Rhondda Cynon Taf County Borough Council And Merthyr Tydfil County Borough Council

Service Specification for the Provision of an Independent Domiciliary Care Service

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PART A INTRODUCTION

1 Introduction

1.1 This Service Specification sets out the requirements of an outcome based Domiciliary Care Service that will support people who need community based social care services. The service will support people to be as independent, active and safe as possible whilst promoting and protecting their human rights.

1.2 The successful contract providers for Rhondda Cynon Taf County Borough Council & Merthyr Tydfil County Borough Council, hereafter referred to as the Contracting Authorities, will deliver their services in accordance with this service specification, relevant legislation and recognised and accredited practice, in particular the National Minimum Standards for Domiciliary Care Agencies (Wales) Regulations 2004, the Social Services & Wellbeing (Wales) Act 2014 and the Regulation and inspection of Social Care (Wales) Act 2016, regulations and codes of practice.

1.3 The Contracting Authorities may choose to change aspects of this Service Specification during the course of the contract, in response to revised legislative requirements or where changing National or local priorities or Policy necessitate this. However, the contract providers will be consulted on any proposed change to the requirements in this service specification which will include discussion regarding how those changes are implemented in practice

2 Outcome based Domiciliary Care Services in Rhondda Cynon Taf CBC & Merthyr Tydfil CBC

2.1 *'Outcomes' refer to the impacts or end results of services on a person's life. Outcome-focused services therefore aim to achieve the aspirations, goals and priorities identified by service users – in contrast to services whose content and/or forms of delivery are standardised or are determined solely by those who deliver them. Outcomes are by definition individualised, as they depend on the priorities and aspirations of individual people.*

SCIE 2006

2.2 The delivery of Domiciliary Care Services will contribute to the Wellbeing Outcomes that the Local Authority is required to meet under the Social Services & Wellbeing (Wales) Act 2014 of:-

- I know and understand what care, support and opportunities are available to me , I get the help I need, when I need it, in the way I want it
- My rights are respected, I have voice and control, I am involved in making decisions that affect my life ,my individual circumstances are considered, I can speak for myself or have someone who can do it for me, I get care through the medium of Welsh
- I am safe and protected from abuse and neglect
- I am healthy, I am happy
- I belong, I have safe and healthy relationships

These outcomes will be monitored via the wider Local Authority Outcome performance arrangements.

2.3 In addition it is expected that the delivery of Domiciliary Care services will support the local outcomes which are:-

- That people will be supported to become as independent as possible in their own homes and reliance on formal service delivery will be reduced;
- That people are supported to meet their identified wellbeing outcomes;
- That Vulnerable people are safe from harm;
- That people receive a quality service that supports the outcomes they wish to achieve, that is delivered consistently, by appropriately trained staff

2.4 The commissioned Domiciliary Care provider will be required to be registered to provide support to:

- people who have a physical disability or chronic illness;
- people with dementia (regardless of age) and older people who are experiencing mental health problems;
- people with a mental health problem and/or substance misuse problem;
- people who have a duel diagnosis, which may include:
  mental health; substance misuse; dementia or a learning disability
- people with sensory loss/impairment

2.5 As part of the requirements of the Social Services & Wellbeing (Wales) Act 2014, for the provision of information, advice and assistance, Providers will also be expected to provide relevant information to the Contracting Authorities on the services they provide through the Cwm Taf information directory 'DEWIS'.

2.6 **Approximate Tender & Implementation Timeframe**

	Activity	**Date**
1	Issue PQQ	January 2016
2	PQQ Return	February 2016
3	PQQ Evaluation	March 2016
4	Issue Tender	March 2016
5	Tender returns	April 2016
6	Final tender evaluation	May 2016
7	Contract Sealing	July 2016
8	Contract mobilisation	July – September 2016
9	Contract start date	1st October 2016

3. Milestones for implementation

The framework will be implemented on 1st October 2016, though it is anticipated that there will be phased expectations of the framework

- **Phase 1** Transfer Implementation arrangements

This phase will commence 3 months prior to the implementation of the framework. There is an expectation that the service provider will provide the Contracting Authorities with a detailed implementation plan, outlining and time scaling the necessary actions they will undertake to ensure the seamless transfer of service that will reduce any adverse impact on service users. This will include:

- Liaison with any outgoing provider
- TUPE transfer arrangements of staff
- Liaison with service users and their families / carers
- Liaison with care management staff where appropriate
- Preparatory scheduling arrangements

- **Phase 2**

  Adjustment period to the revised process (practical implementation) Year 1.

- **Phase 3**

  Increased accountability for results and enhanced flexibility in service delivery methods from Year 2, to a fully implemented outcomes based service delivery model, enabling service users to have full voice and control over the service they receive, become as independent as possible, and to fully achieve their assessed outcomes.

4 The model for Rhondda Cynon Taf and Merthyr Tydfil

4.1 The agreed model for Adult Social Care Services is that of Universal, Targeted short term intervention and specialist support. Strategically the community based Domiciliary Care Service sits in the specialist area of the model for Adult Social Care

4.2 The Contracting Authorities in partnership with the Cwm Taf University Health Board acknowledge the vital unpaid role carers play in looking after relatives who need help and support because they are ill, frail, elderly or have a disability. The care they provide can be physical, social or emotional and often involves a great deal of their own time and energy. We want to ensure Carers are valued and looked after as well. They need to have the right to assistance to enable them to balance their caring role and their life outside of caring. A new Cwm Taf Carers Strategy is being developed and as part of this contract, you will provide a vital role as a key partner in the delivery of this role. You

are advised to ensure that you are familiar with this strategy in order to meet the needs of Carers.

4.3 Assessment and Care management staff across Cwm Taf will work with people to identify the personal outcomes they wish to achieve and where the eligibility criteria are met (Care and Support (Eligibility) (Wales) regulations 2015) how the provision of domiciliary care services will support the meeting of the identified needs and outcomes.

4.4 The Contracting Authorities may also at its discretion, commission domiciliary care services where the individual has not met eligibility criteria but the provision of such service will support the achievement of personal outcomes, that will negate or defer the need for a care and support plan.

4.5 Where it is identified that a Domiciliary Care service is required to support the person then the appropriate contract provider will be commissioned, the care and support plan shared and the agreed outcomes discussed. The Provider will confirm the service start date via the appropriate process with the Council

4.6 The contract provider will, from the start of the service, develop a service delivery plan supporting the person to achieve their outcome(s). Initially this will primarily be care delivered in the home but as the contract matures we anticipate that alternative methods of service delivery could be considered.

4.7 The care and support plan will be costed by the Contracting Authorities at the agreed contract rate and confirmed with the Provider.

4.8 It is anticipated that the service will continue until the planned review. However where there is a change in the persons circumstances, including proposed increases or decreases to time spent with the service user that affects the ability of the contract provider to support a change or maintenance outcome as agreed, then the provider should notify care management service as soon as possible.

4.9 The planned review (see point 10) will focus on the person's progress in achieving the outcomes agreed and consider any changes required to the care and support plan for the future, which may or may not require a new service delivery plan. It is expected that the Provider will report progress against outcomes at least annually and provide the Council with a written summary of outcomes and whether these have been met or not.

4.10 It should be noted that for the duration of this contract the Reablement and Intermediate Care service will continue to be provided directly by the Local Authority and there is no requirement for contract providers to respond to people requiring an acute reablement service for short periods of time. However, the Provider will be required to inform the Contracting Authorities where they assess a reablement or intermediate care programme may be beneficial to the service user. The Contracting Authorities reserves the right to suspend a service in order for an intermediate care or reablement programme to be provided where it is identified this may benefit the service user. This may lead to an unplanned review of the service users needs, which could lead to a change in the service provided including the withdrawal of service.

4.11 It is anticipated that the people receiving care from the contract providers will have disabilities and illnesses that require a long term involvement with social care services.

Nevertheless, there is an expectation that service delivery plans will demonstrate an enabling approach to service delivery that maximises the opportunity for people to achieve as much independence as possible and reduce reliance on others to meet their needs.

4.12 Where people are transferred from the Contracting Authorities intermediate care, reablement or dementia reablement services, the service provider will work with the Intermediate care services to achieve a positive and timely transfer of care and support.

4.13 The Contracting Authorities has a clear expectation that the positive outcomes these services have achieved will not only be maintained, but further built upon, to enable the service user s to become as independent as possible.

4.14 The model will require an effective and productive working relationship between the providers and Contracting Authorities. It is expected that the milestones of the model will be managed by a joint steering group of the Contracting Authorities and providers.

4.15 It is also expected that providers and care management teams develop positive operational working relationships and efficient communication arrangements; to include quarterly patch meetings with team managers, attendance at quarterly provider forums as well as having an operational base within the Cwm Taf region.

PART B Service Implementation Arrangements

5 Assessment of Needs

5.1 Any service to an individual/family should be identified as being required through the established needs assessment process of the Contracting Authorities

5.2 Funding will only be available if the assessment establishes that the person is eligible for care and support and that the outcomes agreed between the individual and the Care Manager can only be achieved through the support of a Domiciliary Care service.

5.3 The Contracting Authorities currently works with two types of assessment documentation

- A specialist mental health assessment for people subject to Care and Treatment Planning
- A specialist social care assessment for all adults excluding the above

During the life of this contract the Contracting Authorities will be moving to an integrated assessment that meets the requirements of the national assessment and eligibility tool.

6 Care and Support Plans

6.1 All people eligible for care and support will have a Care and Support Plan or Care and Treatment Plan that identifies the agreed outcomes based on assessed needs.

6.2 The Care and Support Plan or Care and Treatment Plan will be prepared and completed by the Care Manager in partnership with the person and made available to the provider, prior to the commencement of the service. Where the person has received intermediate care or reablement, the service delivery plan used will be made available to the contract provider upon request.

7 Referral Process

7.1 The referral process is as outlined below:

7.2 <u>The Council employee or Health professionals delegated by the Local Authority</u>

- Completes the Assessment of need
- Agrees outcomes with the service user based on assessed needs.
- Devises a Care and Support Plan or Care and Treatment Plan with the person that will help them achieve the outcomes
- Shares the Care and Support Plan or Care and Treatment Plan with the contract provider and discusses the specific outcomes the domiciliary care service is required to support
- Initiates the commissioning process with the contract provider

7.3 <u>Framework provider</u>

- Develops and agrees a Service Delivery Plan (including a moving and handling assessment) with the person, in line with the agreed outcomes detailed in the care and support plan provided by the Council.

8 Service Delivery Plan

8.1 On receipt of the Care Plan the provider will work with the person to develop a Service Delivery Plan that will detail the care and support arrangements, required to meet the agreed outcomes, identified in the Care and Support Plan or Care & Treatment Plan, including the pattern of service delivery

8.2 The Service Delivery Plan will advise the Care Manager, the person themselves, care workers and others about the type and intensity of the actions agreed with the person to achieve the agreed outcomes. The Service Delivery Plan will include a detailed Risk Assessment in relation to risks including moving and handling requirements and outline the actions staff are to implement to mitigate the identified risks.

8.3 The Service Delivery Plan must be agreed and signed where possible by the person or the person acting on their behalf.

8.4 The agreed Service Delivery Plan must be kept at the persons home and available to inform care staff of their duties and responsibilities in relation to the case. This plan must be regularly reviewed, and updated to reflect the services users change in need but as a minimum must be reviewed annually. Evidence of the review must be available upon request.

8.5 The Service Delivery Plan must include as a minimum the following information:

- Pen picture of the person
- Emergency contact information
- Outcome/s to be achieved
- Actions needed and appropriateness of these actions
- The times those tasks are required
- The amount of time allocated to each task
- Risk assessment including a moving and handling risk assessment, including actions to mitigate risks

8.6 Wherever possible the Service Delivery Plan must be agreed and available prior to the service starting. However where the service is required urgently, arrangements must be put in place within 24 hours for an interim Service Delivery Plan and the completed service delivery plan being in place within 3 working days.

8.7 Instances where the Risk Assessment identifies the need for moving and handling equipment the Provider will make a referral to the Community Occupational Therapy Team.

9. Care and Support Plan Review

9.1 All Care and Support Plans will identify a planned review date; however the Council reserves the right to undertake an unplanned review at any time.

9.2 The Contracting Authorities currently work with two types of Care and Support Plan Review documentation

- A specialist mental health Care and Support Plan review for people subject to Care and Treatment Planning

- A Care and Support Plan review for all adults excluding the above

9.3 The Care Manager will arrange the Care and Support Plan review which will involve all relevant contributors to the Care and Support Plan

9.4 The purpose of the Care and Support Plan review is to

- consider progress and success against the agreed outcomes
- identify any barriers to that progress and success
- Consider any changes required to the agreed outcomes and the Care and Support Plan

9.5 Following the Care and Support Plan review any changes required to the Service Delivery Plan will be commissioned following the same process as outlined in point 8 above by using the Commissioning Record

10. Service Reviews by the Provider

10.1 Service reviews will be planned by the provider according to the complexity of the care package and in proportion to the risk. However it is anticipated that as a minimum there would be an initial service review following the first 4 - 6 weeks of the service starting and thereafter at 3 – 6 monthly intervals depending on the complexity of the case

11. Unplanned Review

11.1 The provider must advise the Care Manager when there is a significant change in the person's circumstances which is likely to affect the achievement of the agreed outcomes (e.g. deterioration in health etc.) by completing the Unplanned Review Form.

11.2 The provider must also advise the Care Manager where a service review has identified that the Service Delivery Plan is not proving to be effective in achieving the agreed outcomes

11.3 The provider must also advise the Care Manager where a service review or call monitoring data has identified that the time required to complete the agreed outcomes, has been reduced or the outcome itself has been achieved indicating that the care plan requires amendment. Conversely, the Provider must advise the Care Manager where there is an increase in the time taken to complete the agreed outcome or the outcome itself is no longer achievable indicating that the care plan requires amendment.

11.4 The Care Manager will determine, based on the information provided, the action required which may include

- An adjustment to the Care and Support Plan
- An early Care and Support plan review
- A re-assessment of needs,
- A case conference

Part C – Outcomes, Performance Indicators and Requirements

12 Strategic Outcomes

12.1 As identified earlier, there is an expectation that the contract providers will deliver specific strategic outcomes for the Contracting Authorities during the course of the contract.

12.2 To ensure this is achieved set out below are the Performance Indicators that will be used to monitor providers performance in achieving those outcomes and also the associated requirements. Performance reports will then be discussed at the quarterly provider forum.

Strategic Outcomes – Domiciliary Care

1. **That people will be supported to become as independent as possible in their own homes and reliance on formal service delivery will be reduced**

2. **That people are supported to meet their identified wellbeing outcomes**

3. **That Vulnerable people are safe from harm**

4. **That people receive a quality service that is delivered consistently by appropriately trained staff**

13 Outcome 1 - That people will be supported to become as independent as possible in their own homes and reliance on formal service delivery will be reduced

13.1 **Performance Indicators**

Measure	Target	Collected by	Method of monitoring
Service user feedback	Year 1 - 75% Year 2 – 85% Year 3 – 95% of questionnaire responses indicate that their individual outcomes are being met	Provider Quality Assurance	Contracting team to review at annual review
Packages of care commence at the agreed date & time	98% of packages of care commence within agreed start time.	Panel	Monitoring officer to evaluate panel data
number of unplanned review forms received where there has not been a change in the service users level of need	Less than 10 in a 6 monthly period	Care manager and Contracting Team	Monitoring officer to evaluate at 6 monthly periods
Audit of sample cases	To be determined by Monitoring Officer	Monitoring Officer	Case track to determine whether outcomes have been achieved
The number of home care packages that remain the same at review	60%	Care management review	Contracting officer during first annual monitoring visit
The number of home care packages that increase at review	20%	Care management review	Contracting officer during first annual monitoring visit
The number of home care packages that decrease at review	20%	Care management review	Contracting officer during first annual monitoring visit

13.2 **Required Service arrangements**

13.2.1 The agency has processes in place to ensure that there is sufficient appropriately trained staff to meet the requirements and fluctuating demands of the contract.

13.2.2 Management / Supervisory staff will have systems in place to monitor the care provided to an individual on a regular basis that ensure the Service Delivery Plans are working to achieve the agreed Care and Support Plan outcomes.

13.2.3 The agency will have processes in place to ensure the continuity and consistency of staff providing support to the individual.

13.2.4 Financial and administrative arrangements and systems are robust and guarantee the sustainability of stable and reliable service provision throughout the course of the contract

13.2.5 Services take into account the race, gender, disability, personal mobility, age, sexual preference, faith, diet, culture, language and lifestyles of service users and their chosen method of support;

13.2.6 There are effective business continuity plans in place to ensure the security, sustainability and reliability of the service.

13.2.7 The agency has sufficient capacity to ensure an immediate and effective response is available for all service requests

13.2.8 The agency will have an electronic monitoring system in place, which will be maintained by the contract provider

13.2.9 The agency has in place policies that ensure working practices support the service users to maximise their independence.

13.2.10 There is a robust communication policy to ensure that the person and carers are always informed of changes to the support required.

13.2.11 If a care worker arrives more than 60 minutes outside of the contracted call time or does not arrive at all for the call this is classed as a missed call.

14. Outcome 2 -That people are supported to meet their identified wellbeing outcomes

14.1 **Performance Indicators**

Measure	Target	Collected by	Method of monitoring
Service user feedback indicates that their wellbeing outcomes are being achieved	Year 1 - 75% Year 2 – 85% Year 3 – 95% of service users consulted report that their wellbeing outcomes are being met	Provider as part of quality review process	Contracting team to review at annual review
% of care packages where outcomes are being met at review	100% are being met	Care Management during planned reviews	Contract monitoring visit and feedback from care management
Service delivery plans clearly indicate the outcomes and how they will be achieved	100% of audited service delivery plans clearly identify outcomes and how they will be met	Contracting staff	Monitoring Officer to Sample Audit on a 6 monthly basis

14.2 **Required Service arrangements**

14.2.1 The agency employs sufficient skilled and experienced staff to prepare Service Delivery Plans to ensure the plans provide assistance only where and when it is necessary to supplement the strengths and resources already available to the person.

14.2.2 Staff tasked to develop effective links with the councils short term intervention service to ensure that where individuals are transferred from intermediate care, reablement or the dementia reablement services the positive outcomes these services have achieved are maintained

14.2.3 Service planning considers the risk to the individual becoming dependant on the service and identifies monitoring or review requirements accordingly

14.2.4 The Service Delivery Plans will be in place at the service commencement date. In an emergency the provider will be expected to complete an interim Service Delivery Plan within 24 hours, with the completed Service Delivery Plan being in place within 3 working days of the service commencing.

14.2.5 The agency provide all Care staff with training and information to ensure they understand the importance of avoiding unnecessary dependence on the services and the organisation actively promotes a culture where reducing reliance on services safely is encouraged

14.2.6 There are effective processes in place to update the Care Manager of any exceptional circumstances that affect the ability of the service user to achieve their agreed Care and Support Plan outcomes with the agreed Service Delivery Plan

15 Outcome 3 - That Vulnerable people are safe from harm

15.1 Performance Indicators

Measure	Target	Collected by	Method of monitoring

Number of POVA's directly relating to poor practice of the agency or staff providing support, resulting in a strategy meeting	0 number of POVA's directly related to agency & staff	Safeguarding unit	Quarterly report from safeguarding unit to contracting team
% of missed or late calls (Definition of a late call is over an hour late where as a missed call is a call that has not been received).	Less than 5% at any one period	Electronic call monitoring system	Contracting team to monitor on a quarterly basis
Training records – indicate that staff have received health & safety and moving and handling training to the All Wales passport level	100%	Provider training records	Contracting team to monitor on annual basis
Recruitment records- % audit of staff files that contain appropriate documentation	100% of sampled files have the relevant recruitment documentation	Provider	Contract monitoring team sample of 10% of staff files during annual contract monitoring visit

15.2 **Required Service arrangements**

15.2.1 There will be a clear set of Policies and Procedures in place to support the delivery of a Domiciliary Care service that is compliant with good practice, regulation and legislation and includes as a minimum the requirements of the National Minimum Standards for Domiciliary Care in Wales that are reviewed annually

15.2.2 The Agency will have policies in place that ensure that all staff will be issued with identification and promote its use by service users.

15.2.3 The agency will have management arrangements in place to ensure that there is a rigorous recruitment and selection procedure that meets the requirements of legislation, equal opportunities and anti-discriminatory practice and ensures the protection of the person and their relatives or representatives.

15.2.4 The agency will have in place a policy covering the appropriate safe use of vehicles including insurance requirements.

15.2.5 The agency must have in place clear processes for recording and reporting changes in service user needs and concerns.

15.2.6 All staff are instructed that any new convictions incurred following recruitment must be reported

15.2.7 There is a process for checking the competencies of all new care workers through planned supervision and observation.

15.2.8 The agency has in place robust Health and safety policies and effective risk assessments undertaken on the commencement of a service by a competent person.

15.2.9 There are systems in place for systematically monitoring, reviewing and updating risk assessments when necessary;

15.2.10 The agency will have in place a process for monitoring the effectiveness of service delivery plans. This should be done in conjunction with the person and according to the agreements made with the relevant care manager

15.2.11 All staff have regular Health and Safety training

15.2.12 The agency has a responsibility to immediately notify the Contracting Authorities in the event of an improvement notice being issued by or the cancellation registration of the Responsible Individual by CSSIW or any other regulatory breach

16. Outcome 4. That people receive a quality service that is delivered consistently by appropriately trained staff

16.1 **Performance Indicators**

Measure	Target	Collected by	Method of monitoring
CSSIW reports demonstrate good practice	100%	Monitoring officer	CSSIW website
Contract monitoring identifies good practice	100%	Monitoring officer	Annual monitoring visit
Learning from complaints process in place	100%	Monitoring officer	Corrective action plan and focussed monitoring review
Staff are trained to undertake role	50% of care staff hold or are working towards a qualification as listed as the recommended occupational qualification in the Care Council for Wales Qualification Framework	Provider	Annual audit of training records
Rotas show consistency of allocated staff	100%	Monitoring officer	Spot check of % sample of rotas

16.2 **Required Service arrangements**

16.2.1 The contractor will have in place a suite of policies and procedures that will be implemented across the organisation and compliance will be monitored through an effective Quality Assurance mechanism

16.2.2 All managers and staff will be issued with a copy of the Care Council for Wales Professional Code of Practice for Social Care and the organisation will ensure that its practice and procedures support the requirement within the Code

16.2.3 Managers will ensure that effective records are maintained to validate the service provided. Records will include but not be limited to, staff work schedules, daily/weekly reporting logs, medication charts where required, and an individual Service Delivery Plan that will detail progress in the achievement of desired outcomes for the person.

16.2.4 There are policies, procedures and operational arrangements for all managerial and care staff to receive regular and documented supervision, appraisal, observation in the workplace and managerial support by an appropriately trained and competent individual

16.2.5The ethnicity of the workforce is mapped and monitored through job applicants via the

application form;

16.2.6 Management arrangements are in place to ensure that all Care workers and managers commence a structured induction programme on the first day of their employment, and are assessed by the end of their twelfth week in employment. The programme must take account of the guidance on induction published by the Care Council for Wales as the Social Care Induction Framework. Care workers should also receive an induction pack and manual containing information on the organisation's aims, policies and service principles, together with the procedures and guidelines relevant to their role as home care workers

16.2.7 Management arrangements will ensure that the material on service principles include the following statements:

- Staff are required to promote the dignity, choice and independence of the people they support
- Staff are required to respect the right of each person to be treated as an individual (regardless of age, gender, class, race, religion culture, mental or physical ability, mental health, sexual orientation or other factors which could result in discrimination;
- Staff are required to maintain the confidentiality of personal information about the person and their families;
- Staff should realise that people are entitled to complain about the service or make suggestions for its improvement and that these matters should be dealt with within the procedures of the organisation;

16.2.8 There is a written record of the individual care workers induction indicating their competency with regards to the care worker role and the organisations principles, policies and procedures. Clear action plans are in place where an individual care worker is not yet demonstrating competency in any one area of induction.

16.2.9 The agency has in place processes that ensure that all staff have a 3 months probationary period and systems in place to assess their suitability to undertake the role.

16.2.10 The agencies induction training clearly sets out the expectations of good practice and behaviour for care workers and management staff that will include, but not be limited to the following.

- use terms of address, which the individual service user prefers.
- order tasks to suit the person's preference.
- seeks permission from the person before beginning any domestic or personal care task or assisting with mobility.
- establishes the level of support required by the person so that he/she can be as self-managing as possible.
- provides support at a pace which suits the individual, using methods which the service user prefers (within the requirements of Health and Safety).
- asks the person on completion of the task whether they are satisfied.
- respects the privacy and dignity of the person especially where they are assisting with personal care.
- checks that the individual is comfortable and has all his/her immediate needs met before leaving the service user's home

- records information accurately, legibly and in non-judgemental language.
- Know not to use person's appliances for their own purposes including personal phone unless the call they are making is on behalf of the person or is undertaken as an agreed, pre-determined part of service delivery.
- do not bring other people, including children or pets to Service users 'home;
- do not smoke whilst on duty;
- are not under the influence of drink or drugs whilst on duty;
- do not discriminate against service users;
- do not use their personal mobile phone whilst providing support. If their mobile phone is provided to support lone-working, it should remain on silent and only be used if the Care Worker needs to make contact in an urgent or emergency situation.

16.2.11 Management arrangements will need to ensure that all staff are trained and competent by having a training strategy with defined aims and objectives, identified methods of training for each staff group and evidence of which staff in the workforce have participated, management will also be required to monitor the ongoing competence of staff

16.2.12 There is a clear policy in place that identifies the organisations commitment to the Continual Professional Development of its staff.

16.2.13 Specific person related training is available for staff where required.

16.2.14 Staff work with and actively participate in the work of the Contracting Authorities Social Care Workforce Development Partnership

16.2.15 There is a system for continually assessing and recording the competencies of care workers linked to the annual appraisal. Clear action plans are in place where staff are not able to meet any required competency related to their job;

16.2.16 The organisation seeks to include the individual, their families/primary carers in staff training where appropriate

16.2.17 Care Workers receive specific training on medication which must be regularly reviewed and updated.

16.2.18 All staff are able to pursue a qualification relevant to their role and the organisation must demonstrate acceptable levels of qualifications amongst all their staff groups which will include QCF 5 for managerial staff, QCF 2 for care staff with evidence of progress to QCF level 3

16.2.19 Arrangements will be in place to provide a contact point for both service users and staff ensure a prompt response to individuals calls 7 days a week / 24 hours

16.2.20 The manager or a senior member of staff will check, either by telephone or personal visit, whether the person is satisfied with the service within six weeks of the commencement of the service;

16.2.21 The manager will ensure an appropriate advocate or interpreter is available for people where required - this should be arranged in consultation with the relevant care manager/care co-ordinator

16.2.22 The views of individuals should be gathered on a regular basis but not less than twice a year. The contract provider should ensure they can demonstrate how feedback is used to improve the service provided;

16.2.23 That care workers are introduced at the assessment meeting and comprehensively briefed about the care needs of the person and the outcomes they have agreed they need to achieve

16.2.24 Care workers are provided with and familiarise themselves with a written work programme, detailing the Service Delivery Plan and risk assessment for each case

16.2.25 Care workers are required to read care notes and complete an entry at each visit;

16.2.26 The agency provides service users with a written statement explaining:-

- their right of access to their own personal records;
- their right to have personal information treated confidentially;
- their right to complain and a procedure for doing so.
- their right to request a change of care worker;

16.2.27 The contract provider will have up to date records about each member of their care staff. This should include skills, aptitudes and personal attributes such as age and ethnic or cultural background, together with an indication of any group or individuals they feel best/least able to work with. This information will be required to be submitted to the Contracting Authorities Social Care Workforce Development Partnership on an annual basis in order to comply with Welsh Government requirements ;

16.2.28 The provider will be able to demonstrate an effective system of matching the skills and competencies of care staff with the needs and preferences of individuals;

16.2.29 The provider will match suitably skilled staff with people who have mobility problems and require competent and sensitive support moving around indoors or outside the home;

16.2.30 The provider will have an effective system for sharing with care staff the information they need to know in order to meet the particular needs and preferences of individuals.

16.2.31 Managers will undertake regular spot checks on service delivery which must be recorded for monitoring purposes;

16.2.32 The provider will have an effective management of individual workloads;

16.2.33 The provider will ensure care workers have regular core work patterns;

16.2.34 The provider will ensure there is adequate care worker cover for sickness and annual leave

16.2.35 The provider will ensure contingency arrangements and a team approach are utilised to cover the service if the regular care workers are unavailable or unable to visit by implementing a continuity plan of support to secure a stable staff team;

16.2.36 The provider will ensure effective arrangements are in place to contact service users and inform them of any changes to their service or expected care workers

PART D – QUALITY ASSURANCE, MONTIORING AND REVIEW

17. Quality Assurance

17.1 The responsibility for ensuring compliance with this specification and with the requirements stipulated in the needs assessments, care and Treatment Plan, care and Support Plans and Service Delivery Plans rests with the provider and the Contracting Authorities.

17.2 There must be an effective and clearly documented system for quality assurance based on the outcomes for service users, in which standards and indicators to be achieved are clearly defined and monitored on a continuous basis by care workers and their line managers.

17.3 The Domiciliary Care Regulations, Minimum Standards and other relevant National service standards and indicators must be incorporated into the organisations Quality Assurance arrangements.

17.4 The Outcomes, Performance indicators and service requirements stipulated in this service specification must be incorporated into the organisations Quality Assurance arrangements.

17.5 There is a process and a procedure for consulting with service users and their carers about the standard of the care service on a regular basis including a mechanism to ensure service users understand the standard of quality that they should expect

17.6 Care workers must know and understand the standards of service they are required to provide and actively monitor and meet the standard on a continuous basis.

17.7 The outcome of the Quality Assurance process must be published annually and made available to service users, their representatives and all relevant stakeholders particularly the Contracting Authorities.

17.8 Standards and the Quality assurance process are reviewed and revised as necessary, but at least on an annual basis.

17.9 It is the responsibility of the provider to notify the nominated officer who has responsibility for all matters relating to this contract promptly, in writing, of any failure to apply the standards and requirements together with actions being taken to rectify this situation.

17.10 The Contracting Authorities will be entitled to introduce, to operate, to change, to withdraw, and to replace systems of specifications monitoring and quality control as they may see fit, notwithstanding and in addition to quality assurance and quality control systems operated by the provider. Three months notice will be provided for the introduction of any major changes.

18. Service Monitoring and Review

18.1 All individuals in receipt of a service will be supported by an organisation that wants to improve and will be supported to participate in the monitoring of quality.

18.2 The purpose of the service monitoring and review is to:

- Identify whether the service is meeting the identified outcomes for the person in accordance with their Care and Treatment Plan/Care and Support Plan and Service Delivery Plan
- Assess the quality and effectiveness of the service with a view to sharing good practice and negotiating service improvements

19 Monitoring

19.1 The provider will be required to submit written reports on any aspect whatsoever of their ability to meet the specification. Any costs of providing such reports shall be borne by the provider.

19.2 The means by which quality monitoring will be undertaken will be through all or some of the following systems and processes designed to monitor, review and measure performance. The Contracting Authorities will measure the performance of providers by these means:

19.2.1 Individual Service monitoring

Monitoring of the Care and Treatment Plan/Care and Support Plan and Service Delivery Plan will be the responsibility of the Care Manager and the contract provider.

This will include gathering evidence and comments made by the individual, their families and/or advocates regarding their service.

The Care Manager will provide data on the outcome of the individual monitoring in order to identify issues/trends/concerns. This will be forwarded to the Contract Monitoring Officer.

19.2.2 On-going monitoring and review programme-

The on-going monitoring and review framework will give an indication of the arrangements providers are required to have in place to help ensure the delivery of high quality support services.

As part of the ongoing monitoring and review arrangements providers will be required to evidence what arrangements they have in place to monitor measure and support the delivery and development of high quality support services.

The ongoing monitoring and review arrangements will enable the Contracting Authorities to identify where the service is or is not in compliance with the requirements of the contract and service specification and give a structured approach to plan, prioritise and monitor agreed service improvements. The outcome of the monitoring and review programme will feed into the Contracting Authorities Escalating Concerns Procedures

19.2.4 Quarterly contract monitoring meetings and Provider Forum

Providers will be required to attend quarterly provider forums, to discuss general contractual matters and performance reports There will also be quarterly contract monitoring meetings between the provider, the Contracting Authorities nominated contract Officer, Contract Monitoring officer and commissioners (where appropriate).

Feedback from monitoring processes and the Contracting Authorities escalating concerns procedures will be provided, including any recommendations identified in relation to service deficiencies. The provider will be required to develop an action plan to address any service deficiencies. Failure by the provider to remedy any service deficiencies to an agreed level within the times specified may result in the Provider being required to attend a meeting at the Contracting Authorities office, to discuss contractual matters and performance reports, failure to attend such meetings may evoke a termination notice under the terms and Conditions of the Contract.

19.2.5 Survey of service users on a six monthly basis.

This will be developed in consultation with providers and sent to a random sample of individuals in receipt of a service. Where people require assistance to complete the questionnaire, the most appropriate person/s to do this will be agreed with the Care Manager and may, as an example, be an independent advocate or someone independent of the organisation.

19.2.6 Care Monitoring Reports and Invoice Payment

The Contracting Authorities have implemented an electronic care monitoring system from Webroster. The provider, under the terms and conditions of this contract is required to use an electronic care monitoring system, and the provider will make arrangements to ensure that appropriate data is transferred between their system and the Contracting Authorities system. These arrangements will be required to be in place by the start of this contract.

Reports from the Electronic Care Monitoring system will be used to inform the councils monitoring of this contract and service specification requirements.

19.2.7 Strategic Performance Indicators

The contract provider will be required to provide quantitative information on an annual basis (as a minimum) in relation to the strategic outcomes specified in Part C. The provider will be required to collate and submit this information when required whether through written reports or electronic care monitoring reports, through the interface with the council's electronic care monitoring system.

19.2.8 Organisational Monitoring

Contract monitoring, using information taken from the monitoring and review framework, Quality Assurance reports, individual service monitoring reflecting the provider's ability to meet individual service outcomes and quality will be carried out on a regular basis by the Contract monitoring Officer. This will include review of ;

- Individual Service Monitoring Reports
- Care and Support Plan reviews
- Service Delivery Plan reviews
- Care Monitoring Reports
- Monitoring and Review framework scores
- Service Performance Indicators

- Quality Assurance reports
- Survey of individuals in receipt of the service
- CSSIW reports