Schedule 1 - Service Specification

Care home services for older people and adults of working age whose primary support need is ageing-related

Long and short-term services

November 2025

Contents

1 Introduction 10
2 Purpose of care home services 10
3 Desired outcomes 10
4 Summary of required services 11
4.1 SERVICE CATEGORY MODEL 11
4.2 SHORT TERM SERVICES AND THE SERVICE CATEGORY MODEL 12
5 Regulatory requirements 12
6 Service user needs 12
7 Service user bands (CQC) 13
8 Provider service information 13
9 Eligibility for services, funding and commissioning 14
10 Matching service user needs to Service Categories 16
11 Exclusions 16
12 Referrals and Trusted Assessors 16
13 Admissions and the referral response period 17
14 Provider's pre-admission assessment 17
14.2 FURTHER ASSESSMENT 17
14.3 DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) 17
15 Out of hours and emergency admissions 18
16 Exceptional circumstances 18
17 Placement agreement process 19
18 Care and support planning and delivery 19
18.1 CARE AND SUPPORT PLANS 19
18.2 RECORD KEEPING - GENERAL 20
19 Cognitive impairment and behavioural support 21
19.1 GENERAL 21
19.2 BEHAVIOURS THAT REQUIRE SUPPORT 21
19.3 BEHAVIOUR SUPPORT PLANNING 22
19.4 STAFFING LEVELS - Service Categories 2, 2a and 4 23
19.5 RECORD KEEPING – BEHAVIOURAL SUPPORT 23
20 Reviewing Service User's care and support needs 23
20.1 SCHEDULED REVIEWS 23
20.2 IF THE SERVICE USER'S NEEDS CHANGE FOLLOWING ADMISSION 24
20.3 OTHER TRIGGERS FOR REVIEWING SERVICE USER'S NEEDS AND REQUIREMENT TO NOTIFY 24

21 Supporting Service Users 25
21.1 PRIVACY, DIGNITY AND RESPECT 25
21.2 AUTONOMY, CHOICE, INDEPENDENCE AND FULFILMENT 25
21.3 RIGHTS 26
21.4 DIVERSITY, EQUALITY AND INDIVIDUALITY 26
21.5 SOCIAL CONTACT, ACTIVITIES AND COMMUNITY INVOLVEMENT 26
22 Transport 27
22.1 TRANSPORT ARRANGEMENTS FOR ADMISSIONS TO A CARE HOME 27
22.2 TRANSPORT ARRANGEMENTS BETWEEN CARE HOMES WITH AND WITHOUT NURSING 28
22.3 TRANSPORT TO NON-PRIMARY CARE NHS-FUNDED HEALTHCARE APPOINTMENTS 28
23 Access to wider health and social care services 28
23.1 PROVISION OF AND ACCESS TO HEALTH AND SOCIAL CARE 28
23.2 MEDICAL COVER AND CLINICAL SUPPORT 29
23.3 MEDICATION SUPPLY 30
23.4 CONTINENCE PRODUCTS 30
24 Medication Management 30
25 Pressure area care, tissue viability and wound management 32
26 Nutritional Care 33
27 Infection Prevention and Control 34
28 Accident and incident reporting and recording 36
29 End of life care, dying and death 37
30 Equipment provision, storage and maintenance 38
31 Technology-enabled care (TEC) 39
32 Environment and accommodation 40
33 Management, leadership and staffing 40
33.1 MANAGEMENT AND LEADERSHIP 40
33.2 STAFF RECRUITMENT AND RETENTION 41
33.3 STAFFING LEVELS AND WORKFORCE PLANNING 43
33.4 CULTURE 43
33.5 STAFF INDUCTION AND TRAINING/EDUCATION 44
33.6 REFLECTION AND LEARNING 45
33.7 STAFF SUPERVISION AND APPRAISAL 45
33.8 SUPPORT FOR WORKING CARERS 46
34 Quality assurance and reporting 46
35 Data, intelligence, and reporting 46
35.1 USE OF ELECTRONIC RECORDS AND OTHER DIGITAL SERVICE REQUIREMENTS 46

35.2 IDENTIFYING AND ESCALATING PHYSICAL DETERIORATION 47
35.3 ADULT SOCIAL CARE WORKFORCE DATA SET 47
35.4 CAPACITY TRACKER (CT) 47
ENDS 48

Appendices

Appendix A	Residential and Nursing Service Category Overview
Appendix B	Summary of Residential Service Categories (without nursing) – Service Categories 0,1,2 and2a
Appendix C	Summary of Residential Service Categories (with nursing) – Service Categories 3,4,5
Appendix D	Admission Scenarios by Service Category
Appendix E	Contacts
Appendix F	Supporting Information for Reviewing Service User Needs
Appendix G	Think Local Act Personal – Making it Real ‘I’ Statements
Appendix H	Better Together Recording Sheet
Appendix I	Pan-Dorset Equipment Guidance Revised 2024 V1.10

Glossary

Abbreviation	Term	Definition
ABC	ABC forms	An ABC data form is an assessment tool used to gather information that should evolve into a behaviour implementation plan. ABC refers to: Antecedent- the events, action, or circumstances that occur before a behaviour. Behaviour- The behaviour. Consequences- The action or response that follows the behaviour.
	Adults of working age	Persons aged 16-64 years
	Allocated worker	Officer nominated to undertake / co-ordinate the assessment of the person's longer term care and support needs whilst in the service.
	ASC Team	Adult Social Care Team
	Assistive Technology	Can include but not be limited to Telecare, Telehealth or Sensors
	Behavioural support plan	This plan provides carers with a step by step guide to managing challenging behaviour. It is based on the results of a behaviour assessment, and includes proactive and reactive strategies.
BIA	Best interest Assessment	This outlines what someone needs to consider before taking an action or making a decision for you while you lack capacity. They should: Consider your wishes and feelings. This means your current wishes and those you expressed before losing capacity to make the decision.
BIA	Best Interest Assessor	In relation to Deprivation of Liberty, a Best Interest Assessor carries out two vital tasks: deciding whether a restrictive situation is authorised by Sections 5 and 6 of the MCA, or whether it amounts to a deprivation of the person's liberty.
	Care and support plan	A care and support plan details why a person is receiving care (their assessed health or care needs), their medical history, personal details, expected and aimed outcomes, and of course what care and support will be delivered to them, how, when and by whom.
	Care Home	A communal setting where nursing, and or personal care, and accommodation are provided together. Both the care and accommodation are regulated by the Care Quality Commission.
CQC	Care Quality Commission	The independent regulator of health and adult social care in England
	CHC checklist	A Continuing Healthcare (CHC) Checklist is the first step in determining eligibility for NHS Continuing Healthcare funding. It involves an initial assessment that is conducted by a nurse, doctor, social worker or other qualified healthcare professional, who carries out a brief evaluation of the person's care needs to rapidly assess whether an individual should proceed to have a Full CHC Assessment of their needs.
	Competent person	A person who has the required level of knowledge and skills for a particular task.
CHC	Continuing Health Care	Package of health and social care that is arranged and funded solely by the NHS where an adult aged 18 or over is found to have a primary health need.
	Contract management	Contract management is the process of creating, implementing, and reviewing contracts. It involves monitoring of compliance with the contract including the service requirements.

DST	Decision Support Tool	The decision support tool (DST) is a tool that has been developed to support practitioners in the application of the national framework for continuing healthcare and NHS-funded nursing care 2022, and aid consistent decision making. The DST supports practitioners in identifying the individual's needs.
	Dementia Champion	Dementia champions are staff members who lead and influence dementia provision in each home, providing guidance, support and encouragement to other staff members. A dementia champion is likely to be actively involved in providing specialist care and support to individuals who are living with dementia and their families / NOK. They will work with the care home's management and staff team to develop and improve the care and support provided to residents who are living with dementia.
DoLS	Deprivation of Liberty Safeguards	The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.
	Direct care	The provision of care and support to an individual
	DOLS Assessors	Relates to both Mental Health Assessors and Best Interest Assessors. Mental health assessors must first of all meet the regulatory requirements of the MCA DoLS Regulations 2008. (52) They must be medical doctors experienced in mental health: either approved under section 12 of the Mental Health Act 1983, or be registered medical practitioners with at least three years' post-registration experience in the diagnosis or treatment of mental disorder, such as GPs with a special interest. It includes doctors who are automatically treated as being Section 12 approved because they are approved clinicians under the Mental Health Act 1983. They must have completed the standard training as laid out by the Royal College of Psychiatrists. Best interests assessors are often the main assessors though a mental health assessor may also assess capacity. They are responsible for ascertaining that the person is 18 or older (the age assessment, now generally incorporated as part of the best interests assessment). They are solely responsible for assessing whether there are any lawful decision-makers who object to what is proposed (the 'no refusals' assessment). If qualified also as Approved Mental Health Professionals under the Mental Health Act 1983 (as amended), they are able to carry out the eligibility assessment, to decide whether this person's rights should be protected by the use of the MHA or the MCA, via the Safeguards.
	DOLS Standard Authorisation	The Deprivation of Liberty Safeguards (DoLS), which apply only in England and Wales, are an amendment to the Mental Capacity Act 2005. The DoLS under the MCA allows restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes – but only if they are in a person's best interests. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority.
DCF2	Dorset Care Framework 2	DCF2 is a long-term Framework Contract that enables the purchase via block and spot contracts of a wide range of services, including residential care home services, with and without nursing, for older people and adults of working age whose primary support need is ageing-related (Lots 6 & 7).
DC Purchasing Area	Dorset Council Purchasing Area	Being the administrative areas covered by Dorset Council, Bournemouth, Christchurch and Poole (BCP) Council, and all or part of local authority areas that share a border with Dorset Council.

	Dorset Integrated Care System	The organisation formerly known as Dorset Clinical Commissioning Group (CCG)
EOLC	End of Life Care	The care provided in the time leading up to a person's death
	Equipment	Equipment, including any specialist equipment, which is required to provide the Services in accordance with the requirements of the Service Specification..
Fast Track	Fast Track CHC	Individuals with a rapidly deteriorating condition and the condition may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS Continuing Healthcare.
	Framework Agreement	See DCF2
FNC	Funded Nursing Care	NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.
GDPR	General Data Protection Regulations	Regulation which governs how the personal data of individuals in the EU may be processed and transferred
HCAI's	Healthcare-associated infections	Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile). HCAIs pose a serious risk to individuals, staff and visitors. As a result, infection prevention and control is a key priority.
	Immedicare scheme	Service to support care homes 365 days a year providing 24/7 access to virtual clinical assessment; supervision; training and safe supported care delivered from a dedicated Digital Care Hub
IMCA	Independent Mental Capacity Advocate	IMCAs are a safeguard for people who lack capacity to make some important decisions. The IMCA role is to support and represent the person in the decision-making process. Essentially they make sure that the Mental Capacity Act 2005 is being followed.
	Infection Prevention Control Assessment	An infection control risk assessment identifies particular tasks that may carry the risk of contamination or the spread of disease.
ICB	Integrated Care Board	NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the ICP's integrated care strategy.
ICS	Integrated Care System	A statutory partnership of organisations who plan, buy, and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups, and independent care providers.

LPA	Lasting Power of Attorney	Legal document that enables the appointment of one or more people to make decisions about an individual's care and/or welfare.
	Litigation Friend	Someone who makes decisions about a court case on behalf of someone who is unable to manage their case for themselves.
MUST	Malnutrition Universal Screening Tool	A five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
(MAR charts)	Medication Administration Records	A MAR chart is a printed or electronic chart used by workers in health and social care, for example in domiciliary care, to record medicines given and/or taken by a person, and those instances where a medicine that was supposed to be given was missed, skipped, refused and so on.
MCA	Mental Capacity Act 2005	The Act as set out in the statutory obligations and regulations
	Mental Capacity Act Team	Dorset Council's designated team
NOK	Next of kin	
	Night-time care	Evidenced interventions over-night following assessment
	Older People	Someone over the age of 65 years
	Person-centred	Constructing the provision of the Services based on what is important to the Individual, utilising the Individual’s strengths to be independent, enabling effective communication and supporting the development of the Individual
	Provider	The Organisation that has been contracted with to provide the Services
	Referral handling teams	The Team or Teams designated by the Commissioning Partners’ to manage referrals to the Services.
	Registered Manager	The Provider’s Manager who will be registered in accordance with CQC requirements
	Respite care	Respite care is planned or emergency temporary care
	RESTORE2	RESTORE2 is a tool to help care and nursing homes to recognise physical deterioration and to escalate this information
	Risk assessment	The identification of any hazards and potential harm that can affect the health and safety of staff, Individuals and members of the public
	Service Category Model	The model which describes and differentiates the type and level of needs to be met under the various Service Categories. See Appendix A.
	Service Inputs	The services, facilities, environment and culture provided by the Service Provider to meet the Service User's needs.

	Service User Bands	As defined by CQC, Service User Bands are a range of specialisms that describe the services that you intend to provide. Examples include dementia, physical disability, sensory impairment, mental health, learning disability or autism.
	Service users	A person who receives the commissioned Service.
	Spot Basis	A service that is commissioned for a single individual. Otherwise known as an 'individual placement'.
	Strengths Based	Strengths-based (or asset-based) approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing.
	Terminal phase	Terminal phase is the period of inexorable and irreversible decline in functional status prior to death. It is the period when there is day-to-day deterioration, particularly of strength, appetite, and awareness.
	Trusted Assessor Scheme	Service that encompasses regular reviews and assessments completed by specifically trained members of staff
UKHSA	UK Health Security Agency	UKHSA is an executive agency, sponsored by the Department of Health and Social Care. It is tasked to prevent, prepare for and respond to infectious diseases, and environmental hazards, to keep communities safe, save lives and protect livelihoods. It provides scientific and operational leadership, working with local, national and international partners to protect the public's health and build the nation's health security capability.

Service Specification

1 Introduction

1.1 This document together with its' appendices, sets out the service requirements for Care Homes providing long and short term residential care services, with and without nursing, for older people and adults of working age whose primary support need is ageing-related.

2 Purpose of care home services

2.1 The purpose of care home services provided under this Contract is to:

a) Provide residential accommodation with appropriate care, support and stimulation to Service Users who are not able to live in their own homes because they have care and support needs that are prevalent 24/7 and may include night-time care needs, whether on a short or long-term basis.

b) Enable and support the initial and/or ongoing assessment of Service Users' care and support needs, working closely with system partners as required.

c) Provide care and support that is genuinely strengths-based, person-centred, seeks to maximise the choice and control that Service Users can exercise in as many aspects of daily living as possible, and which anticipates and is responsive to the Service User's changing needs.

d) Where applicable, work proactively and collaboratively as part of the wider Integrated Care System to optimise individuals' social and health care outcomes, prevent avoidable admissions to hospital and facilitate timely hospital discharges and admissions from the community.

e) Provide and maintain a workplace learning culture and environment that demonstrates and encourages individual and organisational learning, and where both gaining and sharing knowledge is prioritized, valued, and recognised.

3 Desired outcomes

3.1 **Strengths-based, person-centred care** – individual service users are supported to achieve their maximum life-potential and their care and support needs are consistently met by the provision of the appropriate level of professional expertise and skill mix. Please see Appendix G – Think Local, Act Personal 'I' Statements.

3.2 **Effective management, leadership and quality assurance** – the service is led by a suitably qualified and Registered Manager who models and develops and leads a resilient staff team that ensures that

service users' outcomes are achieved and sustained, that best practice is embedded in the service, and that any deficiencies in the quality of the service are promptly rectified at all times.

3.3 **Workforce capacity and capability** – there are enough appropriately inducted, trained, fit and competent staff on duty at all times to ensure the safe and effective delivery of services to meet the individual assessed needs of the Service Users.

3.4 **Workplace learning culture** – systems, structures and practices that enable learning, reflection and continuous improvement by all members of staff are in place and maintained, and positively impact users' experience of the Service.

3.5 **Collaboration and wider system working** – proactive and effective collaboration between health and social care staff is evident in delivery of the Service, resulting in the optimisation of Service Users' social and healthcare outcomes, prevention of avoidable hospital admissions and facilitation of timely hospital discharges and admissions from the community.

4 Summary of required services

4.1 SERVICE CATEGORY MODEL

4.1.1 Care home services are required on a long or short-term basis, to meet the care and support needs of older people and adults of working age whose primary support need is now ageing-related, including:

Service Category 0	Residential – low level needs
Service Category 1	Residential – medium level needs
Service Category 2	Residential – high level needs
Service Category 2a	Residential – advanced dementia and mental health needs
Service Category 3	Nursing
Service Category 4	Nursing – advanced dementia and mental health needs
Service Category 5	Advanced / Complex Nursing

4.1.2 The following Appendices to this Schedule 1 describe the type and level of needs to be met in the various Service Categories:

- Appendix A – Residential and Nursing Service Category Overview
- Appendix B – Summary of Residential Service Categories (without nursing) – Service Categories 0,1,2 and2a
- Appendix C – Summary of Residential Service Categories (with nursing) – Service Categories 3,4,5
- Appendix D – Admission Scenarios by Service Category

4.1.3 Appendices A to C to this Schedule 1 highlight the key differences between the Service Categories, across key elements including:

- Amount, frequency and timeliness of the care and support required
- Level of risk to the person's health (Nursing Service Categories only)
- Likelihood that the person's behaviours may impact on the delivery of care, and ability for

these risks to be managed via planned interventions
- Potential for the person's behaviours to cause harm to themselves or others

4.1.4 Schedule 2 to the Contract Terms - Finance and Payments sets out:

- the number of direct care and/or nursing hours that are expected in each Service Category
- the basis on which fee rates will be agreed

4.1.5 The Service Category Model will apply to all Services commissioned under this Agreement, whether short or long-term.

4.1.6 Service Category 0 is included for completeness. An individual with this level of need would not normally be eligible for a residential care Service purchased by the Commissioning Partners, because the person's needs could otherwise be met at home. However, where a person has been residing in a care home and it is no longer possible for them to return home, the Commissioning Partners may provide care and support under this Service Category.

4.2 SHORT TERM SERVICES AND THE SERVICE CATEGORY MODEL

4.2.1 Where a service is commissioned on a short-term basis, eg. Respite Care, End of Life Care, the Service Category which best describes the Service User's needs will apply.

5 Regulatory requirements

5.1 The Service Provider must be registered with the Care Quality Commission [CQC], be compliant with the CQC's inspection regime, and make clear in their Care Home's Statement of Purpose the range of needs that their service intends to meet.

5.2 The Service Provider shall ensure that a Registered Manager, who is compliant with the requirements of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is appointed and is accountable for the delivery of the commissioned Services.

6 Service user needs

6.1 Service Users will be people who:

a) are not able to reside in their own homes AND
b) have care and support needs that are prevalent 24/7 and include night-time care needs AND
c) have needs which cannot realistically be met in any other way at home, for example, through use of Assistive Technology, aids and equipment[1] in the person's home and/or because the frequency or unpredictability of the person's needs, makes support at home non-viable AND
d) have needs that reflect those outlined in the Service Categories shown at (Appendices A, B and

[1] Assistive Technology, aids and equipment may, nevertheless, benefit the Service User within a Care Home setting

C) AND which may include health care needs which may be eligible for:

- Continuing Health Care funding (to be funded by the relevant Integrated Care Board) OR
- Joint funding by the relevant Integrated Care Board and Dorset Council OR
- S.117 funding under the Mental Health Act 1983

Appendix D presents a range of admission scenarios related to the Service Categories.

6.2 The majority of Service Users will be older people aged 65 years and older, of which most are expected to be 80 years and older but may also include adults of working age whose primary support need is now ageing-related. This may include from time-to-time people:

- with a learning disability and/or autistic spectrum disorder
- with mental health needs
- with a history of substance misuse

6.3 The Commissioning Partners expect that the majority of Service Users will have some form of cognitive impairment and/or dementia that will require service inputs that are appropriate to meet the individual's needs.

7 Service user bands (CQC)

7.1 Providers of the commissioned Services, in whichever Service Category[2] [see Appendices A to C], must include within their CQC Statement of Purpose both of the following Service User Bands:

- Older people
- Dementia

7.2 This requirement reflects the fact that the majority of older people living in a care home in the UK are estimated to have dementia or severe memory problems.

7.3 In line with CQC guidance[3], the Service Provider must be able to demonstrate their ability to meet the needs of individuals covered by these Service User Bands throughout the time that the person requires the Service.

7.4 Providers that can demonstrate specialism in the following areas – as evidenced by the inclusion of additional Service User Bands in their Statement of Purpose – may be better placed to provide services to a wider range of Service User needs:

- Learning disabilities
- Neurodiversity
- Mental health
- People who misuse drugs and alcohol
- Physical disability
- Sensory impairment
- People with an eating disorder

8 Provider service information

8.1 The Service Provider will maintain an accurate written statement of the service user group(s) that it caters for, which reflects the type and level of needs described at Appendices A to C, and how it intends to meet these needs.

8.2 This statement must be available and accessible to both users of the commissioned services and their representatives, and to people who intend to self-fund their own care, in the form of a Service User's Guide or similar document.

8.3 The Service Provider must declare to prospective residents and their representatives the full range of what is available within and covered by the core service cost, e.g. indoor and outdoor facilities, social and community activities, cultural aspects, opportunities for education or work, recreation and leisure, information technology and electronic communications, and what, if any, additional charges the Service User will be responsible for, eg. hairdressing, chiropody services.

8.4 An introductory visit for individuals, their family or friends shall be facilitated upon request.

8.5 The Provider shall keep a register of all service users within the home including room numbers, funding authority, next of kin and General Practitioner details. Such information must be kept up to date and be immediately accessible upon request by the Commissioning Partners when required.

9 Eligibility for services, funding and commissioning

9.1 Eligibility for services is based on an assessment of the Service User's needs and risks to independence, to be undertaken by an appropriately qualified member of the Commissioning Partners' community and hospital-based operational teams.

9.2 Assessments will take into account specific Service User needs, including the impact of equality issues such as race, culture, gender, age, disability, sexuality.

9.3 Eligibility across the Commissioning Partners differs:

- **Adult Social Care Service Users**: services are provided to those Service Users who are unable to meet two or more of the outcomes specified in the Care Act 2014[4], and where there is a significant impact on their wellbeing as a result.

- **Continuing Health Care Service Users**: where a person has been assessed to have a primary health need, they are eligible for NHS Continuing Healthcare and the NHS will be responsible for providing for all of that individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need. Determining whether an individual has a primary health need involves looking at the totality of the relevant needs.[5] In order to determine whether an individual has a primary health need, an assessment of eligibility process must be undertaken by a multidisciplinary team (MDT)[6] which must use the national Decision Support Tool (DST)[7].

- **Section 117 Aftercare Funded Service Users**: Consideration must be given to a Service User's

[2] With the exception of Service Category 0 – Residential – Low Level Needs
[3] Service user bands - Care Quality Commission (cqc.org.uk)

[4] Care and Support (Eligibility Criteria) Regulations 2014
[5] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - Paragraph 55
[6] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care – Paragraphs 139-143
[7] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care – Paragraphs 151-161

eligibility for After-care funding under Mental Health Act 1983 where the person meets the following S117(6) criteria and requires After-care services which have both of the following purposes:

a) meeting a need arising from or related to the person's mental disorder; and
b) reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).

Care Act eligible needs which are not S117 After-Care needs require separate assessment.

9.4 Occasionally, some Service Users will be eligible for Joint Funding of their needs by the relevant ICB and Dorset Council. These will be individuals who, although they are not eligible for NHS Continuing Health Care funding[8] nonetheless have some specific health needs that are beyond the powers of a Local Authority to meet because either Section 22 (a) or (b) of the Care Act 2014 applies[9].

9.5 The agreed fee rate for each placement made under this Agreement will apply regardless of funding source, including when the funding source changes.

9.6 The Service Provider must give consideration – and take action as required, as indicated at Paragraph 9.9 below - to a Service User's eligibility for Continuing Health Care Funding or Joint Funding in all cases where:

- indicators of the four key criteria for Continuing Health Care Funding are apparent, eg. nature, intensity, complexity and unpredictability, OR

- when funding under s.117 of the Mental Health Act is reviewed or terminates

9.7 Where the Service User is deteriorating and may be approaching the end of their life, eligibility for CHC funding must also be considered, with eligibility for Fast Track CHC funding considered urgently if the Service User has a rapidly deteriorating condition, and where that condition may be entering a terminal phase[10].

9.8 Eligibility for Continuing Health Care Funding or Joint Funding is most likely to apply to Service Users in Service Categories 2a, 3, 4 and 5 but could apply in other Service Categories.

9.9 Where a Service User has or appears to have a number of health care needs or a single significant health care need which are indicative of one of the four key criteria for Continuing Health Care Funding, the Service Provider must:

a) alert any relevant health professionals and inform the appropriate Adult Social Care Locality Team[11] named health or social care professionals to this fact immediately [via usual route of contact e.g., telephone/email] AND

b) submit a change of circumstances for to this effect to the Commissioning Partners

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[8] Because 'taken as a whole' their needs are not beyond those that a Local Authority has the powers to meet.
[9] *Policy for consideration of joint funding* – Adults, Our Dorset, May 2022
[10] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - Paragraph 98
[11] Via the allocated worker or the locality duty worker where no worker has been allocated. See also Appendix E – Contacts.

immediately [see Appendix E – Contact Details], AND

c) provide evidence of the person's needs, e.g. via 72 hour needs recording chart, ABC (Antecedent, Behaviour, Consequence) forms, incident records, and/or case notes.

10 Matching service user needs to Service Categories

10.1 The Council's community and hospital-based operational teams will determine which Service Category an individual requires based on their understanding of the person's current, presenting needs at the point of referral to the Service, and with reference to the Service Categories described at Appendices A to C.

10.2 The Service User's current, presenting needs will be recorded in the relevant referral form and discussed with the Service Provider upon referral or, in the event of capital depletion, where the Service User requires state-funding to support their continued placement, with the Service Provider.

11 Exclusions

11.1 The Services will not be appropriate for the following groups:

a) Individuals who were not resident in the Dorset Council area at the point of their admission to the Service
b) Individuals who were not registered with a GP within the Dorset Council area and are not themselves resident within the Dorset area at the point of their admission to the Service
c) Individuals with medical care needs which require hospital care
d) Individuals without recourse to public funds unless funded by NHS Continuing Health Care

12 Referrals and Trusted Assessors

12.1 The Service Provider must maintain a robust and reliable system to receive and respond appropriately to referrals within the admissions and referral response period (See Clause 14).

12.2 Referrals may only be accepted from the Commissioning Partners' designated Referral Handling Team(s).

12.3 Referral documentation will typically comprise of a range of documents that provide a comprehensive overview of the person's needs, including an anonymised version of the Service User's Care Act Assessment.

12.4 The Service Provider is required to participate in any Trusted Assessment Scheme operated on behalf of the Commissioning Partners to provide additional support to Providers for the timely completion of Pre-Admission and Re-admission Assessments of the Service User's needs following a

stay in hospital, and reviews of Service Users' needs. See also Section 21.4 (Future plans for delegated review).

13 Admissions and the referral response period

13.1 The Service Provider must maintain a robust and reliable system to receive and manage admissions appropriately within the referral response and admissions acceptance periods.

13.2 The Service Provider must be able to:

a) Provide a same day response to referrals received between 9am to 5pm Monday to Sunday
b) Receive admissions 9am to 5pm Monday to Friday

14 Provider's pre-admission assessment

14.1.1 It is assumed that, in all cases:

- Service Providers will have entered into their agreement with the Commissioning Partners, based on a full understanding of the type and level of needs to be met in the relevant Service Category(s) and the services and capabilities required to meet these needs, and
- Assessments will be undertaken by a competent person, and will involve the prospective service user, his/her representatives (if any) and relevant professionals.

14.1.2 Given this understanding, the Service Provider should consider the extent of the pre-admission assessment required to ensure that they are able to meet the assessed and ongoing needs of all residents, whilst adhering to the required timescales for referrals and admissions.

14.2 FURTHER ASSESSMENT

14.2.1 The Service Provider will undertake a further strengths-based, person-centred and detailed assessment of the Service User's needs upon their admission to the Service, to determine the person's self-care and functional abilities, physical, emotional, social, mental health and spiritual needs.

14.2.2 This must include a Risk Assessment, which highlights any significant and immediate risks to the Service User and/or others. These assessments shall be completed within 48 hours of the Service User's admission to the Service.

14.3 DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) [12]

14.3.1 The Service Provider's assessments will identify any potential requirement for Deprivation of Liberty Safeguards (DoLS), or any such arrangements as are mandated to replace them and referred promptly to Dorset Council (See Appendix E).

14.3.2 The Service Provider must identify whether the Service User is objecting to the placement, or the care provided, by indicating whether the Service User is 'settled' or 'unsettled' on the online referral form (See Appendix E).

14.3.3 The Service Provider must notify the Mental Capacity Act Team [please see Appendix E – Contacts] within 72 hours if the Service User starts to object to the placement and becomes unsettled. The

[12] See Clause 20.1 Framework Agreement for the Provision of Care, Support, Housing and Community Safety

Service Provider must notify the Mental Capacity Act Team within 72 hours if the Service User's care plan requires the use of covert medication or physical restraint / safe holds.

14.3.4 If the Service Provider identifies prior to the Service User's admission, that the person requires a DoLS application to be made, this may be completed up to 28 days in advance of the person's admission. If the Service Provider identifies following the Service User's admission, that the person requires a DoLS application to be made, this must be submitted within 48 hours of the person's admission.

14.3.5 To facilitate the completion of the DOLS assessment, the Service Provider must provide the DOLS Assessor with a copy of the Service User's care plan and any other records requested by the DOLS Assessor. The Service Provider must allow DOLS Assessors to visit the Service User any day of the week, as required by the DOLS Assessor, to enable the DOLS assessment to be completed promptly.

14.3.6 The Service Provider must provide any other information to the DOLS Assessor as required. The Service Provider must also facilitate any visits, information requests, or provide copies of the Service User's records to any Independent Mental Capacity Advocate (IMCA), Paid Representative, Litigation Friend, or the Relevant Person's Representative (including family representatives) to enable the completion of any statutory duties in connection with the DOLS process.

14.3.7 Once a DOLS Standard Authorisation is granted, the Service Provider must follow the instructions provided by the Mental Capacity Act Team regarding sharing the reports with the Service User/ their representative. The Service Provider must adhere to any conditions attached to the DOLS Standard Authorisation and notify the Mental Capacity Act Team if a condition is unworkable.

14.3.8 The Service Provider must re-refer the Service User for a new DOLS assessment prior to the expiry of the DOLS Standard Authorisation if the Service User remains deprived of their liberty. This referral is done via the online portal (See Appendix E).

15 Out of hours and emergency admissions

15.1 In exceptional circumstances the Service Provider may be asked to receive Admissions outside of the admissions acceptance period, for example to facilitate readmittance of an existing resident when the health and social care system is under extreme pressure, in accordance with the Service Provider's emergency admission protocol, where this exists.

16 Exceptional circumstances

16.1 In exceptional circumstances, for example when the wider health and social care system in the county is under extreme pressure, the Commissioning Partners may ask the Service Provider to relax

the eligibility criteria for the service for a short period of time with the result that excluded groups may be admitted.

16.2 These exceptional circumstances shall not include normal busy periods within the system. This will be subject to confirmation that the Service Provider can safely meet the needs of those admitted to the Services and by agreement between the Commissioning Partners and the Service Provider.

16.3 The Service Provider will also co-operate with the Commissioning Partners in times where system-wide plans are needed to manage exceptional events, such as a pandemic, including responding to reasonable requests for information.

17 Placement agreement process

17.1 When making a referral, the Commissioning Partners' will:

a) Provide information regarding the Service User's needs by reference to the Service Categories described at Appendices A to C. This may be supplemented with additional information about the person's needs where available.

b) Agree with the Provider a fee rate for the placement that is / maybe informed by the considerations outlined at Schedule 2 Finance and Payments, Clause 2.1.

c) Confirm by email the Council's intention to make the placement subject to the Provider having accepted by written signature the Council's terms and conditions prior to the placement start date.

d) Confirm the expected start date for the placement and notify the Provider in a timely fashion wherever possible if this changes.

e) Issue an Agreement for Placement to confirm the details of the placement.

17.2 In the event that the placement cost exceeds the Council's published base / working rate or that the service user is an existing resident of the care home and their capital has fallen below threshold, it may take some time before the Agreement for Placement can be issued to the Provider.

17.3 The Provider is required to sign and return the Agreement for Placement within 7 days of receipt of the Agreement for Placement. Electronic signatures are acceptable for this specific purpose.

18 Care and support planning and delivery

18.1 CARE AND SUPPORT PLANS

18.1.1 The Service Provider will produce, update and maintain a strengths-based, person-centred care and support plan for each Service User, which will be informed by:

a) the Provider's pre-admission and initial assessments of the person's needs and related risks
b) advice and guidance received from relevant social and health care professionals involved in the Service User's care, including Care Act Support Plans, S.117 Mental Health Act Aftercare

Plans, and Therapy Plans

18.1.2 Risk assessments for all identified and potential needs[13] will be carried out and documented no longer than 48 hours after the Service User has been admitted to the home.

18.1.3 Service users and/or their representatives, including advocacy support where necessary, must be involved in the production of care and support plans and invited to attend care review meetings.

18.1.4 The care and support plan will cover all identified and potential needs (ie, where there is a potential for the service user's needs to change as a result of their condition changing or deteriorating).

18.1.5 The Service Provider's care documentation will provide clear, concise and directive information that reflects the care required to meet the service user's individual needs and will include goals for independence and maintaining service users' abilities.

18.1.6 Care and support plans and risk assessments will be reviewed as a minimum on a monthly basis or more frequently if the service user's needs change.

18.1.7 The Service Provider will ensure that both verbal and written communication will be conducted in a way that is understandable to the service user and in a way in which they can make themselves understood.

18.1.8 The Mental Capacity Act will be considered at every stage of the care planning and review process to ensure that the principles of the Act are followed or adopted in a timely manner.

18.2 RECORD KEEPING - GENERAL

18.2.1 The Service Provide will maintain clear and concise contemporaneous records pertaining to service users' care and support. This may include but is not limited to:

- Daily records
- Nutrition and Hydration records
- Medication records
- Repositioning records
- Bowel records
- Social support records
- Accidents and incident records

18.2.2 All documentation will be concise and accurate and nursing documentation will meet Nursing & Midwifery Council Guidelines for Record and Record Keeping.

18.2.3 All records including documentation to evidence care delivery and monitoring must be made contemporaneously and chronologically.

18.2.4 Service users will have access to their records and information held about them by the provider. All individual records will be secured, maintained and used in accordance with the General Data

[13] For example, where there is potential for the Service User's needs to change as a result of their condition changing or deteriorating.

Protection Regulation (UK GDPR) - Data Protection Act 2018 and other statutory requirements.

19 Cognitive impairment and behavioural support

19.1 GENERAL

19.1.1 The Provider will ensure that individuals with a diagnosis of dementia, cognitive impairment or mental health problems are suitably supported by appropriately skilled and trained staff to promote a good quality of life.

19.1.2 Care and support planning shall take account of the impact of these symptoms and direct staff how to meet service user outcomes and needs.

19.2 BEHAVIOURS THAT REQUIRE SUPPORT

19.2.1 The Provider shall ensure

a) The application of good practice that focuses on strengths-based, person-centred and behaviour support to service users whose behaviour may challenge, and ensure staff are suitably trained and competent in those practices.

b) That the home has a lead Dementia Champion, who is available throughout the week to role model, coach and embed training into practice, and to monitor the quality of dementia care.

19.2.2 The Provider shall differentiate between symptoms of aggression, confusion and disorientation which may be the result of a delirium/toxic confusional state due to infection, dehydration, constipation or the side effects of medication. This will rely on registered nurses where relevant or other medical advice being sought.

19.2.3 For service users who may require behavioural support, the Provider will ensure that staff

a) accept and uphold service users' sense of reality from moment to moment and respond in a way that is meaningful to them and support them to safely express themselves.
b) understand that interrupting a service user's sense of reality shall only occur if the person's wellbeing, or the safety of another, is likely to be adversely affected, and the least restrictive interruption shall be used.
c) work collaboratively with loved ones to offer support around dementia diagnosis and best practice to support acceptance and a changing relationship.
d) are able to articulate in detail, on request:
    - a clear portrait of the person's needs, behaviours, and triggers
    - what staff actions and interventions are employed, eg. distraction techniques, and with what effect, to support the person in managing their behaviours

19.2.4 The Provider shall arrange for the physical environment, daily routine and the way staff behave to uphold the mental and emotional wellbeing of service users and reduce potential barriers and separation.

19.2.5 The Provider shall organise staffing to ensure that the following practices are carried out

competently:

a) Interpersonal skills in communication including non-verbal
b) Build meaningful interactions to include promoting empathy and unconditional positive regard, maintaining service users' personal world, identity, personal boundaries and space
c) Adapting own behaviour to promote relationships
d) Recognise the signs of anxiety and distress resulting from confusion, frustration or unmet need and respond by understanding the events the service user is experiencing and diffusing their anxiety with appropriate therapeutic responses
e) Monitoring and effectively reviewing the effects and side effects of anti-psychotic medication
f) Meaningful occupation/activities and stimulation as a part of effective therapeutic intervention and care and avoiding isolation. Understanding the changing nutritional care needs of those with dementia and providing services and support in a flexible, strengths-based, person-centred manner
g) Being flexible about the physical layout, facilities and routines
h) Effective management of behaviours that challenge and how agitation and aggression is a method of communicating unmet need
i) Risk assessment and management, emphasising freedom of choice and reasonable risk taking
j) Promoting social and community networks and relationships.

19.3 BEHAVIOUR SUPPORT PLANNING

19.3.1 The Provider must ensure that where a service user requires behavioural support, a behaviour support plan is produced that reduces the likelihood of behaviours that may cause concern happening, identifies early warning signs and shows how to support the service user in a way that suits them.

19.3.2 The behaviour support plan must be documented and applied to ensure all those providing support to the service user use a consistent approach. The plan must include:

- a description of the person's behaviour that challenges
- a summary of the most probable reasons underlying the person's challenging behaviour
- proactive and preventative strategies
- reactive strategies
- incident briefing
- monitoring and review arrangements
- implementation arrangements
- who was involved in devising the plan.

19.3.3 Separate plans will be devised as necessary for specific situations (e.g car journeys, around food).

19.3.4 Behaviour support plans will:

a) Consider all aspects of the service user's life to include how meeting their support and care outcomes and their physical, mental, social and emotional wellbeing has an impact on their behaviour.
b) Be informed by a "Functional Assessment" where this has been carried out by a clinical psychologist or behaviour specialist or, if a functional assessment has not been done, the plan will identify what behaviours need to be addressed based on what is important for the service user and an assessment of risk. An understanding of the reasons for these behaviours shall be

determined with the service user and others involved in their life.

c) Provide guidance to staff on how to prevent the emergence of behaviours that challenge and how to react in a situation where the service user is likely to behave in a way that challenges.

d) Include procedures to be followed after an incident or expression of behaviour that causes concern to include a description of how the person is likely to look and behave as they recover, eg. a recovery plan that identifies what support the person needs to re-settle.

19.3.5 Behavioural support plans must be reviewed and updated on a regular basis and where an incident or change in the service user's behaviour or care and support needs calls for a review of the plan.

19.4 STAFFING LEVELS - Service Categories 2, 2a and 4

19.4.1 The Service Provider's staffing levels and arrangements will

a) Reflect the higher level of support required in these service categories.

b) Be organised to allow time for supporting service users in groups or one-to-one to include, where relevant, connections to social networks, community facilities or an external environment that is meaningful to them. Evidence of this shall be clearly recorded.

c) Ensure that an appropriate level of dementia support is available throughout the day and night and meaningful engagement is available when individuals require it.

d) Ensure that staff are visible and accessible at all times to actively support individuals in accordance with their support plan, including management of addictive behaviours and lifestyle choices, eg. access to fireproof aprons, sufficient staffing to supervise cigarette breaks outdoors as and when the person needs this.

19.5 RECORD KEEPING – BEHAVIOURAL SUPPORT

19.5.1 The Provider will ensure that staff;

a) Staff maintain detailed notes that are updated daily, and aligned to up-to-date Risk Assessment(s), to provide accurate evidence of the person's needs and care and support required to meet these needs at the current time.
b) Staff record all behavioural incidents and near misses to ensure that effective monthly auditing takes place. This will enable robust review of staff skills, staff levels and identification of any other patterns or trends.

20 Reviewing Service User's care and support needs

20.1 SCHEDULED REVIEWS

20.1.1 Prior to the Service User's admission to the Service, an assessment of the person's needs and risks to their independence will have been undertaken by an appropriately qualified member of the Commissioning Partners' community and hospital-based operational teams.

20.1.2 This assessment will be documented by the person's Key Worker in a strengths-based, person-centred care and support plan and risk assessment which will be made available to the Service

Provider on referral and regularly reviewed with input from the Service Provider, the person and/or their family/NOK and other health and social care professionals as required.

20.1.3 Scheduled reviews will take place by phone or in person, according to the needs of the individual.

20.1.4 The Service Provider is required to support these reviews with appropriate representation at review meetings and sharing relevant documentation if requested.

20.2 IF THE SERVICE USER'S NEEDS CHANGE FOLLOWING ADMISSION

20.2.1 If, following admission to the home and, where appropriate allowing a reasonable period for the person to settle, the Service Provider anticipates a change in the Service User's needs they should discuss this with the Locality Duty Officer in the first instance.

20.2.2 If, following admission to the home and, where appropriate allowing a reasonable period for the person to settle, it appears to the Service Provider that the Service User's needs have changed such that the person's needs,

a) Remain consistent with the relevant Service Category but the person requires additional hours of care that exceed the assumptions set out at in Schedule 2 Appendix A (Fee rates, hourly rates and assumptions about care hours and service duration), or

b) Are no longer consistent with the relevant Service Category, including where the Service User no longer requires such a high level of care and support,

the Service Provider should refer to Section 6 of Schedule 2 [Reviewing changes in service user needs and requests for fee uplifts], and if appropriate, promptly supply the information set out an Appendix F – Supporting Information for Reviews.

20.2.3 On receipt of this information, the Commissioning Partners will carry out an initial review of the Service User's needs, in consultation with the Service Provider, the person and/or their NOK and other health and social care professionals as required.

20.2.4 The outcome of this review will be to;

a) Accept, reject or propose modification of the Service Provider's request for additional hours of care within the existing Service Category, or

b) Accept, reject or propose modification of the Service Provider's request for a change in the Service Category, or

c) Recommend that a more detailed review should be undertaken to be led by the person's Key Worker, due to complexity, where a CHC checklist is required and/or a high cost of the care needs in question.

20.3 OTHER TRIGGERS FOR REVIEWING SERVICE USER'S NEEDS AND REQUIREMENT TO NOTIFY

20.3.1 In care homes with nursing, the Service Provider must contact the Commissioning Partners [please see Appendix E – Contact Details] within 24 hours where a Service User:

a) Qualifies for Funded Nursing Care, but has not previously been in receipt of FNC and this is not

reflected in the Service User's current Service Category, or
b) Ceases to be eligible for or in receipt of Funded Nursing Care.

20.3.2 In care homes with and without nursing, the Service Provider must contact the Commissioning Partners [please see Appendix E – Contact Details] within 24 hours where a Service User is detained in hospital for treatment of a mental disorder on Section 3 of the Mental Health Act as this will trigger entitlement to Section 117 Aftercare.

21 Supporting Service Users

21.1 PRIVACY, DIGNITY AND RESPECT

21.1.1 The Service Provider will promote a culture that reflects and demonstrates that service user privacy, dignity and respect is embedded in the beliefs and values of the service.

21.1.2 Suitable facilities will be available and staff practices will enable modesty and protect privacy at times that are important to individuals and particularly when supporting them with their continence needs and when bathing and dressing.

21.1.3 Service users will be cared for in a polite and courteous manner and agreement will be reached with them regarding how they would prefer to be addressed.

21.1.4 Service users will be treated as individuals, receiving a personalised service, and encouraged to exercise choice and control. They will be listened to and supported to express their needs and wishes.

21.1.5 Service users will be facilitated to make and receive personal phone and/or video calls in private. This will include provision for those who are unable to use a phone independently.

21.2 AUTONOMY, CHOICE, INDEPENDENCE AND FULFILMENT

21.2.1 The Service Provider will provide care and support that is strengths-based and person-centred, ensuring that staff are aware of and work with the outcomes described by the Think Local, Act Personal 'I' Statements (please see Appendix G).

21.2.2 Service users shall be encouraged and supported to make independent choices and to express their needs, beliefs, culture, preferences and values.

21.2.3 A service user's ability to make their own decisions will be assumed unless demonstrated otherwise in accordance with the requirements of the Mental Capacity Act (2005). Service users shall have the right to think and act without having to refer to others, including the right to say 'no' to help.

21.2.4 The Service Provider will ensure that all staff understand how the service user's right to autonomy, choice, independence and fulfilment is maintained within the context of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

21.2.5 The Service Provider will work with service users to identify the circle of people to be involved in their life (e.g. partners, relatives, friends) and establish how they would like them to be involved. This circle of people will be provided with adequate and timely information (eg. timing of health care appointments, opportunities to participate in a review of the Service User's care and support

plan), so they can be involved in accordance with the service users' wishes.

21.3 RIGHTS

21.3.1 Individuals retain all their legal rights and entitlements when they enter a care home and the Service Provider will help each Service User to exercise those rights. This includes, for example, participation in government elections and other civil processes. These fundamental rights will be written into the Provider's statement of values, aims and objectives, and Service User guide.

21.3.2 The Service Provider will ensure that staff uphold Service Users' right to confidentiality and the protection of personal information relating to communication (verbal and written) and recording.

21.3.3 The Service Provider will ensure that service users are aware of and have access to formal mechanisms for consultation about the running of the home and to contribute ideas. The Provider will maintain written documentation to evidence any actions taken or not taken in response to service users' comments, complaints or other contributions.

21.3.4 Service users will have the right to take risks. Risk taking is a normal part of everyday life, so service users shall be involved in agreeing any controls or interventions that may be put in place. Risks shall be fully assessed and reasons for actions taken and outcomes clearly documented.

21.3.5 Referrals shall be made to Independent Mental Capacity Advocates where the Service User needs assistance to support decision-making.

21.3.6 The principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards will be upheld by staff supporting service users.

21.4 DIVERSITY, EQUALITY AND INDIVIDUALITY

21.4.1 The Service Provider will understand and be committed to promoting a culture for both service users and staff which reflects and demonstrates that diversity, equality and individuality is embedded in the beliefs and values of the service adhering to the Equality Act 2010.

21.4.2 The Service Provider will adopt a strategic approach in delivering education to staff so that they understand the:-

- Organisation's aims and objectives
- Relevant policy provisions
- Difference between acceptable and unacceptable behaviour
- How personal attitudes and values can affect behaviour
- Role they play in making the management of diversity a reality
- Meaning of cultural diversity
- Meaning and impact of discrimination in the workplace.

21.5 SOCIAL CONTACT, ACTIVITIES AND COMMUNITY INVOLVEMENT

21.5.1 The Service Provider will support Service Users to spend time in a way that is meaningful and stimulating for individual and which suits the person's needs, preferences, aspirations, lifestyle, choices and capacities. This means leisure and recreational activities in and outside the home, including activities provided by the provider and those arranged independently by the service user.

21.5.2 Service users will be assisted to maintain confidence, positive self-esteem and protected from

loneliness and isolation in a way that promotes their individuality and identity.

21.5.3 Individuals will be encouraged to exercise their lifestyle, culture and beliefs through planned opportunities and in a spontaneous way.

21.5.4 Staff providing group or individual activities will be appropriately skilled to deliver effective and meaningful activities that are both tailored and suited to meet individual needs.

21.5.5 Consideration will be given to the needs of people with dementia and other cognitive impairments, those with sensory impairment, and those with physical disabilities or learning disabilities or mental health needs.

21.5.6 The Service Provider will ensure that a comprehensive life history is captured through dialogue with the service user and/or their representative so that past and present life experiences, along with the person's priorities for the future inform the Service User's Care and Support Plan, including their participation in social and other activities.

21.5.7 The Service Provider will ensure that the Service User is able to have visitors at any reasonable time and maintain links with the circle of family, friends and local community in accordance with their individual preference.

21.5.8 The Service Provider will ensure that up to date information about activities is made available to all service users in formats that meet the needs of individuals.

21.5.9 The Service Provider will consult Service Users about the programme of activities offered and will ensure that participation in activities is recorded and evaluated regularly to ensure that outcomes and service user needs continue to be met.

21.5.10 The Service Provider will ensure that any activities involving Service Users that are planned and undertaken outside of the Care Home and its' grounds are properly risk assessed and that people that Service Users may come into contact with are appropriately vetted.

22 Transport

22.1 TRANSPORT ARRANGEMENTS FOR ADMISSIONS TO A CARE HOME

22.1.1 Where appropriate and practicable, the Commissioning Partners will ask the Service User's family or friends to assist with their transfer to the Care Home.

22.1.2 Where the Service User is a self-funder but has approached the local authority to assist in making arrangements for their care and support, the Service User or their representative will be expected to fund the cost of the transport.

22.1.3 Where a Service User is residing in the community immediately prior to their admission to the Care Home and the person's needs are complex the relevant Adult Social Care Team will co-ordinate the person's transport to the Care Home and explore the most appropriate best value option.

22.1.4 Where a Service User who is registered with a GP practice in Dorset[14] is being discharged from hospital immediately prior to their admission to the Care Home and the person requires 'specialist

[14] NEPTS – NHS Dorset

transport'[15], non-emergency patient transport will be arranged and funded by the relevant ICB. Provision for escorts and carers to travel with the person may also be made and funded by the relevant ICB[16].

22.1.5 Service Users are likely to qualify for ICB-funded non-emergency patient transport if they have[17] a:

a) Medical need for transport
b) Have a cognitive or sensory impairment that requires oversight
c) Have a significant mobility need which makes other transport arrangements impractical. This is likely to include patients who:
    - need to travel lying down and/or by stretcher for all or part of the journey and
    - need specialist bariatric provision

22.2 TRANSPORT ARRANGEMENTS BETWEEN CARE HOMES WITH AND WITHOUT NURSING

22.2.1 Where appropriate and practicable, the Commissioning Partners will ask the Service User's family or friends to assist with their transfer to another the Care Home, where this is necessary in order for the person's needs to continue to be met.

22.2.2 Where the person's needs are complex the relevant Adult Social Care Team will co-ordinate the person's transport to the new Care Home and explore the most appropriate best value option. Very occasionally, the provider may be asked to assist with these arrangements, for example, by providing a carer who is familiar to the person being transferred to travel with them. Arrangements for covering the cost of a carer's time where required will be negotiated and agreed between the relevant Commissioning Partner and the Service Provider on a case-by-case basis.

22.3 TRANSPORT TO NON-PRIMARY CARE NHS-FUNDED HEALTHCARE APPOINTMENTS

22.3.1 Where – during the period of their short or long-term placement in a Care Home – a Service User is referred by a doctor, dentist or ophthalmic practitioner for non-primary care NHS-funded healthcare services[18], and the person requires 'specialist transport' is also likely to qualify for ICB-funded non-emergency patient transport[19].

22.3.2 Subject to eligibility, access to ICB-funded non-emergency patient transport may be provided by the relevant ICB regardless of the geographical location of treatment.[20]

22.3.3 Provision for escorts and carers to travel with the person may also be made and funded by the relevant ICB[21].

23 Access to wider health and social care services

23.1 PROVISION OF AND ACCESS TO HEALTH AND SOCIAL CARE

23.1.1 The Service Provider must ensure that Service Users' health, independence and wellbeing is promoted, monitored and maintained, and that access is provided in a timely manner to relevant

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[15] Non-emergency patient transport services eligibility criteria – NHS, 31st May 2022
[16] Please refer to Section 4 Non-emergency patient transport services eligibility criteria – NHS, 31st May 2022
[17] Please refer to Section 3 Non-emergency patient transport services eligibility criteria – NHS, 31st May 2022 for detailed guidance
[18] Please refer to Section 2 Non-emergency patient transport services eligibility criteria – NHS, 31st May 2022
[19] Where the Service User is registered with a GP practice in Dorset, Dorset NHS ICB will be the responsible body.
[20] Please refer to Section 5 Non-emergency patient transport services eligibility criteria – NHS, 31st May 2022
[21] Please refer to Section 4 Non-emergency patient transport services eligibility criteria – NHS, 31st May 2022

primary care and specialist health and social care services to meet assessed individual need.

23.1.2 The Service Provider must provide support to enable Service Users to engage in their care and will involve Service Users and/or their representatives in decision-making around care and health intervention.

23.1.3 Oral health care will be supported by the provider who will ensure access to appropriate dental services.

23.2 MEDICAL COVER AND CLINICAL SUPPORT

23.2.1 The Service Provider must ensure that, where a Service User has been admitted on a permanent or long-term basis, the person is registered with and has access to a GP that can provide medical advice and support as required.

23.2.2 Where a Service User has been admitted on a short-term basis, including for respite care, the Service Provider will be supported by the following medical support arrangements:

a) Individuals are expected to remain registered with their existing GP.
b) If an individual needs a face-to-face appointment, the Service Provider will ensure that they are registered as a temporary resident with the local GP Practice.
c) During their stay, if medical advice or support is required and the person's existing GP is unable to respond, the Service Provider and the Commissioning Partners' Operational Team(s) will work together to access suitable support and guidance.

23.2.3 Where a Service User has a rapidly deteriorating condition and/or has been assessed as needing Fast Track-Funded End of Life Care, the Service Provider will be supported by the following medical support arrangements:

- NHS Dorset Fast Track Team [See Appendix E – Contacts]
- District Nursing Team [See Appendix E – Contacts]
- The relevant GP (please see Sections 24.2.1 and 24.2.2 above]

23.2.4 In all cases, the Service Provider must work proactively to develop and maintain effective working relationships with local community health teams, such as district nurses, and speciality teams for elderly care, as well at Community Mental Health Teams and the Intermediate Care Service for Dementia, to ensure that Service Users are able to access appropriate advice and support to meet their assessed needs.

23.2.5 Where available, the Service Provider will make appropriate use of any relevant scheme or service commissioned by the Commissioning Partners to improve Service Users' access to health care services, such as the Immedicare Scheme [please see Appendix E – Contacts].

23.2.6 The Commissioning Partners expect that where it appears that a service user's needs have changed and advice, guidance or support maybe required from an external health care professional, the escalation process should be as follows:

1. Internal escalation in accordance with the Service Provider's procedures
2. Contact the relevant GP and/or appropriate community-based team, eg. Frailty, Community Rehabilitation, Learning Disabilities Nurse, Community Mental Health Team (CMHT), Diabetes Nurse etc., dependent on the needs of the individual and the related

concern
3. Call NHS 111 for non-emergency help out of hours
4. Call 999 in the event of an emergency

23.3 MEDICATION SUPPLY

23.3.1 Where a Service User is referred from hospital the ward staff will ensure that their provision of prescribed medication is arranged and transferred with the person.

23.3.2 Where a Service User is admitted from home or another community setting, the person will be admitted with the medications being taken at the time, which may then be re-prescribed by a GP.

23.3.3 The Service Provider should work with the relevant GP practice to maintain any ongoing prescriptions of medication and ensure adequate supply.

23.4 CONTINENCE PRODUCTS

23.4.1 Where a Service User is referred from hospital the ward staff will ensure that their provision of supplied continence products is arranged and transferred with the person.

23.4.2 Where a Service user is admitted from home or another community setting, with an existing prescription for continence products approved by Dorset Healthcare’s Dorset Bladder and Bowel Continence Service, it may be possible for the person’s relatives to bring into the Care Home products already supplied by this service.

23.4.3 The Service Provider may contact the Dorset Bladder & Bowel Continence service to check if the Service User is known to this service and whether they are already in receipts of products. (see Appendix E for contact details).

23.4.4 The Service Provider must ensure the provision of ongoing supplies of Continence Products to meet the Service User’s needs through timely liaison with the Dorset Bladder and Bowel Continence Service, and at no additional cost to the Service User.

24 Medication Management

24.1 The Service Provider must ensure that Service Users are protected and supported by the Service Provider’s policies and procedures for the management and administration of medication.

24.2 The Provider will have clear policies and procedures which demonstrate recognised best practice in the management of medication.

24.3 In care homes with nursing, responsibility for medicines administration may be delegated to care staff who must be appropriately trained and assessed as competent to undertake this role.

Registered nurses will remain accountable for medicines administration in the home and must provide supervision to care staff undertaking the task.

24.4 The Provider will regularly assess and be able to provide documentary evidence of the competency of staff in the management of medication to ensure that practices are compliant with the standards outlined in the Provider’s policies and procedures and relevant national guidance, eg. NIHCE.

24.5 The Service Provider will seek information and advice from a pharmacist or, where appropriate, other relevant medical professional, in relation to administering, monitoring and reviewing medication.

24.6 The Provider will support service users to take medicines independently within a risk management framework and will provide suitable lockable facilities for this purpose.

24.7 Where a Service User is unable or chooses not to take their own medication this will be recorded and the required medication will be administered by suitably trained and competent staff, following completion of a risk assessment.

24.8 Records should include details of any capacity assessments and Best Interest decisions made on behalf of any service user lacking capacity to consent to the administration of medication.

24.9 Any arrangements for covert medication must be made in accordance with Mental Capacity Act guidance and with the involvement of a relevant professional and service users and representative. This should be clearly documented and kept under continual review.

24.10 Service users’ medication will be reviewed with their General Practitioner or relevant health professional six monthly or more frequently as required. The Service Provider will identify and

contact the relevant party if this review has not happened according to this schedule, or if a change in the Service User's needs might warrant a more immediate review of their medication.

24.11 The Service Provider will ensure that Medication Administration Records (MAR charts) are audited each month to provide an audit trail of stock control and storage of medicines including monitored dosage systems and evidence that correct procedures have been followed.

24.12 Additional audits will include monitoring the administration, recording and disposal of medicines. Audits should be robust and comprehensive and identify that measures are in place to ensure safe practice.

24.13 Where a medication error is made or suspected, the Service Provider must contact an appropriate health professional immediately to discuss the risk to the individual and communicate the error to the Dorset Safeguarding Adults Team.

24.14 The Service Provider will notify the Service User and/or their representative of any errors in relation to the administration of their medication.

25 Pressure area care, tissue viability and wound management

25.1 The Service Provider must ensure that Service Users receive care that supports healthy tissue viability and wound management in line with their assessed care plans.

25.2 The Provider shall have up to date policies and procedures to support evidence-based tissue viability and wound management practice.

25.3 The Provider will ensure that:

a) Staff involved in the assessment and/or delivery of care are trained to identify individuals most likely to develop pressure ulcers and to identify when advice and guidance should be sought from an appropriate health professional. Staff will be competent to recognise pre-disposing risk factors for pressure ulcers as a part of both the pre-admission assessment and on-going assessment process.

b) Tissue viability interventions and wound management are carried out by competent Registered Nurses (either employed by the Provider or through community nursing services) with up to date knowledge and skills in the prevention, assessment and management of pressure ulcers and management of wounds.

c) Wound management takes into account the service users' preferences for information and understanding of their wound care, and their compliance with both treatment and the care plan. Clear communication of essential evidence-based information will enable the service user to make informed decisions about their care.

d) Wound care documentation is descriptive and directive incorporating a holistic assessment of the service users' individual health needs, links into risk assessment, predisposing factors, include a rationale for the selection or change of a treatment or dressing and document clinical outcomes. Documentation will include planned preventative strategies and plans for reassessment.

e) Wound assessments and care/support plans will include:
   - The location and measurement (grade and dimensions) of the wound demonstrated by a wound map and photograph (subject to the service user's consent and any documented

Best Interests Assessment / Lasting Powers of Attorney [BIA/LPA])

- A record of any underlying or undermining intrinsic and extrinsic factors that may have contributed to the wound for example general health status, malnutrition, systemic disease, poor mobility or medication
- A description of the colour or appearance of the wound bed and status of the surrounding skin, including any undermining/ tracking sinus or fistula
- A record of any exudate, pain or malodour
- A rationale to support the selection of a treatment or dressing which may be determined by the type and position of the wound, the amount of exudate, pain, odour, any known allergies, the service user's compliance/concordance with the dressing and the frequency of dressing changes. (Care Homes with Nursing only) The wound should be evaluated and reviewed at each dressing change and documented accordingly.

25.4 Wound care documentation will clearly document clinical outcomes and provide a chronological history of the progress or deterioration of the wound demonstrating regular evaluation and review and any specialist input or referral.

25.5 Care homes without nursing will liaise with the relevant health professional if they have any concerns in relation to skin injuries and pressure ulcers/areas/ and will follow the guidance provided. This may include advice in relation to (but not exclusively) hygiene, repositioning regimes or appropriate equipment to be used. Such guidance will be clearly documented in a plan of care.

25.6 An appropriate and evidence-based risk management tool shall be used to assess risk and where necessary an action plan put in place. A baseline risk assessment shall be undertaken within six hours of admission to the home and reviewed regularly thereafter.

25.7 Robust assessment of the person's tissue viability and proactive preventative care must be considered when applying moving and handling techniques to ensure individuals are not placed at risk of traumatic skin injuries.

25.8 The Service Provider will ensure that staff involved in the delivery of care are alert to the risks associated with the person's ability to sit or lie comfortably and will take action to ensure that appropriate seating is provided, and that the person is supported to get out of bed where there is a risk of contractures developing or worsening.

25.9 Appropriate equipment to prevent the development and, where necessary, relieve the effects of pressure ulcers, will be identified by the provider and/or a professional and provided in a timely manner.

25.10 The Service Provider must undertake a monthly prevalence audit of pressure ulcers.

26 Nutritional Care

26.1 The Service Provider must ensure that:

a) Service Users have enjoyable meal experiences that meet and are tailored as necessary to the individual's nutritional needs and preferences.

b) Service users are nutritionally screened using the Malnutrition Universal Screening Tool (MUST) or appropriate alternative questions asked within 6 hours of admission and then on a

monthly basis as a minimum or when needs change.

c) Scales used are suitably and regularly calibrated and maintained to provide reliable and accurate measurement of service users' weight.

d) A clear action plan is in place for staff to follow if a Service User is found to be at medium or high risk of malnutrition and all care and catering staff will be made aware of the actions to take. All care and catering staff shall be trained in the implementation of MUST and the home's action plan.

e) Service users are encouraged to maintain a healthy, balanced diet and are supported to sustain adequate hydration. Appropriate records are kept where necessary to evidence food and fluid intake.

f) Mealtimes are enjoyable experiences and promoted as a social activity. Dining rooms and other eating areas should be pleasant, environments conducive to eating that are welcoming, clean, tidy and free from malodours.

g) All care and catering staff are trained in the special dietary requirements of individual Service Users, especially those with diabetes, dementia, chronic illness or with swallowing difficulties. Kitchen staff will be promptly made aware of any changes to an individual's dietary requirements.

h) Appropriate equipment to support independence at mealtimes will be provided, including adapted plates, cutlery and guards.

i) Service users must be offered a choice of at least two options for each mealtime.

j) Information about allergens used within the food made and served will be available to Service Users and visitors and updated as and when menu changes occur.

k) Service users are able to access drinks and snacks at all times.

l) Food, including that which is texture modified, is presented in an appetising way that respects dignity.

27 Infection Prevention and Control

27.1 The Service Provider must ensure that:

a) Service Users reside in a clean environment where standard precautions and routine safe practice ensure that the infection risks to service users, staff and visitors are minimised.

b) Procedures and practices protect service users from infection and assurance frameworks are in place which are regularly updated to ensure that these remain consistent with the most current

legislation and guidance, and are accessible to and understood by all staff to include:

- Safe handling and disposal of clinical waste
- Managing accidents, dealing with spillages
- Provision and disposal of personal protective equipment and clothing
- Optimum hand hygiene and support for 'Bare Below the Elbows' when carrying out personal or clinical care
- Service user hygiene
- Environmental hygiene
- Food hygiene
- Cleaning and decontamination of reusable equipment
- Management of laundry and soiled/infected linen
- Management and disposal of sharps and inoculation injury
- Reporting of Health Care Acquired Infections (HCAI's)
- Management and notification of infectious diseases, including outbreak control
- Clinical procedures especially Standard Aseptic No Touch Technique (ANTT)
- Management of indwelling devices
- Good communication with other health and social care workers, service users and visitors
- Staff training and education.

c) The care environment is designed and managed to minimise reservoirs for microorganisms and reduce the risk of cross infection to service users, staff and visitors.

d) Protective equipment is available and worn for all aspects of care which involve contact with blood or body fluids or where asepsis is required and/or in the event of infectious diseases/outbreaks.

e) All service users' equipment will be cleaned and maintained appropriately to prevent cross

infection.

f) The premises are kept clean, hygienic and free from offensive odours throughout.

g) Laundry facilities are sited so that soiled articles, clothing and infected linen are not carried through areas where food is stored, prepared, cooked or eaten and do not intrude on service users.

h) Hand washing facilities are prominently sited in areas where infected material and/or clinical waste are being handled and this will include liquid soap and disposable hand towels.

i) Procedures are in place to prevent and control Legionella bacteria including an up-to-date Legionella assessment with a plan of preventative maintenance.

j) Notifiable diseases and infections that could be a potential risk to others are recorded and reported to UKHSA, local Environmental Health and the Care Quality Commission in accordance with local arrangements.

k) There is a designated lead/link person for infection prevention and control.

l) A local outbreak policy is in place for the surveillance, recognition, control and management of infection and outbreaks with information available to service users and their visitors. Staff are trained and aware of actions to take including reporting to UKHSA. All infection outbreaks must be reported to UKHSA within two days of an outbreak.

m) Infection control procedures are explicitly included within all staff job descriptions, induction, development and on-going training for all staff.

n) Clinical practice reflects infection prevention and control guidelines and reduces the risk of cross infection to service users whilst providing appropriate protection to staff.

o) An annual Infection Prevention and Control assessment is completed and an action plan developed and implemented to address any areas of non-compliance.

p) Monthly audits are undertaken to ensure that best practice is followed and maintained, and include incidence/prevalence rates for HCAI's, wound infections, urinary tract infections notifiable infections, antibiotic prescribing, hand washing and decontamination of equipment.

q) Robust monthly audits will be carried out to ensure staff follow correct infection prevention and control measures including an audit of the cleanliness of the environment.

r) Information related to Healthcare-associated infections (HCAIs) e.g. notifiable infections, wound infections etc will be shared with other health and social care providers, where appropriate.

28 Accident and incident reporting and recording

28.1 The Service Provider must ensure that:

a) Its' policies make clear the procedures to be undertaken following an accident or incident and that staff are fully aware of the processes. This must include what actions should be taken

following a head injury.

b) All accidents and incidents are comprehensively and contemporaneously documented using a system that meets current GDPR guidelines. Additional records, such as falls diaries and behavioural charts will be implemented and maintained to support ongoing monitoring and management.

c) Details of accidents and incidents are recorded within service users' daily records together with information to reflect the service users' health, safety and wellbeing.

d) Injuries, including bruises that are sustained following an accident or incident, are fully documented, using body maps.

e) Treatment required/delivered following an accident or incident is clearly documented, including the precise treatment and support and any necessary health or social care professional input ie, Paramedics, District Nurses, General Practitioner, Community Mental Health Nurses.

f) Accidents and incidents are regularly audited and a comprehensive monthly analysis undertaken and documented to identify patterns or trends in order to investigate and put in place timely measures to minimise or prevent such events reoccurring.

g) Where there are repeated incidents, patterns, or themes, the provider will continue to implement risk management strategies whilst seeking additional support from specialist health and/or social care professionals. The Service Provider will be able to evidence a dynamic approach which attempts to design-out or pre-empt hazards and/or potential triggers and delivers a proactive response before an incident occurs.

29 End of life care, dying and death

29.1 The Service Provider must ensure that:

a) An End-of-Life Care Policy and Guidelines are in place that reflect local and national guidance.

b) Service Users feel assured that staff will treat them and their family with care, sensitivity, dignity and respect at the end of their life and that they will receive, where possible, planned, measured and seamless care at the time of their death in line with their wishes and preferences.

c) Advanced Care Plans including the person's wishes in relation to Do Not Attempt Resuscitation (DNAR) are captured and in place for all Service Users and that the service user and/or their representative (e.g LPA) has been involved in their preparation and agreement.

d) Comfort and support is provided to service users and that those closest to them are treated with compassion and sensitivity, when it is recognised that the person is entering the end-of-life phase.

e) Timely access to specialist services, eg. Frailty Team, District Nursing, is sought where required.

f) The home provides private space for service users and those people who are important to them, to remain close at the end of life. Relatives and partners will be able to spend as much time with

service users as they wish in line with the service user’s individual preferences.

g) All deaths are managed with dignity and propriety and service users’ spiritual needs, rites and functions should be observed. Systems are in place to ensure that, when death is expected, service users do not die alone unless it is their wish to do so.

h) Where a service user requires end of life or palliative care, an assessment is sought from an appropriate health professional to determine whether it is appropriate for that care to be provided by the existing Provider or elsewhere and whether the person may be eligible for CHC Fast Track funding [see Clause 9.7].

i) A keyworker is nominated to co-ordinate the service user’s end of life care pathway and ensure continuity of care including out of hours support.

j) Care and support is offered to the Service User’s family, friends and staff after the person has died, including sign-posting as required to appropriate information on support agencies and bereavement counselling.

k) A policy and procedure is in place for the verification of death.

l) Staff are appropriately trained to manage the processes and procedures sensitively, to ensure service users and those closest to them are treated with dignity and respect, and that service users receive appropriate care and symptom relief.

m) When a Service User dies, the Provider will notify the Commissioning Partners and other stakeholders as appropriate, in line with the timescales set out in the Terms and Conditions.

30 Equipment provision, storage and maintenance

30.1 The Service Provider must comply with the requirements of the Pan-Dorset Equipment Guidance, February 2024[22]. In line with these requirements, the Service Provider must provide a range of equipment that

a) is appropriate for meeting the type and level of needs described in the relevant Service Category [see Appendices A to C][23], and

b) enables the service user’s needs to be safely met in the least restrictive way (see also

[22] Please see Clause 4.9 Framework for the Provision of Care, Support, Housing and Community Safety
[23] For example, where the relevant Service Category indicates that Service Users’ may experience anxieties or exhibit restless behaviour, the Service Provider should consider what equipment and or other interventions may help ease this, such as robotic cats and dogs that respond to petting, hugging and motion and may help ease a service user’s anxieties or restless behaviour.

Technology-enabled care below.

30.2 Section 11 of the Pan-Dorset Equipment Guidance sets out the range of equipment that is likely to be required in a care home that provides services for older people and adults of working age whose primary support need is now ageing-related.

30.3 The Service Provider must ensure that staff are trained and assessed as competent in the safe usage of this equipment.

30.4 The majority of the items identified are ‘standard’ pieces of equipment, that are capable of supporting individuals of greater weight and proportions and are transferrable between individuals.

30.5 The Service Provider must ensure that equipment required for the delivery of the Service(s) is safely stored, on or off the property, and that it can be quickly retrieved and made available in a timely fashion when required to meet a Service User’s needs, including the person’s ability to access and enjoy the range of amenities available within the home, where appropriate.

30.6 The equipment required to meet Service Users’ needs must be maintained, repaired and where necessary replaced in a timely fashion to ensure that the Service(s) remains capable of meeting the type and level of needs described at Appendices A, B and C as appropriate.The Service Provider is required to follow all elements of the Service User’s Care Plan, including elements advised by a health care professional to avoid for example, health deterioration or contractures. This may include practical support and encouragement to undertake exercises or other movement that will enable the person to maintain or regain a level of dignity and independence.

30.7 The Service Provider is encouraged to ensure that staff undertake training in optimal-handed care to provide a strengths-based, person-centred and proportionate approach to the delivery of care and deliver benefits for both the Service User and Service Provider.

31 Technology-enabled care (TEC)

31.1 The service provider must provide and maintain technology-enabled care that

a) is suitable for the provision of the contracted Service(s), and the type and level of needs described at Appendices A to C.
b) promotes independence, autonomy, safety and wellbeing giving the person more choice and control over their participation in physical and social activities both within and outside of the home.
c) maintains participation in daily activities and assists the person in maintaining a daily routine in the least restrictive environment and enabling them to access all areas of the home that they need to.
d) supports and or monitors the promotion of health and reduces or defers an escalation of needs.

This maybe in conjunction with local health clinicians

31.2 The service provider shall use technology to promote a suitably flexible and stimulating environment for each service user that supports the person's individuality, sense of reality, and mental and emotional wellbeing.

32 Environment and accommodation

32.1 The Service Provider must provide and maintain an environment which

a) is suitable for the provision of the contracted Service(s), and the type and level of needs described at Appendices A to C.

b) enables service users to navigate and make optimal use of the care home's spaces and facilities, including secure outside space, limiting the impact of the person's disability(s), and minimising confusion and distress.

32.2 The Provider shall adapt the physical layout of the care home and its facilities, day to day routines and staff culture within their service to provide a suitably flexible and stimulating environment for each service user that supports the person's individuality, sense of reality, and mental and emotional wellbeing.

32.3 Security and other safety arrangements for the building, garden and other areas and activities will mean that service users freely use facilities whilst being protected from harm.

32.4 The Service Provider should familiarise themselves with relevant best practice guidance on the design of care home environments for people who are living with dementia. See also Appendix F – Supporting Information for Reviews.

32.5 People living in the home will have private single accommodation (unless shared accommodation is requested by choice) which they call their own to use as and when they wish. Service users will be offered a choice about the nature and decoration of the room e.g. the ability to lock their room and lock up personal belongings.

32.6 Subject to safety considerations including fire prevention guidelines, Service Users will be encouraged to bring personal possessions into the care home, including small items of furniture where practical.

32.7 The Service Provider must ensure that arrangements are in place for the recording of people's property and secure storage for valuables and the person and/or representative is informed of the level of insurance.

33 Management, leadership and staffing

33.1 MANAGEMENT AND LEADERSHIP

33.1.1 The Service Provider must ensure that the Service(s) is led so that service user outcomes are achieved and sustained for the duration of the person's stay in the Service.

33.1.2 The Provider will take responsibility for the leadership and management of the home through the

Registered Manager as well as their own investment of finance, interest and time.

33.1.3 The Service Provider will 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.

33.1.4 Where a nursing service(s) is delivered, registered nurses will play an important role in ensuring care quality and leading care improvement in the home, in line with the Royal College of Nursing's Principles of Nursing Practice24 and Principles of Accountability and Delegation of tasks[25]. The Service Provider must ensure that registered nurses understand that this is part of their role, and that they are supported to do this effectively.

33.1.5 The Service Provider must notify the Council immediately of any changes to the management arrangements of the home, extended absences or a delay in appointing a registered manager, and of its plans to ensure the effective management of the home in the interim.

33.1.6 The Registered Manager will ensure that the philosophy within the Service is strengths-based, person-centred and promotes the benefits of open, trusting and collaborative relationships between staff, service users and their social and professional networks.

33.1.7 The Provider shall ensure that the home is managed in such a way that it complies with all requirements under the Care Act 2014 and the Care Quality Commission (Registration) Regulations, or any amending legislation.

33.1.8 Care promotes enablement and partnership working with all service users, social care and health practitioners and family/friends that are important to service users.

33.1.9 A manager shall be appointed who:

a) is registered with the Care Quality Commission or has applied to be registered with the Commission within three months of commencement of employment within the home. clearly demonstrates up to date knowledge and skills, leadership, competence and experience to effectively manage the home on a daily basis and shows a sound understanding of the requirements set out in the Framework Agreement and Service Specification.

b) holds a qualification or is working towards QCF Level 5 Diploma in Leadership in Health and Social Care within three months of appointment and completed within two years.

c) maintains and demonstrates personal and professional competence and credibility in line with current practice and will ensure they delegate appropriately with clear lines of accountability.

33.2 STAFF RECRUITMENT AND RETENTION

33.2.1 The Service Provider must ensure that:

a) A robust, values-based, written policy and procedure for staff recruitment and selection is in place which;

- takes all reasonable steps to ensure that individuals employed, including volunteers, and those appointed through an agency and workers from other countries, are in all

[24] https://www.rcn.org.uk/professional-development/principles-of-nursing-practice
[25] https://www.rcn.org.uk/professional-development/accountability-and-delegation

respects appropriate persons to work with vulnerable people, and
- reflects best practice and guidance on staff recruitment and retention[26]
- adheres to equal opportunities legislation and embraces the principles of diversity.

b) Staff who are required to obtain permission to work in the United Kingdom either directly or through an agency meet the legal entry requirements, that they have the necessary skills, expertise and qualifications required and all necessary and relevant documentation is available prior to employment, copies of which must be evidenced in their personal file for inspection and monitoring purposes.

c) When recruiting staff, at least two appropriate written references are taken up one of which must be from the individual's last employer. The Service Provider shall be able to demonstrate that the suitability of all staff has been assessed by appropriate means. Where the reference provided only gives dates of employment the Provider must be able to demonstrate that all attempts have been undertaken to ensure a safe and robust system of recruitment.

d) Staff have gone through a full recruitment process including completion of an application form which provides complete employment history and addresses any gaps in employment history.

e) Staff have the personal qualities and caring attitudes which enable them to relate well to service users and carers.

f) Staff possess the required skills in spoken English, written literacy and numeracy to do the tasks required for caring for and supporting service users.

g) Staff appointed from overseas are supported to:
- access education to improve English language skills, where required, and
- understand British/English cultural differences

h) Contemporary evidence of professional registration/PIN number checks is obtained for all qualified nursing staff employed and regularly reviewed. A personnel file is updated and maintained for each employee which evidences all required documentation for inspection and monitoring purposes. Such documentation will include evidence of a written record of interview to demonstrate the applicant’s suitability for the post.

i) Volunteers will be subject to many of the same checks as paid staff to ensure that suitable individuals are supporting the service. The Service Provider must ensure that an individual’s personal information and evidence of the right to live in the UK along with references and a DBS check have been checked as a minimum, prior to the individual undertaking any voluntary work in the service.

j) For agency staff, a staff profile has been obtained prior to the commencement of the employment, that includes photographic ID, relevant skills and competencies for the position, qualifications, professional registration and an up-to-date training record. All agency staff new

[26] https://www.skillsforcare.org.uk/Recruitment-support/Recruitment-support.aspx

to the home will undertake orientation and induction to the home which includes fire safety.

33.2.2 Section 24 of the Framework Agreement expands on DBS requirements.

33.3 STAFFING LEVELS AND WORKFORCE PLANNING

33.3.1 The Service Provider must ensure that:

a) There are enough appropriately trained staff on duty at all times to ensure the safe and effective delivery of services to meet the individual assessed needs of the Service Users.

b) Staffing levels and the mix of staff skills, experience and competencies reflects the needs profile and service requirements of the commissioned Service Category(ies), both day and night.

c) The Service Provider will review staffing arrangements on a regular basis and be able to provide written evidence to demonstrate that they reflect the changing needs of the service users.

d) The Service Provider is expected to develop workforce plans to be updated at least annually and more often as appropriate to ensure that arrangements are in place to maintain the workforce capacity and capabilities required to deliver the Service.[27]

e) A contingency plan is in place to cover staff absence, sickness, annual leave and succession planning.

33.3.2 In care homes with nursing, the Service Provider must, in determining the level and frequency of professional nursing expertise and intervention required, be mindful of the assumptions as to the hours of care to be provided in the relevant Service Category (See Appendix C), and ensure that:

- The level, frequency and quality of time and intervention provided by a registered nurse undertaking actual care delivery, including clinical/technical or therapeutic activities on the service user's behalf, is sufficient to meet their assessed needs and provide the ongoing management of care interventions
- The level and frequency of supervisory skills required by a registered nurse for teaching, guiding, advising, supporting and monitoring both service users and staff is sufficient to meet the service user's assessed needs and promote and maintain standards of care The Registered Nurse providing nursing care demonstrates the skills, knowledge, clinical judgement and expertise to accurately assess and manage the stability and predictability of the service users' health.

33.3.3 Appendices A to C of this Appendix A to the Contract Terms and Schedule 2 – Finance and Payments (Appendix A) detail the expectations regarding the maximum number of direct care and nursing hours across different service categories.

33.4 CULTURE

33.4.1 The Service Provider will support and encourage staff to work collaboratively as an effective team in a culture of openness and transparency, promoting mutual support and respect with an

[27] http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-planning/Workforce-planning.aspx GUIDANCE

appreciation of each other's roles, and reflecting the duty of candour[28].

33.5 STAFF INDUCTION AND TRAINING/EDUCATION

33.5.1 The Service Provider must ensure that:

a) No staff member, including agency staff, commences duties unsupervised until they have been assessed as competent for the role, and been orientated within the home.

b) Systems, structures and practices are in place and maintained that enable learning, reflection and continuous improvement by all members of staff.

c) A comprehensive staff induction, training and development programme is in place, which meets the Skills for Care standards and, where registered nurses are employed, the Nursing and Midwifery Council (NMC) Code of Professional Conduct Practice Guidance. These expectations will be clearly included in written policies and procedures to reflect the Service Provider's commitment to a supportive working and learning environment.

d) Staff who are new to care achieve the Care Certificate within twelve weeks of commencing employment and evidence of this is recorded. All existing staff should be able to demonstrate that they also meet the standards of the Care Certificate.

e) All staff working within the home are fully trained and assessed as competent to meet the individual needs of service users, as appropriate for their role. This will including all mandatory training and specialist and clinical education. Such training will be evidence-based to reflect up to date specialist and social care and clinical guidance. This will be undertaken on commencement and completed within 12 weeks. All refresher training will be delivered to staff regularly.

f) An annual training needs analysis is undertaken for all staff which is reviewed regularly and updated and formulated into staff personal development plans.

g) Documentary evidence is available on request to demonstrate the Provider's assessment of staff competency and performance management.

h) Training providers are suitably qualified and that the content of the courses relates to and is appropriate for the delivery of Adult Social Care Services. Learning undertaken by individuals prior to employment with the provider does not give automatic exemption to the training requirements, and that the Provider can demonstrate that the individual is fit to provide the services for which they are employed.

i) Casual staff/trainees and student workers are subject to the same requirements of all permanent staff.

j) Staff that require membership of a professional body in order to practice will provide evidence of continued registration as part of the appraisal process.

33.5.2 In care homes with nursing, the Service Provider must ensure that:

a) Where a newly qualified nurse is employed, mentorship/preceptorship is provided for the first

[28] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

six months of the person’s employment.

b) Where student nurse placements and nurses’ registration and adaptation programmes are supported, the Provider can provide evidence of accreditation with a participating University.

c) Where the Provider is supporting a candidate to undertake Nursing Adaptation Programme placements, appropriate mentoring and provision of the required period of protected learning is provided, in accordance with Nursing and Midwifery Council requirements.

a) The requirements for the Nursing and Midwifery Council (NMC) Revalidation are supported by the Provider’s supervision and appraisal processes.

33.5.3 The Service Provider is encouraged to engage with Partners in Care and the Dorset Care Association, and to submit and maintain an up-to-date return of workforce-related data to the Adult Social Care Workforce Data Set (formerly NMDS-SC), in order to learn about and benefit from potential training and development opportunities.

33.6 REFLECTION AND LEARNING

33.6.1 The Provider will ensure that following significant events/incidents staff are engaged in a debrief to understanding what has happened, capture any learning points and identify any changes that may be required to the individual's, team's or organisation's policy, practice or processes.

33.7 STAFF SUPERVISION AND APPRAISAL

33.7.1 The Service Provider must ensure that:

a) All staff receive formal supervision, including clinical supervision for Registered Nurses, at least four times per year.

b) Supervision is used systematically to guide the work of staff, to reflect upon their work practices, and any recent significant events/incidents, and as a means of support for staff to facilitate good practice. Casual staff, trainees and student workers will receive proportionate support and review. Supervision and appraisal sessions will be documented.

c) Staff are supported and advised between supervisions and that additional meetings are facilitated where required.

d) Robust appraisal systems are in place and all staff participate in an annual appraisal/personal development review.

e) Poor performance or staff conduct is identified, challenged and managed and documentary evidence can be made available on request to demonstrate that appropriate support has been provided and action taken.

f) Staff know when and how to raise an issue, comment, concern or complaint with their manager

or supervisor or another member of the organisation they work for.[29] [30] [31]. For reference the requirements from the Commissioning Partners and links to their whistleblowing policies are included at clause 49 of the Dorset Care, Support, Housing, and Community Support Framework.

g) A record of any incidents where the Service Provider's disciplinary procedure is applied is updated and maintained, with details entered into the relevant staff member's personnel file as required.

33.7.2 In care homes with nursing, the Service Provider must ensure that:

a) Clinical supervision is a critical element in the provision of safe and accountable nursing practice, remains linked to professional development and provides an opportunity to reflect on practice and enable practitioners to establish, maintain and promote standards and innovations in practice in the best interest of service users.
b) Staff that require membership of a professional body in order to practice will provide evidence of continued registration as part of the appraisal process.
c) Employers should support the requirements for the Nursing and Midwifery Council (NMC) Revalidation in their supervision and appraisal processes.

33.8 SUPPORT FOR WORKING CARERS

33.8.1 The Service Provider shall adopt and apply policies that help employees who are also working carers to sustain their caring responsibilities.[32]

34 Quality assurance and reporting

34.1 The Service Provider must have in place effective quality assurance and improvement systems to ensure that the care home operates in the best interests of Service Users.

34.2 Full details of the requirements for quality assurance and management are outlined in clause 26 of the Framework Agreement.

35 Data, intelligence, and reporting

35.1 USE OF ELECTRONIC RECORDS AND OTHER DIGITAL SERVICE REQUIREMENTS

35.1.1 Consistent with the ambitions of the People at the Heart of Care white paper and the Dorset Integrated Care System, the Service Provider must:

a) Utilise a Digital Social Care Records (DSCR) system, preferably from one of the NHS Assured Solution suppliers (Assured solutions for digital social care records | Digitising Social Care), for the purposes of creating, handling, storing, recording and updating resident/client care plans

[29] http://www.cqc.org.uk/content/regulation-13-safeguarding-service-users-abuse-and-improper-treatment#guidance
[30] http://www.cqc.org.uk/sites/default/files/documents/20120117_whistleblowing_quick_guide_final_update.pdf CQC GUIDANCE
[31] http://www.skillsforcare.org.uk/Standards/Care-Quality-Commission-regulations/Care-Quality-Commission-regulations.aspx

[32] http://circle.leeds.ac.uk/files/2012/08/carers-uk-report-6.pdf

and other relevant information.

b) Be compliant with the Data Security Protection Toolkit (DSPT) and complete the toolkit to enable a secure NHS email address to be adopted.

c) Ensure that all staff involved directly or indirectly in the delivery of the commissioned Services are aware of cyber security risks and know what they need to do to minimise the risk of potential data breaches of sensitive information.

35.1.2 The Service Provider is strongly encouraged to:

a) Embrace digital ways of working with respect to resident/client records and to communicate information via electronic means, such as emails.

b) Complete and publish their Data Security and Protection Toolkit self-certification on a yearly basis.

c) Sign up to and use NHS mail, particularly when communicating information regarding their residents/clients care plans, to further mitigate the risk of insecure email transmission.

35.2 IDENTIFYING AND ESCALATING PHYSICAL DETERIORATION

35.2.1 The Service Provider must ensure a suitable system in place, such as RESTORE2, to monitor and provide records relating the deterioration of an individual's health. Staff must be appropriately skilled to complete the tool and escalate concerns in a timely manner.

35.3 ADULT SOCIAL CARE WORKFORCE DATA SET

35.3.1 The Service Provider is encouraged to submit and maintain an up-to-date return of workforce-related data to the Adult Social Care Workforce Data Set (formerly NMDS-SC), to inform the data and intelligence available and to benefit from related funding for staff training and development.

35.4 CAPACITY TRACKER (CT)

35.4.1 Section 277A of the Health and Care Act 2022 requires Adult Social Care Providers that are regulated by the CQC, to update the Capacity Tracker (CT) during each monthly submission window.

35.4.2 The provider shall, unless otherwise notified by the Council/ICB:

a) make monthly submissions to the Capacity Tracker at such frequencies as are required by Department of Health and Social Care [DHSC] (or any other regulatory body) and/or the Council/ICB

b) submit/refresh data at least once during each monthly DHSC submission window as required DHSC

c) register and maintain registration of an account on the Capacity Tracker,

d) where possible, ensure there are two registered users able to use the Capacity Tracker

e) ensure providers details and contact details are regularly updated/refreshed on the Capacity

Tracker

35.4.3 In the event that the Capacity Tracker is no longer able to meet the needs of the Council/ICB, the Commissioning Partners reserves the right to initiate local data collection methods in order to collect detailed information.

ENDS