SCHEDULE 1
SERVICE SPECIFICATION

1. INTRODUCTION

1.1. This document sets out a service specification for the provision of Home to Assess service within a community setting for Service Users aged 18 + ordinarily resident in Essex. It describes the key features of the service and should be read in conjunction with the Terms and Conditions of the Agreement.

1.2. The Council reserves the right to amend any aspect of this specification during the Agreement Period. In the event of change, the Council will discuss with the Service Provider any proposed changes and agree how they are to be implemented. Changing national or local policies and priorities may also necessitate changes to the specification. The Provider shall work with the Council to implement any new and evolving requirements during the Agreement Period.

1.3. The views of the Service Provider, Service Users and their carers will be taken into account in any review of the specification. The Council welcomes any views from the Service Provider, Service User and their carers at any time during the life of the Agreement Period.

1.4. The Services shall be those services detailed in this Schedule 1 (*Service Specification*) performed in accordance with the Agreement and relevant ISP.

1.5. On-going domiciliary care is out of scope of this Agreement. In the event that the Service User requires long term domiciliary care, this shall be arranged by the Council outside of this Agreement.

2. SERVICE USER CRITERIA

2.1. Service Users must fulfil the criteria detailed in this paragraph 2.2 (Service User Criteria) in order to be referred to the Service Provider to receive the Service.

2.2. A Service User must be:

2.2.1. 18 years of age or over;

2.2.2. resident in the districts of Colchester or Tendring; or

2.2.3. Professionally assessed (by the referring party e.g. a social care or health professional) as requiring domiciliary care support, regardless of diagnosis or life limiting illness.

2.2.4. If the person is coming home from hospital then they are medically fit for discharge

3. THE SERVICE PROVIDER

3.1. Subject to the provisions of this paragraph 3 (*The Service Provider'*) and the provisions of Schedule 3 (*Payment Schedule*) the Service Provider shall make available to the Council a number of guaranteed hours available for the provision of the Service

3.2. The Staff engaged in the delivery of the Service must fulfil the requirements of paragraph 16 (*Staff Training Requirements*).

3.3. The Council shall purchase a mixture of guaranteed hours and additional spot purchase hours as required to fulfil this agreement. The Council shall be required to pay the guaranteed hours in accordance to paragraph 2 schedule 3 *(Payment Schedule).*

3.4. The Council shall be under no obligation to pay for the additional spot purchase hours unless all of the guaranteed purchase hours for the associated lot have been used.

3.5. The Service Provider must be appropriately registered with the Care Quality Commission such registration must be maintained throughout the Agreement Period

3.6. The number of Guaranteed hours are:

Lots	**Lot 1 – Colchester**	**Lot 2 – Tendring**
Guaranteed Hours per week	150	150

4. SERVICE REQUIREMENTS

4.1. Throughout the Agreement Period and during delivery of the Service the Service Provider must:

(a) Encourage the Service User to regain as much independence as possible in relation to the outcomes detailed in their Individual Support Plan; this is to be achieved by working in partnership with the identified (Home to Assess Co-ordinator (referred to as trusted assessor below), the service provider will not be required undertake its own assessment in the hospital

(b) Respect the Service User and their way of life, paying particular regard to ethnic, religious and cultural issues;

(c) Involve the Service User in all decisions which affect the delivery of the Services, addressing their specific communication needs and being responsive to their informed choices and wishes;

(d) Respect the dignity and have regard for and maintain the self-respect of the Service User at all times

(e) Give assistance in a safe, practical, reliable manner and in ways acceptable to the Service User;

(f) Maintain the Service User's current support networks;

(g) Maintain the Service User's confidentiality at all times unless a disclosure is required by this Agreement, necessary to protect the health, safety or welfare of the Service User or other Service Users;

(h) Avoid any discriminatory practices;

(i) Ensure that Service Users who may not have capacity in relation to part(s) of their Individual Support Plan are involved in decision making and that decisions made are in the person's best interests and are the least restrictive option available

(j) Promote the quality of life of the Service User;

(k) Involve Service Users and their carer(s) and families (where appropriate) in their care;

(l) Feedback to carers on the Service User progress;

(m) Ensure Service Users consent to care and treatment;

(n) Ensure the care and welfare of Service Users;

(o) Cooperate with other providers where appropriate to ensure service continuity;

(p) Safeguard Service Users from abuse;

(q) Ensure the Service Provider's employees comply with cleanliness and infection control requirements;

(r) Manage medicines in accordance with requirements;

(s) Ensure that any equipment is safe, available and suitable for the purposes of the Service;

(t) Comply with requirements relating to training and suitability of Staff;

(u) Assess and monitor the quality of service provision;

(v) Ensure complaints are handled in accordance with the Agreement; and

(w) Keep accurate and up to date records as required by this Agreement.

5. CORE SERVICE PRINCIPLES

To promote the quality of life of Service Users, the Service Provider and Staff are required to observe the following principles:

5.1. CREDIBILITY

5.1.1. The Service Provider and Staff shall adhere to any relevant codes of conduct for their profession.

5.1.2. The Service Provider shall ensure Staff have knowledge of the requirements of their job, and in particular the Services to be provided, the policies and procedures under which the Services will operate, and provides training to the national standard as a minimum.

5.1.3. The Service Provider must have ways of finding out whether the Service User is satisfied with the Services they receive from time to time and throughout the Agreement Period.

5.2. **COMPETENCY**

5.2.1. The Service Provider must ensure that its organisation:

(a) is run by people who are competent to do so;

(b) recruits and employs staff competent to do the job;

(c) adheres to legal requirements;

(d) operates safe working practices; and

(e) is properly insured and financially sound.

5.2.2. Pursuant to the Council's policy for dealing with complaints (set out in Schedule6 (Council Policies)) the Council has a statutory duty to handle complaints about social care as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

5.2.3. The Service Provider must have arrangements in place for the handling and consideration of complaints about any matter connected with its provision of services commissioned by the Council. These arrangements must comply with statutory regulations and the Service Provider must ensure that the complainant is fully advised of their right to request that the Local Government Ombudsman review the handling of their complaint, if they remain dissatisfied. The response to the complainant and details of the investigation must be made available to the Council on request, for the purposes of supporting resolution and for quality assurance purposes.

5.3. **RESPONSIVENESS**

5.3.1. The Service Provider must respond to the Service Users' individual needs; providing choice to the Service Users and their carers about when and how the Service are provided. The Service Provider shall ensure that the Service responds appropriately to the specific needs of any protected characteristic (as defined by the Equality Act 2010) as appropriate.

5.3.2. The Service Provider must have a process by which Service Users, Carers, the Council or any other interested party may make comments, suggestions, complaints, and compliments, and a system in place which will ensure that such comments, suggestions, complaints and compliments may be considered fairly and acted upon if appropriate from time to time.

5.4. **RELIABILITY**

5.4.1. The Service Provider shall deliver provide the Service Users and Carers with information about the individual Services to be provided to them and have policies to keep Service Users, Carers & the Council informed of any significant changes in services.

5.4.2. Service Users and their carers may approach the Council if they wish to lodge a complaint against the Service Provider. The Council will investigate complaints in accordance with the Council's complaints policy where appropriate. However,

it will usually be appropriate for the Service Provider to undertake the initial investigation.

5.5. **UNDERSTANDING, DIGNITY & RESPECT**

5.5.1. The Service Provider shall ensure that the Staff providing the Services are properly briefed as to the Service User's needs and respect the Service User's wishes, independence, race and gender.

5.5.2. Many Service Users have a disability and the Service Provider and its Staff must respect the Service User's independence and consult with them as necessary. Staff must always work with Service Users in an enabling manner.

5.5.3. The Service Provider shall ensure that Service Users and Carers are treated with respect and must have a policy on how Staff should conduct themselves with Service Users.

5.5.4. Staff must be aware of and respect the Service User's cultural and religious needs and understand the influence this may have on their behaviour.

5.5.5. Staff should demonstrate respect for the Service User's privacy and dignity.

5.6. **SECURITY**

5.6.1. The Service Provider shall employ Staff who respect the Service User and their property, and who keep information about them confidential.

5.6.2. The Service Provider shall only recruit staff who have satisfied all necessary recruitment checks. Staff will be trained in Safeguarding of Vulnerable Adults (SOVA) guidelines and actively support the SOVA guidelines.

5.6.3. The Service Provider will maintain the Service Provider's Premises and grounds in a way which will ensure the Service User's safety and security.

5.6.4. Information security policies and procedures must be in place that is as robust as the Council's policy (See Schedule 6a (Information Handling).

5.6.5. The Council will regularly review the third party policy and procedures and may audit the organisation to confirm compliance.

5.7. **ACCESSIBILITY**

5.7.1. The Service Provider shall have a written form of a statement of purpose.

5.7.2. The Service Provider shall access where required interpreting and translation services for minority ethnic Service Users as well as Braille and signing services for Service Users with sensory impairment. The Service Provider shall be sensitive to Service User need and willing to facilitate access to these services.

5.7.3. The Service Provider shall ensure that the Staff providing the Service are properly briefed as to the Service User's needs and respect the Service User's wishes, independence, race and gender. Many Service Users have a disability and the Service Provider must respect their need for independence and to be consulted and must always work with them in an enabling manner.

5.8. **EQUALITY**

5.8.1. The Service Provider will ensure that it and its Staff do not discriminate against people because of any protected characteristic (as defined by the Equality Act 2010).

5.8.2. The Service Provider's policies will promote respect for Staff and Service Users irrespective of any protected characteristic (as defined by the Equality Act 2010).

5.8.3. The Service Provider shall take all reasonable steps to prevent unlawful discrimination and promote equal opportunities and good community relations between people from different racial groups.

5.8.4. Staff must be aware of and respect the Service User's cultural and religious needs and understand the influence this may have on their behaviour or their decisions.

6. REFERRALS TO THE HOME TO ASSESS SERVICE

6.1. The needs of each individual Service User will be assessed by a health or social care professional in collaboration with the Service User and the Service Provider.

6.2. The assessment will identify whether the Service User is eligible for Home to Assess using the criteria in paragraph 2 (*Service User Criteria*).

6.3. If following assessment the Service User meets the criteria detailed in paragraph 2 (Service User Criteria), the social care professional will contact the Council's Appointed Brokerage Service to make the referral to the provider.

6.4. All referrals to the Service Provider will be made by the Council's Appointed Brokerage Service. The Council reserves the right to amend the referral process. In the event of such change the Council shall notify the Service Provider in writing 14 (fourteen) days in advance of the change to the referral process.

6.5. The Appointed Brokerage Service will issue the Service Provider with an ISP. The issue of an ISP shall be the time of referral for the purposes of paragraph 7 (*Response)*

6.6. The ISP shall detail:

(a) The Service User or Service User's carer's name and contact details;

(b) The Service User's needs and objectives;

(c) The outcomes to be achieved

(d) How the outcomes are to be achieved

(e) The agreed start date

(f) The care package expiry date; and

(g) Confirmation of the hours required per week

6.7 Once referral has been accepted, Appointed Brokerage Service will send the Service Provider a contract letter.

7. RESPONSE

7.1. The Service Provider will respond within 2 hours of the time of referral to acknowledge receipt of the referral and confirm the start of the care package.

7.2. Subject to the provisions of paragraph 7 (Response), the Service Provider shall ensure that the care package will commence within agreed timescales subject to any circumstances beyond the Service Provider's control (e.g. delay in hospital discharge).

7.3. Where, Service Provider is of the opinion that the Service User is not suitable for Home to Assess Service, the Service Provider shall comply with the provisions of paragraph 8 (*Non Acceptance of Referral*).

7.4. The Service Provider shall provide the Services to the Service User from the agreed start date detailed in the ISP, until the care package expiry date unless the care package is cancelled, suspended or varied in accordance with the Agreement.

7.5. Where the Service Provider is not able to comply with the response times detailed in this paragraph 7 (Response) the Service Provider must make an Exceptions Report to the Appointed Brokerage Service immediately.

7.6. Where the Service Provider has failed to meet the timescales referred to in this paragraph 7 (Response), the Council shall be entitled to liquidated damages in the sum of the charges made to the Council in respect of delayed hospital discharge for the Delay Days.

7.7. The Council shall take into consideration the day and time at which the referral was made when reviewing the Service Provider's performance of the requirements of this paragraph 7 (*Response)* and the corresponding Performance Measure.

8. NON ACCEPTANCE OF REFERRAL

8.1 In the event that the Service Provider is of the opinion that a Service User that has been referred by the Council's Appointed Brokerage Service is not suitable for Home to Assess and/or does not meet the criteria detailed in paragraph 2 (*Service User Criteria)* the Service Provider must provide detailed reasons for this rejecting the referral to the Council's Appointed Brokerage Service by way of an Exceptions Report.

9. SERVICE COMMISSIONING

Services shall be commissioned in the following way:

9.1. The specific outcomes to be achieved for the Service User shall be agreed between the Care Manager, Multi-disciplinary team, Service Provider and Service User and recorded in the Individual Support Plan.

9.2. To achieve the outcomes, the Service to be delivered by the Provider will be agreed between the Care Manager, Multi Disciplinary Team and the Provider. Actual tasks, times and the duration shall be agreed between the Service User and the Multi-Disciplinary Team and be recorded in the Service User's Individual Support Plan.

9.3. Any changes necessary to the Individual Support Plan will be reviewed on a weekly basis at a Multi-Disciplinary Team meeting and alterations agreed in line with the Service User to ensure the Home to Assess Period is optimised.

10. SERVICE DELIVERY

10.1 General

10.1.1 The Service Provider shall provide a Home to Assess service that is:

a) for a maximum period of up to 6 weeks

b) a mixture of one-to-one support, supporting the use of equipment and assistive technology;

c) person-centred with agreed individual goals and outcomes expressed in the Individual Support Plan. Such plans must be reviewed on an on-going basis during the Home to Assess Period with new goals set and inputs adjusted as progress is made;

d) a domiciliary service within a multi-disciplinary model that, in addition to care workers, will involve occupational therapists, physiotherapists and specialist nurses where required. The Service Provider will not deliver all of the requirements of a multi-disciplinary service using its own Staff, the Service Provider is required to work closely with other community services to ensure that the service is multidisciplinary;

e) available to Service Users that fulfil the Service User criteria detailed in paragraph 2 (Service User Criteria) including those with dementia, physical and sensory disabilities and other challenges as long as their care support needs can be met;

f) aimed at helping people to regain/maintain independence in order that they are able to maintain in their own home. Care should be provided in accordance with the Individual Support Plan which include the following areas personal care, meal preparation, falls avoidance, undertaking domestic cleaning tasks, laundry, using public transport and local community facilities, shopping, budgeting and the use of equipment and adaptations

g) During the 6 week period of Home to Assess Service the provider will be able to adjust the number of weekly hours to support the individual service user.

h) Provided in the service users own home.

10.2 Core and Support Tasks

10.2.1 The Provider shall:

(a) Support the Service User with self-care when this is difficult because of his/her frailty or disability in line with their Individual Support Plan;

(b) Support the Service User to retain his/her self-respect and dignity when he/she meets, sees, or is seen by others within the home (this includes the staff of the service).

(c) As well as personal care tasks, the Service Provider shall make it a clear and acceptable aspect of the work of Staff, that part of their role is to spend time talking to, relating with and understanding the lives of service users.

(d) Each Service User must be assisted in such a way so that any distress or discomfort is avoided or minimised, paying due regard to his/her health, safety and dignity and encouraging the development of personal skills and the exercise of choice and control.

(e) In addition, and in the context of a person-centred approach, the Service Provider will assist with social, spiritual, emotional and healthcare needs such as:

i. Orientation within the home and outside.

ii. Companionship.

iii. Intellectual stimulation.

iv. Socialising with friends and family.

v. Management of medicines – The Service Provider must ensure safe medication practices are being carried out in accordance with the Care Quality Commission Regulations and therefore must adhere to the Council's Medication Guidelines and Workbook will be used as a tool to support the Service Provider to achieve the required standards. Updates to the Council's Medication Guidelines and Workbook will also be notified to the Service Provider.

vi. Assistive technology training and support

10.3 Supporting Sensory Care

10.3.1 Service Users may have sensory impairment. Staff must be made aware of the Service User's sensory impairment

10.3.2 Staff must always consider the additional needs of Service Users with a sensory disability and must ensure that the Service User feels empowered by their support and engagement.

10.3.3 Supporting Service Users with sensory impairments requires the Staff to have knowledge and understanding of the impact of visual and auditory impairments. Staff must have training in communication tactics, and be able to communicate with Service Users in a manner that is not discriminatory or oppressive.

10.4 Supporting Service Users with Dementia

10.4.1 The Service Provider must ensure that Staff have training on and understand behavioural changes and cognitive impairment that is associated with dementia and issues relating to pain management. An understanding of the impact of cognitive impairment is paramount.

10.4.2 The Service Provider and Staff must be familiar with national and local strategies related to dementia care and NICE Quality Standards for Dementia and ensure that support staff are kept abreast of the National development in dementia care and receive appropriate training and support.

10.4.3 The Service Provider must:

(a) have a system in place to assess the wellbeing of people who are unable to complete feedback surveys, e.g. wellbeing profiling, dementia care mapping or other observation tools;

(b) an identified Dementia Champion within the home to take a lead on new initiatives, to support staff, to develop best practice and quality improvement;

(c) ensure Staff receive full training with a clear developed pathway in relation to all aspects of supporting people with dementia;

(d) ensure Staff have an understanding of the effects of medication on people with dementia and management strategies which can assist people with behavioural disturbances to avoid dependence on anti-psychotic medication an d

(e) ensure that Staff are trained to spot potential early signs of dementia and ensure that the details of the early signs are stated in the Individual Support Plan, the care summary supplied to the Service User's GP required by paragraph 11.3 (*Leaving the Home to Assess Service*) and any ongoing care referral.

10.5 Supporting Epilepsy Care

10.5.1 The Service Provider must ensure that Staff are trained in epilepsy care and in first aid.

10.6 Individual Support Plan

10.6.1 The Individual Support Plan is agreed with the Service User and trusted assessor based on the initial assessment undertaken at the commencement of the Home to Assess Period.

10.6.2 The Individual Support Plan shall:

a) be a living document throughout the Home to Assess Period with a defined end date for Home to Assess;

b) be reviewed on a weekly basis during the Home to Assess Period working in partnership with the trusted assessor and adjusted as progress is made in accordance with paragraph 10.4 *(Service User Progress and Review)*;

c) contain a written plan,

d) record information to help manage current and shape future requirements; and

e) contain Service User feedback .

10.7 Service User Needs and Outcomes

10.7.1 The Service Provider will support the Service User to achieve or re-establish Service User's the ability to live as independently as possible in the community using outcome-based care.

10.7.2 The Service Provider shall, as a minimum:

(a) Encourage and empower Service Users to take an active role in their own long care term management;

(b) Engage with family members, carers and other professionals as necessary;

(c) Develop attainable goals and aspirations with the Service User for the Home to Assess Period and incorporate these within the Individual Support Plan;

(d) Encourage Service Users to achieve their goals where possible and/or develop new ones in the course of the service;

(e) Develop a sustainability strategy with the Service User to maintain the Service User's independence;

(f) Offer advice and information to Service Users on community resources, including but not limited to the maximisation of benefits;

(g) Aim to have Service Users completing Home to Assess with little or no on-going care requirements;

(h) Set Goals with the Service User. There is no single universally accepted tool for goal-setting, although focusing on Service User strengths and what they want to be able to do is a good basis for the process;

(i) Involve Occupational Therapy, Physiotherapy and other professionals as required by the Service User's Individual Support Plan to achieve the Service User's goals and outcomes.

10.4 Service User Progress and Review

10.4.1 The Care Manager will participate in a weekly Multi-Disciplinary Team Meeting to review each Service User's progress and access their goals, updating the Individual Support Plan as necessary.

10.4.2 The Multi-Disciplinary Team Meetings will be the main professional communication forum where progress and the achievement of goals detailed in the Service User's Individual Support Plan is assessed and any plans for discharge are drafted.

10.4.3 A joint review will be held with each Service User and their family where necessary to discuss progress and confirm draft discharge plans.

11. LEAVING THE HOME TO ASSESS SERVICE

11.1. If the Service User's Individual Support Plan indicates that there is a need for ongoing care following the Home to Assess Period,

11.1.1 The trusted assessor and Council's Social Work Team shall make arrangements based on the Service Provider's feedback of the Service User's Individual Support Plan for on-going care for Service Users with substantial or critical need using the Fair Access to Care Services criteria; and

11.1.2 The Service Provider shall work together with the trusted assessor to signpost all other Service Users not referred to in paragraph 11.1.1 (*Leaving the Home to Assess Service*) to advice and information about accessing other services to meet their ongoing care needs.

11.2. The Service Provider shall work with other providers in the community to ensure that Service Users have a plan for their on-going care.

11.3. Subject to the Service User's consent to share such data, the Service Provider must arrange and ensure that a Service User's care summary is transferred to the Service User's GP practice and other care providers at the end of the Home to Assess Period,

12. PLACEMENTS WHICH BECOME UNSUITABLE

12.1 In the event that the Service Provider believes that the Service User has become unsuitable for Home to Assess and/or no longer fulfils the criteria detailed in paragraph 2 (*Service User Criteria*) the Service Provider shall liaise with the Multi-Disciplinary Team providing specific detailed reasons for this, for further discussion. The Service Provider shall maintain the placement until a mutually acceptable alternative is sourced.

13. NOTIFICATION TO THE COUNCIL

13.1. The Service Provider shall immediately inform the Council's Authorised Representative using the form in Appendix 1 of this Schedule 1 (*Service Specification*) if:

(a) the CQC issue the Service Provider with an Enforcement Notice;

(b) The Service Provider is subject to an investigation relating to the Safeguarding of Vulnerable Adults;

(c) circumstances where the Service User has consistently refused provision of the service or medical attention;

(d) Serious accident, serious illness or serious injury to the Service User;

(e) Death of the Service User ;

(f) Bequests to Provider and/or staff;

(g) Unplanned absence of the Service User;

(h) Hospital admission.

14. SERVICE STANDARDS

14.1. The Service Provider shall meet the regulations and standards set out in the CQC Essential Standards of Quality and Safety and as updated or replaced from time to time.

14.2. The Service Provider shall allocate dedicated Staff specifically trained in personal care to work within the Home to Assess service. Continuity of Staff must be a priority, with a Service User receiving the Service from as few different support workers as possible.

14.3. In addition to meeting the CQC Essential Standards of Quality and Safety, the Council also requires the Service Provider to meet the Contract Standards detailed in the Annex 2 of this Schedule 1 (*Service Specification*).

14.4. The Council reserves the right to update this section "Service Standards" where in its reasonable opinion it is necessary to do so. The Council will provide the Service Provider with reasonable notice where an alteration is made.

15. STAFF

15.1. In addition to the provisions of Clause 7 (*Personnel and Staff*) the Service Provider must:

(a) employ Staff who respect the Service User and their property, and who keep information about them confidential;

(b) only recruit staff who have satisfied all necessary recruitment checks. Staff will be trained in Safeguarding of Vulnerable Adults (SOVA) guidelines and actively support the SOVA guidelines;

(c) make it a clear and expected aspect of the work of their Staff that part of their role, is for Staff to spend time talking to, relating with, and understanding the lives of Citizens and supporting them with appropriate activities as well as personal care tasks;

(d) ensure that all Staff deliver the Services in a person centred way using the ethos of reablement and rehabilitation that supports the citizen to maximise their independence and health and wellbeing; and

(e) ensure there are sufficient staff available at all times to deliver the service outcomes and ensure staffing capacity to meet fluctuations in demand or at peak times of the day and cover any staff shortages due to holiday or sickness.

16. STAFF TRAINING REQUIREMENTS

16.1 The Service Provider must have a policy and/or procedure that is applied to all Staff that stipulates the training that all Staff must undertake at the start of their engagement with the Service to ensure:

(a) All Staff are adequately trained to perform the tasks needed of them;

(b) Training is given both at induction and on an ongoing basis covering routine skills, general updates, and specialist skills where required;
(c) All training is carried out by suitably qualified or experienced persons.
(d) All care staff employed have the relevant qualifications, knowledge, skills and experience to carry out the role;
(e) Manual Handling training is a requirement for all Staff whose role includes moving and handling processes. This should be updated every year and must be carried out by a qualified Manual Handling trainer;
(f) All Staff receive medication training at induction and at regular intervals thereafter;
(g) All Staff receive training on and adhere to published guidance about how to use medicines and health related tasks and are clear about the limits that they need to adhere to;
(h) Safeguarding of Vulnerable Adults training is provided for all staff and is updated at least annually;
(i) Mental Capacity Act 2005 training is provided for all staff and should be updated at least annually;
(j) Dementia Awareness Training is required by all staff working with Service Users with Dementia.

16.2 All Staff will undertake suitable induction training (e.g. Skills for Care) at the commencement of their engagement to ensure that Staff are suitably trained to work unsupervised. The start and completion date for this induction must be recorded in the employee training record.

16.3 Staff induction training must cover the following as a minimum:
(a) A written induction pack including copies or summaries of all policies and procedures listed in this Agreement.
(b) A verbal induction that will include all of the Providers' general procedures including (this list is not exhaustive):
(i) Code of conduct;
(ii) Confidentiality;
(iii) Philosophy of care;
(iv) Missing person procedure;
(v) Anti-discriminatory practice; and
(vi) All Health and Safety responsibilities.
(c) A practical induction for all Staff including those that may state they have previous experience. This must include:
(i) Formal Manual Handling training;
(ii) Dealing with personal and continence care;
(iii) Safeguarding of Vulnerable Adults; and
(iv) Mental Capacity Act 2005.
(d) Service Specific Training which covers the following elements:
(i) Principles of Reablement/Rehabilitation
(ii) The Role of the Multidisciplinary Team
(iii) Effective Communication
(iv) The Service User and their Environment
(v) The Service User and Long Term Conditions
(vi) Therapeutic Relationships

(vii) Therapeutic Skills
(viii) Assistive technology and Equipment
(ix) Positive Risk Taking and Risk Factor

16.4 In addition to the requirements of paragraph 16.3 *(Staff Training Requirements*), All professional staff should must have the relevant qualifications and be registered with the appropriate professional bodies.

17. ADVOCACY

17.1. The Service Provider shall, at its own cost work directly with the Service Users' Care Manager to ensure Service Users have access to an appropriate advocacy service if required and that advocates are granted good access to Service Users.

17.2. The Service Provider will take a positive and co-operative approach and organise advocates to come in when this is desirable for the Service User.

18. CONTRACT MONITORING AND REVIEW

18.1. The Council will review the Service Provider's performance against the Agreement in accordance with the provisions of Schedule 2 (*Performance Standards*). The Council reserves the right to alter its contract monitoring and review procedures when in its reasonable opinion it is necessary to do so. The Council will provide the Service Provider with reasonable notice in the event that the contract monitoring and review processes within this contract are altered.

APPENDIX 1

Notification to the Council

A requirement of the Home to Assess Service Contract 2015 is that the Council is notified for various reasons in line with this Schedule 1 (*Service Specification*), paragraph 13 (*Notification to the Council*)

The following information must be completed and returned for all incidents covered by paragraph 13 (Notification to the Council) of Schedule 1 (Service Specification).

Name of Service Provider:
Date of notification:
Reason for notification

Please complete and return to the appropriate team as follows:
E-mail Notification to: service.placementteam@essex.gov.uk

Safeguarding Essex – SafeguardingEssex@essex.gov.uk or secure email

via SafeguardingEssex.gcsx@essex.gcsx.gov.uk or faxed to 01245 550355

Deprivation of Liberty Forms – dolforms@essex.gov.uk or faxed to 0808 280 0550