SERVICE SPECIFICATION

FOR CARE WITHIN THE HOME SERVICES

(Schedule 1) OCTOBER 2021- SEPTEMBER 2027

Contents

Care within the Home: Services provided on behalf of Surrey County Council and NHS Surrey Heartlands CCG

1. Brief Summary of Care within the Home services

1.1 This specification and supporting documentation details service expectations for the delivery of Care within the Home services within Surrey. Section 2 of the Package Purchase Protocol (Schedule 2) details the commissioner's expectations of providers delivering all Care within the Home services and must be read in conjunction with this service specification.

1.2 There are several services to be delivered under what SCC define as Care within the Home. These services will be delivered through a joint Dynamic Purchasing (DPS) arrangement for Surrey County Council (SCC) and NHS Continuing Healthcare (CHC) in Surrey.

1.3 The DPS therefore includes the provision of the following services;

1. Home Based Care (HBC)- including services for people with additional needs and future ambition for HBC Carers Breaks

2. High Needs (CHC)

3. Live-in Care

4. End of Life Care (EOLC) Placeholder Lot – Please note this lot will not be available at the beginning of this DPS and is currently a placeholder for a future requirement which may become available under the DPS. The Council reserve the right to present this lot to bidders in the future, and qualification criteria and detailed specifications will be provided then.

1.4 Each provision constitutes CQC regulated care activity to be contracted for and delivered as per the service requirements set out within this specification detailed later as service schedules.

1.5 The requirements for each specific service will constitute separate award criteria through the tender process recognising that in some instance's providers will wish to tender for contract award for more than one service.

1.6 Home Based Care (HBC) is otherwise referred to as Domiciliary Care. To residents of Surrey and here within the service will be referred to as Home Based Care (HBC).

1.7 The legal requirement to provide care and support to adults in need is detailed in the Care Act 2014. The Care Act gives local authorities the ability to meet the needs of eligible individuals in several ways.

1.8 In meeting the needs of adults in their area, local authorities can provide a service themselves or arrange for a service to be provided by other organisations This document sets out the expected standards for the provision of high-quality Care within the Home services for Surrey residents. The standards outlined in this service

specification are the minimum requirements, which the commissioner expects the service provider to achieve.

1.9 This service specification is joint between Surrey County Council (SCC) and NHS Surrey Heartlands Clinical Commissioning Group (CCG) who hosts Continuing Healthcare (CHC) on behalf of the two Surrey CCGs. Some services are jointly commissioned by SCC and the CHC, whilst other services are solely commissioned by one partner. The term 'commissioner' referred to in this document hereafter refers to either arrangement.

1.10 Within this tender opportunity and through the delivery of this contract, providers will be expected to demonstrate 'strength-based' practices and a focus on continuing enablement in order to maximise the independence of residents throughout Surrey who require these services.

1.11 The commissioner wishes to work with providers in order to develop services as detailed within this specification for the benefit of Surrey residents, the commissioner and the providers themselves. This will be achieved through focused partnership arrangements, collaboration, co-production, regular communication and the development of brokerage services for better commissioning of care.

1.12 The commissioner will support providers in developing their 'strengths-based' practice, including, where appropriate linking with reablement as part of the health and social care ambition to implement Discharge to Assess (D2A) which sees individuals being supported to return home, with support, following a hospital admission. Background information about reablement and emerging practice messages is available.

1.13 The commissioner's expectation is that providers will deliver effective models of service delivery that meet the needs of all residents requiring a service including those with Dementia and other long-term health conditions/requirements. The commissioner will work with providers to develop this approach and to ensure they have appropriately trained and supported staff.

1.14 The service(s) and new contract(s) will apply only to new packages of care. Existing business will remain on 'legacy' arrangements until such time as packages may need to be sourced / re-brokered such as through hand backs, admission to hospital or as per the commissioners and providers rights to end a package of care.

1.15 Over the lifetime of the contract, the commissioner will work in partnership with providers to:

- provide on-going monitoring of contract performance and quality.
- work co-operatively to resolve problems and barriers arising from time to time.
- establish viable business in areas known to be challenging in terms of demand, demographics and or geography as examples.

1.16 During the term of the contract if a provider leaves the DPS the earliest opportunity the commissioners will consider an application from a provider to re-join the contract will be 6 months after the date the provider left the contract.

2. Background and Context

2.1 Surrey's elderly population is increasing each year, and statistics show that 20-25% of the population will be aged 65 or over by 2025. This growing number of older people will have a major impact on health and social care provision, as they are more likely to experience disability and long-term conditions. Between 2016 and 2025, the rate of increase in over 85s is predicted to be greater than that for over 65s.

2.2 This growth in the older people population will see an increase in the demand for HBC services. According to the 2011 census 19,355 people aged 25 to 64 reported that their day-to-day activities were limited a lot. This represents 3.2% of the 25 to 64 population. The strategic vision of supporting people to live well and independently in their own community will also increase the need for HBC.

2.3 Commissioners expect that as there will be more residents supported under 'discharge to assess' schemes and improved hospital discharge arrangements for all residents, there is likely to be an increase in services needed to support individuals within their own home.

2.4 This specification covers the provision of services to residents who require support because of older age, dementia, mental health conditions, a physical or sensory disability, a lifelong learning disability and/or autism. Any specific requirement for a care group beyond the delivery of CQC regulated services will be clearly defined when packages are offered to DPS providers and the commissioner may seek the most appropriate service provider where this is necessary.

2.5 It is important that providers are aware of the geography of Surrey and how important it is to understand the local interaction and place-based vision for each area and system. The commissioners will support providers to recognise and maximise these opportunities. The map in figure 1 illustrates the geography of Surrey in terms of the 11 borough and district councils.

2.6 Surrey borders many other local authority areas including London boroughs and other large counties such as Hampshire, East Sussex and West Sussex. As a result of Surrey's proximity to London, some parts of Surrey are highly urbanised while other areas remain predominantly rural. Commissioners expect providers to be aware of the diversity of the geography in Surrey and how this can affect the delivery of HBC.

2.7 Considering the diverse nature of Surrey's population and demography providers are asked to consider which postcode areas in Surrey they can provide services in. A profile of the 94 postcode delivery areas in Surrey can be found in the Delivery Areas and Pricing Guidance. Section 1 of this guidance shows how postcodes have been grouped into urban, rural, and semi-rural delivery areas.

2.8 To maximise opportunities for the commissioner to ensure the availability of good quality services for residents it is recommended that providers consider neighbouring post codes or clusters where they can begin to establish rounds and develop their business effectively.

2.9 Surrey postcode areas are those postcodes which fully or partly cover the current administrative boundaries of Surrey. These are the areas where services are

provided by the eleven Surrey district and borough councils as detailed in the map at Figure 1:

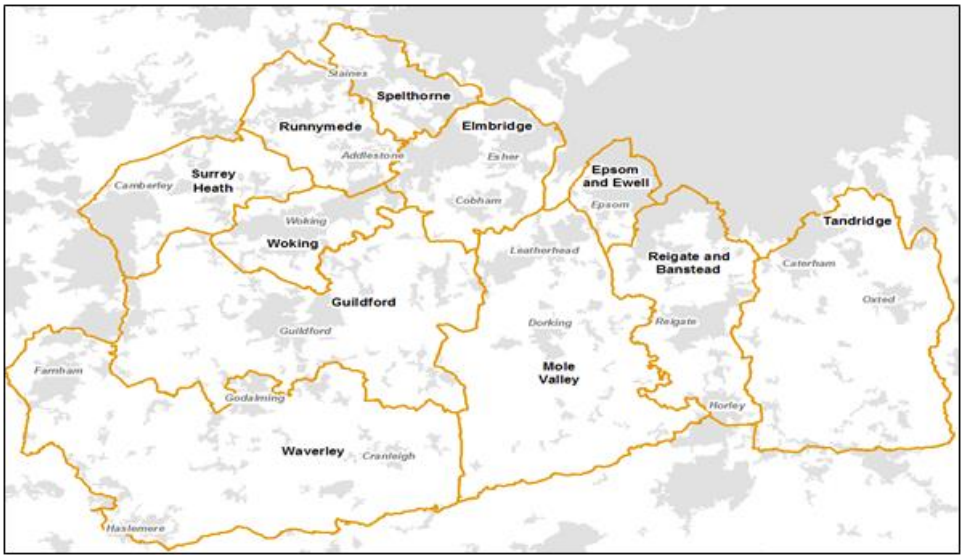


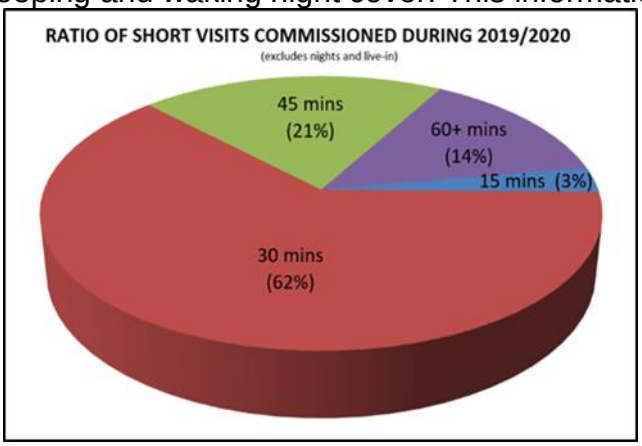
Figure 1: Map of Surrey showing District & Borough Boundaries

2.10 For a map of the different health systems in Surrey, please refer to Appendix 1.

Current Adult Social Care position –

2.11 In October 2020 Surrey County Council purchased on average 3,600 packages of HBC each week with an average weekly spend of £1.1m, which equates to an estimated annual spend of £57m. The average weekly cost of a HBC package is around £300.

2.12 The breakdown of the length of visits commissioned by adult social care in 2019/20 is as follows: 3% 15-minute calls, (was 6% in 2015/16.), 2% 30 minute calls (was 51% in 2015/16), 21%45 minute calls (was 19% in 2015/16) and 14% were calls of an hour or longer (was 24%in 2015/16). Please note that this does not include live-in care or sleeping and waking night cover. This information illustrated in figure 2.below.



2.13 Live-in care, sleeping nights, and waking nights combined accounted for approximately 20% of total visits in 2019/20 (compared to 50%

in 2015/16). However, with live-in care being a 24-hour service these visits represented around 19% (compared to 15% in 2015/16) of the total HBC hours commissioned.

2.14 SCC recognise that the delivery of good quality and effective regulated care is unlikely to be supported through a model of service delivery that commissions 15-minute calls. The commissioner will no longer look to commission these calls under the new DPS. Presently, exceptions to this proposed approach, are for specific time and task services only or for Extra Care settings where 15-minute services are required from regulated care providers. Therefore the commissioner will seek to commission these types of calls through an alternative procurement in the future. (For more information on this please refer to Section 3 of the Delivery Area & Pricing Guidance).

Current NHS Continuing Healthcare position –

2.15 The NHS Continuing Healthcare (CHC) team commission approximately 1100 packages of HBC each year. This number of packages remains stable to previous years and the average cost of a CHC package of home care is £854 per week. In 2019/20, the total market spend on home care packages for Continuing Healthcare was £13.05 million.

2.16 The packages of care commissioned by the CHC team are more likely to be live-in care, QDS (four times a day) double up packages and waking nights, and there is a wide variety of need as people's conditions change.

2.17 The CHC team also commission High Needs packages for people who have complex health needs. Please refer to the High Needs specification within section 6 of this Service specification.

2.18 The team commission less than 100 new packages per annum for people who would fall under this High Needs Spec and so providers are to be aware that high needs packages are not offered on a regular basis. Part of the reason for this is because a lot of the more complex packages tend to be for younger people who wish to receive a Personal Health Budget, which gives them more control over their care.

2.19 NHS Surrey Heartlands CCG are the host organisation for the Surrey CHC team. The team is responsible for caring for people registered with GPs under both CCGs in Surrey which are NHS Surrey Heartlands CCG and NHS Frimley CCG (Surrey Heath & Farnham).

3. Strategic Vision

3.1 Market position context – There are 260 CQC registered locations in Surrey that fall under the CQC inspection category of community-based adult social care services. These services are all registered to provide the regulated activity of personal care categorised as homecare agencies which includes Live in Care. The 260 branches provide services as summarised below:

- 194 branches provide care and support to mostly older people in their own homes.
- 60 branches provide care and/or supported living services to people with learning disabilities. Supported Living services are where people live together typically with support staff in the accommodation providing support in the home and in the local community.
- 6 branches provide other types of regulated care in the home for example services to children with disabilities or supported living to people with mental health conditions.

3.2 The market for HBC is dynamic, with around 25-30 new homecare branches registered in Surrey each year and therefore the new DPS is open through the life of the contract for new entrants to ensure Surrey has a thriving market of providers.

3.3 The Adult Social Care Directorate at Surrey County Council is responsible for organising the provision of Care within the Home services to adults eligible for social care services in Surrey. The Adult Social Care Directorate is working to contribute towards the wider corporate objectives of Surrey County Council between 2020 and 2025 .The corporate objectives can be viewed on Surrey County Councils website

3.4 The new contract arrangements for Care within the Home services in Surrey will deliver on all the SCC corporate objectives to varying degrees as summarised in the following paragraphs. Organisations who wish to provide Care within the Home services to Surrey residents on behalf of SCC and the NHS will need to demonstrate how they can work in partnership to meet the objectives for the long-term vision for Surrey as set out by SCC.

- **Tackling Inequality** – providers must be prepared to provide Care within the Home services to Surrey residents from a wide range of backgrounds. Providers must ensure that residents with protected characteristics are provided with equal opportunities to receive high quality care and support when needed. Information about the Equality Act and protected characteristics can be viewed on the EHRC website.
- **Supporting Independence** – providers must work with residents to support their independence building on 'strengths-based' approaches and a focus on enablement, so that only enough care to meet identified needs is provided. Providers must work with social care and health teams to feedback on outcomes achieved by individuals they support and participate in the annual review process. When leaving hospitals, Care within the Home providers will be key partners in delivering the 'home first' principles that will enable people to be supported in their own homes as quickly as possible and for as long as possible.
- **More joined up health and social care** – providers must work in partnership with the wider health and social care structure within Surrey. This will include enabling better discharge for patients from hospital and enabling patients to be discharged home where possible under Discharge to Assess arrangements.
- **Creating a greener future** – Surrey County Council has declared a climate emergency . Providers will need to demonstrate that the services they deliver are done so in the most environmentally sustainable way, for example minimising car journeys, travelling sustainably where possible and pooling

resources if possible and where appropriate, with other care companies. Information about Surrey County Council's climate change policy can be viewed on Surrey County Council's website.

- **Embracing Surrey's Diversity** – providers must work with residents of all backgrounds and cultures. Commissioners will make it clear individuals must treat their Care within the Home staff with respect and consideration for their cultural backgrounds. In addition, providers must ensure their staff treat all individuals with respect and consideration for their cultural backgrounds.
- **Partnership working** – providers are part of the social care and health integrated system in Surrey. Providers who deliver services on the DPS contract are delivering care on behalf of statutory agencies. Providers must work as part of the integrated system meeting needs of residents in line with statutory assessment completed by social care or health professionals.
- **Supporting the local economy** – providers must support the local Surrey economy where possible, through employment and procurement practices.
- **Digital revolution** – providers must utilise digital technology where possible and if appropriate inform the resident who is to receive the Care within the Home service when the care worker is expected to attend the home, advise of any delays or issues in delivery of the care and ensure outcomes of the care provided are recorded on a care system. Face to face and telephone communication methods are also appropriate for residents who lack the latest technology. SCC is also looking to explore the greater use of technology enabled care to maximise individual independence and reduce the need for personal care where appropriate, SCC would like to develop this offer within Care within the Home services.

4. Sustainability, Equalities, Social Value and other impacts

4.1 A full Equalities Impact Assessment can be viewed here

4.2 Social Impact – this service will have a positive social impact on the lives of Surrey residents requiring HBC in particular and Care within the Home services. Through the commissioning of this service and harnessing closer relationships with the market individuals receiving care and support will be enabled and supported through strengths- based practices to live longer and with greater independence and dignity within their own home. The development of a robust DPS also signifies greater opportunities for providers to establish viable businesses therefore stimulating the employment market for the Care sector.

4.3 Environment - The DPS for Care within the Home services operates within post code areas which should limit the requirement for travel across the county and therefore reduce the impact on the environment. SCC will work with providers to build rounds that will maximise the use of the workforce and again reduce the impact on the environment where possible through a better ability to plan rotas and manage staff movement.

4.4 Social Value – SCC remains committed to delivering greater social value as defined within the Public Services (Social Value) Act 2012. SCC however recognises that providers delivering social care services are already contributing to enhanced Social Value for Surrey therefore;

- Surrey County Council aims to provide and enable the delivery of services which are innovative, provide employment opportunities for its residents, make its communities stronger and more effective, and keep its residents safe.
- Surrey County Council hopes to increase community resilience through the development of local skills and jobs. The Council will always seek to work with the market to increase the number of new businesses developed recognising the significance this has on local places and people and therefore the DPS remains open to new providers
- Surrey County Council wishes to embrace stronger partnerships, new technologies and other opportunities to recognise, develop and champion Social Value within the sector.

5. Home Based Care Service

5.1 Home Based Care, the provision of home care is one way that local authorities in England can meet the needs of individuals. Home Based Care (HBC) covers the provision of personal care to individuals in their own home. Organisations that provide personal care to people in their own home are regulated by the Care Quality Commission (CQC). The regulated activity 'personal care' involves supporting people in their homes (or where they are living at the time) with things like washing, bathing, or cleaning themselves, getting dressed or going to the toilet. This should be read in conjunction with the Package Purchase Protocol and Service Delivery Requirements, Schedule 2: Section 2

5.2 Night visits would typically be regarded as being delivered between the hours of 10pm to 6am, however this may vary to meet the needs of the individual receiving support and their families/carer.

- Waking Night - Care Worker is awake for the entire visit at Individual's house as they will require attention throughout the night.
- Sleeping night - Care Worker stays over at Individual's house and is mainly asleep for the duration of the visit and should normally be interrupted not more than twice.
- Long Visit Rate (visits between 4 & 12 hours long) Where the Care Workers stay at the individual's home exceeds 4 continuous hours. The Care Worker would not be expected to deliver care for additional individuals during this time. The Long visit Rate submitted (quoted as per hour) will not exceed the hourly rate the provider offers. Commissioners encourage providers to submit a preferential rate for this offering.

5.3 Service expectations for people with additional needs – SCC understand that in some instances additional needs may require a specific type of service. SCC will be tendering for providers who are particularly focussed on, and whose staff are trained in, supporting people with additional needs. These will in many cases be people with a learning disability and / or autism; people with mental health problems, people with physical disabilities and / or sensory impairment, and –people with acquired brain injury.

5.4 We expect all providers to offer personalised care, but this is especially pertinent for people with additional needs, which may vary from day-to-day and require flexible support.

5.5 Providers indicating that they wish to provide HBC to people with a learning disability and / or autism; people with mental health, people with physical disabilities and / or sensory impairment conditions should ensure the CQC registration confirms that they are registered to provide the appropriate specialisms / services.

5.6 Submissions from providers will be assessed by commissioners from the SCC Disabilities and Mental Health Commissioning Teams. Providers will need to evidence the appropriate skills, training and track record in delivering HBC to people with needs as detailed in paragraph 5.7. This will ensure that the commissioner can select the most appropriate provider to deliver a package of care based on an individual's assessed needs.

5.7 Support needs include, but are not limited to:

- Help and encouragement with daily activities, such as getting dressed, taking a shower, and preparing a meal.
- Prompting the person to take their medicine.
- Helping the person to clean their home.
- Reminding the person of any appointments.

5.8 The commissioner expects providers to:

- Work with the individual recognising and encouraging their strengths, skills, and community connections to retain independence and stay well in the community, and
- Work in a personalised and responsive way as the clients' needs may vary from day to day / hour to hour depending on the nature of their condition.
- Your staff will need to be skilled in understanding people with a learning disability and/or autism; people with mental health, people with physical disabilities and /or sensory impairment. They will need to be non-judgmental, patient, listen to what will help the person and how they would like things done.
- The person you support may have complex and challenging behaviours which may be stressful for your staff and the person. Your staff should be skilled in supporting people to stay calm and safe and receive the support they require.
- Your staff should get the support they need to manage their own stress in difficult situations.
- You can support people who use communication aids and assistive technology.

5.9 Specifically, for people with learning disabilities and / or autism.

- Providers must ensure that care staff complete the core training in line with the frameworks provided by Skills for Care and Skills for Health .
- Providers must ensure staff complete core training in Positive Behaviour Support (PBS) as described by the UK PBS Alliance and the PBS Academy .

5.10 Specifically, for people with mental health problems.

- Providers will support people who have mood / anxiety disorders, psychotic / trauma related disorder, substance misuse / eating disorders.

5.11 Specifically, for people with physical disabilities and / or sensory impairment.

- Providers may be required who can support people with brain injuries and understand how such injuries may impair the person's cognition and impact on behaviours, interactions, and their ability to communicate.
- Providers are required who can support people with high spinal injuries who may have more complex needs and who may use technology to communicate.

5.12 HBC Carers Breaks – SCC want HBC providers on the DPS to deliver a 'carers breaks' service to give carers respite from their caring responsibilities. HBC provided as a 'carers break' will provide replacement care for an individual and gives an opportunity for providers on the DPS to consolidate rounds and maximise business in post code areas where they are active. Carers break provision can be regular or, for limited periods of time, and offer valuable respite provision for a maximum of 3hrs per week.

5.13 Carers Breaks will not be a care item offering through e-brokerage when the contracts initially go live however future market engagement will be undertaken when these packages are to begin being offered through e-brokerage. This is a key ambition for SCC in order to support carers and help providers consolidate rounds within their post code areas for delivery.

5.14 Ambition for Provider reviews - SCC is committed to working more closely with providers through the life of the new DPS. As such, specifically for HBC, it is the ambition of the commissioner that a shared partnership between the commissioner and provider(s) will develop whereby the provider will undertake reviews, where appropriate and able to do so, of an individual's care and support. These reviews will be shared with the commissioner and reviewed to ensure they meet the Care Act duty for a resident's care to be reviewed. This partnership will create more positive relationships and an ability to share skills, expertise and experience to the benefit of both parties particularly in terms of agreeing variances and changes to packages over time.

5.15 SCC will maintain responsibility for the six-week review of all new packages and will work with providers to identify individuals who can / should be reviewed by providers thereafter. This may take the form of an initial pilot, but the ambition is to embed this practice with all DPS providers over time. Providers should continue to be prepared to assist assessors from SCC and the NHS with completing reviews and making recommendations about the ongoing delivery and level of care.

5.16 Whilst no Key Performance indicators for provider reviews are included in this specification from the outset of the DPS, the commissioner reserves the right to introduce these through the life of the contract.

5.17 All packages will be offered to DPS approved providers and will clearly define the type of care and support required and in what area of Surrey.

6. CHC High Needs

6.1 CHC - High needs - The CHC team commission High Needs packages for people who have complex health needs. High Needs packages are not offered on a regular basis as this cohort of patients are relatively low in number and often prefer to become Personal Health Budget holders in order to manage their own care and support needs. Providers will be expected to meet additional KPIs for this service.

6.2 This document sets out the specification and quality standards of service delivery that apply to the provision of HBC complex care to the Adults within the county of Surrey who are assessed as being eligible to receive services under NHS Continuing Healthcare.

6.3 This service is commissioned on behalf of NHS Surrey Heartlands Clinical Commissioning Group (CCG), NHS Frimley CCG (Surrey Heath and Farnham).

6.4 Emphasis will be placed on the promotion of independence and the achievement of positive outcomes for the individual in keeping with strength-based practice and enablement.

6.5 The HBC complex care service will include the provision of trained care staff who have appropriate skills and competencies to meet an individual's assessed health needs. The service may also include using specialist equipment and stock control of ancillary supplies, prescription management as required by the individual and set out in their care plan. Individuals may have a range of complex health needs and/or a significant disability and/or an additional mental health need that impacts upon their daily lives. The service may also be required to support families/carers.

6.6 Geographic coverage/boundaries – The service will be provided to individuals who are registered with a GP within NHS Surrey Heartlands CCG, NHS Frimley (Surrey Heath and Farnham) boundaries that have been found eligible under the relevant criteria.

6.7 Aims – The HBC High Needs complex care service will aim to:

- Enable individuals who have been assessed as eligible for NHS Continuing Healthcare to remain living in their own homes for as long as is practicably possible and clinically appropriate. This will be achieved by maintaining and/or enhancing their quality of life and promoting and maintaining standards of health, hygiene, safety and comfort in their home, provided in such a way as to complement the existing range of community services.
- Support informal and formal carers with provision of relief and respite care at times and in a manner that suits them and the individual and minimises any further disruption to their lives as agreed by the NHS Commissioner.
- Provide responsive complex care HBC services that are person-centred, by providing a range of flexible, responsive, and co-ordinated services, from highly complex interventions to low-level HBC support such as personal care.
- Provide services within the individual's own living location, which are compatible with the individual's circumstances This means providing services in the least intrusive way in order to minimise any disruption to the individual and other members of the individual's household where appropriate.

- Work within the policy standards and legislation relating to this cohort of individuals.
- Promote social inclusion and enhance the life choices of people.
- Enable the individual to attend or access services such as cultural, spiritual, leisure and practical needs and where appropriate educational needs.
- Ensure individuals are treated with respect and dignity and their opinions listened to. All decisions about the individual should take their wishes into account and be compliant with the Mental Capacity Act 2005.

6.8 Objectives – The level of service will be defined and commissioned by the Commissioner dependent upon the complexities and intensity of need as identified in the NHS Continuing Care Assessment and detailed in the care plan.

6.9 The direct care and support will be delivered by the Provider as agreed jointly with the Commissioners and in accordance with the individually assessed needs. The staff will provide the appropriate level of agreed care through a planned rota.

6.10 The Service Provider will ensure that the care team will have the qualifications, competencies and skill mix required to meet an individual's specific needs which may be numerous and varied over a 24-hour period.

6.11 Dependency Levels – A High level of dependency will be commissioned when some or any of the following applies.

- There are complex and intense tissue viability needs which require analgesia and on-going pain and symptom management and repositioning.
- Mechanical and technological intervention is required.
- Medications require significant adjustment by the practitioner according to fluctuating medical conditions or require complicated medication administration regimes/ routes such as intravenous or intrathecal.
- The levels of unpredictability evident or characteristic of the individual's condition and/or behaviour are such that they present an increased risk to the carer.
- Nutritional requirements necessitate intravenous therapy such as TPN.
- Complex respiratory and airway management where airway management is unstable.
- High risk of asphyxiation and/or aspiration requiring clinical intervention.

6.12 For this level of dependency, the individual will need support from a specific care worker who has received training in specific health interventions which are considered as complex or complicated. Immediate intervention would be required as the health need may be life threatening. Care would be provided by a named care worker who has received training for a named individual from a healthcare professional and assessed as competent to provide these interventions.

6.13 The following table includes the range of more complex needs and associated tasks that the Provider may be asked to deliver.

Need level	Example of intervention	Associated task
HIGH	• Intravenous infusions • TPN • Central lines • Tracheostomy and ventilatory support night and day 24/7 including deep suction. • Haemodialysis • Ventilatory support either night or day with Naso pharyngeal suction • Complex Continence care • Peritoneal Dialysis • Medications management complex – intrathecal and other routes • Complex Tissue Viability	• Complex respiratory and airway management where airway management is unstable. • High risk of asphyxiation and/or aspiration requiring clinical intervention. • Long term complex nutritional management • Life limiting and life-threatening conditions requiring. immediate response by a trained nurse. • Problematic continence management outside of mainstream services. e.g. • Manual Evacuation, frequent re-catheterisation (i.e., more than weekly) • Pain and symptom management requiring clinical judgement outside of a prescribed regime for example a seizure management protocol or rescue medication regime • Manual Handling constraints bespoke equipment with clinical risks to the underlying condition • Palliative-End of life care not met by routine care or input from the General Palliative Care services or district nursing services • Specialist and frequent dressing requiring analgesia, within a pain and symptom management plan. • Severe communication needs • Challenging behaviour requiring a specialist behavioural management plan.

6.14 On occasion certain tasks may require interventions from a Registered Nurse.

These are described as Nursing level.

This can be defined as:
The provision of specific nursing intervention outside of case management, which require the specific skills of a registered nurse. Interventions that are classified as non-delegated where an individual's condition is unstable or life threatening. Or the delivery of training to carers to feel confident to undertake elements of care.

Examples include

- Central line management
- Parenteral nutrition
- Specialist training to parents, family, carers and assessment of competency
- End of life care – syringe driver management etc
- Complex medicines management
- Non delegated tasks
- Specialist assessment

6.15 Individuals who have needs as described above may also have lower levels of need which the provider will also be expected to deliver and are described in the tables below.

Need of level	**Example of intervention**	**Associated task**
MEDIUM	• Ventilatory support either night or day – oral suction • Non-invasive ventilatory dependency with stability/predictability using BiPap or CPap • PEG/JEG feeding/dysphagia. • Stoma management • Medications management • Naso gastric feeding	• Respiratory and airway management- airway is stable and requires predictive management. • Nutritional management predictable but with some risk to the individual when providing nutrition support. • Continence needs requiring routine care. • Medication administration to a predictable regime oral/rectal routes- seizure protocol where individual responds to rescue medication. • Tissue viability noncomplex management and wound is responsive to treatment.

Need of level	Example of intervention	Associated task
		• Mobility issues within a risk management plan. • Non-invasive ventilation where the individual is unable to apply the mask independently and without prompting.
Level of need	**Example of intervention**	**Associated task**
LOW	• Medication- non poly pharmacy with compliance • Nutritional- encouragement and education • Tissue viability grade 1-2 • Continence • Communication • Non-invasive ventilatory dependency with stability /predictability using oxygen or nebulisers. • Personal care – to include (but not exhaustive) assistance with mobilising e.g., Bed to chair etc, washing, dressing, bath/shower, food and drink prep and assistance	• The nature and characteristics of the condition are stable and predictable. • Low level seizure management, monitoring/ observation. • Medications administered via non-complex routes. • Non-problematic gastrostomy/PEG • There is requirement for low intensity, predictable interventions which can be provided by a trained/skilled and competent carer wound management prevention. • Minimal mobility risk. • Routine Continence management • Prompts to aid communication. • Non-invasive ventilation where the individual is able to apply the mask independently and without prompting.

6.16 The following table is linked to national domains and represents the three Dependency levels, but the examples are not exhaustive and may require discussion with the Commissioner on a case-by-case basis. Providers will be expected to be able to meet needs described in the High Level for each domain according to each individual's needs

DOMAIN AND DESCRIPTOR	High Dependency level	Medium Dependency level	Lower/ Low dependency level
Challenging Behaviour	Behaviour requiring specialist health interventions and posing a serious risk to the physical safety of the person and/or carer	Behaviours that require multi-agency involvement and where an adolescent is unable to self-regulate their behaviour, including impulsive behaviour and self-neglect	Behaviour that is predictable and can be managed by a skilled carer
Communication	Very limited communication despite support from carers and professionals and/or the individual demonstrates severe frustration through challenging behaviour at being unable to communicate.	Basic needs are difficult to interpret or anticipate. Support with communication aids is usually required	Special effort required to anticipate and interpret needs
Mobility	Completely immobile and unstable clinical condition where movement presents a high risk of serious physical harm	Unable to move in a developmentally and or age-appropriate way and unable to assist carers. Needs more than one carer. Involuntary spasms placing self or carer at risk. Extensive sleep deprivation the carer or individual? 1-2 hourly 4+ nights per week	Unable to stand but can assist with one carer. Some sleep deprivation due to underlying medical needs 3 times per night for at least 2 nights per week.
Nutrition	IV feeds -/TPN Severe dysphagia with	Specialised feeding plan.	Non-problematic gastrostomy/

DOMAIN AND DESCRIPTOR	High Dependency level	Medium Dependency level	Lower/ Low dependency level
	associated risk of aspiration/chokin g. Naso gastric feeds On-going skilled assessment required.	Problematic Gastrostomy/jejunostomy	jejunostomy Requiring dietary support/advice because of underlying condition
Continence/ **Elimination**	Requires peritoneal/haemo dialysis to sustain life. Problematic stoma care. Problematic continence care – e.g., Intermittent catheterisation by skilled carer.	Doubly incontinent but with routine care Self-catheterisation Occasionally unstable stoma	Routine continence care with pads, etc. Stable stoma.
Skin/Tissue Viability	Life threatening skin conditions or burns. Open wounds which are not responding to treatment and requires a specialist dressing regime and intervention by the Tissue Viability Services.	Responsive open wound. High risk of skin breakdown requiring preventative intervention several times per day from skilled carer. Active skin condition requiring daily monitoring and treatment	Pressure or minor wound requiring clinical reassessment less than weekly. Active skin condition requiring minimum of weekly clinical reassessment.
Breathing	Requires mechanical ventilation either	Requires use of intermittent or continuous	Requires assistance with

DOMAIN AND DESCRIPTOR	High Dependency level	Medium Dependency level	Lower/ Low dependency level
	permanently or just when asleep. Highly unstable tracheostomy with frequent occlusions requiring suction and difficult to change tubes. Frequent unpredictable apnoeas requiring oral and/or naso pharyngeal suction	low-level oxygen and/or oral suction. Has episodes of acute breathlessness requiring clinical input	use of inhalers and nebulisers.
Drug Therapies and **Medication**	Intractable pain requiring medical and nursing management to ensure effective pain and symptom control. Extensive sleep deprivation causing severe distress to the individual due to intractable pain. RN required for drug management.	Skilled carer required for drug management. Sleep deprivation due to essential medicine management occurring at least 4 times a night 4 times a week.	Sleep deprivation due to essential medicine management occurring 2-3 times a night at least twice a week.
Psychological and **Emotional**	Rapidly fluctuating moods of distress, anxiety and depression necessitating	Frequent low mood/depression with noticeable fluctuations in concentration.	Occasional anxiety/low mood.

DOMAIN AND DESCRIPTOR	High Dependency level	Medium Dependency level	Lower/ Low dependency level
	specialist intervention. Total withdrawal from daily activities due to an individual's psychological and emotional needs and as a result of impaired cognition Risk of self-harm or symptoms of mental illness, placing the individual at risk. Mental health services actively managing the individual	Withdrawn and limited response to necessary prompts. Noticeable deterioration in self-care requiring prolonged intervention from key staff. Individual known to Mental Health services	Responds to prompts and reassurance.
Seizures	Requires daily intervention and clinical judgement by RN to select and implement appropriate interventions to manage the individual's seizures. Severe, uncontrolled seizures not responding to medication and treatment is administered as detailed within an	Seizures resulting in loss of consciousness. Skilled intervention required within an individual's protocol Sleep deprivation due to essential seizure management occurring 3 times a night.	Occasional seizures or periods of unconsciousness requiring supervision by a carer to Increase the individual's comfort and well-being.

DOMAIN AND DESCRIPTOR	High Dependency level	Medium Dependency level	Lower/ Low dependency level
	individualised protocol.		

6.17 Provider Obligations

6.18 Please also read this section in conjunction with the Service Expectations section (Section 11) of this service specification which applies to all providers.

6.19 The provider is required to advise the Surrey Continuing Healthcare Team Duty Desk – syheartlandsccg.surreydutynurses@nhs.net of any significant changes or events that are brought to their attention with regard to the individual or associated care team. Such notifications should be made in a timely manner.

6.20 Interdependencies and other services. Stakeholders will vary as identified in Section 11 and the interface with NHS universal services cannot be overstated. Access and support from NHS universal services should be sought as circumstances allow.

6.21 The provider will demonstrate clear knowledge of how to access local NHS primary and acute services, if required

6.22 All individuals in receipt of a package of care commissioned through NHS Continuing Healthcare funding will maintain their entitlement to access mainstream NHS services. The Provider shall establish and maintain links with key primary and secondary NHS services that may be involved in the individual's overall care provision.

6.23 Referral and Funding Authorisation – Packages of care for individuals within the High Level of need as described above will be advertised via E-Brokerage to all providers who have been awarded a High Needs contract at evaluation.

6.24 When the Provider has expressed an interest in the package and received further details which should usually include an outline care plan from the Placements Team, the Provider shall undertake an initial assessment of the individual. The Provider shall bring to the attention of the Commissioner, any differences in the proposed care plan that are identified by the Provider's assessment. Once the Provider has completed their assessment, they should agree the individual's care plan with the Commissioner.

6.25 The Provider shall submit to the Commissioner a quotation of cost for the service to be provided as outlined in the agreed care plan. The Commissioner reserves the right to negotiate the proposed cost

6.26 All quotations should be based on the standard prices as quoted by the Provider at the time of tender and may include additional costs needed to meet the individual's assessed complex needs. NB- Where an individual is assessed as no longer being eligible for CHC and is found eligible for local authority funding any higher rates for care agreed will revert to the standard rate.

6.27 Where higher rates are agreed as described in section 6.26 above the Provider is required to quote standardised higher rates e.g., no variable rates for bank holidays, week-ends, evenings etc

6.28 Once the weekly fee has been agreed and the package of care commenced the Commissioner will issue an Individual Service User Placement Agreement (ISUP) and send to the Provider. (Please see Schedule 6 – for ISUP Agreement).

6.29 The Individual Service User Placement agreement (ISUP) must be signed and returned by the Provider.

6.30 Ongoing Service Provision – The Service model comprises of a team leader/supervisor with the relevant skills and qualifications in line with the Providers statutory obligations under its registration, and a team of qualified nurses, where appropriate and trained carers with a:

- Named key worker identified for each individual
- Clear system for handover of information re the individual's specific needs from key worker/named nurse, in place.
- Documentation and recording systems, including paper and electronic
- Written protocols in place for any specific procedure undertaken with the individual

6.31 Regular reporting of information to be submitted for the Continuing Healthcare High Needs Home Based Care Key Performance Indicators (KPI) as defined in Appendix 2 of this Service Specification.

7. Live-in Care

7.1 This section is for providers who have applied to deliver Live-in Care as a part of the tender process.

7.2 Live-in care will be commissioned along the same requirements as HBC with this section defining the additional requirements for providers delivering a live-in care service.

7.3 Live-in care is a personal, full-time care service, usually delivered by a care worker who lives within the individual's home. The nature of the care and support required will vary depending on individual circumstances. Some individuals may require a long-term service while others may only require live-in care as a short-term emergency intervention.

7.4 In some circumstances an individual's care arrangement may need to be in place until an individual's long-term needs are assessed and determined, and an appropriate package of HBC is sourced. In all instances notice to end a live-in care package will need to be given in line with section 10 of the Package Purchase Protocol and Service Delivery Requirements (Schedule 2), Termination of an individual Care Package.

7.5 Live-in care is available to any resident assessed as requiring this service by the commissioner.

7.6 Intensity of care required will vary according to individual need as laid out in the individual's support plan/NHS care plan. If the demands of an individual package exceed the level of care deliverable by a live-in care worker, providers are reliably trusted to communicate this with the commissioner. Packages of care will be reviewed to ensure live-in care continues to be an appropriate means of meeting the individual's needs.

7.7 Competitive rate ranges have been shared by the commissioner in order to ensure providers understand the current Surrey market (see Table 2 of Delivery Areas and Pricing Guidance for rates).

7.8 Clarity over pricing and rates for different package types is essential in order for providers to be able to pick up packages in a timely manner and for the commissioner to make informed decisions about who is best placed to deliver care to an individual.

7.9 Live-in Care is a competitive market and providing informed decision making to providers relating to rates should reduce the number of providers who currently unsuccessfully tender for new packages through e-brokerage.

7.10 The commissioner recognises that some providers may offer 'specialist' care and support therefore providers can submit differing rates to those shared in Table 2 of Delivery Areas and Pricing Guidance. The commissioner will clarify with the provider to understand the need for this differential pricing approach prior to acceptance onto the DPS.

7.11 Care will be delivered to the recipient on the support plan/NHS care plan only, unless otherwise agreed with the commissioner and provider. The care worker is not expected to:

- Prepare meals or carry out tasks for the individual's family unless specified.
- Clean the whole property.
- Be responsible for the care of pets.
- Undertake laundry and ironing for the individual's family.
- Complete other tasks within the home that have not previously been agreed by the commissioner.

7.12 Service Delivery Model - It is recognised that providers of live-in care work in different ways. Whilst a high number also deliver HBC, some providers only deliver live-in care. This specification marks a clear intent by commissioners to focus on the quality of care and support received by Surrey residents and an ambition to work more closely with our provider market.

7.13 Covering Breaks - Where care is required to support the individual during the live-in care worker's break, commissioners will prioritise work with:

- Live-in care providers able to deliver packages of care including required break cover (where the commissioner has ruled out voluntary or family support).
- Where a provider does not deliver HBC, providers are asked to partner with another HBC provider who is applying to join the new HBC DPS to arrange and deliver the required break.
- Where a provider is unable to partner with another provider on the HBC DPS, it will only be acceptable for a provider to partner with a HBC provider not on the HBC DPS where it has been explicitly agreed with the commissioner.

7.14 Providers who only deliver live-in care will only be accepted on to the DPS where it is demonstrated within their tender application that the live-in care worker break cover can be arranged where required through a subcontracting arrangement.

7.15 All subcontracting or changes to these arrangements must have been agreed in advance with the commissioner. The provider delivering the break cover must be CQC regulated and the commissioner along with quality assurance colleagues will confirm this arrangement pending satisfactory information. Please see clause 20 of Care within the Home Dynamic Purchasing System Terms and Conditions for more detail.

7.16 In some instances it will be necessary to arrange break cover through an alternative HBC provider on the DPS. The commissioner reserves the right to do this where it is considered a suitable option to meeting an individual's needs and will communicate this with the provider(s).

7.17 Additional Care - For the purpose of this specification additional care is any care required in addition to a live-in care worker and care worker break cover. Examples of additional care are waking night shifts and scheduled care calls required to deliver double handed care.

7.18 Where the live-in care provider also delivers HBC, they are encouraged to and will be supported to align their HBC and live-in care delivery areas. As with the delivery of care to support the individual during the care worker break, it is preferable for the live-in care provider to deliver any additional care to an individual. In the instance of additional care being required beyond daily break cover, this will be arranged and costed in line with hourly care delivery, and therefore it must be within the provider's hourly care coverage, as set out in Schedule 4, Care within the Home Pricing Schedule.

7.19 As in section 7.16 the commissioner reserves the right to arrange for additional care to be delivered by an alternative provider on the HBC DPS where it is considered an appropriate means of meeting the individual's needs. Again the commissioner will discuss this with the provider(s).

7.20 Where the individual's needs require additional care to meet their needs, these requirements cannot be subcontracted by the live-in care service.

7.21 Service Expectations - In order to further ensure residents of Surrey receive a good quality service, the live-in care provider will be visited during the duration of the DPS by the Quality Assurance team to complete audits. This will include speaking with care workers and recipients of care.

7.22 Surrey County Council and Continuing Healthcare are committed to ensuring that care workers are entitled to certain employment rights, and therefore it is the expectation that live-in care workers are directly employed by the live-in care provider. Where this is not the model of delivery the commissioner will seek assurances that appropriate agreements and insurances are in place during the tender. It remains the providers responsibility to ensure all recruitment and employment arrangements are compliant with relevant laws and regulations.

7.23 The importance of professional boundaries must be reiterated with live-in care workers, for example an agreement not to share personal mobile phone numbers and to make contact outside of the placement. It is not appropriate at any time for friends or family of the care worker to visit the premises.

7.24 Live-in care workers may have periods of time where they are not in placement. If a live-in care worker has not delivered care for the live-in care service within the previous 6 months, the commissioner expects the organisation to assess the care worker's competency prior to commencing a new package of care. This may take the form of face-to-face training, supervision, or an interview to ensure their knowledge and understanding is up to date. It also gives the provider an opportunity to update them on any changes in practice, for example, in light of Covid-19. Information pertaining to this process should be available upon request.

7.25 It is recognised that early notice for a live-in care package to commence is preferable for a number of reasons; to allow individuals to be matched to the best carer to meet their needs and for the live-in care worker to arrange travel arrangements, where they do not live locally to Surrey. The commissioner will aim to avoid circumstances where care packages are cancelled after arrangements have been made. Providers must be clear they have received confirmation that a package is agreed to avoid unnecessary cost where a package does not commence as expected.

7.26 Night Needs - There are likely to be instances where an individual will need occasional support at night. Where the care does not regularly exceed two disturbances per night these needs will be met by the live-in care worker.

7.27 Care workers must record care needs and communicate with the commissioner where night needs regularly exceed two disturbances per night or where they believe there is an ongoing change to the package originally requested.

7.28 Care Worker Wellbeing - The provider will ensure that live-in care workers are receiving the appropriate breaks and rest days. The commissioner will assume that live-in care workers require a break of 2 hours per day. It remains the providers responsibility to ensure all recruitment and employment arrangements are compliant with relevant laws and regulations.

7.29 If the demands of an individual package exceed the level of care deliverable by a live-in care worker, providers are reliably trusted to communicate this with the commissioner at the earliest opportunity.

7.30 Coverage - Providers seeking to deliver live-in care are asked to identify which postcode areas in Surrey they are able to provide services in, see section 1 of the Delivery Areas and Pricing Guidance for Profile of 94 delivery areas. Providers should only submit postcode areas where all live-in service levels can be delivered.

7.31 Maintaining SCC and CHC's focus for quality of live-in care provision, we are strongly encouraging providers, and will work proactively with providers, to align their live-in care delivery with their homecare coverage to ensure continuity of delivery, and confidence that break cover can be easily arranged where required. For further information see 7.13, Covering Breaks and 7.33, Rates. Providers are asked to respond to all requests for care and as noted in 8.2 of this specification, providers who do not respond within specified times will be removed from the DPS contract.

7.32 Surrey County Council and Continuing Healthcare encourage a flexible approach to live-in care coverage and may invite providers to review or amend their coverage through the duration of the contract. If a provider would like to review their postcode coverage, they must contact their lead commissioning contact to explore this. On award of the contract providers will be advised of their commissioning contact.

7.33 Rates – Providers must submit two (2) rates for both 24-hour live-in care excluding AND including care worker break cover. This ensures clarity for both the commissioner and the provider as to what is being requested and what the cost will be. The support plan/NHS care plan will set out the requirements of the package and what type of care applies. The commissioner also requests that providers who wish to be considered for delivery of care and support to 'shared households' must also submit two (2) rates;

7.34 24-hour live-in care excluding break cover.

To apply where an individual is assessed as safe to be left in the home alone for the duration of the care worker's daily break, or where alternative provision, for example friend, family member, or voluntary organisation, can provide care for the daily breaks needed by the live-in care worker.

7.35 24-hour live-in care including break cover.

To apply where the individual is assessed as requiring care and support during the live-in care worker's daily break and commissioners have asked the provider to arrange replacement care for the duration. Care during this time must be delivered by the replacement care worker and not the existing live-in care worker.

7.36 24-hour shared household rate excluding break cover.

To apply where it is assessed that it could be appropriate for a live-in care worker to meet the needs of two individuals living within the same home (see Household Delivery, section 7.40).

7.37 24-hour shared household rate including break cover.

To apply where it is assessed that it could be appropriate for a live-in care worker to meet the needs of two individuals living within the same home, with the addition of replacement break cover (see Household Delivery, section 7.40).

7.38 There may be instances where calls to provide break cover are not required daily due to support available through the individual's friends, family or a voluntary organisation. Where breaks are not required daily, support plans/care plans may be made up of a variety of rates including and excluding the break cover.

7.39 Live-in care rates submitted will not vary according to postcode.

7.40 Household Delivery:

- The shared household rate will be applied when two individuals living within the same home are assessed as live-in care being a suitable means of meeting both their needs. One live-in care worker will meet the needs of the individuals within the home.
- It must have been agreed by the commissioner and will not apply without written agreement. The provider must receive a support plan/care plan for each individual.
- There will be occasions when the needs of two individuals living in the same home will exceed what is deliverable by one care worker. In these instances, shared household delivery will not be an appropriate care arrangement.

7.41 Where live-in care workers are delivering care to two individuals' providers must consider the level of support the care worker is required to deliver and must take steps to ensure staff are supported regularly.

7.42 Where one individual no longer requires care at home due to absence, including temporary absence for example hospital admission, the rate will revert to the individual 24-hour live-in care rate, including or excluding break rate as required by the individual who will continue to receive care. Commissioners will update individual support plans to reflect this. In this instance a retainer for the absent individual referenced in section 7.47 will not be required.

7.43 Charging the Individual - Other than providing live-in care worker accommodation, the individual will pay all the expenses of a normal home, including utility bills, and their own day to day and personal expenses, but they and the commissioner will not be expected to pay for the following (this list is not exhaustive):

The keep of the care worker, including;

- care workers' food or meals, the cost of which should be included in the package cost,
- the transport of care workers, or
- any charges relating to the CHC / SCC agreed package of care.

7.44 Living Arrangements - A live-in care worker should expect to be provided by the individual with a bed within a private space, for example within a spare bedroom.

7.45 The live-in care worker will be classed as a 'service occupier' as they are required to live-in the property in order to deliver the care that the care provider they work for has been contracted to provide on behalf of the commissioners.

7.46 If alternative accommodation is required by the live-in care worker, for example to carry out an isolation period during the Covid-19 pandemic or in any other similar scenarios, this must be arranged by the care worker or care provider and will not be funded by SCC or CHC.

7.47 Absence – Instances of absence will be dealt with on a case-by-case basis with the needs of the resident informing decision making. Where the individual being cared for is admitted to hospital the care worker must advise the agency and, in most cases, seek alternative accommodation within 24 hours of admission. A discussion will take place between the commissioner and provider about whether the individual requires continuity of care to facilitate an effective discharge or support the individual with tasks whilst they are in hospital. The provider and locality team/CHC duty team should discuss whether they are requested to retain the service and whether a retainer fee is appropriate, ensuring time frames for any agreements are clear.

7.48 On closure of an individual live-in care package, the live-in care worker will need to ensure plans are in place to leave the property at the agreed time of package end.

8. Additional requirements for Care Within the Home Services

8.1 This section references requirements for Providers delivering Care within the Home services and should be read in conjunction with;

- ‘Package Purchase Protocol’ (Schedule 2)
- Pricing & Invoicing Protocol for full details of the invoice requirements (Schedule 3).

8.2 Providers must be signed up to and use the e-brokerage system (electronic referral system) to receive and respond to new requests. Providers who do not respond or take on new work within specified times may be removed from the DPS contract.

8.3 For ASC funded packages, providers must work with an e-invoicing system. Providers who are not able to use an e-invoicing system or would choose not to sign up to use one will not be accepted onto the DPS to access referrals for ASC funded packages.

8.4 The Commissioners require providers to utilise a suitable Electronic Care Management (ECM) system. An ECM system will be essential to improving the quality assurance, transparency and accuracy of care provided by the provider. Where a provider does not currently use an ECM system, they must demonstrate through their tender how they intend to have a system in place by October 1st 2021. This does not apply to providers who only deliver live-in care.

8.5 The information captured through an ECM will be essential in evidencing outcomes for individuals and enabling payments to be accurate and for the commissioner(s) to understand care delivered by agencies and therefore services received by residents.

8.6 ECM will not be used to implement minute by minute billing.

8.7 Satisfactory ECM systems should have a suite of reporting capabilities that can deliver analytical insight of the services being provided by the organisation contributing to the quality assurance and continuous improvement of services provided. This reporting functionality will also simplify the process of gathering the contractually required Key Performance Indicators of this contract from the ECM system as set out in the Performance Monitoring Framework (Schedule 5).

8.8 There are numerous ECM Systems available to Providers in the marketplace. A satisfactory ECM system would be expected to deliver the following:

- Providers will know in real time the punctuality of care visits e.g., if a care worker is early or late. This will enable an appropriate and timely response.
- Providers will know how long a care worker has stayed (this will support flexible use of total time available over a week, and billing according to what is delivered)
- Be simple to use and allow people in receipt of care and allied health and social care workers to view details of care calls and care plans.
- An ability to run reports of information captured.
- An ability to raise alerts, concerns or feedback to the office team.
- Be system secure having clear data protection features and system audit functions.

8.9 An enhanced ECM system might include additional features such as:

- Mapping functionality
- Digital care plans that can be updated during the visit as tasks or outcomes completed.
- Ability to capture and log any unexpected issues e.g. Falls
- Ability to share handover notes between care staff
- Family, Carer or Next of Kin system access to be updated on care activity delivered.
- Having an Open API (Application Programming Interface) to potentially interface with future Commissioner systems directly.

8.10 Providers should consider the length of contract that they are agreeing when purchasing an ECM system and understand what system improvements will be in development over the course of the contract length.

8.11 Where people cannot access the system easily (or at all in the case of people who do not use mobile technology, cannot link to mobile internet or appropriate IT) clear physical records should be maintained as back-up.

8.12 The commissioners require rates to be fully inclusive of all costs associated with delivering a service, this includes travel time, mileage, and staff training as with all relevant legislation and legal requirements. Providers are required to submit standard rates e.g., no variable rates for bank holidays, weekends, evenings etc.

8.13 Providers will not charge more to an individual using a direct payment or a Personal Health budget than if they were receiving a directly commissioned service.

8.14 Surrey County Council and the NHS in Surrey require all providers it contracts with under Care within the Home to be registered with CQC for the provision of care. Organisations that support people in their own homes with activities that do not need to be regulated by CQC do not need to join this contracting arrangement.

9. Quality, Provider Support and Performance

9.1 Quality – Providers must be registered with CQC to provide the regulated activity of personal care. Registration must show that the type of service provided is homecare. Providers' CQC ratings will be checked regularly, and commissioners will respond with action depending on the rating of the service, as detailed below:

CQC rating Contract Management activity

- **Outstanding** Ongoing oversight, commissioner will respond appropriately to future CQC rating changes
- **Good** Ongoing oversight, commissioner will respond appropriately to future CQC rating changes
- **Requires Improvement** The relevant SCC Quality Assurance Team area manager will make contact to monitor and coordinate support for the provider to achieve a CQC 'good' rating and tackle immediate issues where these present before the provider is accepted on to the DPS. The provider may receive a visit from the commissioner or their representative to review quality standards.
- **Inadequate** Providers rated 'inadequate' by CQC will not be accepted on to the DPS. If a provider receives a CQC 'inadequate' rating after joining the DPS, new purchases of care packages will cease. The SCC Provider Support & Intervention Protocol will be initiated, and meetings will be held regularly until services improve.
- **Not yet inspected** The SCC Quality Assurance Team area manager will work with the provider as required until a CQC rating is awarded. Any further action to be considered in line with the rating received.

9.2 CQC quality rating 'requires improvement' – Commissioners, QA and the provider will work together to review ongoing performance and ensure that improvements to service standards are sustained.

9.3 CQC quality rating 'requires improvement' – Commissioners, QA and the provider will work together to review ongoing performance and ensure that improvements to service standards are sustained.

9.4 CQC quality rating ‘inadequate’ – Providers who are rated ‘inadequate’ will not be accepted onto the DPS until quality standards and CQC ratings improve before considering to join the DPS.

9.5 CQC quality rating ‘not yet inspected’ – Providers who are accepted on to the DPS that have not had a rating from CQC because they are a new provider or because there has been a change to their registration status for any reason will be supported by commissioners during the initial months of their time on the contract to ensure that the provision of support is in line with the specification and any issues can be resolved quickly. The support and intervention offered by commissioners will vary on a case-by-case basis, depending on the profile and experience of the provider.

9.6 Provider Support is a key part of SCC’s offer to providers. As part of the council’s Care Act Duty to support a vibrant and diverse market(s) SCC will work with providers to address issues of performance and quality.

9.7 Provider Management and Support - It is required that all providers are familiar with:

- The Surrey County Council Care Provider Support and Intervention Protocol [Providers will be sent a link to the PSIP following contract award].
- The Surrey Safeguarding Procedures as referenced on the Surrey County Council website .

9.8 Providers will be allocated a lead ‘relationship manager’ who will be a first point of contact for providers to discuss issues with.

9.9 Providers can attend a monthly meeting arranged by commissioners. The meeting is held on the fourth Thursday of each month from 1200-1300 and is a forum to discuss general issues informally regarding the provision of HBC in Surrey.

9.10 Providers will be supported to use E-brokerage, the system the commissioners will use to send individual referrals out to providers registered in each postcode area. Providers will also be added to the FREE online directory Surrey Information Point

and will be able to edit and update their profile page in order to advertise their services to residents across Surrey.

9.11 Providers will be supported by receiving referrals from a new centralised ‘Brokerage’ team which will present requirements for services in ways that will help providers build rounds in postcode areas.

9.12 Provider suspension - Commissioners expect that services delivered through the DPS contract will be to a high standard and providers are thanked in advance for their commitment and dedication to supporting vulnerable adults across Surrey. However, there will be instances when concerns need to be addressed and therefore the commissioners reserve the right to suspend a provider when certain concerns

and issues arise. The application and lifting of suspensions will be normally be agreed within the context of a provider support and intervention process. The timescales for suspending placements will be confirmed in the meeting and will vary from case to case depending on the specific issues. The issues or circumstances that would or may lead to suspension of placements are:

- Inadequate rating of a service by CQC that leads to CQC taking enforcement action
- Safeguarding concerns
- Quality concerns
- Market changes (including financial failure)
- Legal issues
- Management and staffing changes
- Complaints regarding the behaviour of management and staff

9.13 Providers are also asked to note that the commissioners' intentions are to only purchase home based care services through the DPS contract arrangements and there are no guarantees that levels of business purchased will be maintained during the term of the contract. Commissioners may choose not to purchase services from providers if the delivery of care falls below stated quality standards and expectations as detailed in this service specification.

9.14 Performance - Key performance expectations are detailed below;

9.15 Regular quality monitoring and contract management will be undertaken by the commissioners. The provider must submit contract monitoring data and information electronically on a monthly, quarterly, and annual basis and may be subject to a quality review by Adult Social Care and NHS CCG Quality Assurance Teams.

9.16 Commissioners will review performance of services delivered under the contract through several Key Performance Indicators (KPIs). For further details please see the Performance Monitoring Framework (Schedule 5).

9.17 In order to review ongoing quality of services provided and to help providers address any issues with delivery of services, all providers must have an Electronic Care Management (ECM) system – Please refer to Section 8 of this service specification for more information on ECM system requirements.

9.18 Providers must conduct their own customer feedback surveys and the commissioner as part of contract management processes reserves the right to have access to the analysis of the surveys.

9.19 Regulating the service - The commissioner will conduct visits as part of the quality monitoring and market surveillance requirements as set out in the Care Act 2014 .

The five key questions that CQC ask are :

- **Are people safe?** – People are protected from abuse and avoidable harm
- **Is the provider effective?** – People's care, treatment and support achieves good outcomes, helps people maintain quality of life and is based on the available evidence.
- **Is the provider caring?** – Staff involve and treat people with compassions, kindness, dignity and respect.
- **Is the provider responsive to people's needs?** – Services are organised so that they meet people's needs.
- **Is the service well led?** – The leadership, management and governance of the organisation makes sure it's providing high quality care that is cased around your individual need, that encourages learning and innovation, and that it promotes an open and fair culture.

9.20 The commissioner reserves the right to visit the provider as part of ongoing monitoring of the service. If a service is judged by the CQC or other regulator e.g., Surrey Fire and Rescue Service, the Border Agency not to meet its standards or regulations, the provider will be expected, upon request, to share with the commissioner any action plan they have put in place to meet the regulators requirements as part of our regulatory requirements.

9.21 Business Continuity Plans - The provider will be required to provide a detailed business continuity plan relevant to each service type (e.g. HBC, Live-in care) which sets out the arrangements for dealing with interruptions and to ensure that there is no or minimal disruption, following an event (planned or unplanned) which interrupts the provider's normal core business.

9.22 The provider must have the ability to respond to emergencies e.g., pandemics, winter pressures, adverse weather conditions, which should be clearly set out in their business continuity plans. The provider must have the ability to respond and plan for major sporting events or other things which could cause disruption.

9.23 Pandemic response and preparedness - The following sections are included due to the ongoing (as of March 2021) Covid-19 pandemic. This section will be kept under review during the term of the contract and may be revised, amended or added to as required by local or national policy directives. Commissioners will work with providers at the earliest opportunity in relation to any changes that may be required.

9.24 Providers must be able to follow the general guidance issued by the government regarding infection control relating to the Covid-19 pandemic and any subsequent pandemic or outbreak. The guidance is regularly updated and is available for review and providers must ensure that all staff who deliver home based care are aware of the requirements regarding use of personal protective equipment (PPE).

9.25 Providers must utilise and follow good practice guidance on supporting people who have returned home who have had Covid-19 where applicable.

9.26 CQC registered homecare providers must complete the 'Update CQC on the impact of coronavirus' online form. CQC email homecare providers every weekday with a unique link to their form .

9.27 The provider must, when requested by the coordinating commissioner, provide evidence of the development and updating of its processes and procedures to reflect changes in the legislation and good practice and update the HBC Capacity Tracker regularly in line with CQC and NHS guidance.

10. Training and Staffing

10.1 Supervision & Appraisal - Staff should receive formal supervision at least every 3 months. Supervision should cover practice issues, staff wellbeing and development needs. All staff should receive an appraisal at least once a year.

10.2 Training requirements - Providers must have a programme of ongoing training to ensure that their staff have the skills and knowledge appropriate for their role. The provider must be able to evidence how all staff are meeting the Care Certificate Standards .

10.3 Providers are required to submit to the commissioner their list of core and mandatory training, this list will form part of contract management arrangements. If the list of core and mandatory training does not meet the requirements of the commissioner, the commissioner reserves the right to follow this up with the provider.

10.4 The Care Certificate standards are the minimum standards that should be covered as part of induction training of new care workers. In order to be CQC compliant, the Care Certificate is required for care workers joining the care sector after April 2015. All staff providing home based care must have completed the Skills for Care 'Care Certificate' and be annually assessed by providers that they follow and understand the 15 core standards. The SCC Quality Assurance team will conduct spot checks of provider records to ensure there is evidence all staff have completed this training programme.

10.5 Making Every Contact Count . All providers that join the DPS must ensure all staff involved in frontline delivery of HBC complete this online programme (or similar) which will help staff recognise and understand the wider factors that affect individuals' public health. The SCC Quality Assurance team will conduct spot checks of provider records when they make planned visits to providers to ensure there is evidence all staff have completed this training programme.

10.6 The core training that the commissioner expects all the providers care worker staff to have undertaken and be up to date in are:

- Moving and handling
- Dementia awareness
- Mental health awareness
- Medication training
- Infection prevention and control

- Fluids and nutrition
- Safeguarding in accordance with the Surrey Safeguarding Adults Board Procedures
- Equality and diversity
- Privacy and dignity
- Health and safety

10.7 For providers who are on the CHC High needs specification, it may be necessary for care workers to acquire skills specialist nursing care, in order to meet Service User needs. Where these are required, the provider must be able to evidence that these competencies are reviewed and maintained regularly.

10.8 Staff must be able to deliver care and treatment to meet all Service User needs (including End of Life Care) safely to an appropriate standard and this must be reviewed on an on-going basis.

11.Service Expectations

11.1 Medication administration and associated health tasks - This section sets out some key requirements for medication administration and management.

11.2 Providers are expected to have a medication policy that reflects good practice as set out in Nice Guidance NG67 ‘Managing medicines for adults receiving social care in the community.’ This sets recommendations on:

- Governance arrangements and joint working between health and social care
- Assessing medicine related support needs
- Supporting people to take their medicines, including covert administration and managing concerns
- Staff training and competency
- Sharing medicines information and record keeping
- Safely ordering and supplying medicines and transporting, storing and disposing of medicines

11.3 The full guidance from NICE can be found here:

11.4 The medication policy and procedures must also set out how the service will comply with relevant CQC regulations and guidance can be found here:

11.5 Providers must have clear policies in place with regards to the good governance of medication administration. These should describe clear processes for auditing and monitoring all aspects of managing medication on an ongoing basis, examples include auditing; staff training; assessment of staff competency; regular auditing of medication administration of records (MARs); identification of potential missed medicines; reporting and responding to errors.

11.6 Where shortfalls have been identified in medication management, providers are expected to be able to demonstrate how issues have been addressed, such as through training or process reviews. The provider must also be able to demonstrate that they have followed their own internal reporting procedures in relation to medication errors and documented how learning has been shared.

11.7 The tasks outlined in the following table are grouped into three different levels; each having different levels of responsibility:

- Level 1 - general support tasks where the individual remains responsible for administering their own medicine and general support is provided by the care worker.
- Level 2 - tasks where the care worker would be responsible for administering.
- Level 3 - the responsibility remains with the healthcare worker and can be administered by the care worker if appropriate training is provided. Training is specific to the individual and the ability to provide that health support cannot be transferred to other customers.
- Further details of these tasks are found within Appendix 3 of this service specification

11.8 As described in the NICE guidance, medicines should be supplied in their original packaging. The appropriate use of monitored dosage systems can reduce reliance on a care provider to support with this task, allowing the individual to self-administer. Monitored Dosage Systems (MDS) e.g. Nomad boxes should only be supplied following an assessment by a pharmacist (in line with the Disability Discrimination Act 1995). Where MDS are being used, the support plan must demonstrate that the provider's involvement with this task has been reduced to a minimum or to no involvement at all. It is important to note that MDS are not there to support providers to administer medication - the MDS should be put in place to support the individual and not the provider.

11.9 Medication errors and safeguarding. Providers should adhere to requirements as set out in the Surrey Safeguarding Adults Board Adult Safeguarding Policy and Procedures , and with section 42 of the Care Act 2014 and section 14 of the Care and Support statutory guidance when dealing with medication errors and missed medication.

11.10 The provider should refer adult safeguarding concerns to Surrey County Council when it appears to the provider that the criteria in s42(1) Care Act 2014 may be met; that is to say, when it appears that an adult with care and support needs has experienced, or is at risk of, abuse or neglect due to medication being missed or a medication error, and they are unable to protect themselves from that abuse or neglect because of their care and support needs.

11.11 SCC cannot provide stand-alone visits to provide any support with the administration of medication under this contract. This includes prompts, checks and administering the medication. SCC can provide support with medication (subject to assurances provided in Appendix 3) if such support is provided within an existing visit. SCC will provide within an existing visit subject to appropriate training, a clear line of clinical responsibility to an identified NHS practitioner and subject to regular review

11.12 Moving & Handling - The Single-Handed Care approach has well evidenced benefits for service users, their carers, the care agency, and commissioner. Consequently, The Commissioner, requires all providers to promote and fulfil these risk assessed care tasks.

11.13 In addition, the support from a single carer rather than multiple carers is often preferred by individuals for the following reasons:

- It allows for better relationships between the individual and care worker as the care worker is more likely to be attending consistently.
- It offers more control of the process to the individual
- The individual's privacy and dignity are better respected
- There is less chance of care worker illness affecting the ability of the agency to provide temporary replacement support.

11.14 Providers need to operate single handed care when it has been assessed as appropriate by an appropriately qualified person representing the commissioner and when suitable equipment is in place to allow care and support to be given to the individual.

11.15 Providers are expected to comply with single handed care when the above has been met as environmental, physical and cognitive hazards are identified and taken into consideration when making recommendations. During the assessment all factors are considered, including the individual's behaviour, unpredictable physical symptoms and weight. We acknowledge that the main purpose of equipment provision is to increase the individual's independence, facilitate safe moving and handling and to reduce the risk to an individual and those involved in their care during transfers, and not to manage behaviour.

11.16 When using equipment such as hoists, or non-standard equipment, an appropriately trained assessor will provide the agency with a Moving and Handling Risk Assessment and Management Plan clearly detailing the risks and actions required and future review schedule. This document will detail any additional tasks and skills required to implement safe single-handed care.

11.17 All care workers are expected to have up to date moving and handling training and the risk assessment will not provide details of basic manoeuvres, such as how to roll an individual on a bed, sling insertion, etc. More detailed information will be provided when an individual's needs require specific manoeuvres which deviate from the norm and when non-standard equipment has been provided, as well as when using hoists and non-standard equipment with only one care worker. As a result, the determining factor for whether single or double handed care is required is based on a risk assessment, and not on a standard policy which is associated with the type of equipment provided, e.g. a hoist may be used with one carer if this is assessed as being safe.

11.18 Equipment provided by the Commissioner - Care staff will have received training from their employer on the commonly used pieces of equipment e.g. profiling beds, mobile and ceiling track hoists, slings, slide-sheets and other transfer aid items of equipment.

11.19 Equipment provided for the Service User by the Commissioner must be:

- managed safely and securely, with staff undertaking the appropriate training.
- operated safely, following any risk assessed care plan provided by the prescriber of the equipment.
- operated in line with the manufacturer's instructions and daily safety checks.

- made available for maintenance; and
- only used in relation to the named Service User.

11.20 The provider must report to the equipment provider and the prescriber any identified faults or concerns in any equipment used in the care of the individual or likely to cause harm to the individual or others, appropriately and in a timely way.

11.21 In the event of the equipment no longer being required by the Service User for whom the equipment was identified, the Provider must advise the Commissioner within 24 hours in order that arrangements can be made for the equipment's collection.

11.22 Protective Personal Equipment (PPE) – Protective Personal Equipment for the staff in the event of COVID-19 contamination will be provided by the Provider. Providers may seek support through the local resilience forum. However, in the event of any problems providing this equipment the Commissioner will provide support in acquiring the equipment required to safely care for patients.

11.23 Management of Disposable Equipment and Ancillary Items - Stock levels and the supply of disposable equipment and ancillary items will be agreed prior to discharge together with a mechanism for re-ordering.

11.24 The NHS (Community Provider) will:

- Provide all agreed disposable equipment and ancillary items relating to the individual e.g., incontinence pads.
- Agree a routine stock take and delivery schedule with the Individual's family.
- Provide a mechanism for obtaining items out of hours in the event of an unexpected increase in usage.
- Provide all agreed ancillary equipment.

11.25 The Provider will:

- Supply disposable items for use by provider staff e.g. disposable gloves and aprons and any other items required under the HSE guidelines.

11.26 Records – The following to be delivered as a minimum:

- Record management policy, which ensures as a minimum adherence to GDPR, confidentiality and regular audit of records.
- Care plans to have been developed in conjunction with the individual and/or their representative and to reflect the individual's wishes.
- Care plans to include risk assessments where appropriate.
- All visits/activity must be recorded in a legible, timely and accurate manner.
- Only one record to be kept per individual. Where community working requires an accessible record, this should be filed with the notes when the individual is discharged, and the notes should refer to the additional record and where it is held.
- Clear process for moving and tracking records to be in place.

11.27 Records are to include:

11.28 Care Plan:

- The individuals care plan is outcome based as identified from the holistic assessment and in accordance with the person's care plan where appropriate with a minimum weekly review.
- The individual has an up-to-date plan of his/her care, which recognises the abilities, and responsibilities retained by him/her and their next of kin) and encourage him/her and next of kin to share and supervise the care provision where appropriate.
- The care plan has been fully developed and discussed with the individual and their representative).
- The care plan is regularly reviewed to ensure it continues to reflect the individual's needs.
- The care plan is updated in a timely manner, outside of regular reviews, where a change in need or a new need has been identified.

11.29 Risk Assessment - minimum monthly review

- All assessments tools are in accordance with national guidance and evidence-based practice and where available, a joint assessment tool has been used.
- The care plan and the assessment of need are made available to all involved in the care of the individual.

11.30 Daily records

- Daily records are maintained as a contemporaneous record of care delivery.
- Daily records to include completion of any additional documents e.g., fluid charts.

11.31 Links with relevant agencies – The provider should link with other relevant agencies and providers and with the statutory services providing other elements (where appropriate).

11.32 The provider shall also liaise with other care and mainstream medical service providers as necessary to ensure a co-ordinated approach.

11.33 It is recognised that home-based care/ complex healthcare services are an integral part of the wider care services provided. The provider must work in collaboration with the wider partners to address the needs of the individual to increase the ability of the individual to attain optimum outcomes. Partners will include (where appropriate):

- Community health services
- Acute and specialist hospital providers
- Multi-disciplinary team key worker
- Consultants
- Education
- Leisure
- Housing
- Voluntary sector e.g., hospices
- GP's
- Others specific to the individual
- Social Services

12. National Guidance and Service User expectations

12.1 The objectives of these services are based on national guidance published by NICE (National Institute for Health and Social Care Excellence), SCIE (Social Care Institute for Excellence) and the Care Quality Commission (CQC) and detailed under each Lot description. These objectives will form the basis of the performance monitoring requirements for each service specification.

12.2 The NICE Quality Standard is the commissioners' expectation that all providers who sign up to deliver HBC in Surrey adhere to the NICE Quality Standard for Home Care for Older People (QS123) , as published in June 2016. This Standard has the following quality statements:

- **Statement 1** people using home care services have a home care plan that identifies how their personal priorities and outcomes will be met.
- **Statement 2** people using home care services have a home care plan that identifies how their home care provider will respond to missed or late visits.
- **Statement 3** people using home care services receive care from a consistent team of home care workers who are familiar with their needs.
- **Statement 4** people using home care services have visits of at least 30 minutes except when short visits for specific tasks or checks have been agreed as part of a wider package of support.
- **Statement 5** people using home care services have a review of the outcomes of their home care plan within 6 weeks of starting to use the service and then at least annually.
- **Statement 6** home care providers have practice-based supervision discussions with home care workers at least every 3 months.

12.3 Expectations by individuals of a high-quality service - Individuals should expect the following from a provider (as set out in the SCIE and NICE 'Better Home Care for Older People – a quick guide for people who arrange their own care')

- The care that individuals get should reflect what they want and what they have agreed with the agency. The care should consider what the individual feels they can do and are not able to do.
- The care worker should respect the cultural and religious values of the individual e.g., ensuring that individual food needs are met.
- The care agency should let the individual know in advance if a different care worker is going to conduct the visit.
- The individual should have a home care plan that describes the care the agency will be providing and is focused on the things that are important to them. The plan should consider any specific health problems or disabilities.
- The individual should feel comfortable around their care workers. The care worker should get to know the individual and be familiar with their needs. Including how they would like to communicate and their likes and dislikes.
- The care workers should have the right skills to meet the needs of the individual. They should be able to support the individual, for example if they have dementia, are deaf, deafblind or need help coping with bereavement.
- The agency should ensure the individual has a copy of the care diary to keep in their home. Home care workers and others who help the individual at home

(like community nurses and physiotherapists) should update it every time they visit.

- The agency should review the plan with the individual within six weeks of the first care visit to sure the individual is happy with it. After that, the plan should be reviewed at least once a year.

12.4 The National Framework for Continuing Health Care and NHS Funded Nursing Care by individuals of a high-quality service - As stated above this specification is joint with NHS Surrey Heartlands CCG for CHC services across Surrey. It is therefore important that providers note the National Framework for Continuing Health Care and NHS Funded Nursing Care and the following expectations for care planning needs.

12.5 Providers must ensure that they can demonstrate that they follow the six themes detailed in Making it Real which reflect the most important elements of personalised care and support. Each theme has several 'I' statements that describe what good looks like from an individual perspective. These are followed by 'We' statements that express what organisations should be doing to make sure people's actual experience of care and support lives up to the 'I' statements.

- Put the individual, their needs and choices that will support them to achieve optimal health and well-being at the centre of the process.
- Focus on goal setting and outcomes that people want to achieve, including carers.
- It should be planned, anticipatory and proactive with contingency planning to manage crisis episodes better
- Promotes choice and control by putting the person at the centre of the process and facilitating better risk management
- Ensures that people, especially those with more complex needs, the socially excluded and particularly vulnerable or those approaching the end of life, receive coordinated care packages, reducing fragmentation between services
- Provides information that is relevant and timely to support people with decision-making and choices
- Provides support for self-care so that people can self-care/self-manage their condition(s) and prevent deterioration
- Facilitates joined-up working between different professions and agencies, especially between health and social care, and
- Results in an overarching, single care plan that is owned by the person but can be accessed by those providing direct care/services or other relevant people as agreed by the individual, e.g. their carer(s).

12.6 The Accessible Information Standard - All organisations that provide NHS or adult social care must follow the accessible information standard by law. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services.

12.7 Healthwatch Surrey is the local and national consumer champion for health and social care. Healthwatch is another means by which individuals can share positive comments, issues and concerns about a health or social care service they are receiving. The commissioners expect providers to refer to Healthwatch Surrey in their service user information leaflets.

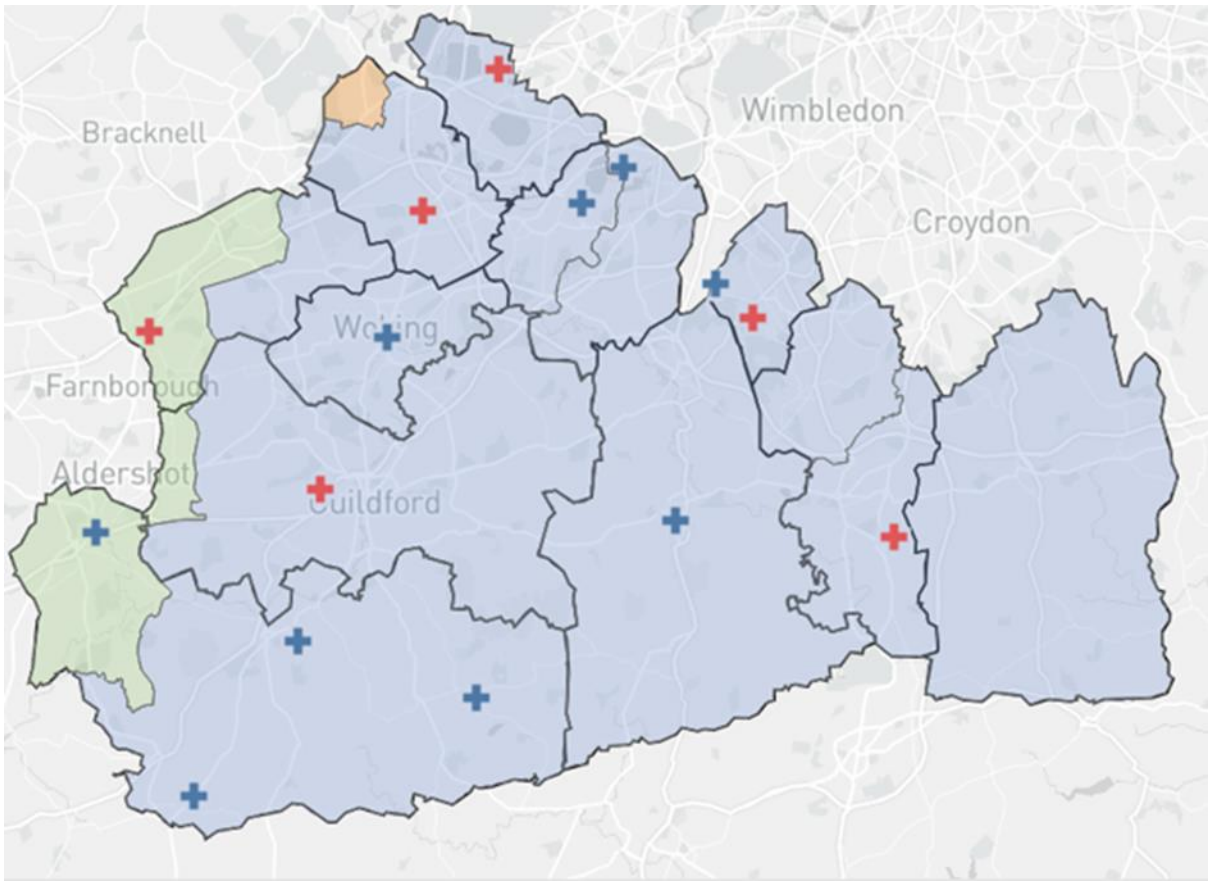
12.8 The provider should use a variety of accessible methods to actively seek feedback from services users around satisfaction levels. This could include surveys, phone calls, texts. The commissioner reserves the right to seek feedback on what actions have been taken because of service user feedback.

13. Business Rules

13.1 Modifications to the Business Rules and Package Purchase Protocol - The Council has discretion to modify the Business Rules by way of any deletions or amendments the Council sees fit during the Initial Term and any Extension Period. Such modifications are not considered to be material amendments under the Public Contracts Regulations 2015 and may include but are not limited to:

- Amendments to provider reviews
- Amendments to E-brokerage system
- Amendments to pricing approach during extension periods

Appendix 1 - Map showing the different Health systems in Surrey



NHS Surrey Heartlands CCG is made up of East Surrey, Guildford & Waverley, North West Surrey and Surrey Downs Integrated Care Partnerships (ICP).

NHS Frimley CCG includes the former CCGs Surrey Heath and NE Hants & Farnham

Appendix 2 - Continuing Healthcare High Needs Key Performance Indicators

KPI Number: KPI HN1

Performance Indicator:

1. Staff are trained to meet complex care needs as indicated on an individual basis
2. Staff competencies maintained on a regular basis
3. Evidence of how staff training and maintenance of competencies is delivered

Driver: Quality Assurance

Source of Data: Provider to share training logs, competency assessment, process for delivery

Questions, target and reporting frequency:

1. Percentage of staff trained in complex care needs, target 100%, reporting quarterly
2. Percentage of staff with up to date assessments of competencies, target 100%, reporting annually
3. Provide process and evidence of delivery of training and assessment of competencies, target 100%, reporting annually

Appendix 3 - Different levels of medication administration

Level 1: General support tasks	**Level 2: Administration by care staff**	**Level 3: Administration by care staff using a specialist technique.**
These are tasks that care staff can carry out to help a customer self-medicate and maintain their independence. The customer **must** be able to understand how to take their medication and the consequences of not taking it.	Care staff take responsibility for confirming they have selected the correct medication i.e. confirming that they have: The right medicine, for the right person, have selected the right dose, at the right time and given via the right route or method. Printed medicines administration records should be used for a person receiving medicines support from a home care provider. Staff should be trained in how to undertake this safely. Staff should be trained in what to look out for regarding effects of and contra-indications of medication and what they should do/who they should alert re concerns identified	These types of medicines will normally be administered by a health care professional. However, if appropriate, a health care professional may delegate these tasks to care staff provided they agree this with the Registered Care Provider Manager, they personally provide extra training and are satisfied that the care staff are competent. Staff should be trained in what to look out for regarding effects of and contra-indications of medication and what they should do/who they should alert re concerns identified.
Physical assistance at request of the customer (customer having identified required medication.): For example: • Unscrewing lids • popping tablets out of a pack • Assistance with preparing an inhaler • Applying a creams/ ointments /gels /lotions etc. • Help to apply transdermal patches	**Level 2 tasks may include some or all of the tasks listed below**: Ongoing support (and clinical oversight) for the care staff is required from the health professional as ultimately responsibility for these tasks remains with the health professional. Care staff should be given the opportunity to decline to administer medications via specialist techniques if they do not feel confident in their own competence.	**Level 3** covers tasks where a Care Worker can be trained appropriately, and where the health professional identifies that this is appropriate. It does not cover the provision of services for which a registered nurse is required, e.g. clinically invasive procedures, which should be provided by community and/or district nurses. In most circumstances SCC would not commission the tasks listed below in level 3 as these should be undertaken by community/district nurses. However, there are some occasions where SCC may commission such services -for

Level 1: General support tasks	Level 2: Administration by care staff	Level 3: Administration by care staff using a specialist technique.
(incl. controlled drugs). • Applying medication to the eye, nose or ear at customer request **Occasional infrequent prompts:** • Verbal reminders may sometimes be required for a self-medicating customer. The occasional need for a prompt does not mean a customer should be assessed as incapable of self-medicating.	Level 2 tasks include: • Frequent verbal reminders to take medication • Selecting the correct medicines for administration • Administration of oral medication including tablets, capsules and liquids (including controlled drugs) • Measuring out doses of liquid medication • Administering inhaler devices • Applying external medicated creams/ ointments /gels /lotions etc. • Applying transdermal patches (including controlled drugs) • Applying medication to the eye, nose or ear	example, where joint funding responsibility has been agreed because the person has a mix of health and social care needs. These tasks are likely to generally be commissioned for some of the CHC funded packages, both from the generic home care specification and also from the High needs specification. Level 3 tasks include The administration of medication via enteral feeding tubes such as • Percutaneous Endoscopic Gastrostomy (PEG) • Nasogastric (NG) • Nasojejunal (JG) Injections The administration of medication via rectal route PICC lines/TPN The administration of medication via sub cutaneous route such • Intra -Muscular (IM) Intra-Venous (IV) • Peripherally Inserted Central Catheter (PICC)

Level 1: General support tasks	Level 2: Administration by care staff	Level 3: Administration by care staff using a specialist technique.
		• Total Perenteral Nutrition (TPN) Ongoing support (and clinical oversight) for the care staff is required from the health professional as ultimately responsibility for these tasks remains with the health professional. Care staff should be given the opportunity to decline to administer medications via specialist techniques if they do not feel confident in their own competence.

Appendix 4 -Other useful contact details

Adult Social Care Contact Centre

Open between 8am to 6pm, Monday to Friday:

Telephone: 0300 200 1005

Email: contactcentre.adults@surreycc.gov.uk

SMS: 07527 182 861 (for the deaf or hard of hearing)

VRS: Sign Language Video Relay Service

https://www.surreycc.gov.uk/website/accessibility/options#bsl

Surrey Multi Agency Safeguarding Hub (MASH):

In an emergency where the immediate safety of a child, young person or adult is at risk, dial 999.

If you suspect that someone is at risk of abuse or neglect, please contact the Surrey Multi Agency Safeguarding Hub (MASH):

Telephone: 0300 470 9100 (9am to 5pm Monday to Friday)

Email: acsmash@surreycc.gov.uk

Emergency Duty Team (out of hours):

For emergency situations outside the standard lines' hours above:

Telephone: 01483 517898

Email: edt.ssd@surreycc.gov.uk

Continuing Healthcare (CHC)

Duty Desk

Email: syheartlandsccg.surreydutynurses@nhs.net

Continuing Healthcare (CHC) Placements Team:

Email: syheartlandsccg.chcplacements@nhs.net

For out of hours queries on health matters, please contact the District Nursing teams of the relevant Community Health Provider if required

Continuing Healthcare (CHC) invoicing address:

Email: sbs.invoicing@nhs.net.

Adult Social Care Duty Teams

- **Elmbridge Locality Team:** 01372 832695
  elmbridgelocalityteam@surreycc.gov.uk
- **Epsom and Ewell Locality Team:** 01372 832360
  epsom.ewelllocalityteam@surreycc.gov.uk
- **Guildford Locality Team:** 01483 517262
  guildfordlocalityteam@surreycc.gov.uk
- **Learning Disabilities and Autism Team (countywide):** 01483 404770
  learningdisability.admin@surreycc.gov.uk
- **Mole Valley Locality Team:** 01372 833456
  molevalleylocalityteam@surreycc.gov.uk
- **Reigate and Banstead Locality Team:** 01737 737179
  reigate.bansteadlocalityteam@surreycc.gov.uk
- **Runnymede Locality Team:** 01932 794800
  runnymedelocalityteam@surreycc.gov.uk
- **Spelthorne Locality Team:** 01932 795292
  spelthornelocalityteam@surreycc.gov.uk
- **Surrey Heath Locality Team:** 01276 800205
  surreyheathlocalityteam@surreycc.gov.uk
- **Tandridge Locality Team:** 01737 737500
  tandridgelocalityteam@surreycc.gov.uk
- **Transition Team:** 01276 800270 transitionteam@surreycc.gov.uk

Hospital adult Social Care Duty Teams

- **Epsom General Hospital Team:** 01372 735297
  epsomhospital.team@surreycc.gov.uk
- **Royal Surrey County Hospital Team:** 01483 464008
  rschospital.team@surreycc.gov.uk
- **St Peters Hospital Team:** 01932 722526
  duty.sph@surreycc.gov.uk
- **Surrey and Sussex Hospital Team:** 01737 231802
  sashospital.team@surreycc.gov.uk

Appendix 5- Glossary of Terms

Term	Definition
Assessors	Representatives from SCC or CHC who have responsibility for carrying out the statutory assessment of need
Assessment	Statutory assessment of an individuals' eligibility for care and support under the Care Act 2014 Assessment of an individual's eligibility for NHS Continuing Healthcare in line with the requirements of the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (Revised) 2018
Business Continuity Plan	an effective plan of helping business to build resilience against events including staffing shortage, pandemics, natural disasters.
Care Act (2014)	The Care Act (2014) sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.
Care Plan (see also Support Plan)	A care plan describes the tasks required to meet the assessed needs of the eligible individual and is provided by a CHC clinician or other designated healthcare professional.
Care Quality Commission (CQC)	Care Quality Commission (CQC) – the Regulatory body that ensures that standards of quality and safety are being met where regulated activity is provided.
Carer	An individual who looks after family, partners or friends in need of help because they are ill, frail or

Term	Definition
	have a disability. The care provided by the carer shall be unpaid.
Care within the Home	Care within the Home covers services being tendered for within this specification and procurement opportunity: Home Based Care, CHC High Needs, Live in Care, Waking Night/Sleep in.
Care Worker	A care worker is an employee of the provider who provides care and support to all Individuals.
Clinical Commissioning Group/ CCG(s)	Clinical Commissioning Groups are responsible for commissioning health services in their area.
CQC	CQC is an acronym for the Care Quality Commission with responsibility for the inspection and registration of registerable care providers and any successor regulatory body.
Commissioners	Commissioners are representatives of Surrey County Council Adult Social Care Directorate and NHS Surrey Heartlands CCG who have responsibility for purchasing the care through the contract.
Continuing Healthcare (CHC)	NHS Continuing Healthcare (CHC) is an ongoing package of health and social care that is arranged and funded solely by the NHS where an individual is found to have a primary health need. Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness.
ContrOCC	ContrOCC is the finance system used by SCC adult social care (as at March 2021). It links to

Term	Definition
	the case management system to ensure that payments are made in line with support plans.
Council	Refers to the Adult Social Care Directorate of Surrey County Council
Delivery area	The county has been divided up into 94 'delivery areas' which are aligned to the postcodes in Surrey e.g. TW12 or GU1. Some of the larger postcodes have been split further if they cover a large geographical area and will have the format GU8 5 or RH6 9. An interactive map has been created to demonstrate the delivery areas – available here[1]
Discharge to Assess (D2A)	Where people who are clinically optimised and do not require an acute hospital bed but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'. Quick Guide: Discharge to Assess (www.nhs.uk)
Dynamic purchasing system (DPS)	A dynamic purchasing system is a procedure available for contracts for works, services and goods commonly available on the market. As a procurement tool, it has some aspects that are like an electronic framework agreement, but where new suppliers can join at any time. Guidance_on_Dynamic_Purchasing_System_-_Oct_16.pdf (publishing.service.gov.uk)
ECM – Electronic Care Management System (ECM)	Electronic Care Management (ECM) systems are integral to the efficient running of a home care business, including functions such as:

[1] Full link for the delivery areas map

Term	Definition
	Real time information on care visits, electronic care plans and communication with office staff.
E-brokerage	E-brokerage is a web-based sourcing tool used to send care requests to awarded providers who have signed up for specific delivery areas and service levels. It is a contractual requirement that providers respond to package requests on this system.
Emergency Duty Team	The Council's out of hour's service. Out of hours social care contacts - Surrey County Council (surreycc.gov.uk)
End of Life Care (also known as Palliative care)	End of Life Care has been defined by the National Council for Palliative Care as: 'care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support'
GDPR - General Data Protection Regulation	The General Data Protection Regulation is a regulation in EU law on data protection and privacy in the European Union (EU) and the European Economic Area (EEA).
High Needs specification	The High Needs specification describes the tasks required to deliver packages of care commissioned solely for CHC funded individuals who have a significantly higher level of need and intervention.
Home based care	covers the provision of personal care to individuals in their own home. Organisations that provide personal care to people in their own home are

Term	Definition
	regulated by the Care Quality Commission (CQC).
Individual	means an individual person receiving support and a person who has been assessed by a Social Care Practitioner or Health Care Practitioner as requiring the Services and for whom the Provider is contracted by a Support Plan to provide the Services.
Individual Care Package	means the package of care as detailed in the Support Plan of the Individual
Individual Service User Placement/Package agreement (ISUP)	An Individual Service User Placement agreement (ISUP) is issued by the CHC Placements team and sent to the provider for review, signature and return. The ISUP contains details of the individual receiving the care (including a Patient ID number to be quoted when invoicing), the number of care staff, frequency and duration of calls and the start date for the package of care.
Key Performance Indicator (KPI)	criterion that helps to measure service quality and the contractual obligations for providers of the service
LAS	Adult Social Care system provided by Liquid Logic which holds all client records, assessments and support plans
Missed call (see also other call definitions – all included below this line (Late call, Re-scheduled call and Cancelled call)	A **missed call** is where an individual has not received a visit where one is scheduled, and does not receive a visit before the next scheduled visit, and has not been contacted to rearrange the time of visit
Late call	A **late call** is where an individual has not received a visit within 30 minutes of the scheduled time and has not been contacted to rearrange the time of visit.
Re-scheduled call	A **rescheduled call** is when a call is delayed and the individual receiving care has agreed for the call to be delivered at a different time/ or the individual has requested it be delayed.
Cancelled call	A **cancelled call** is when a call has been cancelled prior to the due time and the individual receiving care has agreed for the call to be cancelled/ or the individual has requested it be cancelled.

Term	Definition
NICE	National Institute for Health and Social Care Excellence
Non-personal Care	Means non-physical care such as advice, encouragement, supervision and prompting; emotional and psychological support, including the promotion of social functioning, behaviour management, and assistance with cognitive functions.
Package of Care (POC)	a combination of Services put together to meet a person's needs arising from an assessment or a review.
Personal Care	This is a regulated activity by CQC and involves supporting people in their homes (or where they are living at the time) with things like washing, bathing or cleaning themselves, getting dressed or going to the toilet.
Package Purchase Protocol	means the document outlining the specific terms under which care packages shall be made pursuant to Schedule 2.
Pricing and Invoicing Protocol	means the document outlining the Council's payment terms and agreed contract pricing pursuant to Schedule 3.
Provider	means the persons or person's firm or company whose tender has been accepted by the Council as set out at beginning of this Contract.
Provider Portal	The Provider Portal used by SCC adult social care is an electronic invoicing system which improves efficiency for payments administration and allows service providers to see payment reports.
Reablement	Reablement has been defined as 'services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living'. The focus is on restoring independent functioning rather than resolving health care issues, and on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves. SCC has a therapy led Reablement service, focusing on clients strengths and goals which enable them to engage in a skills gain programme for up to 6 weeks.

Term	Definition
Representatives of the Commissioner	This could include, but not limited to, social workers, CHC placements team, social care development coordinators, commissioners from the commissioning team, or the brokerage team.
Review	Care and Support Plan review – a statutory Review of a person's Care and Support Plan which must take place at least annually, in line with the Care Act. A Review may also be triggered at any time by a change in circumstances, such as a deterioration or improvement in condition, or the introduction of a piece of equipment.
Service(s)	means the services provided under this Contract described in the Service Specification (Schedule 1) and the Package Purchase Protocol (Schedule 2) and as set out in the Support Plan and the Contract Documents.
Social Care Team	means the Council's team of which the Individual's Social Care Practitioner is a member.
Strength based approach /practice	A way of working that Adult Social care use which considers an individuals strengths and networks, focusing on what is most important to the person. The aim is to help people to stay connected to their communities and support people to feel safe.
Support Plan	A document setting out the social care support that a person requires in order to achieve specific outcomes and meet assessed needs.
Surrey Information Point	Surrey Information Point is a website for Surrey residents and their families. It helps people to identify and select suitable advice and information on different services including statutory care and health services, along with local voluntary and community services.