.11

The Service Provider will ensure prompt contact is made with the Service User and or their carer or representative to introduce a named member of staff and arrange an initial meeting.

2.12 Service Users and their family/carers are treated with empathy, courtesy and respect and in a dignified way by:

* + - agreeing their expectations about their care and support
    - always respecting confidentiality and privacy
    - providing a reliable service that Service Users and their carers can trust
    - regularly seeking feedback about quality and suitability of care and delivering improvements/changes as a result.
    - prioritising continuity of care
    - using a core team of workers that the Service User knows.

2.13 Service Users are able to talk about their aspirations, needs and priorities as well as what gives them peace of mind and makes them feel safe and unsafe.

2.14 Service Users are able to choose how care and support is provided in line with their personal preferences and lifestyle including areas of their life such as faith, culture, sexuality etc.

2.15 Service Users are supported to maintain or increase their independence wherever possible. Where possible, tasks will be carried out with the person and not for them.

2.16 The Service User will be supported to take agreed risks as set out in their Care and Support plan.

**Key principle 4: Service Users will know what they can expect from their chosen Service Provider and will agree a daily care plan with their Service Provider that is designed to meet their aspirations, needs and goals and reflects the outcomes set out in the What Matters To Me document.**

**Operational requirements:**

2.17

The Service Provider will plan with the Service User and their family/carer / chosen representative how care and support at home may be used flexibly for a variety of tasks according to what is needed and will set this out in the daily care plan.

2.18 Service Users will receive a copy of their daily care plan in a format that meets their needs.

2.19 The daily care plan will set out how the Service Provider will meet the assessed outcomes stated in What Matters To Me.

2.20 The daily care plan will be updated regularly to reflect the current needs of the Service User receiving the service.

2.21 The daily care plan will state any medical requirements that may be part of the provision of care and support arrangements.

2.22 The daily diary log will be completed after each visit to provide an up to date overview of the Service User’s wellbeing.

2.23 The Service Provider will work in partnership with other agencies if they are supporting the Service User to make sure that care and support is delivered in a joined up way ideally in one clear plan.

2.24 The Service Provider will continuously review the care and support arrangements to promote independence and where appropriate, in accordance with the Service Provider review criteria to reduce or increase the package of care.

2.25 The Service Provider will involve the Service User and their family/carers or anyone else they would like in all aspects of the service. The Service Provider will arrange visits in a way that allows staff to arrive at the agreed times and enables them to undertake what has been agreed during each visit.

2.26 Where there is an assessed need for two carers to support particular activity, this second carer may be the Service User’s main carer, and not a second carer from the Service Provider.

2.27 The Service Provider is focused on achieving outcomes, prevention and wellbeing.

2.28 Where the Care and Support plan identifies one care worker, or a need for a reduction of support from two carer workers to one care worker, either supported by training and the use of equipment or by the support of the Service Users unpaid care, the Care and Support plan will provide the appropriate professional risk assessment to support the change.

**Key principle 5:****Service Users receive a high quality, flexible, consistent and reliable care and support at home service:**

**Operational Requirements:**

2.29

* 1. The Service Provider will ensure staff read and understand the daily care and support plan and daily log before providing any services.

2.30 The Service User using the service and their family/carers (if the Service User has involved them in their care) can direct the way their care and support is delivered.

2.31 Staff will arrive at the time and place agreed with the Service User (on-time refers to a flexibility of 30 minutes either side of the scheduled visit).

2.32 The Service Provider will inform the Service User using the service if the visit time changes by more than 30 minutes from that agreed.

2.33 The daily care plan will be developed in advance of the agreed regular visits.

2.34 Service Users are given at least 24 hours’ notice of a change of service unless circumstances are exceptional.

2.35 Service Users will receive up to date information about times of visits and names of visiting staff in a timely manner.

2.36 The Service Provider will prioritise continuity of care so that the Service User knows the staff who will be visiting them and the staff are familiar to them. This will include:

* introducing Service Users to new staff.
* matching staff to the individual’s needs, preferences and wishes where appropriate
* building teams of workers around the Service User and their family/carer.
* informing Service Users in advance if staff will be changed and why.
* working with Service Users to negotiate changes to their daily care plan if needed.
* recognising that changes in staff can make Service Users feel unsettled and therefore be detrimental to their wellbeing.

2.37

* 1. The Service Provider will use the agreed review process if the care package needs to change. These may be triggered by:
* changes in need or family circumstances
* repeated cancellation of service
* hospital admission

2.38

* 1. The Service Provider will ensure that services that include the provision

of personal care are appropriately registered with the Care Quality Commission (CQC). Personal care is defined in the Health and Social Care Act 2008 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2.39 Where a service is regulated by the Care Quality Commission (CQC) the Service Provider will comply with the current standards applicable to the service at all times. For the avoidance of doubt should the definition of personal care, regulated activities, regulations or guidance change the Service Provider will ensure compliance with all CQC requirements prevailing at the time the service is delivered.

**Key principle 6: The Service Provider is able to meet Service Users’ needs as stated in their What Matters To Me:**

**Operational Requirements:**

2.40

* 1. Sufficient staff are available at key times during the day and minimum reliance is placed on agency cover to maintain staffing levels.

2.41 Visits are arranged with the Service User so that staff are able to arrive at the agreed time and spend the agreed time that is sufficient to meet the agreed outcomes set in the daily care plan.

2.42 The Service Provider will ask Service Users which elements of their service are a priority for them and whether some of the time may be used flexibly for a variety of tasks according to what is needed to help achieve their outcomes.

2.43 The Service Provider empowers the Service User as much as possible by recognising what they can and want to do.

2.44 The Service Provider is informed by the experience, skills and insight of the carers providing the service as appropriate.

2.45 The Service Provider describes how success and outcomes will be measured in the daily care and support plan.

2.46 The Service Provider sets realistic expectations about what is achievable and when.

2.47 The Service Provider encourages Service Users to access on site activities and services including those within the local community.

# Arranging care

3.1 This service will be provided by the contracted care provider for the ECH scheme where the person lives. The provider will follow the pathway for assessed care in Appendix 2, ECH pathway.

3.2 The Service Provider and the Referrer have responsibility for ensuring the Service User and or their representative, has all the relevant information they require to safely start the initial care provision.

3.3 Care and support will be planned and delivered by dedicated care staff under the leadership and supervision of the Service Provider. The daily care plan must be developed with the Service User and achieve the outcomes agreed in the What Matter To Me Care and Support Plan. The provider will be responsible for overseeing the delivery of care towards these outcomes, and for reviewing and informing the appropriate Adult Social Care team about the person’s progress.

3.4 The Service Provider will regularly liaise with Adult Social Care staff or the care manager. The Service Provider and Adult Social Care staff will be available to each other to discuss new and on-going cases (or will have a deputy arrangement in their absence).

# Review and monitoring of Service User needs

**Key Principle 7: The Service Provider will continuously monitor the needs of the Service User**

**Operational Requirements:**

4.1 Adult Social Care Service will annually (as a minimum) undertake a full review of the Service User’s needs. The review is of the entirety of the individual’s care plan and therefore may address issues beyond the remit of the Service Provider. The purpose of the review is to ensure that the services being delivered continue to address the presenting needs and risks in the view of Service User and where appropriate their carer, the care workers and the Service Provider delivering services and other key stakeholders.

4.2 The Service Provider will monitor the achievement of, and progress towards, individual outcomes within the agreed timescales identified in the care plan.

4.3 The Service Provider will work with the Housing Provider to reduce the size of care packages by looking at a range of innovative solutions i.e. provision of scheme activities and local community support options.

4.4 The Service Provider will alert the Service Purchaser as soon as practicable when outcomes have been met, particularly where this could result in a reduction in the care and support required.

4.5 The Service Provider must signal the need for review of the Care Plan to the Service Purchaser as soon as practicable where there is any significant change beyond that which can be changed as set out in the Service Provider reviews process.

4.6 The Service Purchaser may, if appropriate, invite the Service User to have present any Carer/family/advocate and any other significant professional working with the Service User. A suitable staff member from the Service Provider must also attend the review meeting.

4.7 The following information will be made available to the Service Purchaser for review meetings on request:

* + - the information pack – dated, reviewed annually and updated as necessary.
    - the diary log - the Service Provider will record evidence of contact and when information is provided to Service Users on a diary log, these will involve outcomes focused summary / review.
    - the daily care plan.
    - Service User Assessment - evidence of user involvement in planning.
    - evidence of Service Provider monitoring of individual services and recording outcomes and actions.
    - feedback from Service Users who use the service.
    - invoice / delivery notes
    - ISF 3 way agreements (where used)
    - spot visits.
    - latest CQC inspection report.

# Temporary Suspension, Re-Start and ceasing of care packages

**Key Principle 8: When Service Users go into hospital they know that when they are ready to leave there will be a joined up, planned approach to help them return home as quickly as possible.**

**Operational Requirements:**

5.1

* 1. The Service Provider will be proactive in communicating with hospitals

following admission.

5.2 The Service Provider will liaise with hospitals to plan for a timely, smooth discharge.

5.3 The Service Provider will follow the hospital re-start process as set out in Appendix 5, Restarting a package of care following a stay in hospital, which includes a checklist to be used to cover the key areas to be discussed with ward staff in hospitals.

5.4 Where possible the Service User will be supported by care workers previously known to them.

5.5 Daily care plans will reflect any changes in need.

5.6 The Service Provider is not expected to terminate care packages other than in exceptional circumstances and by negotiation with the Service Purchaser. The Service Provider will retain supportive evidence of all reasonable steps taken to avoid such a termination. The Service Provider will advise the Service User that they have terminated the Service once that has been agreed with the Service Purchaser.

5.7 Any period of notice will be by agreement to support individual circumstances.

# Record Keeping

**Key Principle 9: Service Users are confident that the Service Provider keeps accurate and up to date records that are safe both within the Service User’s home and with the Service Provider.**

**Operational Requirements:**

6.1

* 1. The Service Provider will maintain all the records required for the

protection of Service Users.

6.2 Records will be secure, up to date and in good order and are constructed, maintained and used in accordance with the Data Protection Act 1998 and other statutory requirements.

6.3 Service Users must be aware of the data held about them and agree to this information being held.

6.4 Service Users or their representatives, where appropriate, will have access to their records and information held about them by the Service Provider and are facilitated in obtaining access when necessary.

6.5 Service Provider staff will record the date and time of every visit, the support provided and any significant occurrence. Records will include:

* assistance with medication
* financial transactions undertaken
* details of changes in the Service User’s circumstances, for example support needs, health condition.
* any accident to the Service User and/or support worker
* any other untoward incidents activities undertaken and any particular achievements or outcomes
* any information that will assist the next support worker to ensure consistency of service provision.

6.6

* 1. Daily records will be factual, legible, signed and dated and kept in

safe place as agreed with the Service User.

6.7 Service Users will be informed about what is written and will have access to it.

6.8 Records will be kept in the home for a minimum of one month after which they will be retained by the Service Provider. Records will be available to the Service Purchaser on request.

6.9 Service Users will be encouraged to have records kept in their home. Where Service User does not agree the Service Provider will record this refusal on the personal file held by the Service Provider. The Service Provider will notify the Service Purchaser of the Service User’s decision.

# Using the Local Community for facilities and services

**Key principle 10: Service Users have opportunities to engage with the local community:**

**Operational Requirements:**

7.1

* 1. Staff are aware of, or know how to find out about activities provided by the Housing Provider on the ECH scheme, local community groups and other such links / partnerships.

7.2 Service Users will receive the support they need to foster and maintain friendships and networks within their ECH scheme and in their local community.

7.3 The Service Provider supports Service Users to access scheme activities provided by the Housing Provider as well as local community activities / groups and where possible reduces or eliminates unnecessary dependence for Service Users using the service.

7.4 The Service Provider works with the Housing Provider to promote community capacity building so that Service Users using their services are able to feel connected and involved within their ECH scheme and in their community if they want to.

7.5 The Service Provider will promote community inclusion and seek opportunities for joint working with other agencies and community groups to identify opportunities for involvement for the Service Users they work with in their community.

7.6 The Service Provider will consider the impact of social isolation on the Service User’s health and wellbeing and work with the Housing Provider to consider using voluntary and community organisations to maintain family and community links, working with the family/carer where appropriate.

7.7 The Service Provider will work with the Housing Provider to identify a range of community connections so that Service Users using their services are able to feel valued and involved in their community.

7.8 Service Users are supported to be part of their local ECH scheme community and use the available facilities.

**Key Principle 11: The Service Provider understands and engages with the community in which it operates and reflects this in service planning and development:**

**Operational Requirements:**

7.9

* 1. The Service Provider works collaboratively with other Service Providers

to ensure a diverse and flexible market by helping to identify unmet need and by using experience in delivery to develop the service.

7.10 The Service Provider will attend appropriate forums and meetings both with the Service Purchaser and their partners to ensure that service ideas and issues are shared and that solutions are sourced in a consistent manner.

7.11 The Service Provider will ensure Service Users have access to information and choice of service, as well as promoting their service through the Somerset Choices website.

7.12 The Service Provider will use Somerset Choices as a tool to help the individual look for local community facilities and assist with arrangements necessary to enable this to happen.

# Keeping safe: Data Protection

**Key principle 12: Service Users know that information about them is handled appropriately and that their right to privacy is respected:**

**Operational Requirements:**

8.1

* 1. The Service Provider will ensure that all appropriate measures are

taken to maintain Service User’s privacy in accordance with the Data Protection Act, The Mental Capacity Act and the Information Sharing Protocol. See Appendix 6, Information sharing protocol.

8.2 Summarised information for these practices and processes is given to the Service User at the start of service provision and the Service User knows how to find the full version.

8.3 Service Users understand how their information is protected and what it is used for.

# Keeping Safe: Management of Medicines and Mental Capacity

**Key Principle 13: Service Users feel safe to be assisted to maintain responsibility for their own medicines wherever possible:**

**Operational Requirements:**

9.1

* 1. Service Providers must have a medicines management policy that

does not exceed the Clinical tasks and medicines policy (Appendix 7) which must be followed at all times.

9.2 The Service Provider will regularly liaise with the prescriber about the Service User’s medicines, particularly if there are any concerns.

9.3 The daily care plan will contain information and guidance about the Service User’s medicines.

9.4 The Medicine Administration Record (MAR) must be checked before assisting with, or administering, medicines and must be updated afterwards.

**Key Principle 14:** **Service Users are supported as much as possible in any decisions made on their behalf and these decisions will be in their best interest.**

**Operational Requirements:**

9.5

* 1. The Service Provider must ensure that the service considers the

capacity of Service Users at all times in line with the Mental Capacity Act (MCA) and the Code of Practice, with all efforts possible being made to maximise involvement and engagement within legislative frameworks and best practice approaches.

This will include working to the five principles of the MCA, Best Interests, the use of independent advocacy and involvement of Service Users who are important to the individual and / or who have Power of attorney for the Service User.

9.6 The Service Provider will have procedures in place to record Best Interest decisions made and will have a clear process for staff to follow when making a Best Interest decision.

# Keeping Safe: Safeguarding

**Key Principle 15: Service Users are protected from abuse, neglect or self-harm and they feel confident that they will be supported in a timely and dignified manner if their needs change.**

**Operational Requirements:**

10.1

* 1. Service Providers will have policies and procedures for dealing with

allegations of abuse that align with the Service Purchaser’s safeguarding policies for adults and children and statutory safeguarding legislation and guidance. See Appendix 12, Somerset safeguarding statement.

10.2 The Service Provider will ensure that all safeguarding duties set out in the Care Act 2014 and the Safeguarding Vulnerable Groups Act 2006 will be adhered to and that their staff know about the safeguarding requirements in the Care Act 2014 and have the appropriate training which is updated as part of the on-going training plan.

10.3 Service Providers will have policies in place that ensure their staff are supported through any safeguarding process.

10.4 The Service Provider will be required to co-operate with the Service Purchaser in any investigation undertaken.

10.5 The Service Provider will carry out their own risk assessment for each Service User they support. This will cover environmental and personal risks. The risk assessment must be signed and dated.

10.6 The Service Provider will ensure that the health, safety and welfare of Service Users is promoted and protected at all times.

10.7 The Service Purchaser has the power to require others to make enquiries under section 42 of the Care Act and the Service Provider will be required to co-operate with the Service Purchaser in any investigation undertaken.

10.8 The Service Purchaser will follow a risk management process to determine whether to instigate a quality improvement process or a safeguarding management process as set out in Appendix 4 Contract, risk management and quality policy.

10.9 Service Users are confident that staff will make every effort to check on their wellbeing if they don’t answer the door on arrival and will follow the Service Purchaser’s no response policy. See Appendix 8 No Response Policy and Appendix 9, No response guidance.

10.10 The Service Provider will build a culture in which the reporting of safety and abuse concerns is understood as a marker of good care.

10.11 Serious and untoward incidents (SUIs) are identified and procedures followed with the Service Purchaser being notified immediately.

**Key Principle 16: Service Users are confident that their health, safety and welfare are protected by robust incident, accident and near miss reporting.**

**Operational Requirements:**

10.12 The Service Provider will have appropriate and proportionate written policies for the recording and reporting of all accidents, incidents, safeguarding alerts and near misses.

10.13 The Service Provider will immediately inform the Service Purchaser and the CQC, if there are any incidents that necessitate the involvement of the Health and Safety Executive under RIDDOR.

10.14 Any accident, incident or near miss which could be reasonably expected to have an effect on the assessed needs, general welfare or well-being of a Service User must be reported to the Service Purchaser immediately, or as soon as the potential effect becomes known (whichever is sooner). The Service Provider’s appropriate documentation should be used and a report made which identifies the actions taken, including any specific requests being made by the Service Purchaser as well as any specific actions proposed by the Service Provider. The Service Purchaser will then review the incident and instigate any further action as required.

10.17 Where accidents, incidents, safeguarding alerts and near misses result in potential distress / harm being caused to Service Users other than the Service User, the Service Provider will have a responsibility to ensure that appropriate support and / or signposting to other services is provided to the affected individual(s).

# Property

**Key principle 17: Service Users feel confident that their property (and access to it), possessions and money are protected at all times.**

**Operational Requirements:**

11.1

* 1. The Service Provider will have written policies and procedures on the

safe handling of money and the Service User’s property.

11.2 The Service Provider will have a written policy and procedures for investigation following any allegation of financial irregularities and will involve the police and the Service Purchaser.

11.3 Any money handled on behalf of a Service User must be accounted for to protect the Service User and staff using the following measures:

* + a record that is signed and dated by staff and the Service User.
  + a Service User’s money shall be kept separately from the staff money at all times.
  + a Service User’s money must not be held by staff or the Service Provider unless there is an agreed client account set up under the Individual Service Fund arrangements.
  + the Service Provider and their staff must never become involved in the Service User’s financial affairs including the borrowing or lending of money.
  + staff will not involve the Service User in any gambling.
  + staff will not take responsibility for looking after any valuable items on behalf of the Service User.
  + the Service Provider will replace any loss or damage to property or possessions caused by negligence or any other action of their staff.
  + the Service Provider, staff or their family members will not accept gifts or bequests from the Service Users they support. they will not advise on wills or act as witness or trustee or assume power of attorney on the Service User’s behalf.
  + staff must not enter a Service User’s home when they know that the Service User is not present and do not have permission to enter unless in exceptional circumstances, such as an emergency, in which case the police should be involved.
  + the Service Provider will ensure the security numbers of key safes are kept confidential, and that staff do not disclose this information to any other Service User or organisation.
  + a key must only be held by staff who require access for the purpose of providing care and support. The Service Provider must not copy additional keys without written permission from the Service User.
  + keys may not be held by the Service Provider if the Service User is not using the service.
  + all staff must be provided with, and wear during contracted hours, identification that shows:
* a photograph of the staff member.
* the name and signature of the staff member.
* the name and telephone number of the Service Provider.
* staff must not drink alcohol or smoke whilst on duty
* staff must not bring family members or pets into the Service User’s home

**Key principle 18: Service Users feel safe with their care and support Service Provider and they understand their rights and responsibilities:**

**Operational Requirements:**

11.4

Service Users feel supported by their Service Provider to take risks that help extend their opportunities. Service Users will be supported to understand the full implications of their choices.

11.5 The Service Provider will produce a risk assessment with each Service User they work with and this will be kept in the Service User’s home.

11.6 The Service Provider will ensure that managers and staff are made aware of and instructed to respond accordingly where choices and decisions are required for Service Users who are subject to Court of Protection or whose family members hold power of attorney. This will be recorded in the Service User’s daily care plan.

# Disaster Recovery Plan

**Key Principle 19: Service Users’ care and support will continue to be provided at safe levels during unexpected or unforeseen external circumstances.**

**Operational Requirements:**

12.1 The Service Provider will ensure that services continue to be provided where particular circumstances may affect the service.

12.2 The Service Provider will have a disaster recovery plan that is up to date and regularly tested.

# Risk Assessment

**Key Principle 20: Service Users feel safe at the service, and they and their representatives, fully understand their rights and responsibilities.**

**Operational Requirements:**

13.1

The Service Provider will recognise the Service Users’ right to take risks in order to extend opportunities and will ensure that Service Users are able to choose the risks they want to take and be given support to understand the full implications of their choices.

13.2 Service Users will be fully involved in formal risk assessments for everyday service activities that are carried out by trained staff and offer a balance between individual needs and preferences and the needs of other users and staff.

13.3 Copies of the Service Provider’s risk assessment report/s will be made available to Service Users and a copy left in the Service User’s home.

13.4 Service Users will be assisted to understand the possible consequences for themselves and others of their choices, and be supported to take responsibility for their actions and decisions recorded.

13.5 The Service Provider will ensure there are sufficient and competent staff at all times to ensure safety.

13.6 Every effort will be made to ensure that Service Users do not experience any form of bullying, harassment, or any other form of abuse. Any concerns must be reported through safeguarding adults’ arrangements.

13.7 The Service Provider will work to the recommendations in the risk assessment for the Service User provided by the referrer. The Service Provider will accept any additional training support offered, for example the use of equipment to reduce the need for two or more carers.

# Communication and culture

**Key principle 21: Service Users are able to use their preferred method of communication and do not feel marginalised because of their needs or because of their cultural, spiritual or religious beliefs, gender or disability:**

**Operational Requirements:**

The Service Provider will:

14.1 Liaise with the Service Purchaser to ensure aids and equipment are available to assist Service Users’ communication requirements as identified in the What Matters To Me care and support plan.

14.2 Support Service Users to use specialist communication aids as prescribed.

14.3 Make sure their staff are aware of preferred communication method and that they are appropriately trained and knowledgeable with the necessary communication skills.

14.4 Make sure that Service Users will be supported to communicate at the speed and style they wish.

14.5 Ensure staff are aware of any religious, cultural and spiritual needs of the Service User before commencing care.

14.6 Inform staff about the appropriate details / implications of cultural and religious belief or faiths.

14.7 Make appropriate arrangements for dietary and personal care needs in keeping with religious beliefs and cultural practices.

14.8 Ensure the needs of Service Users from black and ethnic minority groups are understood and catered for.

14.9 Ensure that all staff have regular equalities training and the Service is delivered in line with the Equality Act and the Public Sector Equality Duty.

14.10 All Service Users are treated with dignity and respect and are not subject to discrimination / harassment.

14.11 The Service Provider puts in place reasonable adjustments to accommodate Service User’s needs.

**Key principle 22: Service Users will be treated with dignity and respect at all times and their individuality will be respected in all aspects of the service.**

**Operational Requirements:**

14.12 Service Users are addressed by their preferred name and title at all times.

14.13 Support is provided in a way that maintains and respects the privacy, dignity and lifestyle of the Service User at all times.

14.15 Service Users will be helped with intimate physical care and treated sensitively, discretely and in a way that maintains their dignity. Support will be provided in the least intrusive way at all times.

**Key Principle 23: Service Users know how to give feedback about the services they receive**

**Operational Requirements:**

14.16 The Service Provider will tell Service Users about the different ways they or their representative can give feedback either in writing or in person.

14.17 The Service Provider will use both compliments and complaints as a valuable and welcomed source of feedback to continuously improve the services specified within this agreement.

14.18 The Service Provider must have a clear written procedure for dealing with compliments and complaints received from Service Users.

14.19 Service Users, carers and their families must be reassured that they will not be victimised for making a complaint.

14.20 Complaints about social work activities will be dealt with under the Adult Social Care Complaints Regulations 2009. Complaints about NHS services will be dealt with under NHS complaints procedures.

14.21 The Service Provider will listen to objectively, and act upon, the Service User’s views and concerns and encourage discussion and action on issues raised to seek to avoid/avert problems and the Service User feeling that they need to make a formal complaint in order for their views to be heard and/or acted upon. Feedback from compliments will be used to inform best practice across the specified services.

14.22 The Service Provider will maintain a log of compliments and complaints showing:

* the name of the Service User
* the contact details of the person giving the compliment or making the complaint
* the nature of the compliment or complaint
* the response to the compliment or complaint
* the level of satisfaction of the complainant to the Service Provider’s response to a complaint.

**The following complaints must be recorded in the complaints log:**

* any dissatisfaction brought to the attention of the Service Provider that cannot or has not been resolved locally to the satisfaction of the complainant.
* allegations of suspected abuse of a Service User or Carer, including physical, sexual, emotional and financial abuse (Please refer to Somerset's Safeguarding Adults Policy for guidance on the action required should a complaint of this nature be received).
* any situation where the complainant states either verbally or in writing that they wish to make a complaint.

14.23 The Service Provider will supply the Service Purchaser with an analysis of compliments and complaints received and their outcome for contract monitoring purposes, and an unredacted copy of the complaint log on request.

14.24 All serious complaints must be acknowledged as soon as practicable with details of:

* A named person to contact in the event of a query or if further information becomes available
* The names of any organisations, and where applicable named contacts, to which it has been referred
* The likely timescale within which the complaint can expect to be contacted again
* All complaints not of a serious nature must be responded to within 28 calendar days.

# Meeting the needs of Service Users with specific conditions

**Key principle 24: Service Users who have specific conditions including but not limited to dementia, mental health conditions and autism receive responsive services provided by appropriately skilled staff.**

**Operational Requirements:**

15.1 Many health conditions can fluctuate and / or change over time, whether that is on a daily basis and / or over weeks/months. The Service Provider must be able to deliver a service that can support the Service User appropriately through these changes in a flexible manner, which not only identifies the changes, but responds appropriately to them.

15.2 The Service Provider will respond accordingly and ensure that care is planned and delivered in a manner that addresses these issues. Examples may include prompting, changing the way in which care is delivered, such as offering finger foods that are left beside the individual rather than offering a large meal that is declined.

15.3 Staff should be equipped with the skills, knowledge and tools to understand behaviours that challenge others, what may be causing them and how to meet the needs of the individual accordingly. In many cases this will involve working in partnership with health and social care services.

15.4 Staff will have the skills, knowledge and tools to understand communication difficulties, what is causing them and how to meet the needs of the individual accordingly. This may be through the use of communication tools, information being simplified or put into alternative forms and staff training.

15.5 Care and support will be tailored accordingly to support the individual through an enablement / recovery model, the emphasis of which is focused on supporting the individual to complete a task / achieve an outcome themselves rather than doing it on their behalf.

15.6 Staff will have the skills, knowledge and tools to support individuals who have difficulties with memory and recognition. Memory and recognition can often be affected either on a short or long term basis and can lead to confusion, anxiety, behaviours that challenge, inability to identify needs and to undertake daily living skills.

15.7 The following Skills for Care guidelines and documents (and any updates, additions, replacements), as well as other national best practice guidance will be used to ensure that the Service is working to best practice models in delivering care and support to Service Users with specialist needs:

* + - Common Core Principles for Supporting Service Users with Dementia
    - Better domiciliary care for Service Users with dementia
    - Supporting Service Users in the advanced stages of dementia
    - Care Certificate – Standard 9 - Awareness of mental health, dementia and learning disability
    - Common Core Principles to support good mental health and wellbeing in adult social care
    - Principles to practice: The worker’s guide to implementing the common core principles to support good mental health and wellbeing in adult social care
    - Autism skills and knowledge list for workers in generic social care and health services.

15.8 Condition-specific training for staff should be mapped to theQualifications and Credit Framework (QCF) with staff being supported to work towards level 2 where they are working with Service Users with certain health conditions and level 3 standards where they are working with Service Users with complex / advanced needs in relation to their health condition.

In addition to this all staff should have training and knowledge in relation to other aspects of care and support for Service Users with certain health conditions / complex and specialist needs, for example the Mental Capacity Act.

15.9 In working with individuals with complex and specialist needs, the Service Provider will ensure that staff are supported accordingly through a variety of means including (but not limited to):

* + - availability of care planning / delivery tools, such as, one page profiles, This is me, memory boxes, life history work.
    - care planning and rotas that allow staff the time required and flexibility to deliver the outcomes identified.
    - a culture that recognises and supports staff in the challenges as well as the positives, of working with Service Users with complex and specialist needs including peer support, regular supervisions, reflective time.
    - leadership and management that values person-centred care and strives to work to best practice models.

# Workforce:

**Recruitment, Training and Supervision of staff**

**Key principle 25: Staff will be trained to an agreed standard, at an appropriate level to meet the needs of the Service Users who use the Service.**

**Operational Requirements:**

16.1 All managers of the service will be suitably experienced and qualified to effectively run the service.

16.2 The Service Provider will have a written recruitment and selection procedure including:

* job description
* person specification
* application form
* suitable references.

16.3 It is expected that the manager responsible for overall day to day management of the service will hold:

* a relevant occupational qualification equivalent to at least an NVQ at Level 4 and
* a qualification in Management that is also equivalent to at least Level 4.

16.4 Staff have the necessary knowledge, skills and experience to deliver the services that the Service Provider states will be provided.

16.5 All staff, employees and volunteers working with Service Users or who access Service Users data, will undergo checks through the Disclosure and Baring Service (DBS) at the appropriate level. The Service Provider will monitor the level and validity of the checks.

16.6 Staff will have the necessary training, experience, skills, competencies, personal qualities and caring attitudes to enable them to meet the needs of each Service User supported by the Service Provider.

16.7 Service Providers will ensure that where a Service User has complex needs (dementia, head injury, mental illness ), all staff allocated to provide support to the Service User are competent and have received the necessary training to be able to effectively work with the Service User.

16.8 Where volunteers are used they will receive a full induction to the service and training will be offered to address any skills shortfall.

16.9 The Service Provider will ensure provision of a structured induction process which is linked to relevant national standards and is completed by all new staff. A basic training programme for staff or volunteers, appropriate to the needs of the Service User group will be provided within an agreed period of taking up appointment.

16.10 The Service Provider will undertake a training needs analysis for each new member of staff and this will be incorporated into the staff training and development plan.

16.11 The need for refresher and updating training will be identified at least annually and will be incorporated into the staff development and training programme.

16.12 The Service Provider will provide ongoing training, development and supervision for all staff to maintain appropriate levels of skill and knowledge. The Service Provider will also provide refresher training on a regular basis and will assess each member of staff’s ongoing competence to perform tasks.

16.13 The Service Provider will ensure that they keep records of all staff training in line with CQC requirements and that they produce an Annual Training Plan detailing new and on-going training requirements to promote service quality and development.

16.14 The Service Provider must ensure that all staff are given a full Induction which covers the following, expected as a minimum standard by the Service Purchaser:

* Assistance with continence
* Safeguarding Vulnerable Adults
* Manual Handling – Moving and lifting
* Completed Dementia Friend training
* Communication
* Data Protection
* Risk Assessment
* Food Hygiene
* Basic Food Preparation and Healthy Meals (where appropriate)
* Health and Safety
* First Aid
* Medication
* Health Inequality Awareness Training Programme
* Support Planning
* Professional Boundaries
* Diversity / Equalities
* Mental Capacity Act
* Deprivation of Liberties
* Whistle Blowing
* Person Centred Approaches
* Skills Building
* Facilitating Community Inclusion
* Disaster Recovery Plan

16.15 Registering for the Care Certificate Induction training.

16.16 Ensure records are up to date and transferable to other Service Providers on request.

16.17 All Service Providers train at least one worker to Champion the Care Certificate. This will include sign up to the Service Purchaser’s Learning Centre to complete the Care Certificate Modules.

16.18 Staff will be supported to complete dementia friendly training and each Service Provider will have a Dementia Champion who will provide training and support to staff.

16.19 The Service Provider will assess the skills and training needs of staff moving to a new role and, based on this assessment, provide any training required in all or some of the standards required by the Care Certificate.

16.20 The Service Provider will ensure that new staff who achieved the Care Certificate while employed in a different role or organisation have retained the competences required by the Care Certificate and, if required, provide any training required in all or some of the standards required by the Care Certificate.

16.21 The Service Provider will ensure that before managers and staff work with Service Users they will receive:

* A thorough, supervised, induction to the specific service that they are employed within and;
* Any specific training required to meet the individual needs of the Service Users they are supporting and;
* Any additional training detailed in the relevant service specification for the service they are employed within.

16.22 Where relevant, Service Users, their carers and families will be involved in the delivery of training.

16.23 All training will be refreshed at intervals appropriate to the type of training that has been undertaken and/or to reflect any changes in law, policy or guidance.

16.24 The Service Provider will evidence appropriate monitoring of the training activity to ensure that it is of high quality and that the outcomes required of it are being met.

16.25 The Service Provider’s induction and basic training programmes will be submitted to the Service Purchaser on request.

16.26 The Service Provider will ensure that all staff receive regular supervision and have their standard of practice appraised at least annually.

16.27 Staff are aware of the process and updates are covered in supervision or regular communications.

16.28 All staff have the appropriate Disclosure and Barring Service (DBS) checks relevant to their roles.

**Workforce Planning**

**Key Principle 26: The Service Provider will have its own workforce plan and will be involved in the development of a workforce plan for the wider care and support at home sector in Somerset.**

**Operational Requirements:**

16.29 The Service Provider will have fair and flexible terms and conditions of employment which meet all relevant legislation.

16.30 The Service Provider will actively promote recruitment from a diverse applicant base.

16.31 The Service Provider will ensure that their approach to career progression is included in the workforce plan.

16.32 The Service Provider will attend meetings with the Service Purchaser to highlight workforce issues and work collaboratively to address and respond to recruitment, training and support.

16.33 The Service Provider will address the issues recommended within workforce plans and be honest and transparent about how they will adopt any changes within their organisation.

# Glossary

|  |  |
| --- | --- |
| Advocate | An independent individual/organisation who speaks on behalf of the Service User. |
| Assessment | A written assessment carried out with a Service User to establish his/her care needs. |
| Best Interests | This establishes whether there is a deprivation of liberty and whether this is:   – in fact in the Service User's best interests    – needed to keep the Service User safe from harm    – a reasonable response to the likelihood of the Service User suffering harm. |
| Care and Support Plan | A person centred plan which outlines the care needs, wishes, preferences and personal goals for the Service User. |
| CQC | Care Quality Commission – the regulatory body for care services. |
| Direct Payment | A cash payment made by a local authority to Service Users with eligible care needs so that they can buy their own care services. |
| Healthwatch | The independent consumer champion created to gather and represent the views of the public. Locally it:   * represents the views of Service Users who use services, carers and the public on the Health and Wellbeing Boards set up by local authorities. * provides a complaints advocacy service from 2013 to support Service Users who make a complaint about services. * reports concerns about the quality of health care to Healthwatch England which can then recommend that the CQC take action. |
| Individual Service Fund | A sum of money provided by the local authority to a Service Provider to manage on the Service User’s behalf. The money is restricted for use in provision of the Service User’s care and support and the Service User is empowered to plan with the Service Provider how the care and support is provided. |
| Service Provider | The organisation with whom the Service Purchaser has a contract to provide the specified services. |
| Service Purchaser | Somerset County Council. |
| Service User | An individual who is eligible for the specified services and is funded by the Service Purchaser. |

# APPENDICES

|  |  |  |
| --- | --- | --- |
| **APPENDIX NUMBER** | **TITLE** | **DOCUMENT** |
| Appendix 1 | List of schemes |  |
| Appendix 2 | ECH pathway |  |
| Appendix 3 | ECH governance arrangements |  |
| Appendix 4 | Contract, risk management and quality policy |  |
| Appendix 5 | Restarting a package of care following a stay in hospital |  |
| Appendix 6 | Information sharing protocol |  |
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| Appendix 10 | What Matters To Me Assessment |  |
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