1.0 Introduction

1.1 Living Well at Home is care and support delivered to Individuals living in their own accommodation (with their own front door) whose occupation of the property is entirely independent of the care and support arrangements (which remain at all times throughout all visiting arrangements) unless specified otherwise as part of the service contract.

1.2 This document sets out the Core Specification for the Living Well at Home Service for Individuals with care and support needs. It describes what the Authority requires from the Service Provider in delivering the Service and must be considered alongside the Living Well at Home Pseudo Dynamic Purchasing System (PDPS) Agreement, Service Contract, and Invitation To Participate (ITP) document.

2.0 Scope

2.1 The Service will be provided to Individuals with care and support needs under the following sublots:

1a. Short Term Care at Home (Intermediate Care)
1b. Homecare Services
1c. Extra Care

2.2 The scope of this PDPS may develop further to include the following services in the future:

a. Night-time care
b. Care provided in settings in which an Individual might be supported e.g., Supported Living

Short Term Care at Home

2.3 Short Term Care at Home Service is a time limited service and will focus on the needs of the Individual at that point in time, providing support in the following situations:

a. Where an Individual requires urgent care and support at home where normal living arrangements (including unpaid/informal care and Mental Health hospital) have broken down unexpectedly or an urgent change in circumstances has led to a need for urgent care and support without which could lead to hospital or care home admission.
b. The service will support all planned discharges from acute and community hospitals, Mental Health hospitals and bed-based care settings and will focus on prevention, recuperation, and rehabilitation. The Service will also receive referrals for Individuals living in the community which will focus on prevention, recuperation, and rehabilitation.

Homecare Services

2.4 Homecare Services are planned care services and will be provided to Individuals who:

a. Meet the national eligibility threshold for care and support as set out in the Care and Support (Eligibility Criteria) Regulations 2015 for the Care Act 2014
b. Have unmet eligible needs and outcomes that could be met through the provision of care and support at home; and
c. Are deemed to be ordinarily resident within the administrative area of Lancashire County Council or for whom we are responsible under S117.

Extra Care Services

2.5 Extra care housing provides safe and secure self-contained accommodation for older adults who require varying levels of care and support to enable them to live independently in a home environment.

2.5.1 The Service is the delivery of care and support within an extra care housing setting including:

a. Onsite staff to provide Background Care and Support and Emergency Response Services. This service benefits all Individuals (tenants and leaseholders) and is not allocated to any one person.
b. Planned Care for Individuals who have chosen to have their assessed care needs met by the on-site Service Provider.

2.6 The Service may also be provided in circumstances where the Authority exercises its powers, under Section 19(3) of the Care Act 2014, to meet an Individual's urgent care and support needs without having first conducted a needs assessment or eligibility determination.

2.7 The Service is predominantly aimed at people aged 18 or over or in cases where a person over the age of 16 and is transitioning to an adult service or is in need of a health service. Except in Extra Care scheme where the Service is predominantly aimed at individuals over the age of 55.

2.8 The Service will be commissioned by the Authority or any organisation acting on its behalf under the Authority's power to delegate its functions (in accordance with the terms of the agreement between the Authority and that third party).

2.9 The Service shall be available to all eligible Individuals.

2.10 The Service shall be delivered within Lancashire County Council's Boundaries with specific requirements detailed at the point of Call-Off. However, there may be occasions when the Service Provider is requested to provide the Service outside of these boundaries; for example, where an Individual is a Lancashire resident but requires care in an alternative location outside of the defined areas.

3.0 Service Requirements

3.1. <u>Regulatory and legal</u>

The Service Provider must be registered to provide personal care with the Care Quality Commission (CQC) and will maintain registration throughout the duration of the Service Contract. Therefore, the regulations required for registration (and their associated standards), and the monitoring of the

achievement of those regulations and standards are not duplicated in this specification.

The Service Provider must comply with all relevant legislation that relates to the operation of their business.

The Service provided under this Service Contract must be provided in accordance with (but not limited to) the requirements of:

a. The Care Act 2014
b. Care Standards Act 2000 (including any amendments, modifications, or re-enactments)
c. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
d. CQC
e. The National Minimum Standards for Domiciliary Care
f. The Domiciliary Care Agencies Regulations 2002
g. Mental Capacity Act 2005 (Deprivation of Liberty Safeguards) and any related codes of practice
h. Equality Act 2010
i. Human Rights Act 1998
j. Autism Act 2009
k. Deprivation of Liberty Safeguards and, when implemented, the new Liberty Protection Safeguards under the Mental Capacity (Amended) Act 2019
l. Counter Terrorism and Security Act 2015
m. Individuals' individual assessed needs and outcomes and any subsequent assessment, Care and Support Plan or review documentation
n. Any future legislative changes or changes to National Minimum Standards that determine the standard of care to be delivered.

3.2. <u>Individuals who will be using the Service</u>

The primary Individuals served by this specification are:

a. Older people
b. People with dementia
c. People with physical disabilities
d. People with learning disabilities and/or autism
e. People with mental health needs

Other Individuals which may receive this Service include Individuals who have:

a. Sensory impairment
b. Spinal injuries
c. Acquired brain injury
d. Neurological conditions
e. Alcohol/Substance dependent
f. Known risk factors i.e., Forensic history or under the restrictions of the Ministry of Justice; or
g. Adults approaching the end of their life

The Authority may require from time to time for the Service to be delivered to other Individuals that fall outside of the scope of the primary and other Individuals detailed above and are to be determined at the sole discretion of the Authority.

3.3. Key principles

The Service Provider must value an Individual's right to:

a. Be independent
b. Be regarded and treated as individuals
c. Make choices for themselves
d. Be treated in an equal and fair way
e. Be treated with respect, dignity, and confidentiality
f. Access specialist support to realise potential
g. Receive non-judgemental support.

In addition, the Service Provider must:

a. Acknowledge that all Care Workers are visitors in Individual's homes and should act accordingly
b. Ensure Care Workers are able to provide the Service in a way that acknowledges and respects Individuals and complies with the Equality Act
c. Maximise an Individuals self-care abilities, independence, and wellbeing
d. Recognise individuality and personal preferences
e. Provide support for informal carers and recognise the rights and involvement of other family members
f. Acknowledge that Individuals have the right to take risks in their lives and to enjoy a lifestyle of their choosing
g. Provide protection to Individuals who need it, including a safe and caring environment
h. Provide a consistent and high-quality Service which is person-centred, flexible, reliable and responsive
i. Focus the Service towards maximising independence and minimising whole life cost of care.

The Service model must be consistent with the five key principles of the Mental Capacity Act 2005 and the associated code of practice, which are:

a. Principle 1: A presumption of capacity
b. Principle 2: People being supported to make their own decisions
c. Principle 3: A person is not to be treated as unable to make a decision merely because they make an unwise decision
d. Principle 4: Best interests
e. Principle 5: Less restrictive option.

The Service Provider must adhere to any conditions of discharge imposed by a Mental Health Review Tribunal, Ministry of Justice and MAPPA and seek authority from the Secretary of State if a condition of discharge is to be varied.

3.4. Service outcomes

The focus of the Service must be firmly on promoting choice, control, independent living, social inclusion, and wellbeing through the provision of

quality care and support. To achieve the Service outcomes the Service Provider will:

3.4.1 **Promote the independence of Individuals through an enabling approach**

a. Support Individuals to gain/regain skills and confidence to achieve greater independence in their day-to-day living
b. Support Individuals to remain in the community and prevent, reduce, or delay the need for more intensive care and support
c. Promote independence both within Extra Care Schemes and within the community
d. Support programmes of rehabilitation, reablement, recovery, education, training, and employment
e. Motivate and facilitate Individuals to develop or maintain skills related to activities of daily living, for example washing, dressing, feeding, toileting, bathing, and mobility
f. Encourage Individuals to acquire or maintain skills relating to areas of non-personal care, for example shopping, cooking, and cleaning
g. Support Individuals to access community resources and encourage best use of assistive technology, such as community equipment and telecare to support activities of daily living
h. Support flexible and innovative solutions for Individuals
i. Support Individuals to develop problem solving skills and coping strategies.
j. The Service Provider must cooperate with the Authority in minimising the provision of double-handed support through the use of specialist moving and handling equipment (e.g. ceiling track hoists, bed positioning systems) and techniques provided by the Authority or the NHS, where it is considered safe as part of a suitable and sufficient individual risk assessment undertaken by a Competent Person, and the Care Worker has received the necessary training and is deemed competent to safely carry out the moving and handling alone, or with a willing and able informal carer.
k. As we move into an increasingly digital world, we want people who have additional support needs to have every opportunity to feel connected and immersed with a digital offer. Service Providers will refer people to the TEC (Technology Enabled Care) service when appropriate and propose creative solutions to increase independence, connectivity with health providers, safety, privacy, choice, and control for people utilising the very best in tech enabled support. Successful Service Providers will keep up to date with the latest innovations and will proactively promote new technology as it comes available.

3.4.2 **Support Individuals to achieve the outcomes in their Care and Support Plan and to maximise independence**

a. Support Individuals to achieve the outcomes identified within their Care and Support Plan
b. Continuously review and record the achievement of, and progress towards, outcomes, enabling Individuals to maintain and enhance levels of independence
c. Work with families and other services so that they understand the approach to maintaining and maximising independence
d. Support Individuals to carry out caring responsibilities they have for a child where this is an eligible need.

3.4.3 **Support Individuals to engage with family/friends, their interests and community services**

a. Support Individuals to sustain significant relationships, including with family carers
b. Encourage and support Individuals to participate in their community and to use community resources and facilities
c. Support Individuals to develop confidence in their own ability to engage with hobbies/interests and to access and contribute to their wider community, e.g., employment, volunteering
d. Support Individuals to communicate and engage positively with others in a way which is appropriate to their personal preferences, lifestyle and needs
e. Support Individuals to identify and report hate crime and to develop approaches to minimise the impact

3.4.4 **Support Individuals to improve their health and wellbeing**

a. Support Individuals to maintain their health and personal hygiene
b. Promote healthy eating and hydration with Individuals
c. Support Individuals to access dentists, opticians, chiropodists, and other healthcare services
d. Support Individuals to comply with medication regimes, including supporting self-administration and use of over-the-counter medications in accordance with agreed Service Provider protocols developed to adhere to CQC guidance
e. Support Individuals to utilise assistive technology such as Telecare to improve their health and wellbeing where the use of such technology is deemed appropriate e.g., medication prompting, falls detection, prompting for food and fluid intake
f. Encourage Individuals to use self-care programmes for long term health conditions
g. Support Individuals to make informed decisions about the management of their care and treatment using appropriate information, including risks and benefits
h. Support the early diagnosis and treatment of mental health needs, such as dementia
i. Support Individuals to alleviate loneliness and isolation
j. Ensure Individuals with learning disabilities/autism who develop mental health needs are supported to access generic mental health services with access to specialist support if needed
k. Make reasonable adjustments as part of the Equality Act and in relation to delivering health care via health action plans, communication passports and assistive technology.
l. Ensure Care Workers recognise the importance of risk assessment and the concepts of hazard, risk, and control measures
m. Ensure Care Workers know where to report their concerns should Individual circumstances change in a way that may require a risk assessment review and note this in the care records kept in the Individual's home
n. Support Individuals and work with families to promote their understanding of key hazards and control measures.
o. Support Individuals to meet their spiritual and faith-based needs

3.5. **Types of care and support tasks**

The Service required will be set out in the Individuals Person-Centred Care and Support Plan or via an initial telephone referral for Short Term Care at Home Service. Therefore, the following list of types of care and support tasks required is not intended to be exhaustive or needed in all cases and should not preclude creative solutions which may better suit an individual where it is part of their agreed Care and Support Plan. Such requirements that the Service Provider must provide may include:

3.5.1 **Support Individual's to improve their health and wellbeing**

Personal care and support is defined by the CQC as meaning physical assistance given to an Individual and could be in connection to the following types of tasks:

a. Direct assistance with or regular encouragement to perform tasks of daily living
b. Providing advice and support on self-care
c. Assistance to get up or go to bed
d. Assistance with sit to stand and transferring to and from various surfaces (Toilet, chair, lounge, wheelchair) with or without equipment
e. Washing and bathing using equipment if necessary, shaving and hair care, denture and mouth care, hand and fingernail care, foot care (excluding any aspect which requires a registered chiropodist or podiatrist)
f. Support with using the toilet, including transfers on and off the toilet, personal care in regards to cleaning and safe disposal of waste/continence pads (including in relation to the process of menstruation).
g. Empty or change catheter or stoma bags and associated monitoring
h. Assistance with skin care such as moisturising very dry skin
i. Dressing, undressing, and supporting choice of what clothes to wear for the day utilising grading techniques and compensatory strategies where required i.e. helping hands or small aids such as sock aids.
j. Settling an Individual at night, including access to fluids and equipment, making the home safe and secure before leaving
k. Providing support to manage the health care of Individuals under the direction of a health professional where this has been specifically agreed and the Care Worker has received the appropriate training and has been deemed competent.

3.5.2 **Other Support that promotes wellbeing and self-care of the Individual**

a. Prompts to take and safely administer prescribed medication in accordance with agreed protocols and CQC standards
b. Assistance with putting on appliances with appropriate training, for example leg calliper, artificial limbs, Thoracolumbar Sacral Orthosis (TLSO) braces and surgical or compression stockings, and assistance with visual and hearing aids
c. Food or drink preparation – ensuring that Care Workers have an understanding of nutrition and hydration, and are able to support Individuals to plan, shop, prepare and cook nutritious food and provide skilled assistance with eating and fluid intake and monitoring

d. Assistance with eating and drinking (including the administration of parenteral nutrition and/or Percutaneous Endoscopic Gastronomy (PEG)), including any associated kitchen cleaning and hygiene
e. Support access to activities including employment, education, and voluntary work
f. Ensuring that any assistive technology such as telecare is active i.e., a regular basic check to ensure the telecare base unit/sensor and/or phone line has not been disconnected
g. Re-familiarisation within the home environment and daily tasks for Individuals who may experience any cognitive impairment.
h. Re-establishing routines by practice to reinforce the Individual's learning as well as introducing new techniques and practices where a change in circumstances means that an Individual needs to adapt their normal routine
i. Standing back, observing, and not automatically intervening when an Individual is struggling to perform an activity but providing encouragement and assisting only where necessary (not assisting solely in order to save time), within the bounds of safe practice and positive risk
j. Being responsive to an Individual's changing needs and ensuring support is adjusted to reflect this
k. Identifying and making appropriate referrals for equipment and assistive technology and supporting the appropriate use of equipment
l. Reinforcing and establishing the safe use of new minor adaptations and equipment
m. Engaging and communicating with other relevant informal carers, including providing information about the Individual's condition and progress and strategies for coping. Signposting them to further resources in the community.
n. Signpost the Individual to other sources of information about services that may be useful to them
o. Signposting to eye examination services for those with visual impairment
p. Work in partnership with the Authority and stakeholders for onward referral for other assessments, interventions, or services to improve the Individual's general health and wellbeing, and to reduce or manage their individual health risks.
q. Individual/informal carer training and education to facilitate maximum independence in mobility (both in and outside the home environment in accordance with the care and support plan) and activities of daily living including assistive technology options.
r. Encouraging the Individual to maintain/ regain support networks
s. Minimise the number of Care Workers delivering care and support to the Individual to promote consistency and continuity
t. Provide information and advice such as self-management and healthy lifestyles (smoking, alcohol reduction, weight management, falls risks)
u. Other support that promotes wellbeing and self-care of the Individual which may be required
v. Seek the guidance of the allocated Care Worker where further advice is needed.
w. Support a person with mental health difficulties to manage difficult emotions
x. Identify evidence of self-neglect and work with the Authority to assist the Individual to improve self-care and identify where additional support may be required

3.5.3 **Other support that promotes safeguarding which may be required of the Service Provider:**

a. Identification, mitigation of any immediate risk and reporting of possible safeguarding adults' concerns
b. Identification, mitigation of any immediate risk and reporting of possible safeguarding children concerns
c. Identification, mitigation of any immediate risk and reporting of possible domestic abuse or hate crime
d. Identification, mitigation of any immediate risk and reporting of possible suicidal ideation and self-harm

3.5.4 **Other support that promotes effective risk management:**

a. Ensuring Care Workers read the risk assessments relevant to the Individual, including informing the Service Provider if an update or review of the risk assessment is required
b. Ensuring Care Workers recognise when key control measures are obviously missing or not working (e.g., handrail broken, smoke alarm removed etc.) and identifying potential equipment to manage any risks

3.6. <u>Service availability and flexibility</u>

3.5.5 The Service Provider must be available to meet the full requirements of the Specification 24 hours a day, 7 days a week, 365 days a year and will not operate on a reduced basis over periods of public holidays or festivities. Individuals must be given the choice as to whether they wish to receive the Service during periods of public holidays, for example Christmas Day.

3.5.6 The vast majority of care will be provided between the hours of 7am and 11pm, however on occasions the Service will need to be provided outside of these hours, as determined by the Individual's Care and Support Plan or via an initial telephone referral on the Short-Term Care at Home Service. The Service Provider must use all reasonable endeavours to ensure there are sufficient Care Workers to cover the boundaries as specified in the relevant Call-Off.

3.5.7 There may be Care Packages that are 'Called-Off ' from this PDPS which may require the care to be provided outside of the times specified in 3.6.2 of this specification and any such differences in required times will be described in the Call-Off relating to that Service.

3.5.8 The Service must be provided in a flexible manner to ensure the Individual's identified needs and outcomes are met. The level and frequency of service provided to an individual will be set out by the Authority. The Individual can choose to vary the times and durations of visits in partnership with the Service Provider

3.5.9 **The Service Provider must:**

a. As far as reasonably and safely possible, be proactive in accepting referrals within the areas to which they are appointed through effective management of referrals, workforce capacity and staff rostering/coordination

b. Report to the Authority as required to confirm the availability and capacity of the service as defined in the individual Lot specifications
c. Provide a response to Care Package requests to the Authority as set out in the individual Lot Specifications
d. Ensure that there is the necessary workforce capacity to accept and commence Care Packages over weekends/Bank Holidays
e. Respond to Care Package requests and queries over weekends/Bank Holidays
f. Encourage reductions in care and support needs where safe to do so and/or where independence permits and notify the Authority
g. Minimise the number of different Care Workers delivering care and support to the Individual to promote consistency and continuity
h. Ensure that there is a match between Individuals' care and support needs and the skill sets, knowledge, and competency of Care Workers
i. Undertake a risk assessment of the Individual prior to commencement of the service and produce a plan to manage these
j. Have 'No Entry' procedures in place which Care Workers know how to follow in the event they are unable to access an Individual's home for an arranged visit
k. Ensure the Service is delivered in accordance with the Individual's Care and Support Plan and personalised outcomes.
l. Aim to improve an Individual's outcomes by helping to motivate the Individual to challenge themselves, to undertake meaningful daily tasks, which are important to them, so they can live as independently as possible and that reduce the risk and dependency on long term care
m. The Service Provider must make every effort to provide the Individual with a Care Worker of their preferred gender as supported by the Equality Act – a male or female Care Worker. If the Service Provider is not in a position to be able to provide the preferred gender of Care worker, they must notify the Individual and work with them to find a reasonable solution.
n. The Service Provider must make every effort to accommodate the needs of any Individual with a sensory impairment. If a British Sign Language (BSL) interpreter is required, the Service Provider would need to liaise with the Authority to meet these needs by accessing specialist additional services which are procured/provided by the Authority or by accessing external services for which the Authority will be recharged.
o. The Service Provider must make every effort to work with people whose first language is not English and where required work with the Authority and an agreed interpreter to ensure that care is delivered in accordance with the Individual's wishes and cultural requirements, and that communication methods are established as part of the support plan.
p. The Service Provider will be flexible and responsive in:
    I. Its approach to Service provision.
    II. The timings of visits.
    III. Identifying and dealing with an Individual's fluctuating needs, including through discussion with the Individual, planning for such eventualities and in ensuring Care Workers are able to adapt to the needs of the Individual.
    IV. Supporting the outcomes of an Individual.

3.7. **<u>Keeping Individuals informed and in control</u>**

The Service Provider must supply Individual's with reliable and timely information via an information pack when their Service commences and update

it as required to ensure they are kept informed and involved. The information pack should be in plain English, be available in formats that suit Individuals with different communication or capacity needs, and include the following:

a. Statement of purpose
b. Contact details for the Service including out of hours and emergency contacts
c. Service provision details – who will support the Person, when will support be provided and what will happen to the Person
d. The contingency arrangements in the event of Service interruption, including if missed or late visits occur
e. Safeguarding information
f. How to access the Service Provider's most recent CQC inspection reports
g. Complaints procedure.

The Service Provider must keep Individual's informed in advance and involved in decisions about any planned long-term changes to their Service and, as far as possible, unavoidable short-term changes to their Service, including changes to the Individual's regular Care Workers and/or changes to the timing of visits.

The Service Provider should give regard to an Individual's choice regarding the specific Care Workers who will attend to provide the Service and, where possible, the opportunity to meet new Care Workers.

3.8. **Recording**

With the Individual's knowledge, the Service Provider must ensure that Care Worker's note in the care records kept in the Individual's home or electronically the time and date of every visit, the care and support provided and any incidents or changes. Records should be made at the time of each visit and include (where appropriate):

a. Details of any change in the Individual's circumstances, health, physical condition or care and support needs
b. Details of any change in the Individual's circumstances that prompts the need for a risk assessment review
c. Any incident or accident, however minor, involving the Individual and/or Care Worker.
d. Progress towards any goals to being independent
e. Details of any tasks undertaken to support the Individual and how the Individual presented at that particular visit
f. Assistance with medication, including time and dosage on a medication chart
g. Other requests for assistance with medication and action taken

The Service Provider must ensure that no information is recorded in the Individual's home or electronically that could compromise their safety and/or wellbeing, and that Care Workers read new entries if they have not seen the Individual recently.

The Service Provider must have in operation an Electronic Time Management System in line with the provisions of clause 12 of the Service Contract prior to the commencement and delivery of Services.

Digital transformation is a top priority for the Department of Health and Social Care. The national goal is all health and social care partners are connected to an integrated life-long health and care record by 2024, enabled by core national capabilities, local health records and shared care records, giving individuals, their approved caregivers, and their care team the ability to view and contribute to the record.

The Authority expects the Service Provider to be compliant with the requirements by March 2024 and that all Service Providers work towards digital social care records by March 2024.

The Authority expects the Service Provider to be compliant with any future requirements set out by the Department of Health and Social Care or other relevant body as and when they are released throughout the period the Service Provider is providing the Service.

3.9. Out of hours service

The Service Provider must ensure that at all times outside of normal office opening hours there is a dedicated responsible person(s) with sufficient knowledge and training to be a point of contact to respond to enquiries and emergencies from Individuals, Care Workers and the Authority. The Service Provider will ensure the out of hours contact service has telephone and email capabilities as a minimum. The out of hours contact details must be clearly communicated to those who may need to use them.

3.10. Care and support planning and assessment

3.10.1 The Service Provider may, without reference to the Authority, mutually agree day to day changes with the Individual to their direct care and support provision and minor revisions to the direct care and support elements of the Individual's Care and Support Plan. The changes made still need to meet an assessed need. In agreeing any such changes, the Service Provider is required to:

a. Ensure that such changes are in keeping with the objectives of the Care and Support Plan and continue to meet the Individual's assessed needs and identified outcomes in a safe way
b. Consult the Authority if the Individual wishes to use funds within their Personal Budget for an outcome that has not been identified within their Care and Support Plan
c. Inform the Authority if an Individual's support needs reduce or if the Individual's needs increase and cannot be met within the existing Care Package and Care and Support Plan
d. Update the Individual's Care and Support Plan so that it remains current and reflects the actual support that is being provided by the Service Provider
e. Consult with the Individual's carer/representative/advocate where they would have substantial difficulty in agreeing such changes, including those who lack mental capacity and document any agreements made either with the Individual and/or their family

3.10.2 Service Providers must make use of the 'Think Local Act Personal' (TLAP) statements when planning care and support[1].

[1] Six themes of Making it Real - About - Making it Real - Think Local Act Personal

3.10.3 Where a planned review of an Individual's Care Package is due to be undertaken by the Authority, the Authority will seek to include the Service Provider in that review and where a joint review has been requested, then the Service Provider must ensure that a member of their assessment team is made available to undertake a joint review.

3.10.4 The Authority may, in the future, introduce trusted assessment or trusted review in which the Service Provider may be asked to undertake an assessment or review of the Individual on behalf of the Authority. Should this be introduced, the Authority will work with Service Providers to ensure a safe and comprehensive process is introduced and training will be provided where appropriate.

3.11. Risk assessment and management

The Service Provider must have a risk management policy and must operate systems to ensure it can complete an assessment of risk and provide a risk management plan where necessary on all aspects of tasks carried out by its staff. A copy of the policy must be available to the Authority on request.

For Staff

The Service Provider must maintain regularly reviewed clear policies, procedures, and guidance for all staff on safety precautions that must be taken relating to risk, including lone working, and will ensure that staff are familiar with the guidelines and their application in the work situation. The policy must be comprehensive and include care tasks, community-based activities, moving and handling, use of equipment and environmental hazards. The Service Provider must have clear monitoring procedures to ensure its staff work to these standards and ensure staff are trained when changes happen to policies and procedures.

For Individuals

Responsible risk taking is a normal part of living. Individuals must not be discouraged from participating in activities solely on the grounds that there is an element of personal risk. Individuals must be encouraged to discuss and judge risk for themselves and make their own decisions where the safety of others is not unreasonably threatened and where the Individual has the mental capacity to do so. Where an Individual lacks mental capacity, a best interest decision must be made, recorded, and retained by the circle of support for the Individual.

A risk assessment must be undertaken in all circumstances where a risk has been identified and maintained on the Individual's care records for Care Worker reference, and for inspection by the Authority if required. Risk assessments must be reviewed as changes arise, and in line with good practice guidance. All Care Workers must have access to the risk assessment and have read and understood its content prior to undertaking any care provision.

In relation to Individuals who present challenging behaviour, the Service Provider is required to ensure that there is an up to date written, behaviour support plan for Individuals that includes:

a. Relational support requirements
b. Proactive strategies. If an Individual needs to be restrained either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible.
c. Reactive strategies
d. Monitoring and review arrangements.
e. Least restrictive arrangements

3.12. <u>Health and safety</u>

To ensure Care workers are informed and deal confidently with accidents, injuries and emergencies, the Service Provider is required to ensure that:

a. There is a comprehensive health and safety policy with clear written procedures for the management of health and safety, which comply with all current and relevant Health and Safety legislation, and define individual and organisational responsibilities
b. There is a detailed policy covering the risks and support for lone workers
c. Infection control procedures are in place when a Care Worker or Individual has a known transmittable disease or infection
d. The provision and wearing of protective clothing where appropriate
e. Procedures for managing violence and aggression to Care Workers are in place
f. One or more competent persons, depending on the Service provided, are nominated to ensure the Service Provider is compliant with health and safety duties and responsibilities, including:

    i. Identifying hazards and assessing risks
    ii. Preparing health and safety policy statements
    iii. Introducing risk control measures
    iv. Providing adequate training and refresher training
    v. Ensuring all records relating to health and safety are accurate and kept up to date

g. Any accidents or injuries to an Individual that require hospital treatment or GP attendance are reported to the Service Provider's service manager and noted on the Individual's care records and subsequently reported to both the Authority and the Individual's family/key contact where appropriate
h. All staff know the Service Provider's procedures for dealing with emergencies
i. All staff have first aid training and manual handling training where appropriate
j. They have a policy and procedure to protect staff travelling to and from the home of the Individual
k. Visible identity cards are worn by all staff undertaking home visits
l. They promote an understanding of the risk of fire and other hazards among their staff and the Individuals they support. This will particularly apply to those whose behaviour or environment may pose particular fire risks e.g., smoking, or open fires. This will include taking account of advice from, and agreements reached with, the Lancashire Fire and Rescue Service to ensure risk assessments are completed and advice is followed.

3.13. <u>Health/medical care</u>

The Service Provider is required to ensure that Care Workers have access to the contact details of the GP with whom the Individual is registered. The GP, the NHS 111 service or 999 (depending on and appropriate to the circumstances) must be contacted without delay whenever an Individual requests assistance to obtain medical attention or appears unwell and unable to make such a request. The Individual's next of kin must be informed as soon as possible.

The Service Provider will need to support the health care of the Individual under the direction of or delegation from a Health Care Professional such as a GP, District Nurse, Community Matron, other health care professional or Community Health Team where this has been specifically agreed and the Care Workers have received the appropriate training and have been deemed competent by a Health Care Professional. This will not ordinarily include any care requiring a medical or professional qualification but will require appropriate training. A record of all applicable training shall be maintained by the Service Provider. The responsibilities for the health care delegated tasks remains with the Health Care Professional at all times.

The Service Provider will also be required to work with a range of health care professionals to support adults who require the Service at the end of their life. The Service Provider must work within the common principles set out by Skills for Care[2] and also take account of the National Institute for Health and Care Excellence (NICE) 'End of life care for adults' standards[3] when supporting Individuals at this stage of their lives.

The Service Provider must ensure that Care Workers who are required to assist Individuals to take prescribed medication receive appropriate instruction and written guidance in accordance with its policies and procedures and are supported by appropriate training and assessment of staff competency.

The Service Provider will ensure Individuals with needs associated with mental health, learning disability and autism access all screening and annual health check appointments as applicable and identify all barriers that make access to health services difficult, including the availability of staff/family who know the Individual well, specific phobias e.g. needles, waiting rooms etc. and set out actions that need to be taken to overcome these barriers, and record in the Individual's care records.

3.14. Partnership working

Partnership working is at the heart of successful delivery of the Service. This applies to the relationship between the Authority and the Service Provider, but also with other significant agencies supporting Individuals.

The Service Provider must cooperate and work in partnership with other organisations or individuals to promote the wellbeing of Individuals; signpost the Individual to other relevant services; contribute to the prevention, reduction, or delay of the development of Individuals' needs; and improve the quality of person-centred and joined-up care and support, including the outcomes Individuals achieve. The Service Provider must work with the community health

[2] http://www.skillsforcare.org.uk/Topics/End-of-Life-Care/End-of-life-care.aspx
[3] Overview | End of life care for adults | Quality standards | NICE

teams, and other partners to prevent inappropriate admissions to hospital at the point of crisis.

This includes, but is not limited to, the following partners:

a. CQC
b. General Practitioner (GP) Practices
c. Community Health Services
d. Community Mental Health Teams/Services
e. NHS Trusts
f. ICB
g. North West Ambulance Services
h. Lancashire Fire & Rescue Service
i. District Councils
j. Other Registered Care Providers
k. Carers' Services
l. Voluntary, community and faith sector organisations
m. Family members/informal carers.
n. Health practitioners to manage and minimise the risks for Individuals with identified health needs i.e., swallowing assessments.
o. The Service Provider must make appropriate use of local networks for information, advice, and advocacy to ensure that an Individual's needs are met holistically, and resources are used effectively.

3.15. **Supporting the wider care system**

The Service Provider must contribute to prevention strategies which are aimed at:

a. Reducing the number of unplanned admissions to hospital
b. Supporting the safe and timely discharge of patients from hospital
c. Keeping people in community settings rather than institutional care and support.
d. Developing integrated care pathways
e. Identifying and meeting the needs of vulnerable Individuals at the earliest possible stage
f. Reporting any observed poor and/or unsafe care.

The Service Provider will work closely with local organisations, across the health and social care system to continually improve the Service-to-Individuals, in accordance with identified needs and taking into account changes in national and local guidance and policy. This may involve working with a range of statutory, voluntary and community sector organisations to deliver the required outcomes and developing information sharing protocols to enhance partnership working where needed.

The Service Provider will be required to assist when care and support is coordinated by a health professional. As such, the Service Provider will liaise with adult social care services, community nursing and therapy teams, voluntary agencies, acute trusts and other professionals and agencies to ensure seamless clinical and personal care provision to Individuals.

Where appropriate, the Service Provider will maintain the therapeutic rehabilitation care plan, including rehabilitation exercises and techniques or mobility and transfers under the instruction of a care professional.

3.16. Emergency response

There will be times when the health and care system is in a period of escalation, for example in emergency situations such as: floods; civil emergency; health outbreak or pandemic; periods of heatwave or cold weather; and periods of severe system pressure, including service closures/suspensions and potential closure or temporary cessation of hospital services.

In these circumstances, the Service Provider will work alongside the Authority around any mitigating action which may include:

a. Take urgent actions in partnership with other organisations
b. Reprioritise delivery of the Service
c. Flex their workforce and the Service
d. Take additional Care Packages at short notice
e. Increase welfare checks in neighbourhoods.
f. Ensure clear lines of communication are maintained with the Individual, their family, and the Authority

4.0 Workforce Requirements

4.1. Data and intelligence

The Service Provider shall register with the Skills for Care Adult Social Care Workforce Data Set (ASC-WDS)[4] and complete the following:

a. The ASC-WDS organisational record and update this data at least once per financial year
b. Fully complete the ASC-WDS individual staff records for a minimum of 90% of the staff at any given time, including updating these records at least once per financial year
c. Apply for funds to support workforce development from Skills for Care.
d. Retain records that ensure they can demonstrate their performance under this Service Contract
e. Records will show resource inputs, organisational processes and outcomes related to the Service and Individuals.

The Service Provider must participate in any survey of Adult Social Care employees organised by the Authority or Skills for Care and actively encourage its staff based in Lancashire engaged in these services to respond.

The Service Provider will be required to provide to the Authority, not to be unreasonably requested, additional workforce related data not covered by the ASC-WDS and other established methods of data collection.

4.2. Planning and management

[4] Adult Social Care Workforce Data Set (skillsforcare.org.uk)

The Service Provider must identify a suitable person or persons with full knowledge and understanding of workforce issues pertaining to the delivery to be responsible for workforce planning for the Service.

The Service Provider must develop workforce plans which need to be updated at least annually or more often as appropriate to ensure that arrangements are in place to maintain the workforce capacity and capabilities required to deliver the Service for the duration of the Service Contract.

Specific plans must be developed for the following:

a. Recruitment and retention of staff
b. Management of sickness and other absences
c. Learning and development.

The Service Provider should develop separate documents for the following:

a. Succession plans for key management posts and/or posts requiring scarce skills
b. Specific plans for issues identified locally/organisationally.

The Service Provider must have in place an effective sickness absence management and monitoring system and must inform the Authority at the earliest opportunity if such absences will impact upon their capacity to deliver the Service.

4.3. <u>Staff supervision and annual appraisals</u>

The Service Provider must ensure that all staff have regular, planned, and documented practice-based supervision sessions at a minimum every 3 months and identify any development needs to be addressed.

The Service Provider must ensure that all staff have a documented annual appraisal and a plan for learning and development and should include, where possible, feedback from Individuals and carers.

The Service Provider must ensure that staff know when and how to raise an issue, comment, concern, or complaint with their manager.

4.4. <u>Leadership and management</u>

The Service Provider must be able to evidence that it is developing effective leadership at all levels of the organisation by encouraging and supporting staff to develop leadership skills and competencies through training, supervision, and reflective learning.

The Service Provider must be able to evidence that its managers, including registered managers, hold or are working towards the appropriate management level qualification, as recommended by Skills for Care, and continue to refresh their learning regularly.

The Service Provider must ensure that individual Registered Manager(s) complete the Manager Induction Standards within six months of taking up a management role.

4.5. Enabling care and support

The Service Provider must ensure that learning and development activities for Care Workers focus on maintaining and promoting independence. Care Workers should be confident in enabling Individuals to make their own choices and supporting them to achieve these. They should treat Individuals, their families and carers as equals and partners in care.

4.6. Core skills, induction, and the Care Certificate

The Service Provider must ensure that all staff possess the core skills their role requires.

The Service Provider must be able to evidence that at recruitment they have assessed the core skills of Care Workers and that they are supported in further developing their core skills. As such, a values-based recruitment and retention process should be adopted to create and maintain a workforce which embraces workplace values in line with national guidance[5].

The Service Provider must ensure that all Care Workers are supported to overcome any cultural communication barriers between Individuals, carers, and other professionals.

The Service Provider must ensure that all Care Workers receive a thorough induction to their new role, the organisation, and the care sector.

The Service Provider must ensure that all new Care Workers achieve the Care Certificate within the time period defined by Skills for Care.

The Service Provider must be able to evidence that they are working to bring all Care Workers to a standard of knowledge and skills as required by the Care Certificate, whether individuals are new starters, or who have previously worked in care or existing members of staff.

4.7. Qualifications and learning

The Service Provider must ensure that its staff are supported to maintain their training, qualifications and continued professional development as appropriate and in accordance with the requirements of regulations and the role they are carrying out.

In accordance with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Service Provider must provide sufficient numbers of suitably qualified, competent, skilled, and experienced staff to meet the needs of Individuals at all times. Staff must receive the support, training, professional development, supervision, and appraisals that are necessary for them to carry out their role and responsibilities effectively. They should be supported to obtain further qualifications.

As a minimum, staff should be working towards, or have achieved, a relevant qualification as advised by Skills for Care:

[5] http://www.skillsforcare.org.uk/Recruitment-retention/Values-based-recruitment-and-retention/Values-based-recruitment-and-retention.aspx

Registered Managers

a. Level 5 Diploma in Leadership for Health and Social Care and Children and Young People's Services.

Care Workers

a. Care Certificate for staff new to health and social care
b. Level 2 Diploma in Health and Social Care.
c. Social Care Institute for Excellence e learning
d. An awareness of suicide prevention e.g., Orange Button

From time-to-time partners may offer free training. Partners often incur significant expense and planning overheads to provide training in this way and consequently the Service Provider will demonstrate reasonableness in accessing the training and ensuring staff attendance.

4.8. <u>Specific skills and knowledge</u>

Generic

The Service Provider must ensure that all staff have access to learning and development opportunities which enable them to meet the needs of all those using the Service. The learning requirements of staff will go beyond the level of induction and the Care Certificate.

The Service Provider will work within the Skills for Care Common Core Principles for Dementia:

The Service Provider must consider what specific skills and knowledge staff require to ensure that the diverse needs of Individuals are met and must put in place plans to enable this within the Service. The following non-exhaustive list of specific skills and knowledge is relevant to the delivery of the Service:

a. Dementia care
b. End of life care
c. Continence care
d. Managing behaviour that is challenging
e. Communication
f. Falls prevention, awareness, and identification
g. Combating loneliness and isolation
h. Fire safety in a community setting
i. Skin care
j. Working with carers
k. Strokes
l. Dignity in care
m. Equipment and Assistive technology
n. The Mental Capacity Act 2005 and consequent deprivation of liberty safeguards
o. Safeguarding adults
p. The requirements and responsibilities under the Equality Act 2010 and the Human Rights Act 1998.
q. Exercise and mobility
r. Promotion of wellbeing and self-care
s. Self-neglect

t. Hoarding
u. Working in an outcome focussed way
v. Advice, information, and signposting - all staff will have the skills and competencies to support people to “navigate” through local health, social care, and wellbeing services
w. Positive risk taking and management
x. Effective writing skills for completing support plans
y. Adopting a strengths-based approach
z. Carer awareness and support
aa. Review, identifying and delivering to any set goals
bb. Community asset building/Social Prescribing
cc. Care Act: wellbeing, prevent, reduce, delay
dd. Delegated health care task training
ee. Mental Health knowledge and awareness
ff. Mental Health first aid
gg. Suicide prevention (Orange Button)

To support Individuals who experiencing a Mental Health episode, Care Workers will need to have undertaken Mental Health training.

To support people who have limited mobility, Care Workers will need to have extensive knowledge of the practical and safe usage of the following items:

a. Stand aids (Rota stands of different complexity & support levels)
b. Hoists & variety of slings
c. Slide sheets
d. TLSO braces
e. Single handed care
f. Bed systems to support single handed care
g. Quick move
h. How to use riser chairs & beds to support moving & handling
i. Handling belts
j. Transfer boards
k. Community assets and how to refer to them to support wider health and wellbeing outcomes
l. Compensatory techniques

The Service Provider must use a positive behaviour support framework for developing an understanding of an Individual's challenging behaviour. It must include:

a. Personalisation of both assessment and care and support arrangements
b. Systematic assessment of the Individual’s behaviour
c. Attention to the broader context to ensure that other factors influencing the Individual's behaviour are properly understood
d. Development of both proactive and reactive support arrangements
e. Preventing the Individual’s challenging behaviour as much as possible through the provision of a more helpful and less challenging environment
f. Avoiding support arrangements that punish the Individual in any way or create unnecessary restrictions on their freedom of movement and choice

The Service Provider will ensure Care Workers receive specialist training in autism[6] and the Care Worker will be able to:

a. Use appropriate communication skills when supporting an Individual with autism i.e., make reasonable adjustments to develop the most effective ways of understanding and communicating the Individual's experience, help others to understand them and find ways of responding
b. Support families and friends, and make best use of their expert knowledge of the Individual
c. Recognise when an Individual with autism is experiencing stress and anxiety and support them with this
d. Recognise sensory needs and differences of an Individual with autism and support them with this
e. Support the development of social interaction skills
f. Provide support with transitions and significant life events
g. Understand the issues which arise from co-occurrence of mental ill health and autism

4.9. **Business continuity management**

The Service Provider must have a business continuity plan in place to ensure the delivery of the Service is continuous and consistent for the benefit of Individuals. Under this Agreement the Service Provider must:

a. Develop and maintain a business continuity plan.
b. Review the business continuity plan on a regular basis, but not less than once every 3 years; and,
c. Provide the Authority with a copy of this plan if requested to do so

The business continuity plan must include:

Identification of service critical functions and the resources required to deliver them, including but not limited to:

a. Premises
b. People
c. ICT Hardware & Software
d. Telecommunications equipment
e. Vehicles
f. Suppliers/Contractors
g. Any other critical equipment/supplies
h. Adverse weather
i. Pandemic
j. Business transfer or fail

Identification and assessment of risks and their impact that could limit the availability of the above resources and potentially lead to a disruption in the delivery of services

Appropriate continuity solutions, how they will be initiated, and escalation process should an impact be experienced

[6] https://www.skillsforcare.org.uk/Developing-your-workforce/Care-topics/Autism/Autism.aspx

Supporting information such as key contact numbers, generic and hazard specific action plans, incident management procedures.

The Authority shall have the right to carry out an open audit of the business continuity plan with no less than 24 hours' notice.

5.0 Quality and safeguarding

5.1. Quality standards and assurance

The Service must be provided by appropriately qualified/experienced staff, in line with the standards set by the CQC.

The Service Provider must ensure that they meet the registration requirements for delivery of the appropriate regulated activities. The Service Provider must at all times achieve and maintain Good or Outstanding overall ratings from CQC inspections. In the event the Service Provider fails to achieve this, the Applicable Terms (Appendix 7, 7a and 7b) of the Living Well at Home Agreement and provisions of clause 8 of the Service Contract shall apply.

The Service Provider should understand NICE guidance[7] and quality standards[8] on care and operate the Service in line with evidence and recommendations contained within them. The Service Provider should also adhere to the Skills for Care Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England[9].

As part of an approach to continuous quality improvement, including promoting better terms and conditions for Care Workers, the Service Provider must:

a. Ensure that from the commencement of the second year of the PDPS (2024) Agreement they do not use zero hours contracts in place of permanent contracts, unless a Care Worker specifically requests to be employed on such terms due to their personal wishes and circumstances; and

The Service Provider must be committed to achieving and maintaining high quality services. This will be a key factor in their own business success, for the Individuals they support and in the achievement of the success of the wider care system.

The Service Provider must ensure that continuous quality improvement systems are in place to ensure the Service is run in the best interests of Individuals, demonstrates the quality and consistency of information, measures Individual outcomes and ensures that risks to Individuals are minimised. As part of the Service Provider's approach to continuous improvement, the Authority encourages the use of the Care Improvement Works guides, tools and resources produced by Skills for Care (Skills for Care Toolkit) and the Social Care Institute for Excellence[10], and collaboration with PDPS Partners to share good practice and learning.

[7] https://www.nice.org.uk/guidance/ng21
[8] https://www.nice.org.uk/guidance/qs123/chapter/using-the-quality-standard
[9] http://www.skillsforcare.org.uk/Documents/Standards-legislation/Code-of-Conduct/Code-of-Conduct.pdf.
[10] http://www.careimprovementworks.org.uk/.

The Service Provider must use an outcome-based approach to supporting positive change around Individual led outcomes and priorities e.g., the Recovery Star for adults managing their mental health.

The Service Provider must have quality assurance and monitoring systems, which seek the views and experiences of Individuals, carers and health and social care professionals, to enable a realistic assessment of the Service provided.

The Service Provider will follow the Skills for Care 'Principles to Practice[11] which defines the principles and key areas to support good mental health.

All staff should be actively involved in the quality assurance and monitoring processes. Quality services will be recognised as a motivating force and staff must strive for continuous improvement and best practice.

The Service Provider's quality assurance system must demonstrate:

a. Measurable organisational improvement
b. The quality and standards of the Service provided
c. Training that provides staff with the skills and tools to promote quality improvement
d. Staff are empowered and supported to make positive changes
e. Positive attitudes and working relationships
f. Early warning systems
g. Learning from complaints, serious incidents, and safeguarding alerts/investigations
h. Continuous building on good practice
i. Introduction of new procedures.
j. Outcomes that have been achieved for Individual's supported by the Service Provider

The Service Provider will be required to cooperate with the Authority in evaluating and improving quality, not only of the care to individual Individuals but also compliance with the PDPS Services Agreement, and in improving the quality of the Service.

The Service Provider must have a clear set of policies and procedures to support good practice and meet the requirements of legislation and this specification. These policies and procedures should be dated and monitored as part of the Service Provider's quality assurance system. They should be reviewed at a timescale that is appropriate to the content of the policy and at least annually.

The Service Provider must ensure that all policies and procedures in place have a person-centred emphasis, which promote feedback of Individual experience, and which ensure safe and appropriate working practices.

5.2. **Complaints, concerns, and compliments**

The Service Provider shall ensure that it has in place a written compliments procedure in addition to a written complaints procedure that complies in all

[9] http://www.skillsforcare.org.uk/Documents/Topics/Mental-health/Principles-to-Practice-good-mental-health.pdf

respects with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309 and any other applicable legislation from time to time in force (the "Complaints Procedure").

The Service Provider shall ensure that all Individuals, their relatives, advisors and/or advocates (as appropriate) are aware of and have access to and have had explained to them the Complaints Procedure.

The Service Provider shall ensure that it has in place arrangements for receiving and acting on complaints that comply in all respects with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936 ('the 2014 Regulations') and any other applicable legislation from time to time in force.

The Service Provider shall ensure that it has an effective system in place for recording all compliments received regarding the Services.

The Service Provider shall acknowledge all complaints and concerns immediately upon receipt and will provide a comprehensive reply within 28 days of the complaint being received. If the Service Provider is not able to respond to the complaint within 28 days, the Service Provider must agree a date with the complainant by which the complaint will be resolved.

In addition to complying with regulation 16 of the 2014 Regulations, for the duration of the term the Service Provider shall operate equivalent arrangements for reporting complaints and compliments received regarding the Services to the Authority, including an obligation to provide the Authority with the following information within 28 days of receiving a request to do so:

a. Sufficient details of compliments received
b. Sufficient details of complaints made
c. Details of the Service Provider's responses to complaints and compliments along with any further correspondence with the individual submitting the compliant or compliment
d. Learning, outcomes, or action plans developed and delivered by the Service Provider as a result of any complaints or compliments; and
e. Any other information as the Authority may request regarding any complaints or compliments received by the Service Provider

The Service Provider shall maintain comprehensive records of all complaints made and compliments received, including all associated correspondence and shall maintain such records, including any investigation records, for period of at least [6] years following the expiry of the Service Contract.

A copy of the Service Provider's complaints and compliments procedure shall be provided to the Authority on request.

A record of compliments received should be retained by the Service Provider and shared with all staff to promote good practice and an understanding of what can make a difference to Individuals.

5.3. **<u>Safeguarding</u>**

The Service Provider must ensure that robust arrangements are in place to safeguard Individuals from any form of abuse or exploitation in accordance with

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Care Act 2014, and the government guidance: Working Together to Safeguard Children 2018. The Service Provider must have in place policies and procedures for identifying and dealing with the abuse of vulnerable people which are complementary to the Pan Lancashire Policies and Procedures for Safeguarding Adults[12] and Children[13].

The Service Provider must also comply with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 – Duty of Candour to ensure its safeguarding practice promotes openness, transparency, and trust.

The Service Provider must ensure that policies and procedures are covered in induction and fully understood by staff. All staff must be given an initial understanding of their safeguarding duties within their first week of employment. Comprehensive training on awareness and prevention of abuse must be given to all staff as part of their core induction within 3 months and updated at least annually. In addition, update training will be provided in light of new policies and procedures introduced either locally or nationally.

The Service Provider will minimise the risk and likelihood of incidents occurring by:

a. Ensuring that staff and Individuals understand the aspects of the safeguarding processes that are relevant to them
b. Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed
c. Ensuring that Individuals are aware of how to raise concerns of abuse
d. Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern
e. Having effective means of receiving and acting upon feedback from Individuals and any other person
f. Having a whistleblowing policy and procedures in place
g. Having a medicines management policy and procedures in place
h. Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:
    I. having clear procedures that are followed in practice, monitored, and reviewed, and take account of relevant legislation and guidance for the management of alleged abuse
    II. separating the alleged abuser from Individual and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the Service Provider
    III. reporting the alleged abuse to the appropriate authority
    IV. reviewing the Individual's Care and Support Plan to ensure that they are properly supported following the alleged abuse incident
i. Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and take any necessary action to ensure compliance

[12] http://panlancashirescb.proceduresonline.com/
[13] http://panlancashirescb.proceduresonline.com/

j. Working collaboratively with other services, teams, individuals, and agencies in relation to all safeguarding matters and having safeguarding policies that link with the Authority's policies
k. Having clear procedures followed in practice, monitored, and reviewed in place about the use of restraint and safeguarding
l. Taking into account relevant guidance set out by the CQC
m. Ensuring that those working with Individuals wait for a full Disclosure and Barring Service disclosure before providing the Service
n. Training and supervising staff in safeguarding to ensure they can demonstrate the necessary competences.

The Service Provider must also have policies and procedures in place on the safe handling of money and property belonging to Individuals.

6.0 Delegated Health Tasks

The following is a list of healthcare tasks which may be delegated the Service Provider subject to instruction, approval of competence and sign off by an agreed relevant healthcare professional. This list is for information only and may not be considered exhaustive.

The following are considered a delegated health care task:

a. administering replacing or removing basic simple dressings
b. skin care and pressure sore relief - monitoring of skin care and application of a range of skin treatments*
c. specialist catheter care (suprapubic), stoma care and bowel care- support with the removal of the bag, cleaning the area and applying the new bag, where "closed" systems are in use.
d. toenail care,
e. removal and reapplication of splints and leg braces for hygiene purposes
f. installation of ear, nose, and eye drops
g. specialist assistance for older people with significant levels of dementia
h. assisting with feeds and fluids via a percutaneous endoscopic gastrostomy
i. mouthcare
j. assistance with health led reablement
k. other similar tasks as defined in the Individual Care and Support Plan
l. tracheotomy care

** Where creams are used for the purpose of preventing the reoccurrence of a pre-existing condition or where there is a high risk of a condition occurring then this will be undertaken as a health task. The support will be delivered under the supervision of a health professional in accordance with the Care Plan.*

The responsibility for the health care remains, at all times, with the Health Professional.

The Health Professional will exercise this responsibility through completion of training and the training record for Health-Related Tasks and ongoing monitoring/supervision of those Individuals receiving care and/or support. This training and sign off will be completed by the health professional prior to the commencement of care delivery. As part of their training Care Workers will be

	advised how to contact the Health Professional or other support, if any changes to the Individual are noticed. The process for completion of the training, completing the training record and maintaining competence will be provided in due course. The Service Provider must be clear where the boundaries lie between the Service and nursing care and must not undertake Health tasks outside of the Specification.