SECTION D: SERVICE SPECIFICATION

1. INTRODUCTION AND DESCRIPTION OF SERVICE

1.1 This document is the Service Specification for the provision of residential and nursing care services in registered care homes for Service Users (18 and over) in Devon County Council footprint.

1.2 This Service Specification does not replace the Law and quality requirements placed upon the Service Provider.

1.3 This section includes:

a. description of the Services
b. description of the type of tasks and activities to be delivered
c. description of the needs of Service Users
d. partnership working

1.4 The purpose of the Services will be to provide suitable accommodation, care, and support to eligible Service Users, for whom it is not appropriate either in the short or longer term, to live independently in their own homes, even with care provided as they require critical or substantial support above what can feasibly be met in the community with the use of Technology Enabled Care and Support, (TECS).

1.5 The types of care home Services the Service Provider can deliver under this Service Specification are split between two types:

(1) **care home without nursing:** a place where accommodation with toileting and bathing facilities, full board, personal care, staffing on a 24-hour basis and daytime and evening social activities are provided.

(2) **care home with nursing:** a place where accommodation with toileting and bathing facilities, full board, personal care, staffing on a 24-hour basis and daytime and evening social activities are provided together, with additional care being provided by qualified nurses.

1.6 Some Services may be registered for both residential and nursing care places.

1.7 The care home may also provide day activity services to people not usually resident in the home. Day services are not covered by this Agreement and the Service Provider will need to apply for a Day Opportunities Spot Contract, this contract will be issued by the Service Purchaser.

1.8 The Service will normally be provided in a single room. If a room is to be shared, explicit and informed consent is required. Room-sharing is limited to situations where both individuals retain the capacity to consent.

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2. UNITS OF SERVICE AND PAYMENT

2.1 A unit of Service is a 24-hour period beginning at 12 midnight on any day and ending at 12 midnight on the next following day, or any part of that period.

2.2 Apart for Fixed Term contracts, the Service Purchaser will pay for both the day of admission and the day of discharge as stated in Section D: Service Specification, Clause **2.1.**

2.3 For Fixed Term contracts including, replacement care and short stays payment will be made for the number of nights the Service User stays in the home.

2.4 **For Hospital Discharge placements,** payment will be made for the number of nights the Service User stays in the home. Hospital Discharge placements are anticipated to be up to **28 days** or until the Care Act assessment has been completed.

3. SERVICE DELIVERY STANDARDS AND VISION & PRINCIPLES

3.1 The Service Purchaser wants to commission appropriate support that will meet the presenting needs of Service Users in a way that enables them to be as independent as possible, in as many aspects of their life as possible.

3.2 Service Providers will deliver the Services in accordance with the following principles:

(1) promote quality of life for Service Users as paramount, supporting using the maximising independence principles to maintain skills and independence as much as is possible and prevent, delay, and reduce the need for ongoing long-term support.

(2) recognise that Service Users are individuals and not defined by their support needs, health condition or disability.

(3) recognise and uphold the diversity, values and human rights of people using the service in accordance with the Equality Act.

(4) promote and uphold Service Users' privacy, dignity, and independence.

(5) provide information that supports Service Users and their support network, to understand the care, treatment, and support and to make decisions about it.

(6) maximise opportunities for each Service User to engage with the wider local community including engaging with key local organisations to build appropriate links.

(7) encourage Service Users and their support network to be involved in how the home is run and to ensure the Service is meeting its duties as outlined in legislation and CQC regulation.

(8) ensure that the views and wishes of Service Users are paramount in the delivery of their support.

3.3 The Service Provider must:

a. be registered with CQC to deliver care under this Specification. It is the Service Provider's responsibility to ensure that their registration is correct and that care does not fall below the

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standards defined by the CQC's fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

b. ensure the Service offered to the Service User by the Service Provider must not exceed "Type of Service" and "Specialism/Services" registered with the CQC.

c. be responsible for supplying the Service Purchaser with the data required and frequencies in accordance with Section E: Additional Clauses, clause **1.2.**

d. provide the Service as agreed in accordance with its obligations under this Agreement and with all the skill, care, and diligence to be expected of a competent provider of residential and nursing homes.

e. follow all rules of the Health and Social Care Act 2008, any related regulations, and guidelines of the Regulatory Body.

f. deliver focused outcomes where the Service Users' wellbeing can be assured whilst supporting person-centred care and support. Wellbeing is defined as follows in line with Care Act guidance:

- personal dignity (including the way people are treated and helped)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control over day to day life (including making choices about the way care and support is provided)
- participation in work, education, training and recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the Service User's contribution to society.

g. ensure there are enough appropriately inducted, trained, fit and competent staff (which may include Agency Staff) on duty at all times to:

- ensure the safe and effective delivery of Services to meet the Service Users assessed needs as detailed in the Service User's Your Care and Support Plan, where this has been provided as part of the referral process.
- ensure that safe and effective delivery of Services within the size, layout and purpose of the care homes.

h. where appropriate, including but not limited to, accompany Services Users to outpatient appointments, emergency hospital admissions, and other activities outside the home at no additional cost to the Service Purchaser as per Section C: Particular Conditions, clauses **13** and **15.**

i. ensure that the need to attend very regular appointments, is reflected in the Your Care and Support Plan.

j. ensure the Service Users' right to privacy is observed and their affairs are respected at all times.

k. ensure the Service is led by an individual who has Registered Manager status with the CQC.

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l. work proactively and collaboratively as part of the wider Integrated Care System (Devon ICS) to optimise Service Users' social and health care outcomes.

m. prevent avoidable admissions to hospital by supporting Service Users to recover from episodes of ill health or injury, and facilitate timely Hospital Discharges and admissions from the community and prevent people dying prematurely.

n. work closely with system partners as required to enable and support the initial and/or ongoing assessment of Service Users' care and support needs taking into account each Service User's age, gender, ethnic origin, language, culture, religion, spirituality, sexuality and disability.

o. work closely with the Service User and representative to understand the Service Users interests, aspirations and past to aid in the delivery of care, support, stimulation and meaningful activities that are genuinely strengths-based, enabling, person centred and safe, and seeks to maximise the choice, dignity, independence 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. These should be in line with the CQC inspection framework.

p. promote equality of opportunity and enable and support Service Users to be active members of their community and maintain relationships.

q. update Your Care and Support Plans regularly to provide detailed information about the person's progress, goals, wishes and aspirations and are made available on request to relevant professionals.

4. DESCRIPTION OF THE NEEDS OF SERVICE USERS

4.1 Service Users who require a care home Service may have a range of social care or health related support needs such as (but not limited to):

- a physical disability and/or restricted mobility;
- frailty related to age;
- dementia;
- long term health conditions;
- end of life;
- a sensory impairment;
- learning disabilities;
- mental health needs;
- acquired brain injury;
- progressive neurological condition, such as motor neurone disease;
- substance misuse issues; and/or
- the presentation of behaviours that can challenge

4.2 Service Users accessing care home Services will need support with a range of daily living activities and will have identified support needs that will require support over and above what can be managed in a community setting such as (but not limited to):

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- personal care
- mobility, high risk of falls and/or orientation
- equipment and adaptations to assist with daily living
- assistance or prompting with eating
- managing continence in a dignified manner
- managing distress
- medication administration
- risk from others e.g. abuse, exploitation, domestic violence etc.
- risk of neglect e.g. health, self care, hoarding, own environment etc.
- risk of physical complications e.g. medical, sensory, methods of substance misuse, nutrition
- memory and cognitive impairment e.g. forgetfulness, medical condition.

5. ENGAGEMENT AND COLLABORATION

5.1 The Service Provider is encouraged to engage in relevant forums and working groups as part of its ongoing relationship with the Service Purchaser and the care sector.

5.2 The Service Provider must take responsibility for staying informed on sector developments, regulatory changes, and Service Purchaser directives shared in these forums or via direct communication from the Service Purchaser. Service Providers must regularly review updates and information disseminated through these channels and ensure their operations comply with the latest requirements.

5.3 The Service Provider is responsible for updating contact information to stay informed of such activities.

6. HOSPITAL DISCHARGE

6.1 The purpose of the Service is to support with Hospital Discharge transfers to the community, in accordance with the Hospital Discharge guidance as described by Department of Health and Social Care (DHSC). The Hospital Discharge guidance is subject to change; however this is the current guidance.

6.2 Service delivery standards apply as Section D: Service Specification, clause **3** but with an additional focus:

(1) **Pathway 2:** for Pathway 2 discharges, the Service Provider will work in promoting the Service User's rehab and recovery goals, with the expectation that they will return home.

(2) **Pathway 3:** The Service Provider will support a Service User in a 24-hour bedded setting enabling the Service Purchaser to complete a Care Act assessment for the person as soon as is practicable with the aim of completion of 28 days. Occasionally, it may take longer for a Care Act assessment to take place. The price agreed at placement remains until the Care Act assessment has taken place. Subsequently supporting the Service User as defined in the Service User's Your Care and Support Plan. The goal for every Pathway 3 discharge is:

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a. for the Service Provider to assist with any rehabilitation and recovery from illness and assist the Service User to achieve a level of independence and

b. to allow the Service Purchaser to complete the Care Act assessment and Your Care and Support Plan

6.3 The fee rates for Hospital Discharge are currently set by NHS Devon ICB.

6.4 In the event of a readmission to hospital the placement will end 2 days after the admission date. The Service User may return to the home with a new Hospital Discharge agreement setting out their needs and outcomes. A Service User who has been admitted to hospital will not automatically return to the same care home.

PATHWAYS INTO SERVICE

7. ELIGIBILITY CRITERIA

7.1 This Service is for Service Users 18 years of age and over who have been assessed with critical and substantial needs and are eligible for social care as defined under the Care Act 2014 or eligible for support on health grounds e.g. Continuing Health Care (CHC) or section 117 aftercare to receive a commissioned residential or nursing service funded by the NHS.

7.2 Once eligible needs are identified, the Service Purchaser will take steps to meet those needs in a way that supports the Service Users aspirations and the outcomes that they want to achieve.

8. REFERRAL PATHWAY

8.1 All referrals to Service Providers are manged via the Service Purchaser's CDP team regardless of the type of placement or time period required.

8.2 The Service Provider is required to respond to referrals and admissions 7 days a week .

8.3 The CDP team will identify vacancies by using the Capacity Tracker therefore, Service Providers are encouraged to update the tracker whenever bed availbility changes.

9. COMMUNITY PATHWAYS

9.1 This includes all referrals from the community It does not include Hospital Discharges .

9.2 A Your Care and Support Plan shall be agreed in respect of any Service provided to a Service User under this Agreement. The Service Purchaser is responsible for ensuring that referral information is of sufficient quality and contains a written Your Care and Support Plan detailing the outcomes of the service provided.

9.3 Referrals for a placement in an Older Persons Care Home will also have the Services Descriptor assessment which will support a description of Service User's needs and set the fee rate for placement

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9.4 If the Service Provider considers the Service User unsuitable for the Service, or is of the view that the Service Prvider is unable to meet the Service User's needs, they must inform the Service Purchaser and give reasons why.

10. HOSPITAL DISCHARGE PATHWAYS

10.1 Referrals will usually be made by ward staff via a transfers of care form and will be shared with the Service Purchaser's Care Direct Plus (CDP team) to source placements.The individual contract is the Health Service Agreement until a Care Act assessment takes place. This is currently under review.

11. NHS FUNDED CARE

11.1 National Health Service (NHS) funding for care is considered under the National Framework for NHS Continuing Health Care (CHC) and NHS-Funded Nursing Care (FNC) July 2022 (Revised and any future revision). The purpose of the National Framework is to provide fair and consistent access to NHS funding across England, regardless of location, so that Service User with equal needs should have an equal chance of getting their care funded by the NHS.

11.2 By Law, local authorities cannot directly provide registered nursing care. For Service Users in care homes with nursing, registered nurses should be employed by the care home itself and, in order to fund this nursing care, the NHS will make payment directly to the care home. This payment is called Funded Nursing Care (FNC). Payments will only be made in respect of service users receiving nursing care in a bed that is registered with the CQC as a nursing bed. Care homes will not receive FNC payments for Service Users in residential beds. The Service Provider is responsible for applying for FNC directly with the relevent Service Purchaser with statutory duty.

11.3 Eligibility for CHC is a decision to be taken by NHS Devon ICB based on an Service User's assessed needs. The diagnosis of a particular disease or condition is not in itself a determinant of eligibility for CHC.

11.4 NHS CHC Service Users will need to be assessed and meet the nationally determined NHS CHC criteria, using the NHS CHC Continuing Healthcare Checklist. Ongoing eligibility is subject to regular Review and assessment by NHS Devon ICB's NHS Continuing Health Care Assessment Team. Service Users who meet NHS CHC criteria have a 'primary health need' and typically have care needs that are complex, intense and unpredictable and therefore require high quality care delivered by well trained staff who can provide a flexible and reliable service.

11.5 Upon completion of an assessment, NHS Devon ICB will advise the Service User (or their representative) and the Service Provider whether the Service User is eligible or not eligible to receive FNC or CHC.

11.6 A Review of FNC will take place 3 months after the placement and annually thereafter.

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11.7 Before moving a Service User from a residential bed to a nursing bed, the Service Provider will request an assessment from the Service Purchaser.

11.8 In the case of self-funders who place themselves within the home, the care home should complete a Health Needs Assessment and FNC Consent Form and submit this to NHS Devon ICB.

11.9 Where a Service User is found to be eligible for CHC funding their support needs will be funded by NHS Devon ICB for the period of eligibility.

11.10 If, as a result of the CHC Assessment, the Service User no longer meets the eligibility criteria for CHC funding, the Service User may be referred to the Service Purchaser for a Care Act eligibility assessment for an assessment of the needs of the Service User and plan the most appropriate way to meet those needs ongoing.

12. JOINT FUNDED CARE

12.1 Some Service Users may not be entitled to CHC, however, may have a specific need identified through the Decision Support Tool (DST) that are beyond the powers of a local authority to meet on its own. This could be because the specific needs are not of a nature that a local authority could be expected to meet, or because they are not incidental or ancillary to something which the local authority would be doing to meet needs under sections 18 - 20 of the Care Act 2014.

12.2 Section 117 of the Mental Health Act (MHA) places a duty on health and social care services to provide aftercare to people who have been detailed under the Mental Health Act. Section 117 funding is joint funding.

12.3 Funding bodies will work in partnership to agree their responsibilities with regard to such cases.

13. REFERRAL ACCEPTED BY SUPPLIER ONGOING DELIVERY OF SERVICE

13.1 Once a Service Provider accepts a referral, the Service Provider is required to complete their own assessment and develop a support plan using the information from the Service Purchaser. Service Providers' assessments and plans must be in place prior to the Service commencing.

13.2 The Service Provider must ensure that they regularly update the support plan. Progress towards specific outcomes and any significant change in need must be recorded on the Your Care and Support Plan and evidenced.

14. SERVICE PROVIDER UNABLE TO CONTINUE DELIVERING SERVICE TO SERVICE USER

14.1 The Service Purchaser expects all residential and nursing Service Providers to have sufficient resources and skills to meet the needs of referrals and make all reasonable efforts to maintain service delivery.

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14.2 Where a Service Provider can no longer continue to deliver a Service to a Service User, the Service Providers must ensure that all reasonable efforts have been taken and, where appropriate, the Service Provider has contacted the Service Purchaser prior to any action being taken regarding any proposed notice being served on the Service User to assess whether issues can be resolved jointly.

14.3 Reasonable efforts should include (but are not limited to) the following:

a. managing family and/or Service User expectations.
b. mediation between all relevant parties where Services/support appear to be breaking down.
c. ensuring referrals made to support services
d. communicating at the earliest opportunity with the assigned Care Practitioner any issues that cannot be resolved.

15. REFERRAL TO THE SERVICE PROVIDER FROM A PRIVATELY FUNDED INDIVIDUAL OR REPRESENTATIVE

15.1 If a Service User or their representative directly approaches the Service Provider with a view to purchasing a Service on a privately funded basis, the Service Provider must establish that the individual has adequate funds to purchase their care over a reasonable period of time.

15.2 If the Service Provider is unable to establish the funding arrangements of the Service User, then the Service Provider shall refer the Service User to the Service Purchaser. The Service Purchaser will not accept any financial responsibility for Service User accommodated in the home who have not been referred and assessed as eligible for funded services by the Service Purchaser.

15.3 The Service Purchaser expects any referrals to be made promptly when the Service Provider has reason to suspect financial abuse or that an individual is not able to manage their finances where there is a debt . The Service Purchaser will not accept responsibility and would expect all reasonable steps to have been taken by the Service Provider before referring.

15.4 The Service Provider should ensure that all privately funded Service Users are aware that they may be eligible for financial support in the event that their funds drop below the statutory threshold. To establish eligibility, the Service User or representative will need to contact their local Care Direct Plus (CDP) for a Care Act 2014 assessment and a financial assessment to determine their financial situation. It will remain the responsibility of the Service Provider to invoice in accordance with the terms and conditions of the private arrangement, until the Care Act assessment has been completed and eligibility established.

15.5 The Service Purchaser will assess the individual needs of the Service User to determine where the most appropriate placement will be in the event the Service User is unable to privately fund the placement. The Service Provider cannot be guaranteed the placement and placement cost will be accepted by the Service Purchaser.

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15.6 Service Providers should review the financial situation of privately funded Service Users regularly to ensure that referrals are made to Care Direct Plus (CDP) in a timely manner.

16. REVIEW OF INDIVIDUAL SERVICE USER

16.1 There is a Care Act duty to keep plans under Review generally, and it guides that the plan is Reviewed no later than every 12 months, although a light-touch check, or Review should be considered 6-8 weeks after the care and support has started. However, Care Practitioners have discretion to set the timescale for this according to the circumstance of each individual case.

16.2 After the Initial Period, it will be the responsibility of the Service Purchaser to arrange formal Reviews following commencement of the Service. The frequency of the Reviews will be determined by the Your Care and Support Plan and will be within the Service Purchaser's minimum requirements of 12 months.

16.3 If it is considered that the care needs of the Service User have changed then any Party to the Your Care and Support Plan may reasonably request a Review which will consider what changes, if any, need to be made. If the outcome of the Review is that the Your Care and Support Plan is to be amended, then the amendment will be back dated to the date at which the Review was requested.

17. SERVICE DESCRIPTORS

17.1 The Service Purchaser will determine which Service Descriptor overall level a Service User requires based on their assessment of the Service User's current presenting needs and with reference to the Service Categories described in Appendix Two – Service Descriptors. X .

17.2 Where an Service User's needs exceed those described in the Service Descriptors the placement will be individually brokered. This process will allow Care Direct Plus (CDP) staff to contact care homes to assess if they are able to meet the Service User's need. Where a care home(s) can demonstrate, they can meet the Service User's need, the weekly rate will be individually negotiated.

17.3 The process will require the care home to provide a staff rota and a full breakdown of costs which will be benchmarked against the council's older persons fee rate (accomodation costs and staff costs per hour)

17.4 The Service Provider will be required to evidence that the Service User's needs cannot be met within the normal staffing rota and the increased cost to the Service Provider. Provision of this level of funding will be authorised for a specific period with a planned Review schedule.

18. CARE HOME EQUIPMENT AND TECHNOLOGY

18.1 Care homes are expected to be fit for purpose in relation to and have in place a range of suitable handling, mobility and lifting equipment and adaptations to meet the needs of Service Users as determined in Providing community equipment in care and nursing homes – January 2025 - Provider

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Engagement Network This includes the purchasing and servicing of equipment, with staff trained to ensure safe and compliant use of equipment.

18.2 In exceptional circumstances, where a person may have eligible needs for a non stock or bespoke piece of equipment it will be subject to an assessment by the Service Purchaser and eligibility criteria will be applied as detailed Providing community equipment in care and nursing homes – January 2025 - Provider Engagement Network

18.3 Service Providers should have or will need to develop their own equipment and TECS strategy which should include the points highlighted in section 18.1 In addition its should assist in delievering the least restrictive practices and keep Service Users and staff safe and benefit the workforce in delivering care and support.

18.4 The Service will look to maximise the independence of Service Users accessing the Service and minimise the requirements for one to one support by making effective use of equipment and completing appropriate risk assessments and referrals. The Service Provider is required to employ Technology enabled care and Support (TECS) in line with the Service Users support plan to minimise reliance on one to one support hours.

19. CONTINENCE PRODUCTS

19.1 Where it is identified that a Service User requires an assessment for the provision of continence products this will be undertaken in line with local access criteria. In the case of a care home without nursing through a referral from a community nurse or bladder and bowel services, or in the case of a care home with nursing by the Service Provider completing a referral/assessment form.

20. TERMINATION OF YOUR CARE AND SUPPORT PLAN AND/OR HEALTH AGREEMENT

20.1 Upon the termination of a Your Care and Support Plan and/or Health Agreement, the Service Purchaser agrees to pay the Service Provider in accordance with this Agreement as set out in the table below:

Notice Period required/termination terms for all Community Placements **(NOT Hospital Discharge)**	**Reason for Termination**
a. **7 days'** notice in writing by either Party	▪ During the Initial Period for long term placements ▪ Fixed term contract or on end date of fixed term contract if earlier.

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	▪ During a temporary absence.
b. **28 days'** notice in writing by either Party	▪ After Initial Period with the exception of Section **c** of this table.
c. Contract terminates on the **day the Service User leaves the home**	▪ Where it is agreed by both Parties that the placement is inappropriate because the Service User displays behaviours that challenge that pose a risk to themselves and others. The Service Purchaser will make alternative arrangements taking into account the urgency of the situation. ▪ Where the home's environment causes a risk to the Service User. The Service Purchaser will make alternative arrangements taking into account the urgency of the situation. ▪ Where it is established by the Service Purchaser that the assessed needs of the Service Users are outside the category of registration held by the home.
d. Contract terminates **2 days** after the date of death.	▪ Death of the Service User on a long-term placement
e. Contract terminates on the **date of death**.	▪ Death of the Service User of on a fixed term placement
f. Contract terminates **3 weeks** after start of temporary absence.	▪ Any temporary absence with the exception of hospital admission.
g. Contract terminates **6 weeks** after start of temporary absence.	▪ Hospital Admission.

Notice Period required/termination terms for Hospital Discharge Placements	**Reason for Termination**

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a. **7 days'** notice in writing by either party	▪ The same notice and payment terms will apply until a Care Act assessment has been completed.

21. DEATH OR DISCHARGE OF A SERVICE USER

21.1 The Service Provider will notify the Service Purchaser no later than **48 hours** in writing of the death of any Service User in respect of whom a Your Care and Support Plan has been made, or if any Service User for whom a Your Care and Support Plan has been made, discharges themselves from the home for any reason. The Service Provider shall inform the Care Practitioner in the first instance by telephone and confirmed by email to:

Care Direct Plus Eastern - cdpeasternassessmentreviewteam-mailbox@devon.gov.uk
Care Direct Plus Southern - cdpsouthernassessmentreviewteam-mailbox@devon.gov.uk
Care Direct Plus Northern - cdpnorthernassessmentreviewteam-mailbox@devon.gov.uk

21.2 If a Service User dies during the period of the Your Care and Support Plan, the Your Care and Support Plan shall end **two days** after the date of death. In the case of a Fixed Term Placements the Your Care and Support Plan shall end upon the date of death as will a Hospital Discharge placement.

21.3 The Service Provider shall be responsible for requesting the Service User's next of kin or where appropriate the local district council, to make the necessary arrangements upon the death of a Service User, including funeral arrangements. Recovery of any expenses incurred by the Service Provider shall be the sole responsibility of the Service Provider.

21.4 In the event that a Service User self-discharges from the home this shall be treated as a temporary absence for reasons other than hospitalisation.

21.5 Arrangements for emptying a room will be made between the Service Provider and the Service User or representative. The Service Purchaser will not be responsible for funding the storage of the Service User's belongings.

22. TEMPORARY ABSENCE FROM THE HOME

22.1 If a Service User receiving the Service should become absent from the home because of admission to hospital, or for any other reason, the Service Provider shall inform the Care Practitioner in the first instance by telephone and confirm the details by email to the locality finance assistants within **one working day** of the period of absence commencing.

22.2 On the day the period of absence has reached **three weeks** the Service Provider will again notify the Care Practitioner and the locality finance assistants in the manner described above. The contact email addresses for the locality finance assistants are:

Care Direct Plus Eastern Finance - cdpeasternfinance-mailbox@devon.gov.uk

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Care Direct Plus Southern Finance - cdpsouthernfinance-mailbox@devon.gov.uk
Care Direct Plus Northern Finance - cdpnorthernfinance-mailbox@devon.gov.uk

22.3 The Service Provider shall ensure that the accommodation occupied by the Service User is kept available until the Service User returns or the Your Care and Support Plan is terminated in accordance with Section D: Service Specification clause **6**.

22.4 Where a Service User becomes absent from the home for more than **six weeks** in the case of hospitalisation or **three weeks** in the case of other absences the Your Care and Support Plan shall automatically terminate upon the expiry of such period

22.5 Where the period of absence is known or expected to be in excess of **six weeks**, the Service Purchaser may terminate the Your Care and Support Plan, before the end of the six week period, giving **seven days'** notice in writing.

22.6 Where the Service User becomes absent from the home, except in the case of Fixed Term Contracts which shall terminate in accordance with the Your Care and Support Plan or by giving **seven days'** notice in writing, the Service Purchaser shall pay the Price excluding any one to one support or any other Extras which shall cease immediately, for the first **twenty-one** consecutive days, thereafter the Price shall be adjusted to 80% of the Price for each and every day until the Service User returns or the Your Care and Support Plan is terminated.

22.7 **Hospital Discharge placements** - In the event of a readmission to hospital, the placement will be paid up to **2 days**' after the admission date and the placement will end.

23. SERVICE DEVELOPMENT AND TECHNOLOGY

23.1 During the period of the Agreement the Service Purchaser and the Service Provider shall work together to reshape the Service to meet changes in demand, technology, and demographic trends.

23.2 The Service Purchaser may, at some point in the future, give reasonable notice to the Service Provider that all information required under the terms of this Agreement shall be made available in an electronic form.

24. DEMENTIA CARE

25.1 When meeting the needs of Service Users in a residential setting who have dementia needs, in accordance with the individual needs of the Service Users, the Service Provider shall:

a. follow and implement best practice in creating a supportive care environment that reduces agitation, distress, promotes indpendence and social interaction, promotes safety and enable activities of daily living.

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b. ensure all Service Provider staff are trained in a level of dementia awareness appropriate to their role, including cleaning, catering and other domestic staff consistent with their roles and responsibilities and be able to evidence this training throughout the work that they do.

c. promote understanding of dementia amongst families/carers/other visitors to the home.

d. ensure dementia-related medication reviews are timely and use of medications closely monitored.

e. comply with the National Institute for Health and Care Excellence (NICE) quality standard guidance for the care of those with mental health needs in residential care settings

f. ensure that dementia is considered as part of Support Planning.

g. consider wider community involvement within their care setting in order to improve awareness of dementia and that the setting becomes part of the dementia community.

h. ensure that the Service User with dementia are afforded the same opportunities that Service Users without a diagnosis of dementia are offered within the care setting.

i. be aware and be vigilant for signs of cognitive impairment with those without a formal diagnosis and ensure that the appropriate referral is made to promote early diagnosis and best outcome for the Service User, and;

j. comply with the NICE guidelines on supporting people with dementia and their Carers in Health and Social Care.

25. END OF LIFE CARE

25.1 Service Users should be made as comfortable as possible in the period leading up to their death. Their physical, emotional, and spiritual needs should be met so that they live out their lives in a dignified and peaceful manner of their choosing. Where possible, Service Users should be involved in assessment and planning their end-of-life care.

25.2 The Service Provider should ensure that the support provided minimises pain, discomfort and distress experienced by Service Users at the end of their life.

25.3 Service Providers will ensure that staff are appropriately trained and supported to cope with death, dying and bereavement; and to manage the processes and procedures sensitively to ensure the Service User receives the appropriate care and symptom relief.

25.4 Service Providers should use the latest policies, procedures, and best practice guidance to support them to provide excellent end of life care.

26. SOCIAL INCLUSION AND ACTIVITIES

26.1 The Service Provider should identify ways to alleviate social isolation by promoting a culture of social inclusion and wellbeing.

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26.2 Service Providers should ensure that opportunities for activity are available and that staff are trained to offer spontaneous and planned opportunities for Service Users in care homes, enabling Service Users to participate in activity that is meaningful to them and that promotes their health and wellbeing.

26.3 Meaningful activity can include physical, social and leisure activites that are tailored to a Service Users needs and preferences. Activity may provide emotional, creative, intellectual and spiritual stimulation. It should take place in an environment that is appropriate to the person's needs and preferences which may include outdoor spaces or making adaptations to a Service Users environment.

27. BEST PRACTICE

27.1 Service Providers must be fully conversant with best practice and guidance available in delivering services in care Homes and supporting Service Users needs. Service Providers should be able to demonstrate how the guidance is applied on a continuous basis to inform and reinforce best practice in their service. Below is a **non exhaustive** list of prospective best practice and guidance:

- NICE guidance for Care homes
- The Framework for Enhanced Health in Care homes
- The Fundamental Standards- CQC
- SCIE- Social Care Institute for Excellence – Care Providers
- Person Centred Care for older people
- Supporting people with Dementia
- Dementia Friendly environments
- Skills for Care
- Adult Social Care Outcomes Toolkit
- NICE- Mental Wellbeing of older people in care homes
- CQC Services for Autistic people and people with a learning disability

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28. Summary of Individual contracts

	Devon County Council (DCC)		
	Long term placements The expectation is that an individual will reside in a care home for an extended period, often indefinitely.	**Fixed Term placements** These are often used as a temporary arrangements for a specified period. As an example, but not limited to replacement care or as a trial before a long-term care decision.	**Hospital Discharge placements** These are temporary placements either on Pathway 2 or 3 that require a Care Act assessment before any long-term care decisions.
Individual Contract	Your Care and Support Plan	Your Care and Support Plan	Health Service agreement
Duration	Start date with no end date	There is a defined duration that has a clear start and end date.	Start date with the intention of care act assessment taking place within 28 days. No end date recorded
Unit of service (section2)	A unit of Service is a 24-hour period beginning at 12 midnight on any day and ending at 12 midnight on the next following day, or any part of that period.	The Service Purchaser will pay for both the day of admission and the day of discharge as stated in Section D: Service Specification, Clause 2.1. For Fixed Term contracts including, replacement care and short stays payment will be made for the number of nights the Service User stays in the home.	For Hospital Discharge placements**,** payment will be made for the number of nights the Service User stays in the home. Hospital Discharge placements are anticipated to be up to **28 days** or until the Care Act assessment has been completed
Does the initial period apply (28 days)	Yes - it is the first 28 days of a long-term placement	No	No
Notice Periods to terminate the individual contract (section 20)	Within the initial period 28-day notice period **7 days' notice** is required in writing by either party After the Initial Period **28 days'** notice in writing by either party with the exception of section 20.1 c	The contract automatically ends on the end date of the fixed term contract. Or 7 **Days'** notice can be given by either party if term needs to finish earlier.	7 **Days'** notice can be given by either party
Contract terms for death of a Service User (section 21)	Contract terminates **2 days** after the date of death of the Service User.	Contract terminates on the date of death.	Contract terminates on date of death
Temporary absence from the home (section 22)	Where a Service User becomes absent from the home for more than	Fixed Term Contracts which shall terminate in accordance with the Your Care and Support	In the event of a readmission to hospital, the placement will be paid

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	six weeks in the case of hospitalisation or **three weeks** in the case of other absences the Your Care and Support Plan shall automatically terminate upon the expiry of such period Where the period of absence is known or expected to be in excess of **six weeks**, the Service Purchaser may terminate the Your Care and Support Plan, before the end of the six-week period, giving **seven days'** notice in writing.	Plan or by giving **seven days'** notice in writing, the Service Purchaser shall pay the Price excluding any one-to-one support or	up to **2 days** after the admission date and the placement will end.

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