Schedule 1 – Service Specification

SERVICE SPECIFICATION

FOR THE PROVISION OF
CARE AND SUPPORT SERVICE AT REARDON COURT

Contents

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SECTION A

1. Introduction

1.1 In line with the Care Act 2014, government policy and the wishes of older people, Enfield Council has been steadily increasing support to assist older people to continue to live independently in their own homes. The overall objective of extra care linked to national policy is to address the issues of moving away from institutional provision towards supporting older people in houses in their communities. As older people become more frail housing issues become more crucial, such as physical location; characteristics of the person's living situation coupled with the interface with care support, health transport and community access. The provision and service design of extra care seeks to address these challenges to allow the individual to maintain feelings of safety, security and quality of life.

1.2 This document sets out the contract service specification for high-quality Care Quality Commission (CQC) registered adult social care for the range of residents at Reardon Court Extra Care housing (ECH). This document describes the key features of the service to be provided; and should be read in conjunction with the terms and conditions of the contract.

1.3 The services outlined within this specification describes the holistic and personalised arrangements for providing domiciliary-based care to all Service Users, working alongside Enfield Council Housing.

1.4 The Service Provider will start delivery of the Mobilisation Services at the Commencement Date and delivery of the Services at the Service Commencement Date in line with existing arrangements for Service Users as outlined in their Care & Support plans and risk assessments.

1.5 Over the lifetime of the contract the Service Provider will be expected to work flexibly with the London Borough of Enfield ("the Council") to improve the cares services. This will be subject to regular performance monitoring and review focused on evidenced based outcomes, including Service User satisfaction, quality assurance & organisational capacity and cost effectiveness & efficiency detailed in this contract and agreed between the parties.

2.0 Background and Service Context

2.1 Extra Care housing provides vulnerable people with access to on-site 24/7 personal care, community health and housing support services. The service is targeted at those with various levels of care needs, including complex needs, who have been assessed as needing this level of support and they are Care Act 2014 eligible. Individuals hold an assured tenancy and live in a self- contained flat with their own front door. The service provides a range of activities to improve quality of life and reduce isolation, including access to a meals service for Service Users if they wish to eat together. Service Users can contact the Service Provider's staff outside of their planned care times through an on-site alarm service.

3.0 Enfield Council Strategic Objectives

3.1 The Specification is an opportunity for the Provider to establish or maintain a reputation for effective partnership and development working with a Local Authority.

3.2 The key strategic objectives relevant to this service specification are:

3.2.1 Good homes in well-connected neighbourhood.

To increase housing choice for adults with support and care needs living in the London Borough of Enfield, by developing an appropriate supply of good quality, specialist accommodation options to meet the changing needs of existing and emerging communities.

3.2.2 Sustain strong and Healthy Communities

To ensure adults and their families/carers, including hard-to-reach groups have good access to clear and consistent information about specialist accommodation options in the London Borough of Enfield, so they are empowered to make informed decisions about where and how they are supported to live.

To enable adults with support and care needs to live as fulfilling, independent, healthy and well lives as possible and contribute to the prevention and early intervention agenda by development of specialist accommodation options.

To support the re-ablement of older people and contribute to the prevention and early intervention agenda through the development of short stay specialist accommodation options for older people with care needs.

3.2.3 To Build our local economy to create a thriving place

Maximise opportunities for independent living by improving the quality, design and accessibility of specialist accommodation for older people.

Better understand the changing aspirations of older people in Enfield with regard to specialist accommodation services.

Support the development of modern, innovative accommodation models that extend choice and empower vulnerable adults to take control of the services they receive in line with the Personalisation agenda and policy direction.

Ensure the availability of culturally accessible and socially inclusive specialist accommodation services to support Enfield's diverse population of older people and facilitate community cohesion.

Ensure the availability of accommodation services for older people in the borough that effectively meet the specialist or acute needs of those with long-term conditions, including dementia and stroke, and to appropriately support end-of-life care.

Work in partnership with the external provider market to raise quality standards in specialist accommodation services for adults at risk of abuse or neglect.

3.3 The Service will be underpinned by the above strategic objectives, Care Act 2014, the Council's Dignity Strategy for Adult Social Care, the Principles of Adult Social Care Enablement Policy and the Council's service promise.

4.0 Contribution to Strategic Outcomes

The Council believes that a fairer Enfield is better for everyone. It is determined to reduce the gap between rich and poor, to make a difference to the lives of those in the community who most need a helping hand and to make Enfield a fairer place for everyone who lives and works in the Borough. The Council believes that a combined effort by the public, private and third sector, together with local people, offers the best chance of achieving lasting improvements for residents.

5. The Premises

5.1 Reardon Court offers 70 units of Extra Care Scheme, comprising of

61 one-bedroom
5 two-bedroom
3 flexi flat one bedroom utilised as stepdown beds by Adult Social Care
1 flexi flat two bedroom utilised as a stepdown bed by Adult Social Care

5.2 The service is located at: 26 Cosgrove Court, Winchmore Hill London N21 3BH.

5.3 All Flats are available under social rent through Enfield Council Housing.

5.4 Office accommodation would be made available however this will be shared with the Council's Housing Team.

6. Needs of Service Users

6.1 This section provides an overall picture of the needs of potential future Service Users in the Extra Care Scheme. It is an aggregated view and not intended to prescribe individual Service User's needs fully. Service Users at Reardon Court will have differing needs and preferences which will be

outlined in their individual Service User Care & Support Plans, which are regularly reviewed. The Service Users who will be placed at Reardon Court can be categorised into four broad groups described below. The information below contains a brief summary of the metrics associated with the needs of each Service User group.

6.2 *Group 1: Older Service Users who currently have eligible social care needs and have less significant problems in daily living* but may benefit from some degree of support (not long-term care) in communal living. Occasionally, such individuals may need one-off or short-term care, e.g. following a hospital episode, or as part of a short-term NHS or Council Service (minimum of 7 hours). If the care represents a defined episode of short-term NHS care, it should be noted that this service is outside the scope of this Specification. The Service Users in Group 1 will have the assistance of the Provider to support their care needs.

6.3 *Group 2: Older Service Users who have more substantial problems in daily living* and who are eligible for long-term care under the Care Act 2014, but who nonetheless also benefit from fixed care and support in the facility in the same way as Group 1. All users in Group 2 will have their care provided by the Service Provider and the Service Provider should facilitate them to have as much choice & control over choosing & managing their care.

6.4 Group 3 *Older Service User who have high care needs i.e. more than 14 hours per week* and who are eligible for long-term care under the Care Act 2014, but who nonetheless also benefit from fixed care and support in the facility in the same way as Group 1 and 2 Service Users. All users in Group 3 will have their care provided by the Service Provider and the Service Provider should facilitate them to have as much choice & control over choosing & managing their care.

6.5 As part of a well-established care pathway in Extra Care, Service Users with less significant problems in daily living who choose to move into the Extra Care scheme may develop long-term, more complex problems in the future due to ill-health and frailty as they get older. This means the balance of numbers of Service Users in Groups 1, 2 & 3 will change over time, although the intention is to ensure the proportions of Service Users in these two groups reflect a “balanced community” living in the Extra Care facility (see Section 10 of this specification).

6.6 Group 4: Service User who form part of the Council’s Integrated locality Team Service programme to support independence within 4 flexi flats which are commissioned by Adult Social Care for a fixed period to regain function which will enable them to continue living safely and return back to their home. The Service Provider through an enablement approach is to support service Users living in the flexi flats to get back to living independently in the community.

6.7 The principle purpose of the flexi flats is to support the Council’s Enablement policy and all referrals will come through the Integrated

Locality Team Service within the Council's Adult Social Care function. This is a time limited, up to 6-week period of treatment designed to maximise people's long-term independence and minimise or otherwise delay the requirement for ongoing care and referral to more acute care accommodation.

6.8 Where the flexi flats are not being used for a client directly placed by the Integrated Locality Team Service, the ASC may also use the flexi flats to support trial placements / assessment periods to determine whether a potential Service User's needs can be effectively met in the extra care housing environment within the service levels provided.

6.9 The Service Provider may not be required to work directly with clients referred from the Integrated Locality Team Service. Flexi flat Service Users may also be supported by the Council's Integrated Locality Team Service or another professional.

However: -

6.9.1 The Service Provider will still need to maintain an effective liaison with the Integrated Locality Team Service and any other professionals that may be working with the Service Users.

6.9.2 If a flexi-flat Service User (including one placed directly by the Integrated locality Team Service) is suitable for and expresses an interest in, a longer-term vacancy at Reardon Court, then the Service Provider would be expected to take on a more direct involvement and the Council will inform the Service Provider in writing detailing the care and support required for the Service User.

6.10 The Service Provider will be required to include flexi flat outcomes and move on as part of key performance indicator monitoring arrangements.

6.11 The service delivery model will be available to provide care to all households at Reardon Court, and when necessary the Service Users who form part of the Integrated Locality Team Service within the Flexi Flats. The Service Provider is encouraged to consider ways in which the contract Services staff can be deployed flexibly to maximise the amount of care outcomes able to be delivered within the service model.

7.0. Aims and Outcomes

7.1 The overarching aim is for the Service Provider, including Enfield Housing and Adult Social Care to work together (along with the Service User) in a coordinated way to provide high-quality adult social care services tailored and flexed to meet the agreed needs and outcomes of individual Service Users.

7.2 In providing this Model, a number of outcomes for Service Users should be achieved, under-pinned through the Council's ethos of Extra Care, which is *"providing well-designed housing that enables people to self-care for*

longer and gives them access to care of their choosing as unobtrusively as possible to help them retain independence." The outcomes associated with this Model are therefore:

- *Enabling Independence:* Service Users will maintain as much independence as possible by adopting a strength-based approach to supporting them in daily living and hence improving their quality of life;
- *Feeling Safe & Secure:* However, there will be an appropriate balance between managing risk, choice & safeguarding for individuals and for others; and Service Users should feel that support is provided as safely & securely as they need;
- *Being Healthy, Clean & Comfortable:* Service Users will be facilitated and supported to be as healthy and well as they can and be clean and comfortable in the delivery of care at all times; This aim also includes the provision of a meal at least once a day as an assessed need.
- *Treated with Dignity & Respect in a Person-Centred Way:* Service Users will always be treated with dignity in a way that respects their individual social, cultural, ethnic, religious etc. needs and be at the centre of planning, choosing, managing and financing the care & support that's right for them; and
- *Having Company & Contact and Feeling Engaged:* Service Users will be facilitated to have as much company & contact with others as they feel they need and are facilitated to take part in activities and interests that are important to them, including in the wider community.

7.3 As a result of achieving these outcomes for individual Service Users, it is expected there will be wider health & social care outcomes including:

- Working with Service Users in an enabling way that helps them to regain functions for a period of six weeks or longer if further enablement will support move on;
- To reducing the risk of hospitalisation admission; and
- To reduce the need for a residential or nursing care placement.

7.4 The personalised response to a wide range of individuals' needs and the intensity of these needs facilitated via this model will mean Extra Care facilities and services will support a 'balanced community at Reardon Court (Section 9 and 10 of this Specification).

7.5 The Service Provider is expected to support the delivery of health and social care for individuals in line with relevant NICE guidance and related standards specifically relating to older people, people with severe and enduring mental health issues and learning and physical disabilities. This includes (but it is not limited to) Older people with social care needs and multiple long-term conditions (NG22), Older people: independence and mental wellbeing (NG32) or Falls in older people: assessing risk and prevention (NG161). Other examples are highlighted below.

The Service Provider will deliver the services in line with the **NICE Guidance for dementia care**, including the best practice dementia pathway as well as:

- NICE Quality Standard for Dementia: support in health and social care (June 2010) https://www.nice.org.uk/guidance/qs1
  NICE guideline [NG97] Dementia: assessment, management, and support for people living with dementia and their carers (June 2018)

7.6 The Contract Management Section (Section 17 of this specification) sets out contract governance mechanisms, including how the degree to which these outcomes are achieved for Services Users within the Model will be monitored.

8.0. Description of Care Model

8.1 The Care Model is based on a guaranteed weekly block hour arrangement for all the Service Users within Reardon Court for 24 hours 7 days a week. The Model relates to delivery of well-coordinated, consistent and high-quality care & support needed to deliver Service User outcomes on a day-to-day and longer-term basis:

- The model includes personal care for Group 1, Group 2 and Group 3 Service Users who have been assessed as in need of this support.
- Social Activities to engage Service Users in meaningful activities (A full description of what in practice may be defined as care is included in Annex 1 of this Specification.
- Service Users' outcomes will be delivered through a collaborative, person-centred and strength-based approach taking account their expressed wishes and choice.
- Contract management arrangements described in Section 17 of this specification therefore includes provision for monitoring & assessing Service User outcomes.
- There is a requirement for the Service Provider to act as a coordinating agency amongst all stakeholders involved in the care & support of individuals ensuring expectations in the Service User's Care & Support Plans and their outcomes are met satisfactorily, both on a daily basis and in the longer-term. This includes health and specialist agencies. The Service Provider shall ensure care and support is well co-ordinated and well governed to meet individual Service Users stated needs and outcomes
- The model includes the provision of 4 Flexi Flats that support Service Users for a period of 6 weeks or more. The period of enablement needed will be determined by the Integrated Locality Team Service (See sections 6.6 to 6.12).

9.0 Service Provision

9.1 The overriding approach to service provision must be to deliver the aims and outcomes of the service model described in Section 7, of this specification particularly those relating to a caring and enabling / strength-based approach. The onus of the Service Provider – *including with respect to the requirement at the Commencement Date (i.e. the mobilisation start date) of providing a seamless service to Service Users on the basis of their*

existing Care & Support plans, Care Plans and Service User risk assessments - will be on ensuring the needs and outcomes identified in the plans and assessments are met appropriately, and to the Service User's satisfaction, in the context of the Model.

9.2 Annex 1 of this Specification provides a summary of the care needs of potential Service Users at Reardon Court. This is meant to be an indicative 'snapshot' analysis of the support needed, as individual Service Users' needs may vary on a day-to-day and longer-term basis.

9.3 Delivery of this service model is based on the Service Provider delivering on their areas of responsibility which includes:

- Responsibilities for the planning and delivery with others, including the Service User, for individual Service User's Care & Support Plan.

- Day time personal care arrangements to deliver the care functions included, but not limited to, those described in Annex 1 Day time" is defined as the period 7 am – 10 pm.

- Night-time personal care arrangements: "Night-time" is defined as the period 10 pm to 7.00 am. Night-time provision will be available to all Service Users.

- The Service Provider will ensure that a staffing rota system is in place to provide adequate cover at all times, A minimum of 4 staff is expected to be on site to cover night-time care.

- Adhere to the support plans and the cover required/respond to all emergency call bell respond night and day- have enough staff on site day/night.

- Skillset of workforce to have an understanding of physical disability, mental health needs, learning disability, dementia, frailty and end of life care.

- The Service Provider ensures that an assessment is undertaken of the potential risks to Service Users and staff associated with delivering the Service and a risk management plan put in place. This should be updated annually or more frequently if necessary.

- The Service Provider will be expected to engage Service Users in meaningful social activities to enhance their lives and wellbeing. Minimum requirements should include:

    - Coffee morning sessions
    - Exercise for therapeutic and social needs
    - Day and annual outings
    - Games and quizzes

- External speakers and befriending organisations supporting social inclusion

- Responsibilities for the managerial oversight and administration of the Service to fulfil the above functions. This extends to ensuring that the identity and purpose of visitors to the scheme e.g., health workers and family is ascertained and recorded to mitigate risks of unauthorised entry.

- The Service Provider will be required to utilise all commissioned hours to its best ability. The use of all hours must be demonstrated through weekly returns to the Council, including unused allocated hours within the contract.

9.4 The Provider must seek to operate a culture where the approach to services is caring, collaborative and flexible, rather than being solely concerned with the completion of a set pattern of care tasks. It will do so through engendering good relationships among the community at Reardon Court and other health providers, including the Council's Housing Services. In doing so, the Service Provider must recognise Service Users' daily requirements may vary (and respond flexibly and accordingly), with some people requiring more assistance one week, then potentially less the next, and so on.

9.5 There may be occasions when individual Service Users may call upon the Service Provider to provide (particularly) personal care however, the long-term or continuing need for such a Service User to call upon the Service Provider care should trigger the need to assess or review that Service User's Care & Support Plan with other relevant parties. Such cases should be raised to the Council at the earliest practical opportunity.

9.6 There is expected to be a staff presence on site 24 hours per day from the Service Commencement Date. The Service Provider will operate the agreed staffing structure in place t

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Care & Support Plans for individual Service Users. However:

- There should be staff members available at all times to be able to respond to Service Users care and emergencies outside of planned care
- The Service Provider is to provide flexible support during the peak hours in the morning, evening and daytime hours which will mean additional staff members, if needed, should be available to meet needs
- The Service Provider will support Service Users if required to report emergency repairs outside of normal working hours

9.8 Night care workers are expected to be supported by an on-call service from within the Service Provider’s organisation that should give them access to advice, support and intervention from managers as appropriate.

9.9 It is anticipated the night-time provision will be supported, as a contingency, Assistive Technology (as detailed in Section 14 below) will be available to provide an unplanned mobile response service. if triggered through the use of assistive technology (Section 14 of this specification). It is expected that the assistive technology service will be available to Service Users and staff at all times. It should be noted, however, that accessing this Service during the daytime and/or night-time hours will be a contingency and that any longer-term and regular requirement to support a Service User via assistive technology should lead to a review of the individual’s care and support needs.

9.10 The service model is funded on the basis it reflects the following:

- The aspiration to have a “balanced community” of older residents in Group 1,2 and Group 3, i.e. those who need little personal care on the one hand and differing levels of care needs on the other throughout the lifetime of the contract; (see Section 6 of this specification which further explains the percentage split of balance community).

- Service Users requiring Housing related support or Housing Benefit advice will link into

Housing Management Terms (appended at Schedule 2 of the Contract for advice and support with benefits or any benefit maximisation requirements, contact should be made with the Adult Social Care Finance and Assessment Team.

- It will have the capacity to provide support to all 70 households in Reardon Court during the lifetime of the contract working in partnership with relevant ASC and Council Housing staff and NHS staff including Hospitals, the Care Home Assessment Team (CHAT), GPs, District Nurses, Physiotherapists and Occupational Therapist.

9.11 The Service Provider will account for all commissioned care hours and report back any variation to ASC Commissioners. The Service Provider will be accountable for the delivery of long-term outcomes for Service Users that are included within individual social services care plans.

9.12 It should be noted that following successful implementation of the contract at the end of Mobilisation Phase, the Council wishes to work with the Service Provider in investigating possibilities for greater flexibility and efficiencies in the staffing model.

Care & Support Plans and Service User Risk Assessments

9.13 The requirement at the contract Commencement Date to continue to meet the terms of Service Users' Care & Support Plans and Service User risk assessments in their agreed form, the Service Provider must have:

- reviewed all Care & Support plans and Service User risk assessments in conjunction with all relevant parties, including Service Users themselves;

- transferred these relevant Service Users onto the Provider's Care & Support plan format, containing an up-to-date view of Service Users' care and support needs and their desired outcomes in the context of the aims and outcomes framework in Section 7 of this Specification, and which are agreed with Service Users. Where necessary for individual Service Users, this will be coordinated with other providers including the Enfield Housing;

- agreed with Service Users, how the Service Provider can best support them to meet their needs & goals and manage & reduce risks, including the role of any other Providers for that Service User; and

- record and deliver Services detailed within Service Users' Care & Support Plans and risk assessments, which should be signed by Service Users or their representatives.

9.14 The Service Provider will work with Service Users in an enabling way to support independence and regain functions and/or skills. Coinciding with the intention of Extra Care Housing to promote and prolong independence,

the Service Provider must contribute to a culture that fosters an approach of risk awareness over risk aversion; encourages all Service Users to retain independence, and which appropriately balances risk, choice and control and safeguarding in their lives and their care and support.

9.15 Care & Support Plans and Service User Risk Assessments should have a minimum review frequency of 6 months but must also be reviewed after one of the following:

- A request by the Service User (who must be informed by the Service Provider they have this opportunity);
- An incident or a significant change in the Service User's personal circumstances, including a change to their health status or level of independence;
- A material change to the Service User's Council Support Plan, if relevant.

9.16 For the relevant Service Users discussed in Section 9.14, of this Specification responsibility for developing, recording, storing, implementing (in a timely fashion) and reviewing Care & Support Plans and Service User Risk Assessments lies with the Service Provider, including where there is a need to coordinate the care and support across other provider(s), including the Enfield Housing.

9.17 Each relevant Service User in Groups 1, 2 & 3 must have a nominated key worker employed within the Service Provider who will be their primary point of contact from the Provider for day-to-day queries and on the longer-term delivery of their (potentially coordinated) Care & Support plans and Council Care Plans. The key worker is therefore expected to coordinate the care & support with all other relevant parties.

9.18 The Service Provider is to use all best endeavours to reduce staffing cost by making use of specialist equipment and assistive technology for those Service Users in Groups 1,2, 3 & 4 to reduce the need for double handed care.

9.19 Service Users receive a consistent, well managed and planned service

- Day to day operations will be from the Reardon Court premises and staff should be accessible to Service Users.

- The Service Provider must be registered to provide domiciliary care with the CQC and be consistently capable of meeting the national minimum standards. This will be the minimum level of quality acceptable to the Council and the Service Provider must be able to demonstrate that it exceeds these standards. Copies of registration reports and documentation must be made available to the Council, and any change in registration status must be notified immediately to the Council.

- The Service Provider shall put a management structure in place, with clear lines of accountability, which enables the Service Provider to deliver

the Service effectively on a day to day basis, in accordance with the Service Provider's business plan.

- The Service Provider shall have a governance structure in place that provides robust leadership with clearly defined roles and responsibilities.

- The Service Provider must have a robust, routine mechanisms in place to monitor and audit the quality of service provided.

- The Service Provider must have policies and procedures in place governing the safe storage and administration of Service Users medicines within the scheme.

- The Service Provider must have clear guidelines and information governing the provision of a safe, nutritious and quality meals service across all sites and information is available to Service Users detailing the service they can expect to receive, written in clear English.

- The Service Provider must demonstrate sound financial management of the organisation.

Joint working and Liaison

9.20 As part of the delivery of an individual's Care & Support Plan and the findings of its Risk Assessment, the Service Provider is expected to take a proactive role (as directed by Service Users) in liaising with key agencies to meet the needs and outcomes in such Plans as outlined in Annex 1 of this specification. These agencies include (but are not limited to): London Borough of Enfield (including social services), health & emergency services and other care & support providers, community services transport, benefits, financial and leisure. As part of an enabling approach, the Service Provider should encourage the Service User to be fully involved in this liaison.

9.21 An exception to the responsibilities for the Service Provider laid out in 8.23 of this specification will occur where Service Users have capacity and have expressed their desire to conduct this liaison directly, through a named representative such as a family member or appointed advocate.

9.22 As directed by Service Users, the Service Provider will be required to work with families and advocates to assist in the delivery of the Service User's Care & Support Plan.

Mobilisation

9.23 The requirement at the Commencement Date is for the Service Provider to implement the Mobilisation plan as agreed by the Council. The Mobilisation plan will include but not be limited to the following requirement below:

- The Availability of a Mobilisation Team with formal job roles and responsibilities and contact information.
- Recruitment and retention of staff taking into account the diversity of borough residents. Ongoing training, learning and development should also form part of the area.
- Operational Resources to include any equipment or other resources needed to service the Contract.
- Out of hours operation.
- IT and tele communication systems.
- Communication and Engagement Plans.
- Record keeping, data protection and confidentiality.
- Risk Management plans.
- (See Section 9.13 and 9.22).

10.0 Nominations & Admission to Reardon Court

10.1 Enfield Council has 100% nomination rights**.**
Applications of new residents to Reardon Court will be made by the Extra Care Housing Panel chaired by the Sheltered Housing Services Manager.

Applicants must:

- Have Care Act 2014 assessed adult care needs of a minimum of 7 hours consistent with provisions of the principle of a "balanced community" at Reardon Court.
- Be aged 60 years or over (or aged 55+ if there is a diagnosis of dementia or the applicant has a learning difficulty or physical disability).
- Be a resident in the London Borough of Enfield or have a local connection with the area or a strong social need to live in the area. This would usually be part of the local authority housing department's eligibility criteria;
- Have a housing need and be eligible for Sheltered Housing in the Borough, including having a local connection with the area.
- Have a positive desire to remain independent within the community.
- Have assessed adult care needs consistent with provisions of the principle of a "balanced community" at Reardon Court.
- Consideration will be given to individuals whose needs can be managed safely within the resources committed to the extra care housing scheme. Cognitive impairment and functional mental illness are not a bar to entry or to continued tenancy as long as it is not sufficient to jeopardise the individual's ability to live independently or to place others at risk.
- Service User's cognitive and physical health may deteriorate over time, but it is only when the person's level of needs can no longer be supported safely and with dignity in the extra care setting that further assessment and possible transfer to another setting will be considered.
- The approach to decision making will at all times be one of multidisciplinary working and of collaboration between the Service

Provider and the Council, however the final decision is made by the Council.

- The minimum age requirement could be waived in exceptional circumstances

10.2 The expectation is that the social care practitioner, the Service Provider and the Service User's relatives will support the Service User to move into their property within a maximum period of 28 days once agreed at panel, except where a flat is not available or in extenuating circumstances.

10.3 NHS Funded Continuing Healthcare: Service Users with increasing healthcare needs may be entitled to Continuing Care funding, which means the costs of a person's healthcare, social care and accommodation becomes the responsibility of NHS North Central London ICB rather than the Council and payments from the Council will cease. Any privately funded care or continuing health care will cease to be part of the block contract arrangement.

10.4 The principle of a "balanced community" at Reardon Court will be adhered to as much as possible, although a degree of flexibility will be needed in considering new applications, including those individuals' potential future care needs. Applications will be made with consideration to the promotion of a "balanced community" as follows

- 30% of the residents with low dependency care needs, i.e. those requiring 7 hours or less of care per week;
- 30% with moderate dependency care needs, i.e. those requiring between 8 and 14 hours per week; and
- 40% with high dependency care needs, i.e. those requiring 14 and 30 hours per week.

It should be noted that should a Service User's health within any of the above categories change, this should trigger a review of the care through the London Borough of Enfield's Integrated Locality Team Service.

10.5 The final decision about nomination will be made by the Extra Care Housing Panel, taking account of the individual application and the principle of a "balanced community". The Panel will make this decision in consultation with the Service Provider. Part of this consultation will be if there is sufficient capacity to provide care to the applicant within the Model.

The Service Provider will accept the Council's nomination unless:

- there are no available units
- the Service Provider is unable to meet the health and/or social care needs of the prospective Service User as agreed with adult social care

10.6 The care needs of each applicant will be assessed with the individual and their representatives, relevant Council professionals and Enfield

Housing, to determine the outcomes that might be needed as detailed in the Aims and Outcomes Section in Section 7 of this specification.

10.7 Referrals and Assessment

All referrals to the scheme will be presented firstly to the Council's Adult Social Care Panel in order to approve funding. Following this, referrals to extra care housing will be made by the care professional who presented to Adult Social Care Panel. The Provider has 3 **Business days** to check the referral paperwork and ensure all information required to carry out an assessment is complete. If information is missing the social worker should be informed so that documents can be gathered with minimum delay within the 5-day period. The Service Provider has a further **5 calendar days** in which to assess the service users care plan for acceptance to the service. Once a decision has been reached (no more than **2 calendar days** from the date of assessment) the social worker should be contacted with the outcome and a moving in date agreed. In the first instance any such cases will be discussed in the extra care referral panel that takes place bi- monthly. If a decision is not reached then, the case will be escalated for a final decision to the Service Manager for Commissioning and equivalent for care on the Service Provider's side. A final decision must be reached within the 6-week void period. Should this remain unresolved after 6 weeks the issues will be managed through the dispute resolution as per contract.

11.0 Voids

Void management will be the responsibility of the Council. However, following Adult Social Care Panel approval of a new Service User, the Service Provider will be responsible for assessing the care and support to be provided to the Service Users in accordance to the care plan arrangements.

12.0 Move-on, Temporary Absence and End-of-Life & Death

12.1 Move on

Every effort should be made to accommodate Service Users' needs within Reardon Court. It is however recognised there are times when the care needs of a Service User are deemed to be sufficiently intensive to be no longer be most effectively met at Reardon Court.

12.2 The possibility of a Service User needing to move on should be part of the review of their Care & Support Plan and Risk Assessment, which will be undertaken by relevant parties with the Service User or their representatives. If all parties, including the Service User or their representatives, agree the Service User's needs and outcomes can no longer be met, the Council will be responsible for identifying a suitable alternative provision for Group 2 Service Users. Potential suitable

permanent alternatives include other Extra Care or supported accommodation; private homes with support; residential or nursing care home; or long-term non-acute hospital environments. It should be noted the principle of "move-on" excludes temporary planned or emergency inpatient admission to hospital and residential step-down/intermediate care; in such cases, the Service User's permanent main address will remain at Reardon Court.

12.3 The Service Provider, together with all relevant parties, including Enfield Housing, will continue to support the Service User's care until a suitable alternative provision for the Service User is found. The Service Provider, together with the above relevant parties, should actively support the transfer of the Service User to the alternative provision to ensure move-on is as smooth as possible during the period of transition, as directed by the Council.

12.4 Temporary Absences

Service Users who have been in hospital will be supported to settle back into Reardon Court. In the case the Service User who have received inpatient care in a psychiatric setting this may include a period of home leave before formal discharge. This will involve liaising closely with hospital staff, the person's GP, and relevant community services. The Service Provider will, where appropriate, be involved in discharge planning arrangements.

12.5 If Service User is admitted to hospital or prevented from receiving the Service due to sickness or incapacity during the contract period, the Service Provider will report this to relevant officers within the Integrated Locality Team.

12.6 The Service Provider will contact the police on the occasions where a Service User has failed to return from community visits and the relevant officer within the Integrated Locality Team as soon as they become aware that the Service Users has not returned to the scheme as expected.

End-of-Life Care

12.7 Every effort should be made to accommodate care and support needs of all Service Users within this specification. The Service Provider is expected to support the needs and wishes of those who need end-of-life care including to live their last few days of life at Reardon Court, as part of the policy direction to support people to die in their own homes rather than in hospital.

12.8 To support this goal, the Service Provider will deliver the Service in line with NHS England's End of Life Programme. This includes:

- Relevant NICE guidance, particularly End of Life care for adults: service delivery (NG142) and Care of dying adults in the last days of life (NG31)

- One Chance to Get it Right: Improving people's experience of care in last few days and hours of life (June 2014). Leadership Alliance for the Care of Dying People;

  https://www.scie.org.uk/publications/misc/lcpbriefing.asp;

- The Programme' Ambitions for Palliative and End of Life Care: A national framework for local action 2015- 2020 (2015). http://endoflifecareambitions.org.uk/

12.9 In situations relating to the end-of-life for a Service User, the Service Provider will

- be part of the planning and/or delivery of any agreed Advanced Care Planning arrangements for the Service User, as relevant to the Service Provider's role for that Service User;
- manage end-of-life with the Service User and their representatives with empathy, sensitivity, dignity and respect at all times;
- work effectively with other specialist services (e.g. Palliative Care Nurses) for any Service User for whom it is providing care or assure any other provider is doing so for any relevant Service User who has chosen to use their direct payment ;
- liaise with the Council - including on the overall sustainability of the staffing model at times of sustained peak need; and
- liaise with and address the concerns of the Service Users and their family/advocates in conjunction with other relevant parties.

12.10 If a Service User's needs change to the point where they can no longer be effectively met by a combination of Service provided by the Service Provider along with other specialist services, the Service Provider must bring this to the Council's attention (facilitating consistent messages to the Council's social work teams and contract management staff) to initiate a Care & Support Plan review, which might also include any specialist end-of-life service providers involved in the case. These parties will work toward a mutually acceptable solution. Each case will be judged on its own merits and all parties will work together to facilitate this process.

13.0 Housing Management

13.1 The landlord (housing provider, London Borough of Enfield) retains an onsite housing management function. A key responsibility of the Service Provider will be to liaise with the landlord on Service Users' behalf as requested regarding:

- Repairs
- Rent and Service charges
- Other issues related to the building or are otherwise the landlord's responsibility
- When a death has occurred, or a service user has moved on to another accommodation

- Business Continuity Plans

13.2 However, it is anticipated the Service Provider should work closely with the housing provider in the delivery of all Service User's Care & Support Plans. The housing provider should therefore be seen an integral party in delivery of support in the framework of the outcomes in Section 7 of this specification in particular in engendering an enabling and flexible approach to the delivery of these outcomes. To support this quarterly joint meeting with the housing provider should be scheduled.

13.3 The Service Provider must maintain records of their assistance and advocacy with the landlord; including in Service Users' files where appropriate.

13.4 The Service Provider is to refer to the Housing Management Terms appended as Schedule 2 of the Contract which details the requirements of the Council on Housing Management.

14.0 Use of Assistive Technology: Alarm & Alert Systems

14.1 Reardon Court will be equipped with an emergency call system; with maintenance provided for the system. There will be a pull chord in each flat and corridor. Service User calls will come through to the onsite care staff.

14.2 The Service Provider will utilise the available assistive technology to assist in the efficiency of care provision. This would be a combination of assistive technology purchased and/or fitted by the Council as well as the Service Provider's own provision.

15.0 Service Development and Scope

15.1 The Council will work with the Service Provider in exploring greater flexibility and efficiencies, including in the staffing model, to reflect potential reduction/increase in care needed and more generally across the care Model. Potential efficiency opportunities will be discussed as part of the regular contract meeting, which may affect the agreed projected budget for the Service Provider. The realisation of these efficiencies will be the subject of contract performance and discussed during the course of the year in which they need to be realised. Such monitoring will not simply be in terms of whether such efficiencies are realised, but also in terms of the ongoing sustainability and quality of the Provider's provision.

General Service Developments

15.2 The Service Provider will work in partnership with the Council to develop the Services. The mechanism for agreeing this will be through contract performance monitoring and Services Review. This includes the opportunity for the Service Provider to suggest key priorities and plans for developing the Services throughout to the Contract period.

16.0 Service and Quality Standards

16.1 The Service Provider shall be registered with the Care Quality Commission (CQC) where they provide regulated care activities e.g. personal care. The Service Provider shall notify the Council of any changes to their registration status.

16.2 The Service Provider shall provide and manage the Services in accordance with, and to, the standards set out in this Specification and Contract. Repeated failure to meet or maintain any of the required standards or quality detailed in this Specification shall be regarded as a material breach of Contract.

16.3 The Service Provider must ensure and evidence current registration with the Care Quality Commission (CQC) or any succeeding regulatory body is maintained throughout the entire Contract Term.

16.4. The Service Provider must maintain throughout their accreditation period at least 'Good' quality rating from the CQC in line with the 'Key Lines of Enquiry' (KLOE) and strive for excellence in all areas.

16.5 If the Service Provider is assigned a CQC rating of 'Requires Improvement' or' Inadequate' the Service Provider shall work jointly with the Council to agree an action plan is developed for immediate measurable improvement in the areas identified. The Service Provider will need to demonstrate the improvements within 3 months of receiving the 'Requires Improvement' rating from the CQC. The agreed action plan must ensure a safe and effective Services for existing Service Users.

16.6 The Service Provider shall notify the Council of the outcome of any CQC review of compliance, or any action being taken by CQC in relation to the quality standards of the Service Provider, within five Business Days of receipt of the CQC notice/report.

16.7 The Service Provider shall share as requested, any action plan which is required in response to a CQC review of compliance or other inspection, with the Council.

16.8 The Service Provider must work in partnership with the Council to satisfactorily and reasonably meet the requirements of any improvement plans put into effect as a result of poor performance against the scope of concerns about the quality of the Services delivered.

16.9 Failure of the Service Provider to achieve the necessary improvements outlined in an action plan agreed with the Council and to gain at least a 'Good' quality rating from the CQC on the next review, in response to a CQC rating at any time during the Contract period, shall be regarded as a material breach of the Contract and the Council thereafter reserves the right to step in or terminate the block Contract or enforce any remedies available to the Council.

16.10 Additional Reporting Requirements

The Provider will notify the Council within 7 days of the following *(unless otherwise stated. This should not be seen as an exhaustive list of daily requirements)*:

- No replies* within 24 hours)
- Unexpected hospital admissions* (within 24 hours)
- Accidents and emergencies involving a Service User and/or a carer* (within 24 hours)
- Significant change to a Service User's health or wellbeing
- Death of a Service User or carer* (24 hours)
- Declined referrals*
- Safeguarding concerns *(within 24hours)

* Details must be provided.

16.11 Changes to Requirements

The Council will be entitled to introduce, or change, any systems of contract monitoring and quality control giving reasonable prior notification to the Service Provider.

16.12 Key Contacts

The Council and the Service Provider's authorised representatives for all matters relating to quality and monitoring matters are as detailed in Schedule 8 (Contract Management) of the Contract.

17.0 Contract and Performance Management

17.1 Performance of the Service will include a focus on a mixture of measures of appropriate service delivery under

- **Service User Outcomes**
- Enabling Independence
- Feeling Safe and Secured
- Being Healthy and Clean
- Treated with Dignity and Respect
- Having company and feeling engaged

(See Section 7 Aims and Outcomes)

Key Performance Indicators

- Service Delivery
- Assessment and Support Planning
- Change and Response

- Competent, Capable and Supported Workforce
- Health and Safety
- Safeguarding
- Risk Management
- Complaints, Compliment and Feedback
- Partnership and Engagement

(See Appendix 2).

The above will be measured, alongside basic monitoring data. The Service Provider will have a quality assurance system that is capable of monitoring and assessing provision of the service. The Service Provider will be required to collect data to demonstrate compliance to the required Outcomes and Key Performance Indicators and report their performance on the Council's Pentana Performance Measuring Tool on a quarterly basis

The Council is responsible for ensuring the needs of residents and outcomes set out in this specification and any that are subsequently added under variation arrangements are met. To this end, the Council will work with stakeholders, including the Service Provider, to ensure:

- Service Users, their representatives and the Council are satisfied with the quality, appropriateness, consistency, reliability and range of service they are receiving, including nursing care, in accordance with the principles and standards outlined in this Service Specification;

- Individual Service Users' outcomes as (agreed and outlined in their person-centred Care & Support plans) are met consistently on a day-to-day basis and as longer-term objectives.

- The Service Provider is delivering an appropriate, effective, efficient and sustainable service in terms of governance and staffing requirements, in line with this Specification and contract (or its future variation) and is delivering continuous development and improvement of service in response to feedback about its performance.

17.2 Monitoring Approach

The Council has a robust monitoring process; which includes a quarterly self-assessment form to be completed by the Service Provider. Review of these self-assessments will be part of quarterly meetings between the Service Provider and the Council of the core monitoring data and outcome measures in Section 7 of this specification. These quarterly meeting will incorporate discussions about:

- Any new referrals, departures from the service since the previous meeting;

- Findings from the Service Provider's Quality Assurance systems, which should include complaints, compliments, and feedback from residents' meetings and from families/advocates; and any actions and outcomes thereof; as well as the findings of the Service Provider's Self-Assessment form (see below). This will include discussion of any serious untoward incidents, safeguarding concerns or alerts (including number and actions taken) or provider concerns;

- Feedback from discussions with Service Users and their families, Service Provider management and staff.

- Actions or concerns arising from visits and inspections, including any of those conducted by the Care Quality Commission;

- Any issues raised by either party regarding payment or each party's respective obligations under the terms of the Contract.

17.3 Service improvements identified by the Council will be given timescales and measurable outcomes which will be agreed with the Service Provider and form part of the next quarterly meeting.

17.4 The first such meeting should take place immediately from the Commencement Date (start of mobilisation) and thereafter weekly for 4 months throughout the Mobilisation Phase. Following that, meetings will be held every quarter from the Service Commencement Date.

17.5 The Council will arrange Service Review during the lifetime of the contract as part of this quarterly cycle of meeting in which the Council and Service Provider will discuss the contract performance over the last year with the focus described in Section 16 and 17 of this Specification.

17.6 The Council reserves the right to arrange a formal *ad hoc* Service Review and contract meeting with the Service Provider in addition to those scheduled in the Programme, if it believes it has sufficient grounds for concern about Service Provider performance in respect of this Specification and contract.

17.7 The Council and its partners, including stakeholders, will use a variety of mechanisms to ensure the above aims are consistently delivered including (but not limited to):

- *Service Provider Self-Assessment:* The Service Provider is responsible for the day-to-day delivery of services and will need to review and self-monitor medium-term service delivery, alerting the Council to significant changes in needs of individual(s) or service provision. Furthermore, the Service Provider will be required to complete a quarterly self-assessment/monitoring form using a Council template prior to the review meeting. There is an expectation any improvements identified and progressed through self-assessment will incorporate the results of any actions in the jointly agreed action plan with the Council arising

from contract performance. A key part of this self-assessment will be the findings from the Service Provider's Quality Assurance system. This should include monitoring of complaints, safeguarding and serious untoward incidents, actions taken and their outcomes;

- *Care hours' data:* At the end of every week the Service Provider must supply the Council with a current list of Service Users with the hours of care they have received over that past week. This will be aggregated across the quarter and discussed as part of the quarterly Service Provider / Council contract review meetings.

- *Reviews of the Service User's Support Plan*. Reviews will be conducted at the end of the 6-week trial period and at least annually thereafter and/or at the reasonable request of any party involved in the Support Plan. The Council's reviews will take into account information from the Service Provider and all other relevant parties.

- *Other Assessments:* Where appropriate, the Service Provider will be required to host visits from Enfield Healthwatch and/or London Borough of Enfield's Quality Checkers Programme, both of which are lay assessors of the quality of care for, and experience of, Service Users and carers. It is expected any recommendations agreed with either of these parties and the Service Provider will be incorporated into the Provider's action plan as agreed between the Service Provider and Council;

- *Case File Audit:* As part of the quarterly contract review, the Council's monitoring officers will audit including but not limited to the Care & Support Plans, staff files, rosters and any other information that can be reasonably assumed to provide information about the operation and delivery of the Service. The Council reserves the right to inspect documentation and processes, and audit Service Users' files, plans and records to ensure quality assurance systems are in place and to assess the effectiveness of the Service in accordance with this Specification and Contract;

- *Service User & Other Stakeholder Feedback & Engagement*: As part of preparation for the quarterly contract review, the Council's monitoring officers may meet with Service users or their representatives individually or in groups at a convenient time for them to discuss whether outcomes important to them are being delivered and whether they are satisfied with the Service provided. The monitoring officers will also meet, if needed, the housing provider and any other professionals involved in the management of individual Service Users' cases to gain feedback about their perceptions of service delivery;

- *LBE Visits:* This relates to announced and unannounced monitoring visits to the Service by suitably trained Council monitoring officers. Upon conducting these visits, the Council will compile a report and action plan to be discussed at review meetings to remedy any

perceived areas of underperformance or ensure that the Service Provider strives to continuously improve in line with the expectations in this Specification and contract. These visits will incorporate the opportunity to interview Provider staff, Service Users and their representatives and care professionals working with them, and audit cases in the way described above;

18.0 Contract Hours and Price

18.1 The contract for this service is based on a block contract arrangement covering a maximum of 960 hours to be delivered per week. This must cover the outcomes stated in this Specification in relation to care and support. The weekly hours of 960 may vary to take account Service Users who may have higher or more complex care needs and/or be at end of life stage.

If this scheme reaches maximum hours the Service Provider is to notify the Council and discussion about future arrangements can be had.

18.2 The maximum hourly rate for the first contract year is £18.00. The first contract year is from the Commencement Date to 31st March 2024

19.0 Contract Period

19.1 This contract is for an initial term of 5 years from the Commencement Date. Following the Commencement Date, there will be a Mobilisation Phase of up to three (3) months (or as advised by the Council in writing) for the Mobilisation Services. The Council (at its sole discretion) may exercise an option to extend the contract at the end of the initial term for a further period or periods of up to 2 years.

20.0 Environmental Impact

20.1 The Service Provider should employ systems and processes to manage their impacts on the environment. The Service Provider will be required to provide data to demonstrate their environmental improvements throughout the duration of the contract.

20.2 The Service Provider should consider the impacts that their services will have on waste production and identify and implement measures to minimise these negative impacts. The Service Provider should adhere to the Council's environmental rules and any relevant codes which aim to reduce the negative environmental impacts throughout the supply chain.

20.3 The Service Provider should be mindful of energy efficiency in the provision of their services and demonstrate methods by which energy savings have been made.

21.0 Social Value, Sustainability and Ethical Practices

21.1 Enfield Council has adopted a Sustainable and Ethical Procurement Policy for the years 2022-2026. The policy sets out how the Council procures value for money goods, services and works, whilst maximising social value, protecting the environment, ensuring workers are treated and paid decently and ensuring human rights are upheld in supply chains.

Four core principles of the policy are:

· Social Value

· Ethical Procurement

· Supporting local economy and employment

· Climate Action

Implementing the Council's Sustainable and Ethical Procurement Policy is being embedded within the service specification as one of the main requirements of the Extra Care Services contract.

Social Value

Useful feedback has been obtained through the Soft Market Test Questionnaire of the Market Engagement for the Extra Care Services at Reardon Court including:

- Focus on local employment / apprenticeship opportunities - working with local colleges/job centres for recruitment etc.
- Partnerships with the VCS communities
- Training
- Environmental considerations/local initiatives including recycling
- Digital technology and assistive technologies

The Service Provider shall implement the requirements as detailed here and in, but not limited to, this service specification and the Council's Policy.

Climate Action

The below is taken from the left hand column of the Sustainable and Ethical Sustainability Strategy for the Climate Action section (pages 16 to 22), showing the summary of minimum standards and minimum assessment approach for Contracts of £5m.

Carbon emissions

The Service Provider is expected to provide a Carbon Reduction Plan and confirm their commitment to achieving Net Zero by 2050 in the UK.

The Service Provider shall submit its Carbon Reduction Plan to the Council.

Energy

The Service Provider has a commitment to reduce their energy consumption

The Service Provider shall submit a written confirmation of:

- Commitment to using low carbon energy
- Commitment to reducing energy consumption

Travel

The Service Provider shall commit to switch to low or zero emission modes of transport in the future.
The Service Provider shall submit a written confirmation of:

- Commitment to using low or zero emission means and modes of transport
- Timescales for using low or zero emission means and modes of transport (which must be within contract Term)

Circular Economy
The Service Provider shall provide information on:

- Their approach to the removal and disposal of waste and recyclable materials
- The strategy they have in place to minimise the amount of waste generated
- Any waste management verification policies which are in place

Purchased goods
The Service Provider shall make efforts to purchase products they use for delivering the Service (if any) meet the minimum Government Buying Standards (GBS) and is in line with Council Policy

Water
The Service Provider must seek to minimise the use of water wherever possible and promote the use of water efficient equipment and services.
The Service Provider shall submit written evidence of overall water consumption split by location and / or activity to the Council.

21.2 The Service Provider is required to submit the Social Value Sustainability and Ethical Practices deliverables (Social Value Delivery Plan) , which, as a minimum, must include the requirements of the Council in the method statement question of the Invitation to Tender on Social Value, Sustainability and Ethical Practices. The Council will consider the Social Value Delivery Plan and agree Social Value KPIs with the Service Provider for the submitted Social Value Delivery Plan (Social Value Deliverables). The Social Value Deliverables shall set out Social Value KPIs (SV KPI) for each measure in the Social Value Delivery Plan so that performance against it can be rated as one of the following:
● Good. The Service Provider is meeting or exceeding the SV KPI targets that are set out within the Social Value Deliverables (SV Deliverables).
● Approaching Target. The Service Provider is close to meeting the SV KPI targets that are set out within the SV Deliverables.
● Requires Improvement. The performance of the Service Provider is below that of the SV KPIs targets that are set out within the SV Deliverables.
● Inadequate. The performance of the Service Provider is significantly below that of the SV KPIs targets that are set out within the SV Requirements.
The Social Value Deliverables shall form part of this Contract as the contractual obligations of the Service Provider.

21.3 The Service Provider shall:

a) promptly deliver the Social Value Deliverables.

b) on a quarterly basis, provide to the Council, data to demonstrate the Service Provider's progress against delivery of the Social Value Deliverables for that quarter.

21.4 If the Service Provider fails to deliver any or all of the Social Value Deliverables, the Service Provider shall within fourteen (14) Business Days of request by the Council submit to the Council a draft action plan setting out how the Service Provider intends to rectify the notified failures within a three (3) month period. The Council shall consider these proposals and amend or clarify them as it deems appropriate and the Council shall issue the agreed finalised proposals as an agreed action plan (an "Action Plan") and the Service Provider shall implement the Action Plan forthwith.

21.5 Every twelve (12) months during the Contract Term the Parties shall meet to discuss the Social Value Deliverables (each an "Outcome Review"). At the Outcome Review the Parties shall discuss whether the Social Value Deliverables are delivering social value in line with the requirements of the Council's community. In assessing this the Parties may have regard to:

a. the Council's policies including but not limited to policies on sustainable and ethical procurement and climate action then in force;
b. changes to the demographic of the community; and
c. the previous performance by the Service Provider in relation to the Social Value Deliverables.

21.6 If the Parties conclude that the Social Value Deliverables are no longer fit for purpose, then the Parties may agree to:

d. amend the Social Value Deliverables;
e. remove all or any one of the Social Value Deliverables; and/or
f. create new Social Value Deliverables.

22.0 Health and Safety

22.1 The Service Provider must ensure that the service has regularly checked and updated systems and procedures in place to comply with the relevant legislation governing the provision of extra care housing, e.g. health and safety, whistleblowing, staff training / induction / supervision / appraisal.

22.2 The Service Provider shall ensure all staff have the appropriate Personal Protective Equipment (PPE) to undertake their work within a safe environment and effectively manage any potential hazards, infections and pest control

22.3 The Service Provider will maintain a register of care responses to emergency incidents. In this register, the Service Provider will record details of the emergency incident, including the condition of the Service User, the nature of the incident (what happened) and the response to the incident by the Provider. Following every emergency incident, the Service Provider will carry out a review within 24 hours and identify any lessons to be learned and actions to address any issues.

23.0 Safeguarding

23.1 The Service Provider shall follow the council's Safeguarding policy and procedures if abuse is identified or if the Service Provider has grounds to believe that abuse may have taken place. The Service Provider will liaise with the Council immediately if there are safeguarding concerns.

23.2 The Service Provider shall prepare its own internal guidelines to protect adults from abuse taking into account any multi-agency agreements.

23.3 The Service Provider shall immediately bring to the attention of the Authorised Officer any allegation, complaint or suspicion of abuse by or regarding any Service User, whether the suspected abuser is employed by the Service Provider, by the Council or by any other person.

Risk of Accidents and Harm to Service Users and Staff

23.4 The Service Provider ensures that an assessment is undertaken of the potential risks to Service Users and staff associated with delivering the Service and a risk management plan put in place. This should be updated annually or more frequently if necessary.

24.0 Equalities and Diversity

24.1 The Service Provider shall recognise and respond to the individual needs of Service Users, in accordance with their Care & Support Plan. This includes any issues relating to culture, gender, disability and/or sensory impairment.

24.2 The Service Provider will recognise and respond to the needs of people who are less able to access and engage with services; including those with protected characteristic under the Equalities Act 2010, taking steps to ensure services are delivered and needs are met through personalised approaches.

24.3 Service Users will be treated with respect and dignity and the Service Provider will adopt a person-centred approach to Service Delivery

25.0 Staffing

25.1 The Service Provider will ensure that there is a staff development and training programme within the organisation, reviewed and updated annually, which ensures staff are able to fulfil the aims of the organisation and meet the changing needs of Service Users, their relatives and representatives.

25.2 The Service Provider will ensure that 100% of care workers are either trained to a minimum of NVQ level 2 or are working towards it or its

successor Health and Social Care Diploma L2. Supervisors will be trained to a minimum of NVQ level 3, or successor Health and Social Care Diploma L3 and Managers to NVQ level 4 or successor L5 Diploma in Leadership. Registered Manager would have or be working towards a level 5 any staff that do not have a level 3 will be enrolled on the care certificate

25.3 Skillset of workforce to have a good understanding of physical disability, mental health needs, learning disability, dementia, frailty and end of life care.

25.4 The Service Provider will ensure staff receive induction, regular supervision and have their standard of practice appraised annually.

25.5 The Service Provider will also ensure that each member of staff has the appropriate legal permits to work within the UK and that the Working Time Regulation 1998 are adhered to.

25.6 The Service Provider will obtain an enhanced Disclosure and Barring Service (DBS) check for each member of staff, including staff who may be re-employed after a period of absence. The Council expects the Provider to renew these checks after a period of 3 years. The Provider will also make the appropriate checks against the Safeguarding Adults and Child Protection Registers.

25.7 The Service Provider shall also be able to demonstrate a stable skilled workforce with measures in place to ensure continuity of care and ensure a low staff turnover. The Service Provider will also be able to evidence and demonstrate at contract monitoring and contract review meetings that it is able to provide services in periods of high demand and that it continually and proactively takes steps to ensure this happens.

25.8 The Service Provider should have in place processes to ensure that recruitment activities positively impact on ensuring a sustained diverse workforce capable of meeting the requirements of this Specification. Consideration should be given to attracting key staff that reflects the cultural diversity of the borough and the specific cultural and dietary needs of Service Users.

25.9 The Service Provider will ensure that Service Users are able to maximise independence at all times and staff are expected to work with an enabling approach in all cases.

25.10 Appropriately skilled staff will be an essential part of the model of care. Enfield values the work that staff undertake and feel that it is important to recognise the skill and dedication that workers offer to Service Users. We want to ensure that staff have career opportunities to develop skills that will offer a pathway into more advanced social care or health care provision.

Understanding Dementia

25.11 The Service Provider staff will be trained in how to work with people living with dementia including an understanding around mental capacity. In addition, the Service Provider staff will receive appropriate training in order to demonstrate the common core principles and indicative behaviours for supporting people living with dementia, as set out by Skills for Care and Skills for Health.

These principles are:

Principle 1: Know the early signs of dementia

Principle 2: Early diagnosis of dementia helps people receive information, support and treatment at the earliest possible stage

Principle 3: Communicate sensitively to support meaningful interaction

Principle 4: Promote independence and encourage activity

Principle 5: Recognise the signs of distress resulting from confusion and respond by diffusing a person's anxiety and supporting their understanding of the events they experience

Principle 6: Family members and other carers are valued, respected and supported just like those they care for and are helped to gain access to dementia care advice

Principle 7: Managers need to take responsibility to ensure members of their team are trained and well supported to meet the needs of people with dementia

Principle 8: Work as part of a multi-agency team to support the person with dementia

Medication Management

25.12 The Service Provider must ensure all designated staff have regular competency assessment training in their policies and procedures (including agency staff). For medicines management best practice, see guidance issued by the Royal Pharmaceutical Society 'The Handling of Medicines in Social Care' and CQC Essential Standards of Quality and Safety-Outcome 9; Management of Medicines Managing medicines for adults receiving social care in the community NICE guideline [NG67].

Training should ensure that:

- Staff are trained to prompt and assist with taking medicines rather than using medicines compliance aids (MCAs), which in themselves introduce additional risks as not all medicines (including some tablets) can be placed in an MCA; and
- Service Users identified as being suitable for self-administering who need help with medicines should be supported to speak with their dispensing community pharmacist who is paid within his/her contract to make a reasonable adjustment

26.0 Record Keeping

26.1 Procedures will be in place to ensure that any significant safeguarding concerns identified by a staff member on a visit will be shared.

26.2 Personal information about Service Users will be held on the secure case management system.

26.3 Records and plans relating to Service Users are written in clear, concise, factual and non-judgemental language and include daily recording of services delivered, and recording of information relating to changes in need and risk

26.4 Enhanced care planning (requires service user's consent) – the Service Provider will ensure that service user requirements relating to end of life care and preferred place of death are accurately recorded in a separate plan and checked at least annually with Service Users to ensure they are up to date and reflect current situation.

27.0 Policies and Procedures

27.1 The Service Provider will implement a clear set of policies and procedures to support practice and meet the requirements of legislation, which are dated, and monitored, as part of the quality assurance process. The policies and procedures are reviewed and amended every three years at a minimum, with core policies reviewed at earlier intervals and all polices having reviews triggered by change of law, by relevant incident or issue arising, or by a gap being identified through inspection or contract review.

27.2 The Service Provider must be able to demonstrate that all policies and procedures are effective, including, but not limited to the following key areas of Service:

- Recording of information
- Risk Assessment
- Health & Safety
- Continence management
- Medication management
- Moving and handling
- Confidentiality
- Data sharing and data management
- Complaints
- Financial management in relation to SUs- weekly allowance
- Safeguarding and protection from abuse
- Fire safety and emergencies
- End of life care
- Whistleblowing
- Staff induction, supervision, appraisal and training
- Food hygiene and nutrition

27.3 The Service Provider will ensure that at least 2 members of the management team are registered Dignity Champions and that they take active steps to promote the Dignity in Care agenda across the Service Provider's workforce. The Service Provider will ensure that in each operational year of the contract Term at least 50% of the workforce are active, registered Dignity Champions.

28.0 Complaints, Compliments & Feedback

28.1 The Service Provider ensures that there is an easily understood, well publicised and accessible procedure to enable Service Users, their relatives or representative to make a complaint or compliment and for complaints to be investigated.

28.2 The Service Provider shall have a written procedure and provide information in accessible formats to enable Service Users, their Carer or Advocate to make comments or complaints relating to the Service provided to them.

28.3 Every Service User should be made aware of their right of access to the Service Provider's Complaints and Compliments Procedures.

28.4 The Service Provider will maintain an up-to-date register of all complaints received, the action taken and the outcome of any investigation. These will be reported quarterly.

28.5 A complaints procedure will be given to every Service User and representative by the Service Provider.

28.6 There will be opportunities for Service Users to influence how the overall service is run and managed

SECTION B

APPENDIX 1
Care & Support Provision within the Model

Please note:
The Service Provider is encouraged as part of the Mobilisation Phase & implementation period to consider this Annex alongside current job descriptions of onsite staff for a fuller understanding of how care services are currently delivered in practice.

Annex 1 is indicative only and not intended to be exhaustive or restrictive. It is likely that Service Users may present needs that warrant outcomes or activities not included.

1 Care & Support Plan

Each Service User in Groups 1, 2 & 3 will have an agreed needs and risk-based Care & Support Plan which is developed, assessed and reviewed with Service Users and others in the way described in the main body of this Specification. This process should clearly detail Service Users' aspirations, goals and expected outcomes within the principles set out in the outcomes framework in this Specification. The scope and detail of individual Plans should reflect the underpinning needs of individual Service Users for example, Service Users in Group 1 (who do not need routine personal care needs) expected to have less complex Plans than those individuals with "high" care needs in Group 3.

Items 2–5 below are those most likely to be part of the "care" offered to Group some of Group 1 and all of Group 2 and 3, Service Users.

2 Personal Care

To assist the Service User with:

1. Getting-up or going to bed.
2. Washing, bathing, hair care, denture and mouth care, hand and fingernail care, foot care (but not toe-nail cutting or any other aspect of foot care which requires a state registered chiropodist). Request for gender specific key worker staff should be taken into consideration
3. Catheter care (external).
4. Assisting Service User with dressing and undressing.
5. Toileting, including necessary cleaning and safe disposal of waste.
6. Food preparation, taking account specific cultural and dietary needs assisting, Service User with eating and drinking, including associated kitchen & domestic cleaning and hygiene.
7. Accompanying Service Users in attending day care, hospital appointments etc.
8. Taking medication prescribed to them in accordance with agreed protocols.
9. Responding to alarm calls and out of hours call monitoring.
10. Rehabilitation following hospital discharges.
11. Organising access to Services/liaises with relatives, health services etc.
12. Prompting/assisting Resident to undertake activities.
13. Supervising general health and well-being.
14. Operating and enabling Service Users to make use of Assisted Technology.
15. Food Shopping

3 Cleaning and House-care

Assist the Service User with cleaning the home, which may include vacuuming, sweeping, washing-up, polishing, cleaning floors and windows, bathrooms, kitchens, toilets etc. and general tidying, using appropriate domestic equipment and appliances as available; including:

- Making beds and changing linen.
- Disposing of household and personal rubbish.

- Cleaning areas used or fouled by pets.
- Assisting with the consequences of household emergencies including liaison with local authority and local organisations

4 Social activities will be provided on a daily basis

APPENDIX 2

1.0 KEY PERFORMANCE TARGETS

PERFORMANCE AREA		
KPI 1	**Service Delivery**	**Target**
	% of the service provided 24 hours a day, 7 days a week, 365 days per year	**100%**
	Service user's overall satisfaction of services provided	**100% pa**
KPI 2	**Assessment and Support Planning**	
	% of referrals that receive an assessment within 5 working days	**100%**
	% of Support plans in place within 5 days of placement	**95%**
KPI 3	**Change and Reponses**	
	The changing needs of service users are communicated to key stakeholders within 5 working days	**100%**
KPI 4	**Competent, Capable and Supported staff**	
	Staff have up to date learning and development plan	**100%**
	% of Care worker turnover	**Less than 25% pa**
KPI 5	**Health and Safety**	
	Notification of Emergencies, accidents and incidents are reported within 24 hours	**100%**
KPI 6	**Safeguarding**	
	Notification of Safeguarding incidents reported within 24 hours. and investigated internally within	**100%**
KPI 7	**Risk Management**	
	All Risk assessments updated at 6-month interval following placement	**100%**
KPI 8	**Complaints Compliments and Feedback**	
	% of formal / informal complaints resolved to service user/practitioner/families /LBE representative satisfactory within 4 weeks 4 Meetings held with Commissioners, Housing and other Stakeholder per annum	**98%** **8 per annum**
KP I9	Partnership and Engagement	
	Working with VCS, local community groups to support service user's well-being	Engaging with a minimum of 3 VCS Organisation per annum

2.0 The Service Provider shall monitor its performance against each Target KPI and shall send the Council a report detailing the Achieved KPIs. The reporting and performance monitoring of the KPIs shall be as detailed in section 17 of this Specification (Contract and Performance Management).

2.1 The Service Provider is to note that the Council may exercise its rights to terminate the Contract in whole or in part if a Consistent Failure occurs. **"Consistent Failure"** shall mean:

2.1.2 A failure by the Service Provider to meet four (4) or more of the KPIs in a rolling three (3) month period; **OR**

2.1.3 The Council serving two (2) Remediation Notices in a rolling six (6) month period; **OR**

2.1.4 The Service Provider repeatedly breaching any of the terms of the Contract in such a manner as to reasonably justify the opinion that its conduct is inconsistent with it having the intention or ability to give effect to the terms of the Contract.