

# **SCHEDULE 1**

## **SERVICE SPECIFICATION FOR HOME-BASED CARE**

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# 1. INTRODUCTION

1.0.1 Providing Home Based Care (HBC) support services to vulnerable adults with eligible needs in Surrey is a statutory obligation for the commissioners. This document sets out the expected standards for the provision of a high quality HBC service in Surrey. The standards outlined in this service specification are the minimum requirements, which the commissioner expects the service provider to achieve.

1.0.2 This service specification is joint between Surrey County Council (SCC) and the six Surrey Clinical Commissioning Groups (CCGs) and to meet the needs of individuals through providing quality care services, some services are jointly commissioned by SCC and the six CCGs, whilst other services are solely commissioned. The term 'commissioner' refers to either arrangement in this document.

## 1.1 Strategic vision

1.1.1 The NHS Five Year Forward View (2014)<sup>1</sup> set out a shared vision for the future of the NHS based around new models of care. The health and care systems are working together to develop and implement place-based plans built around the needs of local populations. The Better Care Fund programme spans the NHS and local authorities, and is based on the six Clinical Commissioning Group (CCG) level plans to develop fully integrated health and social care services. Each area is developing its own model of integrated care, providing an opportunity to bring commissioners and providers together to accelerate the transformation of services and achieve better outcomes for the residents of Surrey.

1.1.2 In December 2015 the government asked local areas to deliver the NHS Five Year Forward View by developing Sustainability and Transformation Plans (STPs). The STPs are 'place based plans' which involve a wide range of health and social care key stakeholders to deliver greater integration and improved outcomes for the local population.

1.1.3 The vision for health and social care services for Surrey is: "Through mutual trust, strong leadership and shared values we will improve the health and wellbeing of Surrey people". (Surrey Health and Wellbeing Strategy in July 2016). <sup>2</sup>The health and social care outcomes that the whole system has signed up to are:

- Supporting people to live well and independently in their community
- Reducing admissions to residential care
- enabling people to stay at home
- enabling people to return home sooner from hospital
- Improved reablement and rehabilitation support following discharge

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<sup>1</sup> NHS Five Year Forward View (2014) <https://www.england.nhs.uk/ourwork/futurenhs/>

<sup>2</sup> Surrey Health and Wellbeing Strategy (2016) <http://www.healthysurrey.org.uk/about-us/health-andwellbeing-strategy/%20>

## 2. SCOPE OF THE SERVICE

### 2.1 Population needs

2.1.1 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. Figure 1 is a pictorial representation of the increased demand facing adult social care.

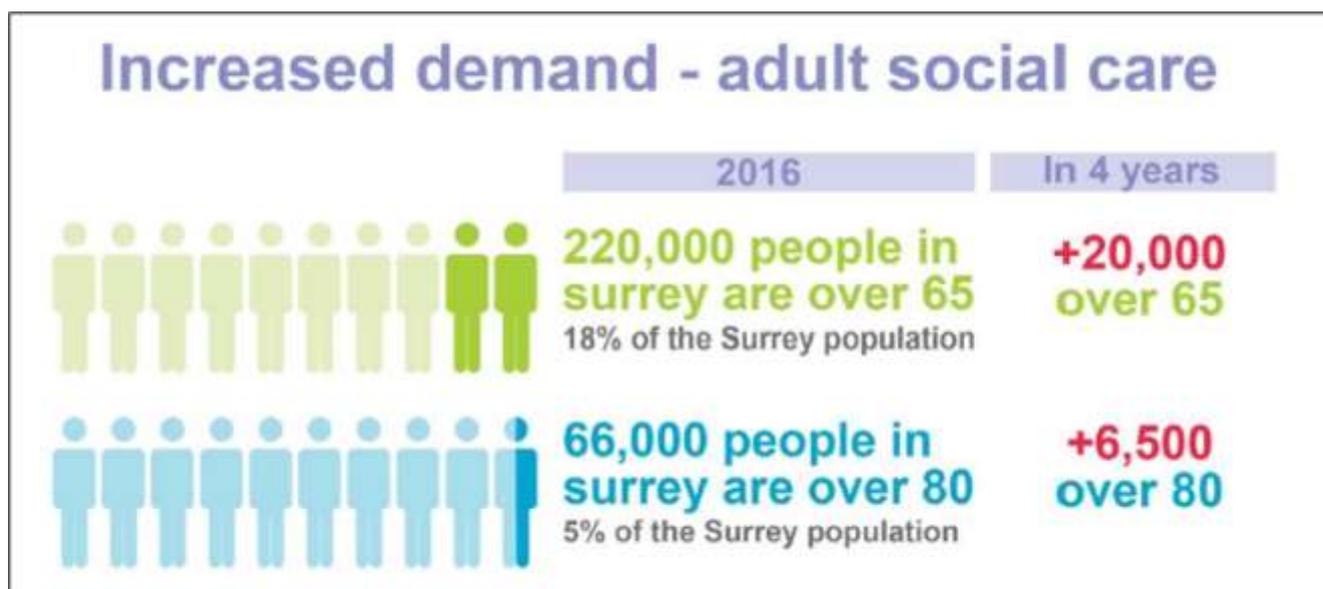


Figure 1: Demand for adult social care, 2016-2020 (Source: Surrey-i Partnership, 2017)

This growth in the older people population will see an increase in the demand for home based care 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.

2.1.2 The maps in figure 2 and figure 3 illustrate the geography of Surrey both in terms of the boundaries of the Boroughs and Districts within Surrey and the six CCG boundaries. It is important that providers are aware of the geography of Surrey and the challenges and opportunities that the geography presents. 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 other areas remain predominantly rural. The commissioners expect providers to be aware of the diversity of the geography in Surrey and how this can affect the delivery of HBC in Surrey.

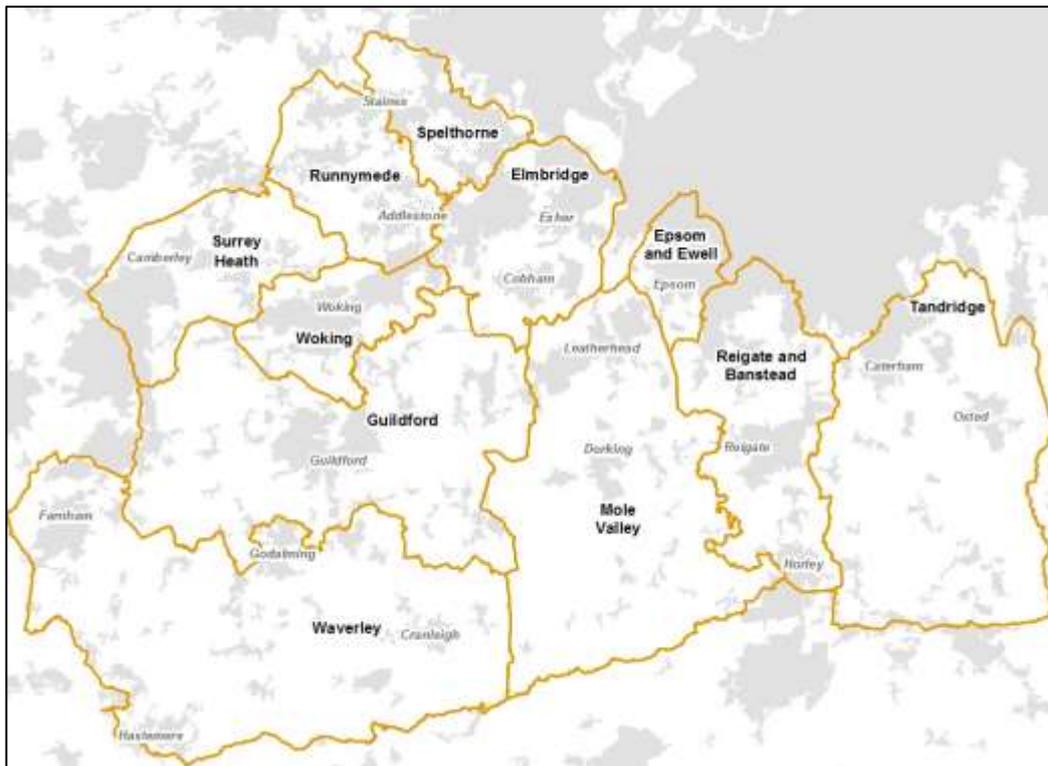


Figure 2: Map of Surrey showing District & Borough Boundaries

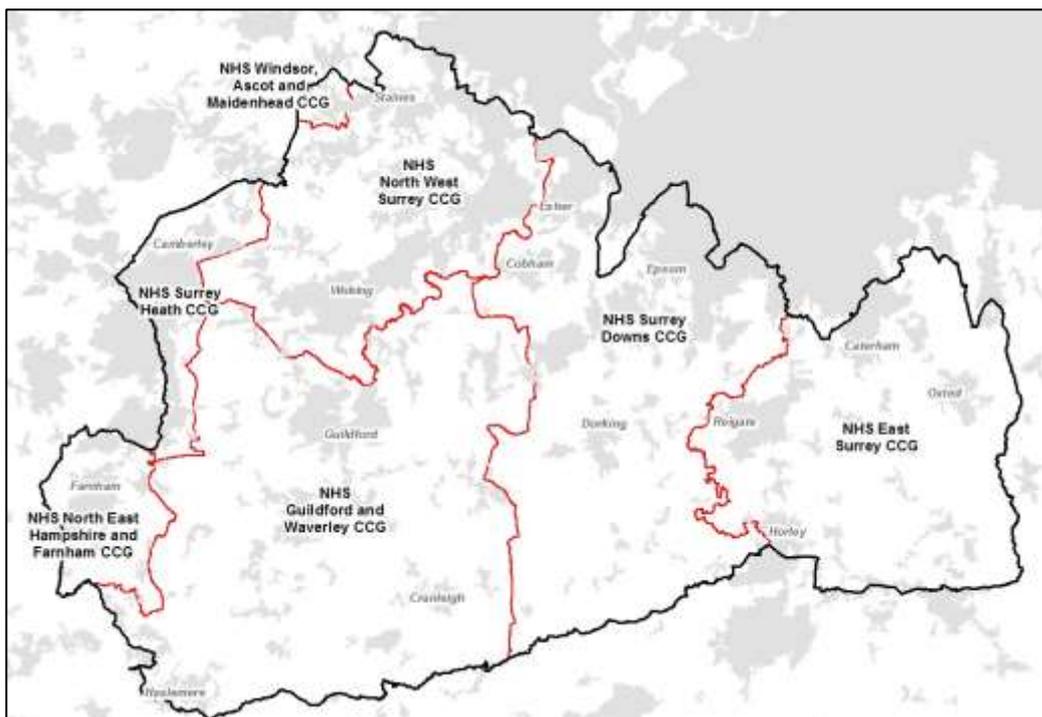


Figure 3: Map of Surrey showing Clinical Commissioning Group Boundaries

N.B: Surrey Continuing Health Care do not place HBC packages in NHS Windsor, Ascot and Maidenhead CCG area

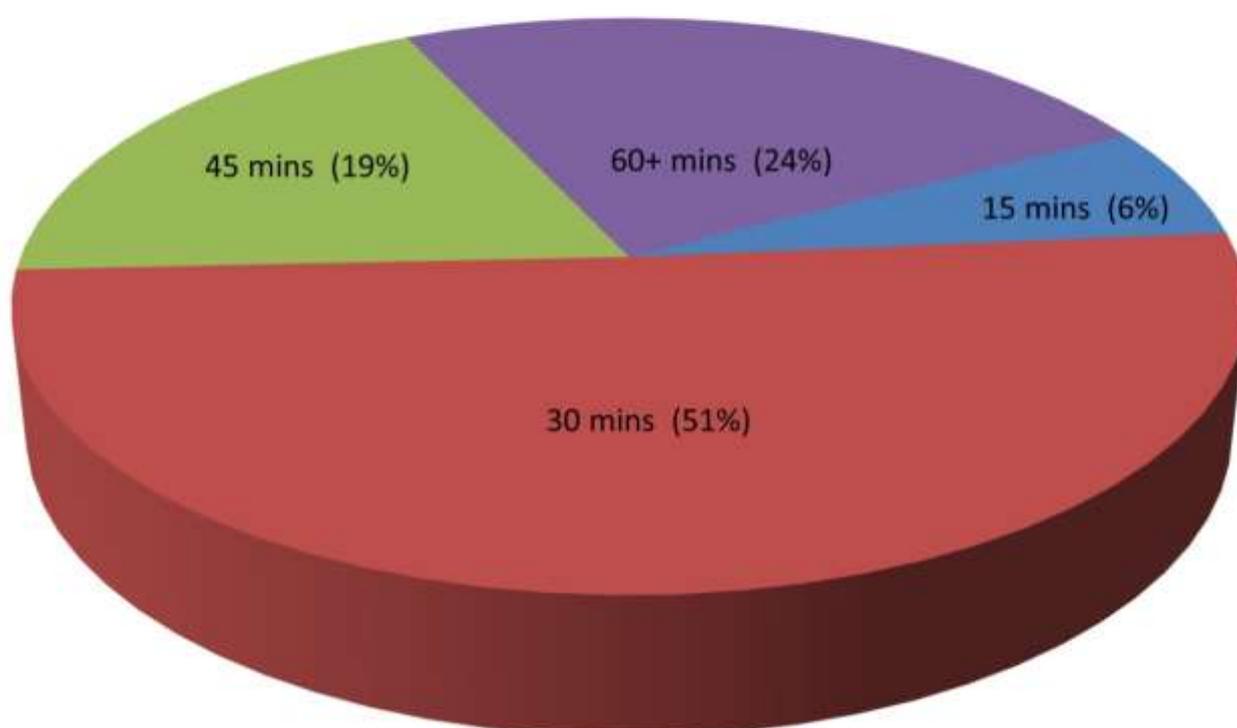
## 2.2 Current Adult Social Care position

2.2.1 In 2015-16 the total direct market spend by Adult Social Care (ASC) on HBC was approximately £47 million. The current average weekly package costs £235. 6,300 people were supported with HBC through Surrey County Council commissioned services in 2015/2016. This compares with 5,812 in 2014/15. Approximate growth in spend over the last three years was 8% per annum, this is due to movements in both cost and volume.

2.2.2 The breakdown of the length of visits commissioned by adult social care in 2015/16 is illustrated in figure 4. This does not include live-in, sleeping and waking nights.

### RATIO OF SHORT VISITS COMMISSIONED DURING 2015/2016

(excludes nights and live-in)



- 6% were 15-minute calls (in accordance with guidance on short term welfare visits – please see section 6.9)
- 51% were 30-minute calls
- 19% were 45-minute calls
- 24% were calls of an hour or longer in length

Figure 4: Breakdown of ASC funded visits excluding live-in, sleeping and waking nights, 2015/16

2.2.3 Live in care, sleeping nights, and waking nights combined accounted for half a percent of total 2015/16 visits. However with live in care being a 24 hour service these visits represented around 15% of the total 'hours' commissioned.

2.2.4 Please refer to Appendix 1 for ASC volume of business by geographical area as at January 2017.

## 2.3 Current Continuing Health Care<sup>3</sup> position

2.3.1 The total market spend on home care packages for Continuing Health Care (CHC) in 2015/16 was £12.5 million. The total number of CHC funded patients receiving a home care package was 1165 in 2015/2016. The average weekly cost of a CHC home care package is £780 across all 6 Clinical Commissioning Group areas in Surrey. There has been a significant increase in CHC spend on home care packages in the last 3 years since 2014, with annual spend in 2013/14 being £7.8 million. The CHC team are more likely to commission 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. Please refer to Appendices 2 and 3 for HBC packages by number and spend by CCG for 2015-16.

## 3. OBJECTIVES & PERFORMANCE MONITORING OF THE SERVICE

3.0.1 The objectives of the 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). These objectives will form the basis of the performance monitoring requirements for this specification as set out in Schedule 4.

### 3.1 The NICE Quality Standard (QS123)

3.1.1 It 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)<sup>4</sup>, 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.

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<sup>3</sup> <http://www.surreydownsccg.nhs.uk/local-health-services/nhs-continuing-healthcare>

<sup>4</sup> <https://www.nice.org.uk/guidance/qs123/chapter/List-of-quality-statement>

- **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.

## 3.2 Expectations by individuals of a high quality service

3.2.1 Individuals should expect the following from a HBC 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')<sup>5</sup>:

- The care that individuals get should reflect what they want and what they have agreed with the agency. The care should take into account 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 take into account 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.

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<sup>5</sup> [https://www.nice.org.uk/Media/Default/home\\_care\\_quick\\_guide/A-quick-guide-for-people-who-arrange-their-own-home-care-amended.pdf](https://www.nice.org.uk/Media/Default/home_care_quick_guide/A-quick-guide-for-people-who-arrange-their-own-home-care-amended.pdf)

- 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.

### **3.3 The National Framework for Continuing Health Care and NHS Funded Nursing Care**

3.3.1 As stated above this specification is joint with the six CCGs. It is therefore important that providers note the National Framework for Continuing Health Care and NHS Funded Nursing Care<sup>6</sup> and the following expectations for care planning needs:

- Put the individual, their needs and choices that will support them to achieve optimal health and well-being at the center 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 center 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).

### **3.4 Individual outcomes and performance monitoring**

3.4.1 The Individual Outcomes and performance monitoring are adapted from the Think Local Act Personal, Making it Real (2010)<sup>7</sup> “I” statements and will be used to monitor the service provided.

3.4.3 Monitoring will be undertaken by the commissioners. The provider is required to submit data and information on a quarterly and annual basis as requested and may be

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<sup>6</sup> [NHS National Framework for CHC'](#)

<sup>7</sup> Think Local, Act Personal (2010)  
<http://www.thinklocalactpersonal.org.uk/Browse/ThinkLocalActPersonal/>

subject to a quality review by Adult Social Care and CCG Quality Assurance Team's (please see Schedules 4 for further details).

3.4.4 Providers are required to conduct their own customer feedback survey's and the commissioner as part of contract management processes reserves the right to have access to the analysis of the surveys.

3.4.5 A summary of the "I" statements are as follows, with more detail regarding the expectations and guidance on how they may be experienced by the individual provided in Appendix 7. The detail of how providers can ensure they are meeting the requirements of 'I' statements and how individuals will know if they have received care as described in the 'I' statements were developed in Surrey with people who use services, carers, providers and professional stakeholders including commissioners:

| <b>Outcome title</b>                            | <b>"I" statement</b>   |
|---|--|
| <b>1) Information and advice</b>                | I have the information and advice that I need, when I need it  |
| <b>2) Active and supportive Communities</b>     | I am part of an active and supportive community, maintaining friends and family relationships  |
| <b>3) Flexible integrated care and support</b>  | I get the support I want and need in the way I wish to receive it, with mutual respect and understanding                             |
| <b>4) Workforce</b>                             | I feel confident that I am supported by people who have the values, skills, training and competence to meet my specific needs        |
| <b>5) Risk enablement</b>                       | I am in control of my life and am enabled to remain safe   |
| <b>6) Personal budgets and self-funding</b>     | I know what money is available for my care and support and am in control of my finances with access to skilled advice when I need it |
| <b>7) Health</b>                                | I will be supported to stay as healthy and as well as possible for as long as possible   |
| <b>8) Where I live and my personal property</b> | I am involved in decisions about where I live, who I live with and my personal belongings  |
| <b>9) Partnership working</b>                   | I experience seamless services from commissioners and my service provider(s) who work quickly and professionally together            |

## 4. REGULATING THE SERVICE

4.0.1 The commissioner will only contract with organisations that are registered, if they are required to do so, with the CQC and meet any other legal requirements relating to the services they provide.

4.0.2 The commissioner will conduct visits as part of the quality monitoring and market surveillance requirements as set out in the Care Act 2014<sup>8</sup>. The five key questions that CQC ask are<sup>9</sup>:

1. Are people safe? – People are protected from abuse and avoidable harm
2. 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.
3. Is the provider caring? – Staff involve and treat people with compassion, kindness, dignity and respect.
4. Is the provider responsive to people’s needs? – Services are organised so that they meet people’s needs.
5. Is the service well led? – The leadership, management and governance of the organisation makes sure it’s providing high quality care that is centred around your individual need, that encourages learning and innovation, and that it promotes an open and fair culture.

4.0.3 The commissioner reserves the right to visit the provider as part of the expression of interest process and 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.

4.0.4 The provider will be required to provide a detailed business continuity plan 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.

4.0.5 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.

4.0.6 Heathwatch Surrey<sup>10</sup> is the local and national consumer champion for health and social care. Heathwatch is another means by which individuals can share positive comments, issues and concerns about a health or social care service they are receiving.

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<sup>8</sup> The Care Act (2014) <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

<sup>9</sup> CQC Regulations (DATE) [Regulations for service providers and managers | Care Quality Commission](#)

<sup>10</sup> Heathwatch Surrey (<http://www.healthwatch.co.uk/>)

The commissioners expect providers to make reference to Healthwatch Surrey in their service user information leaflets.

## 4.1 Training Requirements

4.1.1 Providers are expected to 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<sup>11</sup>.

4.1.2 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.

4.1.3 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.

4.1.4 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

4.1.5 In addition to the above care standards, please see the following sections of this specification which refer to training:

- Section 6.5.5 which refers to the fact that all care workers are expected to have up to date moving and handling training
- Section 6.7 which refers to a situation where a care worker can be trained by an appropriate health professional for certain tasks.

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<sup>11</sup> Skills for Care (2015) - <http://www.skillsforcare.org.uk/Learning-development/CareCertificate/Care-Certificate.aspx>

## 5 PROVIDER MANAGEMENT AND SUPPORT

5.0.1 It is required that all providers are familiar with:

- The Joint Community and Care Home Provider and Service Failure Protocol<sup>12</sup>, and
- The Surrey Safeguarding Procedures as referenced on the [Surrey County Council - Surrey Safeguarding Adults Board](#) webpage.

5.0.2 Providers are required to attend their local HBC forum. The purpose of these forums is to share key messages, best practice, develop peer support and to raise local issues and identify solutions as required.

### 5.1 The Care Act 2014 and the Provider Failure Protocol

5.1.1 The Care Act 2014 sets out the duties of local authorities to promote the efficient and effective operation of the local care market. Local Authorities are required to have a Provider Failure Protocol. The purpose of the protocol is to work proactively with providers to prevent any form of failure and to support the market as a whole and to respond to providers when they are in failure. The protocol sets out the ability to hold 'Provider Planning Meetings' which can decide on the course of action when there are concerns around the present and potential ongoing provision of care.

### 5.2 Provider suspension

5.2.1 The commissioners reserve the right to suspend a provider when certain concerns and issues arise. These concerns will be addressed either via a Provider Planning Meeting or a Provider Failure Meeting depending on the severity of the circumstances. The timescales for suspending placements will be confirmed in the above meetings and will vary from case to case depending on the specific issues. The issues or circumstances that would 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

5.2.2 Providers are also asked to note that the commissioners are not obliged to make placements with providers.

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<sup>12</sup> Joint Community and Care Home Provider and Service Failure Protocol  
<http://www.surreycc.gov.uk/social-care-and-health/care-and-support-for-adults/information-for-professionals-partners-and-providers/adult-social-care-strategies-policies-and-performance/jointcommunity-and-care-home-provider-closure-protocol>

## **6 EXPECTATIONS OF A PROVIDER DELIVERING HOME BASED CARE UNDER THIS SERVICE SPECIFICATION**

6.0.1 HBC providers are an essential part of the whole health and social care system and therefore a responsive service from HBC providers is a core way to ensure that the health and social care system functions at an optimum level.

6.0.2 The commissioners require HBC rates to be fully inclusive of all costs associated with delivering a service, this includes travel time, mileage and staff training. The costs of training, travel time and mileage should be accounted for separately from a care workers hourly rate of pay. Providers are required to submit standard rates e.g. no variable rates for bank holidays, week-ends, evenings etc.

6.0.3 The commissioners expect providers to be able to adapt to new processes and systems throughout the life of the contract. The commissioner is expects providers to be able to work with an e-invoicing system.

### **6.1 General service delivery expectations**

6.1.1 Please refer to the Placement Protocol (Schedule 3) for full details of the service delivery expectations, which include the following:

- A 365 days a year (including bank holidays) service
- Travel time must be built into rota's for care workers
- Respond to requests for new packages and/or re-starts from 8a.m. to 8p.m. week days and 9a.m. to 5p.m. weekends
- Signed up to and using our electronic referral system (e-brokerage) to receive and respond to new requests
- Respond to requests for new packages and re-starts within three hours of the request being made (even if the package of care cannot be picked up it is important that the commissioner is informed of this) unless stated otherwise
- The commissioner will confirm within forty eight (48) hours from the deadline set for responses whether the provider has been awarded the POC or not. If the provider receives no communication from the commissioner within forty eight (48) from the deadline set for responses then the provider is no longer obliged to hold the space on their rota.

It is expected that a provider should pick up a hospital discharge on the same day where they have been notified before 10 a.m.

- Be in a position to commence new packages or re-starts of care within forty eight (48) hours of the original request being made or within the timescales specified by the provider.
- In the event of an absence for any other reason than death, the commissioner expects the provider to retain the service for 14 days. The commissioner will not pay retainer fees.

- If the service is retained, the provider must resume the service within twenty four (24) hours of being informed by the commissioner.
- Both the commissioner and provider (whoever is aware first) must notify the other party of a death immediately and within twenty four (24) hours at the latest.
- The provider must ring and inform the service user if they are going to be late for their scheduled visit.
- The commissioner must be notified of missed calls within two (2) hours.
- Both the commissioner and provider must notify the other part of a planned absence within five (5) days at the latest.
- Both the commissioner and provider must notify the other party of an unplanned absence within twenty four (24) hours at the latest.
- If the individual prevents the provider from delivering the service the commissioner must be notified within twenty four (24) hours at the latest.
- If you suspect that someone is at risk of abuse please contact the Multi Agency Safeguarding Hub (MASH) during office hours on 0300 470 9100, [mash@surreycc.gov.uk](mailto:mash@surreycc.gov.uk). Outside of office hours the Emergency Duty Team should be contacted on 01483 517 898
- Have the ability to respond to emergencies e.g. winter pressures, adverse weather conditions, which should be clearly set out in their business continuity plans
- Have the ability to respond and plan for major events such as Ride London
- Providers will not charge more to an individual using a direct payment that if they were receiving a directly commissioned service
- To treat all people that are part of the health and social system be that people in receipt of care, provider staff and the commissioners staff with dignity and respect

## **6.2 Recording and monitoring the delivery of care**

6.2.1 Providers must have a robust system in place to proactively record and monitor the delivery of care, including the start and end time of the visit, the name of the worker delivering the care, and the tasks and outcomes required. This is so the commissioner can be assured that the service is reliable and timely. 6.2.2 Providers must be able to demonstrate how this is met, and it is desirable that providers operate a real time (electronic) monitoring system which can reliably meet the following outcomes, and report on them, and produce monthly evidence that:

- Providers will know in real time if a care worker is 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)
- Call monitoring systems should be secure and have simple processes in place to allow people in receipt of care and allied health and social care workers to view details of care calls and care plans.

- 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.

### **6.3 The Accessible Information Standard**

6.3.1 The Accessible Information Standard<sup>13</sup> is a new mandatory standard that all NHS and publicly funded adult social care services must follow. It aims to ensure people have information they understand and the communication support they need. It is about improving the quality of care received and people's involvement in decision making.

### **6.4 Moving and Handling**

6.4.1 It is acknowledged that the ability and confidence to deliver single handed care when required can greatly reduce the stress and alleviate the pressures the HBC market and the health and social care systems are facing.

6.4.2 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.

6.4.3 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.

6.4.4 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.

6.4.5 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 singlehanded care. It worth noting that 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

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<sup>13</sup> Further information is available via <https://www.surreycc.gov.uk/social-care-and-health/careand-support-for-adults/mental-health-and-disabilities/your-right-to-accessible-information>

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 nonstandard equipment with only one care worker.

6.4.6 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.

## 6.5 Medication and Pressure Area Prevention

6.5.1 This section sets out what is required of providers in terms of medication. More detail can be found in the In-House Medication Policy developed by SCC ASC in 2016<sup>14</sup>.

6.5.2 The tasks outlined in the following table are grouped into three different levels; which each have 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 are when 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. Please note that the 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 4.

6.5.3 As described in the draft NICE guideline (October 2016), medicines should be supplied in their original packaging. Monitored dosage systems (e.g. Nomad boxes) should only be supplied if an individual assessment of the patient by a pharmacist (in line with the Disability Discrimination Act 1995) has identified a specific need to suggest it will provide benefit to the individual patient.

6.5.4 Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. Pressure ulcers tend to affect people who are confined to lying in a bed or sitting for prolonged periods of time, in particular people over 70 years old are vulnerable to pressure ulcers, as they are more likely to have mobility problems and ageing skin.

6.5.5 The commissioner recognises that interventions for the prevention of pressure ulcers need to be a part of community care and would therefore specify that care workers have the knowledge and skills of the risks associated with pressure areas, including:

- Having the knowledge to check for pressure areas in individuals with poor mobility
- Being able to look at pressure areas to identify whether skin is damaged to alert clinical staff to the needs of the individual.

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<sup>14</sup> <https://www.nice.org.uk/guidance/GID-MANAGINGMEDICINESCOMMUNITYSOCIALCARE/documents/short-version-of-draft-guideline>

## 6.6 Variances in Care Packages

6.6.1 To support a shift in culture away from task and time commissioning a formal process is followed to inform the commissioners of a variance in a package of care.

6.6.2 Variances in packages frequently occur and they can be for a wide variety of reasons, e.g. one-off instances such as needed to call an ambulance for a person. If it is a one-off, isolated occasion the provider must inform the commissioners with the reasons why the variance occurred and include the reason on the invoice.

6.6.3 If a pattern emerges regarding an individual's care where lots of small variances are occurring then the commissioner must be notified. In regards to ASC the practitioner must be informed of the variance who can decide how best to proceed i.e. does the individual need to be re-assessed or of it is a small adjustment e.g. an increase to a call by 15 minutes the support plan be updated to reflect this.

6.6.4 If the individual is funded by CHC then a Package of Care Amendment request form should be completed and countersigned by either the District Nurse or Hospice Community Nurse Specialist involved with the patient to confirm that the package variation is clinically indicated. The form should then be submitted to [SDCCG.SurreyDutyNurses@nhs.net](mailto:SDCCG.SurreyDutyNurses@nhs.net) for consideration and approval. This form can be found in Appendix 6

NB: Where appropriate, the CHC Team may arrange an urgent review of the care package before approval is confirmed.

## 6.7 Guidance on late and missed calls

6.7.1 The commissioners view planned and timely visits to vulnerable people in their own homes as a very important part of meeting individual needs and ensuring their wellbeing. It is clear that missed or late calls are not acceptable, as they leave individuals feeling anxious and forgotten and potentially at serious risk. In particular the consequences of each missed or late call must be considered.

- 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 (e.g. visits are scheduled to take place three times a day and the first visit of the day does not take place and the first achieved visit is the scheduled second visit of the day.) The consequence of a missed call needs to be risk assessed according to the commissioners' safeguarding procedures. Any missed call should be communicated to the practitioner as soon as practically possible. This is different to a cancelled call (see below).
- 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.
- 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.
- 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.

6.7.2 Call times should only vary if there has been prior agreement with the individual receiving support, and after the commissioner has been notified.

6.7.3 If a visit cannot be delivered at the scheduled time the commissioner expects the provider to ensure that the individual is contacted and advised of the delay by, at the latest, 15 minutes after the start of the scheduled time.

6.7.4 The provider will only be paid for services delivered. The only circumstances in which a provider will be paid for non-delivery of a service is when either a) the commissioner gives less than 24 hours' notice that the care is no longer required or b) the individual/ individuals family give less than 24 hours' notice that the care is not required.

6.7.5 The provider must inform the commissioner if there is a regular pattern of late cancellations either by the individual or the individual's family e.g. family takes individual out every Sunday for lunch. In the event that the individual lacks capacity the individual's family/ Carer should be contacted. The provider must have a clear and auditable communication strategy in place to action this.

6.7.6 A prioritisation plan should be in place to manage occasions where calls need to be rescheduled or cancelled (e.g. in extreme weather). This should take into account the vulnerability of individuals, the complexity of care needs and whether the visit is time critical (e.g. medication). As part of this strategy, communication with individuals about changes is essential.

6.7.7 Once either the provider or commissioner become aware of an unplanned absence by an individual e.g. admission to hospital, they must inform the other party as soon as practically possible and at the latest within 24 hours.

6.7.8 In the event of an unplanned absence the provider will invoice for the first scheduled visit but not for any subsequent planned visits.

## **6.8 Guidance on short welfare and safety visits (e.g. 15 Minute Calls)**

6.8.1 The purpose of this guidance is to support commissioners and providers with guidance on when it may be appropriate to commission short welfare and safety visits to people in their own homes, often known as 15 minute visits. This guidance is to ensure that every service commissioned is delivered at the right quality and achieves the best outcomes possible for the individual concerned. It is expected that this guidance is always taken into account when commissioning short welfare or safety visits.

6.8.2 The commissioners support the guidance published by the National Institute for Health and Clinical Excellence (NICE) <sup>15</sup> in September 2015: "1.4.2 Home care visits shorter than half an hour should be made only if:

- the home care worker is known to the person, and
- the visit is part of a wider package of support, and

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<sup>15</sup> <https://www.nice.org.uk/guidance/ng21/resources/home-care-delivering-personal-care-and-practical-support-to-older-people-living-in-their-own-homes-1837326858181>, pp12-13.

- it allows enough time to complete specific, time limited tasks or to check if someone is safe and well.”

6.8.3 Commissioners recognise that care workers should have time to do their job without being rushed or compromising the dignity or well-being of the person who uses services.

6.8.4 When commissioning short welfare and safety visits, consideration must be given to preferences, circumstances and support needs of the individual, their carer and family members. What can be delivered well and in a safe manner in a short welfare and safety visit will depend on the needs and aspirations of the individual and his or her circumstances.

6.8.5 The following activities are examples of what may be delivered within a short welfare or safety visit:

- Safety check – a visit to ensure the individual is safe and well
- Welfare check – to ensure the individual has eaten their meal and is well hydrated
- Security check – to ensure the individual’s property is secure (where the Individual doesn’t require assistance to prepare for bed)
- Assisting with, or fitting certain aids – such as hearing aids

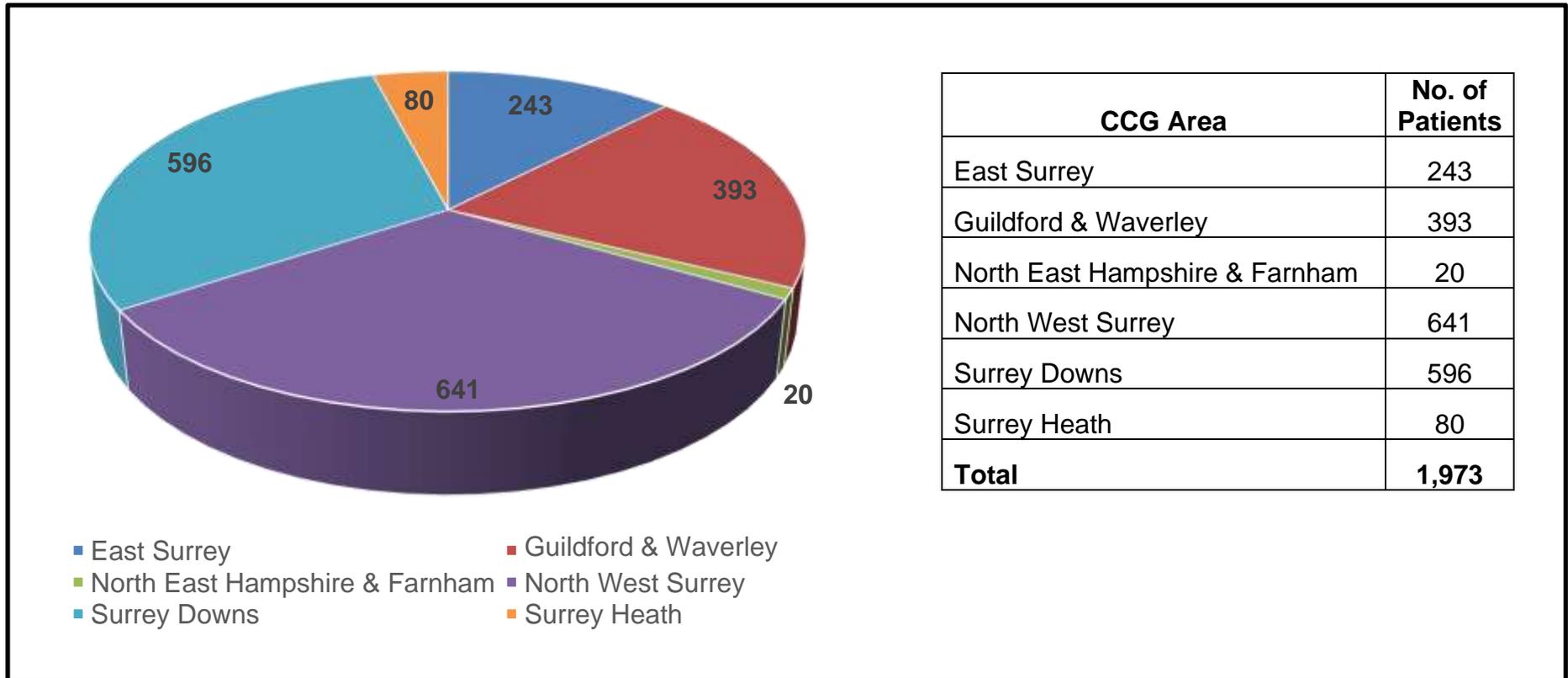
6.8.6 The following activities are **not deemed appropriate** to be commissioned in short welfare or safety visits:

- Any hands on personal care – including enabling and assisting
- Assisting/supervising baths or showers
- Preparation of food/meals
- Supervising an Individual to eat their meal
- Toileting – including changing an incontinence pad or stoma □ Medication visits

**APPENDIX 1 Volume of Surrey County Council funded HBC by Zone & Locality Team, as at 6 January 2017**

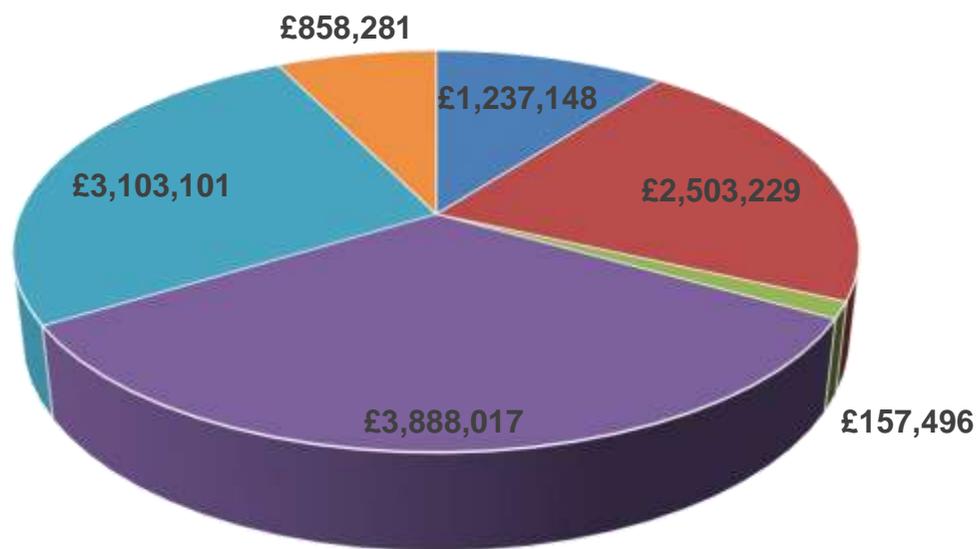
| <b>Zones (from 1 Oct 2014 to 30 Sept 2017)</b> | <b>No. of POCs</b> | <b>Locality Team</b> | <b>No. of POCs</b> |
|--|--------------------|----------------------|--------------------|
| Zone 1 Reigate & Banstead North                | 153                | Elmbridge            | 375                |
| Zone 2 Reigate & Banstead South                | 336                | Epsom & Ewell        | 283                |
| Zone 3 Tandridge Mid                           | 84                 | Guildford            | 490                |
| Zone 4 Tandridge North                         | 132                | Mole Valley          | 342                |
| Zone 5 Tandridge South                         | 57                 | Reigate & Banstead   | 482                |
| Zone 6 Elmbridge                               | 366                | Runnymede            | 414                |
| Zone 7 Epsom & Ewell                           | 283                | Spelthorne           | 408                |
| Zone 9/10 Dorking & Surrounding areas          | 170                | Surrey Heath         | 290                |
| Zone 11 Runnymede                              | 396                | Tandridge            | 273                |
| Zone 12 Spelthorne                             | 426                | Waverley             | 572                |
| Zone 13 Woking                                 | 516                | Woking               | 435                |
| Zone 14 Farnham                                | 183                |                      | -----              |
| Zone 15 Guildford                              | 325                | <b>Total</b>         | <b>4,364</b>       |
| Zone 16 Haslemere & Hindhead                   | 77                 |                      |                    |
| Zone 18 South Guildford & Cranleigh            | 134                |                      |                    |
| Zone 19 Guildford & Godalming                  | 208                |                      |                    |
| <b>Total</b>                                   | <b>4,363</b>       |                      |                    |

**APPENDIX 2 Home based care packages by CCG area, 2015/16**



NB: The figures above include patients who had more than one home care package during 2015/16 The total number excluding duplicates is 1,162.

### APPENDIX 3 Home Care expenditure by CCG during 2015/2016



| CCG Area                       | Home Care expenditure during 2015/2016 |
|--------------------------------|--|
| East Surrey                    | £1,237,148                             |
| Guildford & Waverley           | £2,503,229                             |
| North East Hampshire & Farnham | £157,496                               |
| North West Surrey              | £3,888,017                             |
| Surrey Downs                   | £3,103,101                             |
| Surrey Heath                   | £858,281                               |
| <b>Total</b>                   | <b>£11,747,272</b>                     |

- East Surrey
- Guildford & Waverley
- North East Hampshire & Farnham
- North West Surrey
- Surrey Downs
- Surrey Heath

## APPENDIX 4 Table of health care tasks by level

| Level 1: General support tasks  | Level 2: Administration by care staff   | Level 3: Administration by care staff using a specialist technique  |
|---|---|---|
| <p>These are tasks that care staff can carry out to help a customer self-medicate and maintain their independence.</p> <p>The customer <b>must</b> be able to understand how to take their medication and the consequences of not taking it; and be able to identify that they have been passed the right drug, dose, strength and form of medicine at the right time.</p>  | <p>Care staff take responsibility for confirming they have selected the correct medication</p> <p>i.e. confirming that they have:<br/>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.</p>  | <p>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.</p>  |
| <p><b>Physical assistance at request of the customer:</b><br/>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 (incl. controlled drugs). Applying medication to the eye, nose or ear at customer request</p> <p><b>Occasional infrequent prompts:</b></p> <p><input type="checkbox"/> 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.</p> | <p><b>Level 2 tasks may include some or all of the following tasks:</b></p> <p>Frequent verbal reminders to take medication</p> <p>Selecting the correct medicines for administration</p> <p>Administration of oral medication including tablets, capsules and liquids (incl. controlled drugs)</p> <p>Measuring out doses of liquid medication</p> <p>Administering inhaler devices</p> <p>Applying external medicated creams/ ointments /gels /lotions etc.</p> <p>Applying transdermal patches (including controlled drugs)</p> <p>Applying medication to the eye, nose or ear</p> | <p><b>Level 3</b> 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 will be provided by community and/or district nurses.</p> <p>Ongoing support 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.</p> |

## **APPENDIX 5 Useful contact details**

### **Adult Social Care Contact Centre**

Open between 8am to 6pm, Monday to Friday: 0300 200 1005

Email: [contactcentre.adults@surreycc.gov.uk](mailto:contactcentre.adults@surreycc.gov.uk)

### **Continuing Healthcare Team**

CHC switchboard: 07372 201645

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

### **Multi-Agency Safeguarding Hub (MASH)**

If you suspect someone is at risk of abuse, neglect or harm you need to report it to the Surrey Multi Agency Safeguarding Hub (MASH)

Open between 9am to 5pm, Monday to Friday: 0300 470 9100

Email: [mash@surreycc.gov.uk](mailto:mash@surreycc.gov.uk)

Website: <https://www.surreycc.gov.uk/social-care-and-health/contacting-social-care>

### **Emergency Duty Team**

For emergency situations outside our standard lines' hours (above) the Emergency Duty Team should be contacted: 01483 517 898

Email: [edt.ssd@surreycc.gov.uk](mailto:edt.ssd@surreycc.gov.uk)



## Package of Care Amendment Request Form

Version: Feb 2017

|                      |  |             |  |                |  |
|----------------------|--|-------------|--|----------------|--|
| <b>Patient Name:</b> |  | <b>DoB:</b> |  | <b>NHS No:</b> |  |
|----------------------|--|-------------|--|----------------|--|

**Provider Name:**

**Contact details:**

**Current Package of Care:**

| Time of Call | Number of Carers | Length of Call | Tasks to be done |
|--------------|------------------|----------------|------------------|
| X            | X                | X              | X                |
| X            | X                | X              | X                |
| X            | X                | X              | X                |

**Reason for change:**

*Please give as much clinical information as possible to support the request.*

**New Package of Care Request:**

| Time of Call | Number of Carers | Length of Call | Tasks to be done |
|--------------|------------------|----------------|------------------|
| X            | X                | X              | X                |
| X            | X                | X              | X                |
| X            | X                | X              | X                |
| X            | X                | X              | X                |

Please note this is a request for change in the package of care and not agreement to fund. A member of the Procurement and Invoicing Team will be in touch to confirm if this has been agreed.

**Approved By: (Please give details of District Nurse/Hospice Community Nurse Specialist involved)**

|                    |   |              |   |
|--------------------|---|--------------|---|
| <b>Name:</b>       | X | <b>Role:</b> | X |
| <b>Signature:</b>  | X | <b>Date:</b> | X |
| <b>Contact No:</b> | X |              |   |

**NHS CHC Team use only:**

|              |  |              |  |                   |  |
|--------------|--|--------------|--|-------------------|--|
| <b>Name:</b> |  | <b>Date:</b> |  | <b>Signature:</b> |  |
|--------------|--|--------------|--|-------------------|--|

**NHS Continuing Healthcare Team**

**Cedar Court, Guildford Road, Leatherhead, Surrey, KT22 9AE**

**Duty Tel: 01372 201 587/626**

**Fax: 01372 202 697**

**Email: [referrals.surrey@nhs.net](mailto:referrals.surrey@nhs.net)**

Surrey Downs Clinical Commissioning Group hosts Continuing Healthcare on behalf of the following CCGs:

Surrey Downs CCG, Surrey Heath CCG, East Surrey CCG, North West Surrey 28 CCG, Guildford and Waverley CCG, North East Hampshire and Farnham CCG.

## APPENDIX 7 Individual outcomes

| <b>INDIVIDUAL OUTCOME</b><br><b>(“I” Statement)</b>  | <b>PROCESS FOR PROVIDER</b>  |
|--|--|
| <p>I am the person receiving service</p>   | <p>We are the organisation providing the service</p>   |
| <p><b>1) Information and Advice</b>      <i>I have the information and advice that I need, when I need it</i></p>  |  |
| <p>“I have the information and support I need in order to remain as independent as possible.”</p> <p>“I have access to easy-to understand information about care and support which is consistent, accurate, accessible and up to date.” “I can speak to people who know something about care and support and can make things happen.”</p> <p>“I have help to make informed choices if I need and want it.”</p> | <p>The Provider will ensure that:</p> <ul style="list-style-type: none"> <li>• Our information sources, are maintained, accurate, free at the point of delivery, and linked to local and community information sources including Surrey Information Point, Hubs, Wellbeing Centres, CHC website.</li> <li>• All Care Workers are able to communicate effectively with the Individual. Where an Individual’s first language is not English, information and correspondence should be in a format that can be understood by that person or an appointed representative. Equally, where an Individual’s first language is English, they must be communicated with in a way that is clear and effective.</li> <li>• Individuals have an up to date communication assessment and recommendations from this assessment are implemented.</li> <li>• A range of information sources are made available to meet individual communication needs, which are free from jargon and available in different formats including appropriate IT software and technology, videotape, audio tape, large print, drawings and symbols which encourage an active dialogue and empower individuals to make their own choices.</li> </ul> |

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| <b>INDIVIDUAL OUTCOME<br/>("I" Statement)</b>                             | <b>PROCESS FOR PROVIDER</b>   |
|---|---|
| "I know where to get information about what is going on in my community." | <ul style="list-style-type: none"><li>• We communicate in a timely manner with Individuals around any changes to their service which may be necessary (including late delivery, change in worker)</li><li>• Carers have information about support available to them as Carers.</li><li>• Individual's will have access to appropriate professionals who can help them understand their care and support, including Social Care Practitioner, liaison nurses, health professionals, service managers, broker or advocate, Carers with specialist communication skills where appropriate (e.g. British Sign Language, Makaton, PECS etc) and the individual is aware of who the accountable lead professional is.</li></ul> |

[Type here]

| <b>2) Active and Supportive Communities</b> <i>I am part of an active and supportive community, maintaining friends and family relationships</i>  |   |
|---|---|
| <p>“I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.”</p> <p>“I have a network of people who support me – carers, family, friends, community and if needed paid support staff.” “I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities.” “I feel welcomed and included in my local community.”</p> | <p>We the Provider will ensure that:</p> <ul style="list-style-type: none"><li>• Individuals are supported to access a range of networks, relationships including families and friends, and activities to maximise independence, health and well-being and community networks.</li><li>• Individuals are given a full range of opportunities to access and participate a diverse range of activities in the community, informed by the outcomes based Support Plan. .</li><li>• Individuals pursue their own interests, tastes, abilities and aspirations and are actively enabled to realise them in their community. e.g. volunteering, training opportunities, faith groups etc.</li><li>• Individuals’ dignity is respected within their local community and we will exercise discretion when visiting Individual’s homes.</li></ul> <p>We support community activity and engagement which involves and is contributed to by the individuals we support, their families and carers.</p> |

[Type here]

| <b>2) Active and Supportive Communities</b> <i>I am part of an active and supportive community, maintaining friends and family relationships</i> |  |
|--|--|
| <p>“I feel valued for the contribution that I can make to my community.”</p>   | <ul style="list-style-type: none"><li>• We help individuals to understand their responsibilities in contributing to their community, by identifying positive community roles individuals can undertake.</li><li>• Longer term community support and not just immediate crisis is considered and planned for. Systems and organisational culture support both people and carers to achieve and sustain employment if they are able to work.</li></ul> |

| <b>3) Flexible integrated care and support</b>   | <i>I get the support I want and need in the way I wish to receive it, with mutual respect and understanding</i>  |
|--|--|
| <p>“I am in control of planning my care and support.”</p> <p>“I have care and support that is directed by me and responsive to my needs.”</p> <p>“My support is coordinated, cooperative and works well together and I know who to contact to get things changed.”</p> <p>“I have a clear line of communication, action and follow up.”</p> <p>“I know how to complain if my support is not as I wish”</p> | <p>The Provider will ensure that:</p> <ul style="list-style-type: none"><li>• Individuals and carers are able to exercise the maximum possible choice over how they are supported and are able to direct the support delivered. This includes enabling the Individual to maintain cultural, religious and personal wishes.</li><li>• Support is adapted to individuals needs as identified in their support plans, across all settings. It is simple, rapid and proportionate to risk and assessments are kept to a minimum, from which outcome focused support plans are developed with the individual identifying how support will be delivered and when, taking into account the Individual’s wishes. The support plan will also consider the individuals wishes in relation to their death including who to contact, alongside the next of kin and the social care practitioner.</li><li>• We will review Individual’s needs annually and seek relevant input to this. There will be good communication between the Individual, family, care worker, and others.</li></ul> <p>Individuals, their Carers and support staff will know what they are entitled to, and who is responsible for doing what enabling individuals to carry out tasks where possible enabling maximum independence.</p> |

|  |  |
|--|--|
| <b>3) Flexible integrated care and support</b> | <i>I get the support I want and need in the way I wish to receive it, with mutual respect and understanding</i>  |
|  | <ul style="list-style-type: none"><li>• If changes are needed, we will meet needs in the best manner possible and work with Practitioners to agree a revised support plan. We will ensure best value, and identify where support can be reduced as well as where additional support is needed.</li><li>• Support is 'joined-up', so that individuals and their carers do not experience delays in accessing support or fall between the gaps, with minimal disruptions on changes.</li><li>• Transition between support services are pre-planned and well managed, so that support is centred on the individual, rather than services and organisational boundaries.</li></ul> <p>There are easy to read and accessible complaints, compliments processes and Individual's and Carer's are aware of how to make a complaint which will not result in reprisals or jeopardise the service being delivered. It will include information about where the Individual can obtain independent support, for example from Advocacy services.</p> |

| <b>4) Workforce</b>  | <i>I feel confident that I am supported by people who have the values, skills, training and competence to meet my specific needs</i>   |
|--|--|
| <p>"I have good information and advice on the range of options for choosing my support staff."<br/>I have considerate support delivered by competent people."<br/>"I have access to a pool of people, advice on how to employ them and the</p> | <ul style="list-style-type: none"><li>• All staff are trained and assessed as competent in meeting needs identified in the individual's Support Plan, attaining qualifications in line with the Health &amp; Social Care Act 2008 (Regulated Activities 2010) and Care Act (2014) and that they operate in line with the Ten Point Dignity Challenge.</li><li>• All staff receive induction training and training in the use of specialist equipment (such as hoists, bath chairs and stair lifts) before working with Individuals and supervision when working with Individuals.</li><li>• Our recruitment and training factors in staff ability to build rapport with people, including a good ability to communicate in English and understand culture.</li><li>• The workforce is supported, respected and valued.</li><li>• We have a workforce plan which identifies how staff have the skills necessary now and in the future.</li><li>• There is a sufficient number of staff and that the workforce is focused on and able to help people build and sustain community connections.</li><li>• We register with Skills for Care and provide an annual return of my staff's training and skills (National Minimum Data Set).</li><li>• We will have a contingency plans agreed with the individual and the care worker</li></ul> |

[Type here]

|  |  |
|--|--|
| <b>4) Workforce</b>  | <i>I feel confident that I am supported by people who have the values, skills, training and competence to meet my specific needs</i> |
| opportunity to get advice from my peers."<br>"I am supported by people who help me to make links in my local community." |  |

| <b>5) Risk enablement</b><br><i>“I am in control of my life and am enabled to remain safe.”</i>  |  |
|--|--|
| <p>“I can plan ahead and keep control in a crisis.”</p>  | <p>The Provider will ensure that:</p> <p><input type="checkbox"/> The individual’s Support Plan will highlight what makes the Individual feel safe and unsafe, taking account of levels of capacity, risks and understanding the consequences and taking</p>   |
| <p>“I feel safe, I can live the life I want and I am supported to manage any risks.”</p> <p>“I am supported to feel safe in my community. I have access to a network of people who can help me to feel safe ” “I am supported to feel safe in my home”</p> <p>“I have systems in place so that I can get help at an early stage to avoid a crisis.” “I feel assured that all of my personal information is kept safe.”</p> | <p>responsibility for them. This will inform the risk management strategy. The Support Plan will outline any contingency plan for the Individual.</p> <ul style="list-style-type: none"> <li>• Management of risk is proportionate to individual circumstances.</li> <li>• Safeguarding is relevant, appropriate and coordinated so that everyone understands their role (in line with the Surrey multi-agency procedures) to ensure the individual’s welfare.</li> <li>• All staff understand and implement the SCC Missing Person Protocol as appropriate. We will attempt to ascertain individuals’ whereabouts through contact with neighbours and involved agencies. We will alert involved individuals and next of kin and escalate as appropriate and, where relevant, will alert emergency services.</li> <li>• Where equipment is utilized in order to deliver a service, the condition of the equipment will be taken into consideration as part of the risk assessment. We will ensure that individuals have access to telecare, telehealth and moving and handling equipment appropriate to their needs to mitigate risks.</li> <li>• We will support people to identify where fraud, scams or exploitation may exist and support them to alert</li> <li>• We will ensure appropriate vetting and barring checks are undertaken</li> <li>• Risk assessments and management strategies are in place. These will need to address all aspects of risk including:</li> </ul> |

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## 5) Risk enablement

*“I am in control of my life and am enabled to remain safe.”*

- Situations that challenge, ensuring the well-being and safety of all (if necessary a code of conduct should be agreed between all parties).
- Storage of hazardous substances (installation of locked cupboards if necessary for the safety of the individual or someone they live with).

We operate in line with the requirements set out in the Data Protection Act

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| <b>6) Personal budgets and self-funding</b>  | <i>"I know what money is available for my care and support and am in control of my finances with access to skilled advice when I need it."</i>   |
| <p>"I can decide the kind of care &amp; support I need and when, where and how to receive it"</p> <p>"I know the amount of money available to me for my care and support needs, and I can say how this is used (whether it's my own money, direct payment, or a council managed personal budget, or a Personal Health Budget)."</p> <p>"I can get access to the money quickly without having to go through complicated procedures."</p> <p>"I am able to get skilled advice to plan my care and support if I need it, and be given help to understand costs and make best use of the money involved where I want and need this."</p> | <p>The Provider will ensure that:</p> <ul style="list-style-type: none"><li>• All Individuals receive the information and advice around how to spend the money and are supported to have maximum choice and control.</li><li>• We make available the cost of our services and where and when we operate so Individuals can make informed choices, including supporting Individuals to choose different arrangements if they wish.</li><li>• We have easy booking/cancellation /payment arrangements.</li><li>• We will agree with the individual and their support network how their services will be purchased and managed.</li><li>• We support Commissioners to understand how Individuals are spending their money on care and support. We track the outcomes achieved, and use this information to improve delivery.</li><li>• We inform the Individual and the Commissioner in an agreed timescale if we are not able to fulfil the Support Plan.</li><li>• We have an open and fair charging policy for all individuals receiving care (whether using a Commissioner managed personal (health and social care) budget, a Direct Payment or Supported Managed Account).</li><li>• We support individuals to achieve best value when spending their money by using all available services and community resources, by the sharing of support where appropriate.</li></ul> <p>We will provide signposting information on alternative services such as community services, cleaning, befriending, dog walking, gardening, house repair.</p> |

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**6) Personal budgets and self-funding**

*“I know what money is available for my care and support and am in control of my finances with access to skilled advice when I need it.”*

- We are able to offer advice regarding grants and local furniture projects for those individuals who require it.

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| <b>7) Health</b>   | <i>“I will be supported to stay as healthy and as well as possible for as long as possible.”</i>  |
| <p>“I have access to a range of support that helps me to remain well and healthy.” “I am able to have a healthy and balanced diet that respects my personal, cultural and religious needs.” “I am able to receive skilled medical advice when I need it.” “I am able to access good and equitable health care and support as required.” “I can access specialist support if I am in a situation where my behaviours are perceived as challenging.”</p> | <p>The Provider will ensure that:</p> <ul style="list-style-type: none"><li>• We assist the Individual, where necessary, to remain well and healthy.</li><li>• We provide information and enable decision making, in line with capacity and risk, of lifestyle and wellbeing choices including the effects of smoking, alcohol, drugs, leisure, personal care and sexual health, but will not restrict choice.</li><li>• Individuals are registered with a GP and other primary care professionals e.g. dentists and supported to access healthcare including annual health checks and screening programmes, participating in appointments and acting on advice given/prescribed. We will inform the Adult Social care within one day of becoming aware of an Individual being admitted to hospital. We will liaise with health liaison nurses to aid smooth transitions between health services and community settings. Where Urgent Care is needed, we will facilitate access. Where emergency care is needed we will contact Emergency services.</li><li>• We keep clear records of health professionals involved with the Individual.</li><li>• We enable the Individual to make informed choices around their nutrition, and support them in meeting these. We will ensure support delivered to Individuals around preparation of food is compliant with Food Standards Agency guidance (December 2012)</li></ul> <p>We will ensure Individuals are able to maintain hydration. This will include sharing information. We will actively contribute to a co-ordinated network supporting Individuals to enable a consistent approach. We have techniques to manage Individuals who are resistant to hydration and nutrition. Hydration Action plans will be developed if appropriate.</p> |

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| <b>7) Health</b> | <i>“I will be supported to stay as healthy and as well as possible for as long as possible.”</i>  |
|                  | <ul style="list-style-type: none"><li>• We have implemented effective procedures to prevent the spread of infectious diseases and all staff are adequately trained. Staff are able to monitor change in condition through signs of wellbeing, and be aware of early reporting and multi-agency working.</li><li>• Individuals that we support to access the support of the wider community teams e.g. mental health, learning disability etc and are actively involved within the health action planning and care planning approaches as appropriate.</li><li>• We will take account of best practice and National guidance relating to specialist areas of care.</li></ul> |

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| <p><b>8) Where I live and my personal property</b></p>  | <p><i>“I am involved in decisions about where I live, who I live with and my personal belongings.”</i></p>  |
| <p>“I want to be included in decisions as to where I live and with whom.”</p> <p>"I want to make a contribution to my surroundings."</p> <p>“I want to be able to decorate my own space &amp; be involved in choices in shared areas”</p> <p>“I know that my personal possessions are safe and will be treated with care.”</p> <p>“I am in control of who comes into my property or personal space in shared accommodation by Care Workers and others.”</p> | <p>The Provider will ensure that:</p> <ul style="list-style-type: none"> <li>• Individuals are included in all decisions about where they live, who they live with, personal decor and are supported to understand what is provided what is shared and what belongs to them. This should include visiting prior to moving in.</li> <li>• Individuals are involved in who moves in to shared living environments □ Staff are respectful of Individuals’ homes and property.</li> <li>• Any loss or damage of the Individual’s personal possessions or property should be immediately reported to the appropriate authorities. In the event that the Care Worker(s) are found to be responsible for any damage/loss, we will reimburse the Individual.</li> </ul> <p>We recognise the individual’s right of tenure and help them to communicate with their landlord, advocating for the Individual as required. We will help the Individual understand their responsibilities as a tenant, and manage their relationships with other people in shared accommodation.</p> <ul style="list-style-type: none"> <li>• We enable Individuals to maintain a clean home in accordance with their risk assessment and support plan. We will enable them to consider how best to meet outcomes around this and how they may make use of effective, universal solutions cost.</li> <li>• We recognise that where people live, e.g. residential care, shared, living alone, will have a requirement of safe storage of personal items including medication, personal records and financial statements/books etc</li> </ul> |

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| <b>9) Partnership Working</b> <i>“I experience seamless services from the commissioners and my service provider(s) who work quickly and professionally together.”</i> |   |
| <p>“I know that all those responsible for my care and support work together to provide one efficient service”</p>   | <p>The Provider will ensure that:</p> <ul style="list-style-type: none"><li>• We will work with those commissioning care and support to achieve the individual’s required outcomes within agreed timescales for assessment, support planning &amp; implementation.</li><li>• We work with other Service Providers and Local Authorities/ Health to ensure smooth transitions, ensuring continuity for the individual.</li><li>• The service provided to the individual continues to meet their assessed need and is being monitored and reviewed appropriately. We will alert the commissioner of any changes in needs that require a care review</li><li>• We will promptly notify relevant others of significant events or incidents including:<ul style="list-style-type: none"><li>• Safeguarding concerns in line with local policy and procedures</li><li>• Falls or accidents causing injury or requiring medical attention</li><li>• Incidents which lead to restrictive interventions</li><li>• Missed calls for home based care services</li></ul></li><li>○ Serious medication errors with potential to affect the welfare of the individual</li><li>○ Information governance breaches</li><li>○ CQC enforcement action (including warning notices)</li><li>○ Death of a service user</li><li>○ Threat to financial viability of the ○ Change of manager</li><li>○ Improvement Notices issued by Environmental Health Officer, Fire and Rescue Service, Health and Safety Executive</li></ul> <li>• We work with Surrey County Council and CCGs in the following areas, and in accordance with the agreed terms and conditions:</li> |

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|  | <ul style="list-style-type: none"><li>○ Business continuity planning (including risk management for service delivery and prioritisation of needs)</li><li>○ Resolving issues</li><li>○ Providing monitoring information</li><li>○ Facilitating announced and unannounced visits to enable quality monitoring and audit</li><li>● Business failure (SCC Provider Closure Protocol and Care Act 2014)</li></ul> |
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