London Borough of Southwark and South East London Clinical Commissioning Group

Community-based Re-ablement Tender

High Level General Service Specification

Community-based Reablement
General Service Specification

This document provides a description of the service required and should be read in conjunction with the accompanying appendices listed at the end of the document. The Council intends for successful providers to work closely with each other and in a developmental way with the Council and Clinical Commissioning Group (CCG).

1. Background and context

Intermediate Care Southwark (ICS) provides a time limited multi-disciplinary approach to deliver a support programme based on identified rehabilitation goals agreed with the service user. The service focuses on the person's own strengths to help them to realise their potential and regain independence.

The core purpose of ICS is to:

- provide responsive holistic, home-based person-centred, coordinated care, treatment and support focused on enabling people to regain their independence or recover from illness or injury
- improve people's individual outcomes to enable them to live safe and well at home in their community
- reduce dependency on long-term services
- work effectively with all parts of the health and social care system to provide seamless, smooth, and safe transfers of care for people – right person, right time, right place.

The ICS aims to maximise individuals' independence so they can continue to manage aspects of daily living that have been identified as important to them.

2. Collaborative delivery

In addition to the commissioned service, the service offer in Southwark will be enhanced and strengthened by a team of Occupational Therapist Assistants (OTAs) working alongside the successful provider. Analysis of current caseloads confirms that a team of 9 OTAs with a Senior Practitioner would be required to support the service model. Rather than a 'one size fits all' approach, the new service will tailor its responses across three levels as described below:

Community Reablement Offer.	Levels and features of intervention.	Length of reablement episode and target intervention.
Level 1 'Routine'	The service user rarely requires nursing or pharmacy intervention. An Occupational Therapist (OT) develops a therapy plan. A Reablement Support Worker then delivers this plan. Progress is monitored by the OTA assigned to the service user, who attends weekly multi-disciplinary meetings and feeds back to OT or Physiotherapist (PT) to agree discharge from the integrated service. In addition, a transfer of care plan for ongoing community, voluntary sector and/or social care engagement is developed where appropriate.	2- 3 weeks. A reablement support worker delivers therapy goals.
Level 2 'Degree of complexity'	The service user may require one off intervention from nursing or pharmacy staff. A therapy plan is developed by an OT or PT lead professional and can be a one-off intervention. The plan is then delivered and monitored by OTA who attends weekly multi-disciplinary meeting and feeds back to the OT/PT Lead to agree a discharge from Intermediate Care Southwark. The service user may have occasional additional visits from therapists and support from a Reablement Support Worker throughout A transfer of care plan for ongoing social care or community and voluntary sector engagement is developed.	Up to 4 weeks. Therapy goals are delivered by an OTA with support from a reablement support worker.

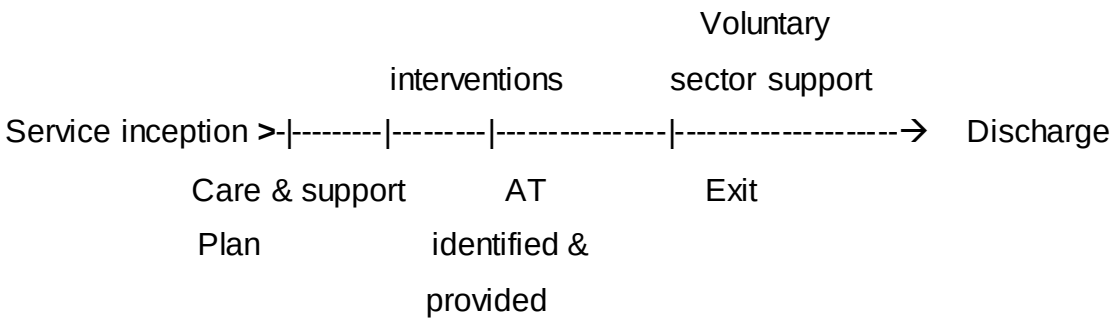
Level 3 Complex	Working closely together, the OTA and the Reablement Support Workers together with other professionals, providing a wider multidisciplinary approach, including social work, nursing and/or pharmacy intervention. The intervention often includes the use of moving and handling equipment and the plan is to incrementally step down from use of this equipment. The lead therapist identified from the team, develops the plan and coordinates intervention. The service user may need additional days subject to the lead professional's discretion. A wellbeing/crisis plan is developed at the point of discharge. In addition, a transfer of care plan for on-going social care or community and voluntary sector engagement is developed.	4-6 weeks. Therapy goals are delivered by a Reablement Support Worker/s and OTA.

What is Reablement?

Reablement is a time limited and focused process of supporting an individual to regain skills or gain new/alternative skills and confidence to enable them to remain living independently in their own home. Research indicates that reablement is an appropriate response for much of the population and can achieve positive results both for the person and the local authority in managing the needs of an ageing population.

In many cases service duration will be less than six weeks with individuals leaving the service as and when agreed outcomes are achieved

For example:



(AT - Assistive Technology)

The service is of a short-term nature up to a maximum of six weeks with the expectation that support will gradually reduce over this period, and where appropriate services users may be discharged at any point, for example, when outcomes are met. Where it is identified that a person requires on-going care and support beyond this period that will be decided on a case by case basis.

3. Aims and Objectives of Service

The overall aim of the service is to support adults in Southwark over the age of 18 who have a social care or health need, including needs arising from dementia, by providing reablement and rehabilitation with integrated working between services.

The main objectives of the service will include:

- Delivery of a reablement service which will support people recover effectively at home or other community setting as appropriate following a hospital admission
- Delivery of service that enables people to maximise their potential and maintain their independence
- Facilitate with timely support, discharge from hospital and/or temporary care at home and enable to maximise their full independence potential.
- Avoid unnecessary hospital re-admission by providing reablement and rehabilitation as a preventative service in the community enabling people to remain independent in their own home.

3.1. Tasks may include:

- assistance with daily living and personal care with an emphasis on support to re-learn and to manage tasks and activities that maintain independence
- working to achieve agreed outcomes
- enabling individuals to access community services to reduce social isolation.

The service provider shall work as part of a multi-disciplinary team (MDT) which shall include the therapy led in-house team of OTAs described above, and the reablement plan will be developed within this multidisciplinary context.

3.2. Multi-disciplinary Meetings (MDMs) will:

Comprise of staff participation and input from differing disciplines to plan the effective delivery of the services and explore and identify progress and any additional service interventions necessary for individual service users. MDMs may take place weekly, for example, for people with therapy plans led by a therapist, or agreed appropriate frequency

4. Social Care Related Quality of Life Outcomes

The service will be expected to capture outcome information relating to the Social Care Related Quality of Life domains:

- Control over daily life
- Personal cleanliness and comfort
- Food and drink
- Personal safety
- Social participation and involvement
- Occupation
- Accommodation cleanliness and comfort
- Dignity

5. Access

The Community based reablement service will be accessible to people who live in the community or are returning home from a period of bed-based care, who have potential for improved independence, self-care and wellbeing.

The service is for:

- individuals18 years of age or over who are a resident of Southwark and
- are in hospital or living in the community and require reablement

It is expected that service exclusions will be:

- people with advanced cognitive impairment
- people who are identified as being 'end of life'

Subject to the exclusions above the service will be expected to accept all referrals that have been assessed by the referrer as having reablement potential. All referrals will first be screened by the reablement triage service in GSTT (Guys and St Thomas Hospitals NHS Trust) before being passed to the service provider.

Service users must be over 18 years old and resident of Southwark. Service users are likely to be frail, have a specific physical or sensory disability, may have been diagnosed with dementia or other specific conditions that affect the brain, may have a learning disability, or a combination of any of the above.

Generally, diagnoses **must not** be used by the provider as a reason to refuse referrals eg dementia, mental health issues and learning disabilities. Service users must be reviewed on their reablement goals and ability to carry over reablement learning at the end of the intervention. In exceptional circumstances, if the service provider considers that a referral is inappropriate this will need to be discussed with the GSTT referral and screening triage service and an alternative plan agreed.

For referrals made for service users that have had more than 3 separate episodes of reablement, there will need to be a joint discussion by the provider with the GSSTT screening and triage service and the therapy led OTA team prior to accepting the referral, to ensure it is the right service for the service user.

For people that were receiving a package of care and support prior to admission, reablement input will be decided on a case by case basis. If the referrer and the therapy led OTA team believe it is in the person's best interest to receive a combination of homecare and reablement for a short period, this should be arranged to enable the best possible outcome for the individual service user. In this situation it is expected that the reablement provider will work in partnership with the homecare provider to ensure service delivery to the resident is coordinated

6. Outcomes

6.1. For the individual

The eligible outcomes for each individual service user will be assessed in relation to the Council's statutory duties under the Care Act 2014 and other relevant legislation and produced as a support plan. The outcomes for each service user's support plan will be set out in a care plan to be held in their own home. These outcomes will include:

1. Enabling service users to live as independently as possible for as long as possible in their own homes.
2. Support service users to achieve individual outcomes established at the point of assessment and developed through the care and support planning process
3. Enable service users to achieve their own agreed outcomes to support living independently with therapy services, where required, to support discharge planning from the point of admission.
4. Enabling service users to maintain their own networks of support within the community and support service users' personal care networks.
5. Providing a kind, caring, encouraging and motivational approach to the support of service users, that seeks to optimize independence and wellbeing backed by good evidence.
6. Contributing to making sure that the most effective use is made of assistive technology and other innovative support solutions, including those that may be 'universal' or community-based services that maximise independence and wellbeing. Opportunities can be considered at any point in an individual service user's pathway.
7. To ensure that other reasonable outcomes for the service user, as identified in their support plan, are compliant with terms of the community based reablement contract and the Council's duties under the care Act 2014.
8. To work effectively with multi-disciplinary staff including those from the Council's OTA/therapy-led team and from within the GSTT reablement and rehabilitation service in agreeing the interventions required and the resources necessary to achieve the outcomes set.

6.2 For the Council

The Council commissions community based reablement services as one means of discharging its statutory duties under the Care Act 2014 and to implement its vision for the future of adult social care, namely:

The Care Act 2014 (Section 3) requires that Local Authorities exercise their functions with a view to ensuring the integration of care and support provision with health provision where it considers that this would:

a) promote the wellbeing of adults in its area with needs for care and support and the wellbeing of carers in is area
b) contribute to the prevention or delay the development by adults in its area of the need for support, or the development by carers in its area of the need for support
c) improve the quality of care and support for adults, and of support for carers provided in its area (including the outcomes that are achieved from such provision)

6.3 For the wider health and social care economy and the population of Southwark

Within the context of the evolving work between the CCG and Southwark Council, community based reablement services will play a significant role in achieving positive health outcomes for adults with complex health and social care needs, namely:

1. To ensure that social, cultural and religious needs of service users are properly taken into account in delivering support
2. To contribute to reducing the number of emergency admissions to hospital.
3. To work effectively in a vital day-to-day role alongside other health and social care agencies within the context of an individual's overall care and health.
4. As part of their daily work to promote and maintain the health and wellbeing of the local population.
5. To ensure that the investment made positively adds social value to the local population in Southwark.
6. Contribute to the achievement of the NHS outcomes framework.
7. Provide an additional and complementary pathway to services provided by the NHS in Southwark
8. To support whole system flows including timely and safe discharges from acute care, ensuring that system-wide resources are used appropriately.

7. Strategic Outcomes

In addition to the individual outcomes, there will be range of strategic measures to evidence the overall effectiveness of the service including:

- Number of people reaching their reablement goals
- Percentage increase in number of people accessing reablement
- Percentage of people requiring a long-term package of care at the end of reablement period
- Of those that go on to require further care at the end of reablement, the percentage of people with a decrease in hours of care needed.
- Percentage of people admitted/readmitted to hospital during the period of reablement
- Percentage of people admitted to hospital within 91 days following the end of reablement period
- Percentage reduction in care packages of existing service users who receive the reablement service
- Service user perception of achieving goals and feeling enabled to live independently at home

8. Delivering an outcome-focused service for the individual

An outcome-focused service applies a person-centred approach, recognising that each individual is unique and will have different requirements and that these may vary over time, and from day to day. It includes stepping down part of the care and support interventions ato establish an individual's ability to manage independently.

The service will operate from 7am to 10pm seven days a week. it will operate on outcome-based assessment, and delivery of the service user's assessed reablement support /therapy plan, which will focus upon a number of themes:

- **Working in a reabling way** Tasks that promote independence and self-reliance and reduce the dependence of a person with significant care needs on acute, residential or home care. An example might be a person who is able to do most of their morning routine independently (getting up, choosing what to wear and doing most or all of their own food preparation) following a period of reablement.
- **Maintenance** Tasks which help to improve the independence of the person with care needs and maintain them in their community. Examples might be: providing personal care that attempts to maximise a service user's personal functional capacity; supporting the service user to maintain or build social networks by signposting and prompting them to take advantage of community resources; supporting them to feel safer because of increased confidence in use of aids and adaptations in their homes; supporting money management through the use of charge cards; and having a routine to ensure medication compliance. The Medication Management Protocol is detailed in Appendix 4.

- **Notifying and Responding to Change** Early alerting. As the Reablement Support Worker is likely to be the professional who sees the service user in their own home most frequently, they are in a unique position to recognise deterioration in the health and function of the individual and escalate concerns. Crucially, the Reablement worker will also play a key role in identifying further opportunities to improve independence and wellbeing of service users. They should be aware of the changes each service user is likely to experience linked to their particular health conditions and notify health and social care professionals when there is deterioration or when other changes happen that could impact upon the service users' health or threaten to reduce their independence. The Reablement Support Worker also needs to be mindful when there is a lack of engagement over a significant period of visits, particularly with people with learning disabilities and people with mental health conditions. The Reablement Support Worker needs to ensure that these issues are communicated to key personnel within Social Care, including the therapy-led OTA team.

These outcomes require a different approach to conventional 'time and task' support by placing the emphasis upon achieving the outcomes that are required on the service user. Motivating, reabling, helping people to practice, and regular reinforcing of progress will all be key elements, along with identifying further opportunities, including other services which could enhance an individual's independence and wellbeing. In essence, the emphasis will more often be on working with the person rather than doing for them and persisting in this approach.

9. Safeguarding

Safeguarding of the service user is paramount. Providers will adhere to safeguarding procedures set out below:

http://www.southwark.gov.uk/info/200312/hr_safeguarding/1924/recruiting_safely

http://www.southwark.gov.uk/info/731/keeping_safe_and_reporting_abuse/656/safeguarding_adults-policies_and_protocols

10. User Experience

Southwark service users have formulated a series of 'I' statements which articulate the outcomes that are most important to them in the way they receive the service:

- I want you to be honest with me.
- I want to feel safe and protected from abuse.
- I want to be treated with dignity, empathy and respect at all times.
- I want regular and replacement carers who know me and respect who I am, my culture and my beliefs, and what is important to me.
- I want suitably trained, supervised, and professional staff.
- I want to receive clear good quality information right from the beginning.
- I want to know where to go for advice.
- I have the right to choose how I live my life and be as active and go outside as I want.
- I want to stay living in my own home and maintain my community, social, cultural and/or religious networks.
- I want to recover elements of independence and be able to live life in a time of crisis and change
- I want help to achieve my outcomes
- I want workers who do what they say they will do
- I want to be able to speak to someone who I can understand and who understands me, in a way that I have agreed works best for me.
- I want my family and friends to be involved and consulted, with my consent.
- I expect that the quality of my care will not depend upon me having family or friends who advocate on my behalf.
- If I am not at home, please check that I am OK by contacting the named person

11. The Reablement Support Worker

The provider must ensure that the requirements for a well-trained, motivated and empathetic workforce are met at all times.

The service is required to meet and support the outcomes and needs in the service users' reablement/therapy Support Plan, identified by either the Council or an appropriate health care professional. These needs are then transcribed on to care and support plans retained in service users' homes. This may include a number of statements and outcomes similar to those highlighted above. An element of flexibility and common sense is required to enable Reablement Support Workers to respond flexibly to temporary and unpredictable fluctuations of need in service users, and in emergencies.

The tasks of Reablement Support Workers will be driven by the outcomes agreed at the point of referral by the in-house therapy led team and with service users. The potential tasks will be varied, and therefore necessary training will need to be provided to enable workers to respond appropriately.

Appendix 1 The Workforce Schedule covers the specific expectation on delivery of care and support and its management, including the expectation that providers will employ sufficient appropriately trained staff to deliver the service effectively.

It is accepted that in exceptional circumstances, for example in responding to a medical emergency, civil emergency, or in extreme weather conditions, that workers will support a client beyond the areas identified in their support plans, in the spirit of partnership working.

In such circumstances, the Reablement Support Worker should:

- Consider whether the risk justifies the action. For example could the task wait, or should emergency services be involved? The RSW must escalate where necessary and seek guidance and advice from their line manager, who will in turn liaise with the therapy-led OTA service, Council and NHS colleagues as appropriate.
- Document actions for their line manager to advise the appropriate health and social care professionals associated with the service user as required.

Reablement Support Workers will need to be effective 'alerters' within the London Multi Agency Safeguarding Policy and Procedures and will be required appropriate training for this role.

11.1 Staff skills

Staff will need to be able to work effectively with other professionals including the therapy-led in-house team, participate in MDM discussions, care and reablement support planning and decision making with individuals and their families

Staff will need to be able to motivate, encourage and build confidence through their work with individuals who may have lost confidence or functional ability through illness or crisis.

In some cases, RSWs will need to work to the directions given by the Council's in-house therapy team in respect to individual service interventions, for example, supporting an individual to follow an exercise plan to help achieve improved stamina and strength.

12. The Provider of Community Based Reablement services

The Provider should, at all times hold the appropriate and acceptable Care Quality Commission (CQC) registration status and employ sufficient competent and trained staff to deliver the care and support needs identified in service users' care and support plans. The provider should ensure that reablement support is provided in a consistent way with minimal changes in staffing. Workers should maintain good contact and communication with service users and receive regular reflective supervision to motivate them and have access to appropriate training. The Provider will ensure staff can meet together to promote good team working.

Appendix 1The Workforce Schedule details the provider's requirements with regard to workforce.

The Provider will ensure that telephone and electronic contact points are available at all times for the Council and service users to inspect. The expectation is that the Provider must respond in a timely fashion to persons who contact them.

If sickness or other events prevent the usual Reablement Support Worker from attending a visit, it is the Provider's responsibility to make appropriate alternative arrangements and to communicate these changes to the service user in a manner which is compatible with their sensory, literacy, language and cognitive abilities.

13. Service Mobilisation

There will be an agreed plan for the mobilisation of the contract, to be agreed between the Council and the Provider, ensuring that all necessary arrangements are in place, including the workers required.

The Provider will work cooperatively with the Council to ensure that the transfers of packages to new providers will:

- Ensure service continuity for service users, with new arrangements established in a safe, timely and sensitive manner
- Ensure information, finance, premises, management and other systems are in place and to scale to new or increased levels or activity.

14. Referral Process and Authorisation

Community-based reablement referrals will be sent to the single, borough-wide, reablement service provider who is awarded the contract. The provider will be given one hour to respond to referrals, indicating if they have the capacity and capability to meet the reablement needs of the person referred. If in the event that the service provider is unable to accept the referral due to service capacity issues, the service required will then be referred to the Council's framework home care providers by allocated area i.e. North or South depending on the postcode of the package.

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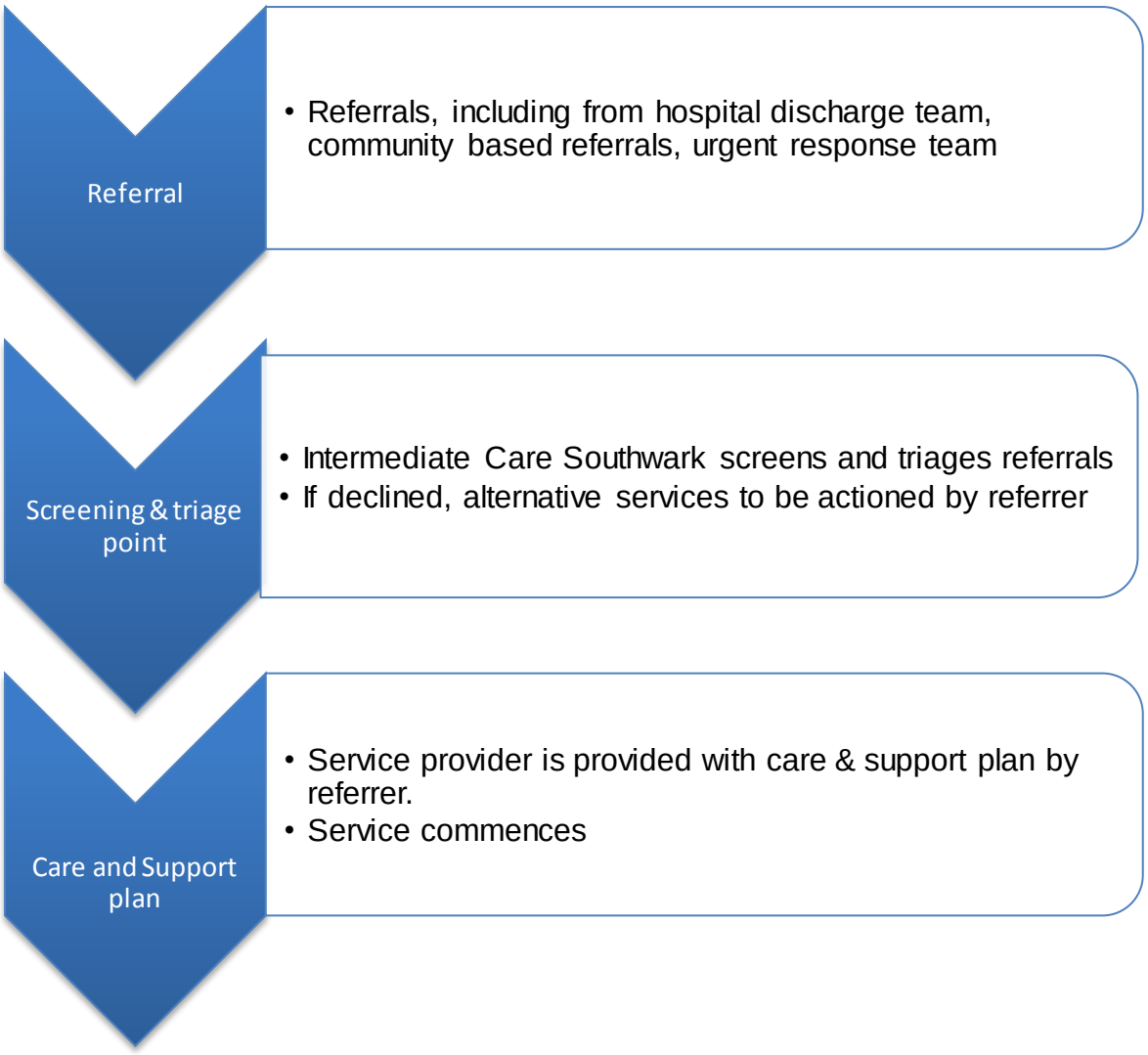
The referral process: Community Reablement



15. Operational Delivery

The service is to be delivered within Southwark Borough boundaries. The Provider will work with NHS Services as well as other social care providers contracted by the Council. The service will operate from 7 am to 10 pm, 7 days a week, 365 days per year. On this basis, the service will need to ensure provision for service for referrals for people coming out of hospital as part of Discharge to Assess.

For urgent cases identified as such by the screening/triage process, service will commence within three hours, or the next working day if the referral is made less than three hours before the end of the normal working day (5pm).

For 're-starts' (services temporarily stopped which then require to be re-started) and for new cases leaving hospital, there is a requirement for the provider to respond on the same day providing the referral is made to the provider before 2.00pm on the day that the service is requested. Referrals received after 2 pm will be expected to start the following day.

The successful delivery of community-based reablement will depend on the services working effectively with the Council's in-house therapy team and within the wider network of the CCG and the Council services so that service users receiving care and support from other agencies feel that their care is as integrated and coordinated as possible. To this end:

- The Provider will need to ensure that they have required capacity at all times.
- The Provider will need to ensure that they can maintain business continuity in the event of exceptional circumstances (such as adverse weather conditions, transport closure/strikes etc)
- The Provider will need to provide organisational leadership at management level to ensure improving working relationships and effective communication across teams such as community health, adult social care and acute care.
- Reablement Support Workers will need to have an effective understanding of other roles and responsibilities and have the training to support that understanding. This will include ensuring that all workers are trained to comply with their distinct role set out in the London Multi Agency Safeguarding Policy and Procedures, alongside their understanding of risk.
- Reablement Support Workers will need to record and share information, including with the therapy led in-house team, to assist in decisions within the MDT and in delivering a coordinated service.

The Provider will at all times be required to comply with the Southwark Ethical Care Charter:

http://moderngov.southwark.gov.uk/documents/s52528/Appendix%201%20Southwark%20Ethical%20Care%20Charter.pdf

The Provider must comply with all regulatory requirements of the CQC plus any other relevant regulatory bodies.

15.1 Community reablement provider and the OTA/therapy-led team working together

The successful service provider is expected to work collaboratively and innovatively with other professionals and services. Examples include:

- Joint training initiatives *(particularly those compliant with the expectations of Appendix 1 Workforce Schedule of this specification)* and those with the in-house OTA team.
- Co-operating with other service providers providing on-going care and support, where identified in the handover from the Reablement service to another provider
- Work with other services to ensure continuity of care for specific service users who may relocate to another area of the borough and wish to retain their RSWs (if this is the wish and in the best interest of the service user) at the tendered fee
- Building links with the wider community

Further details are set out in the Collaboration Agreement *(Section 13 of ITT).*

Allocated time for Reablement Support Workers to attend assessment and support plan reviews as well as MDMs will be expected as part of the agreed contract hours.

15.2 Care delivery

Promoting the independence of service users must be a key aim wherever appropriate. To enhance and maintain service users' skills and abilities in their home, the provider should ensure that staff have a clear understanding of the importance of promoting independence and the value of reablement.

Care and support should be provided in a proactive and preventative way rather than a reactive way. This means that the delivery of reablement support may need to fluctuate when the need for additional or reduced reablement support is identified.

Due to the very nature of reablement, supporting people to do things for themselves rather than 'doing it for them' it is acknowledged that the length of time required at visits may change over the period of support.

The time of visits will be agreed either by the referrer or within the MDM and with the service user at the first visit. The provider must try to accommodate service user preferences, but it is acknowledged that this will not always be possible.

It is expected that the maximum number of visits per service user per day is 4. This will be managed by the service.

The promotion of a reduction in care and support by increasing service user ability or independence should underpin all approaches. However, reductions should not be sought if they would place the service user at risk or undermine their health, independence, dignity or choice.

15.2.1 Activity

The provider is expected to deliver an average of 1,400 hours of support each week over a monthly period. The hours are expected to support approximately 100 service users at any one time

16. Contact Monitoring and Review

The Provider will have an active role in performance management, and this is outlined fully in *Appendix 3 (Performance Framework Schedule)*. The Provider will monitor performance against each service user's outcomes and specific outcomes and goals and develop a performance reporting tool in which to submit the Key Performance Information (KPIs) set out in section 19 below, as well as any performance indicators as set out in *Appendix 3 (Performance Framework Schedule)*.

The Provider will need to operate the CM2000 Electronic Call Monitoring (ECM) system which interfaces with the Council's Mosaic social care client record and SAP finance systems.

17. Approach to implementation and developmental work

The Provider will be required to work in partnership with the Council, the in-house therapy-led team, the CCG as well as other service providers to respond to the evolving local health and social care economy set within the context of the evolving health and social care system in Southwark. The Provider will be expected to take part in the learning and change process involved in working as a partner with the Council and the CCG.

The Provider will be expected to work collaboratively at all times with the Council's in-house therapy-led team and other authorised officers.

In addition, the Provider will be required to attend and contribute to any Care at Home Forum that is supported or facilitated by the Council or other Care at Home providers.

At the point of contract award, a timetable will be agreed to implement any TUPE requirements and transfer of service users to maintain continuity of care as much as possible.

18. Units of support

The service will be commissioned on the basis of outcomes. These will be described, and payment made against hours within which the agreed outcomes for individuals are expected to be supported and delivered.

19. Key Performance indicators (KPIs)

KPI	Target	Measured by
% of individual outcomes achieved	80%	To be measured through progress on the individual service user's reablement plan
% of people having a reduction in on-going care support	75%	*To be agreed following award of contract*
Average length of stay	4 weeks	First visit to service cessation
% of reablement referrals accepted	100%	Report with number of referrals accepted and reasons for any declined
% of people identifying improvement in independence and self-care at service cessation	95%	User survey undertaken by the Provider and reported on 6-monthly basis
All quality alerts are considered & investigated & responded to within agreed timescales	95% of quality alerts are resolved satisfactorily within five working days	Number and outcomes of QAs responded to within agreed timescales Should the number of quality alerts go above 5% of the service user population, this will trigger a concern
Staff are suitably trained, inducted and experienced	100%	Annual training schedule. Number of staff supervision sessions provided each month.
Service users remaining at home 91 days after discharge from hospital	90%	Number of people re-admitted to hospital following reablement support with reasons why.
Referrals by the provider to other services including community and universal services	No target	Provider records
Where complaints have been raised to the Council, the provider must submit their investigation of findings and outcomes within 10 working days.	Number of complaints upheld	Provider records and reports to the monitoring officer on a quarterly basis

Provider works effectively with other professionals in the delivery of the reablement support plan, ensuring a holistic multi-agency approach	Staff contribute to documentation as required in100% of cases Staff raise concerns in respect of prevention or deterioration with other health and social care professionals where relevant in 100% of relevant cases Staff attend case review meetings and MDMs as when required	Qualitative case study of effective partnership working, and impact on service user and provider submitted by provider on quarterly basis Provider submits number of meetings attended
Compliance of the Southwark Ethical Care Charter (SECC)	100% compliance	Evidence of compliance, staff contracts, payroll reports and any other supporting information requested by contract monitoring officer at monitoring visits
All staff receive planned and recorded individual supervision from their designated supervisor on at least a quarterly basis	100% of reablement support workers	
All reablement staff have an annual written appraisal including training plan and feedback from service users All reablement staff have the opportunity to meet together to ensure there is effective team working and communications on at least a 6-monthly basis	100% of Reablement staff	Quarterly return Annual Staff survey conducted by Council Sample review interviews by the Contract Monitoring Officer at monitoring visits
Staff obtain the Care Certificate within 12 weeks of starting employment	100% of reablement staff	Quarterly return Annual Staff survey conducted by Council Sample review interviews by

		the Contract Monitoring Officer

20.Appendices

Appendix 1 Workforce Schedule

Appendix 2 Performance Framework

Appendix 3 Payment and Charges Schedule

Appendix 4 Contract Management

Appendix 5 About Me and My Home Care

Appendix 6 Essential Policy Requirements