# SCHEDULE B, ANNEX A, APPENDIX 3: SERVICE SPECIFICATION FOR RESIDENTIAL CARE WITH OR WITHOUT NURSING

## Contents

## Introduction

This document sets out the care specification and standards, which apply to the provision of care in a registered care home with or without nursing ("the Service"). The Service Provider ("the Provider") shall deliver a residential care service for people living in a registered care home who are ordinarily resident within the administrative area of Surrey County Council.

In 2022, the Council tendered for a long-term Dynamic Purchasing System (DPS) contract for Residential and Nursing Care. The contract is joint between Surrey County Council (SCC) and NHS Surrey Heartlands Clinical Commissioning Group (CCG) who host Continuing Healthcare (CHC) on behalf of the two Surrey CCGs. The Council will make spot purchases outside of the Residential and Nursing DPS Contract only in exceptional circumstances. Providers with whom we initially purchase Residential and Nursing Care services outside of the DPS contract are expected to apply to join the DPS for any subsequent purchases by initially registering at: Proactis, our tendering platform

The Provider will provide Services in accordance with:

- The Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as monitored, inspected, and regulated by Care Quality Commission to ensure Services meet fundamental standards of quality and safety
- The Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999
- The quality requirements included in this Service Specification

## Co-production

Several co-production sessions were held with the residential and nursing care provider working group, as well as group sessions with practitioners and care home staff to work collaboratively to develop this specification.

Two sessions were held in partnership with the Surrey Coalition of Disabled People to work with older residents to inform the development of the specification. Please see Appendix B for more details, but key themes that will form part of our expectations of providers include:

- Meaningful activity/occupation
- Delivering care compassionately
- Understanding resident's assets, strengths and interests
- Improving mental health awareness and treatment
- Improving complaints mechanisms and resident choice
- Updating methods of communication
- Promoting wellbeing
- Choice and control
- Use of media and digital technology
- Managing falls

A survey was sent to all care homes to capture information from their residents (and family members) on what makes a good care home. This information has been captured in the picture in Appendix C and we expect providers to recognise and respond to this feedback.

## National Guidance and Service Outcomes

The purpose of the Service is to provide accommodation, care, support and stimulation (including access to the community) to those people in the client group for whom it is not appropriate, either in the short or longer term, to live in their own homes. The Provider will ensure residents have access to good quality care, support and accommodation that can enable them to meet their health and social care needs and outcomes twenty-four hours a day, enhancing their quality of life.

The Provider will observe the principles of national and local good practice and clinical guidance, including but not limited to the appropriate NICE guidelines, quality standards, pathways and local authority briefings. The Specification could also be subject to change in response to any future changes in Legislation or Government guidance.

In observing the principles of care, the Service will work to those set out in the NICE guidelines www.nice.org.uk, quality standards and pathways including, but not limited to:

- Long–term conditions
- Dementia pathway
- Care for adults with depression
- Managing medicines in care homes
- Mental wellbeing for older people
- Nutrition and hydration support in adults
- Falls prevention in older people
- Prevention and control of healthcare associated infections
- End of Life Care for adults (Quality Standard 13)
- Oral health in care homes (Quality Standard 151)

Furthermore, the Service must be delivered in accordance with the guidance provided by; Public Health England, Resuscitation Council UK and the Royal Pharmaceutical Society Guidelines in relation to issues including but not limited to infection control.

Whilst the Commissioners aim to refer Providers to good practice guidance, the Provider is expected to know and keep up to date with best practice. Providers are advised that details of the current legislation which is applicable to this Service is available on the CQC website which can be accessed via the following link: http://www.cqc.org.uk

**Outcomes Frameworks**

- The Provider will endeavour to support Commissioners in achieving the outcomes set out in the Outcomes Frameworks for Adult Social Care, Public Health and the NHS, specifically:
- Adult Social Care Outcomes Framework:
- Enhancing the quality of life of people with care needs
- Delaying and reducing the need for care
- Ensuring that people have a positive experience of care
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.
- Public Health Outcomes Framework:
- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities.

NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill-health or following injury
- Ensuring people have a positive experience of care
- Treating and/or caring for people in a safe environment and protecting them from avoidable harm.

Commissioners may review information to evidence how outcomes have been achieved by the Service, including but not limited to:

- Outcome of the Service User's review
- Monitoring of Key Performance Indicators
- Contract Review Meetings
- Monitoring of trends arising from safeguarding
- Quality Assurance reporting
- Feedback and response to feedback from Service Users, Relatives and Staff
- Provider's compliments and complaints log and response
- CQC inspection and reporting documents
- Business plans and other relevant documents
- Other information the Commissioner may reasonably request from time to time.

**Service User outcomes**

The Service User Outcomes in this Specification are based on the Social Care-Related Quality of Life domains as defined below:

- Control over daily life: The service user can choose what to do and when to do it, having control over his/her daily life and activities
- Personal cleanliness and comfort: The service user feels he/she is personally clean and comfortable and looks presentable or, at best, is dressed and groomed in a way that reflects his/her personal preferences
- Food and drink: The service user feels he/she has a nutritious, varied and culturally appropriate diet with enough food and drink he/she enjoys at regular and timely intervals

- Personal safety: The service user feels safe and secure. This means being free from fear of abuse, falling or other physical harm and fear of being attacked or robbed
- Social participation and involvement: The service user is content with their social situation, where social situation is taken to mean the sustenance of meaningful relationships with friends and family, and feeling involved or part of a community, should this be important to the service user
- Occupation: The service user is sufficiently occupied in a range of meaningful activities whether it be formal employment, unpaid work, caring for others or leisure activities
- Accommodation cleanliness and comfort: The service user feels their home environment, including all the rooms, is clean and comfortable
- Dignity: The negative and positive psychological impact of support and care on the service user's personal sense of significance

## Care Home Facilities and Services

The Provider will:

Provide Services in approved locations, 24/7, 365-days per year

Ensure Placements are provided on a single occupancy basis, unless a shared room is requested by a couple or other recognised arrangement such as friends etc. The Provider will also provide telephone, television, Internet, and radio facilities; and provide accessible communal areas / facilities which offer an appropriate environment for Service Users, such as, quiet areas, designated smoking and non-smoking areas.

Ensure that access to drinks and light snack facilities will always be available. Where appropriate Service Users will be encouraged and supported to prepare snacks and drinks themselves. Meals will be provided at appropriate times of the day, be appropriately served, and meet the preferences, as well as the dietary and nutritional requirements of individual Service Users. Assistance must be provided where required.

Create an environment that actively contributes to the health, wellbeing and independence of each Service User who lives there; and in a culture which promotes privacy, dignity, choice and control.

Provide appropriate, well-maintained accommodation that offers the Service user opportunities to:

- Access the garden and outdoor spaces
- See and look after their visitors
- Engage in meaningful activities
- Spend time together with others and time alone.

Provide personal care, in accordance with the Person's Care and Support Plan, and in a personalised way through understanding that person's history, interests, needs and strengths

Provide nursing care, in accordance with the Person's Care Plan, where the Care Home is registered as a Care Home with nursing or facilitate access to community nursing provided by the NHS if the Care Home is registered as a Care Home without nursing

Provide staffing at an appropriate level to ensure the service user and all Residents' care and support Needs are met in accordance with their Care and Support Plans.

Encourage the Service user to personalise their room. This includes bringing their own furniture and personal possessions, providing the physical condition of these possessions meets with the reasonable approval of the Care Home and do not constitute a health and safety risk. Details of any property brought into the Care Home by the Service user will be accurately recorded on admission.

Ensure the Service user can choose to have access to a television, telephone and internet in their own bedroom. This will be at the service user's request with any additional costs of installation and ongoing charges at the Service user's expense. People with a hearing aid must be provided with a hearing loop to access the television and radio at their request.

Provide access appropriate equipment and / or assistive technology to support Service Users and enhance their quality of life. See section 12 for further guidance on use of equipment.

Wherever possible, support gender matching for personal care to Service Users, and where possible, provide a mix of staff that reflects the cultural background of the Service User group.

Support Service Users to attain or retain appropriate skills to maximise their independence. Within this tender opportunity and through the delivery of this contract, Providers will demonstrate 'strengths-based' practices[1] and a focus on continuing enablement to maximise the independence of Service Users throughout Surrey who require these services. Providers will develop plans with Service Users to look at what they want to achieve, and how they will be supported to meet their goals. There will be a culture of 'doing with' rather than 'doing for' embedded in the service.

Ensure accurate records are maintained on a daily basis in order to evidence service delivery, outcomes and activities completed, and to support the identification of any changes in need. Support Service Users to develop their social skills and maintain relationships with friends and family; and proactively support Service Users to

[1] Strengths-based approaches - Care Act guidance | SCIE and Strengths-based approach: Practice Framework and Practice Handbook (publishing.service.gov.uk)

maintain contact with their friends and family through visits, telephone, email or internet (e.g., Skype) as appropriate.

Create an environment that meets the Service Users needs in the least restrictive way – identifying the need to make an application for Deprivation of Liberty Safeguards (from April 2022, this becomes Liberty Protection Safeguards) should a Service User be restricted from leaving the Service independently, lack the capacity to consent to their support or be restricted in other ways in their best interests. Ensure all relevant information for each Service User is available in accessible format or a format which is specific to that Service User. Information will include safeguarding and complaints/compliments (including escalation to the commissioner, regulator or ombudsman).

The Provider will demonstrate how service users' wellbeing can be assured whilst providing person-centred care and support[2]. Wellbeing is defined in line with Care Act guidance as follows:

- personal dignity (including the way people are treated and helped)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control over day-to-day life (including making choices about the way care and support is provided)
- participation in work, education, training and recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the Service User's contribution to society.

The Provider shall ensure that:

- Service Users have the right to enjoy the privacy of their own rooms.
- Service Users feel that their dignity and privacy is respected and safeguarded.
- Services are delivered compassionately.
- Personal environments are maintained to the service users own standards
- Religious and cultural beliefs are respected.
- Service Users are given choices about their care and activities
- Staff assist personal care with discretion in a way that the Service User's dignity is maintained with staff taking direction from service users, wherever possible.
- Service Users know that information relating to them is kept confidential and only shared on a need-to-know basis with their consent.
- Service Users are actively engaged in their care planning where possible.

## Care Requirements

The Service will hold the following CQC registration:

[2] Providers may find the Surrey Wheel of Wellbeing useful in considering ways to improve wellbeing of both staff and Service Users: Welcome to the Wheel of Well-being - Healthy Surrey

Accommodation for persons who require nursing or personal care/support
Treatment of disease, disorder or injury (care homes with nursing only)
It is a requirement that all Providers will be registered with the Regulator and will maintain registration throughout the duration of this contract. Therefore, the regulations required for registration (and their associated standards), and the monitoring of the achievement of those regulations and standards are not replicated in full in this Specification. The service offered to the Commissioner shall not exceed the "Type of Service" and "Specialism/Services" registered.

**Table of Service needs and requirements**

| Need | Requirements |
|---|---|
| Behaviour<br>Severe dis-inhibition<br>Intractable noisiness or restlessness and/or wandering<br>Resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance)<br>Aggression, violence, or passive non-aggressive behaviour/ terminal agitation<br>Severe fluctuations in mental state<br>Extreme frustration associated with communication difficulties<br>Inappropriate interference with others<br>Identified high risk of suicide<br>Agitation in relation to pain | Staff will:<br><br>Understand the triggers for each Service User that can lead to behaviour that challenges or presents a risk.<br><br>Have the skills and knowledge to be able to work with Service Users in order to reduce the incidence of the behaviour reoccurring.<br>Liaise with external professionals as appropriate including referral to the Intensive Support Team (IST) via Community Mental Health Team (CMHT) for support and advice.<br><br>Make a DoLs application where appropriate (from April 2022, this will become Liberty Protection Safeguards – LPS).<br><br>Take all reasonable endeavours to mitigate Service User eviction from the home. The Provider will work with the Commissioner to take steps to resolve issues as and when they arise. Eviction should only occur if all other demonstrable efforts to resolve issues have been unsuccessful.<br><br>Be working towards greater Positive Behavioural Support awareness to ensure Service User with behaviours that challenge have a positive behavioural support plan, which promotes understanding, the context and meaning of behaviour to inform the development of supportive environments and skills that can enhance a Service User's quality of life[3].<br><br>Be trained to prevent and manage violence and aggression and can offer physical intervention techniques when appropriate. |

[3] Further information at http://pbsacademy.org.uk/commissioners-and-caremanagers/

| Need | Requirements |
|---|---|
| | Document any incident fully and include the antecedent, behaviour, and consequence (ABC). All incident forms must be audited by a suitably experienced manager to identify any triggers, patterns and safeguarding concerns.<br><br>Be trained to prevent and manage violence and aggression and can offer physical intervention techniques when appropriate. It is not acceptable to use any form of restraint (unless this has been agreed by a MDT subject to DoLS (from April 2022, this will become Liberty Protection Safeguards – LPS). |
| Cognition<br>Marked short- and long-term memory deficit<br>Disorientation to time, place, and person<br>Limited awareness of basic needs and risks<br>Difficulty making basic decisions<br>Dependent on others to anticipate basic needs | Staff will:<br><br>Have appropriate training.<br><br>Provide a suitable environment.<br><br>Encourage Service User's family/friends to visit and bring in Service User's personal possessions (for instance, photographs).<br>Use reality orientation and validation or similar techniques.<br>Provide Activities that are Engaging and Meaningful to the Service User<br><br>Please refer to NICE Quality Standard on mental wellbeing of older people in care homes (QS50)[4] |
| Psychological and Emotional needs<br><br>Unable to express their psychological/emotional needs<br>Mood disturbance<br>Hallucinations<br>Anxiety<br>Periods of distress<br>Withdrawn from attempts to engage in daily activities | Staff will:<br><br>Use prompts to motivate towards engagement with daily activities.<br><br>Provide additional support to facilitate Service User involvement as required.<br><br>Support Service User with life changing events as required<br>Recognise Service User depression and its effects on behaviour.<br><br>Refer Service User to primary and secondary care services.<br><br>Be trained to recognise psychological and emotional problems and refer to appropriate services.<br><br>Support Service Users relationships (including partners, families and friends) |

[4] Overview | Mental wellbeing of older people in care homes | Quality standards | NICE

| Need | Requirements |
|---|---|
| | Have an activity programme tailored to meet the Service User's needs and prevent isolation<br><br>Refer to NICE Quality Standard on mental wellbeing of older people in care homes (QS50)[5] |
| Communication (relates to difficulty with expression and understanding, not with the interpretation of language)<br>Sometimes unable to reliably communicate<br>Unable to express needs, even when assisted | Staff will:<br><br>Provide special assistance if needed to ensure accurate interpretation of needs, including Service Users who are hearing and/or sight impaired.<br><br>Be able to anticipate needs through non-verbal signs.<br><br>Have a communication strategy to assist Service Users to express needs and make decisions.<br><br>Ensure environment is suitable to meet the needs of those with cognitive impairment, hearing or sight impediments, e.g., large print/picture menu, dementia friendly signage, hearing loop, etc. |
| Mobility<br>Unable to consistently weight bear<br>Completely unable to weight bear<br>High risk of falls<br>Needs careful positioning<br>Unable to assist or cooperate with transfers and/or repositioning<br>Involuntary spasms or contractures | Staff will:<br><br>Have a falls prevention strategy based on NICE Falls in Older People Guidance[6] (including NICE-endorsed guidance on falls in care homes[7])<br><br>Have a falls risk assessment in place for each Service User.<br><br>Be trained in moving and handling and falls prevention.<br><br>Provide and maintain appropriate mobility equipment, and replace where necessary<br><br>Provide incident reporting and trend analysis of falls within the service, considering safeguarding as appropriate.<br><br>Provide specific information on supporting the Service User if they have fallen.<br><br>Ensure the environment is safe and is clear of slip, trip and fall hazards as appropriate |

[5] Overview | Mental wellbeing of older people in care homes | Quality standards | NICE
[6] Overview | Falls in older people | Quality standards | NICE
[7] React To Falls: Training resources for care home staff

| Need | Requirements |
|---|---|
| | Refer Service Users, if appropriate, to external Healthcare Professionals e.g., occupational therapists, physiotherapists.<br><br>Explore smart technology such as smart plugs and Alexa which can prevent the need to bend down or reach up. Falls detectors can also be used. |
| Nutrition – food & hydration<br><br>At risk of malnutrition, dehydration and aspiration<br>Significant unintended weight loss or gain<br>Dysphagia<br>Risk of choking<br>Requires assistance | Staff will:<br><br>Ensure the Chef is aware of each Service User's personalised needs and wants.<br><br>Support the Service User's nutritional requirements, providing specialised diets for medical or cultural reasons and personal preferences.<br><br>Have accessible information about meals e.g., easy read/large print/picture menus and the arrangements for mealtimes.<br>Be familiar with nutritional assessment tools and use appropriately, e.g., MUST[8]<br><br>Seek GP/ dietitian advice when a significant change in weight occurs.<br><br>Use Food First approach to minimise use of nutritional supplements.<br><br>Provide skilled intervention to ensure adequate nutrition/hydration<br><br>Provide a well-balanced diet and ensure that a range of nutritional snacks are available throughout the day and on request<br><br>Ensure Services Users are well hydrated including use of Fluid Charts to include daily fluid targets where required.<br><br>Promote good hydration through Hydration Champions, hydration-based activities, positioning of "Hydration Stations" around the home environment |

[8] Malnutrition Universal Screening Tool (bapen.org.uk)

| Need | Requirements |
|---|---|
| | Minimise risk of aspiration to maintain airway.<br><br>Refer to Speech and Language Therapy as necessary and be able to meet individual requirements as defined following assessment e.g., different food consistency, thickened fluids etc.<br><br>Ensure appropriate assistance is given to residents who are less able to feed themselves, including use of adapted cutlery and crockery, protected mealtimes etc. |
| Skin (including tissue viability) - a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin. | Staff will:<br><br>Have policies and procedures that comply with current NICE guidance for preventing pressure ulcers in adults[9]<br><br>Be trained to promptly recognise changes to risk factors in skin integrity<br><br>Have appropriate equipment in place to maintain Service Users' skin integrity to minimize the risk of pressure damage |
| End of Life Care | Staff will:<br>Ensure there is a named End of Life champion who can be aware of local End of Life protocols and influence improvements by undertaking audits at least annually on significant incidents and deaths to inform Service improvement.<br><br>Involve Service Users and their family/friends (as appropriate) in planning for their EOLC<br><br>Support formal and recognised End of Life care pathways. This will include early and sensitive consideration of end of life issues with Service Users, such as offering and reviewing Advanced Care Plans (ACPs), shared End of Life documentation, onward referral for Specialist advice, provision of holistic assessment, support planning and care delivery in accordance with the Service Users wishes.<br><br>Train all nursing and care Staff in end of life planning and coordination skills in line with a model such as the Gold Standards Framework. Training to be delivered by an accredited EOLC specialist, e.g., the Hospice. |

[9] Overview | Pressure ulcers: prevention and management | Guidance | NICE

| Need | Requirements |
|---|---|
| | Ensure appropriate referral and ongoing liaison with the GP, district nurse, hospice community nurse specialist (CNS) and nearest relative as required.<br><br>Manage Service User care in final days of life<br><br>Manage care in line with the NICE Quality Standard: End of life care for adults [QS13].<br><br>Develop links with Community Palliative Care Team/ Hospice.<br><br>Ensure spiritual needs are met<br><br>Manage posthumous arrangements |
| Dementia Care | Staff will:<br><br>Ensure a 'dementia champion' is nominated who will ensure the requirements of this service specification and any local dementia strategy are met, as appropriate to the Service provided.<br><br>Ensure all care and support is provided within the legal requirements of the Mental Capacity Act (2005) and Mental Health Act (1983 and 2007), including Deprivation of Liberty and Safeguards.<br>Ensure all care and support provided for Service Users with dementia is delivered in line with NICE Guidance.<br><br>Ensure staff have a knowledge and understanding of signs and symptoms of long standing/chronic/severe dementia including supporting Service Users to effectively manage their condition, to pre-emp risks arising from their presenting support needs and to effectively respond in situations that are potentially distressing for them.<br><br>Alert community health teams to ensure a diagnosis is made, and that this is documented clearly in the Service User's Care Plan and communicated clearly at each transition of care.<br><br>Communicate effectively with people with dementia.<br><br>Work towards ensuring the Care Home environment is consistent with recognised good practice on creating a dementia friendly environment. |

| Need | Requirements |
|---|---|
| | Include activities of daily living that maximise independent and individual activity, enhance function, adapt and develop skills and minimise the need for support wherever possible. The Service will be responsive to the Service User's individual needs, provide choice and facilitate the Service User's ability to make decisions about their care.<br><br>Ensure that each Service User that experiences behavioural and psychological symptoms of dementia is referred to the GP to consider a specialist assessment. The formulation of the Service User's Care Plan will detail the non-pharmacological interventions for behavioural and psychological symptoms of their dementia to aid in a reduction in the use of antipsychotic and other medication.<br><br>Consider technology to assist the Service User with dementia to gain a more fulfilling quality of life.<br><br>Refer to NICE Quality Standard on mental wellbeing of older people in care homes (QS50)[10]<br><br>Refer to NICE guidelines on dementia and Quality Standard on Dementia (QS184)[11] |

## Care planning

The Commissioner will be responsible for identifying the Service User's care and support needs and developing a plan for their needs to be met. The Provider will be responsible for developing a set of Care Plans that reflect the needs identified.

Following the Service User's Placement and on an ongoing basis thereafter, the Provider will ensure that the Care Plan is developed utilising information included in the Service User's Needs Assessment, their medical treatment plans and the Care Home's own pre- assessment of the Service User's needs. The Provider will clearly set out how they will meet the Service User's care needs and outcomes. This will include information about the Service User's mental capacity including their ability to make decisions and how the Care Home will support the Service user in doing so. It will also include the outcome of any mental capacity assessments and associated Deprivation of Liberty authorisations.

The provider will ensure any valid advanced decisions to refuse treatment and defined Best Interest Decisions stated in the Service User's Care and Support Plan are adhered to, including end of life wishes e.g., Advance Care Plans, ReSPECT where possible and Treatment Escalation Plans (TEP) as appropriate. Wherever a

[10] Overview | Mental wellbeing of older people in care homes | Quality standards | NICE

[11] Overview | Dementia: assessment, management and support for people living with dementia and their carers | Guidance | NICE

Best Interest Decision has been made, the Provider will continue to encourage the Service User's participation in these decisions. The Provider will notify the Commissioner of any changes in circumstance, which may necessitate a review of the specific Best Interest Decisions.

The Provider will review the Service user's care and support Needs on an ongoing basis and no less than monthly.

Where a change in need is identified which requires amendment to the care plan in order to address that change, the amendment should be made contemporaneously to reflect the change in need going forward.

The Care Plan will include Risk Assessments, where appropriate, taking into account the risks to the Service User, other Service Users, the care home staff and visitors to the home as required. Risks may include (but are not limited to) risks from the care environment; safeguarding risks; risks related to the Service user's behaviour; and risk assessments for nutrition (Malnutrition Universal Screening Tool – MUST) & hydration, pressure ulcers (Waterlow), falls etc. The Risk Assessment will also include any specific requirements for managing and mitigating risks.

Providers will ensure each Service User is provided with a written care plan that meets assessed need, is outcome focused and person centred, rather than task based. The Service must include Service Users and their families, or other representatives, as partners in planning, developing and reviewing their care plans. Care plans must be available in the Service User's preferred language or in easy read / pictures as required. Advocates must be engaged where Service Users have no family or independent support to act on their behalf where the Service User has substantial difficulty in understanding the care planning process.

Where a review of a Service User's Care Plans shows that the needs of the Service user have changed to the extent that they may require a change in the level or type of service provided. The Provider will instigate a formal Review with the Commissioner. The review may be undertaken with a view to appropriately increase or reduce the Services provided or change the care setting in line with Section 9 of the Contract Terms and Conditions.

## Training and staffing

Providers will ensure that they recruit and retain an adequately qualified and trained workforce to ensure CQC compliance and the delivery of high-quality Services.

Providers will ensure adequate staffing ratios are always maintained to support bed capacity; assessed care needs; and to ensure Service User and Employee safety. The Provider will ensure there is a designated leader on duty at all times. The lead member of staff will be aware of their roles and responsibilities and will be accessible to both Staff and Service Users at all times. For Services registered as Care Homes with Nursing, the Provider will ensure there is a Registered Nurse on duty and on site at the Care Home at all times.

Staff rotas are to be clear, concise, and appropriate to meet assessed needs and ensure delivery of Services and Service User safety. They should be displayed prominently allowing all Staff access. The rota should allow permanent Staff an opportunity to plan their personal and working lives, notwithstanding the need for flexibility that will be required to ensure adequate cover to the Service

Staff are trained/skilled in supporting Service Users maintain independence and can recognise and manage risks effectively whilst maximising independence. All Staff understand and deliver Service User outcomes in accordance with a Service Users care plan

Where appropriate, Providers will ensure that staff demonstrate skills and knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (from April 2022, this becomes Liberty Protection Safeguards) and the knowledge and skills to determine if a Service User is likely being deprived of their liberty and seek for an application for a DoLS (LPS) order to be made.

Staff (including temporary staff and volunteers) who have regular contact with Service Users shall only be employed following the satisfactory completion of an enhanced Disclosure and Barring Service (DBS) check or other vetting requirement that the Government may introduce during the Term of the DPS

Sufficient checks shall be undertaken to ensure that Staff are eligible to work in the UK and that Services are at all times compliant with UK Border Law including UK Borders Act 2007 and the Borders, Citizenship Act 2009

An induction programme is to be in place for all Staff and Volunteers that provide an understanding of the needs of Service Users, a positive view of their potential, details of working practices and standards of the Service. As previously outlined the Provider shall ensure that all non-qualified Staff induction includes attainment of the Care Certificate.

Temporary Staff shall receive suitable induction with additional “on the job” support from permanent Staff.

Staff will be encouraged to take part in continuous professional / vocational development and as such individual training records and training schedules are to be maintained. Staff employed in the provision of care and support will meet or be working towards the Care Certificate standards. New Staff will be supported, skilled and assessed as competent to carry out their roles and have an appropriate level of literacy and numeracy for their role. Those Staff who do not already hold a Level 2 NVQ/ Diploma in Health and Social Care / Care / Healthcare or equivalent should be supported to achieve this. Refresher Training will be provided to all Staff in line with recommendations from the Sector Skills Council as a minimum.

Staff will receive regular supervision as required, in line with the requirements of the relevant professional regulator, that is at an appropriate frequency to their level of training and experience and not less than four times per annum.

Volunteers will be assessed by obtaining a completed Application Form and References. Volunteers shall be subject to the same scrutiny and support given to paid staff. Volunteers shall receive suitable induction and training. Each Volunteer shall be given a clear, written description of their role and an identified member of Staff who would be able to offer them support on a regular basis to enable them to make a valued contribution to the Service. This member of Staff shall additionally have the responsibility for making other staff aware of the contribution expected from the volunteer.

## Nursing care

Where the Care Home is providing nursing care for the Service User, the Provider will ensure the availability of a qualified nurse on site 24 hours a day.

Care Homes with nursing will provide care for the Service user where:

- Their primary need is for accommodation and social care, but have a nursing need which requires 24-hour availability of a registered nurse
- Their primary need is for accommodation and nursing care.

As set out in the NHS Contract for Funded Nursing Care, nursing care will include but is not limited to:

- Direct nursing tasks required to meet a Service user's Needs
- Assessment, planning, supervision and monitoring of Residents health care Needs and delivering appropriate nursing care.
- Recognising preventable or reversible medical conditions and the changing dependency of the Service user's condition
- Offering nursing interventions in health care and treatment plans including infection control, wound management, continence care, pressure area care, oral care and care of the Service user with dementia and end of life palliative care under the direction of primary or secondary or emergency health services.

The Care Home will ensure all nursing Staff hold up to date registration and revalidation status with the Nursing and Midwifery Council (NMC) and has a checking process in place to provide further assurance.

The Care Home will ensure nursing Staff are compliant with NMC Code of Conduct, the professional standards that nurses must uphold in order to be registered to practise in the UK. Other allied health professionals who are employed by the Provider and working in the Care Home must be registered with the Health and Care Professions Council.

## Healthcare

The Provider will link with other relevant agencies and providers and with the statutory services providing other elements (where appropriate). The Provider shall

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

The Provider must work in collaboration with the wider partners to address the needs of the Service User to increase the ability of the Service User to attain optimum outcomes. Partners will include (where appropriate):

- Community health services
- Acute and specialist hospital providers
- Multi-disciplinary team key worker
- Specialist health services such as the local continence service
- Voluntary sector e.g., hospices
- GP's
- Others specific to the Service User
- Social Services

- Providers shall ensure:
- Within 7-days of a placement commencing the Service User will be registered with a GP.
- Service Users permanently registered with a GP are supported to access to the full range of Primary Healthcare services including local dental, pharmaceutical, audiology, chiropody, optician services and receive care from Hospitals and community services according to their need.
- Service users are referred to their GP in a timely manner.
- Compliance with NICE guidelines in managing specific conditions.
- Service Users receive medical consultation in their own room.
- Establish what medicines a Service User has been prescribed prior to admission.
- Encourage and promote Service User self-administering of medication.
- Use electronic alerts, reminders, posters and facilities which aid Staff and Service Users to follow the correct procedures for managing medicines.
- Participate in local NHS medicines management or health plan audits as requested.
- Undertake monthly audits of medication administration charts, medication stocks; liaising with the Service Users GP to avoid duplication.

## Medication

The Provider will have policies and procedures for medicines management in place with regard to relevant NICE Guidance and ensure staff have the skills and knowledge in medicines management.

Where necessary, the Provider will seek information and advice from CCG Care Home Pharmacist or Pharmacy Technician or other appropriate pharmacy professional regarding medicines policies (including the management of homely remedies).

The Provider will:

- Ensure that the medicines administration policy will include procedures for Service Users to take responsibility for their own medication if they wish.
- Ensure that individual Service Users are given their prescribed medication as directed i.e., Correct dose, correct time, correct frequency and is recorded accurately and contemporaneously on the MAR chart for that Service User, including where medication was not administered e.g., due to non-compliance.
- Maintain a 'Controlled Drugs (CD) Register' - in particular the Misuse of Drugs Regulations 2001 as amended and any subsequent amendments.
- Carry out a six-monthly self-audit to confirm compliance - Providers may wish to use their own toolkit for the self-audit
- Ensure all medications are stored safely and securely and in the appropriate temperature-controlled environment where indicated e.g., refrigeration unit

The Provider will recognise Medication Errors, conduct Root Cause Analysis and implement learning as required. Any medication errors will be reported to Surrey MASH team in line with local safeguarding requirements.

## Infection Prevention and Control

The Provider will:

- Identify a named lead who will take responsibility for Infection Prevention and Control and Decontamination.
- Ensure there are simple, up to date policies, procedures and processes relating to the prevention and control of infection and that all Staff can demonstrate knowledge and operational compliance.
- Develop their policy and procedure in accordance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and all related guidance. Include the provision and correct use of Personal Protective Equipment, decontamination of equipment and waste disposal.
- Ensure that all Staff are always trained to work safely with the Service User and are trained in and infection control
- Ensure all Service Users are proactively encouraged to be vaccinated against influenza and COVID-19, in line with NHS guidelines and their personal choice.
- Put in place the necessary emergency plan to respond to any infection or disease outbreaks and ensure early detection and reporting of outbreaks.
- Report any incidents to CQC, Public Health England and other relevant public health authorities.
- Update all the required information on the NHS Capacity Tracker (or any replacement) at least weekly or whenever there is a change in circumstance or vacancy situation at the Service.

## Equipment and technology

The Provider will at all times, at its own cost, ensure the availability of any equipment necessary to provide Services that promote the independence, safety and mobility of the Service user.

The Provider will at all times comply with the Law (including Health and Safety Regulations / Health and Social Care Regulations) and any applicable quality and performance indicators in relation to the environment and the equipment used, and will ensure that they are clean, safe, suitable, adequate, functional and effective, and fit for the purpose of providing the service. The Provider will store, use and maintain all equipment strictly in accordance with the manufacturer's instructions and with good practice in relation to infection control.

Wherever possible and appropriate, the Care Home will maximise the use of technology to ensure monitoring and timely response. This will enable the Provider to improve the quality of care, prevent falls and avoidable admissions to hospital. The Provider may, where they have risk assessed as safe and appropriate to do so, utilise assistive technology and telecare in the delivery of the Service, in accordance with the Service user's Care and Support Plan. The Provider will ensure that use of any assistive technology and telecare equipment is included in Staff training and that instruction for operating any equipment is part of the induction for new Staff.

## The Service user's Legal, Financial and Personal Affairs

The Provider will ensure Service Users:

- Are encouraged to manage their own financial affairs wherever possible, in accordance with the Service User's Care Plan.
- Are supported to access assistance with their financial affairs if they so wish.
- Are supported to obtain appropriate independent advice and assistance.
- Are informed that Care Home Staff are unable to provide such help and assistance with their financial and personal affairs directly, unless it is of a very practical nature including day to day administration of the Service user's personal expenses allowance and other small sums of personal cash used for day-to-day purchases and to meet the cost of Other Services.

The Servicer Provider will:

- Liaise with the appropriate appointed person about the Service user's financial affairs
- Liaise with the Commissioner or the Service user's Representative if the Service user loses the capacity to manage their financial arrangements while in residence at the Care Home.
- Provide secure facilities for the Service user to keep valuables near to them.
- Support the Service user to ensure their valuables are safely stored and secured.
- Ensure the Service user's personal cash is managed appropriately.

The Care Home will ensure:

- Personal cash is held securely in a locked cash box or equivalent and is kept separately for each service user.
- A clear log of all transactions is made, including where money is given to the Service user directly.

- Receipts for all personal cash transactions made on the Service user's behalf will be available, including Other Services provided by the home for which the Service user is charged.
- Monthly audits are undertaken to ensure the appropriate transfer and recording of personal cash transactions.

With the exception of small sums of personal cash, the Provider will not handle the Service user's money unless appropriate authority has been duly obtained by written consent from the Commissioner or the Service user's Representative.

Written consent from the Commissioner is required where the Commissioner has responsibility for the Service user's finances. If a Service user has capacity or a financial appointee, this will not apply.

The Provider and its Staff will not influence Care Home Residents with regards to their Last Will and Testament or any other legal document.

If the Service user does not have the capacity to manage their finances, the Commissioner will assist the Service user to make arrangements to check or secure the services of an Appointee or Deputy. Until such time that this process is concluded the Care Home will take steps to safeguard the Service user from potential financial abuse.

## Equalities

As set out in Clause 39 of the Terms and Condition, the Provider shall comply and shall ensure that its employees, agents and Sub-Contractors comply with all Laws (including but not limited to the Equality Act 2010) as well as statutory and other official guidance and codes of practice relating to equal opportunities. In making any decision in respect of an individual/Service User, the Service Provider shall make every effort to give due consideration to the individual's/Service User's gender, sexual orientation, religious persuasion, racial origin and cultural and linguistic background. For example, the Provider will:

- At all times work with cultural sensitivity.
- Where Service Users first language is not English arrangements should be made for interpretation services.
- Ensure Staff can communicate fluently and clearly in English both written and verbal.
- Consult with Service Users or give them a reasonable opportunity to express their views on matters that affect their lives, this may include using communication and language aids.
- Ensure Services, care planning, information and advice is provided in ways which are accessible including to Service Users who are deaf/blind.
- Be acquainted and compliant with any special requirements associated with diet and food preparation, toilet and washing, hair care, dress, religious and spiritual needs, and customs associated with illness and death.
- Support the needs of Service Users from specific ethnic, religious, or cultural groups and clearly state these in their individual care plans.

## Capacity and choice

Providers will ensure:

- Service Users are treated as having capacity to make their own decisions in accordance with the Mental Capacity Act 2005 (including Deprivation of Liberty safeguards) and the Care Act 2014.
- Service Users can express their needs and choices through their preferred means of communication.
- Care plans cover choice and capacity.
- Service Users, family, or representatives are supported to make informed choices.
- Service Users are involved in the running of the service.
- Service Users are informed and enabled to influence the way in which care is provided in a flexible and appropriate way.
- Services are responsive to service users' needs and preferences.
- Service Users feel confident that Staff support their choices regarding all aspects of daily living.
- Service Users are listened to when complaining about or complimenting services.
- Service Users are encouraged and supported to take greater control in the care planning process.

## Service user activities

Providers will:

- Have named Activity Co-ordinators i.e., named Staff or Volunteers to undertake this role to ensure that a variety of activities are available between 9am – 5pm seven days a week.
- Provide meaningful activities that maximise and sustain quality of life and assist in preventing a Service Users needs deteriorating.
- Encourage visits to Service Users by family, friends, befriending schemes or through the recruitment of Volunteers.
- Organise activities and events inside and outside of the Service.
- Encourage Service Users to access community, sport, leisure, arts and cultural facilities appropriate to their preferences and abilities whether through visits or by bringing local communities into the care home.
- Provide activities that improve health, promote wellbeing, and enhance quality of life, including opportunities to nurture such as gardening, visits from animals or intergenerational engagement.
- Where appropriate, support Service Users to access learning, training, or employment opportunities.

## Operational policies and procedures

Providers will ensure that there are written policies and procedures for the guidance of Staff involved in a Service Users care. The policies shall be in accordance with all regulatory and national standards or requirements. The policies and procedures shall include (but not be limited to):

- Staff code of conduct
- Medicines Management in accordance with NICE quality standards
- Service User group and / or condition specific guidance
- Infection control in accordance with the 'Prevention and Control of Infection in Care Homes' PHE Guidance and compliance with the code of practice on the prevention and control of infections commonly referred to as the 'Hygiene Code'.
- Nutrition in accordance with Eating and Nutritional Care Guidance (2013)15 f) Wellbeing in accordance with NICE quality standards
- Feeding techniques
- Do not attempt resuscitation (DNAR) procedures
- Choice and control (and positive risk taking)
- Care planning
- Management of behaviour that challenges
- Positive and proactive interventions
- Restrictive practice guidance
- Complaints policy
- Safeguarding / Deprivation of Liberty Safeguards (including Radicalisation and Prevent Duties)
- Whistle blowing for staff, service users, families
- Duty of candour
- Record keeping
- Health & Safety procedures in accordance with HSE Guidance for Care Homes

## Enhanced Care Provision

If a Service User requires enhanced care provision as a result of the Service User's behaviour that challenges (in exceptional circumstances only), the Provider will obtain agreement from the Commissioner in advance of the enhanced care provision being put in place by contacting the locality duty team. Authorisation will be sought in writing by the Commissioner, and supported by a clinical rationale, including Behaviour Charts and/or Care Diaries. Enhanced care provision is not to be used to manage any other activity, e.g., Falls Risks.

The Provider will complete an enhanced care provision request form provided by the Commissioner to describe the Service User's clinical condition and demonstrate why enhanced care provision is needed.

In emergencies, where it is not possible to seek advance agreement from the Commissioner, authorisation must be sought on the next working day.
The Provider will ensure a staff diary is submitted to support invoicing and evidence provision of enhanced care provision. Further observation information e.g., behaviour charts, care diaries, must be kept as part of the Service User's daily notes and provided to the Commissioner upon request.

Any request for enhanced care provision will be a temporary agreement for a specific reason with clear review dates.

Surrey CHC and Surrey County Council reserve the right to recognise that there may be additional costs for other needs, services and equipment alongside behavioural support. Where these are recognised, changes to the Enhanced Care Provision Framework this may be applied at any point in the duration of the contract.

## Safeguarding

As set out in Clause 38.15 of the Terms and Conditions, in providing the Services the Service Provider shall have regard to the relevant provision of the Care Act 2014 including those specifically set out below:

The Service Provider shall have and shall operate an adult safeguarding policy and procedure acceptable to the Council and which complies with the requirements of any policy, procedures or guidance produced by Surrey Safeguarding Adults Board (available at https://www.surreysab.org.uk/information-for-professionals/ssab-policies-and-procedures/ and as is updated from time to time), or where the placement is outside of Surrey the requirements of the Safeguarding Adults Board for that area.

The Service Provider shall comply with and ensure that all the Service Provider's Personnel performing Services for the Council under this Contract understand and comply with, the Service Provider's adult safeguarding policy and procedures.

The Service Provider's adult safeguarding policy and procedure will be made available to the Council and individuals/Service Users on demand.

The Service Provider shall ensure that all Service Provider's Personnel performing Services for the Council under this Contract have had the training and support reasonably required to enable them to meet the expectations of the Service Provider's adult safeguarding policy and procedure. In addition, the Service Provider shall ensure that all Service Provider's Personnel performing Services for the Council under this Agreement attend any adult safeguarding training sessions when requested to do so by the Council's Contract Manager, with any costs associated with this to be borne by the Service Provider;

The Service Provider shall assist and comply with any Safeguarding Adults Enquiry under Section 42 Care Act 2014 which the Council instigates or is asked to cooperate with.

The Service Provider shall assist and comply with any Safeguarding Adults Review under Section 44 Care Act 2014 which is instigated by Surrey Safeguarding Adults Board or any other Safeguarding Adults Board.

If the Service Provider or any of the Service Provider's Personnel performing the Services for the Council under this Agreement become aware of any safeguarding adults concerns that may meet the statutory criteria in Section 42(1) Care Act 2014, or of improper conduct by the Service Provider's Personnel, the Service Provider shall immediately report these to the Council.

## Community Impact and social value

A full Equalities Impact Assessment can be viewed on our website[12].

For those working in the public sector, the Social Value Act requires us to reflect on our core services and products, and to consider how we might design and deliver these in a way that generates even greater value for our communities. At Surrey County Council, we don't just deliver services. Increasingly we work with communities to design solutions together, supporting existing projects and ideas with our resources, networks and expertise. See Appendix C for more details.

## The Accessible Information Standard

All organisations that provide NHS or adult social care must follow the accessible information standard[13] by law. For more information, see clause 5.13 in the Terms and Conditions. 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.

Healthwatch Surrey[14] is the local and national consumer champion for health and social care. Healthwatch is another means by which Service Users 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 in their service user information leaflets.

The Provider should use a variety of accessible methods to actively seek feedback from services users around satisfaction levels. This could include surveys and regular residents and family meetings. The commissioner reserves the right to seek feedback on what actions have been taken because of service user feedback.

[12] https://www.surreycc.gov.uk/council-and-democracy/finance-and-performance/equality-and-diversity/equality-impact-assessments
[13] https://www.england.nhs.uk/ourwork/accessibleinfo/
[14] https://www.healthwatchsurrey.co.uk/

## Appendix A: Glossary of terms

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| Assessment | Statutory assessment of a Service User's eligibility for care and support under the Care Act 2014<br>Assessment of a Service User's eligibility for NHS Continuing Healthcare or NHS Funded Nursing Care 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<br><br>(See also Support Plan) | A Care Plan is the documentation developed by the provider for each Service User to identify that Service User's health (where appropriate), support and care needs and describe the actions to be taken in order to meet those needs. professional. Not to be confused with the home's own care plan. |
| 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. |
| Care Worker | A care worker is an employee of the Provider who provides care and support to all Service Users. |
| 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. |

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| Commissioners | Commissioners<br>are representatives of Surrey County Council Adult Social Care Directorate or NHS Surrey CHC Team 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 a Service User is assessed as having a primary health need. Such care is provided to a Service User aged 18 or over to meet needs that have arisen as a result of disability, accident, or illness. |
| Council | Refers to the Adult Social Care Directorate of Surrey County Council |
| 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 providers can join at any time. |
| End of Life Care (also known as Palliative care) | End of Life Care has been defined by the National Council for Palliative Care as:<br>'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' |
| 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 |
| NICE | National Institute for Health and Social Care Excellence |

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| 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. |
| Review | Care and Support Plan review – a statutory Review of a Service User'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. |
| Strength based approach /practice | A way of working that Adult Social care use which considers a Service User's strengths and networks, focusing on what is most important to the Service User. 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 Service User requires in order to achieve specific outcomes and meet assessed needs. |

## Appendix B: Resident Coproduction

Co-production sessions were held in partnership with the Surrey Coalition of Disabled People and worked with older residents in Surrey, including those with experience of working in a care home or with relatives in a care home, to inform the development of the specification. The following questions were asked:

- What's most important to have help and support with?
- What is a priority for you living in a care home (or for relatives living in a care home)?
- What do you look forward to in the day? (or for family – how best can the care home ensure your relative is not only well cared for but enjoys living in the care home)?
- If you could give the staff in the care home one piece of advice, to help them make sure the people in a care home feel at home, what would it be?
- Has anything ever not gone well – what happened, why, how could it have been better?
- Since living in a care home, what choices have you been given, and do you feel able to make a change if something isn't right for you?

Participants raised several key points around the following issues:

- Meaningful activity/occupation
- Delivering care compassionately
- Understanding resident's assets, strengths and interests
- Improving mental health awareness and treatment
- Improving complaints mechanisms and resident choice
- Updating methods of communication
- Promoting wellbeing
- Choice and control
- Use of media and digital technology
- Managing falls

***It must be noted that this feedback has been presented as it was shared by participants. Commissioners recognise that these do not reflect all experiences of residents in all care homes across Surrey at all times but we must recognise that the aspiration is for all residents to be treated with respect, dignity and sensitivity towards their own values, needs and choices.***

**Meaningful activity/occupation**

Participants placed a strong emphasis on the importance of providing activities to residents based on their interests, including visits out of the care home. There was concern about how the Covid-19 pandemic has prevented visits and activities and the impact this may have had on residents. One participant spoke about a trip to the seaside which residents had really enjoyed. Another participant mentioned some reminiscence work that had taken place with residents, using old music records to recall fond memories, or looking at historical objects from their younger days.

**Delivering care compassionately**

Participants were concerned that some care staff displayed a lack of compassion towards residents and felt that training should go further to try and address this. There were examples given of residents who were very distressed, being shouted at, or showing signs of depression and loneliness. Some felt there were care staff who were very busy and 'going through the motions' when delivering the care, without properly engaging with the person beyond responding to their care needs.

Participants sometimes felt that staff didn't think through their actions logically and from the perspective of what would be most comfortable for the residents. Family, friends, carers and other advocates were very important to involve in the understanding of people's needs and interests, as well as in the delivery of their care. Residents were often uplifted by visits from friends and family. However, one participant mentioned that the care worker had abruptly told her that visiting time was up without any sensitivity to the impact of her words.

Innovative forms of training should help to enable the staff to see life from the perspective of their residents, experiences some of the challenges they face to be able to show greater empathy and compassion towards them.

Participants also touched on the importance of physical contacts for some residents – one participant spoke about a hand treatment that residents had found relaxing and enjoyed. This part of responding to someone's personal wellbeing and care is very important.

**Understanding resident's interests**

Participants stressed the importance of understanding an individual's personal background and history to inform the way they care for that person. One participant shared an information questionnaire that had been used to collate information on the resident's assets, strengths, interests and dislikes. Even very small changes could make a huge difference to someone's happiness.

This was left out in the common areas and chatted through from time to time over a cup of tea. This type of approach would also allow the care home to understand that person's personal goals. The information received through assessment needed to provide next of kin details and a decent level of background on the resident's personal history.

**Improving mental health awareness and treatment**

One participant raised concerns around the lack of mental health awareness in care homes, with staff often lacking key information through assessment about that person's mental health needs. They felt there could sometimes be poor understanding and management of someone's mental health needs in the home. Staff needed to be trained in the different stages of mental health, particularly agency staff who may not have a long period of time in each care home to fully understand a person's background.

**Improving complaints mechanisms and resident choice**

There were several examples of incidents happening which had made the residents unhappy or which they had not chosen to happen. These included:

- A more forceful approach to handling than the resident was comfortable with
- A missing wedding ring, but no apology or investigation by the home
- Residents not being given a choice on what to watch on TV
- Residents refusing food based on their preferences, but not being given an alternative
- Residents feeling uncomfortable about the gender of the staff who were washing them

Often residents would have friends and family to speak up for them on their behalf – pointing out choices the residents would like to make or perhaps making a complaint clear to staff. However, we need to ensure that care home have mechanisms in place for those who may not have a relative or friend to advocate on their behalf.

**Updating methods of communication**

Finally, an important point was made about the need to make technology such as iPads available to residents when they required to contact friends and family. Making these connections and communicating with loved ones is a basic communication right. As technology evolves, we need to ensure that care homes keep up with change to communication methods.

**Promoting wellbeing**

A key priority was for residents to feel at home and comfortable in the care home. Human connection was an important right for anyone in a care home. Following the pandemic, we need to ensure that care homes strive to maintain human connection wherever possible within public health guidance.

The group were keen for residents to have activities in and out of the care home, with opportunities to do more than just “sit in front of the TV” with no personal interaction. Other examples were given of people being encouraged to get up and dance to music, as well as residents with advanced dementia doing puzzles. The group were very keen for the wider community to connect with the care home. Examples were given of a recent clay workshop with the Watts Gallery. Another participant mentioned a swimming club where people came to splash about and socialise.

Where possible, animals could be brought into the home or opportunities to see young children. Owning and looking after a pet or cultivating an accessible patch in the garden also helps improve people’s wellbeing through being able to nurture something.

**Choice and control**

For example, participants felt residents should not only eat fresh food, with important dietary requirements recognised, but also have any food likes or dislikes catered for. Residents should have level access to any area in the home, including outdoor space. Residents should be able to set their own routine, and this be upheld by staff. Care homes should not be regimented. If they have the capacity, residents

should have access to their money and be able to spend it when they like. Residents should be confident that their belongings will be respected (e.g., not found wearing other people's clothes)

Personal freedom is very important – not everyone in a care home has a a Deprivation of Liberty in place. People can leave the care home if they want to and move freely around the home.

Participants stressed the importance of person-centred care and the need for the individual to be "calling the shots", rather than the care worker or the service provider. The group were keen for care staff to really engage with residents, to listen to them and treat them as an equal and an individual. The need for respect and being treated with dignity was discussed throughout the session.

**Use of media and digital technology**

WIFI in all areas of the home is very important including private spaces where someone needs to connect with family and friends over the internet. They should have contact details to be able to text relatives, call or email them when required.

The care home should support the use of tablets and all forms of media should be available free of charge. For people with a hearing aid, TVs must be loop enabled. The group also recommended a digital champion in each care home. Zoom can also be used to encourage activities and group sessions, either getting together for a book club, to learn something new or engage in creative tasks.

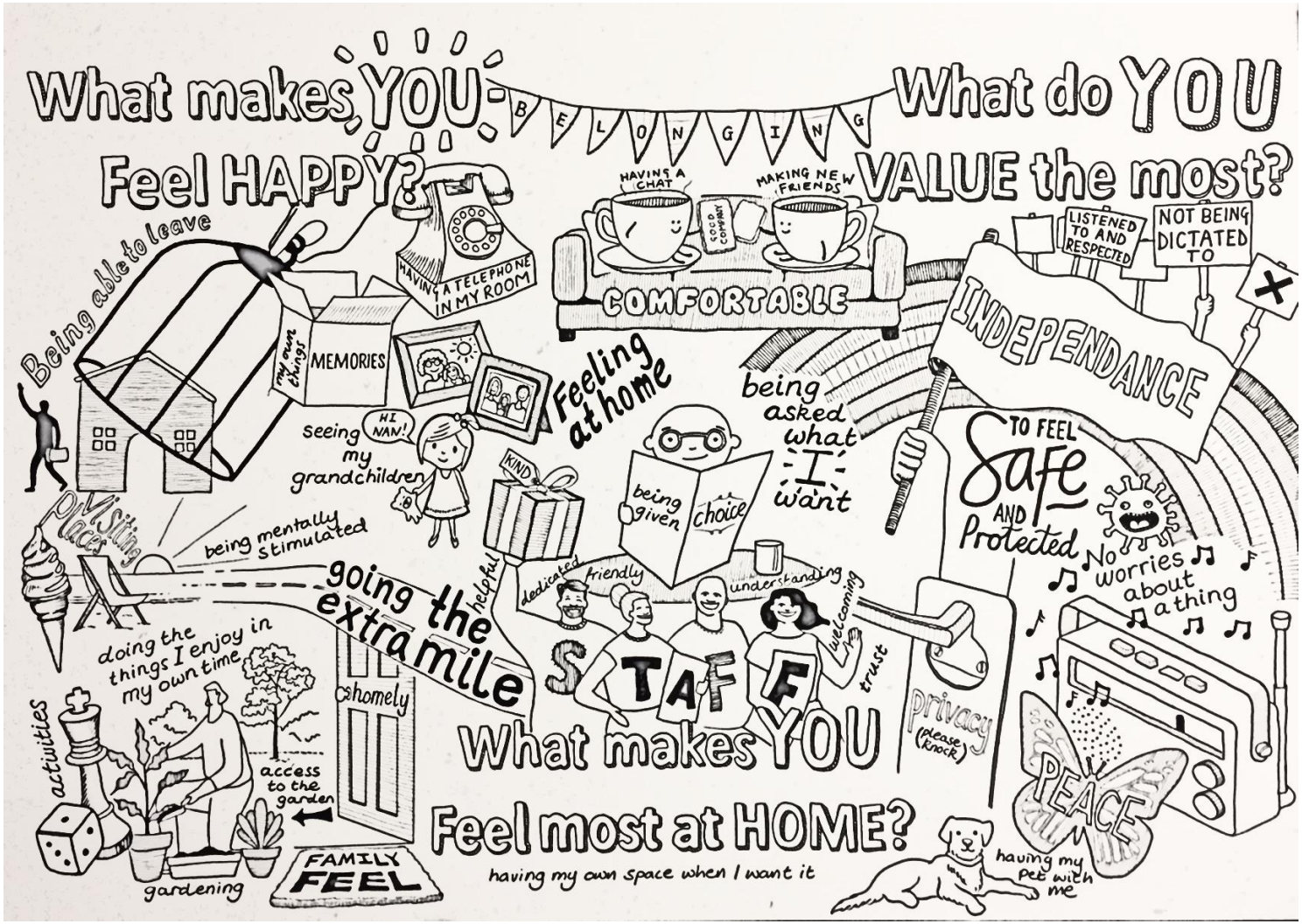
**Managing falls**

There was concern that people had additional care workers continually present if they were at risk of falls, with someone continually nearby or following them around. The group felt it was important to discuss the risk of falling with the family and resident to explore their risk appetite. Staff need to address underlying factors quickly and ensure they promote exercise options.

They should also explore smart technology such as smart plugs and Alexa which can prevent the need to bend down to switch off a plug or reach up to turn on a light. Falls detectors can also be used.

The group felt that having staff continually on hand to prevent falls could be perceived as intimidating and undignified by the resident.

## Appendix C What makes a good care home?



## Appendix D: Social Value

### Theme 1: Social Impact

In Surrey we have a particular focus over the next five years on tackling health inequality, as detailed in the **Organisation Strategy 2021 to 2026 (PDF)**. There are four groups of people who we particularly want to work together with to achieve this: those with special education needs and learning disabilities; people living with long-term illness or physical disabilities; those with caring responsibilities and people living in material deprivation or with other vulnerabilities. Our equality, diversity and inclusion (EDI) action plan for 2021 to 2022 aims to make EDI central to the council's culture.

- We want to make Surrey a fairer place to live and work, and ensure services are responsive to individual needs so all residents can access them easily and have opportunities to improve their outcomes.
- We want to enable local voluntary and community organisations to become effective and resilient. Could your care home offer facilities for local voluntary and community groups or allow staff time to volunteer locally? Or could your staff and residents organise fundraising activity for local charities?
- We want to ensure people are healthier and more independent in Surrey. Could you bring the local community into the care home to improve social connectedness and reduce isolation?
- We want to encourage local businesses to engage more with their local communities. Could you partner with any local voluntary or community groups to deliver key services in your care home?

**Case study: Keswick Care Home and Eastwick School in Bookham**

Elderly residents from Keswick Care Home and children aged 10 and 11 from Eastwick School came together to bridge the gap between generations, using music making to inspire confidence and tackle loneliness, anxiety and isolation. The innovative Together with Music pilot was the result of a collaboration between Mole Valley District Council (MVDC), Surrey Downs Integrated Care Partnership (ICP) and Intergenerational Music Making (IMM). The 6-week pilot followed a time of isolation and has supported those living with dementia and challenging circumstances to create a stronger, healthier, intergenerational local community.

The Together with Music pilot focussed on supporting the mental health and wellbeing of both the young and old through intergenerational music therapy practice. The project aimed to showcase the benefits of intergenerational music therapy practice and successful partnership working across the sectors, demonstrating all bodies striving to create positive change and support both individual and collective wellbeing through music. Data suggested that the interactions between the generations, supportive behaviours and human connection were key to the participants' experience. Themes such as self-agency and self-awareness suggested an increase in confidence, sense of purpose and fulfilment because of the group. It emerged from the data that there was an overwhelming positive effect on the mood of all the participants.

### Theme 2: Economic Impact

Our organisation strategy also includes a strong focus on growing a sustainable local economy, which is especially meaningful in the growth and recovery period following the COVID-19 pandemic. There are people in Surrey who feel underconfident and/or are unable to enter the workplace for a variety of reasons. Many of these people have skills, attributes and behaviours that could add huge value to businesses and organisations that offer them employment opportunities.

- Could you support the local workforce to develop key skills through NVQ qualifications and other professional development opportunities?
- Could you team up with local colleges and schools to provide students with work experience or opportunities to shadow staff? Could you work with other care homes in your local area to provide career awareness days at local schools?
- Could you develop ways to support local, long-term unemployed or people with disabilities into employment? Could you work with Surrey County Council to employ an apprentice to work in your care home?

**Theme 3: Environmental Impact**

Reducing carbon emissions is the Council's number one priority in this area, and we are working together across the organisation, with our suppliers and with people and organisations across Surrey to reach our county's net zero carbon target by 2050. The majority of purchases made with public money can involve additional investment in improving the local environment and increasing biodiversity, and people and organisations across the county can play a very hands-on role through the way we manage our own land no matter how small, for example by rewilding or planting trees.

- Could you commit to reducing single use plastics?
- Could you invest in solar panels or simply switch to a supplier of renewable energy
- installing motion sensors can be a good idea. For preventing lights from being left on by accident or taps running for too long, or use Smart technology to manage the environment of the home
- Could your care home aim to reduce the use of paper where possible and switch to recycled paper wherever possible?
- Could the care home switch to energy efficient light bulbs?
- Could staff be encouraged to use public transport, share lifts or even provide shared transport to pick up staff from their homes?