CARE AND SUPPORT IN THE HOME SERVICES SPECIFICATION

Service	This Schedule defines the Services and activities in scope to be delivered within the Care and Support in the Home Service.
Strategic Commissioning Lead	Jack Moss - Senior Commissioning Manager

Table of Contents

1. Introduction

1.1.1. This Specification sets out the requirements of Care and Support in the Home Services. This brings together several Services within one Service Specification which were previously known as Home Care, Supporting Independence Services, Discharge to Assess and Extra Care Support. The objective of Care and Support in the Home Services is to support the Council's strategic objective 'to help people to improve or maintain their well-being and to live as independently as possible'. The Council has an ambition to deliver the Service through a sustainable market that has the capability and capacity to deliver a quality and accessible Service countywide, in both urban and rural locations

1.2. Care and Support in the Home

1.2.1. The Care and Support in the Home Service will replace a number of existing Services and bring the delivery of these multiple services together under one Contract to form an 'umbrella' of interventions. These interventions aim, wherever possible, to support a person to achieve the outcomes that are important to them, in line with the Care Act and the vision set out by the Council in its 'Your life, your well-being' Strategy.

1.2.2. Aligning Services under one contractual arrangement will enable the Council to promote a consistent approach to the delivery of Services and ensure equitable access to Services for residents across client groups and localities. It will also support the shaping of the market to focus on the personalisation and outcomes agendas within the 'Your life, your well-being' strategy. Services must all support the Council's strategic outcome that 'Older and vulnerable residents are safe and supported with choices to live independently'.

1.2.3. Bringing Services together will also develop a clearer pathway, with less transfers between Services for people, supporting improved continuity of care. Providers will also have greater flexibility and control to manage fluctuations in demand to meet assessed needs as defined by the Care Act.

1.2.4. Care and Support in the Home Services are designed to promote individual well-being and keep people safe, help people do as much as they can for themselves and allow people to live as independently as possible in their own home. Care and Support in the Home can provide suitable alternatives to Residential, Hospital, Parental or other institutional care.

1.2.5. In Kent, Care and Support in the Home Services will form part of a continuum of care and support delivered by the voluntary and community sector, private sector and the Councils In-House providers. This continuum of care and support ranges from support to access communities and care for people in their own homes, through to specific supported accommodation with appropriate levels of care for assessed need, to high-level residential and nursing care home accommodation.

1.2.6. This Specification describes the key features of the Service and the outcomes required and should be read in conjunction with the Terms and Conditions of the Contract, including the Contract Management Schedule.

1.2.7. It is imperative that people are at the heart of adult social care Services and activities are delivered in the way the person would like to receive them, with courtesy, dignity, compassion and respect. It is important that people receive Services that are easy to access, of good quality and that increase choice and control. Services must support people's well-being and maximise their ability to live independently and safely in their community.

1.2.8. This Specification also details how Providers must consider how Services are delivered, including with clear governance protocols and principles as a guide to their actions.

1.2.9. This Specification encourages those Providers with the ability and skills to organise their resources in the best way possible to achieve the outcomes specified. Providers are encouraged to operate flexibly and be innovative with delivery, with an emphasis on continuous learning and improving the delivery style.

2. Scope

2.1.1. The scope of this Contract (which constitutes Phase 1) includes the Home Care (formerly known as Domiciliary Services), Supporting Independence Services and the Service offer for more complex needs, Supporting Independence Services Plus. The Council may choose to change any aspect of this Specification during the life of the Contract. If the Council chooses to do this, they will discuss with the Provider any proposed changes and how they may be implemented. Changing national or local policies and priorities may also necessitate changes to the Specification. The views of Providers, people receiving support and their Care/Support Workers will be considered in any review of the Specification and their views will be welcomed at any time during the life of the Contract.

2.1.2. This Specification supports the aim of developing a new outcome-focused care model throughout the Contract term to meet the Council's strategic objective that 'Older and vulnerable residents are safe and supported with choices to live independently'. The Council's Modernisation Programme is delivering changes to its workforce and Services to drive improvement, underpinned by the 'Your life, your well-being' Strategy. There are a number of programmes which together deliver the objectives of the Strategy and implement new pathways across adult social care. These projects are delivering changes which sit under three key strands of activity:

2.1.2.1. **Promoting well-being**: Services which aim to prevent, delay or avoid people from entering formal social care or health systems, by helping people to manage their own health and well-being.

2.1.2.2. **Promoting independence**: Providing short-term support that aims to prevent or delay people's entry to the system and provide the best long-term outcome for people. They will have greater choice and control to lead healthier lives.

2.1.2.3. **Supporting Independence**: Services for people who need ongoing support that aims to maintain well-being and help people do as much as they can for themselves. The aim is to meet people's needs, keep them safe

and help them to live in their own homes, stay connected to their communities and avoid unnecessary stays in hospitals or care homes. Care and Support in the Home will fall within this category and will support people in the longer term to ensure their needs are met in a way that maintains their dignity and choice.

2.1.3. The Strategy can be found here:

https://www.kent.gov.uk/__data/assets/pdf_file/0003/66576/Your-life,-your-wellbeing-full-strategy.pdf

2.1.4. The Council's aspiration is to encourage and incorporate feedback by embracing the opportunity to work with people receiving Services and Providers over the life of the Contract and where necessary further define and refine the Service requirements and mechanisms for delivery. This will include but is not limited to further integration with Health colleagues, use of technology and delivery through consortia of Providers.

2.1.5. Providers will input into the design and piloting of any new activities to ensure the benefits of a co-produced model which will inform both this Service and future provision. The Council recognises the opportunity to improve the understanding of supply and demand and reserves the right to ask Providers for information, such as their workforce to help inform such areas.

2.1.6. The Services included for Phase 2, for which the Council will specify and determine commencement dates throughout the Contract Term, are:

2.1.7. Extra Care Support; Extra Care Housing is a form of accommodation where older people live independently with their own front door in a scheme that has a range of communal facilities and access to care staff 24 hours a day. There is care on-site, but it is not a care home. The care is flexible and can fit around a person's personal needs, and can support people with Dementia. It needs to support people as a direct alternative to residential care and must be able to address night time needs of people. Extra Care Support refers to the provision of flexible care and support hours within the Extra Care settings, not the built environment of the facilities.

2.1.8. Discharge to Assess; with the progress toward 'Home First'. The aim of the Discharge to Assess Service is to provide the wrap around support to people in their own homes for up to three days post discharge from hospital (with potential to extend for a further two days if the individual's outcomes will either negate the requirement for ongoing Service or reduce the need). It will be an integral part of Home First, which is where people go home with an enabling/assessment/short-term Service to essentially free up hospital beds and contribute to the Council's Delayed Transfer of Care (DTOC) requirements/targets. The focus of the Service is to ensure the person is safe at home and to focus on maximising the independence of the person with agreed outcomes set against an assessment of their needs.

3. Service Requirement

3.1. Outcome and Activities Required

3.1.1. This Specification has been developed to be outcome-focused and therefore articulate Service requirements specific to improving the outcomes delivered to the people receiving the Service. The Care Needs Assessment identifies the needs and outcomes of each individual and the Provider must deliver a flexible approach towards achieving these goals and priorities. This principle reflects the added value delivered by a flexible care approach rather than only focussing on the task undertaken. The Provider must define this through a SMART action plan which shifts the focus from the tasks that are being delivered to the outcomes that these aim to achieve, and the goals that will be worked towards to meet these outcomes.

3.1.2. The lists of activities detailed in this Specification are neither exhaustive, prescriptive or needed in all cases and will depend on the tasks identified to best support the person's outcomes and meet their needs, as identified in their Care and Support Plan and the presenting needs of the person on the day. The activities may require varying degrees of support and an enabling approach. Where the person requires support in decision making or lacks the mental capacity to make specific decisions for themselves the Principles of the Mental Capacity Act 2005 must be applied.

3.2. Expected Outcomes

3.2.1. An outcome can be described as the impact a Service has on the person. Outcome-focused Services are fundamentally person-centred in approach, recognising that each person is unique and will have different needs and requirements. The Council has identified a range of outcomes to be achieved in the delivery of these Services;

- To support people to take greater control of their lives;
- To increase people's choices to live as independently as possible and to live as well as possible;
- To manage any long-term conditions well.

3.2.2. Care and Support Plans and the delivery of care and support packages must be aligned to the Care Act Outcomes, which are detailed in Section 3.3. Care Act Outcomes will form the basis for the individualised outcomes detailed in each person's Care and Support Plan, and the goals that the Provider will work towards to achieve these.

3.2.3. The Service will focus on the person's wellness. Whilst not all of the outcomes detailed above are relevant to each care and support package, those relating to and identifying with the person's Care and Support Plan, will be the basis on which the effectiveness of the Service will be determined and must be documented in the Care and Support Plan.

3.2.4. Any decisions in the Care and Support Plan that the person lacks the mental capacity to make decisions for themselves will be clearly stated in the Care and Support Plan. The Care and Support Plan will also include best interest decisions which have been made by the Council in consultation with the person's

family, friends, advocates and, where appropriate, the Provider.

3.2.5. The Provider must continue to encourage the person to participate in these decisions, considering the person's wishes and feelings and notifying the Council of any change in circumstances which may necessitate a review of the specific best interest decisions. The Mental Capacity Act must be observed where the person is unable to make specific decisions for themselves. The Provider is expected to support the outcomes of the individual to maintain their choice and control and ensure that best interest decisions are upheld.

3.2.6. The precise details of the activities to be completed with any person will need to be negotiated and agreed between them, relatives, carers, advocates and, where appropriate, the Provider. Activities must be linked to how they will achieve the outcomes stated in the Care and Support Plan, the SMART action plan and within the package of care and support hours.

3.2.7. A Provider cannot monopolise a care package (i.e. insist that they are the sole provider of a care package) where it is identified that a person's needs can best be provided by two or more different Providers. This will also apply to homes of multiple occupation where there are people with identified care/support needs and landlords cannot specify the care/support Provider for the property.

3.2.8. The implementation of this Specification must contribute to the following generic outcomes for people which are also those sought through the Department of Health Adult Social Care Outcomes Framework and which the Care Quality Commission will be inspecting and registering Providers against.

3.3. Service Requirements: Care Outcomes and Activities

3.3.1. Personal Care and support. This is defined by the Regulator as meaning physical assistance given to a person and could be in connection to the following types of tasks:

- Keeping clean and presentable in appearance according to the person's personal choice, this may require daily changes and flexibility based on personal choice etc;
- Direct assistance with or regular encouragement to perform daily living tasks;
- Training and providing advice and support on self-care skills including signposting to sites such as Support for Carers, Kent 24hr Dementia Helpline etc.;
- Assistance with all aspects of daily living e.g. to get up or go to bed, transfers from or to bed / chair / toilet, dressing, all aspects of toileting and continence management, washing/bathing (excluding any activity that requires a health care professional e.g. podiatrist, tissue viability nurse etc.).
- Assistance with skin care such as moisturising very dry skin;
- Medication management in relation to home from hospital support.

3.3.2. Promotion of well-being and self-care support for the person:

- Prompts to take medication or safe administration of medication which has been prescribed in accordance with agreed protocols;

- Assistance with putting on appliances with appropriate training for example leg calliper, artificial limbs and surgical stockings and assistance with visual and hearing aids e.g. glasses care, hearing aid battery checks;
- Food or drink preparation including delivery of meals from on-site restaurants/café, planning meals, shopping, healthy eating and budgeting;
- Eating and drinking (including the administration of parenteral nutrition (that is nutrition not administered through the mouth and alimentary canal)), including any associated kitchen cleaning and hygiene;
- Dealing with correspondence;
- Night settling, preparing the person for the night, making the home safe and secure before leaving;
- Support access to activities including employment initiatives, education and voluntary work, social and community;
- Health action plan support;
- Assistance in budgeting and debt avoidance management;
- Support in claiming benefits (including support at tribunals if additional funding for the support was approved by the respective operational team);
- Support topping up pre-paid keys for gas or electricity meters;
- Well-being checks (Extra Care Support).

3.3.3. Promotion of safeguarding support:

- Identification and reporting of possible safeguarding adults' concerns including self-neglect;
- Identification and reporting of possible safeguarding children concerns;
- Identification and reporting of possible domestic abuse;
- Reporting back to the Council's Safeguarding Team where risks or hazards have been identified which may require a risk assessment;
- An awareness of the Prevent Duty Guidance and how to report concerns (guidance can be found): https://assets.publishing.Service.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf).

3.3.4. Social and Vocational Access and Participation:

- Supporting to attend all aspects community day Services and schemes, training, work experience, appointments, laundry Services, all aspects of home improvement including transport arrangements and any other additional schemes;
- Assisting with shopping and supporting to handle their own money in multiple formats e.g. Contactless, including accompanying to the shops;
- Shopping, collecting pensions, benefits, prescriptions, dealing with correspondence, paying bills or other simple errands on behalf of the person where they are not able to do so themselves;
- Travel training.

3.3.5. Cleaning and support around the home:

- Support the person to keep their home clean, which may include vacuuming, sweeping, washing up, polishing, cleaning floors and windows, bathrooms, kitchens, toilets etc. and general tidying as appropriate, using

appropriate domestic equipment and appliances where appropriate. Providers will:

- Make beds and change bedlinen;
- Dispose of household and personal rubbish (including shredding of confidential material);
- Assist with the consequences of household emergencies including liaison with local contractors;
- Assist with household tasks such as cleaning;
- Wash clothes or household linens, including soiled linen, drying, necessary ironing, storage and simple mending;
- Light fires, boilers etc., subject to health and safety guidance;
- Identify and mitigate as far as possible any hazards or risks around the house exit and egress and suggest solutions e.g. rugs or obstacles, areas with soiling subject to a risk assessment;
- Supporting the development of a personal evacuation plan;
- Cleaning any additional aid or adaptation e.g. walking aid, shower chair, etc.

3.3.6. Supporting person-centred planning and delivery

3.3.6.1. The provider will develop a SMART action plan which will include signposting to helpful sites and Services given. The action plan will identify the goals that a person will be working towards to achieve the outcomes identified in their Care and Support Plan.

3.3.7. Double handed care

3.3.7.1. During some care activities two Care/Support Workers will be required and this will be specified in the Care and Support Plan. It is essential that where two Care/Support Workers are required to carry out care that both Care/Support Workers arrive at the person's home in time to work together. The first Care/Support Worker to arrive should not begin to care for the person until the second arrives, unless some of the Care and Support Plan activities relate to a need that a single Care/Support Worker can meet.

3.3.7.2. Utilisation of moving and handling equipment to better manage transfers and care delivery should be considered and actively promoted to and by Care/Support Workers, wherever this has been identified by an Occupational Therapist who has assessed and provided advice. Providers must contact Occupational Therapists where equipment is or can be used for assisted transfers.

3.3.7.3. Occupational Therapists will conduct an assessment for an increase from single to double handed care or decrease from double handed to single handed care as a result of equipment use. Any change to a care and support package as the result of utilisation of moving and handling equipment will necessitate a Care and Support Plan Review and update to the Care and Support Plan. Providers will be required to update Risk Assessments accordingly.

3.3.7.4. Where Providers are working alongside other agencies to deliver care and support packages, they will work in partnership with the other

Provider(s) to ensure the Services are provided in accordance with the person's Care and Support Plan and to maximise gains. Providers will sign up to an interface agreement provided by the Council and will actively support a consortia approach.

3.3.8. Complex Support

3.3.8.1. The standard Care and Support in the Home Service will be provided to most people requiring Support but there will be some exceptions where the Complex Service will be required.

3.3.8.2. The Care and Support in the Home Complex Service is for people requiring Support who are assessed by the Council as having complex and/or challenging needs, where higher risks are present that cannot be reduced by additional Staffing. Complex level Support may also require additional training above that included in the Provider's mandatory expectations.

The Council's Practitioners are responsible for assessing the need for Care and Support in the Home Complex Services and defining the Service required in the Care Plan. Where people are assessed by a Practitioner as requiring Complex Services, this will be approved by the Council's Practice Assurance Panel alongside the Care and Support Plan.

3.3.8.3. In recognition of the additional requirements set out above, the Care and Support in the Home Complex Service contracted rates are higher than those of Standard Support.

3.3.8.4. The Care and Support in the Home Complex Service requires the Provider's Staff to be trained to a higher level to meet the greater complexity of needs of the people requiring Support. In addition to the general standard Providers will:

- Prepare in depth risk assessments around the areas of higher risk and/or specific behaviour(s) together with what has been put in place to minimise and manage those risks;
- Provide clear Behavioural Support Plan for people requiring Support that details: the identified behaviour(s); how the behaviour(s) manifest; clear guidelines as to how the person requiring Support should be Supported to reduce the behaviour(s) and what alternative solutions have been considered and/or implemented;
- Have clear boundary settings;
- Evidence that Care and Support Workers have had training appropriate to the complex needs of the individual, in particular where there are clinical presentations of mental health issues; Dementia and Neurological function;
- Evidence that Care and Support Workers have had training in the delivery of intervention strategies;
- Engage with professionals from other agencies who provide specific Support and guidelines and that you follow their guidelines as required; and
- Engage with relevant professional Support networks.

3.3.8.5. Illustration examples of Complex Support:

Example A: Simon (Standard Support)

A person requiring:

- Prompting with morning and evening medication
- Support with Personal Care
- Prompting with Meal Preparation

10 Hours per week @ Standard Rate

Example B: Ethel (Complex Support)

A person presenting challenging behaviour and hearing loss, requiring:

- Communication via level 3 BSL
- Support with morning and evening medication
- Support with Meal Preparation
- Sleep Night Support

25 Hours Day Support per week @ Complex Rate
7 Sleep Nights @ Contracted Rate

3.3.9. Improved Health and Well-being

3.3.9.1. The Provider will ensure the person maintains good physical and mental health for as long as possible and feels satisfied arrangements are in place to access treatment. People will be supported in managing any long-term conditions and disabilities through promotion of self-care, self-management, self-determination etc. Where possible, the Provider will support the person to improve their management of long-term conditions and/or disabilities.

3.3.9.2. People will maintain well-being, independence and feel in control of their lives. They will:

- Feel the Service has assisted them to regain confidence and access choices;
- Receive Services that reflect and support their changing circumstances and where possible are encouraged to undertake physical activities appropriate to their health, circumstances and abilities;
- Maintain good health, and feel confident that Care/Support Workers are aware of their personal, cultural or otherwise special dietary and nutritional needs;
- Have physical, mental and emotional needs identified (including sadness and depression) and supportive measures put in place e.g. befriending and mental health support Services as appropriate;
- Be supported to monitor and maintain both nutritional and fluid intake to

promote well-being.

3.3.10. Enhancing quality of life

3.3.10.1. The person is central to decision making concerning the support they receive and is encouraged to carry out errands and access leisure and social activities to maximise independence and mental and physical well-being. They feel part of the community, are informed about and participate in local activities and initiatives. The person will:

- Maintain maximum independence both in their own home and local community and be involved in day to day decisions about the care or level of support offered and taking greater control of their life;
- Where possible develop personal resilience and resilience within their wider support networks e.g. family, local community etc.;
- Be supported to undertake useful and meaningful activities and lead a fulfilling life, with whatever assistance is required and is supported to access local social, cultural, vocational, working and/or leisure activities;
- Have the opportunity and feel supported to follow their cultural and/or spiritual beliefs within legal boundaries, to include recent and changing legislation e.g. the Prevent Duty Guidance;
- Be satisfied with the support they receive to access training and employment (where this is an appropriate outcome for the person);
- Be supported to maintain social/community and family networks;
- Receive ongoing information relating to the local community and be satisfied with the arrangements made to assist them in making or retaining contacts with the wider community and encouragement to participate in activities;
- Be supported to maintain health and hygiene within their personal environment;
- Experience support in accessing dentists, opticians, chiropodists and other healthcare Services;
- Develop life skills; including where appropriate support to find employment, reduce debts and manage money better;
- Be encouraged to be involved in local decision making;
- Supporting the person in all aspects of community and social relationships;
- Be supported to continue to develop their decision-making capacity in relation to their own care and support needs.

3.3.11. Promoting Independence - delaying and reducing the need for care and support

3.3.11.1. The person will be supported to maintain their independence and manage this as much as they can themselves, through the delivery of self-care advice and techniques and expert by experience schemes. The person will be supported to develop personal resilience and resilience in their wider support network.

3.3.11.2. People will be supported to manage their independence utilising an asset-based approach, which will focus on their abilities rather than their disabilities or long-term conditions. Where care and support arrangements must be put in place, the least restrictive option must always be considered

first and actively promoted, in line with Deprivation of Liberty Safeguards 2005.

3.3.11.3. Avoidable admissions to hospital will be managed as much as possible with people being supported to access the right care at the right time through the Provider's liaison with health and social care partners. The person will:

- Be supported to better manage their long-term conditions and disabilities and experience improvements through this, wherever possible;
- Be supported by the Provider working across the health and social care economy
- with colleagues in Health teams, social care and within private and voluntary sector Providers and community groups, working in a consortia approach as appropriate;
- Stay in their own home, as independently as possible, for as long as possible;
- Have a delayed and / or reduced need to access residential care;
- Be supported to consider broader housing options;
- Experience increased independence through the utilisation of equipment and Telecare / Telehealth solutions to meet needs previously met in a hands-on way;
- Be supported to consider positive risk taking and be able to identify and manage risks within their environment, making informed choices based on sufficient information;
- Maintain health and hygiene within their personal environment;
- Take prescribed medication safely in accordance with the Provider organisation's medication policy/protocol;
- Understand the benefits of eating healthily.

3.3.12. Ensuring a positive experience of care and support

3.3.12.1. Families, carers and advocates will be, with the person's permission, aware of the support delivered and any improvement in outcomes for the person. Families and carers will feel involved and informed about the support delivered with the person's permission. Where possible and appropriate, the person, their families, carers and advocates will be involved in any Care and Support Plan Review and Statutory Review.

3.3.12.2. The flexible package of support hours will be pivotal to ensuring a flexible delivery model, as the provider will support the person to:

- Be supported to develop communication skills and have a strong voice in the support received;
- Be enabled to control the Service they receive, with minor changes enabled to meet day to day changing needs;
- Experience consistency in the scheduling of Services and times the person expects or requires;
- Experience continuity of care, supported by a 'trusted team' of Care/Support Workers, who they trust and respect, with early introductions made to reduce the fear of new people. Take different opportunities and

use a variety of methods to feed back to the Provider regarding care received and have confidence that appropriate policies and procedures are in place;
- Be better informed regarding their care choices and better able to access information on Providers of care in their local area;
- Experience consistency in the good quality of provision;
- Be assisted in writing/designing their SMART action plan;
- Have their individuality promoted.

3.3.13. Personal Dignity

3.3.13.1. The person and their family does not experience anxieties about the Services received and is satisfied that the person's environment is maintained to their own standards. The person:

- Feels confident that Care/Support Workers will assist in their personal care with discretion and in such a way that dignity is maintained with the Care/Support Worker taking direction from the person, wherever possible;
- Is satisfied that the changes they had hoped to achieve have been realised and the balance between support and assistance is appropriate to their circumstances;
- Knows that information relating to them is kept confidential and only shared on a need to know basis.

3.3.14. Exercising Choice and Control

3.3.14.1. The person is informed and enabled to influence the way in which care is provided in a flexible and appropriate way, with Services responsive to needs and preferences of the person: They will:

- Feel confident that Care/Support Workers support their choices regarding all aspects of daily living;
- Feel confident that the Care/Support Worker will arrive and leave within timescales that enable the completion of the required support and will inform the person if there is any change in timing of the support required;
- Feel listened to and able to give feedback regarding the Service (e.g. complaint or compliment) or when suggesting improvements, including minor changes to accommodate day to day changing needs.

3.3.15. Safeguarding Adults

3.3.15.1. The person will feel and be safeguarded from neglect and abuse and will know that any concerns will be listened to and acted upon promptly. The person will:

- Be free of deliberate abuse and neglect, with the Provider responding promptly to the sharing of any concerns and understanding when this can/should be escalated to the Council;
- Know who to report concerns to and issues regarding their care and support;
- Know that concerns are taken seriously and addressed through the appropriate governance;

- Live safely in their own home/community;
- Know that home security is not compromised by the Service;
- Be supported to develop good communication skills and be enabled to have a voice regarding any concerns, alleged discrimination and/or harassment.

3.3.16. Equality, diversity and workforce development

3.3.16.1. The Provider will ensure that staff receive the appropriate levels of training to ensure each person receives care that reflects their specific needs in all areas. Providers will also consider longer term workforce development and demonstrate action planning to meet longer term development goals.

3.3.16.2. Providers will maintain awareness of and adhere to the Council's equalities policies, all relevant UK employment laws and workers' rights. They will ensure their employees work in an environment where they are shown respect and are not subject to any form of discrimination.

3.4. Service Availability and Referral Pathways

3.4.1. The Service will be commissioned to meet the person's eligible needs under the Care Act based on the Council's social care eligibility assessment. The Service will be available 365 days a year, including Bank Holidays. Unsocial rates will not be applied, as these will be accounted for in the unit cost of the Service.

3.4.2. The Referral Pathway is highlighted below. Please note that this process is for Older People and People living with Physical Disabilities. People with Mental Health needs or people living with a Learning Disability may not go through the same process in regard to Purchasing Officers and Hospital discharge.

3.4.3. The referral will be allocated to the Provider based on the person's address, purchasing protocol and instructions agreed between the person and their case manager. These instructions should include:

- The planned care hours within the flexible package of support hours;
- A start date for the Service;
- Any special requirements that the person has and should be supported with;
- A copy of the statement of need/ relevant sections of the Care and Support Plan;
- A clear statement of the person's agreement with the Service, or any specific parts of the Service for which the person lacks capacity and relevant decisions are therefore made in their best interests by the Council in consultation with their families and advocates (with the person's permission where applicable).

3.5. Provider Supporting Infrastructure

3.5.1. Providers must ensure that during all hours of operation, call Care/Support Workers have access to the Provider's Duty manager/Co-ordinator. An out of hours contact is available to provide advice, information and support to

Care/Support Workers and persons outside of office hours but within the hours of Service provision. This will be staffed by a suitably qualified and experienced supervisor/manager with access to all the information for people and Care/Support Workers necessary to ensure the provision of Care/Support Workers and Service at short notice.

3.5.2. The Provider must have a robust Business Continuity Plan in place to ensure prevention, planning and management of potential harm to the business are identified and minimised effectively.

3.5.3. The Provider will ensure all Care/Support Worker annual leave and sickness is covered within the Service.

3.5.4. The Provider will accept referrals to the Service and changes to existing provision every day of the year to support seasonal fluctuations, including winter pressures and Christmas.

3.6. Access, Assessment, Eligibility and Care and Support Planning

3.6.1. The people who can access this Service will be:

- Adults for whom care in the home has been agreed to help meet the outcomes identified in their Care and Support Plan;
- All groups including Adults living with Learning Disabilities and/or Physical Disabilities, those with Mental Health needs, Older People, and People living with Dementia.
- Ordinarily resident and living in Kent.

It should be noted that this is not an exhaustive list.

3.6.2. The referral process for accessing the Service can be found at Section [TBC]. However, within the contract term covered by this Service Specification the Modernisation Agenda will bring optimisation and pathway changes intended to streamline the process. Changes will occur to document types and names, and to access and referral pathways. The Provider will use the new documents, pathways and systems as instructed by the Council. The document templates issued to Providers will include but not be limited to Review templates, goal monitoring sheets and SMART action plan templates.

3.6.3. Adult Social Care and Health Staff complete an eligibility needs assessment to identify needs. Following this they will work with the person to develop a Care and Support Plan which confirms eligible met needs and eligible unmet needs. The plan thereafter describes the outcomes related to eligible unmet need, what the person wants to achieve and the way the Council has agreed those outcomes will be met.

3.6.4. The Provider will develop a SMART action plan for each person in conjunction with them and if they wish, their family/carers and/or other professionals, based on the Care and Support Plan.

3.6.5. The SMART action plan will be completed at the first visit, and at the latest the second visit with the person. The action plan will show how care will be delivered to meet the identified eligible needs and provide the detail of how Services will help the person achieve their outcomes. The Provider will receive their

instructions from the Service Delivery Order (SDO) and Care and Support Plan which initiates and tailors the Service for the person.

3.6.6. The Service required for a person will not always be prescribed in terms of task requirements, or timescales. A Care and Support Plan will identify a range of desired outcomes for the person, which will be agreed with them, the Provider and the Council. Some Outcomes will have specific Goals that the person wishes to achieve to support their progress towards the Outcome. A Goal is usually something with a shorter timeframe for achievement rather than an Outcome which could be longer term. It is expected that the Provider will make the initial arrangement to confirm the times of call with the person and then confirm this with the Council.

3.6.7. The Regulator requires, under regulation 9 (2)(b) - *designing care or treatment with a view to achieving the person's preferences and ensuring their needs are met that:* "The Service makes sure there is staff cover across the geographical area, so people receive a consistent and reliable Service. The Service considers travelling time to make sure people receive the amount of care that has been agreed in their care plan".

3.6.8. The Council has worked with Providers to design geographical areas called 'Clusters' which form the Lots for Providers to bid against. Clusters are designed to create geographical areas around which Providers can structure their business and rounds of care to ensure capacity in the Service. It is expected that Providers work within their cluster to ensure sufficiency of supply and where appropriate continue their vertical growth within their cluster. Please see Schedule 1 Special Conditions which outlines the clusters within Kent. Providers are also expected to have the flexibility and willingness to take packages of care from neighbouring clusters if the need arises.

3.6.9. Where there are specific decisions in the Care and Support Plan for which the person lacks capacity, these are highlighted in the Care and Support Plan as best interest decisions which are reached following involvement of the person and consultation with families and friends, advocates where appropriate and professionals.

3.6.10. The Provider will start to provide the Service on the start date specified by the Council and shall continue to provide the Service until the end date, unless the package is cancelled, suspended or varied in accordance with the Contract. Providers will:

- Review records at least once a month, to ensure receipt of feedback from the person, carers and staff and to inform whether a more formal Provider or Council review is necessary;
- Provide information to the Council prior to the annual Statutory Review to maximise the effectiveness of the Statutory Review and enable participation from the person receiving the Service where appropriate;
- Maintain oversight of any special requirements and changes to special requirements, and ensure these are integral to all of the person's records the Provider holds;
- Consider the person's requests for adjustments in the Service and make changes in arrangements, provided there has not been a substantial change in the person's circumstances or needs;

- Ensure staff know how to notify the Provider and the Council of any increase or deterioration in physical or mental health and/or any other relevant events and record these in the person's notes kept by the Provider;
- Ensure processes are in place to notify the Council of these changes and ensure that the support provided remains at an appropriate level;
- Ensure the full time indicated on the Service Delivery Order (SDO) and Care and Support Plan is delivered to the person needing the Service and appropriate time is allocated for travel.

3.7. Units of Purchase

3.7.1. The Care and Support in the Home Service will not have a differentiated Social and Unsocial Rate. Therefore, the below units of purchase will apply.

3.7.2. **Day Support (07:00 – 22:00)**; The Care and Support in the Home Service will be purchased and calculated for payment in the following day units:

- Half Hour – Paid at 60% of Provider's contracted Full Hourly Rate.
- Three Quarter Hour – Paid at 80% of Provider's contracted Full Hourly Rate.
- Full Hour – Paid at the Provider's contracted Full Hourly Rate.

3.7.3. Sessions (continuous support of more than one Full hour) will be paid on a pro rata basis from the Provider's contracted Full Hourly Rate.

3.7.4. The Council's Position on Banking / Flexible use of hours for Care and Support in the Home Services:

- The Council commissions services based on the identified needs of an individual following assessment by the Council's in-house qualified practitioners.
- The Provider then agrees to deliver these hours at their contracted rates, within the agreed units set out in 3.7.1 and invoice in line with their payment cycle or agreed payment period (a full week is calculated Monday through Sunday).
- The provider may flexibly provide the commissioned hours within the agreed payment cycle or period but must not exceed the total unless by agreed exception.

3.7.4.1. The following table provides examples of both correct and incorrect use of flexible use of support hours:

Client requires 10 hours of one to one support each week, totalling 40 hours over a 4-week period:

		Week 1	Week 2	Week 3	Week 4	Total
	Commissioned Hours	***10***	***10***	***10***	***10***	***40***
Example A	Actual Hours Delivered	10	12	10	8	40 (commissioned hours flexibly used within period)
Example B	Actual Hours Delivered	10	16	10	8	44 (no KCC approval sought by exception for additional hours)
Example C	Actual Hours Delivered	10	6	8	10	34 (commissioned hours are under delivered and provider wishes to roll remainder over)
Example D	Actual Hours Delivered	10	6	8	10	34 (commissioned hours are under delivered but the provider only invoices for actual hours delivered and communicated with Care Manager)
Example E	Actual Hours Delivered	8	8	8	8	32 (commissioned hours are under delivered but the provider has invoiced for the full 80 commissioned hours)

3.7.4.2. The number of units and frequency of delivery will be outlined in the Service Delivery Order (SDO) or Financial Activation Notice (FAN). No change to the status of the Contract will be made without formal consultation and agreement with the Council.

3.7.4.3. The specific Service for each person must be delivered in accordance with the requirements of the SDO or FAN and must not be varied without the appropriate authorisation as outlined in the table examples under point 3.7.3.1.

3.7.4.1. The Council will monitor compliance to the SDO or FAN through the person's Care and Support Plan Reviews and annual Statutory Reviews, feedback via the Council's complaint process and the agreed KPI through Contract Management. The KPIs are detailed in Schedule [TBC], Contract Management.

3.7.4.2. In the event the Provider does not deliver in accordance with the commissioned units of delivery, the Council is entitled to remedies in accordance with but not limited to Clause 41.4 of the Terms and Conditions.

3.7.5. Night Support (22:00 – 07:00); The Care and Support in the Home Service will be purchased and calculated for payment in 9-hour sessional units.

3.7.6. Please see Schedule 3 Pricing for further information.

3.8. Notifications to the Council

3.8.1. Providers must notify the Council immediately in writing via email of any:

- Safeguarding concerns in respect of the person;
- Emergency incidents as detailed in section 6.3, including serious accidents or incidents involving the person or the Care/Support Worker, hospital admissions and/or deaths of the person, including any other change in the Service related to circumstances or emergency;
- Regular and/or persistent (three or more times in consecutive visits) refusal by the person to accept support to meet outcomes mutually agreed in the Care and Support Plan;
- Failure to provide the Service to the person, missed, late, void or 'No response' calls (within the contract tolerance);
- Delivery of 'flex hours' above or below the hours defined in the SDO and the reason for this change;
- Deterioration in the person's health or well-being;
- Improvement in the person's circumstances, including mental capacity issues – improvement or deterioration of the person's mental capacity in relation to specific decisions of the Care and Support Plan. This may also include the achievement of a goal and/or outcome which may be associated with a reduction in the hours of care and support required.

3.9. Visit protocols

3.9.1. A communications book must be provided in each person's home, or if a Provider is using an alternative electronic document access must be provided for the person, family members and other professionals, to keep an ongoing record of the care provided and any refusals of agreed support, any financial transactions and regular feedback from the person receiving the Service.

3.9.2. The communications book and electronic document remain the property of the Council.

3.9.3. Providers must ensure that all financial transactions are carried out in accordance with the specific requirements identified in the person's Care and Support Plan and Care/Support Workers should be supported to fully understand policies and procedures in this regard.

3.9.4. Late/Early calls are defined as a call starting 45 minutes or more later or earlier from the time stated on the Service Delivery Order.

3.9.5. A missed call is defined as a call not made, or one that is started more than two hours after the time stated on the Service Delivery Order.

3.10. Notice Period

3.10.1. Regarding handing back packages of care and support packages, Providers must immediately discuss with the Council, and give the Council ten working days' notice (not including weekends or bank holidays) of any proposed hand back, except as otherwise mutually agreed. The Provider and the Council will work together to minimise any disruption and maintain continuity of Service to

the person whilst supporting a transition plan for the person.

3.10.2. The communications book and action plan for the person must be handed back to the Council or the alternative provider on the last day of Service delivery.

3.11. Care and Support Plan Review

3.11.1. Formal Reviews of the person's Care and Support Plan will be conducted by the Council. The first review will be a Light Touch Review held within 8 weeks following the commencement of the person's care and support package, in line with requirements under the Care Act. Thereafter, a Care and Support Plan Review will be held as often as the Council, the Provider and the person feels is necessary, or determined by the milestones detailed in the action plan.

3.11.2. Statutory Reviews will be delivered, in line with Care Act requirements, at least annually. These will incorporate a Care and Support Plan Review and review of the SMART Action Plan held by the Provider. Initially these reviews will be conducted by the Council, but in the long-term there is an aspiration that Providers will complete these reviews. More detail is provided in Section 4.

3.11.3. Providers will complete Provider Pre-Review Information Form (PPRIFs) to inform the Council's preparation for the Care and Support Plan Review. PPRIFs allow Providers to clarify hours of support, identify where development is possible and suggest any new goals and to state if there are any current goals being worked towards.

3.11.4. The review will involve the person and the designated Council representative. The Provider will only be present if the person wishes them to be, but they must contribute to, and provide information, for the review and confirm that they are able to support the goals and outcomes identified at the Review. Any other people who can actively contribute and whose input the person has requested may also be present with consent from the person.

3.11.5. The review will also address the extent to which the initial outcomes are being met, determine whether eligibility criteria continues to be met and whether the person still requires the Service or if the level of Service needs to change.

3.11.6. The Provider should note that this process may change as part of the Council's Modernisation programme and review of Care Pathways and Optimisation. Providers will be informed of any changes. Potential changes to the review process, roles and responsibilities are set out in Schedule [TBC].

3.12. Personal Care and Support Plan Review- Provider Responsibilities

3.12.1. It is expected that the Provider will highlight the need for review whether the needs have increased or decreased. The Provider also has a responsibility to report any child or adult safeguarding concerns in accordance with Kent and Medway Multi-Agency Safeguarding Vulnerable Adults Protocols. The Provider's delivery plan may consequently be amended as necessary to reflect new outcomes as required. In addition, upon significant change to the person's condition or in the way that the person would prefer their Service provided, Providers should signal the need for an early review or re-assessment of the arrangements commissioned by the

Council.

3.12.2. The Provider will undertake continuous reviews during visits and, as determined by the person's action plan, and within reason will initiate additional reviews at the Council Council's request, or as requested by the person. The Service review will address the extent to which the outcomes required of the Service are being met. Where the Provider has identified that Telecare/Telehealth (Assistive technology) may be beneficial, this should be notified to the C Council. If outcomes are not being met the Provider will adjust the action plan accordingly in conjunction with the person and notify the Council.

3.12.3. The Provider should signal to the Council the need for an ASCH review upon either a significant change to the person's condition, or a change in the way the person would prefer their Service provided in order that the Service review or re-assessment processes can be commenced.

3.12.4. The Provider should contact the Council and any Attorney or Deputy (as appointed by the Court of Protection) should there be a need for GP intervention.

3.13. Future Service Requirement Proposals

3.13.1. Moving forward into the Contract we expect the focus of the Service to be on outcomes within a flexible package of support hours defined within the Care and Support Plan. The Care and Support Plan will detail the outcomes to be achieved for the person within these hours; the hours can then be used flexibly within the billing period set out to support the person as agreed.

3.13.2. This delivery style will support the flexible delivery of outcomes-based care, give greater choice and control for the person, based on strength-based assessments.

3.13.3. The Provider will be expected to ensure the following is adhered to when managing the flexible package of support hours within the Care and Support Plan:

- The person in receipt of the Service is integral to how the package is delivered to support their changing needs, lifestyle and well-being;
- The package will focus on outcomes and goals as defined in the Care and Support Plan. However, the Council will remain focused and concerned with how providers deliver the Service and operate with cost effectiveness.

3.13.4. The Council expects to start discussions with providers in relation to these proposed changes in Summer 2019.

4. Future Aspirations

4.1. Outcomes-focused care and personalisation

4.1.1. The Council's key strategic objective for older and vulnerable residents is that they are safe and supported with choices to live independently. The Council's 'Your life, your well-being' Strategy lays out how this will be achieved through a move towards more outcomes-focused, personalised care delivered through a more flexible workforce, effective partnership working and commissioning the right Services. This aligns to the Council's duties to promote well-being, prevent needs for care and support and promote integration with health Services under the Care Act.

4.1.2. The Council is presently going through step changes in the way it wishes to commission, deliver and manage Services, as well as the relationships it holds with Contracted Providers. This includes the realignment of the Older People and Physical Disability Division to enable change in the way the Council works with its Providers to develop and deliver Services. This realignment process will enable staff to work in new ways with providers to develop practice and support the delivery of outcomes-focused, personalised care. Providers will benefit from improved access to Council practitioners which will support continuous improvement for quality in care and workforce development opportunities.

4.1.3. Work is progressing within the Council's Lifespan Pathway project to develop outcomes-focused practice within the workforce. The project is also working closely with Providers to ensure that the packages of care and support that are put in place are appropriate for the level of need, remain appropriate throughout their delivery and support people to increase their independence and well-being.

4.1.4. It is expected that Providers will support the development of more outcomes-focused, personalised Services by working closely with the Council through the life of the contract to identify development requirements and produce action plans to meet objectives which support continuous improvement.

4.1.5. This section of the Specification details elements of the Care and Support in the Home Contract that will not be delivered from 8 April 2019, but will be tested and phased in over the life of the Contract as appropriate. The Council will work in partnership with Providers to design and test new methods for care delivery, systems and recording which will support improved outcomes for people and a continuous improvement approach.

4.2. Phased approach to introducing new Services to the Contract

4.2.1. The Council recognises that the bringing together of multiple historically separate Services under one Contract represents a significant challenge, both for the Council and the Providers delivering Services. The Council will adopt a phased approach to Contracting for Care and Support in the Home Services to ensure a stable transition to the new Contract and support market shaping activities.

4.2.2. In the first phase, which will commence on 8 April 2019, the Services previously known as Home Care and Supporting Independence Services will be brought together under one provision. Providers delivering Care and Support in the Home will be expected to demonstrate their capability to meet all needs

supported by these Services from 8 April 2019. Providers will also be assessed against their capability and willingness to develop over the life of the Contract to support ongoing Service improvement and move towards the delivery of more personalised, outcomes-focused care.

4.2.3. Discharge to Assess Services and Extra Care Support will be Let within the life of the Care and Support in the Home Contract in a further competition which will only be open to Providers who hold a Care and Support in the Home Contract.

4.2.4. Supported Living Services will be delivered under a separate Contract.

4.3. Electronic call monitoring and technology

4.3.1. At present there is inconsistency in the use of Electronic call monitoring systems and other technological systems supporting tasks such as automated invoicing, creation of rotas and record keeping across the Provider market.

4.3.2. As part of the Council's aspirations in relation to market-shaping and ensuring market capability to deliver in a more flexible and personalised way, the Council wishes to see increased use of available technology underpinning the delivery of Care and Support in the Home Services. Some of the types of systems that the Council wishes to see Providers scoping and implementing and their associated benefits are listed below:

- Paper-based documentation will be replaced by electronic care plans that support person-centred care and assist providers to more effectively demonstrate and ensure compliance.
- Electronic Call Monitoring systems can give care workers a live rota on their mobile handsets and real-time task lists and service user data. It can also allow managers to see, instantly, if a care worker is running late for an appointment.
- Electronic Medication Administration Records (eMAR) enable care and nursing staff to more effectively coordinate, monitor and administer medications and provide more accurate and timely medication information for staff, and further improve safety.
- Smart scheduling and rostering systems can enhance accessibility to personalised care services in the most efficient ways. This allows an organisation to deliver more flexible and personalised care, therefore driving improved outcomes for the Service user.

4.3.3. It is expected that Providers who are successful in their bid for a Care and Support in the Home Services Contract will work with the Council to test and implement new technological systems which will support more efficient ways of working. Providers will be engaged to design any pilot projects and given appropriate notification of their commencement. The Council will work with providers to agree reasonable timescales for the implementation of new systems. However, it is envisaged that all Providers will be in a position to operationalise from April 2020.

4.4. Health integration

4.4.1. Health Integration is about placing service users at the centre of the design and delivery of care with the aim of improving patient outcomes, satisfaction and value for money. Working more closely with Health partners will seek to improve the customer journey through the service pathway, resulting in a more seamless transition from hospital to care in the community Services. The Council has an aspiration to support the progression of the Health and Social Care integration agenda during the life of the Care and Support in the Home Contract to help meet its strategic outcomes.

4.4.2. Integration could support efficiencies such as joint assessments of a patient's care needs across more than one Service provision, improved use of back-office functions and reducing delayed transfers of care, all of which could support financial savings for both partners.

4.4.3. Improved integrated working could also deliver benefits by sharing best practice across care workers and health professionals. In the longer term, this could support the development of a better-defined career pathway for care professionals.

4.4.4. The Council has already given consideration to how best to enable joint working, particularly in the Lotting Strategy for Care and Support in the Home Services. Where appropriate, clusters will align to Local Care boundaries to enable closer joint working between Health and local Providers of Care and Support in the Home.

4.4.5. It is expected that from 8 April 2019, Providers will engage with Local Care organisations in their localities, and where appropriate will attend and support Multi-Disciplinary Teams to enable a joined up working approach.

4.4.6. Over the life of the Contract, Providers will be expected to work collaboratively with Health partners and the Council to design and run pilots across which will trial methods to progress the Health and Social Care integration agenda. This may include the delivery of a Health Alliance Contract, subject to further scoping during the life of the Contract.

4.5. Piloting flexing of hours

4.5.1. As part of the aspiration to deliver in a more personalised, outcome-focused way and support people's independence in the most appropriate way, the Council recognises that it is sometimes necessary for Providers to deliver additional care above the hours specified by the care and support assessment, for a limited period of time.

4.5.2. The Council recognises that the Providers who deliver Care and Support in the Home Services will be the body best placed to identify where people require additional short-term support and implement this efficiently.

4.5.3. Flexing of hours may be required, for instance, in a situation where a person has developed a urine infection which is being treated with antibiotics but needs additional support for 72 hours to prevent admission to hospital. In a model enabling flexing of hours, a Provider could deliver additional hours within a defined tolerance for a defined, short-term period.

4.5.4. During the life of the Care and Support in the Home Contract, the Council intends to select a discrete geographical area where it will test enabling Providers to flex care up or down for a limited period within a defined tolerance. Testing the concept will enable the Council to build an evidence base and demonstrate whether this approach results in improved outcomes for the individual, and outcomes such as hospital admission avoidance.

4.5.5. Testing the concept of flexing of hours will be subject to additional work to scope the impact on the charging process, implement appropriate systems to support efficient payment mechanisms and consult with the public as required.

4.5.6. It is expected that Providers who are successful in their bid for a Care and Support in the Home Services Contract will work with the Council to test the concept of flexing hours, if they deliver in a Cluster area where the Council wishes to pilot. Providers will be engaged to design any pilot projects and given appropriate notification of their commencement.

4.6. Piloting providers delivering statutory annual reviews

4.6.1. As part of the aspiration to enable Providers to deliver care and support more flexibly, and the recognition that the Provider is best placed to understand and meet a person's changing needs, a long-term aspiration for the Council is to delegate responsibility for annual statutory reviews to the Provider. This will support a reduction in duplication of activity, as it is known that at present both Providers and the Council conduct their own annual reviews of a person's care and support package.

4.6.2. In order to delegate authority for carrying out statutory reviews to Providers, the Council will need to enact robust risk mitigation measures and be assured of the market's capability and capacity to deliver these activities, and the maintenance or improvement of outcomes for people using Services.

4.6.3. During the life of the Care and Support in the Home Contract, the Council intends to select a number of Providers who will test the delivery of annual reviews. Testing the concept will enable the Council to build an evidence base and demonstrate the value of delegating this activity to Providers. It will also allow a time period where the Council can provide a higher level of oversight of these activities to quality assure the delivery before implementing across the market.

4.6.4. It is expected that Providers who are successful in their bid for a Care and Support in the Home Services Contract will work with the Council to test the delivery of annual statutory reviews.

4.6.5. Subject to successful testing of Providers delivering reviews, there will be a further competition for a Contract which delegates responsibility for annual statutory reviews to the Provider. It is expected that Providers will develop their capability and capacity over an agreed timeframe to support this objective.

5. Quality and Safeguarding

5.1. The Requirements of the Regulator

5.1.1. Providers must conform to the requirements of relevant Health and Social Care legislation.

5.1.2. It is a requirement that all Providers will be registered with the Care Quality Commission (or any successor) for the delivery of Regulated Activities, including Personal Care. Providers must maintain registration throughout the duration of the contract as required by legislation. It is the Provider's responsibility to maintain up-to-date knowledge of the current Regulator's codes and to keep to the correct registration.

5.1.2.1. Should a provider, during the life of their Contract, not maintain or cease to hold their Registration, for any reason, the Council reserves the right to Terminate the Contract without prejudice to any contractual notice period set out within the Contract, and at no cost to the Council.

5.1.2.2. Should Paragraph 5.1.2.1 of Schedule 2 (Specification) apply, the Provider will work with the Council to ensure continuity of care for all people using the Service, and provide all information as requested by the Council.

5.1.3. The regulations required for Registration, their associated standards and the monitoring of the achievement of those regulations and standards are not, therefore, duplicated in this specification. It is expected that the regulations will be met through Registration activity.

5.1.4. Providers will inform the Council within 24 hours when a Regulatory inspection has taken place and will share the full result of the inspection as soon as they have been informed.

5.1.5. The Provider will notify the Council, as soon as they have been informed by CQC, of any Regulator Warning Notices placed on the Service/Provider regarding the Provider and/or its associated activities.

5.1.6. The Provider will also inform the Council of any advice / comments received from the Regulator. The Council will be informed of any CQC fines, notification of breaches or formal warnings activity by the Provider (including those imposed when executing the duties for another local authority or person using direct payments) and a failure to do so will mean that the Council will seek to recoup costs and damages incurred from the Provider and we may apply contractual Sanction as detailed in Schedule [TBC].

5.1.7. The Provider must keep the Council informed of Registered Manager vacancies and any fines this attracts from the Regulator. The Provider must inform the Council when new Registered Managers are appointed.

5.2. Quality Assurance Requirements

5.2.1. Providers must ensure that a quality management system is in place to ensure internal quality control and consistency of practice. Providers must also be committed to a process of continuous Service improvement driven by feedback

from people receiving Services, the Regulator and the Council. Outcomes and key performance indicators will be reviewed throughout the life of the contract and the Council reserve the right to utilise a third-party representative to manage this on our behalf.

5.2.2. Providers will inform the Council within 7 days regarding any defaults, incentivisation protocols linked to poor practice and non-contractual compliance.

5.2.3. Contract review visits may be either pre-planned or unannounced and the Council (or our representative) reserves the right to view all records that relate to both our people and those of self-funders that reside in Kent to fulfil safeguarding and Care Act requirements. The Council will utilise contract Sanctions to denote non-compliance with the Contract and Specification. Non-compliance with the Contract and Specification will be identified through KPIs, Contract Management and Monitoring processes and notifications from the Council's Practitioners. There are three types of Contract Sanctions:

- Poor Practice Sanctions to express levels of non-compliance with the Service Specification;
- Contract Compliance Sanctions to express levels of non-compliance with the Terms and Conditions;
- Safeguarding Sanctions where a person(s) is/are reported to be at risk of harm, abuse or neglect.

5.2.4. Each of these Contract Sanctions have three risk levels starting at Level 1 and escalating up to Levels 2 and 3. A copy of these can be found at Annex B. A Level 3 flag will prevent the Provider from being offered or accepting referrals from the Council. The Council will immediately apply a Level 3 Contract Sanction if:

- The Regulator has issued a Warning Notice;
- Significant risks to people have been identified;
- The assessed needs of people are not being met.

5.2.5. Where contractual non-compliance is evidenced, the Council will require the Provider to draw up an action plan that addresses areas of concern and articulates the milestones to be achieved. This must be returned to us within 7 calendar days of the non- compliance being evidenced. The plan will be agreed by the Council and must be delivered by the Provider.

5.2.6. The Council will escalate Sanctions where Providers fail to meet the plan. It is the Provider's responsibility to evidence that improvements have been made and the Council will not commit to monitoring visits with Providers who have not shared some evidence of improvement following a desk top review.

5.2.7. Continuous non-compliance or more than three episodes of non-compliance within a 12-month period could lead to the termination of an order or the Contract itself and the removal of all persons funded by the Council. The Council will be entitled to terminate the Contract or any order without issuing a sanction if the Council finds the Provider to be in serious breach of the Contract.

5.2.8. Providers (owners, corporate managers and local managers) must participate in local health and social care Provider meetings organised by the Council and its

partners. The Provider will take part in any events in relation to The Care Act, other legislative work and the Transformation agenda. Failure to do so may result in a Contract compliance sanction being placed on the Provider. The Council reserve the right to:

- Publish any information in relation to compliance Sanctions or any contractual or quality audits undertaken by the Council or our representatives;
- Publish lists of Providers who attend events managed by the Council and those who do not;
- Recoup any costs incurred in supporting the recovery or managed exits of Services, where Providers have demonstrated an unwillingness or inability to improve or manage the Service themselves;
- Alter this policy at any time and will provide notice to Providers of any changes.

5.3. Complaints and Compliments

5.3.1. Providers must ensure an easily understood, well-publicised and accessible procedure is in place to enable people to make a complaint or compliment and for complaints to be investigated. The Provider's complaints and compliments policy should also refer to the Regulator, Ombudsman and the Council Complaint Team, if the complaint requires an alternate signposting route. The Provider will be expected to investigate any complaints, compliments or quality issues that arise in a clear and concise way with all evidence clearly documented. The Provider will have an established Complaints and Compliments Policy. The Provider must evidence how they ensure learning from complaints and compliments improves the quality of the Service, and an enhancement to the training provided to staff.

5.3.2. Where there is a local advocacy group or Peer Forums, it is expected that the Provider will make constructive use of these organisations always and specifically to help resolve complaints and problems as early as possible. All complaints whether they have been formally or informally resolved should be recorded.

5.3.3. The Provider will report serious complaints and issues to the appropriate organisations e.g. RIDDOR, Police, etc. in addition to the Council.

5.3.4. A record of compliments should be maintained together with evidence if available and be used to reinforce good practice. Providers must be able to evidence how they share feedback on the Service via their quality assurance process.

5.3.5. The record of the complaint / compliment must include:

- The date of the complaint / compliment;
- Details of who made the complaint/compliment;
- Details of the organisational staff member who managed the complaint/compliant;
- Full details of the actual complaint / compliment;
- The date the complaint / compliment was received (if different);
- The date when the complaint / compliment was responded to;

- The outcome of the complaint;
- Details of whether the complainant was satisfied with the response/outcome;
- Any further actions arising from the complaint / compliment to ensure improvement in the Service quality.

5.4. Keeping Customers Informed - Information Packs

5.4.1. Providers will provide an information pack that will include basic information as set out below and will ensure that this is available to the person as the Service starts. The information pack will be in an accessible format e.g. large print, good standard of English, photographs, audio tape, Braille (where necessary), easy read, video etc. and will be made available to person and their Care/Support Workers. It will include:

- Statement of purpose: aims of the Service, model of care and support, who the Service is for, including the range and level of care and support Services provided, cultural and social needs catered for and support for Care/Support Workers;
- Contact details for the Service including telephone numbers for the Service and its Duty Managers/co-ordinator (including out of hours and emergency contact numbers);
- Service provision: the type of Service, facilities, and range of activities;
- A statement of person's rights to self-determination;
- A statement regarding the consequences of unacceptable behaviour;
- The procedures/contingency arrangements in place in the event of emergency
- temporary closure, Service reduction or permanent closure;
- Safeguarding information, including procedures followed;
- The process of quality assurance;
- Information regarding where a copy of the most recent CQC and/or other relevant inspection reports or information can be obtained;
- Details of payment options should they pay all or part of their care direct to the Provider;
- Information management assurance;
- Contact details of the relevant Council departments;
- Complaints/compliments procedure.

5.4.2. Providers will act as first point of contact and triage all queries and/or issues relating to clients' care and support e.g. issues or concerns with individual Care/Support Workers, changes in visit timings without prior arrangement, etc. Providers will resolve all issues and queries except those where Social Services have a statutory responsibility (for example safeguarding or social work).

5.5. Providing Service Information

5.5.1. Providers will register with the Council's On-Line Service Directory (or any site that succeeds it). Providers will keep their contact details up to date on the site and any failure to do so may result in a Contract Sanction. These details will be used to communicate with the Provider including any Service changes, enhancements, developments, price increases etc.

5.5.2. The Council requires Providers to register and actively monitor a suitable generic email address (i.e. admin@provider.com or office@provider.com) that will be used as the main means of communication between the Council and the Provider. This email address cannot change with any staff turnover within the Provider's organisation and avoids the need for many amendments and possible miscommunications. This must be in compliance with Data Security recommendations from the NHS Data Security & Protection toolkit: https://www.dsptoolkit.nhs.uk/

5.5.3. The Council requires Providers to follow the Council's Contract Change Control process.

5.6. Financial Protection

5.6.1. The Provider will have policies and procedures in place for staff on the safe handling of money and property belonging to the person, which covers:

- Recording the amount and purpose of all financial transactions undertaken on behalf of the person. Records which must be signed and dated by the Care/Support Worker and the person or nominated advocate, attorney or deputy;
- Collection of pensions or benefits;
- Safeguarding the property of the person whilst undertaking care and support tasks;
- Reporting the loss or damage to the property whilst providing care and support.

5.6.2. The Provider's Safeguarding policies and procedures must make clear that staff must not:

- Use credit or debit cards, pre-payment cards, or any on-line accounts, cheques belonging to the person, or have knowledge of the person's PIN number;
- Accept gifts (beyond a very minimal value of £5);
- Use loyalty cards except those belonging to the person for the person;
- Use offers, vouchers, stamps or discounts other than for the person;
- Undertake personal activities during time allocated to provide care and support to the person;
- Witness or support with writing legal documentation for the person e.g. Will writing;
- Make personal use of the person's property (e.g. broadband);
- Involve the person in gambling syndicates (e.g. National Lottery, online betting);
- Borrow from or lend money or vouchers to people within the Service;
- Sell or dispose of goods belonging to the person and their family; Sell goods or Services to the person and/or buy goods or Services from the person including any free Services e.g. Freecycle;
- Incur a liability on behalf of the person;
- Take responsibility for looking after any valuables on behalf of the person;
- Allow any unauthorised person (including children) or pets to accompany them when visiting the person, with exception of assistance dogs with consent of the person, without their permission and the Council's approval;

- Make or receive telephone calls that are personal or are regarding other people;
- Use time allocated to care and support the person for any other purpose;
- Undertake any activity which is in breach of UK legislation.

5.6.3. Provider must have policies and procedures in place for Staff concerning the investigation of allegations of financial irregularities and the involvement of Police, Customs Officials, Adult Social Care and Health and other professional bodies.

5.7. Safeguarding and Freedom from Abuse

5.7.1. To ensure that the person is free from abuse and appropriate action is taken where it is suspected, the Provider will:

- Respond to alerts immediately after ensuring the person is safe;
- Attend Safeguarding Adults Review meetings;
- Comply with the requirement that Safeguarding Adults Review Panel requests for Independent Management Reports are completed within six weeks;
- Make representation in court as and when necessary;
- Ensure there is a Safeguarding Adults policy available that compliments the Multi- Agency Safeguarding Policy, Protocols and Guidance for Kent and Medway (protocols available at http://www.kent.gov.uk/__data/assets/pdf_file/0018/11574/Multi-Agency-Safeguarding-Adults-Policy,-Protocols-and-Guidance-for-Kent-and-Medway.pdf);
- Ensure staff are familiar with the Kent and Medway Adult Protection Procedures and with the Providers' own policy and procedures on Safeguarding and Adult Protection;
- Ensure the Kent Adult Safeguarding Form (KASAF) (available at http://www.kent.gov.uk/social-care-and-health/information-for-professionals/adult- protection/adult-protection-forms-and-policies/adult-protection-forms) is completed to notify the Council if adult abuse is witnessed or reported;
- Work in partnership with officers of the Council (or any others that the Council chooses), to make enquires in fulfilling its duties under section 42 of The Care Act 2014;
- Participate in adult protection assessments and enquiries and comply with any recommendations where practicable in post abuse action plans;
- Ensure staff training is provided in safeguarding and is refreshed at regular intervals (minimum of every 2 years) and ensure staff attend relevant safeguarding adults training appropriate to their position;
- Comply with the Disclosure and Barring Service (DBS) requirements for staff. These checks should be done every three years as a minimum;
- Take positive action to combat discrimination in line with UK legislation;
- Respond to the Prevent Duty Guidance.

6. Workforce Requirements

6.1. Workforce

6.1.1. The Provider is expected to use recruitment and selection procedures that meet the CQC minimum standards; ensuring records are maintained to demonstrate best practice in this area. Providers must comply with Disclosure and Barring Service (DBS) requirements for staff.

6.1.2. All roles within the Provider's organisation must also have written job descriptions and person specifications and an Equality Policy for the recruitment, selection, development and care of the workforce (including volunteers, trustees/management committee members, apprentices, work experience, management) must be in place.

6.1.3. All staff should meet formally on a one to one basis with their line manager for supervision, to discuss their work on a quarterly basis (every three months) and written records of these supervision sessions must be kept demonstrating the range, content and outcome of the discussion at each meeting.

6.1.4. Providers should be able to demonstrate how staff are supported and advised between supervisions and that additional meetings are facilitated where required.

6.1.5. With the consent of the person, at least one supervision a year should incorporate direct observation of the Care/Support Worker providing care and support to the person with whom they regularly work to observe competencies.

6.1.6. Regular meetings must be held at least quarterly with peers and/or other team members to discuss and share issues and best practice. This must be recorded.

6.1.7. All staff must have an annual appraisal, and this must include identification of training and development needs with their line manager. A copy of the appraisal will be placed on the personnel file for each Care and Care/Support Worker.

6.1.8. The Provider must ensure that there is a clear link between staff appraisals, identified training and development needs and the training plan. Managers and supervisors must receive training in supervision skills, undertaking performance appraisals and planning for workforce development.

6.1.9. A record must be kept of any disciplinary incidents and details entered in the personal file of the Care/Support Worker concerned, referrals to the Independent Safeguarding Authority must be made, if appropriate, and recorded on the Care and Care/Support Worker's file, or person staff member's personal file. the Council must be kept informed.

6.1.10. Providers must take appropriate measures to understand whether the Care/Support Workers within their employment are also engaged in other employment. The Provider must regularly review with each Care/Support Worker whether any care Sanctions or incidents involving the police and criminal justice system will affect their capacity to carry out their role and responsibilities as a Care/Support Worker.

6.1.11. The Provider must have a written policy for the management of violence and aggression towards staff and ensure that suitable training and relevant risk assessment is provided to reduce the risk of violence and aggression towards staff. Adherence to the Health and Safety at Work Act 1974 will ensure that staff are safe whilst at work.

6.2. Workforce Development

6.2.1. Providers will be registered with the Skills for Care National Minimum Dataset for Social Care (NMDS-SC) and the following criteria must be met:

- All establishments will complete a NMDS-SC organisational record and must update all its organisational data at least once in the financial year;
- The establishment must fully complete person NMDS-SC worker records for a minimum of 90% of its total workforce (this includes any staff who are not care- providing);
- Person records for workers which are included in the 90% calculation must be both fully completed and updated at least once in the financial year;
- The establishment must agree to share information via the facility within NMDS-SC with the Council, CQC and NHS Choices.

6.2.2. Providers must show that they are complying with the relevant Regulations covering staff competence and training. Providers must ensure the completion of the Common Induction Standards (or other standards as set out by the CQC) for all new Care/Support Workers and other employees within 12 weeks of starting their employment. This induction must specifically include Mental Capacity Act (MCA), Safeguarding and Dementia training

6.2.3. Providers must assess workforce training levels, the training already achieved and skills gap for the workforce as a group. Providers must have financially resourced plans in place to address workforce development requirements. The Provider must have a training plan, a training matrix and keep records of successfully completed training on a person's file and central file to continuously monitor and develop the plan.

6.2.4. Registered Managers must complete the Manager Induction Standards and have or undertake a recognised qualification for registered managers within the first year of employment. This must be completed within 2 years of employment. Managers should undertake periodic management training to update their knowledge, skills and competence to manage the Service.

6.2.5. Staff must be supported to ensure appropriate skills are maintained to ensure that the highest level of care and support is provided by qualified and competent staff. Providers will ensure:

- All staff are competent and trained to undertake the activities for which they are employed and responsible;
- All Care/Support Workers hold a relevant qualification recognised under the Skills for Care Regulated Qualifications Framework e.g. Level 2 Diploma in Health and Social Care or equivalent.
- Those who do not already hold a qualification at the relevant standard should be supported to achieve the above qualification as a minimum within one year from commencing employment;

- Care/Support Workers receive specific advice and training about human rights in relation to Home Care Services within three months of starting employment and updated every two years;
- All staff have training on the prevention of abuse within three months of employment and this must be updated every two years;
- Young staff (16-18-year olds) are supported in their work. Young staff should be undertaking an approved training programme – it is advised that the Health and Social Care Apprenticeship framework is used;
- Specialist advice, training and information is provided to Care/Support Workers working with specific groups and / or medical conditions and long-term conditions to ensure they are professionally qualified to do so;
- Staff have training in the requirements of MCA (Mental Capacity Act 2005) and DOLS (Deprivation of Liberty Safeguards);
- All staff are aware of their Safeguarding responsibilities both for Children and Adults;
- All staff are aware of and familiar with the Provider's policies and procedures;
- All staff are aware of their responsibility regarding the Prevent Duty Guidance.

7. Key Principles

7.1. Service principles

7.1.1. Currently the Home Care Services are based more upon a time and task model of Service, whereas the Supporting independence Service is designed around a more flexible version of care and support. During the contract period it is anticipated that there will be movement from the status quo towards the delivery of more outcomes-focused, personalised care.

7.1.2. This will be achieved through negotiation, pilots and collaboration with contracted providers and following any necessary periods of consultation.

7.1.3. The combining of the Home Care and Supporting Independence Services embraces the following key principles, all of which should seek to promote the maximum possible independence for people requiring care and support and to assist them to lead fulfilled lives:

7.2. Equality and Human Rights

7.2.1. The Equality Act 2010 introduced a public-sector equality duty which must be exercised by the Council in performing its functions. The Duty underpins this specification and Service Providers must pay due regard to:

- Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- Advancing equality of opportunity between people who share a protected characteristic and those who do not;
- Fostering good relations between people who share a protected characteristic and those who do not.

7.2.2. These are sometimes referred to as the three aims and arms of the general equality duty. Simplified, the act describes the need to have due regard for the advancing of equality which involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics; Taking steps to meet the needs of people from protected groups where these are different from the needs of other people;
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

7.2.3. Providers must operate in accordance with the Human Rights Act 1998, the statute which made the European Convention on Human Rights (ECHR) part of English law. It requires public authorities and those Services they commission to act compatibly with the ECHR.

7.2.4. It is a priority of the Council to meet its Human Rights Act obligations. This Service specification has been designed to help promote and protect the human rights of people receiving Care and Support in the Home Services. Contracted Providers must deliver Care and Support in the Home in ways that protect persons' rights to respect, dignity, privacy and autonomy.

7.2.5. The Equality and Human Rights Commission's framework for human rights in Care and Support in the Home has been adopted by the Council and underpins our expectations for the delivery of this Service. The Council will take positive steps to protect the human rights of people who receive Care and Support in the Home Services.

7.3. Accessible Communication Standards

7.3.1. Service Providers are under a contractual obligation to promote and protect human rights, with a zero tolerance of neglect and abuse. Providers must find effective ways of communicating with each person to ensure that they are at the centre of their Care and Support Plans

7.3.2. Ensure staff are aware and use the Accessible Communication Standards published by the Department for Work and Pensions, Office for Disability Issues (August 2014).

7.4. Partnership Working

7.4.1. The principle of improved cross-sector working will be supported through the contract management approach using a balanced scorecard methodology with specified KPIs to encourage integrated, participative working with statutory bodies, other Care and Support in the Home Providers, private and voluntary Providers of social care Services and other organisations outside of the social care system.

7.4.2. Providers will be required to sign up to an interface agreement to support long-term consortia plans.

7.4.3. The Council wishes to work in partnership with Providers in delivering a high quality comprehensive Care and Support in the Home Service to its people. By signing up to a partnership approach the Council and Service Providers are

making a commitment to:

- Seek to develop and maintaining constructive working relationships with the person requiring support, carers, families, colleagues, professionals and wider networks
- Have a contract that is flexible enough to reflect changing needs, priorities, strategy, seek continuous improvement through fostering a learning environment and working together, and which has person and Care/Support Worker participation at the centre;
- Work towards achieving key outcomes and objectives;
- Communicate openly and honestly with each other clearly and regularly;
- Share relevant information, expertise and plans;
- Avoid duplication wherever possible;
- Monitor the performance of all parties;
- Seek to avoid conflicts but, where they arise, to resolve them quickly at a local level wherever possible.

7.4.3.1. Improve cross-sector working to ensure integrated, participative working, not only across statutory and voluntary providers of Services and social care but also with and between providers outside the social care system. These could include:

- Faith groups;
- Minority ethnic community organisations;
- Libraries;
- Employers and employment organisations;
- Colleges:
- A full range of providers of sports and leisure activities;
- an Informal support groups.

7.5. Person-centred Support

7.5.1. People must be at the centre of any Care and Support Planning and Services should be easy to access and use, of good quality and designed to maximise people's ability to live independently and safely in their own homes and communities. This will include;

- Providing Services that are personalised, that meet their needs rather than the needs of the Service – developing systems to better match Care/Support Workers to people in terms of their interests, to support the establishment of good working relationships, including the development of one-page profiles;
- Negotiating meaningful and SMART action plans with people. Clarifying the responsibilities of all people who are supporting the person to achieve these goals;
- Ensuring action plans are written with the direct involvement of people and consultation of their families where appropriate and with consent, listening to their needs and requirements and being flexible regarding when support is provided rather than fitting persons into pre-arranged rounds of calls;
- Working in partnership with the person requiring support, carers, families and colleagues to provide care and support interventions that not only make a positive difference but also do so in ways that respect and value

diversity including age, disability, gender reassignment; marriage and civil partnership; pregnancy and maternity; religion or belief; sex; and sexual orientation;

- Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion of people requiring support and carers in all Services. Creating, developing or maintaining valued social roles for people in communities they come from.
- Supporting the person to access existing opportunities in their local community rather than creating or attending segregated activities and increase the capacity of communities to accommodate those with health and social care needs.
- Enabling people requiring support to have greater access to personal budgets, and ensuring that the people requiring support are central in this process. This will enable people requiring support to have greater choice about the things that they wish to achieve, the type of support that is required to achieve this and will help to facilitate dependence.

7.6. Strengths Based Approach

7.6.1. Providers will support people to use their own abilities and strengths to be as resilient and independent as they can. Providers will support people to identify and build on ways they can care for themselves, and will support people to access support from family, friends and carers to resolve problems themselves and deliver their own solutions. This will include:

- Valuing the capacity, skills, knowledge, connections and potential in the person, their families and their communities;
- Working in collaboration, helping people to do things for themselves becoming co-producers of support and developing shared care partnerships;
- Promoting persons becoming active consumers of support, preventing passive consumption;
- Using a strengths-based approach to maintain and improve social networks and enhance well-being;
- Encouraging and supporting self-care and exercise.

7.6.2. The Provider will be expected to work in partnership to provide care and support that enables people to be resilient in regard to their health and social care needs so that they maintain a good level of well-being and can live healthy lives.

7.7. Promoting Safety and Positive Risk Taking

7.7.1. People will be empowered take control of their lives with the support of Providers and the Council's Practitioners. People will be supported to manage the tension between promoting safety and positive risk taking. This will be supported by:

- Ensuring people are supported by a team they trust and not receiving care from numerous Care/Support Workers, the Council recognise that continuity of support is important in building trusting relationships;
- People and their support team identifying, assessing and then managing risks whilst understanding that risk is an everyday experience;

- Care/Support Workers accepting the need to work within a wide range of home conditions, subject to a risk assessment;
- Ensuring people and Care/Support Workers assess risk dynamically, understanding that decision making can be enhanced through positive collaborations;
- Understanding that risks can be minimised, but not eliminated;
- Empowering the person requiring support, within reason, to decide the level of risk they are prepared to take with their own health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for people requiring support, carers, family members, and the wider public.
- Providers taking responsibility in encouraging a no-blame culture whilst not condoning poor practice;
- Providers working with the Council to understand and meet the changing needs and expectations of people and their families and supporting them to have more control over their lives, health and care;
- Conducting risk assessments where there is potential for significant harm, self- neglect, injury or death. Examples could be but are not limited to the following: choking/falling/scalding/transfers (hoisting)/not following specialist instruction/skin integrity/infection control/Control of Substances Hazardous to Health /labelling and signage (for persons living with Dementia).

7.8. Whole Systems Approach

7.8.1. People in hospital when medically fit, who require support on discharge, will be offered an enablement package in the first instance, where this is the appropriate type of care and support. This is a short-term intensive support package focusing on the enablement of the person.

7.8.2. Providers will be expected to support discharge from hospital for known people (who already have a Council funded care package with the Provider), where there is no change in need and no Council re-assessment necessary

Providers will:

- Follow the person's progress through the acute pathway by communicating directly (with permission) with the hospital ward and person, promoting self-care for some needs from the outset (where appropriate);
- Be expected to work with hospital staff to determine when the person is fit for a safe discharge.

7.8.3. The Provider must ensure they are kept aware of all that has happened that will be relevant to their continued care and should visit the person in the acute setting or speak to them via the telephone to ensure they keep in contact.

7.8.4. There may be occasions when the Provider feels that they are unable to support a care package reinstatement from hospital. In these circumstances the Provider should notify the Council and the ward so that appropriate measures can be put in place to reassess the person's needs. Providers must report any safeguarding concerns in the usual way and should trust in their judgement regarding safe discharges from acute settings.

7.8.5. Providers must keep the Council informed whilst the person is in hospital and upon their discharge as the Care and Support Plans may need to be altered to reflect any changes in needs. This notification is important as it will prompt changes to the Council's social care records system to ensure Providers are paid appropriately.

7.9. Informed Decision Making

7.9.1. Kent's residents will be provided with improved information, advice relating to care and support Services for adults and carers in Kent in accordance with The Care Act requirements. This will include:

- Being asked for feedback by their Provider and knowing that a customer feedback loop is influencing continuous improvement of their Service, along with other quality monitoring systems;
- Receiving open and transparent communications from their Provider regarding the quality of their organisation's Services both personally and when benchmarked against competitors;
- Knowing that contracted Providers will be maintaining a Key Performance Indicator (KPI) dashboard to maintain their focus on continuous improvement and the delivery of quality Services;
- The publishing of KPI analysis and any quality audits conducted by us or any third-party representative the Council have appointed to act on our behalf;
- Knowing that the confidentiality of personal information is paramount, unless a disclosure is necessary to protect the health, safety or welfare of the person or other people.

7.10. Supporting the Whole Population

7.10.1. The Council has a duty under The Care Act to support informed choices for all adults within the Council boundary, not just those who are eligible for Council funding.

7.10.2. The Council will regularly collect and collate information from the Provider regarding all customers of the Provider's Services to meet our responsibilities to self-funders under The Care Act. The Council will expect Providers to engage proactively with any such data requests and expect the measurement of outcomes, KPIs and self-funder data to contribute to our shared understanding.

7.10.3. The Council will expect Provider support in ensuring the Council and Provider communication channels dovetail in the provision of information and advice.

7.11. Social value

7.11.1. The Council's Services have a social purpose and therefore the Council will require that services become smarter at determining social value. This will be through improving the economic, social and environmental well-being of Kent. This encourages commissioners to look beyond the price of a service and consider how to maximise the wider impact and benefits which could be possible with the resources available.

7.11.2. The Commissioning Framework sets out some overarching principles for how we will use social value.

The Provider will ensure that they support the Council's Commissioning Framework principles for social value which include;

- Local Employment: creation of local employment and training opportunities, including employment of individuals with disabilities;
- Buy Kent First: buying locally where possible to reduce unemployment and raise local skills (within the funding available and whilst minimising risk to the Council);
- Community development: development of resilient local community and community support organisations, especially in those areas and communities with the greatest need;
- Good Employer: support for staff development and welfare within Providers' own organisations and within their supply chain Community Day Opportunities for Individuals with Disabilities;
- Green and Sustainable: protecting the environment, minimising waste and energy consumption and using other resources efficiently, within Providers' own organisations and within their supply chain.

7.11.3. These themes have been singled out as practical ways to deliver social value outcomes in line with KCC's ambitions. However, there may be other priorities which are particularly relevant for your service.

8. Service Inputs and Outputs

8.1. Continuity of Care/Support Workers

8.1.1. To ensure that the person is comfortable with their Care/Support Worker(s), the Provider will:

- Ensure people are supported by a team they trust; the Provider should try and match Care/Support Workers to meet specific needs of the person wherever possible;
- The amount of Care/Support Workers in this trusted team should ideally be kept to no more than four and in any case as low as possible, or in the case of a high number of support hours delivered, (including double handed, triple handed and live in Care/Support Workers) eight Care/Support Workers;
- The person is consulted and kept informed about their 'trusted team' always and any changes that may become necessary.

8.2. Records

8.2.1. To ensure that records of visits to the person's home and details of support given are comprehensive and shared as appropriate, the Provider must ensure that;

- Any refusal of support agreed within the Care and Support Plans must be recorded in the person's communications book;
- The Council's authorised staff can see records required by this

specification at any time;

- They accommodate visits by the Council's authorised staff, which may take place at any time and could be unannounced at the Provider's premises. The Council will be reasonable in exercising this right;
- Care/Support Workers visiting the person for the first time sign the person's file to show they have read the relevant sections and are familiar with the person's needs;
- Appropriate sections of the person's personal file are accessible to relevant care staff;
- The current communications book is left in the person's home always; completed pages should be removed and placed on the person's file at the Provider's premises after one month;
- Care/Support Workers are aware of the Provider's policy regarding confidentiality of records;
- Care/Support Workers will record the date and time of every visit, the support provided and any significant occurrence. Records will be factual, legible, signed and dated and kept in a safe place as agreed with the person, as per the record keeping policy.

8.2.2. Records will include:

- Assistance with medication;
- Care provided;
- Details of changes in the person's circumstances, support needs, health condition and any mental capacity concerns which raise questions about the person's ability to consent with specific decisions of the care and support arrangements;
- Any accidents, untoward incident, or emergency to the person and/or Care/Support Worker;
- Activities undertaken, and any particular achievements and/or goals achieved;
- Any information that will assist the next Care/Support Worker to ensure consistency in the Service provision.

8.2.3. The person will be informed about what is written and will have access to the communications book and any contents past or present. The person will be encouraged to have the current communications book kept in their home. Records will be available to the Council and/or person on request.

8.2.4. Any significant occurrence or changes in circumstances/support needs should be reported to the Providers and the Council's teams. Where the person does not agree, the Provider will record this refusal on the personal file held by the Provider, with the exception of Safeguarding concerns.

8.2.5. All information must be stored in accordance with current data protection legislation.

8.3. Security

8.3.1. Providers must have clear protocols in place in relation to entering the home of the person. In some cases, it may be necessary for Care/Support Worker to have keys, entry fobs, and/or entry codes. The protocols will cover:

- Knocking/ringing bell and speaking out before entry;
- Written and signed agreements on key/fob/entry code holding;
- Safe handling and storage of keys/fob/entry codes outside the home;
- Confidentiality of entry codes;
- Alternative arrangements for entering the home;
- Action to take in case of loss or theft of keys/fobs/entry codes;
- Action to take when unable to gain entry;
- Securing doors and windows;
- Discovery of an accident involving the person;
- Other emergency situations.

8.3.2. Providers will ensure that all Care/Support Worker and/or staff are identifiable employees of the Provider by supplying identity cards to Care/Support Workers entering the home of the person. Identity cards must display:

- A photograph of the member of Care/Support Worker or staff member;
- The name of the Care/Support Worker and/or staff member and Provider organisation in large print and braille if required for the person in receipt of the Service;
- The contact number and/or textphone number of the Provider;
- Date of issue and expiry date, which must not exceed 36 months from the date of issue.

8.3.3. Identity cards must be:

- Available in large print for people with visual impairments and/or braille if needed by the person in receipt of the Service;
- Laminated or otherwise tamper proof;
- Renewed and replaced within 36 months from the date of issue;
- Returned to the Provider and destroyed appropriately within 24 hours when employment ceases or when the card is renewed.

8.3.4. The Provider will keep up-to-date with the developments in new security technology and where necessary provide enhancements to a person's security after gaining the person's permission and informing the Council.

8.4. Emergency Protocols

8.4.1. Occasionally Care/Support Workers are faced with emergency situations throughout the course of their work/activities. This can be stressful and upsetting. The procedures below give clear instructions about action which should be taken. Care/Support Worker will have received immediate support from the appropriate provider organisation manager/care co-ordinator. Guidance will be immediate, clear, calm and supportive of the person receiving care and the Care/Support Worker.

8.4.2. If a Care/Support Worker cannot obtain an answer from the person at home or the usual family/parent carer they should:

- Check through the letterbox, windows and back of the house to see if it is accessible;
- If you cannot see the person check with neighbours;

- If the neighbour cannot help, telephone the Provider's office and the Duty Manager/Co-ordinator will inform you as to further action.

8.4.3. If the Care/Support Worker can see the person in receipt of the Service and they are on the floor or not responding Providers should advise Care/Support workers to:

- Ring for an ambulance dialling 999 immediately;
- Ring your provider organisation's allocated Duty Manager/Co-ordinator;
- If you are aware of a key holder nearby, go to them – contact your Provider organisation when you reach the additional key holder to gain further advice.

8.4.4. If a Care/Support Workers finds a person in receipt of the Service who appears dead when the Care/Support Worker arrives – providers should advise Care/Support Workers to:

- Call the emergency Services by dialling 999 immediately and advise about the situation;
- Call the Provider office, your provider Duty Manager/Co-ordinator;
- Avoid touching anything;
- Wait for the provider to send a senior member of personnel to assist you at once;
- If the person lives in Extra Care/sheltered accommodation pull the emergency cord.

8.4.5. Should an emergency occur during the course of care being given, Care/Support Workers must ensure the following protocol is followed:

- If a person falls and may be injured they must not be moved unless they are in serious and imminent danger, e.g. form fire, drowning, road traffic accident etc.;
- They must be made comfortable and dial 999 immediately;
- If it is known that the person may be prone to occasional falls or collapse this should be considered in the risk assessment and a contingency action plan devised for this eventuality;
- If a person collapses or is taken seriously ill dial 999 immediately and make the person made as comfortable as possible – the emergency Services personnel may advise you of action to take while awaiting their arrival;
- In these situations, call your Provider Office and speak to the Duty Manager/Co-ordinator who will arrange for your subsequent visits to be covered while you stay with the person or will send someone to relieve you for you to continue the visits on your schedule if you are able to continue.

8.4.6. Providers shall:

- Ensure subsequent visits are covered immediately once a Care/Support Worker contacts to advise about any of the above situations, alternatively you must send someone to relieve the worker for them to continue visits on their schedule;
- Ensure the person (and where appropriate, carers, advocates) is aware of

this Emergency protocol at the commencement of the Service, and is included within the Information Pack;

- Call ahead to advise people in receipt of the Service with the Care/Support Worker/s about the incident and whether they will receive a different Care/Support worker or whether their visit will be late;
- Advise the appropriate Council personnel by phone and followed up with an email within 12 hours of the incident;
- Ensure Care/Support Worker's Induction Training encompasses Emergency Protocols;
- Ensure a refresh of Emergency Protocols is conducted every quarter
- Draft an Emergency Protocols pocket guide is carried at all times by Care/Support workers;
- Decide whether the format of the pocket guide to Emergency Protocols e.g. laminated A6 format, credit card size format, or included on the reverse of the identification worn by Care/Support Workers;
- Put in place additional support for Care/Support Workers who have witnessed a distressing situation;
- Work cooperatively with any additional statutory agency regarding follow-up investigations.

8.4.7. If an emergency or crisis arises the Provider will deploy additional Care/Support Worker time without the prior consent of the Council for the period of 1 hour. The Provider will notify the Council of such a change and any additional Care/Support Worker hours utilised immediately, clearly stating the reasons for the additional hours and any ongoing need. The person will not be required to make any payment to the Provider.

8.5. Transport

8.5.1. Vehicle Usage: To ensure that the person is transported safely and appropriately and in accordance with the current legal requirements. The provider must ensure all Care/Support Workers driving vehicles for people accessing the Service shall:

- Hold the appropriate vehicle insurance;
- Hold the appropriate vehicle licensing;
- Have a valid licence with no more than a maximum of six endorsements, and no disqualifications;
- Have regular driving licence validity, endorsements and disqualifications checks directly with the DVLA using a Driver Check Code, every six months – paper/card licence checks are not valid;
- Have awareness of their responsible for safety of the vehicle whilst driving, etc. and will therefore need to ensure the appropriate pre-driving vehicle checks for road worthiness are completed with the vehicle at the start of each period of driving; the provider will ensure this training forms part of the core training needed for the Care/Support Worker;
- Have time to familiarise themselves with the vehicle, to include understanding of any bespoke features, seat belt usage for wheelchair users, and any other additional non-standard features of vehicles by the person who is the owner of the vehicle;
- Have awareness of the protocols for correct use of Blue Badges where necessary.

8.5.2. The provider will work with the person accessing to the Service to ensure the following:

- The vehicle owner has the appropriate valid documentation for the vehicle each time a Care/Support Worker commences a driving period with the vehicle; to include MOT (Ministry of Transport) test certificate, V5C (vehicle registration document), a print out of vehicle tax validation from the DVLA, and insurance certificate;
- The vehicle owner or appropriate person demonstrates all bespoke controls and safety features, seat belt usage for wheelchair users, and any other additional non-standard features of the vehicle.

8.5.3. Concessionary Travel: The Provider will ensure all Care/Support Workers are aware of the protocols for correct use of the following:

- English National Bus Pass/Kent County Council;
- Concessionary Bus Pass Scheme;
- Disabled Persons Railcard;
- Kent Karrier;

Any form of assistive travel.

8.6. Multi-Disciplinary Teams (MDTs)

8.6.1. Providers may be represented at Local Care Multi-Disciplinary Teams as they develop and will engage with Local Care development in their area where appropriate.

8.6.2. Providers will ensure that any social care needs are recognised, and the correct specialisms are fully engaged. Providers can co-ordinate, arrange and maintain local Services that compliment or are more suitable than the health care Service, to ensure progress towards clients' outcomes (e.g. arrange for meals to be delivered or refer to day care etc.)

8.7. Health and Safety

8.7.1. Accidents and Injuries: To ensure the Provider's Staff are informed and deal confidently with accidents, injuries and emergencies the Provider must ensure that:

- All staff are aware of the Providers' policies and procedures for dealing with medical emergencies;
- Any accidents or injuries to the person that require hospital or GP attendance that the Care/Support Worker has knowledge of, are reported to the Council and noted in the person's Contact Book.

8.7.2. Risk Assessments: To ensure the appropriate risk assessments are conducted for the acquisition, use, and ongoing support of equipment used in the person's home, and activities supporting the person. This will include regular safety checks, appropriate training and preventative measures put in place whilst conducting duties to minimise the risk of harm to the person and Care/Support Workers, associated with the acquisition, use, and ongoing support of equipment used carry out duties for the person, by ensuring:

- There are clearly defined and designated roles and responsibilities for the management of the device/equipment;
- Equipment Audits are carried out annually to include current test certification organised by the equipment owner;
- Care and Support Plans received the Council contain consent forms for the use of bed rails, and these were signed the person or a family member where the person was unable to do this themselves;
- Equipment has an annual assessment for safety and recorded to include LOLER, should this be conducted by another Provider or the Council, this must be shared with the provider;
- Care/Support Workers understand how to use bedrails, shower commode chairs, and how safety straps are fitting to make sure people are safe.

8.7.3. Transmittable Diseases: To ensure that the person, his/her family, staff and visitors are protected from transmittable diseases, the Provider must ensure that:

- A policy in relation to transmittable diseases (e.g. HIV/AIDS and Hepatitis A, B and C) is available and known to all staff;
- Appropriate risk assessments are in place;
- All staff are trained to work safely with people always.

8.7.4. Data Protection and personal security to ensure that the protection of the person's home is maintained, and is not compromised by any action undertaken by a Care/Support Worker from the Provider's organisation, the Provider must:

- Comply with GDPR;
- Make staff aware of the risk of unintended breaches of confidentiality and make sure staff can identify situations in which it may occur through the provision of appropriate training;
- Ensure that staff know of the policies and procedures which are in place in respect of the person's safety;
- Make sure that staff do not carry with them more confidential information than they need for a week's work programme (e.g. lists of names and addresses);
- Ensure, when it is necessary for staff to keep written information detailing passwords or keypad numbers with them, that they understand the need to preserve security; The Provider must also make sure passwords or keypad numbers are not kept alongside names and addresses and key fobs should not carry the name or address of the person on them;
- Liaise and negotiate with the person if a change of Care/Support Worker or a suspected breach of security occurs, to see whether a change of access code number will be acceptable to them;
- Have policies and procedures in place to make sure that when Care/Support Workers leave or change, an appropriate transition plan is in place for the person.

8.8. Workforce Presentation

8.8.1. The Provider will decide which roles may need a uniform and provide the uniform.

8.8.2. The Provider will ensure Care/Support Workers, when carrying out caring of

domestic tasks with people, will not wear nail varnish, artificial nails, hair accessories of any kind and jewellery that is likely to cause a health and safety risk including cross infection.

8.8.3. The Provider shall provide all personal protective equipment necessary for the supply of Services and any small pieces of equipment that help Care/Support Workers to support people back to independence. The Provider will ensure all Care/Support Workers have the appropriate clothing, footwear, and appearance whilst on duty to comply with Infection Control procedures, and the guidance detailed in the Health and Safety at Work Act 1974 and PUWER.

8.8.4. Care/Support Workers own clothing and general presentation and styling must be clean, professional, smart, well presented and fit for purpose whilst carrying out duties. Care/Support Workers do not wear shorts, vest tops, strappy tops, etc; whilst carrying out duties within this contract.

9. Compliance and Governance

9.1. Roles and Responsibilities of the Council

9.1.1. **Strategic Commissioning** is responsible for the commissioning and procurement of this contract. This is the team that Providers should inform of any Regulatory Warning Notices or other actions required by this contract that relate to Service delivery and Service quality. Providers should email [TBC]@kent.gov.uk with this information. Providers will be informed should this email address change; the commissioner will use the generic email address that the Provider has given. The commissioning team also lead on Contract management, arrangement of price uplifts, any Contract variations, and the review of KPIs, although the Council reserve the right to utilise a 3rd party representative to manage this (wholly or in part) on our behalf.

9.1.2. **Purchasing Staff** support the management and control the offering of care packages to Providers in line with the Purchasing Protocol (attached at Annex C). They will issue the Service Delivery Order or the equivalent when MOSAIC is adopted and confirm the persons' details and Care and Support Plan.

9.1.3. **Assistant Directors** and their Service Managers have the responsibility of overseeing Adult Social Care and Health's new geographical areas which have been aligned to the Clinical Commissioning Groups geographical areas where appropriate. Providers should escalate practice concerns to Service Managers if they have not been resolved by the Council in their geographical area, and only then to Assistant Directors if the issue is not resolved.

9.1.4. **Team Managers** are deployed to arrange and review Services of sufficient quality for people who have been found on assessment to be owed a duty under various enactments. This should also be taken to include Care Manager (within Learning Disability), Care Co-ordinator (within Mental Health), Registered Practitioner, Occupational Therapist, Nurse, Social Worker, Physiotherapist qualified/state registered, Purchasing Officer and any other authorised representative.

9.1.5. **The Payments Team** is responsible for the payment cycle, person billing and any issues relating to payment.

9.1.6. **The Safeguarding Team** has the role of safeguarding vulnerable adults and statutory duties regarding adult protection. Providers are expected to work with all the Safeguarding Adults Team to address any relevant issues.

9.1.7. **The Complaints Team** has the responsibility of co-ordinating activity and investigation to support complaint resolution.

9.2. Legal / Legislation Statutes

9.2.1. The Care Act 2014 was the biggest reform in health and social care for 60 years; the act has made care and support more consistent across the country and puts the well-being of people at the heart of health and social care Services.

9.2.2. The Care Act 2014 is the biggest reform in health and social care for 60 years; the act should make care and support more consistent across the country and puts the well-being of persons at the heart of health and social care Services.

9.2.3. Section 29 National Assistance Act 1948 (NAA 1948) and Section 2 Chronically Sick and Disabled Persons Act 1970 are the key provisions for Care and Support in the Home and community-based Services. There is significant overlap between the various statutes, but it is these two provisions that the majority of a person's legal entitlement to support within the home stems from.

9.2.4. Section 30 NAA 1948 allows a local authority to provide the Services itself or to make arrangements for the Services to be provided by a third party. Section 1 Local Government Act 1997 in general terms permits a local authority to contract with that third party to provide the necessary support to people for whom they have a responsibility for.

9.2.5. However, such a contract does not discharge the Council of its duty to the person to ensure that they receive the necessary care. The Council must ensure that the support provided is both adequate and effective. If the care provided to the person is inadequate and inconsistent this could amount to breach of statutory duty. This will of course depend on the seriousness of the complaint and the reasons for the failings e.g. staff sickness, the behaviour of the person etc. Notwithstanding this there is the potential risk of there being a case for maladministration against the Council for failing to have systems in place which keep under review the quality of care delivered and compliance of the Contract with the Care and Support in the Home Service.

9.3. Regulation

9.3.1. The Health and Social Care Act 2008 sets out the framework for the regulation of care Services. Section 8 is an introduction to Chapter 2 of Part 1 of the Act which deals with registration of provision of health and social care. Its starting point is to define a "regulated activity" as an activity that involves or is connected to the provision of health or social care. Section 9 (3) defines "social care" as including all forms of personal care and other practical assistance.

9.3.2. Any person who carries out a regulated activity without being registered as a

Service Provider will be guilty of an offence under section 10 and is liable on summary conviction to a fine not exceeding £50,000 or to imprisonment for a term not exceeding 12 months, or both. If convicted on indictment, then the penalty will of course be greater and there is no upper limit on the fine that the court could impose. The requirement to register pursuant to section 10 applies to a natural person, a partnership or a company

9.3.3. The Mental Capacity Act 2005 is the primary legislation for all adult social care and the 5 statutory principles should be an integral part of all the work of care Providers. Section 44 of the MCA 2005 introduces two new criminal offences, namely ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions.

9.3.4. Additional legislation, regulations and checking Services is listed below however the list should not be regarded as complete or exhaustive but constitutes guidance for Providers. Providers must ensure they remain aware of and comply with all relevant and applicable legislation, this specification and UK law to include the following:

- Care Standards Act 2000;
- Care Act 2014;
- Control of Substances Hazardous to Health Regulations 1989;
- Data Protection Act 2018;
- General Data Protection Regulation 2016
- Disclosure and Baring Service;
- Employment Rights Act 1996;
- Essential Standards of Quality and Safety March 2010;
- Equality Act 2010;
- Health and Safety at Work etc. Act 1974;
- Health and Social Care Act 2012;
- Health and Social Care Act 2008;
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010;
- Human Rights Act 1998;
- Lifting Operations and Lifting Equipment Regulations 1998;
- Management of Health and Safety at Work Regulations 1992;
- Management at Work Regulations 1992;
- Manual Handling Operations Regulations 1992;
- Mental Capacity Act 2005;
- National Association for the Care and Resettlement of Offenders (NACRO) leaflet;
- National Minimum Wage Act 1998 and Regulations 1999;
- Part V Police Act 1997;
- Personal Protective Equipment Regulations 1992;
- Provision and Use of Workplace Equipment Regulations 1999;
- Public Interest Disclosure Act 1998;
- Public Interest Disclosure Act 1998 (Whistle Blowing);
- Rehabilitation of Offenders Act 1974;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995;
- Working Time Regulations 1998 and 1999;
- Workplace (Health Safety and Welfare) Regulations 1992.

9.3.4.1. This list will be kept under review and updated as appropriate throughout the life of the Contract. Any updates to the list will be issued via the Portal. It is the Provider's responsibility to ensure they maintain an awareness of and comply with any updates to this list.

9.4. Provider Failure

9.4.1. If a Provider exits the contract before the end of the contract term the following protocol (subject to yearly review) will be followed, led by the Council.

10. Strategic Direction and Legislative Context

10.1. Understanding the Council's Strategic Commissioning Direction

10.1.1. The Council is continuing its journey to transform adult social care in Kent, as detailed in Section 4. This Service is supporting us towards making this vision a reality.

10.1.2. Providers are expected to attend the Strategic Provider meetings and those detailed in Schedule 14 Contract Management. Provider meetings will support an ongoing understanding of the Council's Strategic Direction and progress towards achieving its long-term objectives.

11. Performance Monitoring and Management

11.1. Performance Monitoring

11.1.1. The Service Provider and the Council will performance manage this Service to ensure current delivery meets the required standard. The Council will continue to use electronic methods for collecting and collating all Key Performance Indicator data, all Providers will be expected to work with the Council to deliver this effectively and to ensure compatibility with the Council's systems and requirements.

11.1.2. This Contract will be managed through a Scorecard approach which looks at the areas of:

- Quality and Contract assurance;
- Cost/ flexibility and innovation;
- Service deliverables;
- Relationship development;
- Business/ workforce assurance and risk.

11.1.3. Each Score card area will be measured through the collection of monthly KPI submissions and quarterly provider self-assessment submissions

11.1.4. The Scorecard and supporting methodology links to a quality and risk matrix approach which will enable triangulation of data sources including:

- Data & intelligence received from feedback from Care and Support Workers and Practitioners, people receiving the Service and their carers;
- Provider self-assessment and reporting;
- Balanced Scorecard
- KPIs;
- CQC inspection results;
- Contract Sanctions and Safeguarding;
- Market Share.

11.1.5. Identification, collection and analysis of this data combined will facilitate:

- Identification of themes and trends;
- Identification of system-wide and local risks;
- The construction of dashboards to show compliance levels and improvements over time, allowing for reports on local, regional and county wide trends.

11.1.6. The level and intensity of quarterly Contract management actions per provider will be directly proportionate to the maturity of the Contract and the level of risk identified by the quality and risk matrix.

11.1.7. Providers will be expected to actively participate in local Cluster meetings where appropriate. These may be conducted either in person of via teleconference.

11.1.8. The Commissioning team will arrange monthly Provider forums for the initial 3 months of the new Contract, these will be diarised and circulated prior to the Contract start date.

11.1.9. It is the Council's aim that Contracted Providers will subsequently take ownership of the Provider forum meetings as a method of peer support and information sharing.

11.1.10. Full Contract management methodology, Scorecard elements and Key Performance Indicator requirements are laid out in Schedule 14 Contract Management.

11.1.11. People within the Service and their carers will be asked to provide feedback via a questionnaire sent out by the Council. The questionnaire will measure the person's/carer's satisfaction with the quality of Service delivery and whether the Service has achieved the outcomes identified in the Care and Support Plan.

11.1.12. Any future additional performance monitoring requirements will be introduced through discussion with persons and Providers and will be informed by the review and development of the Service.

11.2. Contract Reviews

11.2.1. The Council reserve the right to utilise third party Auditors in undertaking any performance management elements including Contract monitoring, quality

assurance and KPI measurement. The Council will develop the roles of various Council staff in relation to this Contract, its Contract management and reviews, therefore a range of Council representatives may conduct any of the performance management elements. However, any third-party auditors will follow the review arrangements set out in Schedule 14.

11.2.2. Schedule 14 Contract Management details the requirements of both the Providers and of the Council. The Council reserves the right to undertake a review of the supply arrangements with Providers within the Clusters at any time and to work with Providers to ensure optimum delivery arrangements. During the first three months of the contract the Council will work with Providers to agree a set of roles, responsibilities and expectations around the Purchasing Protocol and process.

Kent County Council – Strategic and Corporate Services
Sessions House
County Hall Maidstone Kent
ME14 1XX

12. Glossary

Adult Protection – safeguarding vulnerable adults from abuse, harm and exploitation.

ASCH – the Adult Social Care and Health Directorate within the Kent County Council.

Area Referral Management Service (ARMS) – the main access points for people wanting to contact Social Care, Health and Well-being about needs relating to themselves or others. They deal with contacts regarding adults with a physical and/or learning disability, people with sensory needs and older people.

Assistive technology – any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of people with support needs.

Behavioural Support Plan – a document created to help understand and manage behaviour in children and adults who have learning disabilities and display behaviour that others find challenging. It provides carers with a step by step guide to support a good quality of life and to identify when they need to intervene to prevent an episode of challenging behaviour.

Breach (of contract) – an action in the direct opposition to defined agreed requirements.

Branch – the physical office registered with the CQC from which packages of care are Serviced.

Business Continuity Plan – an effective plan of helping business to build resilience against any disaster.

The Care Act – the paper that takes forward the Government's commitments to reform social care legislation and improve the quality of care following the findings of the Francis Inquiry.

Care in the Home (previously referred to as Domiciliary/ Home Care) – Care provided in a person's home following an assessment of need.

Care Package – a combination of Services put together to meet a person's needs arising from an assessment or a review.

Care and Support Plan – a document produced by the Council giving particulars of how to support, enable and achieve independence and well-being. It is a written statement regularly updated and agreed by all parties, setting out the health and social care support that a person requires in order to achieve specific outcomes and meet assessed needs.

Care Quality Commission (CQC) – the Regulatory body that ensures that standards of quality and safety are being met where regulated activity is provided. The body has a wide range of enforcement powers if Services do not meet the

standards required.

Care/Support Worker – a member of staff employed by a Provider organisation to deliver the Care and Support in the Home Service.

Registered Practitioners/ Case Officers – a targeted, community-based and pro-active Council workforce that assesses people who may have care needs, reviews packages of care and produces co- ordinated Care and Support Plans.

Cluster – the geographic boundary(s) that the County has been divided into for the provision of the Services.

Consortium – an association of two or more organisations who participate in a common activity and pool resources to achieve a common objective.

ContrOCC – the Council's database that contains key information on the needs and treatment of children and young adults up to and including 25 years old, receiving a Service as well as the organisations providing care.

Commission – the process by which local authorities decide how to spend money to get the best possible outcomes for persons and communities, based on identified needs.

Commissioner – Members of the Council's staff who have responsibility for determining what Services will be purchased to meet assessed eligible needs.

Common Induction Standards – standards that are set by the CQC that state that all adult social care practitioners should reach within 12 weeks of starting their job.

Communication / Contact book – book used by staff to record interaction with the person.

Co-produce – active input into Service design by the people who refer into and use the Service.

Core Team – means the Care/Support Workers who are rostered to provide the relevant care to the Service User under the Contract. The Provider will seek to match Care/support Workers to meet specific needs of the person wherever possible. This team does not include workers on scheduled annual leave / holiday, however would be impacted by other absences including sickness, failure to report to work and any other reasonable explanation.

The Council – Kent County Council – the Council has a duty to arrange and review Care and Support in the Home Services for people who have an assessed need. In this agreement the Council could include Care Manager (within Learning Disability), Care Co-ordinator (within Mental Health), Case / Care Manager Assistants, Occupational Therapist, Nurse, Social Worker, Physiotherapist qualified/state registered, Purchasing Officer and any other authorised representative.

DVLA - Driver and Vehicle Licensing Agency.

Declined Package of Care – will be defined and confirmed via the Strategic Provider Forum by the end of the first quarter of the Contract. For the first quarter of the Contract KPIs relating to this definition will be monitored but not enforced.

Deprivation of Liberty Safeguards (DOLs) – extension of the Mental Capacity Act (2005) which aims to ensure that the person in receipt of social and health care are looked after in a way that does not inappropriately restrict their freedom.

Disclosure and Barring Service (DBS) – the tool that helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Driver Check Code – This is a code the owner of a driving licence can generate with the DVLA directly, to give to an organisation to enable them access to the driver's licence history and check whether there are any endorsements/penalties or disqualifications on a driving licence.

European Convention on Human Rights (ECHR) – is an international treaty to protect human rights and political freedoms in Europe.

Expert patient schemes – a self-management programme for people with support needs or are living with long-term conditions.

Financial Activation Notice (FAN) – a document which outlines the costs associated with the assessed needs of an individual for the package of care and support.

Flexible Package of Support – a package of hours for a person in receipt of the Service to be used in an outcomes-based way to support the person's care and support needs as specified on the Care and Support Plan.

Improvement Plan – a response to raise standards in key areas in Service development and delivery within agreed specified timescales.

Kent Enablement at Home (KEaH) – the Council's in-house provider of enablement Services.

Key Performance Indicator (KPI) – criterion that helps to measure Service quality and providers' contractual obligations.

Key Performance Indicator dashboard – a tool that communicates Service achievement in a succinct way that facilitates the process of action being taken to raise the quality of the Service.

Late/Early Call – Calls made more than 45 minutes after/before the time stated on the Service Delivery Order.

Locality Team – integrated community health and social care professionals managing the care of people with LD and MH issues (some areas).

Manager Induction Standards – benchmark for managers new in post in adult social care.

Market Position Statement – a declaration that summarises Commissioners' purchasing intentions which also provides intelligence to Providers (the market) to enable them to plan how to respond to the Commissioner's needs.

Missed Call – Non-attendance by staff or attendance more than two hours after time of call identified on the Service Delivery Order.

(Contract) Mobilisation – The development and execution of proposed Service provision.

Mosaic – the Council's new database/ system that will be phased in to replace SWIFT from January 2019.

Must (must) / Will (will) – to be obliged or required by law.

Needs assessment – appraisal of a person's care and support needs for community care Services.

Newly Offered – refers to packages of care that have not been previously offered to the Provider.

NMDS-SC – Skills for Care National Minimum Dataset for Social Care.

Ombudsman / Local Government Ombudsman Officer – whose role is to investigate complaints where persons have been treated unfairly or have received poor Service from government departments and other public organisations and NHS in England.

Outcome – Consequence, impact or result of an activity, plan, process or agreed intervention and the comparison with the intended projected result.

People / Person – refers to the users of this Service.

Personal Care – care and support provided to people that includes assistance with bodily functions such as washing, bathing or shaving, toileting/continence, getting in or out of bed, eating, drinking and taking medication.

Policy – a set of statements which help person to make sound judgments based on legislation, legal terms and conditions and any Regulatory requirements.

Provider Pre Review Information Form (PPRIF) – A form for the Provider to complete two weeks before the Review which highlights the support being delivered, the level of ability of the individual and the goals that are currently being worked towards. This form is a method of identifying issues to be addressed at the Review so that Council workers and Providers can be prepared for the review meeting. Where appropriate, it should be completed with the person receiving the Service.

Practice Assurance Panel – a panel of Practitioners who quality assure assessed

needs and Care and Support Plans and agree spend for care and support packages.

Procedure – the method by which a policy is put into practice.

Protocol – a code of correct conduct.

Purchasing Protocol – the process that the Purchasing Officers and Area teams need to follow to allocate the packages of care to ensure continuity of the clusters that have been designed in collaboration with the Provider market.

Purchasing Officer – an employee of the Council who is authorised to buy goods and Services.

PUWER – The Provision and Use of Work Equipment Regulations 1998

Registered Manager – the person appointed by the Provider to carry out duties as stated in the Health and Social Care Act (2008). Providers must meet the Regulator's requirements in this regard. All Providers must have a Registered Manager and each regulated activity is required to be supervised by the Regulated Manager.

Regulator – the body which is established by statute and whose powers the Provider is subject to. Currently, this is the Care Quality Commission.

Regulatory inspection – an organised examination of an organisation's systems and processes by an authorised body with enforcement powers.

Response time – is the time taken between the package of care being offered to the Provider and the Provider informing the Purchasing Officer if they can take the package of care.

Reviews:

- **Statutory review –** an annual formal review of a person's Care and Support plan and package of hours, in line with the Care Act.
- **Light touch review** – a review of a person's Care and Support Plan and package of hours six to eight weeks after the Service has been put in place, in line with the Care Act.
- **Care and Support Plan review** – a review of a person's Care and Support Plan which may be triggered at any time by a change in circumstances, such as a deterioration or improvement in condition, or the introduction of a piece of equipment. Reviews of the Care and Support Plan will provide assurance that the care and support package, goals and outcomes remain appropriate.

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

Safeguarding – describes the multi-agency process of protecting vulnerable adults and children from abuse or neglect and putting systems in place to prevent harm.

Scorecard – a dashboard-style tool which collects and presents Key Performance Indicator data from Providers and the Council to inform Contract Management processes.

Self-care advice – an umbrella term that includes a range of different situations whereby people are given information on how to better manage conditions or impairments with minimal or no involvement of Services.

Service Delivery Order – initiates and tailors the Service for the person

SMART Action Plan – a statement of intent written by the Provider (usually in conjunction with the person using the Service) describing the goals and aspirations of the person and how these will be achieved. These plans must be Specific, Measurable, Achievable, Relevant and Time-bound.

Strengths based approach – Person led activities that focus on positive outcomes with emphasis on the resources and traits that the person has.

Supervision – a formal recorded meeting on a one to one basis with the Staff member's line manager to enable administrative review, discussion of and reflection on the Staff member's work; learning from practice; personal support; professional development and mediation. Supervision will take place at least quarterly (every three months). Written records of these Supervisions must be kept demonstrating the range, content and outcome of the discussion at each meeting.

Supporting People – the act of assisting a person to complete a task or access the community to remain as independent as possible.

SWIFT – the Council's database that contains key information on the needs and treatment of adults from 26 years receiving a Service as well as the organisations providing care.

Modernisation Agenda – the Council's strategy and teams to improve its Services. This includes innovative ways of working with the Council's partners with renewed focus on rapid response, prevention, targeted interventions, supporting careers and empowering people.

V5C – Vehicle Registration Document.

Warning Notices – to formally make aware in advance of actual or potential harm to the Service or persons receiving care and support.