Haringey LONDON

Haringey
Home Support Service
Adults Specification

Open Framework- Dynamic Purchasing System

INTRODUCTION

1.Commissioning Framework Overview

1.1 Haringey Council (also referred to throughout this Specification as "Haringey" or the "Council"), on behalf of itself and NHS North Central London Clinical Commissioning Group ('NCL CCG'), has established a Dynamic Purchasing System ("DPS") for the procurement of a cost effective Care/Support at Home service for adults which supports and meets Service Users assessed needs while promoting their independence. The services that may be procured using the DPS include a reablement service and longer-term care and support to individuals in their own homes that is based on the principles of continuing enablement through outcome-based contracts.

1.2 This is a developmental Specification and during the course of the lifetime of the DPS Haringey intends to make to changes to the Specification. Haringey intends to develop any such changes in partnership with the Service Providers appointed to the DPS, although, for the avoidance of doubt, Haringey reserves the right to make any changes to the Specification at its sole discretion. The Specification and subsequent service delivery will support an increasingly integrated Health and Social Care agenda in Haringey and will incorporate the potential use of this DPS by key cross Borough and other strategic partners. This DPS covers the Reablement and Care/Support at Home service delivery for adults, More detailed Service Specifications based on individual care outcomes will be developed by Haringey as part of the Requirement that is issued to all Service Providers as part of the Service Agreement Award Procedure .

1.3 It is expected that Service Providers will embrace Partnership working with Haringey Council, other partners and agencies, work co-operatively, to develop a high quality, resilient Haringey Reablement, and Care/Support at Home services across the Borough. Haringey Council wishes to work on an ongoing basis with Service Providers appointed to the DPS to develop the Services to become more outcomes focused, where individual Service Users are able to proactively design their support and care with the agency ending the time and task culture prevalent in recent years. As such the Services will initially be commissioned using units of time and will move towards commissioning based on outcomes. Service Providers will be required to accept and acknowledge that both parts of the Specification (Reablement and Care/Support at Home) will change but that this will be enacted where possible in partnership with them and will be within the remit of the principles of this Specification as it was first produced. For the avoidance of doubt, Haringey reserves the right to make any changes to the Specification at its sole discretion.

1.4. This DPS also includes details for the provision of the Council's external Reablement Service that intends to provide additional capacity to the current internal provision. The part of the Specification that relates to the Reablement services is set out at Appendix 4 of this Specification. Haringey shall notify Service Providers of whether a particular Service Agreement shall include Reablement services as part of the Requirement that is issued to all Service Providers as part of the Service Agreement Award Procedure. Sections I, V and VI of the Care/Support also apply in relation to Reablement services.

1.5 The Council's approach to providing care and support at home is based on the principles of reablement and enablement and is intended to complement and support the more intensive activity delivered by the Reablement Service. Both services (Reablement and Care/Support at Home) will be expected seamlessly to provide both care and support as defined by the needs of the individual and based on the on-going Individual Outcomes Plan. The Care/Support at Home Service Providers will be expected to work with the Reablement Service (this includes both the in house and external provision) and social care practitioners, and to follow and develop these outcomes plans. Care and support services should aim to maximize an individual's independence and support the reduction of need, wherever possible, making use of existing community resources and personal social networks.

1.6 Service Providers are expected to identify changing levels of individual need for care and support on an ongoing basis, and will be required to develop or revise the outcomes-based Individual Care Plan and/or other plans (for example End of Life Plans), in conjunction with the Service User, their family/ Carer, their GP, other healthcare practitioners and the Council.

1.7 Service Providers' performance will be judged according to the extent to which the agreed outcomes are met and the extent to which an individual's independence is maintained with stable or decreased care and support needs. Service Providers, in partnership with the Council will be expected to develop review processes, to measure and record achievement of individual outcomes and meet the requirements of the Council's Performance Monitoring Tool.

1.8 Service Providers' will develop their ethos, knowledge, understanding, practice and service provision to deliver a service that takes responsibility for managing the delivery of personalized outcomes. Service Providers will be expected to have a flexible approach to supporting the individual, so that a more holistic approach is provided to the individual's care, ensuring that the most appropriate model of care is meeting outcomes. This may include engaging with other services to meet the individual service user's needs where necessary (e.g. third sector provided community services and support service for older people, Telecare services, sensory services) and ensure the best possible levels of independence are maintained and improved on. Where an individual does require changes to how their outcomes are being met, or where an individual may no longer be eligible, it is expected that the Service Provider will be working closely with the respective social work community team. This way of working and a process will be developed in partnership with Service Providers.

1.9 The Services to be provided by the Service Providers requires the delivery of homecare to adults aged 18+ with various health and care needs including but not limited to the following conditions:

- memory and cognition
- frailty due to age or long-term health conditions
- physical disabilities and/or moving and handling needs or requirement for specialist equipment.
- learning disabilities including autism and/or behaviour which is challenging
- complex health needs including life limiting conditions
- cognitive impairments
- sensory impairments
- profound and multiple learning disabilities
- mental health problems or mental illness
- End of Life Care is not a separate Service User group but is part of the care for the above groups.

1.10 Both the Council and NCL CCG's expectation is that Service Providers will develop effective models of service delivery that meet the needs of individuals with long-term conditions, including dementia. The Council will work with Service Providers on an ongoing basis to develop this approach and to ensure they have appropriately trained and experienced staff. Service Providers will be expected to proactively work with the Adult Social Care Services..

1.11 As progress towards greater partnership and joint working is made, it is expected that the Council, the NCL CCG and Service Providers working together will become increasingly cooperative and constructive. This may include future co location of services, to further develop partnership and joint working. In addition, the Council requires that Service Providers work cooperatively and positively with the ambition to develop and improve the professional status of the Care/ Support at Home Service. This requires that Service Providers develop strategies to recruit and retain staff, with effective pay, terms and conditions, contracts, training, support and professional development. The Council intends to support this effort and this will be further developed over the duration of the DPS.

1.12 Service Providers will be expected to be innovative in the use and development of technology to promote independence, provide services to individuals, and to manage workload. This will be include, use of Telecare, laptops, tablets, smart phones, e readers and others. It will also include use of electronic care management systems. The DPS covers the provision of Services to a Service User that are eligible for NHS Continuing Healthcare, Care Tiers 1 and 2.

II.STRATEGIC CONTEXT

2.National Strategic Aims & Priorities

For adults (18-64, 65+):

2.1 This Specification responds to three significant developments in adult social care policy:

(i) A shift in focus from time and task to the outcomes achieved;
(ii) Personalization and Self-Directed Support, with people having more choice and control over the services they receive; and
(iii) The Care Act 2014 with its emphasis on promoting wellbeing and preventing, delaying future social care needs.

2.2 Introduction of the Care Act 2014 sets the national context for this service. Haringey Council will seek services that: (i)Promote people's wellbeing;

(ii) Enable people to prevent and postpone the need for care and support;

(iii) Put people in control of their lives so they can pursue opportunities to realize their potential; and

(iv) Ensure people have high quality services and have a variety of Service Providers to choose from whom (taken together) provides a variety of services.

2.3 Service Providers will be expected to deliver against the Service Users Individual Outcomes Plans and the key service requirements and outcomes set out in the Specification and in line with the key Care Act 2014 Outcomes:

- Managing and maintaining nutrition;
- Maintaining personal hygiene;
- Managing continence needs;
- Being appropriately clothed;
- Being able to make use of the home safely;
- Maintaining a habitable home environment;
- Developing and maintaining family or other personal relationships, and avoiding social isolation;
- Access and engaging in work, training, education or volunteering; and
- Making use of necessary facilities or services in the local community, including public transport, or recreational facilities or services

Service Users eligible for assistance from the Council will require care and support to help them in at least two of the Care Act outcome areas outlined above to ensure there is a significant impact on their wellbeing.

2.5 "Wellbeing" is a broad concept, and under the Care Act 2014 is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);

- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- Participation in work, education, training or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation; and
- The individual's contribution to society

2.6 There will also be an expectation that Service Providers ensure that their organizational frameworks support the improvement of service provision and are delivered in line with national guidance and legislation in relation to the following areas, whilst not exclusively:

- Supporting and working with people with dementia, particularly those who have complex needs;
- Implementation of the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards, with appropriate use of mental capacity assessments and best interest decision making;
- End of Life care and support;
- Managing challenging and difficult behaviour;
- Administering medication;
- Identifying, supporting and working with Carers;
- Re-abling approach to service delivery; and
- Rehabilitation of people discharged from hospital.

3. Local Strategic Aims & Priorities

3.1 Local strategies including

- Haringey's Health and Well Being Strategy 2015-2018[1] . Ageing Well Strategy
- NHS North Central London Haringey's Clinical Commissioning (NCL CCG) Groups 5 Year Plan[2]
- Haringey Council and the NCL CCG's Joint Commissioning Section 75 agreement
- Council's Building a Stronger Haringey Together,
- Haringey's Borough Plan 2019-2023

These plans place renewed emphasis on prevention, early intervention, promoting independence, integration, inter-agency partnership working, and community resilience. They all seek to reduce health and social inequalities faced by people living in Haringey through working with communities and residents and to improve opportunities for adults to enjoy a healthy, safe and fulfilling life.

3.2 This service meets the design principles outlined in the Council's overall strategic direction, including:

(i) Maintain a constant focus on long-term quality of support to live at home for Service Users by promoting their health, well-being and independence;

(ii) Increase and improve the variety of services and outcomes available to Service Users whilst supporting the personalisation agenda;

(iii) Establish the right commercial incentives for Service Providers to deliver and maintain high service quality, which delivers on its outcomes;

(iv) Effectively manage Service Provider relationships on a proactive basis to drive continuous improvements in quality of services;

(v) Improve the transparency of Service Provider performance whilst giving consideration to the Council resource impact;

(vi) Increase Service User self-sufficiency and independence through enablement of Service Users:

- Reducing dependency on long term services e.g. residential care, where possible and appropriate, and reducing package growth;

(vii) Reduce the level of intervention over someone's life in care with realistic expectations of the role of the Service User, family and other informal carer support;

(viii) Ensure that the delivery model proactively manages demand and is flexible and able to take advantage of new ways of working e.g. technological advancements;

(ix) Deliver an integrated, efficient and effective service through encouraging internal and external collaboration and partnerships; and

(x) Increase transparency of cost and cost drivers as required by the Care Act (2014).

III SERVICE DELIVERY MODEL- Aims and Objectives

4.1 Feedback from users, Carers and local residents consistently focuses on some key elements of service delivery. We will ensure these values and principles for users, Carers and staff are reflected in the provision which we develop and commission:

(i) Promoting independence and reablement (for adults);
(ii) (iii) Supporting people to live healthy lives for longer;
(iv) Demonstrating respect and dignity;
(v) Empowering and fulfilling lives with opportunity for growth; and
(vi) Developing community resilience, reducing inequalities

4.2 Haringey's Borough Plan sets out priority outcomes. The key outcome delivered by these services is:

- Outcome: 7 All adults are able to live healthy and fulfilling lives, with dignity, staying active and connected in their communities

Objective a) Healthy life expectancy will increase across the borough, improving outcomes for all communities
Objective b) People will be supported to live independently at home for longer
Objective c) Adults will feel physically and mentally healthy and well
Objective d) Adults with multiple and complex needs will be supported to achieve improved outcomes through a coordinated partnership approach

Outcome 8: Strong communities where people look out and care for one another Objective a) Carers are supported and valued, including young carers
Objective b) A strong and diverse voluntary and community sector, supporting local residents to thrive Objective c) Caring and cohesive communities which can offer support.

4.4 The Services will also support the NHS and Council in North Central London in delivering its priorities as an emerging Integrated Care System, which are currently:

(i) Helping people stay healthy and well
(ii) Building health and care services near to where you live
(iii) Services you can rely on in an emergency
(iv) Planning and delivering the care you need
(v) Supporting people to recover from mental ill health

4.5 These above aims and objectives shape the services we commission. Overall, this service will:

(i) Support people who are living at home, who may or may not have been through a period of reablement, to be as independent as possible in carrying out the functions of daily living;

(ii) Provide a reablement and/or enablement service which will maximize people’s opportunities for enhancing their ability to live well, independently and effectively engage with the community;

(iii) Provide the emotional support necessary to enable the Service User to reduce anxiety, build resilience and increase confidence to live independently;

(iv) Work proactively towards reducing packages of care through efficiency gains, delivery of defined outcomes, and use of community resources;

(v) Promote faster recovery from illness and support timely discharge form hospital where Reablement and/or Care at Home has been deemed as the

appropriate discharge service and where no increase or change to an existing care package is required;

(vi) Prevent unnecessary acute hospital admissions

(vii) Prevent premature admission to residential care;

(viii) Increase access to opportunities for independence to people with complex needs and dementia;

(ix) Involve Service Users in the design of and any potential changes to their service delivery;

(x) Empower Service Users to tell the Supplier and NCL CCG and/or the Council if the service has made a difference to their lives and improved outcomes;

(xi) Engage effectively family and informal Carers;

(xii) Enhance the ability of parents/carers to care for the adult they may have by giving them a break from their caring responsibilities;

(xiii) Offer age appropriate approaches and learning opportunities when providing personal care;

(xiv) Identify other services available to the Service User (including referral/signposting to voluntary and community sector services) that meet their needs and maximize independence, either to facilitate exit from the service or enhance existing provision;

(xv) Increase the use of technology to enhance the effectiveness of enablement and workforce capacity;

(xvi) Ensure that the self-funder market for those under the Care Act 2014 and people in receipt of Direct Payments view the service as a service they would like to use;

(xvii) Ensure that the delivery model proactively manages demand and is adaptable so that it can take advantage of new ways of working (e.g. technological advancements) and the changing needs of the Service Users;

(xviii) Puts the health, safety, quality of life and preferences of the Service User at the centre of care provision;

(xix) Supports the Service User to make informed choices about their care as per the NHS Constitution and The Care Act 2014 Supports the health, safety and quality of life of Carers as outlined by the Care Act 2014 and National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care 2012;

(xx) Meets the outcomes through effective working partnerships;

(xxi) Demonstrate that it manages risks with the involvement of users and staff; it ensures the welfare of the vulnerable adult is paramount at all times;

(xxii) Demonstrates that it meets national standards related to registration, safeguarding, employment practice, staff training and behaviour in line with CQC guidelines and relevant NICE guidelines;

(xxiii) The Service User will be treated with dignity and respect at all times. Their privacy and individuality will be respected in all aspects of the services;

(xxiv) Strives to continuously improve the quality of care for the Service User; and

(xxv) Provides continuity of care for the Service User, wherever possible.

Unison's Ethical Care Charter

5.1 Haringey Council has signed up to Unison's Ethical Care Charter. Service providers will be expected to adopt the Charter's recommendations within a reasonable period, including but not limited to: zero hour contracts not being used in place of permanent contracts; and making full payment for travel time between homecare visits.

6. Overarching Outcomes

For adults (18-64, 65+):

6.1 The implementation of this Specification must satisfy the Outcomes described by the Care Act 2014 and also contribute to the outcomes for Service Users which are sought by the Department of Health*, the Adult Social Care Outcomes Framework* and against which CQC will be inspecting and registering:

Outcomes for Adults	
Adult Social Care Outcomes Framework	**NHS Outcomes Framework Domains and Indicators**
Enhancing quality of life for people with care and support needs Delaying and reducing the need for care and support Ensuring that people have a positive experience of care and support Safeguarding adults whose circumstances make them vulnerable and protecting them from harm	Domain 1: Preventing people from dying prematurely Domain 2: Enhancing quality of life for people with long- term conditions Domain 3: Helping people to recover from episodes of ill- health or following injury • Domain 4: Ensuring people have a positive experience of care • Domain 5: Treating and caring for people in safe environment and protecting them from avoidable harm

Please also refer to section 22 of this Specification**.**

7. Service Users & Eligibility for the Service

7.1 The Service will be for:

- Adults aged 18 and above who meet the eligibility criteria of the Council (Care Act 2014 compliant), and
- Adults assessed as having a 'Primary Health Need' and eligible for Continuing Healthcare. This includes Individuals with a rapidly deteriorating condition that may be entering a terminal phase that require 'fast tracking'[1] for immediate provision of NHS continuing healthcare1

7.2 To be eligible to receive services under social care the individual will be a resident of the London Borough of Haringey.

[1] For more information on the Fast Track tool please see Part 1, Page 32 and Part 2, 'Practice Guidance Notes', Page 83-84 of the National Framework for Continuing Healthcare and Funded Nursing Care (2012).

7.3 To be entitled for continuing healthcare in Haringey the individual will be registered with a Haringey GP. The Commissioner will assess the Service User for their eligibility for NHS CHC three months after initially being deemed eligible and at a minimum, annually thereafter. The Service User will be asked if they want family, Carers or Advocates to attend the assessment and outcome discussion. If, as a result of the assessment, the Service User no longer meets the eligibility criteria for Continuing Healthcare the Commissioner will refer the Service User to the appropriate Local Authority. In these instances, the Provider will endeavour to maintain continuity of care.

7.4 The service will be outcome led and expected to meet a range of health and care needs, a summary of these are outlined in Appendix 2. This will mean the service will deliver care to range of care categories such as those who are physically frail, have learning disabilities, service users with cognitive difficulties, such as those with Acquired Brain Injury, physical disabilities, mental health needs including dementia. It will also include those with long-term conditions and disabilities and will come from a diverse cultural, religious and ethnic background. End of Life Care is not defined as a separate care group but included within all groups above. This list is not exhaustive. Service Providers are required to have appropriate registrations to deliver care to people over 65 by award of contract. Please see section 1 of the DPS Entry and Operation Guide Part 1 for further details regarding the system of Service Categories that applies to the DPS.

7.5 The wide range and level of disabilities and needs will require Service Providers to ensure that their staff are appropriately trained and supported to meet these needs. In assigning staff to a particular user, the Service Provider must consider and ensure that the skills and experience of the staff meet the needs of the user, including cultural, religious and ethnic and communication needs.

7.6 Individual Outcomes Plans should build on strengths and reflect cognitive abilities. Service Providers will work proactively alongside and with any provider delivering other support to the Service User. The Outcomes Plan should include the following:

Individual Outcome Plan –

7.6.1 Content

7.6.2 Care Plan contents

7.6.3 Medical contents

This should include

- the Service User’s diagnosis summary and relevant medical history;
- record of the Service User’s medication, and administration details for medication, including the dosage and frequency; and
- are informed by discharge documents and mobilisation plans (e.g. transport, equipment, continence) and existing medicines administration records (MAR).

7.7 Person Centred contents

This should include:

- record of the Service User's needs and the corresponding Service Provider requirements to meet those needs;
- record of the Service User's preferences, as informed by the Care Consultation or life story tools e.g. "patient passport";
- description of the Service User's personal outcomes for the Package of Care;
- Any relevant deprivation of liberty (DoLs) statement or mental capacity statement.
- Record of Advance Care Plans, Do Not Attempt Cardiopulmonary Resuscitation and Advance Decisions to Refuse Treatment Guide where applicable.

7.8 Carer related contents

This should include the roles and needs of any Carers associated with the Package of Care.

7.9 Risk Assessment record

This should include a Risk Assessment record of risks to Carers, Care Workers, the Service User, and others persons associated with the Package of Care (including the parents/carers of children and young people). Risks may include (but are not limited to):

- risks from the care environment;
- safeguarding risks; and
- risks related to Service User behaviour.

8. Service Requirements

8.1 The Care /Support at Home service is not a crisis response service. However, it may be used following a crisis and once the situation has been stabilized and/or where reablement provision has been involved.

8.2 In this Specification, any reference to a "referral", "care package" or "package" is another name for a Service Agreement as referred to in the Supplier Agreement, and a reference to a "referral being received" (or similar) refers to the commencement of a Service Agreement.

8.3 Service Providers will be expected to accept care packages within an acceptable timeframe and dependent on service user needs. Single call care packages will need to be started within 24 – 48 hours of a referral. Double handed care packages where

two staff members are required will need to be set up within 72 hours. Hospital discharges and care package restarts will need to be set up within 24 hours.

8.4 The service will be available 24 hours per day, 365 days per year including weekends and Bank/Public Holidays although service delivery will need to be determined by requirements detailed in the Service User's Individual Outcomes Plan. There might be occasions where a Live-in Care service will be required (Care Services provided 24 hours a day, 365 days of the year).

8.5 The Council will pay the Service Provider the Standard Rates from the Commencement Date until the date that Services cease. The Standard Rates include all costs and expenses incurred by the Service Provider. No additional payments will be made to the Service Provider, e.g. for travel, training or cover for Care Worker breaks. The daytime, waking night and sleeping night Standard Rates are hourly. The live-in Standard Rate is weekly.

Definitions

Waking night (8:00pm – 8:00am): The Care Worker is awake throughout the night to provide care.

Sleeping night (8:00pm – 8:00am): The Care Worker sleeps at the Service User's home. The Care Worker responds as necessary to care needs. If the Care Worker has to get up three times or more to provide care during the night then it will be considered a waking night.

Live-in: A Care Worker lives in the Service User's home to deliver care as required. Hours of care are not set. The Care Worker is provided with a private bedroom. The Care Worker has a daily 2-hour break during which time they are not required to be present or deliver care.
Where another Care Worker is required to cover this break the Service Provider will meet any associated cost. The Council will make no additional payments.

24-hour care: 24-hour care is comprised of 12 hours of daytime care and 12 hours of waking night care.

8.6 The Services for daytime, waking night and sleeping night will be initially commissioned on the basis of a minimum of 30 minutes for care related tasks, rising in units of multiples of 15 minutes, e.g. 45, 60 etc. The relevant hourly Standard Rate would be pro-rate adjusted accordingly. Flexibility around the units of time provided will be considered on the basis of evidence that varying these timings will enable individual outcomes to be better met.

8.7 Service Providers need to be able to respond in a *flexible manner* in the provision of services including diverse requirements for availability, tasks, hours and timing of

visits. Service Providers' staff must only provide services, which are legal and meet the Service Users stated outcomes.

8.8 The Services will be provided in the Service Users' own homes, or in the home of a relative, or any other mutually agreed location. The Council and NCL CCG shall reserve the right in the future to include; care provision within supported living schemes, non 24 hours Housing with Care provision or Extra Care provision within the scope of the Service Agreement.

8.9 The Council and NCL CCG require that the Service Provider will work with the other Service Providers within the locality area to ensure that the referral is accepted, and service provided to client. The Service Provider will be expected to meet the sensory and communication needs of all Service Users. Where the Service Provider identifies that a referral may be inappropriate, the Service Provider must liaise with the Brokerage Function to discuss reasons for this and work towards a suitable solution for the Service User. Where the Service Provider identifies that a referral cannot be accepted for other reasons, including capacity, the Service Provider must liaise with the Brokerage Function to discuss this.

8.10 The Service Providers will have systems in place to commence referrals for support packages at weekends and on Bank/Public Holidays, with staff available to carry out risk assessments to ensure prompt service provision.

8.11 The Service Provider will make contact with the Service User on the same day the referral received and will discuss the Individual Outcomes Plan within 24 hours. This plan will include undertaking a Risk Assessment based on the Plan received and a short-term plan to meet any goals not yet achieved or goals that are realistic to achieve over the following 12 weeks.

8.12 There could be instances where Service Providers will be expected to take and have sufficient capacity packages of care within 24 hours especially in relation to people who have been 'fast tracked' where an individual's condition is assessed as rapidly deteriorating. In the event of receiving these requests Service Providers will confirm by telephone with the commissioner that the service can commence within the timescale, care works are available and an assessment can be done. This manner of referral shall be treated as the award of a Service Agreement pursuant to clause 4.3 of the Supplier Agreement.

8.13 Plans will be set on a 12 or 26-week basis with agreed outcomes and objectives for each period. Outcomes will be those agreed with the Service User with some objectives set by the parameters of the overall initiative, e.g. maintenance or reduction of the needed levels of care and support. This will be done in partnership with social care community teams.

8.14 Service Providers will identify any changes or increase in the Service Users needs and to notify the Council in writing within 24 hours should this be the case. The Service Provider will ensure that all records are maintained in a way that would support a continuing health needs and social care assessment if that should be required.

8.15 The Service Provider will give the Council and the NCL CCG a minimum of 7 days' notice, if, in exceptional circumstances, they are unable to continue to deliver a package of homecare support. However, the notice period would be subject to agreement with the Council's Nominated Contracts Officer in order to provide sufficient time to find alternative service provision. For the avoidance of doubt, the Service Provider may not cease provision of the Services until the end of the agreed notice period.

8.16 Double-up provision will be available when there is an assessed need for it and a risk assessment to support that need. Benchmarking of this provision will be undertaken during the first year of the Service Agreement and risk free innovative solutions to reduce double up provision should be part of the Service User's Individual Outcomes Plan.

8.17 Service Providers will have sufficient capacity to manage any winter and other emergency pressures determined by the Council and Health services and engage with winter and emergency planning with the Council and other planning authorities.

8.18 The office will be staffed fully with both management and administrative staff for usual office hours of between 9am and 5pm, Monday to Friday with emergency support for out of office hours. Staff providing emergency support out of hours must have access to Service User information and records to ensure appropriate service provision and information sharing.

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8.19 The Services must be person centred, flexible and responsive ensuring that all Service Users are able to exercise choice and control over the services that they receive and are at all times treated with kindness, dignity and respect and regarded as equal partners in the delivery of their care:

Personal care tasks must be undertaken with great sensitivity. Service Provider staff must have an awareness of the importance of the preservation of the Service User's dignity and improving where possible their quality of life. Service Provider staff in discharging their duties shall have due regard of the expressed requirements of the Service User in terms of equalities related protected characteristics, or any other consideration deemed important to the person and/or the family.

Enabling tasks involve assisting Service Users to complete tasks. Service Provider staff will support and encourage Service Users to participate in housework and living skills, to restore lost confidence, regain lost skills, gain new skills to achieve and maintain maximum independence and self-reliance. By working in a re-abling manner, the Service Provider will focus on the requirements of the individual Service User rather than delivering a 'one size fits all service'. In order for the Service Provider to deliver support in a re-abling manner, it is important that ongoing monitoring of the Service User be implemented so that changes in the Individuals' circumstances and abilities are picked up and acted upon promptly. Also, refer to Appendix 1. 8.20 With effect from the Commencement Date, Service Providers are required to fully operate all

services from a CQC registered Office established within Haringey or within 10 miles of the Haringey boundary, that is appropriately situated to deliver services to residents in a high quality and efficient manner.

8.21 Haringey Council is committed to improving the quality of services received by Service Users and as such will be applying a strict quality evaluation to Service Providers during the Service Agreement award procedure for this service and during its operation. Service Providers are required to be registered with the CQC throughout the duration of the Service Agreement.

8.22 The Council's requirement is that Service Providers will develop effective models of service delivery that meet the needs of individuals with dementia, other long-term conditions or complex needs, that are outcome based.

8.23 Service Providers who fail to maintain adherence to the performance requirements will be managed in accordance with the terms and conditions of the Service Agreement. Without prejudice to the Council's rights under the Service Agreement, every reasonable effort will be made by the Council to address promptly and successfully in partnership with the Service Provider any underperformance issues but if this fails, Haringey Council reserves the right to remove packages of care and transfer them to an alternative Service Provider.

8.24 Service Providers are encouraged by the Council to pay the London Living Wage to all care workers involved in the provision of the Services under this Service Agreement. The Council will monitor compliance of payment conditions of care staff through the contract by undertaking open book accounting with the Service Provider. Verification of payment will also be sought via interviews with care staff.

8.25 The Council has a strong interest in the staffing structure and contractual arrangements of the service delivered and will monitor the use of different contractual arrangements, including zero hour contracts, to ensure that they do not have a detrimental impact on service delivery for Service Users.

8.26 The Service Provider should note that it is the Council's intention to transition from prescribed timed intervention and support to a culture of outcome identification and flexible working to achieve these outcomes. As such the service will initially be commissioned using units of time (as set out in sections 7.5 and 7.6 above) and will move towards commissioning based on outcome (as referred to in section 27.)

8.27 The Service Provider is responsible for ensuring a safe working environment for Care Workers. As part of the Risk Assessment, the Service Provider will minimize and mitigate risks. The Service Provider will enable Care Workers to make informed choices about risks. In cases where the Service User's home is not smoke-free, the Service Provider will take steps to minimize Care Workers' exposure to smoke. Additionally Care Workers may choose not to work in a smoking environment and the Service Provider will support this decision without penalty. Where the Service User's home compromises the ability to deliver safe and appropriate care the Service Provider will report this to the Council.

8.28 The Service Provider will support the Service User to use Advocates, where appropriate;

8.28.1 have links to local advocacy services where available;

8.28.2 make a referral to an independent Advocate when a conflict arises in the Service User's life and the Service User has no family or Carers, or is particularly frail or vulnerable. In these instances the Service Provider will also notify the Council; and

8.28.3 inform any Advocate representing a Service User of major changes in the Service User's life.

8.29 The Service User's relatives and friends are able to visit without being unnecessarily restricted. The Service User can refuse to see a visitor, and the Service Provider will support this decision. The Service Provider will not permit any persons to enter the Service User's home without the Service User's knowledge and permission, except in cases of emergency. The Service Provider will agree visiting guidelines with the Service User, Carers and family upon commencement of care. If appropriate and with the agreement of the Service User, the Service Provider may maintain a visitor log, recording all visitors to the Service User's home during the delivery of care.

8.30 Service User possessions

All references to Service User below also refer to Parents and Carers where appropriate. Care Workers will not:

- solicit or accept any gratuity, tip, or any form of money taking or reward, collection or charge for the provision of any part of the Services, other than the payment as agreed under the contract.
  - accept any monetary gift or any gift over the value of £25. All gifts will be reported to the Service Provider for approval. The Service Provider will report any concerns regarding the acceptance of gifts to the Council;
  - become involved with the making of Service User's wills or with soliciting any form of bequest or legacy;
  - agree to act as a witness or executor of a Service User's will;
  - become involved with any other legal document, except in circumstances pre agreed with the Council;
  - offer or give advice to Service Users with respect to investments or personal financial matters; and
  - accept direct or indirect financial or non-financial gain from the Service User, this includes but is not limited to the use of personal store cards.

8.31 Property

Care Workers will respect the fact that the care environment is the Service User's home. Care Workers will be sensitive to that environment and its contents. Care Workers will not:

- consume Service User's food or drink without appropriate permission or invitation;
- use Service User's possessions for personal use e.g. computers/telephone; use furniture or possessions in a way that the Service User would not want; and take responsibility for looking after any valuables on behalf of the Service User.

Any loss of or damage to Service User's property should be immediately reported to the Service User. In the event that Care Workers are responsible for damage/loss, the Service Provider will be responsible for compensating the Service User. Service User possessions will only be disposed of with the permission of the Service User unless it causes a health and safety problem.

8.32 Medication

The Service Provider will:

- agree policies and procedures for medicine management with relevant NCL CCG Medicines Management teams;

- seek information and advice from a pharmacist regarding medicines policies (including the management of over the counter medicines and alternative medicines);

- store medicines correctly, dispose of them safely and keep accurate records (where responsible);

- not control Service Users' behaviour with inappropriate use of medicines, in line with Fundamental Standard 13.7 (b); and

- not give medicines prescribed for individual Service Users to any other person.

The Service Provider' medicines management policies will: include procedures for achieving the Service User's preferences and ensuring that the Service User's needs are met, in accordance with Fundamental Standard 9.3(b):

- Meet Fundamental Standard 12.2(g); and include clear procedures for giving medicines in line with the 2005 Act.

8.33 Infection Control and COVID-19 guidelines compliance.

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The Service Provider will:

a) The Provider will keep abreast and ensure compliance with all fundamental infection prevention and control measures as detailed in NICE Fundamental Standard 12.2(h); and meet the requirements detailed in NICE quality standard 61: Infection Prevention and Control, April 2014

• b) The Provider will keep abreast and ensure compliance with government COVID-19 guidelines where relevant to Home Support and Reablement services, including those on social distancing, use of PPE and self-isolation should they experience symptoms.

c) The Provider will inform Public Health England and the Local Authority of any cases of COVID-19 in staff or those they are supporting.

9 Processes / Pathway

9.1 Pre care

Individuals will become eligible through the Councils Care Act assessment or NCL CCG's CHC assessment or fast track pathway. The fast track pathway is where individuals have a rapidly deteriorating condition or entering a terminal phase to receive quickly care in the setting of their choice. In these cases, Service Users will have a completed fast track pathway tool for NHS CHC and a fast track care plan.

If the patient is under CHC, they will receive a copy of the:

- Care Needs Plan,
- Decision Support Tool,
- Health Needs Assessment, and
- other clinical information as part of the referral.

For Fast Track patients the NCL CCG will provide the standard London Wide detailed Fast Track Care Plan

9.2 Referral

9.2.2 Upon receipt of a referral from the Council and/or NCL CCG and prior to commencement of the service, the Service Provider should undertake a full and comprehensive risk assessment. The risk assessment and acceptable risk and/or actions to mitigate risk will be agreed with the Service User and/or representative, and recorded, with one copy left in the Service User's home and one provided to the Council's representative.

9.2.3 The assessment, where undertaken by the reablement service, will be holistic and will cover the physical, sensory, cognitive, environmental, and psychosocial needs of the individual taking into account other professional assessments. This will impact on the content and timescale of the Individual Outcomes Plan and the approaches and methodology required to achieve the identified outcomes.

9.3 Assessment

Service Providers will be expected to complete a care consultation, which will be completed by a senior or qualified member of staff. This will include the development of a risk assessment, establish the needs of the individual, service user preferences and will help inform the care plan

9.4 Individual Outcomes Plans

Those Service Users accessing this service having undergone a period of reablement will have an End of Care Summary and an Individual Outcomes Plan, which will identify achievement of outcomes, goals and aspirations and an indication of future service requirements to maintain this level of independence or further enhance independence leading to a potential reduction in care package over time. In addition, it will also include care related contents (needs / roles of Carers), risk assessment records and contact information. If the patient is receiving End of Life Care, the Care Plan will include ACP's and DNACPRs / ADRTs where applicable.

The Service Provider will subsequently develop a longer term Individual Outcomes Plan with the Service User (and Carer where appropriate) to reflect the outcomes detailed in the Individual Outcomes Plan.

9.5 As part of the initial visit/risk assessment, the Service Provider shall agree the Individual Outcomes Plan with the Service User, as to how and when the services are to be provided, in order to meet the Service User's outcomes. It is, however, accepted that some people who are severely incapacitated may not be capable of fully communicating their wishes. In such cases, employees of the Council, in conjunction with any informal carer or advocate involved, will support the interpreting of choices and wishes.

9.6 The Service Provider will produce an Individual Outcomes Plan with each Service User. Each Plan will be reviewed by the Service Provider a minimum of every six months or when the care changes. The Service User will be central to this reviewing process and their views and judgments should govern the development of their service and future support. Service Providers must notify the Council of any changes relating to the Service User's care package using the agreed process. The care plan will be in accordance of Fundamental Standard 9. Care plans are also living documents and Service Providers are expected to review, edit and develop plans content on an ongoing basis.

9.7 Initial Review

Care Workers and a qualified Service Provider representative will conduct an initial review within the first two weeks of care. The initial review assesses the suitability of the Package of Care and the Care Worker's needs.

The Care Plan will be adjusted to reflect the changes from the initial review. The Service User and Service User's family or Carers will agree all changes. The Service Provider will communicate proposed Significant Changes to the Council in writing. The Council will review the proposed changes and implement clinical review, where appropriate. All Significant Changes must be authorised by the Council in writing.

9.8 Ongoing Care Plan review

The objective of the Care Plan review is to check that the Package of Care meets the Service User needs and outcomes. The Care Plan review incorporates input from the Service User, Service User's family and Carers. The content of the Care Plan will be reviewed and amended as necessary. The Service Provider will assess Service User needs in accordance with Fundamental Standard 9. Where changes are made, the updates will be shared with the Council.

Significant Changes to the Care Plan will be confirmed with the Council before implementation, as per initial review (section 5.2.4).

The Service Provider will review the Care Plan:

- every six months;
- at the request of the Service User, Carers, family, Council, or Care Worker;
- as Service User changing needs require it; or
- as prompted by an incident or complaint.

9.9 Consideration will be given to Carers where they exist, in addition to assessing the individual's needs, desired outcomes and on-going planning for their care and support services

9.10 Service Users will be treated as individuals and their preferences and choices respected. Their dignity and privacy will be protected at all times. Appropriate levels of assistance and support (as defined by the Individual Outcomes Plan), will be made available to each Service User at all times to ensure their safety and dignity. This will include that Care and Support Workers will not talk about, to or around a cared for person in a language they do not understand.

9.11 Service Providers shall refer, arrange or signpost Service Users to universal, targeted preventative or specialist services and other health services such as primary care and community services.

9.12 Individuals who are Continuing Healthcare eligible will receive (no later than) a three month review after the initial eligibility decision, in order to reassess care needs and eligibility for NHS continuing healthcare and to ensure care needs are being met.

Reviews will then take place at a minimum annually by Haringey NCL CCG's CHC Clinical Team. These reviews should be done in consultation with the person being reviewed and it is expected that other relevant people who know the person, including Homecare Service Providers.

Equipment

9.13 The Council considers assistive equipment and technologies to be an integral component to promoting independence. Service Providers may identify service users who may benefit from assistive technologies as part of their Individual Outcomes Plan.

9.14 Where equipment has been identified as a potential to address an identified need, Service Providers shall work with relevant local services e.g. Adult Social Care Teams in order to facilitate Service User access to relevant assessment and/or equipment. Service Providers will ensure that staff is trained and able to use equipment competently. Service Providers will be committed to testing equipment and refer any issues or faults to the relevant department.

For all Equipment, the Service Provider will:

- meet Fundamental Standards 12.2(e) and 15,; and
- use Equipment only for its intended purpose and in relation to the named Service User.

9.15 Service Provider supplied equipment

The Service Provider will supply infection prevention and control equipment in line with Fundamental Standard 12.2(f).

The equipment will be supplied at no additional cost to the Council. The cost of the equipment will be built into the cost of care. This equipment will include:

- single use disposable gloves;
- single use disposable aprons and alcohol hand rub.

The Service Provider will safely and appropriately dispose of the above items and clinical waste in the Service User's home.

9.16 Commissioner supplied Equipment

All required Equipment would be supplied by or via the Council. If the Service User requires further Equipment, the Service Provider must contact the Council to discuss purchasing arrangements prior to supply. The Service Provider will:

- check if Equipment needs to be maintained/serviced;
- arrange required maintenance/servicing or alert the Council to this need; and
- not be responsible for the cost of maintenance.

9.17 If the Service Provider has mistreated or adapted Equipment in any way the Service Provider will be liable for the replacement cost, cost of repairs and/or any other incurred costs. Mistreatment includes but is not limited to unauthorised removal or use of equipment for another person.

9.18 Care activity log

The care activity log details, in English, the delivery of the Care Plan through all care provided to the Service User during each care visit. This record is standardised and includes as a minimum:

- the date and time care was provided
- the type and frequency of care provided;
- any relevant observations;
- any actions to be taken and the name of the person responsible; and
- the signatures of the Care Workers providing the care.

The Provider will complete the care activity log each occasion that care is delivered. A Provider supervisor or manager will review the care activity log as required.

9.19 Contact details

The Care Plan includes contact information for family, Carers and Advocates in case of emergency.

10 Personalisation & Direct Payments

10.1 The Council and NCL CCG are committed to supporting Service Users to be as independent and self-determining as they can be, and is looking for Service Providers that are committed to personalization. All new Service Users and reviewed packages of care will have a choice about whether they want to direct their own care. This will mean that Service Users could potentially opt to have a direct payment or through a 3rd. party managed account arrangement and purchase their own services. In the event that a Service User wishes to use such an arrangement then this Service Agreement shall terminate upon such date as the Council and the Service Provider agree (in each case, acting reasonably). This section 9.1 is without prejudice to any other rights of termination under the Supplier Agreement.

10.2 Direct payments enable individuals to live inclusive and valued lifestyles according to personal choice and control. To achieve this, the Council and NCL CCG is continuing

to move from institutional models of support, including residential care and building based day services, to supporting individuals in their own homes to participate fully in the same range of community options as other citizens.

11 Communication

11.1 Close interaction and communication between Reablement or Social Care Practitioner/ Council's brokerage team and the commissioned Service Provider will be undertaken for purposes of any transfer of care and the Service Provider will be required to work as closely with the Council as possible (potentially including co-location) to ensure the pathway is effective as possible.

11.2Progress towards outcomes will be regularly assessed and recorded by the Service Provider. Communication of any changes will be made to the re aliment service or Social Care Practitioner / Council's brokerage team who will agree any change or amendment to the Individual's Outcomes Plan. This may be through undertaking a joint visit or in a telephone conversation for example.

11.3 Specific pathways for both referral and review (to include the reablement service, Community Teams, Out of Hours and any future partners) will be developed prior to commencement of delivery and updated as required during the duration of the Service Agreement.

11.4 Where the Council has information that it wishes to communicate to Service Users the Service Provider will be obliged to facilitate this communication, such as Service User consultations.

11.5 The responsibilities of the staff delivering the Services will include:

(i) Ensuring that the Service User has a full understanding of what Care at Home is and ensuring reablement and enablement is central to the nature of the service they are to receive. The Service Provider will ensure that the Service User has a full understanding of the number of hours allocated to them per week, how the use of these hours is to be negotiated between the Service User and the Service Provider and the member(s) of staff that will be delivering the service (consistency of care staff will be sought for all service Users).

(ii) Where possible the Service User's preferences are to be considered and accommodated when arranging times, durations and purpose of visits so long as this does not compromise the delivery or progress towards identified outcomes.

(iii) Supporting Service Users to achieve their defined outcomes as detailed in their Individual Outcomes Plan. These will include the personal activities of daily living such as personal care and communication and the instrumental activities

of daily living such as meal preparation and mobility. It may also include enabling the Service User to walk safely down their own path or steps, which may be their first step to reintegration within the community.

(iv) Proactive engagement and liaison with other appropriate professionals or services to support a Service Users needs (e.g. Telecare, Health Visitor, Dementia Advisors, GPs, health and social care professionals, Schools, Housing Departments, Department of Work and Pensions, Citizen Advice Bureau etc).

(v) Acting as community connectors by signposting and facilitating access to services that offer support with tasks such as shopping and prescription collection etc.

(vi) Fully understanding the importance of working in partnership with others i.e. understands why it is important to work in partnership with key people and professionals, advocates and others who are significant to the Service User.

(vii) Being aware of attitudes and ways of working that help improve partnership with others and achieve better outcomes for the Service User.

(viii) Being fully aware of their responsibilities in relation to Safeguarding, Protection from Abuse, and their professional boundaries.

Receive regular and up to date training in relation to specialised conditions such as dementia, mental health, learning disabilities, substance misuse etc. Service Providers working with children and young people should ensure that managers and staff receive additional training in relation to child protection, working with parents and carers and managing challenging behaviour.

(ix) Fully complying with the Council's Electronic Care at Home monitoring system.

12. Unsatisfactory Behaviour

12.1 The Service Provider must ensure that adequate disciplinary procedures are in place to protect Service Users against any form of improper conduct by staff. Such conduct may include (without limitation) rudeness, verbal abuse, emotional abuse, physical abuse and theft of personal possessions including cash. The Service Provider must immediately report any such incident to the Council. The Service Provider must also inform the Council, in writing, of the initiation, nature and outcome of any resulting disciplinary proceedings. The reporting of any such incident shall not prevent criminal proceedings taking place.

12.2 The Service Provider will not permit any person employed in the provision of the Services to be accompanied by a person not authorized to be present by the Service Provider or the Council.

12.4 The Service Provider will not permit the consumption of alcohol, non-prescription drugs or any other banned substances by Care Workers at any time during the provision of the Services, nor will the Service Provider permit any such person to be involved in the delivery of the Services whilst under the influence of alcohol, non-prescription drugs or any other banned substances.

12.5 The Service Provider will advise the Council by the most expeditious means possible of any allegations of misconduct made in respect of a Care worker that might have an impact upon the delivery of the Services and give full details of the allegation and the steps they are taking as a result. The Council must be advised promptly of the final resolution of any investigation or subsequent capability or disciplinary process.

12.6 The Council reserves the right to require a Care worker to be suspended from carrying out duties within this Contract whilst investigations are being carried out but will not act unreasonably in such circumstances. Such decisions are entirely at the Council's discretion but will not be taken unreasonably and the Council will provide written reasons behind the decision.

13. Electronic Care at Home Monitoring System

13.1 Service Providers will need to comply with the Council’s requirements concerning Electronic Data Capture. The Council requires accurate detail of planned visits, the start and end times of each staff visit to each Service User, plus the name of the carer(s) who attended each visit.

13.2 The information must be recorded in a way that provides complete assurance that the carer was present at the times stated. The detail must then be transferred to the chosen system of the Council to allow auditing and payment. Any incurred set up costs or interface to the chosen recording system of the Council will be the responsibility of the Service Provider.

13.3 Providers will be required to adopt or buy into an electronic care management system, which may be instituted by Haringey Commissioners within the duration of the DPS.

Digital infrastructure.

Providers need to have a digital implementation plan, including workforce training and infrastructure to enable:

a) The care of the residents remotely including but not restricted to assistive technology and telemedicine

b) Remote monitoring of the service including access to staff and client files

c) Residents to maintain contact with family and friends.

d) On-line GP’s and other care professional’s appointments and meetings (where relevant).

e) Access to Council to view, monitor and review activity for quality monitoring and audit purposes.

f) Transmission of confidential information via secure email preferably NHS Mail.

g) Service users to participate in on-line social, cultural, spiritual and other activities as appropriate and where revelant.

The plan should be in place by new financial year 2021

14. Additional requirements

14.1 The Service Provider is responsible for ensuring that Service Personnel using their own or the Service Provider's car for work is appropriately insured to do so.

14.2 The Council's Telecare service utilises family and friends of cared for people to provide individualised response on those occasions when a response is needed. For a small number of people, where there is no responder available, the Council will require Care at Home Service Providers to commit to developing with it, occasional responder services, for these specific individuals. This will utilise the Service Provider's paid Carers on extended hours, the availability and basis of this to be agreed for this service on a per Service User basis.

15. Service cancellation or suspension

15.1 The Council may cancel or suspend a care package in whole or in part on giving notice to the Service Provider not later than 5pm on the day before the day of the next visit. A suspension of a care package under this section 14 shall be treated as an Intermission for the purposes of clause 2A of the Supplier Agreement. This section 14 is supplemental to and without prejudice to the provisions of clause; 2A of the Supplier Agreement and for the avoidance of doubt the circumstances other than those contemplated in this section 14 may comprise an Intermission.

15.2 The Council may suspend a package for a period of up to four weeks if the Service User is admitted to hospital. Prior to the expiry of the suspension, the Service Provider must contact the Council officer to confirm arrangements required after the expiry of the suspension. If the package is to be restarted, the Service Provider shall use its best endeavours to ensure the continuation of care and support with the Service Provider's staff used prior to the suspension of the package. If no written agreement is received by the Service Provider to restart the package at the end of the period of suspension as notified to the Service Provider by the Council, the Service Provider may deem the package to have been terminated. In the event that a care package is terminated pursuant to this section 14.2 the provisions of clause 31.5 of the Supplier Agreement shall apply.

15.3 Where the Service Provider's Staff are unable to provide the Services required because the Service User is found to be absent without having given prior notice, the Council shall pay for the abortive visit and any subsequent visits not cancelled or suspended, provided that the Service Provider informs the Council of the Service User's absence within 24 hours and makes reasonable efforts to determine the Service User's whereabouts.

15.4 Where the Service User gives notice not later than 5pm on the day before the day of the Service Provider's next visit, the Council shall not be liable to pay for the

cancelled visit. The Service Provider shall inform the Council of such a cancellation by the next working day after receipt of notice from the Service User.

16. Termination of Care Package

16.1 The package shall terminate immediately on the death of the Service User. Where the Service Provider is not immediately notified of the death, the Council shall pay for one abortive visit only. This section 15.1 is without prejudice to the rights of termination under the Supplier Agreement. In the event that a care package is terminated pursuant to this section the provisions of clause 31.5 of the Supplier Agreement shall apply.

16.2 The Council will notify the Service Provider without prejudice to its responsibilities under the Care Standards Act 2000. The Service Provider will be responsible for notifying the Contract Manager within the Council as soon as it is practical to do so if any of the following occur:

- Any circumstances where the Service User has consistently refused provision of the service or medical attention;
- Serious accident, serious illness or serious injury to the Service User;
- Death of the Service User;
- Outbreak of modifiable infectious disease in the Service;
- Any emergency situation e.g. fire, flood affecting the Service;
- Legacy or bequest to the Supplier and/ or staff;
- Unplanned absence of the Service User;
- Hospital admission; An investigation related to Safeguarding of Vulnerable Adults

17. Complaints, Compliments and Feedback

17.1 The Service Provider will meet the CQC regulations on complaints. The Supplier will issue Service Users with a copy of its Complaints Procedure.

17.2 The Service Provider's Complaints Procedure will be in a form, which is understandable to Service Users. The Service Provider shall maintain and regularly review a written register of any complaints, comments or compliments received to be made available to the Council at any time.

17.3 The Service Provider shall record sufficient detail in the register to enable the Council to ascertain-

- the nature of the complaint / compliment
- the name of the person making the complaint / compliment
- the date and time it was received

- the timescales for remedial action to be taken
- the action taken to remedy the complaint
- the date and time when the remedy was completed
- the names of the Supplier's staff involved in the action complained of and its remedy

17.4 The Service Provider will respond to any complaints within a maximum of 10 calendar days providing remedial actions if required.

17.5 The Service Provider shall analyse complaints, practices and procedures at regular intervals, including its Complaints Procedure (if necessary), and review and amend them to take into account such analysis. Analysis must take into account consideration of the ethnicity of complainants.

17.6 The Service Provider must complete an annual report for each year ending 31st March summarizing its level of complaints and compliments, its analysis, themes and the learning, which has been derived, together with any changes introduced as a result of complaints received. This report will be submitted to the Council no later than one month after the end of the year i.e. by 30th April.

17.7 The Service Provider will request feedback from the Individual, and the Individual's family and Carers periodically. The Service Provider will also encourage the Service User, and the Service User's family and Carers to submit feedback as they wish. The Service Provider will keep a record of all feedback that is collected and the actions that have been taken to incorporate feedback. The Service Provider will be able to demonstrate how feedback is used to shape the service.

18. Emergency Provision

18.1 There may be occasions where it becomes apparent that there is an urgent need for an increase in the number of hours of service provided to a Service User, or for the addition of specific support to alleviate risk arising from an emergency situation. The Service Provider may, in these circumstances, use their professional discretion to make a short-term additional provision. The Service Provider must notify the Council at the earliest opportunity, but no later than 24 hours, in order that a reassessment of the Service User's needs can be arranged if required.

18.2 Should a homecare support package fail due to Care worker or other Service Provider breakdown then the Service Provider will provide emergency support.

19. Homecare Support Service Out of Usual Office Hours

19.1 The Service Provider must have a published procedure and information on how the Service can be accessed outside usual office hours and this should be made available both to Service Users and to Haringey's Out of Hours Service.

20. Illness of Service User

20.1 Should the Service User's condition become critical or they become ill whilst the Service Provider's staff member is in attendance, the staff member should contact the Service User's General Practitioner, Ambulance Service, and/or nursing/medical or other relevant professional within the Council as appropriate. Where deemed appropriate, the next of kin should also be contacted.

20.2 The Service Provider should also notify the relevant officer of the Council at the earliest opportunity and in any case within one working day.

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21 Challenging Behaviour

21.1 In order to manage situations where a Service User may present violent, aggression or unacceptable behaviour to the Service Provider's staff member(s) delivering services to that Service User, the Service Provider will have in place relevant policies and procedures to manage the potential risks to both staff and Service User.

21.2 In some cases it may be necessary to consider a suspension of service due to challenging behaviour. The Service Provider must take account of the vulnerability of the Service User and the risk presented to him/her by the suspension of service. Any such decisions should be agreed with the key parties (Council and/or NCL CCG, Carers, Service User etc). The Service Provider must advise the relevant health or social care practitioner of the situation as soon as possible prior to reassessment and notice of termination or suspension.

22 Provision of Cover

22.1 The Service Provider must ensure that the requirements of each individual Service User are met at all times. This would normally include bank holidays and weekends and in the event of the usual care worker being off due to sickness or holidays.

22.2 The Service Provider shall operate an effective rota, cover planned training and leave, and mitigate staff emergencies and sickness.

IV PERFORMANCE FRAMEWORK

23 Outcomes & Key Performance Indicators. Outcomes are the expected changes or benefits that happen as a result of the Service being delivered. Outcomes will be measured for both the service and the individual Service User.

24 Outcomes and quality

These are the key priorities and outcomes for Haringey's Care at Home service. They are described in statements:

Outcome 1: Promoting independence

For adults:

(i) I want to stay at home as long as possible and as independently as possible

(ii) I want to do as much for myself as I can including managing my personal care needs (iii) I want to keep as active and as healthy as I can (iv) I want to see and talk to people.

(v) I want to go outside my home

Outcome 2: Help in a crisis

(i) I want short term help when I am in a crisis to enable me to do the things I could do before the crisis (ii) I want to be independent as quickly as possible after help

Outcome 3: Safeguarding

(i) I want to be free from abuse

(ii) I want to feel safe

Outcome 4: Quality

(i) I want a responsive service, with consistency of care

(ii) I want a service delivered by people who care

(iii) I want a service delivered by people trained to support my condition

(iv) I want an age appropriate service (v) I want to be involved in decisions about my care package

Outcome 5: information and advice

(i) I want a simple way to access information and advice

(ii) I want good quality information that is easy to access

(iii) I have help to make informed choices if I need and want it.

(iv) I know where to get information about what is going on in my community.

(v) I want to know what it will cost me

(vi) I want to speak to someone at the right time for me.

(vii) I want to speak to someone face to face

System outcomes

(i) Fewer emergency admissions to hospital

(ii) Fewer admissions to residential and nursing care

(iii) Continued focus on reablement throughout the period of the care package with flexible packages which respond to review and take account of people's changing capacity and abilities (iv) Overall reduction in spend on domiciliary care

In addition to the above Service Providers shall work with others to support service users to achieve the following holistic outcomes:

(iv) Service users are supported to be independent of statutory care services wherever possible;

(v) Service users know what the local support options are and who to contact for help;

(vi) Service users feel they have enough company and contact;

(vii) Service users are connected and feel part of their local neighbourhood.

These outcomes will be measured through reviews and feedback from service users and Carers or upon their exit from the Service, with support from advocacy or with power of attorney etc as appropriate. Service Provider will make available evidence and other necessary information, as requested by the Council, to enable audit of evidence submitted to support the Outcomes and Performance Indicators below.

The following outcomes and key performance information will be sent to the Council within two weeks of each quarter.

Outcomes	Details	Target	Supporting Evidence
1. Enhancing quality of life for people with care and support needs	The Service Provider is able to demonstrate that they have Individual Outcomes Plans with each Service User that have been set up within 24 hours of referral to the service	99%	Quarterly workbook Service User and feedback evidence. Other professionals' input
	Service Users are able to demonstrate that their defined outcomes were met during the reporting period	90%	Quarterly workbook Service user / Carer feedback and evidence. Other professionals' input

	The Service Provider is able to demonstrate that they are developing effective and appropriate models of service delivery to meet the needs of individuals with dementia and other long term conditions	100%	Provider reporting information Service User/Carer feedback Service user Annual Survey Achievement of outcomes of individual care plans Development of working group with representatives from the Council and Service Providers. Development of model for implementation in year 1D
	The Service Provider is able to demonstrate they have maximised Service Users' level of independence within the context of their current	90%	Quarterly workbook
	care needs and through their service intervention, specifically: (i) The Service User is confident in carrying out activities of daily living as independently as possible. (ii) The Service User can demonstrate that the care at home service has had a positive impact on their social and emotional wellbeing (iii) The Service User has been enabled to remain living at home for as long as possible as a result of the Care at Home intervention.		Other professionals' input Service User / Carer feedback and evidence. Annual Survey Overall r e d u c t i o n in hospital admissions. Overall reduction in care homes (residential and/or nursing care) admissions
	Service Users manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. The user has care that fully meets their needs.	100%	The proportion of users and Carers who say they are in control of their support planning

	Service Users are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid isolation and loneliness	100%	The proportion of users and Carers who use the service and report that are engaged in meaningful activities, including employment where appropriate, and they have as much social contact as they would like
2. Delaying and reducing the need for care and support – help to gain and maintain independence (Earlier diagnosis, intervention and reablement means that people and their Carers are less dependent on intensive services).	Service Users report that with encouragement, they have been able to do more tasks in their own time or at least maintained the same level of functioning/independence.	90%	Quarterly workbook Other professionals' input Service User/ Carer feedback and evidence Annual Survey Overall reduction in hospital admissions. Overall reduction in care homes (residential and/or Nursing care admissions.

	Older Service Users (65 and over) who are still at home 91 days after discharge from Reablement/rehabilitation services.	90%	Quarterly workbook Other professionals' input Service User/ Carer feedback and evidence. Annual Survey Overall reduction in hospital admissions Overall reduction in care homes (residential and/or nursing care) admissions

3. Ensuring that Service Users have a positive experience of care and support and report that their needs are met with dignity and sensitivity to individual circumstances e.g. of those receiving palliative care	Service Users report that they are involved in decision making on social care including that they are treated with respect, dignity and kindness and support is sensitive to their individual circumstances.	100%	Quarterly workbook Other professionals' input Service User/ Carer feedback and evidence Annual Survey

4.Safeguarding adults who circumstances make them vulnerable and protecting from avoidable harm	Service Users are free from physical and emotional abuse, harassment, and neglect and self- harm. Service Users feel safe in their homes and life.	100%	Quarterly workbook Other professionals' input Service User/ Carer feedback and evidence Annual Survey
5. Continuity of care from regular care workers	Service users are receiving care from the same carers that know them. Any changes explained to the service user in advance by the office.	80%	Unannounced Q&A visits Service User/ Carer feedback and evidence Other professionals' input

6. . Service Quality	Percentage of staff that have had formal supervision with their line manager within the last three months (minimum 1 hour per quarter)	100%	Quarterly workbook Staff Survey
	Percentage of permanent staff leaving the service during the reporting period	Less than 10%	Quarterly workbook Human Resources/Staff Survey
	The percentage of Service Users who have responded to service user surveys stating that they are extremely satisfied with the service during the reporting period	95%	Quarterly/ Annual surveys Monitoring Information
	Care at Home Service Providers throughout the duration of the contract to evidence that they are committed to adding social value to the contract, including improving permanent employment opportunities for Haringey Residents.	30% of employees recruited are Haringey Residents	Quarterly workbook Human Resources/Staff Survey

Output	Target	Supporting Evidence
1. Service availability to take referrals as per individual plan agreed for each Service User.	100%	Quarterly Workbook
2. The percentage of visits which started outside 15 minutes of the stated time of arrival on the Care Plan	0%	Quarterly Workbook
3. Percentage of Care at Home visits that were missed during the reporting period. *Councils reserve the right to claw back costs where appointments are missed*	0%	Quarterly Workbook

4. Number of visits carried out by 3 to 4 regular care workers within a quarter.	80%	Quarterly Workbook
5. Percentage of referrals that providers responded to the referral of a care package/request for services within 24 – 72 hours.	100%	Quarterly Workbook
6. 24 hours Service Delivery, 7 days per week, 52 weeks per year including public holidays	100%	Quarterly Workbook
7. Number of staff delivering Care at Home who are being paid LLW	100%	Quarterly workbook
8. Number of staff delivering Care at Home on fixed hours or salaried contracts	95%	Quarterly workbook
9. Number of complaints resolved (including those that require CQC and Quality officers involvement)	70%	Quarterly workbook
10. Number of incidents dealt with in accordance with a safeguarding policy that meets the Council's minimum requirements	100%	Quarterly workbook

11. Number of people whose Individual Outcomes Plans were activated within the time specified within the plan	95%	Quarterly workbook
12..Number of people contacted on the day the referral received	99%	Quarterly workbook
13. .Number of referrals accepted and detail of how many passed to other Service Provider within zone and detail of rejected referrals	100%	Quarterly workbook

14..Number of people made aware of key community and local services, including the Council's Assistive Technology service	100%	Quarterly workbook.
15..Number of Service Users offered a referral for a Carer's Emergency Plan	100%	Quarterly workbook
16..Number of Service Users with a contingency plan for managing short term fluctuations in care need	100%	Quarterly workbook
17.. Staff trained in Health and Social Care Diploma level 2/NVQ level 2 or equivalent.	80%	Quarterly Workbook
18.Staff trained to Health and Social Care NVQ level 3	60%	Quarterly Workbook.
19..Staff working in registered services have completed their Common Induction standards within 12 weeks of employment	100%	Quarterly Workbook
Information Only Requirements		
1. Number of complaints received		Quarterly Workbook
2. Number of safeguarding incidents		Quarterly Workbook
3. Number of Service Users with a diagnosis of dementia		Quarterly Workbook
4. Number of Service Users with a diagnosed		Quarterly Workbook
long term condition excluding dementia		
5. Older People's provided to specific training sessions staff		Quarterly Workbook
6. Number of staff supervision/support sessions		Quarterly Workbook
7. Number of Service Users who were supported to die in their preferred place. E.g. Home		Quarterly Workbook
8. Number of referrals to access community groups		Quarterly Workbook

24.1 Output Monitoring - Electronic Care at Home Monitoring System Key Performance Indicators (KPIs)

The table below sets out the proposed set of KPIs in respect of the Electronic Monitoring System, however this may be subject to change prior to the commencement of the contract. The targets and indicator descriptions will be reviewed on an annual basis.

Core Indicators	Indicator Description	Annual Performance Target	Measurement Frequency
Commissioning	Care Packages started on the commencement date stated on the referral form from the reablement service or other eligible referral source, including the creation of an outcome based Individual Outcomes Plan in conjunction with Service Users / Carers, as appropriate.	100%	Monthly
Referrals	Percentage of referrals taken by the Supplier within the contracted time frame.	100%	Monthly
Carer visits	Number of visits covering both a log on call and a log off call using a Mobile Solution. Visits can be the home or the Community	100%	Weekly
Missed visits	Number of visits to Service User attended within two hours of planned time.	100%	Weekly

V. COMMISSIONING MODEL

25 Service Categories under the DPS

The DPS shall be divided into service categories.

The Service Categories shall be structured to take account of the following characteristics (each being a "**Service Category Characteristic**"): (i) care specialism; and (ii) age; and (iii) service locality. The following options shall apply in relation to each Service Category Characteristic:

Care Specialism

- Learning Disability
- Physical Support
- Mental Health
- Sensory Support
- Temporary Illness or Frailty
- Substance Misuse
- End of Life

Age

- 18-64 year olds
- 65 year olds and over

Service Locality

- West Haringey
- Central Haringey
- East Haringey

Each Service Category of the DPS shall comprise one option from each of these Service Category Characteristics. The range of Service Categories under the DPS shall therefore reflect the different possible combinations of options under each of the Service Category Characteristics. For example: One Service Category would be End of Life Services for 1864 year olds in West Haringey; another Service Category would be Mental Health for 65 year olds in Central Haringey, and so on.

When applying for membership of the DPS, Service Providers will be invited to select which options within each of the Service Category Characteristics they wish to apply for. There is no limit on the number of options that a supplier may choose – this is entirely at the discretion of the Service Provider. Service Providers that are appointed to the DPS will be appointed to the service category/categories as determined by their selections in relation to the Service Category Characteristics.

When a Service Agreement is being awarded under the DPS, the Council shall select which service category applies to that Service Agreement, and the Service Providers that are registered to the relevant service category shall be invited to submit an offer.

26 Section not used

27 Transition from existing provision

At the commencement of the Service Agreement as deemed appropriate Adult Services Service Users may need to be transitioned to these new arrangements. The Service Provider will work in partnership with the Council's Adult Services department and Service Users to plan and agree the most appropriate transition arrangements, when this applies.

28 Monitoring & Recording Arrangements

28.1 Where a Service User uses double-up provision, the Supplier will work with the Council to review the assessed need for it. Benchmarking of this provision will be undertaken during the first year and risk free innovative solutions to reduce double up provision will be included in the development of the payment by results framework.

28.2 For the avoidance of doubt, any change to the basis of payment (i.e. from the Standard Rates approach set out in sections 7.5 and 7.6 to an outcome based approach as described in this section 27) could be implemented at the commencement of a new Service Agreement/referral and/or be implemented part way through a Service Agreement/referral.

VI ADDITIONAL REQUIREMENTS

29. Sustainability, Equalities, Social Value and Other Impacts

29.1 This Service will have a positive social impact on the lives of the people using the Service as it will support individuals in making choices about their future , and where possible, enable individuals to remain living at home with the minimum number of interventions necessary for independence.

29.2 This service will be available across the whole Borough and will be provided by organisations based in or near the local community ensuring that travel is kept to a minimum thus minimising the carbon footprint of the Service. Service Providers will consider the impact of transport in the provision of this service and will demonstrate this consideration in the monitoring data supplied to the Council.

29.3 The Service will respond positively to the needs of diverse individuals, specifically needs relating to the characteristics protected by the Equalities Act 2010. These are age, ethnicity, religion or belief, disability, gender, gender reassignment, sexual orientation, marriage and civil partnerships. This applies to information about the Service being made available in such a way that promotes equality of access. This also applies to the quality of service delivery across all Service User groups or individuals.

29.4 Social value has been defined as 'the additional benefit to the community from a commissioning and procurement process over and above the direct purchasing of goods, services and outcomes'. Service Providers of this service will be expected to pay due and positive consideration to the employment needs within their local community when recruiting and selecting staff. The Service Provider must give positive consideration to how their recruitment processes support the local economy,

its demographic composition and its social and environmental well-being. Service Providers will be encouraged to involve Service Users and Carers in staff recruitment, quality assurance and service review processes.

29.5 Under the new arrangements, the Council will require Service Providers to be able to evidence that they are meeting the requirements of minimum wage legislation, after travel time and costs are taken into account.

29.6 Service Providers will engage positively with the aims of the Council to develop staff training and professional status of Care work. The Service Provider will be encouraged to use values based recruitment practices to support employers to ensure that the right employees are recruited to work with adult social care Service Users. Values include treating people with dignity, compassion, respect, empathy, integrity, courage, responsibility, imagination, and adaptability. This Service will facilitate the development of the market to deliver services in a new and more personalised way rather than the conventional delivery of Care at Home, which in turn will enhance the skills of staff delivering the Service, and improve the customer experience of the person using the Service.

30. Safeguarding and Serious Incidents

For adults (18+)

30.1 The service will demonstrate how it will ensure that people who use services are safeguarded from:

(i) Physical or emotional abuse;

(ii) Financial abuse;

(iii) Material abuse;

(iv) Psychological abuse or emotional abuse including humiliation (intended or from a lack of understanding or knowledge);

(v) Sexual abuse;

(vi) Discriminatory abuse;

(vii) Institutional abuse;

(viii) Neglect (intended or from a lack of understanding or knowledge);

(ix) Professional negligence

30.2 The Council has agreed with other statutory authority's multi-agency policy and procedures to protect vulnerable adults from abuse. The Service Provider shall follow the policy and procedures if abuse is identified or if the Service Provider has grounds to believe that abuse may have taken place. These can be found at:

London multi agency safeguarding policy and procedures:

[London Multi-Agency Adult Safeguarding Policy and Procedures – LondonADASS]

30.3 The Service Provider will have in place and regularly review policies and procedures to protect adults from abuse. These must be consistent with Haringey's and London's Multi-Agency Policy and Procedures.

30.4 Service Providers will be responsible for reporting actual or suspected abuse in accordance with the local multi-agency policy and procedures for their area and alert officers from the London Borough of Haringey and the Local Safeguarding Team, in writing and within 24 hours, when any safeguarding concern, allegation or complaint is raised or made known to the Service Provider. The Service Provider shall report using the Haringey incidents reporting procedure and form.

30.5Incident of the following must be reported in writing within 24 hours of occurrence to the commissioning authority:

30.5.1 Death, Suicide, Attempted suicide

30.5.2 Actual or alleged Abuse of a Service User;

30.6.3 Complaints from neighbours;

30.6.4 Police Involvement;

30.6.5 Complaints made by Service Users and/or advocates, families etc. of abuse by staff;

30.6.6 Actions by Service Users significant enough to be used as evidence in an eviction;

30.6.7 Evictions of Service Users and any actions toward eviction of a Service User;

30.6.8 Any temporary suspension of service;

30.6.9 Any other incidences or signs of abuse (as described in the Care Act 2014) that would involve a serious risk to Service Users, staff or service viability.

30.7 The Service Provider will be committed to meeting its obligations under health and safety legislation to ensure that the welfare of Service Users and support staff is promoted and protected.

30.8 The Service Provider will ensure that the service has systems and procedures in place, which comply with the requirements of health and safety legislation, including procedures such as lone working, risk assessments and will review these annually.

31Policies and Procedures

31.1 Bidders must provide the following policies and procedures with their bids that are at least compliant with their statutory obligations and Registration requirements but also may demonstrate best practice:

31.1.1 Whistle Blowing

31.1.2 Confidentiality

31.1.3 Freedom of Information Act & Information Sharing

31.1.4 Staffing, Management and Recruitment Staff Training

31.1.5 Volunteers and Agency Staff Files & Record Keeping

31.1.6 Health and Safety

31.1.7 Safeguarding

31.1.8 Critical Incidence

31.1.9 Communication/ Licence to Occupy Agreement

31.1.10 Complaints

31.1.11 Managing complex and challenging behaviour Medication policy

31.1.12 Dealing with seizures Business Continuity

31.1.13 Environmental

Appendix 1 – Summary of Care Needs (Not Exhaustive)

Service User needs
Behaviour • Aggression, violence or passive non-aggressive behaviour • Severe dis-inhibition • Intractable noisiness or restlessness and/or wandering • Resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance) • Severe fluctuations in mental state • Extreme frustration associated with communication difficulties • Inappropriate interference with others • Identified risk of suicide
Cognition • Marked short term memory issues • Long term memory problems • Disorientation to time and place • Limited awareness of basic needs and risks • Difficulty making basic decisions • Dependant on others to anticipate basic needs
Psychological and Emotional needs • Unable to express their psychological / emotional needs • Mood disturbance • Hallucinations • Anxiety • Periods of distress • Withdrawn from attempts to engage in daily activities

Service User needs

Communication (relates to difficulty with expression and understanding, not with the interpretation of language) • Difficulties with expressive and/or receptive communication • Communication through the use of non-verbal means • Use of communication aids
Mobility • Inconsistent ability to weight bear • Completely unable to weight bear • Risk of falls • Needs careful positioning • Unable to assist or cooperate with transfers and/or repositioning • Involuntary spasms or contractures
Nutrition – food & drink • At risk of malnutrition, dehydration and aspiration • Significant unintended weight loss or gain • Risk of choking • Use of artificial feeding e.g. PEG
Continence • Incontinent of urine and/or faeces • Catheterised • Requiring stoma care • Chronic urinary tract infections

Service User needs
Skin (including tissue viability) - a skin condition is taken to mean any condition that affects, or has the potential to affect, the integrity of the skin. • Skin condition that requires monitoring or re-assessment. • Risk of skin breakdown requiring intervention. • Pressure damage or open wound(s) • Open wound, pressure ulcer with full thickness skin loss and necrosis extending to underlying bone.
Breathing • Shortness of breath which may require the use of inhalers or nebuliser • Episodes of breathlessness that do not respond to management Requires low-level oxygen therapy. • Breathing independently through a tracheostomy • Difficulty in breathing which requires suction to maintain airway • Non-invasive ventilation • Invasive ventilation
Drug therapies and medication • Requires supervision and administration and/or prompting • Non-concordance or non-compliance • Administration of complex medication • Medication via PEG • Requires on-going pain control
Altered states of consciousness • A range of conditions including stroke and epilepsy

Service User needs

End of life Care

- Symptoms associated with dying e.g. pain, chest secretions, difficulty breathing
- Emotional support during the dying process
- Implementation of agreed plans e.g. ACP

<u>**Appendix 3**</u>

GLOSSARY

The definitions below are additional to those found in the Supplier Agreement. The following terms shall have the following meanings:

Advance Care Plan (ACP)	A plan of the future care between an individual and their care providers, irrespective of discipline. An ACP might include: • concerns and wishes; • important values or personal goals for care; • understanding about illness and prognosis; and • preferences for types of care or treatment that may be beneficial in the future. (Adapted from: Leadership Alliance for the Care of Dying People, 2014. *One chance to get it right - Improving people's experience of care in the last few days and hours of life*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_ri ght.pdf).
Advance Decision to Refuse Treatment (ADRT)	As defined in 2005 Act. Available at: http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpg a_20050009_en.pdf
Advocate	Advocate can be used in a general sense, as one who speaks on behalf of another, or it can have special meanings derived from the 1983 Act and the 2005 Act. There are formal and informal Advocates and these can be: Individuals acting informally: • Carers, relatives, partners, neighbours or friends and staff; • Those prescribed by legislation, such as Independent Mental Health Advocates and Independent Mental Capacity Advocates; and • Those provided by schemes run by local authorities, the NHS and charities. (CQC, 2015. *Glossary of terms used in the guidance for providers and managers*. Available at: Glossary of terms used in the guidance for providers and managers | Care Quality Commission.
Appointed Person	A Legal Guardian, Advocate, or best interest representative appointed by the Council**.**
Behaviour that Challenges	Behaviour that causes harm to the person or others, or stops the person fulfilling some aspect of their lives. It is the impact of the behaviour that makes it challenging. Behaviour that challenges can be: • self-injurious: head-banging, scratching, pulling, eye poking, picking, grinding teeth, eating things that aren't food;

	• aggressive: biting and scratching, hitting, pinching, grabbing, hair pulling, throwing objects, verbal abuse, screaming, spitting; • stereotyped: repetitive movements, rocking, repetitive speech and repetitive manipulation of objects; and • non-person directed damage to property, hyperactivity, stealing, inappropriate sexualised behaviour, destruction of clothing, incontinence, lack of awareness of danger and withdrawal. Adapted from: Scope, 2015. *Challenging Behaviour*. Available at: https://www.scope.org.uk/Support/Parents/Behaviour/Wh at%2Dis%2Dchallenging-behaviour).
Care Worker	A person employed by the Service Provider to provide the Care at Home services.
Contact Time	The time Care Workers spend delivering care to the Service User.
Care Consultation	The procedure for the Service Provider to assess if and how the Service Provider can meet the Service User's needs, before the Service Provider agrees to undertake the Package of Care**.**
Care Plan	Care Plan is a document detailing agreed care an individual client is entitled to with a breakdown of delivery of service in line with agreed package
Decision Support Tool (DST)	The assessment tool used to determine eligibility for NHS CHC.
Delegated Nursing Tasks (DNTs)	Activities allocated by a registered practitioner to a support worker who is deemed competent to undertake the activity. The support worker carries the responsibility for the task while the registered practitioner retains accountability. (Adapted from: Royal College of Speech and Language Therapists, British Dietetic Association, Royal College of Nursing, The Chartered Society of Physiotherapy, and Trent RDSU University of Sheffield, 2006. *Supervision, accountability and delegation of activities to support workers: A guide for registered practitioners and support workers*. Available at: http://www.rcslt.org/docs/free%2Dpub/Supervision_ac countability_and_delegation_of_activities_to_support_wor kers).
Do Not Attempt Resuscitation (DNACPR)	Management plan put in place if cardiac or respiratory arrest is an expected part of the dying process and CPR is unlikely to be successful. Making and recording an advance decision not to attempt CPR means that the patient dies in a dignified and peaceful manner and that the patient's last hours or days are spent in their preferred place of care by, for example, avoiding emergency admission from a community setting to hospital. These management plans are also called Do Not Attempt Resuscitation orders or Allow Natural Death decisions. (Adapted from: General Medical Council, 2010. *Treatment and care towards the end of life: good practice in decision making.*
Domiciliary Care/ Care at Home	Care for people living in their own homes. The needs of people using the services may vary greatly and packages of care are designed to meet individual circumstances. The person is visited at various times of the day or, in some cases, care is provided over a full 24- hour

	period. Where care is provided intermittently throughout the day, the person may live independently of any continuous support or care between the visits. (Adapted from: CQC, 2015. *Service Types: Domiciliary Care Services*. Available at: Service types | Care Quality Commission
Electronic Call Monitoring (ECM)	A method of recording accurate Contact Time. The date, time and duration of care is recorded by the Care Worker logging in and out while at the Service Users home.
Eligibility Criteria	The criteria used by the Council to determine whether a person is eligible to receive any or all of the Services
End of Life Care (EOLC)	Care for patients who are likely to die within the next 12 months • This includes patients whose death is imminent (expected within a few hours or days) and those with: advanced, progressive, incurable conditions; general frailty and co-existing conditions that of dying from a sudden acute crisis in their condition; and • life-threatening acute conditions caused by sudden catastrophic events. • In general Medical council guidance the term 'approaching the end of life' also applies to patients who are diagnosed as being in a persistent vegetative state (PVS) for whom a decision to withdraw treatment may lead to their death. (Adapted from Leadership Alliance for the Care of Dying People, 2014. One chance to get it right - Improving people's experience of care in the last few days and hours of life. Available at: https://www.gov.uk/government/uploads/system/uploa ds/attachment_data/file/323188/One_chance_to_get_it_ri ght.pdf
Fundamental Standards	Fundamental are the standards below which care provided by Service Providers of care must never fall
Long Term Condition	Conditions, such as diabetes, asthma, arthritis or dementia that cannot currently be cured, but whose progress can be managed and influenced by medication and other therapies.
London Living Wage (LLW)	London Living Wage" means the basic hourly wage set by the Greater London Authority (before tax, other deductions and any increase for overtime) as may be updated from time to time by the Greater London Authority; *London Living Wage*. Available at: https://www.london.gov.uk/priorities/business-economy/vision-and-strategy/focus-areas/london-living-wage).

Medication Errors	Any Patient Safety Incident (PSI) where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. These PSIs can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose or a failure to monitor, such as international normalised ratio for anticoagulant therapy. (NHS England, 2014. Patient Safety Alert Stage Three: Directive Improving medication error incident reporting and learning. Available at: http://www.england.nhs.uk/wp- content/uploads/2014/03/psa-sup-info-med-error.pdf).
Multidisciplinary Team (MDT)	Two or more health and social care professionals who are involved in the assessment of the Service User
National Minimum Wage	The National Minimum Wage is the minimum pay per hour almost all workers are entitled to by law. (UK Government, The National Minimum Wage. Available at: https://www.gov.uk/national-minimum-wage-rates
NHS Continuing Healthcare (CHC)	A package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS CHC places no limits on the settings in which the package of support can be offered or on the type of service delivery. (Department of Health, 2012. National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for- NHS-CHC-NHS-FNC-Nov-2012.pdf).
Nursing Care	As defined in 2014 Regulations. Available at: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/pdfs/ukdsi_9780111117613_en.pdf.
Personal Care	As defined in 2014 Regulations. Available at: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/pdfs/ukdsi_9780111117613_en.pdf.

Reablement	Reablement is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.
Risk Assessment	The process of identifying all the risks to and from an activity, and assessing the potential impact of each risk. (CQC, 2015. *Glossary of terms used in the guidance for providers and managers*. Available at: http://www.cqc.org.uk/content/glossary-terms-used- guidance-providers-and-managers#r).
Service	Contracted community based support to stay at home service
Service User Guide	Service Provider-produced guide to the Services for the Service User.
Service User Outcomes	A series of statements or objectives within the Individual Outcomes Plan, which the Service Provider is expected to assist the Service User to achieve.
Significant Change	An amendment that affects the agreed cost of the Package of Care (e.g. the number of hours of care or the Care Tier). or Any change to the risk profile of care delivery (e.g. turning regime).

Appendix 4

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Reablement in Haringey

1. Background

1.1 The Council's Corporate Plan 2019-2023, Building a Stronger Haringey Together, sets out five strategic priorities for the borough:

Priority 1: Enable every child and young person to have the best start in life, with high quality education
Priority 2: Empower all adults to live healthy, long and fulfilling lives
Priority 3: A clean, well-maintained and safe borough where people are proud to live and work
Priority 4: Drive growth and employment from which everyone can benefit
Priority 5: Create homes and communities where people choose to live and are able to thrive

1.2 These strategic priorities are being delivered in line with six cross-cutting themes:

(i) Prevention and early intervention: *Providing support earlier to prevent problems from occurring or escalating*
(ii) A fair and equal borough: *Tackling the barriers facing the most disadvantaged and enabling them to reach their potential*
(iii) Working with our communities: *Building resilient communities where people are able to help themselves and support each other*
(iv) Value for money: *Achieving the best outcome from the investment made*
(v) Customer focus: *Placing our customers at the heart of what we do* (vi) Working in partnership: *Delivering with and through others*

1.3 The Corporate Plan signalled a new approach for the Council with the focus on achieving outcomes through our five strategic priorities and crosscutting themes, rather than on delivering services through business units as previously. The focus on early intervention and prevention, building community capacity and enabling long-term health and wellbeing links the Corporate Plan objectives with the requirements of the Care Act and the shift we are making in assessment, support planning and connecting to services. Increasing levels of integration – delivered through the Better Care Fund and the wider Health and Social Care Integration Programme – are fundamental to this agenda.

1.4 Whilst there is a focus on improving outcomes for adults with emerging or assessed needs across the Council and in other agencies, many services to adults will be delivered through the programme for Priority 2 and therefore through the following 5 objectives:

A borough where the healthier choice is the easier choice

(ii) Strong communities, where all residents are healthier and live independent, fulfilling lives

(iii) Support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing

(iv) Residents assessed as needing formal care and / or health support will receive responsive, high quality services

(v) All vulnerable adults will be safeguarded from abuse

1.5 Feedback from Users, Carers and local residents consistently focuses on some key elements of service delivery. We will ensure these values and principles for Users, Carers and staff are reflected in the provision which we develop and commission:

- Promoting independence and reablement
- Supporting people to live healthy lives for longer
- Demonstrating respect and dignity
- Empowering and fulfilling lives with opportunity for growth
- Developing community resilience, reducing inequalities

1.6 Our overarching objectives and values shape our Target Operating Model (TOM) for adult services and ultimately the services we commission. On a commissioning and clients' services level, the key outcomes of the Council's TOM are:

(i) To develop a programme of commissioning and complete commissioning strategies on all operational services;
(ii) To contract manage services (in house/ external) to ensure commissioning outputs/outcomes are delivered;
(iii) To challenge performance, drive innovation and deliver continuous improvement; (iv) To review and develop policy;
(v) To seek and secure external funding; and (vi) to identify future savings/income generation.

2. Why reablement?

2.1 As part of the Corporate Plan focus on building a stronger Haringey together, the focus of Priority 2 is to empower all adults to live healthy, long and fulfilling lives through an emphasis on promoting independence and the Target Operating Model is built around this principle.

2.2 Reablement supports the wider principles of Priority 2 at a service level through a focus on independence, which reflects the wishes of the majority of Users to stay at home and to retain maximum independence and control.

2.3 Reablement harnesses the joint input of health and social services to supporting people to live at home – and reaps joint benefits for social care and health care budgets. Without reablement, home support services, and wider social care budgets, will continue to be overwhelmed unless solutions are found that decrease demand and reduce costs overall.

3. Reablement

3.1 Reablement forms part of the mainstream pathway for people, both within the community and on discharge from hospital, who are in need of social care support.

3.2 Reablement has been defined as 'services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living'. Care Services Efficiency Delivery (CSED 2007a). Reablement services should be outcomes- focused, and are provided for a defined maximum period of time, up to six weeks (CSED 2007a).

3.3 In Haringey, the aim of reablement is to ensure that adults being discharged from acute hospital into their own homes in the community receive the support they need to return home, to promote their independence, to reduce their dependency on care in the longterm, and to prevent re-admissions to hospital. Equally, for people accessing the service from the community, the service aims to ensure that people are able to remain in their own homes, to promote their independence, to reduce their dependency on care in the long-term and to prevent admissions into hospital.

3.4 The focus is on enabling people to restore their level of independent functioning rather than resolving social and health care issues, and on helping people to do things for themselves rather than the traditional home support approach of doing things for people.

3.5 Reablement therefore is usually an intervention for up to six weeks, focused on people regaining their abilities – for example in dressing, using the stairs, washing and preparing meals. Where necessary, it will include social re-integration to reduce social isolation.

3.6 This Specification aims to ensure that successful external Service Providers work alongside the Council's in house Reablement Service to provide additional capacity for the provision of reablement and to deliver the goal focused Reablement Support Plan for each service User- as specified in the assessment undertaken by the in house Reablement Service.

4. Aims and Objectives

The Successful Service Providers will work towards the following aims and objectives:

4.1 Aims

(i) To maximise independence and help people to regain skills and confidence by learning or relearning the skills necessary for daily living for example after an illness, or stay in hospital;

(ii) To connect people to their local communities through reablement support outside the home where appropriate and through signposting and advice;

(iii) To be the default offer for all Haringey residents in need of care and support; (iv)To provide an average of 3 weeks intensive support, up to a maximum of 6 weeks;

(iv) To offer an integrated service based on a care co-ordination model

4.1 Objectives

(v) To deliver timely and focused intensive interventions;

(vi) To maximise Service Users long-term independence, choice and quality of life;

(vii) To minimise ongoing support required; and (viii) To minimise the whole-life cost of care.

5. Principles

5.1 The guiding principles underpinning Haringey's Reablement Provision (incorporating both in-house and external service delivery) are:

Early intervention will reduce the development of complex support needs in the future

i. Enabling rather than doing; Use of assistive technology to support the maximisation of independence;

ii. Based on best practice and good governance

iii. Access to and delivery of reablement service are person centred and take into consideration views of informal carers.

iv. Working seamlessly with health and social care pathway partners to ensure joined up services, whilst minimising duplication;

v. Learn from local, national and international best practice and priorities; Continual review of quality of service based on Service User feedback; Holistic and outcome focused service delivery with defined maximum duration;
vi. Continually observe, monitor and review progress against individual and service outcomes
vii. Early setting of Estimated Discharge Dates
viii. Weekly multidisciplinary reviews to ensure that the service is completed as soon as the person using the service has reached their agreed level of independence;
ix. All eligible Service Users will have a named care co-ordinator to act as the main point of contact; xi. Early identification of those on reablement pathway who are not benefitting from reablement; xii. Assessment for ongoing care packages cannot be defined by a one-off assessment but requires observation over a defined period; and
xiii. Timely transition to long term care should this be required.

6. Service Standards

All Service Users of Haringey's Reablement provision (both in house and external provision) can expect that:

- The support they receive will be responsive to their needs;
- The support they receive supports them towards outcome focussed independence;
- The support provided is timely, flexible and of good quality, with due respect to privacy and dignity;
- Confidentiality is observed between the professionals involved;
- Any concerns expressed will be promptly and thoroughly investigated in all cases; and The standard of service will be in line with the Care Quality Commission.

7. Service Offer

Reablement in Haringey will be delivered through a collaborative approach involving the Council and external Service Providers. This section sets out the roles and responsibilities of the in-house elements of the service and those to be delivered by external Service Providers.

7.1 Haringey's Reablement in house provision and the Council will offer:

i. Support for people to do things for themselves through strength based co-ordinated
ii. assessment and support planning for up to six weeks
iii. Support for people being discharged from hospital and living in the community who appear to have care and support needs;
iv. Access to occupational therapists and physiotherapists in the team as appropriate;
v. Fast access to assistive technology (telecare) where this supports independence;
(v) Provision of aids and equipment where this supports independence;
(vi) Development of a goal focused Reablement Support Plan in participation with Service Users with timely review of goals;
(vii) Access to a named person to co-ordinate health and social care needs during the period of reablement;

(viii) Support to Service Users to self manage by providing information and advice and signposting to community and support groups, Neighbourhood Connect or other local activities will be an integral part of work with Service Users;

(ix) Assessment under the Care Act 2014 if ongoing services are required;

(x) Timely transfer of support at home to care Service Providers on discharge from the reablement service;

(xi) Effective integrated working between practitioners;

(xii) Access to specialist and wider community services, including the voluntary sector in a timely way; and

(xiii) Referrals of Service Users for reablement homecare support to external Service Providers as deemed appropriate for the needs of the Service Users.

7.2 Once a referral is received from the in house Reablement Service, the external Service Provider will offer:

Reablement home care support to support the Service User meet their defined reablement goals, which may increase, or decrease during the reablement period. This support *may* include the following tailored to individual needs and goals:

- Personal care i.e. washing, dressing and undressing
- Toileting needs/catheter care
- Meal preparation/kitchen practice
- Mobility, inside and outside the home as appropriate, use of equipment, confidence building
- Support to take medication
- Support to enable independence in community based activities

7.3 It is important that the reablement home care offered continue to support Service Users to meet their defined reablement goals by working alongside Service Users to carry out a number of goals as specified in their goal focused Reablement Support Plan. The reablement home care support will focus on maximising independence and will help people to regain skills and confidence by learning or relearning the skills necessary for daily living where required.

7.4 In all cases, the in house Reablement Service will be the first point of contact for referrals from either the hospital or the community. All assessments will be undertaken by the in house Reablement Service and the information provided by Service Users at this stage will inform the goal focused Reablement Support Plan for each Service User. The plan will contain detailed information about the current needs of the Service User as well as the outcomes that are expected to be achieved during the reablement period.

7.5 The in house Reablement Service will decide which referrals will be forward to the external Service Providers based on capacity and the needs of Service Users. The external Reablement Service Provider will be required to accept all referrals and implement the goal focused Reablement Support Plan for each Service User as devised and determined by the in house service.

8. What happens as a result of reablement?

8.1 Outcomes are the expected changes or benefits that happen as a result of the Service being delivered. Outcomes will be measured for both the service and the individual Service User.

These are the key priorities and outcomes for Haringey's reablement service. They are described in the statements:

Outcome 1: Promoting independence

- I want to stay at home as long as possible and as independently as possible
- I want to do as much for myself as I can including managing my personal care needs
- I want be as active and as healthy as I can
- I want to be able to see and talk to people.
- I want to be able to go outside my home

Outcome 2: Help in a crisis

- I want short term help when I am in a crisis to enable me to do the things I could do before the crisis
- I want to be independent as quickly as possible

Outcome 3: Safeguarding

- I want to be free from abuse
- I want to feel safe

Outcome 4: Quality

- I want a responsive service, with consistency of care
- I want a service delivered by people who care
- I want a service delivered by people trained to support my condition
- I want to be involved in decisions about my care package

Service outcomes

The objectives of reablement are, through the use of timely and focused intensive interventions, to:

- Maximise Service Users long-term independence, choice and quality of life;
- Minimise ongoing support required;
- Minimise the whole-life cost of care; and
- Ensure that all eligible Service Users will receive a period of reablement.

System outcomes

- Fewer emergency admissions to hospital;
- No readmission to hospital within 91 days;
- Fewer admissions to residential and nursing care; and
- Reduction in number and size of home care packages for people on discharge and within the community.

8.2 The external Reablement Service Providers are expected to work alongside Haringey's in house Reablement Service in order to achieve the above outcomes on all levels- individual, service and system outcomes.

8.3 The External Reablement Service Provider will be expected to implement the goal focused Reablement Support Plan and report regularly (as specified by the Council and the in house service) on achievement of outcomes for each Service User.

8.4 The external Service Provider will be required to also measure achievement of the specified outcomes through reviews and feedback from Service Users and Carers and upon their exit from the Service, with support from advocacy or Carers with power of attorney etc as appropriate. The external Service Provider will make available evidence

and other necessary information, as requested by the Council and by the in house reablement team, to enable audit of evidence submitted to support the Outcomes and Performance Indicators below.

9. Service Outcomes

9.1 Service outcomes will include both 'qualitative' and 'quantitative' performance indicators. These will be further developed jointly with Successful Service Providers during the duration of the contract/framework.

Key Performance Indicators (KPIs) for external Service Providers will include the following:

Service Outcome	Measure	Frequency of reporting	Format of Collection
Overall satisfaction of people who use reablement services Service Users feel their quality of life has improved as a result of the service Overall satisfaction of Carers with the quality of provision and positive impact on the quality of Service User' life.	95%, of Service Users and 95% of Carers report during the duration of the intervention and by an exit survey that are satisfied with the quality of contact they have had with the external reablement service and that Service User quality of life has improved as a result of the intervention. Undertake an exit survey on 100% of Service Users and Carers to monitor satisfaction levels- involve Carer where appropriate 100% of Carers feel they are respected as equal partners throughout the care process	Weekly & by the end of the reablement period (exit phase)	Mosaic reporting Service User & Carer feedback End of service survey

Timely Service Provision	100% of referrals to be accepted to the service. Where there is a difference of view about a referral, this will be managed between the external Service Provider and the in- house Service. 100% of new referrals/ Service Users to be contacted within 24 hours (including the weekend) upon receipt of the referral 100% of all first appointments to be arranged within 48 hours, unless this is not suitable for the Service User. 100% of Service Users to have their goal focused Reablement Support Plan reviewed at least weekly, unless the Service User's needs/wishes require more or less often reviews	Weekly & by the end of the re ablement period (exit phase)	Mosaic reporting Service User & Carer feedback End of service survey

Reduction of overall duration of the re ablement intervention	50% of the overall reablement interventions to last for no more than three weeks with clear achievement of at least 95% of the outcomes as determined by the goal focused Reablement Support Plan for each Service User.	Weekly & by the end of the reablement period (exit phase)	Mosaic reporting Service User & Carer feedback End of service survey
Service Users report that their independence has been improved as a result of the reablement service	95% of Service Users report that their independence has been improved (and are able to maintain it long term) as a result of the reablement service. 100% of Service Users can use their telecare/health services effectively and confidently	Weekly & by the end of the reablement period (exit phase)	Mosaic reporting Service User & Carer feedback End of service survey
Overall reduction in the number of people requiring further social care support	60% of those who use the external reablement service require no further social care support (including home care) once the reablement intervention has ceased.	End of the reablement period (exit phase)	Mosaic reporting Service User & Carer feedback End of service survey
Overall reduction in admissions to hospital	Less than 4% of Service Users are admitted to hospital during the duration of the reablement intervention.	Weekly & by the end of the reablement period (exit phase)	Mosaic reporting Service User & Carer feedback End of service survey
Service Users who exit the service with no ongoing care needs do so with appropriate information on local prevention and support services.	100% of all people exiting the service receive accessible information are signposted to local prevention and support services as appropriate and are assisted to be referred to these services as required and within the timelines that suit each individual Service User. 100% of Service Users who use services find it easy to find information about support	End of the reablement period (exit phase)	Mosaic reporting Service User & Carer feedback End of service survey

9.2 Minimum Data Set to be collected by the Service Provider

Number of referrals accepted on to the service
Number of Service Users rejected, including reasons and whether this was
mutually agreed with the in house reablement team and the Council

Demographics of referrals and people accepted into service – age, gender, ethnicity and postcode (with their consent)
• Number of people moving on from the service within 2 weeks (including % of success in achieving outcomes) • Number moving on between 2 to 3 weeks (including % of success in achieving outcomes) • Number moving on between 3 to 4 weeks (including % of success in achieving outcomes) • Number moving on between 4 to 5 weeks (including % of success in achieving outcomes) • Number moving on between 5 to 6 weeks (including % of success in achieving outcomes)
Move on destination for each person using the service to cover: Home (ordinary place of residence) New permanent home in: Sheltered accommodation ECSH Residential Placement Permanent Short Term Nursing Care Rehab Unit Readmitted to Hospital
• If remaining or going home: • Is it with a package of care at home - if yes, how many on a direct payment. • Is it with a package of care at home (Council funded) -if yes, how many hours, costs, length of time • Is it with telecare/health services • Is it without any on-going care support
Number of people with clear review arrangements of their goal focussed reablement plan in place
Provide information on policies, protocols, safe recruitment practices as agreed in the main Home Care/Support part of Specification
Provide information weekly on safeguarding, compliments and complaints-including details of how these have been addressed/resolved

10. Service Delivery

10.1 The Successful Service Providers will be expected to deliver reablement services in accordance with an Outcome Based Reablement Support Plan completed by

Haringey's
In house Reablement Team and in collaboration with that Team. The Service Provider of reablement will request a copy of the Outcome Based Reablement Support Plan from the Council's Reablement Assessment Team when an eligible person is referred.

10.2 Referral for a reablement service will come from Haringey's in house Reablement Service with an initial indication of what will be set with the Service User to achieve independence.

10.3 Assessment and Care Planning*:*

(i) Haringey's Reablement Service aims to visit the Service User within 2 days of discharge to develop a reablement support plan that sets out what goal focussed support is needed in order for the Service User to be as independent as possible and to achieve agreed outcomes. There will be input from the reablement Service Provider, Social Care, Occupational Therapists and Physiotherapists as required to develop this plan.
(ii) The external Reablement Service Provider will receive the reablement support plan from the Reablement Assessment Team.
(iii) The external Reablement Service Provider will follow any guidance given by the Haringey's Reablement Service in relation to maximising independence and ensuring the reablement support plan is implemented.
(iv) The Support plan will be developed into a Service Plan by the Service Provider. A copy will be provided to the Service User and Haringey's in house Reablement Service.
(v) Thorough assessment of risk for complex tasks involving, for example, mobilising or medication, should be the basis of service activity and be drawn up in conjunction with the User, their family and advocates and practitioners. The attitude to risk should be proactive and supportive, and assessment should include guidance for staff around minimising risks and contingency planning should an emergency arise.

10.4 Monitoring and Review:

(i) The Service Provider will form part of a Multi Disciplinary Team to support the Service User to achieve the goals set to achieve as much independence as possible.
(ii) The goals and outcomes of each Service User on the reablement pathway will be reviewed weekly at a multi-disciplinary meeting which the Service Provider will contribute to either by representative in person or by detailed written feedback.
(iii) Where it is apparent the Service User is independent in activities of daily living the Service Provider will immediately inform Haringey's in house Reablement Service.
(iv) Where it is apparent the Service User is no longer benefitting from reablement the Service Provider will immediately inform Haringey's in house Reablement Service.
(v) During the reablement period it is anticipated that for most Service Users the amount of reablement support will be reduced.
(vi) The Multi Disciplinary Team will agree when the Service User has met all attainable goals or is unlikely to meet further goals. Also, a review date will be set and the Service Provider will be informed by the lead worker.

10.5 The service will be monitored in line with the Council's Community Reablement Service. The following information is to be recorded for each client:

- Age of client
- Ethnicity of client
- Gender of client
- Time and date of referral
- Source of referral
- Time and date of first service delivery
- Duration of service
- Number of hours of care and cost of care package in week 1 of the reablement package and in each subsequent week
- Number of multi-disciplinary meetings for the client which were attended in person or for which a report was submitted
- Destination at the end of service
- Achievement of goals set in initial assessment
- Quality of life questionnaire at beginning and end of service (e.g. ASCOT: INT4 survey)
- Progress against Individual, Service and Performance Outcomes

11. Key Partnerships

External Reablement Service Providers will establish key partnerships with other services, namely with:

- Haringey's in house Reablement Service
- Community Rehabilitation Services including the Integrated Community Therapies Team
- Haringey Integrated Locality Teams
- Community Alarm Service (telecare)
- Voluntary and community support organisations, such as Neighbourhood Connects Community nursing
- Pharmacy
- GPs and other local primary care services
- Falls prevention services
- Hospital discharge teams
- Local mental health services (including Barnet, Enfield and Haringey Mental Health Trust
- Other health and social care providers and services as required

12. Staff Competencies, Skills & Behaviours

12.1 The Council wishes to procure a service that is:

- Flexible and responsive
- Able to respond to a varied range of Service User needs
- Outcome focussed and goal orientated

- Promotes choice, control and independence
- Able to deliver the priorities of Haringey Council and Haringey NCL CCG

The table below shows the component behaviours required in staff within Enablement and Home Support		
Behaviours	**Knowledge**	**Skills**
• Less task orientated More able to facilitate and enable Service • User to be more independent • More alert to Service Users feelings, capabilities and needs More focussed on individual's wellbeing • Able to encourage Service User to achieve their goals	• Spotting signs of dementia • Understand communication methods with Service Users with a variety of mental and physical challengers • Safeguarding – how to report • Care Act –their role • Manual Handling • Health and Safety • Medication Management • Person Centred Approach Mental Capacity • When to recommend referrals to partner organisations • Knowledge of Support Plan	• Recognise signs of harm • Written communication (report writing) • Skill of motivating Service Users to achieve their goals • Non-verbal and verbal communication • Implementing the support plan • Engaging effectively with Carers

13. Learning & Development Program

Successful Service Providers should ensure that managers and staff attend training in:

- Emergency First Aid
- Infection Control
- Level 2 Food Hygiene
- Lone Working
- Lone Working and medication policies
- Medication Management
- Moving & Handling Awareness
- Moving & Handling Refresher
- Moving & Handling Risk Assessment
- Nutrition
- An awareness of mental illness, learning disabilities and drug and alcohol dependency
- Communicating Effectively
- Falls
- Person Centred Dementia Care including responding to challenging behaviour
- Pressure Care Management
- Supporting Lifestyle Behaviour Change
- The role of the Health & Social Care Enabler
- Time Management

The list above is not exclusive of other training needs that might be identified during the duration of this framework.

Please also refer to section I, V and VI of the main Care at Home Specification which also apply in respect of the Reablement services.