South Monmouthshire Domiciliary Care and Support – Block Contracts

2025 – 2029

Service Specification

Table of Contents

PART A

1. Introduction

1.1 To respond to the current challenges within the domiciliary care sector in South Monmouthshire we need to manage and deliver domiciliary care in a way that ensures both current and predicted demand for the service can be met.

1.2 We aim to ensure:

- The provision of sustainable high quality domiciliary care to those with an assessed need within Monmouthshire.
  - Increased capacity and resilience within the domiciliary care sector both now and into the future.
  - Improved outcomes for individuals who need or may need care in the future, through targeted reablement and best use of capacity.
- Maximisation of the cost effectiveness of the care.
- Improved and standardised terms and conditions for the independent sector domiciliary care workforce supporting with stability of workforce within providers.

1.3 The aim is to make sure that people who receive care and support and their family carers are supported to live the best lives possible, building on their own strengths and capabilities. This requires organisations to focus their resources on the impact they have, as well as the activities they carry out.

1.4 *The Social Services and Wellbeing (Wales) Act 2014* requires us to focus on people's well-being and put them at the centre of their care and support planning.

2. The Service Model

2.1 For the purpose of the Block Contract for provision of domiciliary care and support in South Monmouthshire, the area has been divided into three geographical lots. Following the procurement process, a single designated Care Provider will deliver all Block Contract domiciliary care and support services in their respective lot area. See Appendix 1.

2.2 Long term care and support including the provision of personal care for older people, people with disabilities and mental health needs and people with dementia.

2.3 The service will operate 365 days a year, 6am – 11pm, dependent on the needs of the people being supported.

2.4 Focusing the service on the quality of the intervention and the benefit it achieves, and not just on time and task.

2.5 Promoting independence and reducing unnecessary dependency on service provision through taking an enabling and strength-based approach.

2.6 Providing support to people which is complementary to their lives and the people in it who support them, building trusting relationships with people and their families.

2.7 Encouraging care providers to use equipment and technology to enhance and promote independence, minimising the need for care and support.

2.8 Encouraging care providers to signpost people to the resources available in our communities.

2.9 Enhancing the workforce experience to improve the quality of care and the reliability of the service to meet demand, including the requirement to pay a real Living Wage for eligible staff and a common minimum travel expense to be paid in line with the current HMRC at a rate (currently set at 45 pence per mile for 24/25).

2.10 **The outcomes we want to achieve for people with this contract are:**

- We want people to have a safe place where they feel at home.
- We want to make it simpler and easier for people to stay independent.
- We want people to be connected to their communities.
- We want people to have a connected system of support.
- We want people to benefit from a well-trained, engaged workforce.

3. Individual outcomes

3.1 Well-being means different things to different people, and people are best placed to determine what matters to them. People who need care and support will want to achieve outcomes that are personal to them and their individual circumstances – these are referred to as personal outcomes. Personal outcomes will be agreed during the assessment process. We will expect the Care Provider to work with the person to support them to achieve the personal outcomes they have agreed in their relevant assessment and support plan.

3.2 We will expect the Care Provider to develop an effective approach to service delivery planning and review that supports people to achieve their personal outcomes.

3.3 We expect the Care Provider to recognise the importance of people's relatives, friends and the wider community that can positively affect and contribute to people's wellbeing outcomes. It is expected therefore that, where appropriate, the Care Provider actively engages relatives/friends to take an active role in the care and daily living of the person receiving the service and considers how community resources can contribute to the person's plan.

3.4 The assumption underlying care or support decisions shall be that people can make their own choices about their own lifestyle (unless restricted by any of the provisions of the Mental Capacity Act 2005 or Mental Health Act 2007 and with due regard to relevant health and safety legislation and All Wales Safeguarding Procedures).

3.5 It is expected that the wishes and preferences of people who lack formal mental capacity to make decisions are respected wherever possible and, again where possible, people with impaired decision-making ability should be supported to make decisions themselves.

3.6 Where a person lacks or may lack mental capacity, the care management team and any appropriate advocate or representative must be involved to ensure the correct process is followed and decisions taken are in the best interests of the person. All decisions taken regarding their daily living including (but not exclusively) financial transactions, living arrangements, support/care etc must be fully and appropriately documented.

PART B: SERVICE IMPLEMENTATION ARRANGEMENTS

4. Assessment of Needs

4.1 Any service to a person must be identified as being required through the established assessment process of the Council.

4.2 Funding will only be available if the assessment establishes that the person is eligible for care and support and that the outcomes agreed between the person and the Care Manager can only be achieved through a directly commissioned Domiciliary Care Provider.

4.3 The Council currently works with 3 types of assessment documentation:

- An Integrated Social Care Assessment undertaken under the Social Services and Wellbeing (Wales) Act 2014.
- A specialist mental health assessment for people that require Care and Treatment in Secondary Mental Health services under the Mental Health (Wales) Measure 2010.
- A Care and Treatment Plan under the Mental Health (Wales) Measure 2010.

5. Care Plans

5.1 People eligible for care services arranged and funded by the Council will have a Care and Support Plan or a Care and Treatment Plan that sets out their assessed needs and personal outcomes. This should be in place before service commences.

5.2 The Care and Support Plan or Care and Treatment Plan will be prepared and completed by the Care Co-ordinator or Care Manager in partnership with the

person/family or advocate and in some cases the Multi-Disciplinary Team (MDT).

5.3 The full Care and Support plan will be made available to the Care Provider prior to the commencement of the service. In the case of a Care and Treatment Plan all relevant aspects of the plan will be made available to the service in the same way.

5.4 Care and Support Plans and Care and Treatment Plans will focus primarily on the outcomes the person wants to achieve. People may have an agreed weekly allocation of hours or specified times and tasks where there is a specific and assessed need. The Council is hoping to move towards weekly rather than time and task allocated hours through the duration of the contract.

5.5 The Care Provider will, from the start of the service agree a Service Delivery Plan with the person and their family/advocate that sets out how the service will support the person to achieve the personal outcome(s) that matter to them.

6. Domiciliary Care Referral Process

6.1 The Council will forward care and support plan or assessment to the allocated Care and Support Provider for the lot area.

6.2 The designated Care Provider for the lot area will contact the person/family/carer to discuss how they will meet their assessed outcomes as documented in the care and support plan and agree a service start date.

6.3 The Care Provider will confirm to the Council when the individual service user's support will commence.

6.4 The Commissioning team and the Care Manager will record start date on relevant records.

6.5 The Care Provider is the contracted provider and is required to deliver the envelope of hours for their awarded lot area and will be required to maintain the capacity to fulfil all commitments for existing packages of care within the lot, in addition to taking all new referrals within the timescales as set out in sections 14 – 19 of this specification and routine referrals within 5 working days.

6.6 Care Providers will be expected to attend any relevant meetings with the Council, care management, reablement and hospital discharge teams as required and relevant in each lot area. Thereby enabling the Care Provider to plan for package start dates to comply with the routine and Hospital Discharge time scales below.

6.7 Care Providers will also be expected to attend meetings with the Council and Aneurin Bevan University Heath Board, which could be daily, when hospitals enter a 'business continuity' position at times of extreme pressure to support

swift hospital discharge for those people who have been assessed as being medically fit for discharge and require home care support.

7. Lots

7.1 The Care Provider is required to accommodate all care packages offered to them within their contracted Lot area within their contractual allocation and within the timescales indicated in this Specification.

7.2 In exceptional circumstances where a new care package cannot be accommodated by the Care Provider, and the hours allocated are within the scope of the Lot hours, the Council reserves the right to claw back these hours from the allocation of monies. The Council also in this circumstance reserves the right to allocate the package of care to another provider. However, the Council would expect this to be a temporary arrangement, considered only in exceptional circumstances and only required where the Care Provider has exhausted all measures, including sub-contracting, to meet their contractual obligation. The Council will expect the Care Provider to rectify the position as a matter of urgency to accommodate the package of care. Whilst this situation may occur from time to time, the Council would not expect this to occur on a regular basis as this would undermine the continuity of care required by service users. Any contractual non-compliance relating to allocations will be evaluated during the contract monitoring process.

7.3 Where a Care Provider is required to sub-contract to deliver its contractual obligation in the delivery of the LOT hours, this must be notified to the authorised officer immediately, and will only be permitted for a short authorised period of time the Care Provider will be expected to remedy this situation as a matter of urgency and bring the sub-contracted hours back within the contracted Care Provider's contractual arrangements as a matter of priority.

7.4 Monthly hours delivered via a subcontractor on the Care Providers behalf will be required to be detailed on the monthly invoice stating who the subcontractor is and how many hours delivered.

8. Termination

8.1 Should this Contract be terminated (in accordance with the clauses 45 within the T&Cs) for any reason then the Council shall offer the care hours effected by the Termination to the appropriate remaining providers who are subject to this arrangement. The Council shall take into consideration the need to ensure quality, continuity, accessibility, affordability, availability, and comprehensiveness of the services when re-awarding these care packages.

9. Service Delivery Monitoring and Payment Validation Process

9.1 The Lot hours will be notified indicatively at tender stage (see Appendix 1) and confirmed at award. For the first year the level of the hours will be reviewed and revised as needed quarterly, and biannually thereafter based on the actuals reported via the Care Provider's electronic call monitoring (ECM) system.

9.2 As per Clause 81 in the Terms and Conditions of Contract, 80% of the LOT hours will be paid 4 weekly in advance see Appendix 2 for the Payment Schedule.

9.3 Any hours delivered between 80 and 100% of the contract value (subject to the maximum 20%) will be payable once all the actual data has been submitted by the Care Provider, and the Council has undertaken a reconciliation process. Following this the Care Provider would then submit an invoice for payment up to the remaining 20%. The payment of this invoice will then be made within the standard 30 days. See Appendix 2 for more information.

9.4 The Care Provider must have a fully operational ECM system on commencement of the contract. There is no requirement by the Council as to the type of system used. The ECM system must be able to provide downloadable and shareable information which will be sent to the Council, within 5 working days of the end of each of 4 weekly payment period. See Appendix 2 for the Payment Schedule. This information must include a breakdown of actual hours delivered per person, details of any planned or unplanned absences per person and totals of actual hours delivered. The Council will use its own management information systems to ratify and reconcile this data, within 10 working days of receipt of the provider information. Once the Council has completed its validation process it will request an invoice from the Care Provider for the validated difference in contract hours between the 80% advanced payment and the 100% maximum contract value. Following, receipt of invoice payment will be made in line with Clause 36 of Terms and Conditions of Contract.

9.5 In the long term, the Council may wish to explore the possibility of a shared system for ECM, when this occurs its introduction will be done in conjunction with Care Provider/s.

9.6 The lot hours will be reviewed and revised at the end of each quarter (Year 1) and biannually (Year 2) to ensure the commissioned lot hours are commensurate with demand. However, either party may request a review more frequently should the hours vary significantly from the agreed lot hours.

9.7 Where actual hours delivered are consistently (2 weeks or more) less than 75% of the contract award hours, the Care Provider must immediately notify the Council.

9.8 Where a person using the service is temporarily absent from their home and or/ not requiring care, the provider is required to maintain their care hours within the allocated contract hours for a period of 14 days. Where the absence from home or non-requirement of care exceeds 14 days the provider must inform the commissioner so a decision can be made as to whether that person's package of care is held open or closed and the hours reallocated to another person.

9.9 Any adjustment to the lot hours (and % guarantee), either up or down, will be undertaken through the review of hours being delivered, outcomes being met and in full discussion with the Care Provider.

10. Care Provider Service Delivery Plan

10.1 On receipt of the Care and Support Plan or Care and Treatment Plan (Care Plan), it is the responsibility of the Care Provider to work with the person to develop a Service Delivery Plan that will detail the care and support arrangements required to meet the agreed outcomes identified in the Care Plan, including the pattern of service delivery, taking into consideration the person's wishes, feelings, values, and beliefs.

10.2 If the person is assessed as not having mental capacity to determine aspects of their care and support needs, particular care must be taken to ensure their wishes, feelings, values, and beliefs are accounted for in a balanced approach to their best interests.

10.3 The Service Delivery Plan will confirm to the Care Manager, the person themself/ family representative, care staff and others the type and intensity of the actions agreed with the person to achieve the outcomes that matter to them. The Service Delivery Plan will include a detailed Risk Assessment in relation to risks and outline the actions staff are to implement to mitigate the identified risks.

10.4 There may be incidences where the individual may temporarily require more or less hours than stipulated within the service delivery plan, to support them to achieve their outcomes (i.e. needing less care during a family visit or more care during a time of ill health). Where care is delivered flexibly over a period within their envelope of hours, this must be clearly recorded in the individual's care notes and evidenced in call monitoring information. Hours will not be able to be rolled over between 4 weekly periods and can only be flexed within the 4 weekly payment period.

10.5 The Service Delivery Plan must be agreed and signed by the person where appropriate. If the person is assessed as not having mental capacity in relation to their care and support needs, the plan should be agreed via a Best Interest Decision Meeting.

10.6 The Care Provider will ensure that the agreed Service Delivery Plan is available to inform care staff of their duties and responsibilities in relation to the care and support required. The Service Delivery Plan will need to be accessible, concise and in an easily readable format.

10.7 The Care Provider must ensure that the Service Delivery Plan is reviewed regularly (in line with regulations) and updated to reflect the person's change in need. Evidence of the review must be available upon request. Any significant change in need should be communicated to the Care Management Team for appropriate response.

10.8 The Service Delivery Plan must include as a minimum the following information:

- Person's profile including:
  - Emergency contact information, including formal and informal networks and legal representatives if appropriate.
  - Specific outcome/s to be achieved and what's important to the person from the service being delivered.
  - Details of how care will be delivered.
  - Actions needed and appropriateness of these actions.
  - Lifestyle choices, including cultural beliefs.
  - Health conditions.
  - Identified medication support.
  - Relevant risk assessments.
  - Contingency plans.
  - Progress of review, including personal outcomes, whether these have been met, next steps and consideration given to sharing information with Care Management Team.
  - Evidence of the service user being involved in the review process, or a family member or other representative

10.9 It is expected that a Service Delivery Plan will be in place on commencement of the service.

10.10 It is recognised that to achieve personal outcomes, people may wish to make choices, which might give rise to risks to their own or others' health and safety. It will be the expectation that risk assessments are in place in accordance with the Care Providers' own policy and procedures, in relation to minimising the risk to individuals and staff.

10.11 Any subsequent significant risks that are identified or arise due to a person's wishes or for any other reason, which are not already identified in the Care and Treatment or Care and Support Plan must be identified by the Care Provider and brought to the attention of the Care Management Team.

10.12 The Care Provider has the duty to act in the best interests of the people they care for as well as to their staff.

11. Care and Support Plan or Care and Treatment Plan (Care Plan) Review

11.1 All Care Plans will identify a planned review date; however, the Council reserves the right to undertake an unplanned review at any time.

11.2 It is a statutory requirement for people who have a Care and Support Plan or Care and Treatment Plan to be reviewed on an annual basis and those who are

subject to joint S117 funding will be reviewed within 3 months of commencement of the service and then on an annual basis.

11.3 The Care Management Team or Health Team will, in conjunction with partners arrange the Care and Support Plan or Care and Treatment Plan review and will involve all relevant contributors to the Care and Support Plan or Care and Treatment Plan.

11.4 The purpose of the Care and Support Plan or Care and Treatment Plan review is to:

- Consider progress and success against the agreed outcomes.
- Identify any barriers to that progress and success.
- Consider any changes required to the agreed outcomes and identify any risks.

11.5 It is an expectation that the Care Provider will participate in the review of the Care and Support Plan or Care and Treatment Plan to provide information on the individual's Service Delivery Plan and progress towards achieving the agreed outcomes. A copy of the Service Delivery Plan should be made available to the care manager/care co-ordinator to inform the review process.

11.6 Following the Care and Support Plan or Care and Treatment Plan review any changes required will be discussed and agreed and the Care and Support Plan/Care and Treatment Plan amended as necessary. The Care Provider will update and amend the Service Delivery Plan as appropriate following.

12. Service Delivery Plan Reviews by the Care Provider

12.1 Service Delivery Plan reviews will be planned by the Care Provider according to the Regulatory requirements, taking into consideration the complexity of the person's assessed needs and in proportion to the risk. However, it is anticipated that as a minimum there would be an initial service review following the first 4-6 weeks of the service starting and thereafter at, at least 3 monthly intervals depending on the complexity of the case

12.2 The Care Provider will develop a method for reviewing individual Service Delivery Plans in a format that is satisfactory to the Council.

12.3 The Care Provider will evidence how it has worked to achieve the outcomes agreed by the person and whether those outcomes have been achieved. This will also be essential part of the Care and Support review process.

12.4 Where the evidence shows that an outcome has not been met, the Care Provider should provide information within the review about why it has not been met. Changes to the Service Delivery Plan can be facilitated with the consent of the person but the Care Management Team would need to be informed of those changes and the rationale.

12.5 Where the evidence shows that the person's outcomes have changed or become unrealistic, this should be reported to the Care Management Team or Health Team, as stated in Care and Support Plan or Care and Treatment Plan for consideration for an unplanned review/reassessment.

12.6 Where a change in the person's circumstances has occurred the Care Provider should contact the Care Management Team or Health Team for an unplanned review/reassessment.

13. Unplanned Review

13.1 The Care Provider must advise the Care Management Team or Health Team when there is a change in the person's circumstances which is likely to affect the achievement of the agreed outcomes (e.g., deterioration in health etc.) as soon as possible.

13.2 This may necessitate an unplanned review or a reassessment if the care needs of the person or their personal outcomes have significantly changed or cannot be met/achieved.

13.3 The Care Management Team or Health team will determine, based on the information provided, the action required which may include:

- An early Care and Support Plan or Care and Treatment Plan review.
- An adjustment to the Care and Support Plan or Care and Treatment Plan.
- A re-assessment of needs.
- A case conference/professional's meeting.

13.4 The Care Provider shall contact the Care Management Team as soon as possible or within 1 working day by contacting the appropriate team for any of the following:

- A Person refuses to accept the service.
- If the care staff are unable to gain access to the property.
- The personal outcomes cannot be met.
- Formal or informal complaints are received from or about a Person.
- There is an allegation of Abuse or neglect of the person and reported as part of the duties set out under Adult Safeguarding procedures.
- There are significant changes to the person's physical or mental health.
- There are significant changes to the person's support network.
- The person suffers a notifiable injury or disease as defined in the "Reporting of Injuries, Diseases and Dangerous Occurrences" Regulations 1995 (RIDDOR).
- The person is admitted to/discharged from hospital.
- There is a disclosure or allegation of abuse about an employee of the Care Provider, or others associated with the person.
- There is a disclosure or allegation of challenging behaviour towards employees or others by the person.
- There is a serious accident involving the person.
- In the event of the death of the person.
- There are any unusual unplanned absences of the person.
- There are changes in the behaviour of the person that increase the risk of harm to the person or to others.
- There are changes in the person's financial circumstances (where they are known).
- There are general concerns for the person's wellbeing.

14. Hospital discharge (Pathway 0)

14.1 Where there have been no changes to the individual's care and support needs during a hospital visit / admission, which has been of 14 days or less. The hospital or community social worker will contact the Care Provider to resume the package of care on the same day to expedite the hospital discharge.

14.2 The provider is required to confirm to the commissioner they can commence the service as specified within 2 business hours (8am – 6pm) of receiving the referral.

15. Hospital discharge (Pathway 1)

15.1 People who are clinically optimised for discharge home with a simple or increased package of care will be referred to the Care Provider by the Care Management Team.

15.2 The Care Provider should accommodate the service request within 48 hours of receipt compiling a suitable risk assessment and service plan to expedite the hospital discharge.

15.3 The provider is required to confirm to the commissioner they can commence the service as specified within 2 business hours (8am – 6pm) of receiving the referral.

16 Hospital discharge (Pathway 3)

16.1 People who are clinically optimised for discharge home but have more complex needs will have a Care and Support Plan or a Care and Treatment Plan that sets out their assessed needs and the co-produced personal outcomes they want to achieve. The Care Provider should accommodate the service request within 48 hours of receipt compiling a suitable risk assessment and interim service plan to expedite the hospital discharge.

16.2 The provider is required to confirm to the commissioner they can commence the service as specified within 2 business hours (8am – 6pm) of receiving the referral.

17 Urgent community response

17.1 People who present with urgent needs for new or increased care and support in the community will be referred to the Care Provider via the Care Management Teams. The Care Provider should accommodate the service request within 48 hours of receipt, compiling a suitable risk assessment and interim service plan.

17.2 A full assessment and care plan should be started by care management within 3 working days and shared with Care Provider along with the completed Care plan within 10 working days.

17.3 The provider is required to confirm to the commissioner they can commence the service as specified within 2 business hours (8am – 6pm) of receiving the referral.

18 Transfer from the Council's Reablement service or Routine Packages of Care

18.1 People who have completed their reablement programme and are considered to need ongoing care and support to maintain their personal outcomes will be referred to Care Providers via Care Management Teams. Care Providers should accommodate the service request within 5 days of receipt of receiving a Care and Support Plan or a Care and Treatment Plan.

18.2 Routine packages of care should be accommodated within 5 days of receipt of receiving a Care and Support Plan or a Care and Treatment Plan.

18.3 The provider is required to confirm to the commissioner they can commence the service as specified within 1 working day of receiving the referral.

19 Manual handling

19.1 Manual handling requirements, where appropriate, will be made available to Care Providers as part of the referral information. If this is unclear the Care Provider should contact the appropriate referral source for clarification prior to accepting the care package.

19.2 Where a manual handling plan is provided by an occupational therapist, Care Providers are required to adhere to it.

19.3 To facilitate this Care workers will be required to have training in the All-Wales Manual Handling Passport or suitable equivalent

19.4 If there are moving and handling challenges that cannot be resolved by the Care Provider, these should be referred directly to the duty workers within the integrated teams.

20 Medication

20.1 The Council will only commission the administration of medication where this forms part of a wider package of care. Calls for the sole purpose of the administration or prompting of medication will not be commissioned by the Council.

20.2 Where medication is required as part of a wider package, we expect this to be delivered under the providers own medication policy arrangements. The Council expects Care and Support Provider medication policies to meet the best

practice 'National Guiding Principles for Medicines Support in the Domiciliary Care Sector 2019' with particular emphasis on ensuring staff are trained

21 Behaviours that challenge

21.1 Occasionally the Care Provider and their staff may be challenged by a person or their family and friends whose behaviour may be intimidating, uncooperative or unreasonably persistent due to the frequency and/or nature of the contact.

21.2 It is recognised that this situation can have an adverse effect on the wellbeing of care workers and can create resource implications for the Care Provider in responding to the associated activity.

21.3 The Care Provider should have in place information for staff and service users with regards to reasonable expectations of mutual courtesy and respect and for managing complaints which should be used by the Care Provider to resolve any initial difficulties.

21.4 However, where the Care Provider has exhausted its own internal processes and is at risk of breakdown of communication with the person, an unplanned review with the care manager or care co-ordinator should be requested to develop a plan, in partnership, to resolve the situation.

21.5 The Care Provider will not be permitted to terminate or hand back the care package and will be expected to achieve a solution in collaboration with the care manager or care co-ordinator.

PART C

OUTCOMES, PERFORMANCE INDICATORS AND REQUIREMENTS

22. General Requirements and Performance Measures

22.1 We expect the Care Provider will put in place governance arrangements to support the smooth operation of the service and to ensure that there is a sound base for providing high quality care and support for people using the service and to enable them to achieve their personal outcomes. This includes the following:

- Setting clear organisational intent and direction by outlining in the statement of purpose the services provided and the actions the Care Provider will undertake to ensure these services are delivered to the required standards.
- Putting in place the underpinning policies and procedures to support managers and staff to achieve the aims of the service and support people to achieve their personal outcomes.
- Establishing sound management structures to oversee and monitor the service in order to ensure that it operates safely and effectively for the people receiving care and support.
- Establishing clear arrangements for an ongoing cycle of quality assurance and review to provide assurance that the service operates in line with legal requirements and its statement of purpose and is supporting people appropriately. Information obtained through monitoring is used for continued development and improvement of the service.
- Establishing any additional processes required to ensure the effective delivery of this contract in line with service specification and contractual terms, particularly ensuring processes are in place to immediately inform the Council of any significant reduction in the hours of care delivered.
- Maintaining oversight of financial arrangements and investment in the business to ensure financial sustainability protecting people from the risk of unplanned removal or change in the service provided due to financial pressures.
- Promoting a culture of openness, honesty, and candour at all levels.

The Outcomes

We want people to have a safe place where they feel at home:

- Where they feel safe and protected.
- Where they can stay as physically and mentally well for as long as possible.

- Where they have the right care and support at the right time to help them achieve their personal well-being outcomes.
- Where people are confident that when things go wrong the service will make sure they respond quickly, thoroughly and prevent it happening again.

22.2 We will know this is being achieved if:

- Waiting times for routine Packages of Care (POC) do not exceed 5 working days.
- Waiting times for hospital discharges start dates do not exceed 48hrs.
- Waiting times for urgent POC do not exceed 48hrs.
- Domiciliary care support has resulted in the avoidance of hospital admissions or minimised time spent in hospital.
- Safeguarding referrals are proportionate to the number of hours commissioned.
- The quality of the service is reported as high by the regulators, contract monitoring staff, care managers, and the service users and families themselves.

22.3 Performance Measures

Measure	**Target**	**Collected by**	**Method of monitoring**
Service user feedback	Year 1 – 75% Year 2 – 85% Year 3 – 95% of questionnaire responses indicate that their individual Outcomes are being met	Provider Quality Assurance	Routine Monitoring Visits as set out in the monitoring schedule in Appendix 3.
CIW Inspection report notes good practice with no Priority Action Notices.	100%	Monitoring officer	CIW website Routine Monitoring Visits (Appendix 3).
The Care Provider has systems and policies in place to learn from both complaints and compliments to improve the quality service delivery.	Quality Assurance system in place at commencement of the contract	Provider Quality Assurance systems	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).

No. of times the Care Provider is subject to provider performance processes per quarter and length of time.	0	MCC Commissioning Team and Safeguarding Team	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3) and Process Notifications.
Packages of care commence in line with the timescales within the specification.	100%	MCC Commissioning Team	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3) and regular meetings.

22.4 The Required Service Arrangements

- The Care Provider will ensure that it complies with all aspects of the Social Care (Wales) Act 2016 (RISCA Regulations) in relation to safeguarding at all times.
- The Care Provider is responsible for ensuring that people using the service are safe, secure, and free from discrimination and harassment, and that they are treated with dignity and respect.
- The Care Provider will actively work with the Council to protect vulnerable adults and will have in place its own adult safeguarding policies and procedures. All safeguarding concerns must be reported to the Council's Safeguarding Team.
- Staff must be aware of safeguarding policies, procedures and guidance and should receive training and ongoing management and supervision in this area. They should understand their duty to report all concerns to the Council's safeguarding team within 24 hours.
- The Care Provider and its employees must be fully aware of the need to protect and safeguard vulnerable children and young people who may be present at the person's property. The Care Provider must comply with all requirements of legislation, procedure and guidance concerning child protection.
- The Care Provider must have a whistle blowing policy, available to all staff, which encourages reporting of possible abuse and provides safeguards for those who raise concerns through this policy.
- The Care Provider will have policies in place that ensures all staff will be issued with identification and that promotes its use.
- The Care Provider must have in place robust Health and Safety policies and procedures as required by law and maintain effective risk assessments undertaken by a competent individual for all people in their care.
- The Care Provider must maintain accurate and comprehensive records of incidents and accidents.
- The Care Provider must ensure through training and information that care staff are supported to manage risk and are vigilant about risk whilst

supporting choice and control for the people they look after. Where the Care Provider is concerned that a person's behaviour is adversely affecting their health, safety, comfort, and quality of life the Care Provider following any medical intervention, must bring the matter to the attention of the Community Mental Health team/ Care Management Team immediately, and may:

- Discuss the matter with the individual taking into consideration their level of mental capacity.
- Discreetly, sensitively and confidentiality gauge the response of those affected by the behaviour.
- Discuss the matter with family or carers if appropriate
- Involve other specialist professionals and notify the Community Mental Health Team/ Care Management Team as soon as possible so that a comprehensive multi-disciplinary risk assessment and actions can be put in place.

- The Care Provider will have policies in place to ensure the safe administration of medication that are in line with the National Guiding Principles for Medicines Support in the Domiciliary Care Sector.
- The Care Provider must make sure care staff receive specific, competency-based training regarding the safe administration of medication which is regularly reviewed and updated.
- The Care Provider will ensure that prescription only medicines are administered in accordance with a valid prescription. Any administration errors are recorded, and Safeguarding and Care Inspectorate Wales notified where relevant, advice should be sought from GP or pharmacist if required.
- The Care Provider will ensure that the person's refusal or omission of any prescribed medicine is documented, and any concerns reported to the GP, pharmacy, Care Manager as appropriate.
- The Care Provider will make every attempt to encourage people to take their medication by usual means.
- The Care Provider will ensure that where there may be a risk of harm to a person, medication is withheld when instructed by the GP or pharmacy.
- The Care Provider will make arrangements for the safe storage and ordering of medication in line with the principles of the 'National Guiding Principles for Medicines Support in the Domiciliary Care Sector 2019", and in accordance with their own medication administration policies if applicable.
- Staff are required to maintain the confidentiality of personal information about the person and their families.

23. We want to make it simpler and easier for people to stay independent:

- Where people live as independently as possible with services that enhance their existing strengths and resources.
- Where people can exert control and choice over decisions that affect their care and support.
- Where people are confident that their care and support is reliable and consistent even if their condition fluctuates.

23.1 We will know this is being achieved if:

- The service delivery plan complements the support people receive from others, supporting people to do things for themselves where possible.
- People to be signposted to use technology to reduce reliance on others.
- Care Providers recognise the value of maintaining or reducing people's reliance on services where it's possible or safe to do so.
- People's care plans have reduced.
- People report that their well-being outcomes are being achieved.
- People know how to access advocacy to have their views heard if needed.

23.2 Performance Measures

Measure	Target	Collected by	Method of monitoring
No. of care plan reviews attended by the Care Provider	100%	Care management	Attendance records for care plan reviews.
No. of care plans where people's independence outcomes have been met	100%	Care management and MCC Quality Assurance Team	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3) and Care management to review through reviews.
No. of People signposted to access assistive technology in a way that is aligned to their desired outcomes and promotes independence.	100%	Care management and MCC Quality Assurance Team	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).

23.3 The Required Service Arrangements

- The Care Provider will develop the person's Service Delivery Plan with them, and their representative as required by Part 5 of the RISCA Regulations. The Care Provider assessment considers their personal wishes, aspirations and care and support needs.
- The Care Provider will ensure that people are provided with the quality of care and support they need to achieve the best possible wellbeing outcomes.
- The Care Provider must be able to demonstrate an effective system of matching the skills and competencies of care staff with the physical, communication and emotional needs of the people they care for.

- The Care Provider must have an effective system for sharing with care staff the information they need to know to meet the needs and preferences of people, for all activities and routines of daily living.
- The Care Provider will ensure that all care is delivered in line with people's outcomes, and in line with preferences. Reporting and escalating any concerns re: self-neglect.

24. We want to connect people to their communities

24.1 We will know this is being achieved:

- Where people have a sense of purpose and meaning in their lives
- Where opportunities to connect with the community are actively explored and signposted to achieve people's wellbeing outcomes.
- Where people are active members of their local community, should they wish to do so.
- Where people can access their care and support in Welsh, as well as English according to their preference.

24.2 Performance Measures

Measure	Target	Collected by	Method of monitoring
No. of People reporting that they have been able to independently access activities in their local community as per the identified outcomes in their care and support plan	100%	Care management and MCC Quality Assurance Team	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
No. of staff accessing Welsh language training in compliance with Welsh Language (Wales) Measure 2011, or number of Welsh speaking staff.	20% of workforce	Monitoring Officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
No. of people reporting they can access a service in Welsh (if wanted)	100%	Care management Review & Monitoring Officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).

24.3 The Required Service Arrangements

- The Care Provider shall establish within the first 6 months of the operation of the contract and keep established an operating base within the county of Monmouthshire, or within a 5-mile radius of its boundaries.
- The Care Provider will ensure it works in partnership with other Care Providers, third sector, voluntary groups and the wider community to ensure they are able to advise and signpost to a wide range of activities available for people to access should they wish.
- The Care Provider will support people to make their own arrangements to attend activities or other opportunities in their local community, where this might enhance their independence and will effectively meet the outcomes agreed in the care and support.
- The Care Provider should ensure that their services in Welsh are of the same standard and are as easily and promptly available as English medium services and are as wide-ranging and thorough.
- The Care Provider must take all practicable steps to ensure that where appropriate people are able to communicate in several ways and communications are conveyed through their chosen language i.e., Welsh, visual, sign and writing.

25. We want people to have a connected system of support

- Where people are supported by systems that works in partnership to deliver effective outcome focused services that promote independence.
- Where people are confident of the service they receive

25.1 We will know this is being achieved if:

- People always know who is visiting them to provide care and support.
- People always know when to expect their service.
- People have a written Service Delivery Plan and understand their care arrangements.
- The Service Delivery Plan does not replace the existing support and connections the person already has.
- People know how to contact the Care Provider's office for assistance.
- The Care Provider actively contributes to care and support plan reviews.

25.2 Performance Measures

Measure	Target	Collected by	Method of monitoring
No. of people, at the onset of the service, with a service delivery plan that is reflective of their outcomes and how these will be met.	100% of reviewed service delivery plans clearly identify outcomes and how they will be met	Monitoring Officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
No. of people who report that they are notified of who will be supporting them including where this changes.	100%	Annual service provider surveys and Care Management review	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
The Care Provider's systems demonstrate consistency of allocated staff	100%	Care Provider system and Monitoring officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
No. of Care Plans Updated and reviewed in a timely manner	100%	Care Provider systems and Monitoring officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
% of sample of daily notes observed that are completed in a full and accurate way in line with Service Delivery Plan	100%	Care Provider systems and Monitoring officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
No. of People reporting that they feel they are treated with dignity and respect in all aspects of their care and daily living	100%	Care Management Review and provider QA processes,	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).

25.3 The Required Service Arrangements

- The Care Provider will provide an information pack at the commencement of services that is in line with RISCA regulations part 6, Regulation 19. This should include information about the support available to unpaid carers in their local area.

- The Care Provider must provide and promote care that puts people at the centre, involves them, their families and their carers in decisions and helps them make informed choices about their care and support.
- The Care Provider must make sure that care staff work closely with other professionals, making sure their care is of a high standard and delivered in a co-ordinated way.
- The Care Provider will ensure that as far as possible people's nutrition & wellbeing is maximised.
- The Care Provider will ensure effective arrangements are in place to contact service users and inform them of any changes to their service or expected care workers.
- The Care Provider will have an electronic call monitoring system in place, which will be maintained by the Care Provider.
- There is a robust communication policy to ensure that the person and carers are always informed of changes to the support required as agreed with the Care Provider at commencement of the service.
- If a care worker does not arrive at all for the call this is classed as a missed call and must be notified to the branch office immediately and immediate contact made with the service users to check on their welfare explain the reason why, arrange a follow up call, if required, and ensure systems are in place to ensure this does not happen again.
- There are effective processes in place to update the Care Manager of any exceptional circumstances that affect the ability of the person to achieve their agreed Care Plan outcomes within the agreed Service Delivery Plan.
- The people's views about the quality of their care should be gathered in line with RISCA Regulations. this feedback must be used to improve the service provided.
- There are systems in place for systematically monitoring, reviewing, and updating risk assessments when necessary.
- The Care Provider will have in place a process for monitoring the effectiveness of Service Delivery Plans. This should be done in conjunction with the person and according to the agreements made with the relevant care manager.
- Management / Supervisory staff must have systems in place to monitor the support provided to a person on a regular basis to ensure the Service Delivery Plan is working to achieve the outcomes that matter to them as set out in their Care and support Plan.
- The Care Provider must have processes in place to ensure the sufficiency, continuity and consistency of staff providing support to people, and consider maximising continuity of care when planning the work rotas for staff and people.
- Care staff must be provided with and familiarise themselves with the Service Delivery Plan and risk assessment for each person they care for.
- Arrangements will be in place to provide a contact point for both people receiving the service and staff to ensure a prompt response to people's calls 7 days a week to include out of standard office hours provider on call arrangements.

- The manager or a senior member of staff will check, either by telephone or personal visit, whether the person is satisfied with the service within six weeks of the commencement of the service.
- Care workers are required to read care notes and complete an entry at each visit.
- The Care Provider will ensure that all staff are trained to understand and promote the rights and entitlements of people, signposting to other services where applicable.
- The Care Provider must ensure an appropriate interpreter is available for people where required - this should be arranged in consultation with the relevant care manager/care co-ordinator.
- Care Provider must ensure staff consider the race, gender, disability, mobility, age, sexual preference, faith, diet, culture, language, and lifestyles of the people they care for and their chosen method of support.

26. We want people to benefit from a well-trained, engaged workforce

- Where staff work together creatively to offer innovative solutions.
- Where an open and transparent way of working meets professional standards, follows best value principles, and considers the impact on our local environment and climate change.
- Where staff terms and conditions are both attractive to new recruits but also support staff retention so that the continuity and availability of the service is enhanced. This should include consideration to how walking routes could be arranged to attract and retain staff that don't have access to a car.
- Where eligible staff are employed and receive real Living Wage and travel expenses in line with HMRC (currently 45p per mile 2024/25) to ensure equity across the sector and reduce sectoral movement.
- Where staff receive adequate induction, ongoing training in all mandatory areas and any additional required areas. Supported by supervision, appraisal and spot checks.
- Where the organisation works positively to learn from any safeguarding, complaints or compliments, inspections, and audits.
- People are treated with dignity and respect and their rights are protected in line with the Equality Act 2010.

26.1 We will know this is being achieved if:

- People receive care from care workers that are well trained and supported to carry out the required care and support tasks in their service delivery plan.
- People have a consistent staff team involved in their care who know and understand the care and support tasks in their service delivery plan.
- People are supported by staff who are engaged in the service they are delivering and have opportunities to support its continuous improvement.
- The recruitment and retention of staff is stable, and the organisation understands how to manage its staff to maintain this.

- The Regulatory requirements for Registration of the workforce are complied with.

26.2 Performance Measures

Measure	Target	Collected by	Method of Monitoring
Recruitment records- % audit of staff files that contain appropriate documentation	100% of sampled files have the relevant recruitment documentation	Provider	Contract Monitoring team review 5 staff files at each annual monitoring visit (more reviewed if required or concerns exist).
Organisation turnover is low.	No specific target: To be considered with reference to overall workforce capacity to meet demand in the lot area	Provider recruitment system & Monitoring Officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
No. of staff in employment is adequate to meet contractual hourly obligations.	To be set with reference to overall workforce capacity to meet demand in the lot area	Care Provider recruitment system & Monitoring Officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
Staff supervisions are held in line with RISCA regulations	100%	Care Provider system & Monitoring Officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3)
No. of 'walkers' employed by the organisation	Expectation is that rota's will support an increase in walkers employed each year in excess of 30% of total staff recruited in the year	Care Provider recruitment system & Monitoring Officer	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).
% of Team Meetings being held at least quarterly	100%	Care Provider systems & monitoring officer	Routine Monitoring Visits as set out in the monitoring schedule.

Staff are trained to undertake their role	100% of care staff are either registered with or working towards their registration with Social Care Wales. 100% of staff have received relevant training to carry out their role to include All Wales Passport or equivalent, health and safety training, Medication training, Safeguarding and all other training relevant to their role. 100% of staff have received timely refreshers.	Care Provider training records	Monitoring Officer quarterly audit of training records
No. of eligible staff paid rLW and HMRC travel expenses	100%	Care Provider employment records	Routine Monitoring Visits as set out in the monitoring schedule (Appendix 3).

26.3 The Required Service Arrangements

- The Care Provider will fully comply with the Code of Practice for Social Care Employers which has been published by Social Care Wales and is in accordance with Section 112 of the Regulation and Inspection of Social Care (Wales) Act 2016 (the Act).
- The Care Provider will ensure that services are delivered in accordance with the Regulation and Inspection of Social Care (Wales) Act 2016 (the Act) and particularly Parts 3 – 20 of the Regulated Services (Care Providers and Responsible Individuals) (Wales) Regulations 2017.
- The Care Provider will adhere to the requirements of RISCA Regulations Part 11, requirements on Care Providers in respect of domiciliary support services and will take specific regard in respect of Regulation 41, Delineation of travel time and care time and Regulation 42 Offering domiciliary care workers on non-guaranteed hours contracts the choice of alternative contractual arrangements.
- The Care Provider will ensure that people are supported by appropriate numbers of staff who have the knowledge, competence, skills, and

qualifications to provide the levels of care and support required to enable the person to achieve their personal outcomes.

- Financial and administrative arrangements and systems are robust and guarantee the sustainability of stable and reliable service provision throughout the course of the contract and is in line with Part 3, Regulation 11 of RISCA Regulations.
- The Care Provider shall provide an induction programme from the first day of employment that will comply with legislation, standards, and guidance in force at the time.
- The Care Provider shall aim to enable trainee care workers to be registered with Social Care Wales within six (6) months of commencing employment with the Care Provider.
- The Care Provider will have a published equality and diversity policy and structures in place to manage and implement the equalities and diversity policy.
- The Care Provider will have management arrangements in place to ensure that there is a rigorous recruitment and selection procedure that meets the requirements of legislation, equal opportunities and anti- discriminatory practice.
- The Care Provider will have a training plan for staff and managers to support equality and diversity for the workforce and for developing inclusive practice.
- The ethnicity of the workforce is mapped and monitored, with evidence of promotion of diversity.
- The Care Provider will have effective wellbeing support arrangements in place to ensure staff working in the community are able to access support, advice, and information when they need it.
- The Care Provider is responsible for ensuring that working practices support people to maximise their independence and are able maintain voice, choice and control over their care and daily living arrangements. The organisation actively promotes a culture where reducing reliance on services safely is encouraged
- The Care Provider must employ sufficient skilled and experienced staff to prepare Service Delivery Plans to ensure the plans provide assistance, only where and when necessary to further support the strengths and skills already available to the person.
- The Care Provider must provide all care staff with training and information to ensure they understand the importance of avoiding unnecessary dependence on care staff and promoting a culture whereby empowering People and reducing dependence safely is actively encouraged.
- The Care Provider must develop effective links with the Council's reablement team ensuring where individuals are transferred from reablement the positive outcomes are maintained.
- The Care Provider will have in place a policy covering the appropriate safe use of vehicles including insurance requirements.
- The Care Provider must have in place clear processes for recording and reporting changes in service user needs and concerns.
- All staff are instructed that any new convictions incurred following recruitment must be reported.

- There is a process for checking the competencies of all new care workers through planned supervision and observation.
- The Care Provider will ensure that all staff are trained to the All-Wales Passport in relation to moving and handling training.
- The Care Provider has a responsibility to immediately notify the Council in the event of an improvement notice being issued by or the cancellation of registration of the Responsible Individual by CIW or any other regulatory breach.
- The Care Provider will ensure that the Designated Manager demonstrates the ability to take charge and effectively lead staff by example, continually developing themselves and other staff, influencing the way in which care is given.
- The Care Provider will have in place a suite of policies and procedures that will be implemented across the organisation and compliance will be monitored through an effective Quality Assurance mechanism.
- There are policies, procedures, and operational arrangements for all managerial and care staff to receive regular and documented supervision, appraisal, observation in the workplace and managerial support by an appropriately trained and competent individual.
- There is a system for continually assessing and recording the competencies of care workers linked to the annual appraisal. Clear action plans are in place where staff are not able to meet any required competency related to their job.
- The Care Provider has in place processes that ensure that all staff have a 3-month probationary period and systems in place to assess their suitability to undertake the role.
- Management arrangements will need to ensure that all staff are trained and competent by having a training strategy with defined aims and objectives, identified methods of training for each staff group and evidence of which staff in the workforce have participated, management will also be required to monitor the ongoing competence of staff.
- There is a clear policy in place that identifies the organisation's commitment to the Continual Professional Development of its staff.
- Specialist training is available for staff where required.
- Staff work with and actively participate in the work of the Council's Social Care Workforce Development Partnership
- Care Workers receive specific training on the administration of medication which is in line with the principles of 'National Guiding Principles for Medicines Support in the Domiciliary Care Sector 2019".
- The Care Provider is required to deliver dementia training for staff that aligns with Dementia Care Matters and the Good Work framework.
- Managers will undertake regular spot checks on service delivery which must be recorded for monitoring purposes.
- The Care Provider will effectively manage individual workloads.
- The Care Provider will ensure contingency arrangements, and a team approach are utilised to cover the service if the regular care workers are unavailable or unable to visit by implementing a continuity plan of support to secure a stable staff team.
- Staff should realise that people are entitled to complain about the service or make suggestions for its improvement and should feel confident that

these matters will be dealt with positively within the procedures of the organisation.

- The Care Provider will ensure that staff are appropriately trained and supported to cope with death, dying and bereavement; and to manage the process and procedures sensitively.
- The Care Provider must ensure that all staff know that it is not acceptable for there to be a relationship between a staff member and the people they support, either physical or financial, and this should be seen as a disciplinary matter or a criminal offence in the case of those who lack capacity.
- The Care Provider will ensure that staff are provided with the appropriate Personal Protective Equipment 'PPE' to ensure the safety of their staff when undertaking their duties.

PART D

QUALITY ASSURANCE, MONITORING AND REVIEW

27. Monitoring Contract Compliance

27.1 The responsibility for ensuring compliance with the Terms and Conditions, the Service Specification and with the requirements stipulated in the Integrated assessments, Care and Treatment Plans and Service Delivery Plans rests with the Care Provider and the Council.

27.2 The Care Provider shall comply with the monitoring arrangements set out in the contract including, but not limited to, providing such data and information as the Care Provider may be required to produce under the contract.

27.3 The Council may monitor, inspect, and examine the work or Services being carried out by the Care Provider without notice, at any time.

27.4 The Care Provider shall give all such assistance as the Council may reasonably require for such inspection and monitoring.

27.5 The Monitoring Officer shall be entitled to ascertain, by whatever lawful means considered appropriate, whether the Care Provider has performed the services to be provided under this contract in accordance with the contract and the Care Provider shall provide access to all information required by the council relating to the provisions of Service under this contract.

27.6 Without prejudice the Care Provider may be required to rectify any deficiencies in service and bring it up to the required standard in a time specified by the Monitoring Officer in writing.

27.7 The Monitoring Officer and such individuals as may be nominated by the Council will require access to all information required relating to the provision of the Services under this Contract at all times, with or without prior notice, to enable monitoring and evaluation of the service to be carried out and to review the performance of this contract. The Care Provider shall make available all information required by the Council relating to the provision of the Services under this contract.

27.8 The services provided under this Contract will be subject to continuous review and monitoring and the Council may carry out any reviews required of the services being provided.

27.9 The Council reserves the right to arrange additional meetings at its discretion to discuss the performance of the service. These meetings may include but may not be limited to some or all the key criteria in this contract and the supporting information.

27.10 For the avoidance of doubt, the Council may also monitor the service through:

- Feedback from people who use the services
- Inspection of the Service Delivery Plans and other care planning documentation
- CIW inspection reports
- Contract reviews
- Annual Monitoring Questionnaires
- If appropriate, other Council Officer reports
- Care Manager reviews
- The Care Provider's Quality Assurance Procedures
- Provider Performance Procedures

28 Contract Monitoring Report

28.1 Following each monitoring visit a report will be compiled summarising the overall contract and service performance of the Care Provider. The Care Provider will be given an opportunity to respond to the comments and recommendations made within the report prior to the report being finalised.

29 Individual Service Monitoring

29.1 The Care Provider is responsible for the monitoring of the Service Delivery Plan. The Integrated Service Plan and Care Plan or Care and Treatment Plan will be monitored by the Care Manager.

30 Provision of Information and Meetings

30.1 The Care Provider shall submit management information to the Council throughout the term of this contract upon reasonable request to include the provision of information to inform workforce planning on a local, regional, or national basis.

30.2 The Care Provider shall attend monitoring review meetings at the Care Provider premises or other such location to be agreed between the parties.

30.3 The Care Provider shall attend Care Provider meetings at the Council's premises, other such location to be agreed between the parties or virtually via an electronic format such as MS Teams.

30.4 The Council may make changes to the nature of the management information that the Care Provider is required to supply and shall give the Care Provider at least one month's written notice of any changes.

30.5 Representation from the Council will be present at any meetings regarding the performance of this contract and any individual concerns.

APPENDIX 1: SOUTH MONMOUTHSHIRE BLOCK CONTRACT LOTS AND SUPPORT HOURS

Please note that these hours are indicative and the final support hours per lot will be confirmed on award. Furthermore, the support hours per lot may change during the term of the contract and will be monitored, reviewed and where needed, revised in line with Section 9 of the Service Specification.

Lot 1 - Chepstow Town and Rural

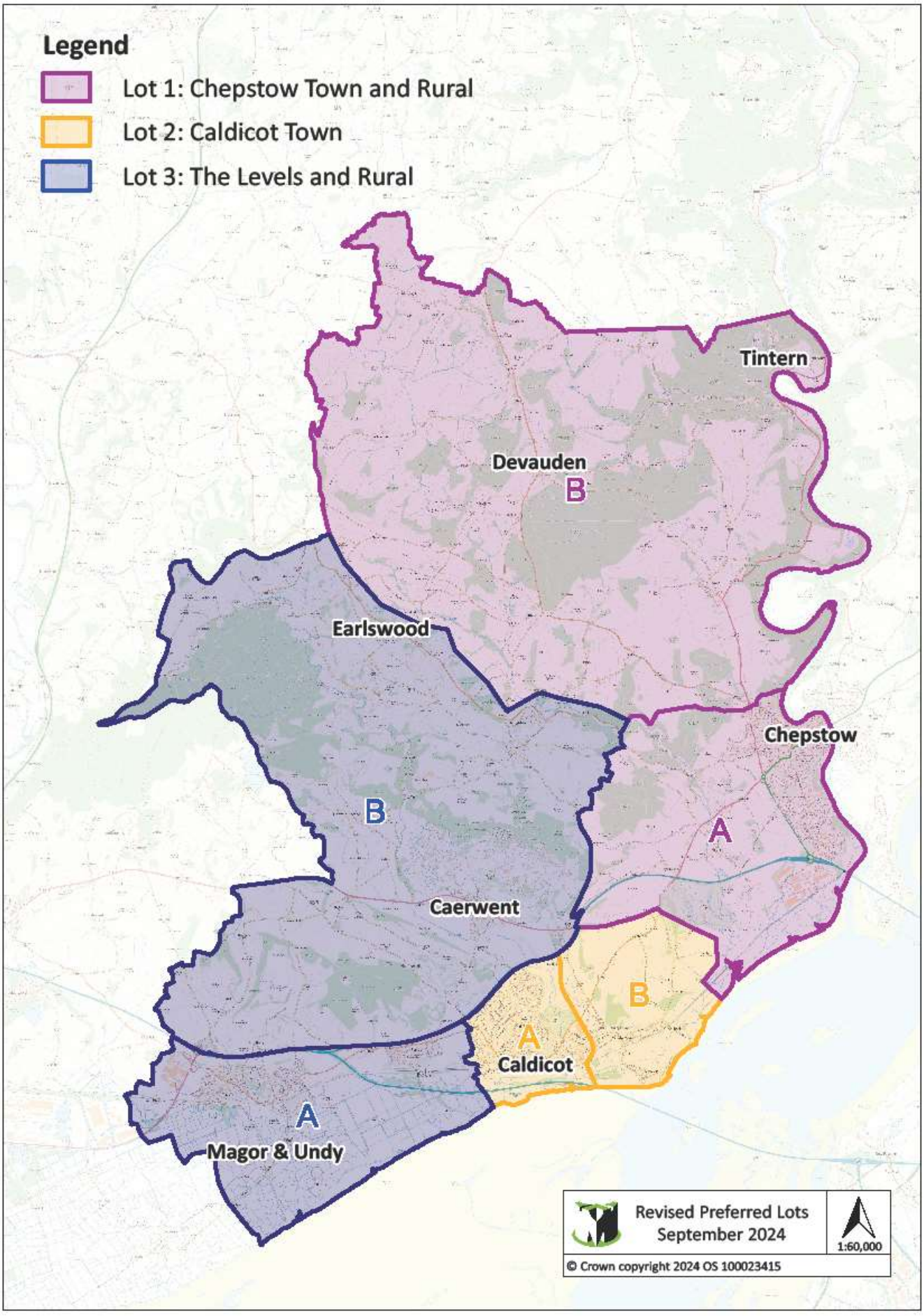
Zone	Total Hours	Total Service Users
A – Chepstow Town, Pwllmeyric & Mathern (& surrounds)	887	52
B – Devauden, New Inn, Tintern & St Arvans (& Surrounds)	82	7
Chepstow Town and Rural Totals:	**969**	**59**

Lot 2 - Caldicot Town

Zone	Total Hours	Total Service Users
A – Caldicot Town	734	56
B – Sudbrook & Portskewett (& surrounds)	53	6
Caldicot Town Totals:	**787**	**62**

Lot 3 - The Levels and Rural

Zone	Total Hours	Total Service Users
A – Magor/Undy/Rogiet (& surrounds)	467	37
B –Caerwent, Shirenewton, Llanvair Discoed, Five Lanes (& surrounds)	164	11
The Levels and Rural Totals:	**631**	**48**


Legend
Lot 1: Chepstow Town and Rural
Lot 2: Caldicot Town
Lot 3: The Levels and Rural
Tintern
Devauden
B
Earlswood
B
Chepstow
A
Caerwent
B
A
Caldicot
A
Magor & Undy
Revised Preferred Lots
September 2024
1:60,000
© Crown copyright 2024 OS 100023415

APPENDIX 2: SOUTH MONMOUTHSHIRE BLOCK CONTRACT PAYMENT SCHEDULE 2025-2026

1. A 4-week advance payment of 80% of contract hours will be paid by the Council to the Care Provider.
2. The advance payment will be made the week prior to the 4 weekly payment period.
3. The Care Provider will submit data to the Council confirming the actual hours of care and support delivered within the 4 weekly payment period, 5 working days after the end of the payment period. (See Service Specification Section 9 for the detail of the data required.)
4. Within 10 working days of receipt of the delivery data submission date, the Council will validate the Care Provider's data and confirm where the hours delivered has exceeded the 80% of contractual hours paid via the advance payment. The Council will notify the Care Provider of the additional hours, above 80% of contract hours and to a maximum of 100% of contract hours.
5. Within 1 week of being advised of the validated hours of delivery above 80%, the Care Provider will submit an invoice to the Council for the additional hours above 80%.
6. The Council will make a top up payment for the additional hours within 30 days of receipt of invoice.
7. The indicative payment and data submission dates for year 1 of the contract are set out in the table below which may change subject to contract commencement date.
8. The Council reserves the right to revise the payment schedule for subsequent years of the contract.

	PERIOD DATES	**4 WEEKLY ADVANCE PAYMENT DATE**	**VALIDATION DATA SUBMISSION DATE**	**MCC VALIDATION PROCESS WITHIN 10 WORKING DAYS**	**PROVIDER TO ISSUE TOP UP INVOICE**	**TOP UP PAYMENT DATE**
1.	31.03.25 – 27.04.25	**-**	**-**	**-**	**-**	**-**
2.	28.04.25 - 25.05.25	21.04.25	30.05.25	By 13.06.25	Within 1 week	Within 30 days
3.	26.05.25 - 22.06.25	19.05.25	27.06.25	By 11.07.25	Within 1 week	Within 30 days
4.	23.06.25 - 20.07.25	16.06.25	25.07.25	By 08.08.25	Within 1 week	Within 30 days
5.	21.07.25 - 17.08.25	14.07.25	22.08.25	By 05.09.25	Within 1 week	Within 30 days
6.	18.08.25 - 14.09.25	11.08.25	19.09.25	By 03.10.25	Within 1 week	Within 30 days

7.	15.09.25 - 12.10.25	08.09.25	17.10.25	By 31.10.25	Within 1 week	Within 30 days
8.	13.10.25 - 09.11.25	06.10.25	14.11.25	By 28.11.25	Within 1 week	Within 30 days
9.	10.11.25 – 07.12.25	03.11.25	12.12.25	By 02.01.26 *	Within 1 week	Within 30 days
10.	08.12.25 – 04.01.26	01.12.25	09.01.26	23.01.26	Within 1 week	Within 30 days
11.	05.01.26 – 01.02.26	30.12.25	06.02.26	20.02.26	Within 1 week	Within 30 days
12	02.02.26 – 01.03.26	26.01.26	06.03.26	20.03.26	Within 1 week	Within 30 days
13.	02.03.26 – 29.03.26	23.02.26	03.04.26	17.04.26	Within 1 week	Within 30 days

*Please note extension of validation period due to Christmas and New Year.

APPENDIX 3: CONTRACT MONITORING SCHEDULE

To be developed and agreed with successful Care Providers at Contract Award.