SERVICE SPECIFICATION

Domiciliary Home Care Services for Adults
(Dynamic Purchasing System)

1. Introduction

1.1 This document sets out the service specification for the provision of a Home Care Service for adults who are ordinarily resident within the Borough of Milton Keynes.

1.2 Milton Keynes Council has adopted the UNISON's Ethical Care Charter (attached) and is committed to abide by its recommendations. The over-riding objective is to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which a) do not routinely short-change Service Users and b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels.

1.3 The time allocated to visits will match the needs of the Service Users. In general, 15-minute visits will not be used as they undermine the dignity of the Service Users and are not recommended by the UNISON Ethical Care Charter.

1.4 This service is for those residents who have been assessed as eligible for support from adult social care.

1.6 This specification describes the key features of the service and the outcomes required and should be read in conjunction with the Terms and Conditions of the Contract.

1.7 The service will offer planned and emergency visits during the core hours of 6.30am and 10.30pm, 7 days a week including all bank holidays.

1.8 It is imperative that Service Users are at the heart of adult health and social care activities receiving services that are easy to access, of good quality and that maximise their ability to live independently and safely in their home and community.

1.9 In ensuring that the services provide seamless good quality Home Care provision the Council and Providers will be committed to working together in partnership through:

- Ensuring that Service Users and Carers are involved in the development, delivery and monitoring of the service provided and are able to contribute views in relation to how the delivery of the service is achieving individual outcomes
- Developing close links with the GPs, local community, families, carers, and all health and social care professionals within the area
- Having a shared vision about the community and individual outcomes which can be achieved through the provision of a good quality Home Care Service
- Collaborating for the benefit of Service Users
- Communicating honestly, openly, regularly and efficiently

- Sharing relevant information, expertise and plans
- Seeking to avoid conflict but where it arises ensuring that it is resolved quickly, efficiently and professionally at a local level with no detriment to the Service User
- Monitoring quality and performance, quickly identifying and taking firm and timely remedial action where necessary
- Striving for continuous improvement, reflecting new learning as it emerges and working together to ensure that available resources are maximised to achieve the best outcomes for individuals and the local community
- Recognising that during the period of the contract there are likely to be changes in service requirements at a national and local level, which will need to be responded to in a professional, flexible, and responsive manner, ensuring outcomes are maintained and best use made of resources available.

2. Service Aims

2.1 The Provider is required to ensure that Service Users are supported to achieve the broad outcomes listed below and all personal outcomes agreed in the Care and Support Plan.

2.2 Home Care should be used to enable Service Users to live more independently with dignity; it should not be done to the Service User but with the Service User, adopting a re-ablement, strengths based approach at all times.

2.3 Receiving Home Care should not automatically be seen as being for life and Service Users will be subject to ongoing review to determine whether the care packages still meet their needs. It is expected that a number of care packages will reduce.

3. Expected Outcomes

3.1 Outcome-focused services are fundamentally person-centred in approach, recognising that each Service User is unique and will have different needs and requirements. The Council has identified a range of outcomes to be achieved in the delivery of the home care services, to support Service Users to take greater control of their lives and live as independently as possible, for as long as possible. Whilst not all are relevant to each care and support package, those relating to and identifying with the Service User's needs (and documented in their care and support plan), will be the basis on which the effectiveness of the service will be determined from.

3.2 The implementation of this specification must contribute to the following outcomes for Service Users and also those sought through the Department of Health Adult Social Care Outcomes Framework

(ASCOF) and which CQC will be inspecting and registering Providers against:

3.3 Improved Health and Wellbeing

3.3.1 The Service User maintains good physical and mental health for as long as possible, feels satisfied arrangements are in place to access treatment and are supported in managing their long term conditions through promotion of self-care, self-determination etc. Service Users will maintain well-being and feel in control of their lives. They will:

- Feel the service has assisted them to regain confidence
- Receive services that reflect their changing circumstances and where possible are encouraged to undertake physical activities appropriate to their health, circumstances and abilities
- Maintain good health by being supported to receive medication as prescribed
- Feel confident that Care Workers are aware of their special dietary and nutritional needs
- Have physical, mental and emotional needs identified (including sadness and depression) and supportive measures put in place i.e. befriending
- Be supported to monitor and maintain both nutritional and fluid intake to promote well-being.

3.4 Enhancing Quality of Life

3.4.1 The Service User is centrally involved in the decision making process concerning the level of support they receive and is encouraged to carry out errands e.g. shopping and access leisure and social activities to maximise independent and mental well-being. They feel part of the community, are informed about and participate in local activities and initiatives. The Service User will:

- Maintain maximum independence in their own home and local community and be involved in day to day decisions about the care or level of support offered and taking greater control of their life
- Be enabled to perform useful and meaningful activities and lead a fulfilling life, with whatever assistance is required and is supported to access local social, cultural and leisure activities
- Have the opportunity and feel supported to follow their cultural and/or spiritual beliefs
- Have their sexual orientation respected
- Be satisfied with the support they receive to access training and employment (where this is an appropriate outcome for the Service User)
- Be supported to maintain social/community and family networks

- Receive ongoing information relating to the local community and be satisfied with the arrangements made to assist them in making or retaining contacts with the wider community and encouragement to participate in activities
- Be supported to maintain health and hygiene within their personal environment
- Experience support in accessing dentists, opticians, chiropodists and other healthcare services
- Develop life skills; be supported to reduce debts and manage money better
- Be encouraged to be involved in local decision making
- Be supported to continue to develop their decision making capacity in relation to their own care and support needs

3.5 Promoting Independence – delaying and reducing the need for care and support

3.5.1 The Service User will be supported to maintain their independence and manage as much as they can themselves, through self-care advice and techniques. Service Users will be supported to self-manage by utilising a strengths based approach. Where care and support arrangements have to be put in place, the least restrictive option is always the first considered and promoted. Avoidable admissions to hospital will be prevented as much as possible with Service Users being supported to access the right care at the right time through the Provider's liaison with health and social care partners. The Service User will:

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

3.5.2 The Council will:

- Measure reducing numbers of care packages through improved levels of self-care
- See and measure reducing intensity of care packages, including delaying increases in care package hours for those able to self-care, or utilise equipment and assistive technologies

3.6 Ensuring a Positive Experience of Care and Support

3.6.1 The Service User will speak highly about the service received and can explain its benefits. Families, Carers and Advocates will be aware of the support delivered and any improvement in outcomes for the Service User. Families and Carers will feel involved and informed about their loved ones needs and the support delivered. The Service User will:

- Be supported to develop communication skills and have a strong voice in the support received
- Be enabled to control the service they receive, with minor changes enabled to meet day to day changing needs
- Experience a flexible service delivery model and be central to communications in this regard
- Experience consistency in the scheduling of service and times the Service User expects or requires
- Experience continuity of care, supported by a 'trusted team' of Care Workers, who they trust and respect, with early introductions made to reduce the fear of new people
- Take different opportunities and use a variety of methods to feedback to the Provider regarding care received and have confidence that appropriate policies and procedures are in place
- Be better informed regarding their care choices and better able to access information on Providers of care in their local area
- Experience consistency in the quality of provision
- Be assisted in writing/designing their care and support plan
- Have their individuality promoted and celebrated
- Be supported with any specific issues relating to equality and diversity

3.7 Personal Dignity

3.7.1 The Service User and their family do not experience anxieties about the services received and is satisfied that the Service User's personal dignity is maintained at all times. The Service User:

- Feels that their dignity, privacy and respect is maintained at all times
- Feels confident that the service assists in improving identified aspects of their day to day lives

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

3.8 Exercising Choice and Control

3.8.1 The Service User is informed and enabled to influence the way in which care is provided in a flexible and appropriate way, with services responsive to needs and preferences of the Service User. They will:

- Feel confident that Care Workers support their choices regarding all aspects of daily living
- Feel confident that the Care Worker will arrive and leave within timescales that enable the completion of the required care and support and will inform the Service User if there is any change in time
- Feel listened to when complaining about or complimenting the service, or when suggesting improvements, including minor changes to accommodate day-to-day changing needs
- Take greater control of their lives and contribute positively to the care and support planning process having had issues of risk explained and having explained information regarding the alternatives available to them and their implications.

4. Service Provision

4.1 It is intended that the contract for services will operate like a framework agreement where the Council will call-off against the framework based on its requirements using an on-line Dynamic Purchasing System.

4.2 Following an Assessment and calculation of the indicative personal budget, the Service User will be supported by the Council's Adult Social Care Team to develop a Care and Support plan, which sets out what they wish to achieve and how this service will be delivered.

4.3 Providers will not be expected to visit and assess the Service User until advised by the Council.

4.4 Where a Service User opts for a Direct Payment they may contact the provider of their choice directly. This will be a private arrangement outside the terms of this contract.

4.5 Similarly for people who are financially assessed as being self-funding and wish to arrange their services independently, they may contact the provider of their choice directly. This will be a private arrangement outside the terms of this contract.

5. Description of Service

5.1 Home Care is the provision of person centred, personal care, enabling care and/or other services that are necessary to maintain a Service User's quality of life, enabling them to remain living in their own home and achieve their specified outcomes. Home Care is not about doing things for people in a way that increases dependency, but about supporting people to do things for themselves as far as they are able.

5.2 The Service will achieve a primary objective of enabling people in the Milton Keynes community to remain living at home for as long as possible and maintaining a good quality of life which meets the Service User's identified outcomes.

5.3 Home Care services will be available 365 (366 in leap years) days a year between the core hours of 6.30am and 10.30pm. Providers are required to offer flexibility of timing outside of these core hours to reflect a person centred approach to the provision of services. For example, where Service Users who do not require regular night time visits (not part of this specification) but needs support to go to bed later than 10.30 on a regular basis, the Council will work with the Provider to ensure continuity of care and that the needs of the Service User are met.

5.4 The Service Providers will have systems in place to respond to referrals for support packages to commence at weekends, with staff available to carry out risk assessments etc., to ensure prompt service provision.

5.5 The Service will be initially delivered in units of 20 minutes, with increments of 5 minutes of support. Flexibility around the units of time provided will be considered on the basis of evidence that varying these timings will enable individual and community outcomes to be better met. As in the UNISON's Ethical Care Charter, 15 minute calls will only be acceptable as part of a larger care package or if requested by the Service User and agreed by the Council. The 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 and will move towards commissioning based on outcomes over the lifetime of the contract.

5.6 The Provider will give the Council a minimum of 14 days' notice, if, in exceptional circumstances, they are unable to continue to deliver a

package of home care support. However, the notice period would be subject to agreement with the Commissioner's Nominated Officer in order to provide sufficient time to find alternative service provision.

5.7 The Service will be delivered in the Service Users' own homes, or the home of a relative, or in any other mutually agreed community setting.

5.8 The Service 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.

5.9 Providers will be required to develop excellent working relationships with Adult Social Care Teams across Milton Keynes to ensure the provision of seamless good quality services.

5.10 As part of the initial visit/risk assessment, the Provider will agree with the Service User as to how and when the services are to be provided, in order to deliver the Care and Support Plan and outcomes. It is, however, accepted that some people who are severely incapacitated may not be capable of fully communicating their wishes. In such cases the Adult Social Care Team, in conjunction with any informal carer or advocate involved, will support the interpreting of choices and wishes.

5.11 The Service must ensure that Service Users are able to achieve and maintain their maximum levels of independence and self-care. As such the Provider will evidence a culture of enabling care to ensure that Care Workers do not foster Service User dependency.

5.12 With effect from the commencement of the Contract, Providers are required to fully operate all services from a CQC registered office within the Borough of Milton Keynes or within a 15 miles radius of the main Council Office in Central Milton Keynes or a 30 minute drive during peak travel times, which is appropriately situated to deliver services to residents of Milton Keynes of a high quality and efficient manner.

5.13 Milton Keynes Council is committed to improving the quality of services received by Service Users and as such will be applying strict quality and compliance controls. Providers that fail to maintain adherence to the quality and compliance requirements will be issued with a default notice and will receive no further referrals until remedial actions have been taken to the satisfaction of the Council. Milton Keynes Council also reserves the right to remove packages of care and transfer them to an alternative provider in the event of poor performance.

5.14 Providers are required to have sufficient staff resource and the necessary infrastructure to respond to service referrals in accordance with the terms of the contract.

5.15 **Personal Care** tasks must be undertaken with great sensitivity; 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. By way of example, these tasks may include:

- Dressing/undressing
- Assisting with transfers from or to bed/chair/toilet/commode/bath
- Assistance with feeding, including peg feeding
- Promotion of personal hygiene by encouraging regular washing and changing of clothes
- Washing hair
- Assisting with personal washing
- Assisting with bathing/showering
- Assisting with shaving
- Assisting with cleaning teeth
- Assisting with toileting
- Assisting with washing feet
- Assisting Service Users in preparation for trips or visits outside their own home
- Monitoring the skin for any signs of pressure ulcers and reporting any concerns
- Support with continence management
- Support with changing and emptying catheter bags/stoma bags
- Administration of medication in accordance with the Royal Pharmaceutical society of Great Britain Handling of Medicines in Social Care guidance for the administration of medicine and instructions of the medicine prescriber and the Milton Keynes Council and CCG Medication Protocol (http://www.milton-keynes.gov.uk/social-care-and-health/adult-social-care/medication-protocol).
- Bed-making, including cleaning up any incontinence
- Emptying and cleaning commodes
- Laundry where appropriate
- Dealing with household refuse/emptying waste bins
- Cooking and meal preparation
- Support with collecting prescriptions (where service is unavailable from the pharmacy)

This list is not exhaustive and is intended to be illustrative only.

5.16 **Double Handed Care**: some care packages require two Care Workers and this will be specified in the Support and Care Plan. It is essential that where two Care Workers are required to carry out the care that both Care Workers arrive at the Service User's home in time to work together. The first Care Worker to arrive should not begin to care for the Service User until the second arrives, unless some of the care and support plan relates to a need a single Care Worker can meet.

5.17 Utilisation of moving and handling equipment to better manage transfers and care delivery should always be considered.

5.18 **Enabling tasks** involve assisting Service Users by supporting and encouraging them to participate in housework and living skills, to restore lost confidence, regain lost skills, gain new skills and achieve and maintain maximum independence and self-reliance. The Provider will be required to liaise with enablement professionals within the care management teams to ensure that the Service User's skills and independence can continue to be maximised. Enabling tasks may include:

- Supporting and guiding the Service User to maintain a healthy balanced diet through provision of advice in relation to fluids and nutrition, menu planning and preparation of meals
- Supporting and guiding the Service User with household budgeting
- Supporting and guiding the Service User in carrying out household functions in so far as they enable the Service User's outcomes to be achieved, for example, in relation to maintaining a clean and comfortable house and/or garden
- Escorting Service Users to attend specific appointments, i.e. hospital, dentist, optician (subject to suitable insurance if a motor vehicle is used)
- Providing information about opportunities, and escorting, where appropriate, for involvement in local community activities, encouraging the continuation of interests and social activities and/or developing the opportunity for involvement in new activities
- Encouraging and assisting in development or maintenance of a healthy lifestyle including the continuation of any exercise prescribed
- Encouraging the use of aids provided, following professional training
- Enabling and encouraging the Service User in the self-administration of medication

5.19 **Escorting and Social Activities:** Supporting and facilitating access to social, vocational and recreational activities as stipulated in the Care and Support plan, including but not limited to:

- Supporting to attend day services and any appointments where required within the care and support plan including transport arrangements
- Supporting Service Users to handle their own money, including accompanying to the shops, where required within the Care and Support plan
- Assisting to access local community based services such as laundry, gardening, shopping, home decoration, household odd jobs etc.

- Helping to make their way to places and to assist in road safety and learning routes
- Social interaction including accessing any appropriate scheme and help to participate

6. Support Outside the Home

6.1 Support may be required outside the home environment which may be for socialisation or to provide support with practical tasks such as collecting shopping, paying bills, attending appointments with Health Workers etc. Details will be documented in the Care and Support plan and must be followed. The Provider must ensure:

- That any insurance policy covers staff performing duties related to the Service that are provided in the community outside the Service User's home
- Staff providing support outside the home must have the necessary skills and training required to respond to situations which may occur outside the home e.g. first aid skills
- Risk assessments must be in place as appropriate and followed
- Arrangements for transport must be clear and agreed before the Service commences, e.g. if using the staff member's car – insurance must be appropriate and fuel costs accounted for
- Arrangements for expenses must be clear e.g. clarity on who is responsible for paying for any admission fees, transport costs, meals etc.

7. Dementia

7.1 The Provider will take an asset, rather than deficits, approach to maintain the Service User's resilience, understand the Service User's cognitive abilities and difficulties, so that Care and Support Plan can build on strengths and promote independence and resilience.

7.2 The Provider will ensure that Care Workers are trained to identify and work with those Service Users living with Dementia. The Provider will also ensure that specialist advanced dementia training is provided to enable Care Workers to deliver services to those Service Users whose dementia is advancing but are still able to live independently with support.

7.3 Knowing a person's life story or biography is important, when working with Service Users, with dementia to help support problem solving, as a communication and engagement cue and to identify preferred coping strategies. As the dementia advances the Provider will need to work with the Adult Social Cate Team to amend the care packages in terms of what support and time is needed.

7.4 Building relationships with Service Users is a key part of the work with those living with dementia therefore the Provider will ensure consistency of care workers, using a minimum of care workers to help foster trust between the Service User and Care Worker.

7.5 The Provider will have a good understanding of balancing rights and risks and how this links with delivering outcomes, including application of the Mental Capacity Act (2005).

7.6 The Provider will work in partnership with carers to support the Service User with dementia and the carer. Maintaining a carer's resilience and ability to carry on caring, where this is their wish, is crucial in taking a preventative approach and maintaining someone at home.

7.7 The Service will be flexible to accommodate the needs and abilities of Service User's with dementia which can change from day to day. It is important to be able to adjust service provision quickly and effectively.

7.8 The Provider will be able to deliver services at very short notice to provide additional support in a crisis, including out of hours. Night time and weekend cover will also be available.

7.9 If the Service User circumstances change between reviews, the Provider must inform the Adult Social Care Team as soon as possible.

8. Challenging Behaviour

8.1 In a situation where a Service User/Carer presents behaviour which may be challenging to a member of staff, a variation to the service may be deemed appropriate and a review may be necessary after consultation with the Adult Social Care Team.

8.2 The Provider shall have policies and procedures and training to support Care Workers in managing challenging behaviour.

9. End of Life

9.1 The Council continues to work in partnership with statutory and non-statutory organisations to take forward the implementation of the Ambitions for Palliative and End of Life Care: A national Framework for local action (2015-2020) this document is built into the Milton Keynes End of Life Care Strategy (2015-2020).

9.2 Providers must ensure that appropriate training is provided to enable staff to work with health and social care professionals in order to provide care to Service Users at the end of their lives and to provide emotional and practical support for informal carers.

9.3 Providers must ensure that Care Workers who are working with individuals who are dying understand the principles of high quality palliative care and have received training in the Care Workers role and responsibilities in user of current good practice during the last days of life. Staff must be able to recognise the dying phase.

9.4 Providers must work in partnership with health and social care professionals to ensure that the Service Users care package is designed around the individual needs of the Service User and their informal carers of all ages. This may include contributing to the discharge process, development of care plans, ensuring that the care arrangements are flexible enough to be responsive to changes in need and working with Services Users and informal carers to accommodate their involvement in care tasks if this is their wish.

9.5 All staff involved with the care of individuals who are dying must be clear about their roles and responsibilities in terms of the expressed wishes of the Service User in advanced care planning and the use of Do Not Attempt Cardio Pulmonary Resuscitation (DNAPR) principles and the law.

9.6 Providers will be responsible for ensuring that Care Workers who are working with Service Users at the end of life are provided with appropriate levels of supervision and support in recognition of the emotional strain associated with this type of service.

10. Service Delivery

10.1 The Provider will make the necessary policy and procedure documents available for checking at the Annual Quality Assurance Review carried out by the Council's Quality & Compliance Quality Team (or supply to the Council upon request). Please refer to Appendix A.

10.2 The office will be staffed fully with both management and administrative staff during usual office hours of 9am to 5pm, Monday to Friday and a duty officer will be available at all other times and in such circumstances an officer competent and authorised to make decisions will always be available, either located at the office or fully accessible.

10.3 The office and its staff will be accessible to Service Users via a range of media such as email, telephone and text phone.

10.4 The Service Provider will make available an emergency 'out of hours' telephone service which will be staffed between 6.30am and 10.30pm outside of normal office hours. This will be a dedicated telephone line for Service Users. The Provider must be able to offer a swift response in urgent cases, and will be adequately staffed to provide support with little or no notice.

10.5 Staff providing emergency support out of hours must have access to Service User information and records to ensure appropriate service provision and information sharing.

10.6 The Provider shall ensure that the Care Worker delivers the full allocated time on direct Service User contact. All staff time, other than direct Service User contact as specified within the Care and Support Plan will be met by the Provider. When scheduling Care Workers' rotas the Provider must allow for a period of travel between each Service User that is both reasonable and appropriate to allow the care worker to travel safely to the next call. The Provider is responsible for the payment of travelling time.

10.7 The Provider shall ensure that Care Workers are provided with appropriate items of Personal Protective Equipment (PPE) to promote good infection control standards and to comply with health and safety requirements of the tasks they will be expected to perform under this Contract. This may include but is not limited to the disposable gloves and aprons. In addition, any representative of the Provider who visits the Service User's home shall wear a form of photographic identification that shows their name and the name of their organisation.

11. Referral Pathway

11.1 Referrals to the Provider will be made via the Council's Dynamic Purchasing System (DPS) for Domiciliary Home Care Services using the web-based procurement tool - SPRoc.Net. Information detailed in the Support Plan which is of direct relevance to the service provision will be made available to the Service Provider. The timescale between the initial contact and the care package starting will not exceed one week, unless previously agreed otherwise.

11.2 If the Service User's support packages increase, decrease or stop and then restart again there will be no need to re-allocate, nor if they transfer to a personal budget, cash option (Direct Payment).

11.3 The Council will only accept financial responsibility for a Service User after a full social care assessment concludes that the Service User has home care needs, is financially assessed as eligible to receive financial support from the Council, and the Provider is able to meet the Service User's needs.

11.4 Details of all care to be provided will have been agreed and confirmed in writing by the Council before the start of the service.

11.5 The Provider must ensure that its Care Workers are given sufficient, appropriate and adequate information regarding the Service User's individual needs and of the way the service is to be delivered, before it commences the service provision and that staff are fully trained in the

uses of assistive technology (Telecare/Telehealth) and can identify when it might be helpful.

11.6 The Provider must ensure Care Workers do not work in a Service User's home when the Service User is absent, unless, in exceptional circumstances, the Service User and the Council have provided written authorisation first.

11.7 The Provider must ensure Care Workers are aware that smoking, the consumption of alcohol or drugs, or suffering the effects of these are not allowed whilst working in the home of a Service User. The Provider must ensure this is adhered to all times.

11.8 The Provider must ensure that Care Workers are aware that they must not accept cigarettes, alcohol or drugs or any gifts/money from Service Users or offer or sell them to Service Users or their carer, family or friends. This would be considered as gross misconduct and could result in immediate dismissal of any Care Worker found to be in default. The Provider must immediately remove any Care Worker found to be in default from working on this contract and promptly follow appropriate HR processes, keeping the Council informed of the outcome and any significant events.

11.9 No Service User must be left without a due visit for any reason. The Service User must be notified by the Provider if there is to be an adjustment in the anticipated time of arrival. In all cases, the Provider must make alternative acceptable arrangements for the Service User, with their agreement.

11.10 All visits, times and service provision undertaken will be recorded in the Service User's daily record.

11.11 The Provider will be flexible and responsive to the needs of Service Users and should respect their wishes at all times.

11.12 The Provider will acknowledge the role played by informal carers (families, friends, and other people who help and support Service Users who use the Services) and shall work with them to provide flexible services that are responsive to the specific needs of Service Users.

11.13 The Provider will take account of the wishes of the Service Users and their carers in respect of gender, sexual, racial, religious and cultural background etc. and of any special requirements or communication skills required.

11.14 The Service User is entitled to refuse entry into their home to Care Workers. If entry is refused or a Care Worker rejected, the Provider is required to investigate the reason and, where possible, resolve the

issue. If not resolved, the Adult Social Care Team must be informed of the situation as soon as possible but no later than one day.

11.15 The Provider must notify the Adult Social Care Team immediately (or the next working day if this is not possible) in the following circumstances:

- Safeguarding concerns arise in respect of the Service User
- Regular and/or persistent refusal by the Service User to accept support to meet outcomes, mutually agreed in the care and support plan
- Failure to provide the service to the Service User, missed, late, void or 'no response' calls
- Deterioration in the Service User's health or well-being
- Improvement in the Service User's circumstances and/or their support needs have decreased
- Serious accidents or incidents involving the Service User or the Care Worker
- Hospital admissions and/or death of the Service User
- Other changes in the service resulting from a change in circumstances or emergency
- Mental capacity issues – improvement or deterioration of the Service User's mental capacity in relation to specific decisions of the care and support plan
- Mental capacity issues – improvement or deterioration of the Service User's mental capacity in relation to specific decisions of the support plan.

11.16 A communications book must be provided in each Service User's home, to keep an ongoing record of the care provided and any refusals of agreed support, any financial transactions and regular feedback from the Service User on the service. Providers must ensure that Care Workers have adequate English language and literacy skills to undertake this duty and record clear, legible, concise and relevant records.

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

11.18 Late calls are defined as a call 45 minutes or more from the time stated on the Care and Support Plan.

11.19 A missed call is defined as a call not made, or one that is more than two hours after the time stated on the Care and Support Plan.

11.20 The Provider must also notify the Adult Social Care Team if little or no progress is being made towards achieving the Service User's outcomes as specified in the Care and Support Plan.

11.21 Service Users and their carers must be enabled to comment on the service they receive at any time and take full part in any decisions made about them.

12. Transfers from Hospital

12.1 Services may be required on hospital discharge. Notice varies considerably depending on need. Given the provisions of the Care Act 2014, we are expected to facilitate discharge on receipt of a Discharge Notice. The minimum notice period is one day.

12.2 When an existing Service User is admitted to hospital the Provider must keep the case open for at least two weeks unless it is clear that the Service User will not be discharged within this period.

12.3 Before closing that case and permanently reassigning Care Workers the Provider must make every effort to contact the hospital and confirm that the Service User is unlikely to be fit for discharge in the near future.

12.4 When a Service User is fit to return home within this two week period the hospital discharge team may seek the Service User's agreement to contact the Provider directly to restart the care package.

12.3 The Provider must clarify the care needs of the Service User with the hospital discharge team and may make reasonable adjustments to the care package as required.

12.4 If the Service User's needs have changed substantially, or they have been in hospital for longer than two weeks, the hospital discharge team will need to arrange a new reassessment of needs prior to transfer home. It will then be the Adult Social Care Team's responsibility to arrange a new care package, in consultation with the Service User.

12.5 Some Service Users will be discharged from hospital to either the recuperation or intermediate services (neither of these are part of this contract). Onward referrals from these services will be accepted by the Provider.

13 Workforce

13.1 The Provider is expected to have a written recruitment and selection procedure which reflects equality and diversity policies. The recruitment and selection procedures must meet the CQC minimum

standards; ensuring records are maintained to demonstrate best practice in this area. Providers must comply with Disclosure and Barring Service (DBS) and Criminal Record Bureau (CRB) requirements for staff. These checks should be carried out every three years as a minimum.

13.2 All roles within the Provider's organisation must have written job descriptions and person specifications and an equal opportunities policy for the recruitment, development and care of the workforce (including volunteers) must be in place.

13.3 All staff should meet formally on a one to one basis with their line manager to discuss their work at least on a monthly basis and written records of these supervisions must be kept to demonstrate the range, content and outcome of the discussion at each meeting.

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

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

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

13.7 All staff must have an annual appraisal and this must include identification of training and development needs with their line manager. A copy of the appraisal will be placed on the personnel file for each member of staff.

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

13.9 A record must be kept of any disciplinary incidents and details entered in the personal file of the Care Worker concerned, referrals to the Independent Safeguarding Authority must be made, if appropriate, and recorded on the Care Worker's file. The Council's Quality & Compliance Team must be kept informed of all safeguarding issues and staff disciplinary incidents.

13.10 The Provider must have a written policy for the management of violence towards staff and ensure that suitable training is provided to

reduce the risk of violence towards staff. Adherence to the Health and Safety at Work Act 1974 will ensure staff safety.

14 Workforce Development

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

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

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

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

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

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

- All staff are competent and trained to undertake the activities for which they are employed and responsible
- Care Workers receive specific advice and training about human rights in relation to Home Care services
- All staff have training on the prevention of abuse within three months of employment and this must be updated annually
- All staff members hold a relevant national occupational standard such as Level 2 Diploma in Health and Social Care. Those who do not already hold a relevant standard should be supported to achieve the above qualification as a minimum
- Young staff should be undertaking an approved training programme – it is advised that the Health and Social Care Apprenticeship framework is used.
- Specialist advice, training and information is provided to support workers working with specific individual groups and/or medical conditions to ensure they are professionally qualified to do so
- Staff have training in the requirements of MCA (Mental Capacity Act 2005) DOLS (Deprivation of Liberty Safeguards)
- All staff are aware of their Safeguarding responsibilities both for children and adults.
- All staff are aware of and familiar with the Provider's policies and procedures

15 Training

15.1 The Provider will ensure that all staff are appropriately trained to meet the requirements of current legislation and all care workers must undergo an induction programme which meets the outcomes of the Skill for Care; Care Certificate.

15.2 The Provider shall maintain accurate and up to date training records for each member of staff which will be made available to the Council's Quality & Compliance Team upon request. The records will include evidence that at least the following topics have been covered by the workforce during the first twelve weeks of employment:

- Induction training
- The basic principles and values of care in the home particularly Service User's independence and dignity
- Health and Safety including fire safety
- Basic first aid
- Medication administration
- Moving and handling
- Use of equipment
- Infection prevention and control
- Food hygiene
- Environmental risks for older people and people with disabilities
- Infection control procedures

- Recognising health needs and seeking help through the Primary Health Care Team
- The process of ageing
- Understanding dementia
- Communication skills appropriate to Service User need
- Basic record keeping and the maintenance of home-based care records
- Common disabilities and diseases
- Awareness and understanding of the risks of abuse of vulnerable adults
- The Provider's Adult Protection Policy
- Awareness and understanding of sensory impairment
- Anti-discriminatory care practice including Culturally Competent Care
- The care of Service Users who are confused or mentally ill
- Dealing with challenging behaviour
- Promoting and maintaining continence
- The care of Service Users who are terminally ill, including people with symptomatic HIV
- Working in partnership with District Nurses, other carers and agencies

15.3 The Provider will establish individual learning and development plans and an overall workforce plan which reflects the needs of their Service User groups and is reviewed annually. Additional training needs or refresher courses should be identified based upon these plans for each member of staff on at least an annual basis.

15.4 The Provider will work towards the continued professional development of all staff and is expected to assist Care Workers to undertake a Qualification and Credit Framework (QCF) Diploma Level 2 in Health and Social Care within their first year of employment (or as soon as the Care Worker's residential status enables funding to be sought) unless the individual has already completed an equivalent qualification.

15.5 Training requirements may also include any Service User specific training that is relevant to the assessed need of the Service User and within the boundaries of a care worker's competencies. All instances of training shall be recorded by the Provider and made available on request to the Council.

16 **Risk Management**

16.1 The Provider must ensure that Service Users are supported to manage their own risk where possible and kept safe within a framework of recorded risk assessment compiled with the Service User and/or their representative.

16.2 The Provider must have a policy and procedure for the management of risk; these are evidenced in systems and practices.

16.3 The Provider must record and implement practical control measures to minimise risk.

16.4 The risk assessment must be reviewed at least annually or earlier if required to ensure that the Service Users changing needs are adequately addressed.

16.5 Risk assessors must be competent and receive specific training e.g. risk assessment, safeguarding, mental capacity assessment, other relevant training.

16.6 Where changes in risk are identified, these must be communicated to the Service User and/or their representative and the Adult Social Care Team. The solution agreed must be the least invasive and offer the Service User maximum independence and control.

16.7 Service Users must be offered the opportunity to accept and assume a certain degree of risk and this procedure must be clearly recorded and, where necessary, agreed appropriately by the Adult Social Work Team.

16.8 The risk assessment and acceptable risk and/or actions to mitigate risk agreed with the Service User and/or representative must be recorded, and a copy left in the Service User's home. A copy should also be sent to the Adult Social Care Team.

16.9 The Provider should undertake an evaluation of any general risks to the health and safety of the Service User and their staff, and ensure that Care Workers are aware of risk and ways to minimise them.

16.10 Where Service Users are unable to take responsibility for the management of their own finances, the Provider must ensure this is recorded on the risk assessment and action taken to minimise any risks.

16.11 For Service Users who have been assessed as lacking capacity, best interest decisions will be made in line with the Council policies and procedures.

16.12 The Provider must notify the Adult Social Care Team as soon as it is practical to do so, and within 24 hours, if any of the following occur:

- Any circumstances where the Service User has consistently refused provision of the service or medical attention
- Any emergency situation e.g. fire, flood affecting the service
- Legacy or bequest to the Provider and/or staff
- An investigation related to Safeguarding of Vulnerable Adults

17. Moving and Handling

17.1 The Provider will undertake the two types of risk assessment required for moving and handling.

- Generic assessments to consider the overall needs of the setting, looking at the type and frequency of moving and handling tasks
    - Overall equipment needs
    - Staffing
    - The environment
- Individual assessments which consider the specific moving and handling needs of Service Users and form part of the care planning process.

17.2 The most common causes of injury and ill health to carers arise from moving and handling, and dealing with behaviour that challenges. Any significant risks to both the care worker and Service User must be adequately assessed

17.3 So far as is reasonably practicable, safe working procedures and appropriate equipment should be provided and Care Workers should be suitably competent/appropriately trained to carry out the tasks safely.

18. Service Users

18.1 The Provider must ensure it obtains a copy of the Care and Support Plan to proceed with its own assessment. Where possible, the Care Worker identified should attend any initial assessment or meeting with the Service User to assist in beginning to develop a good relationship.

18.2 Providers will need to be familiar with the roles and expected functions being undertaken by any other agencies contributing to the care of the Service User, where this has relevance to the service to be provided.

18.3 Clear information that is in line with National Minimum Standards, including the Provider's name, address and telephone number (in and out of hours), and the name(s) of the Care Worker(s), must be provided to the Service User by the Provider from the outset and also outline the agreed services to be delivered and how that can be changed. Where this is not possible, due to urgent support required with little or no notice, information packs must be provided within a maximum of 48 hours of the service commencing.

18.4 All information must be made available to the Service User in a way that is accessible to them and in the manner of their choosing. Service

Users will be informed of their right to make a complaint directly to the Council or to CQC or such other regulatory body as may be appointed by the Government and contact information for such organisation(s) will be provided in the Service User's home. If the Service User is unable to understand the Complaints Procedure their carer, next of kin or representative (where applicable) will be advised of it.

18.5 The information pack supplied by the Provider will include but not be limited to:

- A copy of the current Care and Support Plan, and a section for record keeping allowing other agencies access to any relevant information to support the Service User. The section for record keeping will include a communication record where information regarding visits, observations and any financial transactions must be documented
- Medication records and procedure for administering
- Moving and handling risk assessment (if applicable)
- A generic Health and Safety at Work risk assessment
- An explanation of the complaints procedure and the process through which complaints can be escalated to the Council
- Information on how to access support or help outside usual working hours
- Comments/Complaints/Compliments Procedure

18.6 The Service Provider must ensure it is able to adequately and properly provide care based on the assessment and the identified outcomes in accordance with the Care and Support Plan. There should be no substantial changes on a daily basis. Care Workers must provide the amount of time for each visit as required, with any changes and reasons why recorded and reported.

18.7 The Provider must give each Service User an up-to-date plan of their care which recognises the abilities of the Service User and encourages them to share in and supervise their care provision. The plan should be fully developed and discussed with them and reviewed at least annually or when necessary.

18.8 In an emergency where the Service Provider is unable to deliver the service, the Provider or their representative must contact the Service User and the Council by some means at least 24 hours before the specified due time.

18.9 The Service Provider must consult and involve the Service User before any change to the Care Worker and any and all issues relating to care. Where any significant change in a particular Service User's circumstances necessitates a variation in the services for the Service User, the Service Provider will contact the Adult Social Care Team.

18.10 A formal review of the Service User's Care and Support Plan will be conducted by the Adult Social Care Team. The first review will be held within 28 days following the commencement of the service for the particular Service User. Thereafter, a review of the Service User's Care and Support plan will be held as often as the Adult Social Care Team, the Provider and the Service User feels is necessary, but at least annually.

18.11 The review will involve as a minimum the Service User, and the Adult Social Care Team. The Provider will only be present if the Service User wishes them to be but they must contribute to, and provide information for, the review. Any other individuals who are able to actively contribute and whose input the Service User has requested may also be present.

18.12 The review will address the extent, to which the initial outcomes are being met, determine whether or not eligibility criteria continues to be met and whether the Service User still requires the service or if the level of service needs to change.

18.13 A review may also be convened by the Adult Social Care Team, at the request of the Service User or named contact.

18.14 The Provider shall retain all records, written and electronic, which are concerned with any aspect of this Contract for a period of six years after the financial year (April – March) in which they were created. The Provider shall, when the end of the retention period for the documents has been reached, undertake to dispose of them by a secure method, either using an appropriately assessed provider of secure data destruction services or by its own in-house services. This requirement shall apply to both written and electronic records.

19. Safeguarding

19.1 Safeguarding is protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted.

19.2 In order to ensure that the service user is free from abuse and appropriate action is taken where it is suspected, the Provider will:

- Ensure a safeguarding alert is completed to notify the local authority if adult abuse is witnessed or reported
- Respond to alerts
- Attend Safeguarding meetings
- Make representation in court as and when necessary

- Ensure there is a Safeguarding Adults policy available that complies with the Milton Keynes Safeguarding Adults Multi Agency Policy and Procedures (http://www.milton-keynes.gov.uk/social-care-and-health/adult-social-care/safeguarding-adults-policies-and-procedures) and Milton Keynes Safeguarding Adults Multi Agency Practice Guide (July 2016)
- Ensure staff are familiar with Milton Keynes Multi Agency Safeguarding Policy and Procedures and Practice Guide and with the Providers' own policy and procedures on Safeguarding adults.
- Work in partnership with officers of the local authority, to make enquiries in fulfilling its duties under section 42 of The Care Act 2014; adult protection assessments and enquiries and comply with any recommendations where practicable in action plans
- Ensure staff training is provided in safeguarding and is refreshed annually
- Ensure staff attend relevant safeguarding adult training appropriate to their position
- Take positive action to combat discrimination. Individual's needs arising from specific ethnic, religious, cultural, gender, sexuality, disability or age requirements must be identified in their care and support plans. The Provider must ensure that staff are able to meet these needs.

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

- Use credit or debit cards belonging to the Service User, or have knowledge of the Service User's PIN number
- Accept gifts or cash
- Use loyalty cards except those belonging to the person
- Undertake personal activities during time allocated to provide care and support to the Service User
- Make personal use of the Service User's property (e.g. telephone)
- Involve the Service user in gambling syndicates (e.g. national lottery)
- Borrow from or lend money to the Service User
- Sell or dispose of goods belonging to the Service User and their family
- Sell goods or services to the Service User and/or buy goods or services from the Service User
- Incur a liability for looking after any valuables on behalf of the Service User
- Allow any unauthorised Service User (including children) or pets to accompany them when visiting the Service User without their permission and the Case Manager's approval
- Make or receive telephone calls that are personal or are regarding other individuals. The time allocated to the Service User must be used to care and support the Service User. The Provider must have policies and procedures in place for staff concerning the

investigation of allegations of financial irregularities and the involvement of Police, Social Care, Health and Wellbeing and other professional bodies.

19.4 The Provider shall encourage and enable staff to raise bona fide concern about the care and service provided to Service Users without fear of disciplinary action or reprisal, in line with the Provider's Whistle Blowing Policy.

19.5 The Provider is responsible for ensuring that the provision of care is Satisfactory and any concerns relating to poor practice by staff are addressed. Where concerns are not addressed the Provider must report these concerns to the relevant registration authority and the Council to determine an appropriate course of action.

20 Electronic Monitoring and Electronic Rostering

20.1 All successful Providers will be required to operate their own electronic rostering and monitoring systems for the provision of care to all Health and Social Care Service Users. Providers will be responsible for all costs associated with the procurement, implementation and operation of these systems.

20.2 All visits must be recorded electronically and in real time. The system must be able to generate alerts and should be monitored throughout the service delivery, in real time, to ensure any issues are highlighted early for immediate attention.

20.3 The system shall comply with the requirements of the Data Protection Act 1998 and other laws governing the use and storage of electronic information. It must also provide an audit trail for time sheet entries, when the entries were created and who created them.

20.4 The Council's system is being updated to accommodate electronic monitoring and so the Provider muse ensure that their system is flexible and easily upgraded or modified to cope with future demands.

20.5 The level of integration required with each Provider will be proportionate to the volume of work undertaken on behalf of the Commissioners. This will be evaluated on a case by case basis to ensure this solution is cost effective.

20.6 Where a Service User refuses the use of their telephone for electronic verification of attendance, the Provider will report the problem to the Council's Adult Social Care Team which will endeavour to resolve the issue with the Service User. Should the problem persist the Provider will consider alternative methods of recording visits.

21 The Requirements of the Regulator

21.1 It is a requirement that all Providers will be registered with the Care Quality Commission (or any successor). Providers must maintain registration throughout the duration of the contract as required by legislation. The regulations required for registration, their associated standards and the monitoring of the achievement of those regulations and standards are not, therefore, duplicated in this specification. It is expected that the regulations will be met through registration activity. The Provider will be registered to deliver 'Personal Care' services with the national regulator, currently the Care Quality Commission (CQC). It is the Provider's responsibility to maintain up-to-date knowledge of the current regulators codes and to keep to the correct registration.

21.2 Providers will inform the Council when a regulatory inspection has taken place and will share the result of the inspection, positive or negative. The Provider will notify the Council of any Regulator Warning Notices placed on the Service/Provider regarding the Provider and/or its associated activities. The Provider will also inform Council of any advice/comments received from the regulator. The regulator can place fines or formal warnings on a Provider to suspend or cancel agency's registration. The Council will be informed of any such activity and a failure to do so will mean that Milton Keynes Council will seek to recoup costs and damages incurred from the Provider and may terminate the contract without notice.

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

22 Quality Assurance & Performance

22.1 The main objectives of the quality monitoring and performance management process are:

- Supporting Providers to develop and provide flexible personalised services that focus on the achievement of Service User outcomes.
- Developing the use of objective data from monitoring visits, Service User reviews, and any Notifications of Concern to ensure the things Service Users regard as important, for example, continuity of care worker and reliability of arrival times are being delivered.
- Developing providers through shared training and support events and through the monitoring process to ensure the Essential Standards of Quality and Safety are being maintained, making clear the distinctive roles and responsibilities of the Provider, the Adult Social Care Team and the Quality & Compliance Team in relation to monitoring, reviewing and developing services.

- Identifying and addressing poor performance positively and fairly, but robustly, and where appropriate terminating the Contract in whole or part or suspending Providers from taking on new work whilst they focus on addressing any performance issues identified

22.2 The approach:

- Services will be monitored in the spirit of partnership to ensure best practice is spread across the sector and the continuous improvement of services is supported
- Where information requests are made which overlap with data requested annually by CQC or Skills for Care, then the request will be formatted in a consistent way to avoid unnecessary duplication
- Performance and quality measures may be amended or further developed over the course of the contract in light of experience
- The Provider must have a robust quality assurance system in place to audit and monitor its own performance, taking into account a range of feedback including, reviews, compliments or complaints, Service User and other stakeholder feedback. The Provider must be able to demonstrate that it strives to continually improve performance and service quality.

22.3 Quality monitoring and performance management aims:

- To ensure Service Users receive services that meet the requirements of the Service Specification.
- To support Providers in the monitoring, review and development of their services.
- Where the quality of service does not meet the requirements of the Service Specification, the Quality & Compliance Team will seek to address this positively, fairly and robustly with Providers
- To contribute to the Council's reporting requirements and market intelligence.

22.4 Roles and responsibilities.

- The Adult Social Care Team: monitoring the achievement of Service User outcomes and leading on safeguarding vulnerable adult's investigations.
- Quality and Compliance Team: monitoring the quality and performance of the provider against their contractual obligations.
- Providers: quality monitoring/assurance and service development of their service to ensure compliance with the Service Specification.
- Care Quality Commission: inspection and regulation ensuring compliance with national standards and regulations.

22.5 Quality & Performance Monitoring.

- During the lifetime of this contract Providers will be expected to meet with the Quality & Compliance Team on a six-monthly basis basis.
- The meetings will allow for both the Quality & Compliance Team and Providers to highlight good practice and any issues concerning the service.
- The Quality & Compliance Team will also undertake an annual visit to the Provider's premises. Visits may be more frequent if there are concerns with the service.
- Assessments carried out by the Quality & Compliance Team will include (but not be limited to) the following:

  - Consulting with Service Users and/or their representatives
  - Reviewing written procedures and records for both Service Users and staff
  - Obtaining feedback from the Adult Social Care Team on whether or not the service is meeting the Service User's assessed needs and delivering outcomes in the best possible way.

APPENDIX A

Policy and Procedures

- Record keeping and access to files
- Holding Service User keys
- Records of the management of money or property belonging to the Service User
- Dealing with accidents/incidents
- Handling difficult/violent behaviour
- Procedures in the event of an emergency
- Disciplinary procedure (staff)
- Induction and training programmes
- Health and Safety
- Risk Management
- Personal relationships
- Moving and handling
- Action in the event of the death of a Service User
- Equality and Diversity (relating to both Service User and staff)
- Use of staff vehicles for transporting Service Users
- Whistle blowing
- Infection control
- Fire safety
- Food safety
- Nutrition
- Principles of Care/Code of Conduct/Professional Boundaries
- Conflict of interest
- Personal safety and Out of Hours working
- Protocols and procedures for entering and leaving Service User's homes
- Confidentiality of information/Data Protection/Use of social networking sites
- Adult Safeguarding and the Prevention of Abuse
- Children Safeguarding and the Prevention of Abuse
- Business Continuity Management
- Lone worker policy
- End of life care
- Staff Recruitment, supervision and appraisal
- Medication/Administration of medication

This is not an exhaustive list and is a sample of the procedures that will be required to operate the Service.