ANNEX 1 to SCHEDULE 1

OBJECTIVES

1. INTRODUCTION & SCOPE

1.1 The Council has identified the need to provide additional guaranteed capacity in order to reduce/eliminate delayed discharges from hospital – proposal of Home to Assess.

1.2 The purpose of this contract is to provide care for individuals in their own home to avoid a hospital admission or following a hospital stay for a period of up to six weeks. During the service period a comprehensive health and social care assessment will be undertaken to determine their on-going care requirements at which point they will be referred to the Home Support Service contract.

1.3 This service will accept referrals from 14th March 2016 until 31st May 2016, with an option for ECC to extend for up to a further three months.

1.4 The service will be prioritised to support individuals following hospital discharges, and on some occasions where we are unable to follow the normal care path route.

2. HOME TO ASSESS SERVICE – how it will work

2.1 The Home to Assess Service will be applicable to the given areas identified in Table A below:

Table A

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

2.2 The **main** hospital focus will be as identified in Table B below:

Table B

Hospital
Colchester Hospital University Foundation Trust
Clacton and District Hospital
Fryatt Hospital, Dovercourt

2.3 In the unlikely event that there is unused guaranteed hours the council may approach the provider to support service users identified as suitable from other hospitals, i.e. Princess Alexandra, Broomfield, Basildon and Addenbrookes. These service users will be resident within that allocated lot.

2.3 Under the Home to Assess Service the Providers, will liaise closely with Hospital Staff and Hospital Social Work Staff to ensure that individuals requiring social care support but not suitable for reablement are supported out of hospital

and back to their own home environment (for the avoidance of doubt the service will be for new service users and not re-starts of existing provision).

2.4 The service will be available between the hours of 7am and 11pm seven days per week and requests for service will come from the Hospital Social Work Teams based within the Integrated Discharge Team or Community Social Work Teams based within the Single Point of Access (admission avoidance).

2.5 The Service will have a 6 week pathway during which time the provider will work with health and social care teams to complete a comprehensive health and social care assessment to determine longer term health and care needs. It must be noted that the domiciliary care service provided to service users should be provided in an enabling way as a general principle.

2.6 The Service User will be care assessed by the Integrated Discharge Team (which includes social workers) identifying agreed outcomes and this will be translated into an indicative care and support plan. The provider will be an integral part of the Integrated Discharge Team. The provider will use the indicative care and support plan to respond to the emerging needs of the service user by offering flexible care and support in consultation with the Service User. The Service User will be allocated a block of time, and the Provider will negotiate directly with the Service User, regarding preferred times of calls and flexibility, and will be completed in a person centred and risk focussed way.

3. OUTCOME BASED PURCHASING

3.1 The way in which support services are purchased nationally, is changing. There is a deliberate move away from a task oriented approach to developing services that are seen to deliver positive outcomes for people. Services must be more flexible and able to respond to immediate need. Similarly the knowledge held by providers must be used to its fullest potential, in order to maximise the benefit for the service user, the provider and for the council. Through outcome based purchasing the balance of the relationship between the parties involved will change to one where commissioners assess needs and identify the outcomes and end results to be achieved and Providers deliver a range of agreed provisions that will achieve the outcomes, without having to constantly revisit the assessment.

4. SERVICE AIMS

4.1 The Service is designed to provide care for individuals in their own home to avoid a hospital admission or following a hospital stay for a period of up to six weeks.

4.2 During the service period a comprehensive health and social care assessment will be undertaken to determine their on-going care requirements.

4.3 The Council wishes the Provider to establish the relationship with the Service User as early as possible during the referral process in order that the Service User can direct their own Individual Support Plan.

4.4 The Council wishes, in partnership with Service Users and the Provider, to move towards an outcome based and personalised approach to the provision of the Services and this specification reflects that direction of travel.

5. MEASUREABLE BENEFITS TO THE HEALTH AND SOCIAL CARE ECONOMY:

6.1 The Service is expected to deliver the following measureable benefits:

(a) A reduction in dependency on long-term services

(b) Increased independence with people being able to stay in their own homes

(c) Reduced acute hospital admissions and simplified hospital discharges

(d) Increased choice and service user autonomy.

(e) Reduce barriers to information with regard to the Service User to reduce discharge delays (Integrated Discharge Team)

(f) To participate in any areas of safeguarding vulnerable adults pertaining to the Service Users using this service.

6.2 The Council will support the above measurable benefits by providing the following services to the individual within the care home environment:

(a) Home assessment and equipment provision to allow Service Users to return home.

(b) Direct link with the Provider to ensure guaranteed hours are utilised effectively for the right client group and delayed discharges do not occur unnecessarily.

(c) Lead a weekly multi-disciplinary meeting to review Home to Assess guaranteed hour utilisation and plans for transferring care to alternative provision to avoid Service Users remaining in the service for longer than 6 weeks.

(d) Direct link with other health services to support care needs including D/N's, Long Term Condition Matrons and other specialist nurses if required.

APPENDICES

The following appendices indicate some core tasks and support, which are not exhaustive and are not necessarily needed in all cases but are included for information for the Service Provider.

APPENDIX 1

CARE AND SUPPORT TASKS

The support to be provided for Service Users is likely to include the following, however this list is not exhaustive, nor needed in all cases.

The Services are to be provided in accordance with relevant policies and procedures included in Contract standards.

The Integrated Discharge Team, including the Provider, will agree the requirements for immediate care support to be put in place by the provider via an Indicative Care and Support Plan. An Individual Support Plan will always be provided via the Service Placement Team.

The Provider will:

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.

Support the Service User to retain his/her self-respect and dignity when he/she meets, sees, or is seen by others.

Provide an agreed programme which meets the ISP and with a view to assessment for a longer term support plan (if required) to assist the Service User to regain skills or develop new skills in personal care.

As well as personal care tasks, Providers should make it a clear an acceptable 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 Service Users.

Each Service User should 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.

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

- Orientation within the home and outside.
- Companionship.
- Intellectual stimulation.
- Socialising with friends and family.
- Access to and attendance at doctors, dentists, outpatient appointments, etc. including providing an escort at no additional cost.
- Management of medicines – (The Council expects Providers to ensure safe medication practices are being carried out in accordance with the Care Quality Commission Regulations and therefore expect that the Council's Medication Guidelines and Workbook will be used as a tool to support

Providers in achieving required standards. Updates to the Council's Medication Guidelines and Workbook will also be circulated to Providers).

- Arrangements for worship.
- Fitness activities.
- Assistive technology training and support

For each Service User, the determining factor will be the outcomes to be achieved. The Service User, and where appropriate and, wherever possible, in accordance with their wishes, their Carers, should always be central to discussions as to how those outcomes should be achieved.

Where an unpaid caring role is identified, the Provider should identify signpost the individual to a Carers Assessment via the Multi-disciplinary team.

APPENDIX 2

Supporting Older Adults 65+

The focus of this service is to promote the independence, wellbeing and choice of the Older People of Essex, whilst maintaining dignity and respect. Social inclusion and self-determination are key values to be deployed in supporting Older People who have needs that are more generic in nature.

The Service User should always be central to any discussions as to how outcomes will be achieved, whilst also considering the influence and needs of informal Carers. Individual Support Plans or Care Programme Approach (CPA) and support delivery must focus on achieving maximum levels of independence where this is appropriate. A knowledge and understanding of the health issues faced by older people, such as diabetes, dementia, stroke, bariatric care and end of life care etc. forms an important part of the support staff's skill set.

Older People want to know that they will be able to understand the person(s) who supports them. Good and clear communication skills are key in delivering this service and must be a high priority for the Provider and all their support staff. Older People must feel empowered by their interaction with staff and must be able to take issues up with Providers and/or ECC without fear of losing their support.

APPENDIX 3

Supporting Sensory Care

Service Users may have sensory impairment. It is expected that staff will have a general awareness of such sensory impairment to enable them to meet the needs of this client group.

Service Users may also have a physical impairment and or Dementia or a mental health problem.

Service delivery must be focussed upon achieving outcomes as identified in the Individual Support Plans or Care Programme Approach (CPA), be flexible, responsive and give choice and control to the Service User. Support 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.

Supporting Service Users with sensory impairments require knowledge and understanding of the impact of visual and auditory impairments. This service delivery may include people with a single hearing or sight impairment, AND people with a dual impairment of both sight and hearing, i.e. deaf-blind. They will have training in communication tactics, and be able to communicate with users in a manner that is not discriminatory or oppressive. Where staff will be working with users who are deaf-blind they must have the appropriate training in order to be able to communicate with the user. Such training could be hands on signing or deaf blind manual, or visual frame signing.

People with a sensory impairment must not be viewed with any less dignity or respect and must be supported to live as independently as possible.

APPENDIX 4

Supporting Service Users with Dementia

Providers must ensure that support staff understand behavioural changes and cognitive impairment that is associated with dementia and issues relating to pain management. There is a need to understand how physical and psychological health needs impact upon the person and staff should be able to interpret signs and symptoms of ill health and psychological distress. Staff, therefore, need to have an understanding of dementia and how to support Service Users in order to maintain their choice, control and dignity.

This service will require flexibility in the way it is delivered and the way that outcomes are achieved for the Service User and their Carer. An understanding of the impact of cognitive impairment is paramount.

Providers 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.

When supporting Service Users with Dementia the Council also has the following expectations:

Providers should 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.

The providers training plan would need to demonstrate that staff receive full training with a clear developed pathway in relation to all aspects of supporting people with dementia.

Providers should ensure that 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.

Providers should ensure that staff understands the specific needs relating to the end of life for people with dementia such as identifying and responding to pain, pain relief and capacity issues.

Use of assistive technology that will increase the independence of people with dementia.

APPENDIX 5

Supporting Epilepsy Care

Epilepsy takes many forms, is sometimes more predictable than others, and may have a variety of triggers. Providers must ensure that support staff are trained in Epilepsy care and in first aid. The immediate removal of objects or conditions that may be harmful to a Service User suffering a seizure is critical in minimising the potential for injury. Support staff must be skilled and experienced in dealing with unforeseen or unexpected situations and act in the best interest of the Service User suffering a seizure.

The role of assistive technology as an aid in managing epilepsy must be understood and Service Users must be supported to remain as independent as possible. Services must be delivered with outcomes in mind and must put the Service User at the centre of support and delivery. The dignity of the Service User must be maintained.