SCHEDULE 1 – CARE SERVICES IN SUPPORTED HOUSING - SERVICE SPECIFICATION

1.0 Introduction

1.1 This schedule sets out the specification for Care Services in Supported Housing settings which will be an integral part of care pathways for people with learning disabilities, autism, mental health and other complex needs to ensure a continuum of care and support. It describes what the Council requires from the Provider in delivering the Service, and must be considered alongside the Service Contract and ITT document.

1.2 The Service will promote and actively demonstrate a commitment to citizenship, inclusion and an ordinary life by empowering people to participate in their communities and will focus on prevention, recognising the right level of support to reach the desired outcomes.

1.3 The Service will place an emphasis on managing and responding to recognised needs and risks, developing care and support at point of discharge or will prevent or delay admissions to institutional rather than community based care and support.

1.4 The Service will place an emphasis on Progression[1] and asset based approaches where Services users are supported to maintain or to learn new skills, recovery and moving on to independent accommodation or less intensive forms of support wherever possible.

1.5 The Provider will work with the Housing Provider to ensure that the Service Users receive an integrated and co-ordinated service. It should be noted that the provision of housing is not part of the Service required. Housing is provided by a Third Party Housing Provider.

2.0 Scope

Definition

"Supported housing is defined as any scheme where housing, support and sometimes care services are provided with the purpose of enabling the person receiving the support to live as independently as possible in the community" Making it Real for Supported Housing", Think Local Act Personal, Sitra (June2016)

2.1 Within this specification, Supported Housing is a term used to describe a place where someone lives in order to receive care and support. Typically :

- There is an agreement between the Housing Provider and the Provider, or the property is owned by the Provider
- Support is shared within a scheme between 2 or more people and there is a mix of shared and 1:1 support. There will be an established staff presence within the scheme, varying from visiting to 24 hour presence.
- The scheme may consist of a single building or group of linked properties in close proximity
- The person will have moved to Supported Housing in order to receive care and support, i.e. there is a direct link between the accommodation and receipt of care and support
- The housing, care and support would be considered for people with ongoing care and support needs.

2.2 The Service will be provided to people with care and support needs who:

- Meet the national eligibility threshold for care and support as set out in the Care and Support (Eligibility Criteria) Regulations 2014 for the Care Act 2014 or any replacement legislation;
- Have unmet eligible needs and outcomes that could be met through the provision of accommodation and support and
- Are deemed to be ordinarily resident within the administrative area of Lancashire County Council.

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

[1] http://www.alderadvice.co.uk/images/user/171013%209%20Learning%20about%20Progression%20-%20Thought%20Leadership.pdf

2.4 The Service is predominantly aimed at people aged 18 or over but there are no explicit age restrictions, so there must be flexibility to provide this Service to young people with disabilities or Mental Health needs as they transition to adulthood, typically 16+ in accordance with the Care Act 2014 Statutory Guidance on Transition.

2.5 The Service will be commissioned by the Council or any organisation acting on its behalf under the Council's power to delegate its functions.

2.6 The Service shall be available to all eligible Service Users irrespective of gender, religion or belief, ethnicity or race, culture, sexuality, disability, age, class or socio-economic status or other protected characteristics.

The Service shall be delivered within Lancashire County Council boundaries. However, there may be a small number of exceptional occasions when it is requested to provide Services outside of these boundaries.

3.0 Service requirements

3.1 Regulatory and legal

The Provider must be registered to provide personal care with the Care Quality Commission (CQC) with a Good or Outstanding rating to be accepted onto the Approved Provider List and will maintain registration throughout the duration of the Service Contract. Therefore, the regulations required for registration (and their associated standards), and the monitoring of the achievement of those regulations, and standards are not duplicated in this specification. The Provider must comply with all relevant legislation that relates to the operation of their business.
The Service provided under this Service Contract must be provided in accordance with (but not limited to) the requirements of:

- The Care Act 2014
- Care Standards Act 2000 (including any amendments, modifications or re-enactments).
- CQC
- The National Minimum Standards for Domiciliary Care
- The Domiciliary Care Agencies Regulations 2002
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Mental Health Act -1983 and 2007
- Mental Capacity Act 2005 (Deprivation of Liberty Safeguards)
- Equality Act 2010
- Human Rights Act 1998
- Autism Act 2009
- Fulfilling and Rewarding Lives: The strategy for adults with autism in England HM Government March 2010
- Deprivation of Liberty Safeguards
- Counter Terrorism and Security Act 2015
- Services for Service users with Learning Disabilities and Challenging Behaviour or Mental Health Needs (Mansell Report revised 2007) & Raising Your Sights
- Transforming care: A national response to Winterbourne View Hospital December 2012
- The Regulatory Reform (Fire Safety) Order 2005 where applicable to the premises
- Service Users' individual assessed needs and outcomes and any subsequent assessment, Care and Support Plan or review documentation
- Any future legislative changes or changes to national minimum standards that determine the standard of care to be delivered.

3.2 Service User Groups

The primary Service User groups served by this specification are:

- People with learning disabilities (including with a forensic history)
- People with autistic spectrum disorder (including with a forensic history)
- People with mental health needs (including with a forensic history)

- People with physical disabilities
- Sensory impairment
- People with dementia
- Adults with a disability who display behaviours which challenge and may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).

Other client groups which may receive this Service include:

- Young people 16+ with long term care and support needs transitioning to adulthood. The Council may require from time to time for the Service to be delivered to other Service User groups that fall outside of the scope of the primary and other Service User groups detailed above and are to be determined at the sole discretion of the Council.

The Council may also require the Service to be delivered to people with multiple and complex needs. Multiple needs in this context refers to a person presenting with a housing need further complicated by significant support needs, or a combination of support needs such as an alcohol and or drug dependency. Complex needs in this context refers to high level significant complex needs in addition to a learning disability and/or mental health.

3.3 Key Principles, Objectives and Outcomes

The Service Specification is underpinned by the Care Act (2014) Wellbeing Principle and Care and Support (eligibility regulations) 2015 where Service Users are unable to achieve two or more outcomes without assistance. The Principle applies equally to individuals with or without eligible needs and states the importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist. The Care Act Wellbeing Principles underpinning this Service specification include:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- control of the individual over day-to-day life
- participation in work, training, education, or recreation
- social and economic wellbeing
- domestic, family and personal wellbeing
- suitability of living accommodation
- the individual's contribution to society

3.3.1 Objectives

i. To promote independence and improve health and wellbeing, including reducing social isolation.
ii. To provide ongoing care and support which delivers cost savings
iii. Enable each Service User to reduce anxiety, build resilience and increase confidence to live independently
iv. Ensure Support Workers are able to provide the Service in a way that acknowledges and respects Service Users' gender, sexual orientation, age, ability, race, religion, culture lifestyle and communication needs
v. Maximise Service Users' Progression including their self-care abilities, and well being
vi. Give Service Users flexibility to plan their support to achieve their outcomes
vii. Acknowledge that Service Users have the right to take risks in their lives and to enjoy a lifestyle of their choosing
viii. Provide protection to Service Users who need it, including a safe and caring environment
ix. Prevent or delay the requirement for more intensive care and support services
x. Support and interventions should always be provided in the least restrictive manner.

The Service models must be consistent with the five key principles of the Mental Capacity Act 2005 and the associated code of practice.

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

3.3.2 Service Outcomes

In order that the Key Principles can be met, the Provider will deliver the outcomes specified in each sub-heading:

3.3.2.1 Service Development

The Provider will be required to produce an Annual Service Development Plan which will assure the Council the planned service/s are delivered in a way/s which will support the implementation of the Council's Housing with Care and Support Strategy 2018 – 2025, Our Vision for the Care, Support and Wellbeing of Adults in Lancashire and Support Strategy, namely:

1. To develop innovative Housing with Care and Support options so more people have choice about where they live and receive care and support, are supported to live independently and have a better quality of life;
2. To reduce the number of shared houses and increase the number of Apartment Schemes for younger adults with disabilities;
3. To improve the Housing with Care and Support options for people with complex needs and conditions;
4. To provide ongoing care and support which delivers cost savings to the health and care system;
5. To promote the delivery of better integrated health, social care and housing by joining-up services to improve people's outcomes;
6. To provide a home suitable to meet ongoing needs and a viable and genuine alternative to residential care settings;
7. To provide a wider community resource and facilities to connect and benefit local residents;
8. To locate schemes where they will be in demand and people will be able to access local amenities and feel connected to their community.

In order to promote Service Development, the Provider will produce annual proposals which the Council will review and approve (the proposals will be subject to the Council's policy in managing Provider quality and performance) which will typically include (but not be limited to) any of the following:

i. Reconfiguring support in some 1, 2 and 3 bed properties or otherwise high cost schemes;
ii. The Service will not arrange for Service Users to move between tenancies without notifying the Council in advance
iii. If a service user is not able to understand the tenancy or needs assistance, a best interest meeting must be held to consider the issues affecting the person.
iv. Assistance with moving on to other more suitable accommodation where the need for support changes or no longer exists;
v. Planning with Service Users and families to move from residential services into supported housing where appropriate;
vi. Support nominations and referrals to apartment schemes or other suitable accommodation types;
vii. Establish effective collaboration between Providers;
viii. The appropriate reduction, removal or reconfiguration of night time support;
ix. Introduce assistive technology to reduce reliance on paid support;
x. Any other appropriate reduction in care and support volumes utilising the 'Provider led Review' agenda;
xi. Managing vacancies by reducing unnecessary under-occupancy;
xii. The Service will not create more vacancies without a business case demonstrating an overall plan unless this is planned in conjunction with the Council;
xiii. Reducing the number of support voids and or housing benefit voids in shared houses;
xiv. Plan to meet needs in individualised ways that do not create over reliance on one to one support;
xv. Identifying and delivering more cost effective ways of meeting the daytime support needs of individuals;
xvi. Developing in conjunction with the Council criteria for the use of one to one support;

xvii. Clear mechanisms to monitor the Providers progress from current average weekly cost at commencement of the service contract to a year on year cost improvement.

Noting that:

The Provider must not arrange for Service Users to move between tenancies without notifying the Council in advance

If a Service User is not able to understand the tenancy or needs assistance, a best interest meeting must be held to consider the issues affecting the person.

The Service shall not take any action that will create additional vacancies or support voids without the prior approval of the Council obtained either through the agreement of the Annual Service Development Plan or other approved business case.

Please refer to **Annex 2** for further information

3.4 Service Models

Core support

- Shared support to two or more individuals which may include the provision of personal care.
- Overnight shared support to two or more individuals which may include the provision of personal care.

See **Appendix 1** for more detailed breakdown of requirements and roles

3.4.1 Core Support Day

The Provider shall:

i. Provide a suitable, in terms of physical access, and safe, in terms of minimising risks presented by the Service User and or by others sharing, environment that meets the needs of each Service User.
ii. Continue to provide recovery focussed support Service where the Service User feels safe, respected and is treated with dignity.
iii. Ensure the Service to be delivered within shared supported accommodation is able to meet the assessed social, personal, and healthcare needs of an individual and such needs being detailed within an agreed Care and Support Plan for each Individual Service User.
iv. Support Service Users to maintain their tenancy/licence to occupy agreement.
v. Support tenants to access finances and benefit entitlement
vi. Provide support in instances when additional support is required to the staff member providing individualised support e.g. when 2:1 support is required on a planned/unplanned situation

3.4.2.Core Support Night

The Provider shall:

i. Ensure the night support Service to be delivered in shared supported accommodation is able to meet the assessed night support needs of an individual as set out in their Care and Support Plan.
ii. Deliver support which might include waking night support, sleep in support (Sleep-in shifts are typically delivered between 10pm and 7 am, however, this does vary depending upon the needs of the people receiving the service) or on call systems, or a combination of these models (including personal care). Support may be delivered flexibly in supported housing or across a number of properties, available peripatetically. The Provider may be required to work in partnership with other agencies, including those providing assistive technology solutions.
iii. Ensure the use of assistive technology is maximised to promote independence.

iv. Deliver agreed changes to night support that require a smooth transition into day time support. The Provider will be required to facilitate effective partnership working with Service Users, carers and other agencies as required to manage this change.
v. Ensure the Service to be delivered within shared supported accommodation is able to meet the assessed night support needs of an individual.

3.4.3. Neighbourhood Support

The Provider shall:

i. Ensure the Service will establish community support networks with shared support to two or more individuals which may include the provision of personal care is agreed as a proportionate approach to meeting the identified need/s.
ii. Provide shared support to Service Users in defined locations as part of an agreed plan with two or more individuals as a proportionate response to the identified needs of each Service User as set out in their Care and Support Plan.
iii. Support Service Users to maintain their tenancy/licence to occupy agreement.

3.4.4. Individualised Support

The Provider shall:

i. Deliver outcome focused care based on the Council's Care and Support Plan reporting on Progression regarding identified outcomes
ii. Support to individuals which may include the provision of personal care.
iii. Meet all identified outcomes within the Service User's individualised Care and Support Plan.
iv. To build on Service Users' strengths and potential with a focus on independence, and reflecting the Service User's agreed individualised Care and Support plan
v. Develop and agree approaches to manage and mitigate risk including positive risk taking
vi. Ensure the Service will promote recovery and the wellbeing of the Service User which encompasses improving activities of daily living
vii. Enable the Service User to exercise personal choice and control over their life. in a way which promotes the Service User's health; independence; self-reliance
viii. Support the Service User to live as healthy and independently as possible irrespective of their condition/circumstance.
ix. Ensure that the nutritional and hydration needs and preferences of the Service User are met
x. Assist and enable the Service User to access other services as required including access employment, education or other vocational activities.
xi. Cooperate with discharge planning for patients with the NHS, CCGs and other NHS agents.
xii. Where appropriate, enable the Service User to die with dignity in a manner that supports their wishes along with their cultural and spiritual beliefs.

3.5 Types of care and support tasks

The Service required for each Service User will be set out as part of their agreed outcomes and person-centred Care and Support Plans. Personal care and support is defined by the CQC as meaning physical assistance given to a person. Therefore, the following list of types of care and support tasks required is not intended to be exhaustive or needed in all cases, and should not preclude creative solutions which may better suit an individual where it is part of their agreed Care and Support Plan. Such requirements that the Provider must provide must include:

3.5.1 Care tasks

3.5.1.1 Direct assistance with, or regular encouragement, to perform tasks of daily living
3.5.1.2 Providing advice and support on self-care

3.5.1.3 Regular encouragement to dress, undress and supporting choice of what clothes to wear for the day
3.5.1.4 Assistance when and where required:

a. to get up or go to bed;
b. assistance with transfers from or to bed/chair/toilet;
c. washing and bathing using equipment if necessary, shaving and hair care, denture and mouth care, hand and fingernail care, foot care (excluding any aspect which requires a registered chiropodist or podiatrist);
d. support with using the toilet, including necessary cleaning and safe disposal of waste/continence pads (including in relation to the process of menstruation);
e. empty or change catheter or stoma bags and associated monitoring and; assistance with skin care such as moisturising very dry skin.

3.5.2. Promote the independence of Service Users through an enabling approach:

3.5.2.1 The Provider must use a strengths approach by identifying the current skills and capabilities of Service Users as a basis for supporting Service User led outcomes and priorities to gain/regain skills and confidence to achieve greater independence e.g. shopping, cooking including use of assistive technology.
3.5.2.2 Enabling the Service User to develop strategies and coping skills to respond to known issues.
3.5.2.3 Work with Service Users, families and other services so that they understand the approach to monitoring Progression and contribute to informing annual reviews.
3.5.2.4 Support Service Users to carry out caring responsibilities they have for a child where this is an eligible need.

3.5.3. Other support that promotes wellbeing and self-care of the person

3.5.3.1 Assistance with prosthetics, orthotics or equipment which aids daily living
3.5.3.2 Food or drink preparation - ensuring that staff have an understanding of nutrition and hydration, and are able to support Service Users to plan, shop, prepare and cook nutritious food
3.5.3.3 Assistance with eating and drinking (including the administration of parenteral nutrition), including any associated kitchen cleaning and hygiene.
3.5.3.4 Ensuring that any assistive technology such as telecare is active i.e. a regular basic check to ensure the telecare base unit and/or phone line has not been disconnected.
3.5.3.5 Taking account of the Mental Capacity Act and any safeguarding concerns Service Users will be supported to enjoy their relationships, by establishing a culture in which Service Users will be able to express their sexuality and therefore be able to develop and maintain intimate relationships if they so wish.
3.5.3.6 Act lawfully when supporting or refusing to support a relationship. The Council will be informed if there are any concerns regarding this decision by taking account of the needs and risk to the Service Users and others. (The local authority would need to consider if a court of protection application is required, namely if there is an objection raised in relation to this decision).

3.5.4 Support Service Users to stay safe and take a positive approach to risk, rights and responsibilities:

3.5.4.1 Ensure any risks to the Service User or others are appropriately and effectively managed (e.g. self-harm, harm from others, intimidation) through regular review and updating of risk assessment. Including reporting of possible safeguarding adults, safeguarding children, domestic abuse or hate crime concerns
3.5.4.2 Support Service Users to identify and report mate/hate crime and to develop approaches to minimise the impact
3.5.4.2 Ensuring Support Workers read the risk assessments relevant to the Service User
3.5.4.3 Support Service Users to maintain the tenancy and comply with the tenancy agreement
3.5.4.4 Supporting tenants to develop skills to access finances and benefit entitlement and agree approaches to manage their personal finance in line with Service agreed policies and CQC guidance
3.5.4.6 Enable Service Users to exercise their voting rights
3.5.4.7 Ensuring Support Workers recognise when key control measures are obviously missing or not working (e.g. hand rail broken, smoke alarm removed).

3.5.5. Support Service Users to engage with family/friends, their interests and community services

Supporting, encouraging and facilitating access to community resources and facilities to socialise, work etc as stipulated in the Care and Support Plan, ensuring that support is available to Service Users for events at night beyond 9pm as and when required.

3.5.5.1. Support Service Users to sustain significant relationships[2], including personal relationships and fulfilling their role within their families, e.g. attending celebrations/significant events.
3.5.5.2. Support Service Users to develop confidence in their own ability to engage with hobbies/interests and to access and contribute their wider community e.g. paid employment, volunteering, training
3.5.5.4. Support Service Users to communicate and engage positively with others in a way which is appropriate to their personal preference lifestyle and needs

3.5.6. Cleaning and domestic support around the home

Where it is stipulated in the Care and Support Plan that cleaning and domestic support is required around the supported accommodation the Provider will provide this or support the Service User to do so or make arrangements for Service Users to employ a cleaner. This may include vacuuming, sweeping, washing up, polishing, cleaning floors and windows, bathrooms, kitchens, toilets and general tidying, using appropriate domestic equipment. The Provider will, unless alternative arrangements are in place, also:

a. Make beds and change linen;
b. Dispose of household and personal rubbish;
c. Assist with laundry;
d. Clear areas of any potential slip or trip hazards;
e. Identify and mitigate as far as possible any hazards or risks around the household
f. And other household tasks the Service User requires in order to maintain their home.

3.5.7. Support Service Users to improve their health, mental health and wellbeing

The Provider will be required to encourage Service Users have an active part in in managing their health and wellbeing by using self-care programmes for long term health conditions or Health Action Plans to sustain their health. The Provider will also need to be able to recognise specific health and mental health needs, including those associated with dual diagnosis, and develop approaches to respond to these.

3.5.7.1. Health

a. Support to Service Users to access their GP, dentists, opticians, chiropodists and wider healthcare services, sexual health advice and services, screening programmes for early diagnosis and treatment of mental health needs, such as dementia etc.
b. The Provider will ensure Service Users access all screening and Annual Health Check appointments, as applicable, and identify all barriers that make access to health services difficult, including the availability of staff/family who know the person well, specific phobias e.g. needles, waiting rooms etc.
c. The Provider will set out the actions that need to be taken to overcome these barriers and record details in the Service User's Care and Support Plan.
d. Support to Service Users to comply with medication regimes, including supporting self-administration and use of over the counter medications in accordance with agreed Provider protocols developed to adhere to CQC guidance[3].
e. To work with specialist NHS teams where appropriate to deliver planned interventions, including recording information, adjusting practice and home routines to support positive outcomes for individuals.
f. Participate in community learning disability team local physical intervention quality check and agreed actions.

[2] https://www.cqc.org.uk/news/stories/new-guidance-addresses-relationships-sexuality-among-people-using-adult-social-care
[3] https://www.nice.org.uk/guidance/ng67 https://www.cqc.org.uk/guidance-providers/adult-social-care/treating-minor-ailments-promoting-self-care-adult-social-care

g. Ensure Support Workers know where to report their concerns should Service User circumstances change in a way that may require a risk assessment review and note this in the care records kept in the Service User's home.
h. Implement the recommendations from dysphasia assessments to support Service Users to maintain their communications skills and ability to swallow.
i. Providing support to manage the health care of the Service User under the direction of a health professional, where this has been specifically agreed and the Support Worker has received the appropriate training and has been deemed competent by the trainer or supervisor.
j. Support with the safe disposal of clinical waste.

3.5.7.2 Mental Health

a. A flexible, person centred, empathetic, non-confrontational and non-judgemental approach, which is important for maintaining an appropriate intervention programme.
b. Supportive relationships with clinical or social work professionals to develop a shared understanding with the Service User.
c. An understanding of the chronology of the disorders, but maintaining a holistic focus in addressing the substance misuse, psychological, social and physical health problems.
d. Support Service Users to make informed decisions about the management of their care and treatment, using appropriate information including risks and benefits.
e. Ensure Service Users with learning disabilities/autism who develop mental health needs are supported to access generic mental health services with access to specialist support if needed.
f. Work with Service Users and their care coordinator/social worker to develop and respond to relapse prevention plans and make reasonable adjustments as part of the Equality Duty and in relation to delivering health care via Health Action Plans, communication passports and assistive technology.
g. Support to Service Users with learning disabilities/autism who develop mental health problems to access generic mental health services with access to specialist support if needed.
h. Where appropriate, use the Recovery Star as a framework (or other appropriate alternative) to supporting positive change around Service User led outcomes and priorities.
i. Support to Service Users to alleviate their loneliness and risk of isolation.
j. The Provider must work with other agencies to prevent inappropriate admissions to hospital at the point of crisis.

3.5.7.2.1. **Substance and addiction**

i. An abstinence and recovery approach to substance misuse in the first instance which is an approach that supports people in reducing the negative consequences associated with substance use.
ii. The Provider will support innovative individualised solutions for Service Users. Optimism and building motivation to deal with addiction problems and other associated difficulties.
iii. Advice and information about the impact of substance misuse and support access to specialist services where indicated.

3.5.8. Positive Behavioural Supports

3.5.9.1. The Provider must, where appropriate, use a positive behavioural support framework[4] and standards for developing an understanding of a Service User's challenging behaviour[5] where applicable use this understanding to develop effective support. It must include:

a. Identified lead trainer in PBS/functional assessment or similar
b. Personalisation of both assessment and support arrangements
c. Systematic assessment of the antecedent, behaviour and consequence of challenging behaviour

[4] http://restraintreductionnetwork.org/wp-content/uploads/2016/11/BILD_RRN_training_standards_2019.pdf
[5] https://www.nice.org.uk/guidance/ng93

d. Service User's behaviour, to develop an understanding of its function i.e. how it helps the Service User to cope better or exert some control over their immediate environment. This process is often referred to as functional assessment or functional analysis
e. Attention to the broader context to ensure that other factors influencing the Service User's behaviour are properly understood
f. Development of both proactive and reactive support arrangements
g. How to prevent the Service User's challenging behaviour as much as possible, through the provision of a more helpful and less challenging environment
h. Support for the Service User that enables the greatest possible reduction in the occurrence of challenging behaviour in the context of the best possible quality of life
i. Avoidance of support arrangements that punish the Service User in any way or create unnecessary restrictions on their freedom of movement and choice.

3.5.8.2. The Provider is required to ensure that were deemed appropriate by a multi-disciplinary team or best interest meeting, there is an up to date written, individualised behaviour support plan that includes:

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

3.5.8.3. The Provider must make reasonable adjustments in the approaches used to support Service Users and develop the most effective ways of understanding and communicating individuals' experience, help others to understand them and find ways of responding.

3.5.9.Transforming Care

This section only applies to providers identified to provide these services.

3.5.9.1. The Provider when selected to deliver Care and Support services for individuals who appear on the CCG held Dynamic Risk Register including supporting hospital discharges. The criteria for inclusion on the register are:

a. People with a learning disability and/or autism and who display behaviours that can be described as challenging (for example, who present an active and high risk to others/members of the public or themselves).
b. This could include where this behaviour has led to contact with the criminal justice system, or where there is risk of this (i.e. relating to behaviours which could be construed as an offence or are viewed as pre-cursors to more serious offending behaviours).

3.5.9.2 The provider will develop care and support plans which will be highly individualised tailored to their particular needs, strengths, interests and in some cases the risks they pose to themselves and others (all of which might change over time).

3.5.9.3 The provider will be required to work closely with the transforming care commissioner at an operational and at a strategic level to develop and provide services to these individuals.

3.5.10 Double-handed care

Where a Service User's care and support needs require two Support Workers, for example because the Service User lacks the ability to weight bear, it will be set out in their Care and Support Plan and the Provider will be required to accommodate this in ways which are proportionate to meet the Service Users need.

The Provider must not operate blanket policies, or have insurance cover, that disregard individual situations and require as mandatory practice the use of double-handed care in moving and handling Service Users.

The Provider must minimise the provision of double-handed care through the use of specialist moving and handling equipment (e.g. ceiling track hoists, bed positioning systems) and techniques provided by the Council or the NHS, where it is considered safe as part of a suitable and sufficient individual risk assessment undertaken by a competent person, and the Support Worker has received the necessary training and is deemed competent to safely carry out the moving and handling alone, or with a willing and able informal carer.

3.6 Supported Housing based requirements

3.6.1. Service Users supported by this service have accepted that some of their support will be shared and will be delivered by the Provider based at the property or group of properties sharing support and have agreed to contribute towards the cost of this core support.

3.6.2 Support workers will be in the building at times for core day/night support as specified by the Council, the Provider will complete risk assessments to manage times when Service Users may be unsupported or have some of their needs catered for via assistive technology.

3.6.3. The Provider will provide a support service to Service Users to manage their tenancy including:

a. Providing support to assist in the resolution of disputes with other Service Users and/or neighbours on an informal basis.
b. Providing support to Service Users to enable them to live in the accommodation in accordance with the terms of the tenancy agreement.(Ensure weekly rent is paid, follow requirements set out for safe use of communal areas and safe use of personal space)

3.6.4. Where the Provider is operating in premises where Service Users are tenants, Providers will:

a. Ensure that there are arrangements in place; for example a Management Agreement which clearly establishes roles and responsibilities between the Provider and Housing Provider.
b. The Provider will ensure that there are appropriate protocols and procedures in relation to the following:
    i. Supporting Service Users to sign up to, maintain their Tenancy /licence Agreements using advocacy services where needed;
    ii. If a service user is not able to understand the tenancy or needs assistance, a best interest meeting must be held to consider the issues affecting the person.
    iii. If required the Provider will assist the Council in the making of an application to the Court of Protection for an order authorising the tenancy;
    iv. Completing and submitting Housing Benefit documentation (or its replacement) and resolving any issues e.g. backdated claims in relation to Benefits;
    v. Reporting of repairs;
    vi. On site Housing Management functions and activities;
    vii. Ending tenancies/licences and facilitating move on where the service is no longer needed
    viii. Any other activity as agreed with the Housing Providers that would form part of the Management Agreement;
    ix. Clarify roles and responsibilities to ensure there is not a conflict of interest in instances where the Provider has agreed to lease properties from a freeholder and then manage service user's finances to claim housing benefit.

3.6.5 The Provider will notify the housing provider of any changes in support plans or risk assessments that may require action on the part of the Housing Provider, for the implementation of building based control measures.

3.6.6. The Provider will ensure they have liaised with the Housing Provider to obtain information regarding their operating arrangements for dealing with emergency housing repairs or other emergencies, which may also require out of hours assistance.

3.6.7 The Provider will review the housing needs of Service Users and notify the Council and Housing Provider where current housing is no longer suitable in meet the needs of one of more Service User.

3.7 Service availability and flexibility

3.7.1. The Provider must be available to meet the full requirements of the specification up to 24hrs per day, 7 days a week, 365 days a year (366 days during leap years). The Provider will not operate on a reduced basis over periods of public holidays or festivities.

3.7.2. The Service must be provided in a flexible manner to ensure the Service User's identified needs and outcomes are met. The level and frequency of Service provided to an individual will be set out by the Council unless the Council agrees the Provider will manage a personal budget on behalf of the Service User or the Service User themselves is directing their own care and support.

3.7.3 The Provider must:

i. As far as is reasonably and safely possible, be proactive in accepting all referrals and nominations made by the Council through effective management of referrals, workforce capacity and staff rostering/coordination.
ii. Report to the Care Navigation Service on a weekly basis to confirm the availability and capacity of the Service including any unexpected vacancy or change in individual circumstances.
iii. Provide a response within 7 days to Supported Housing package requests to the Care Navigation Service via the Oracle Sourcing system.
iv. The Service will not arrange for Service Users to move between tenancies without notifying the Council in advance
v. Ensure that there is the necessary workforce capacity to accept and commence care and support over weekends/Bank Holidays if required.
vi. Encourage reductions in care and support needs where safe to do so.
vii. Minimise the number of different Support Workers delivering care and support to the Service User to promote consistency and continuity.
viii. Ensure that there is a match between Service Users' care and support needs and the skill sets, knowledge and competency of Support Workers.
ix. Undertake Service User risk assessments prior to commencement of the Service and produce a plan to manage these.
x. Ensure the Service is delivered in accordance with the Service User's Care and Support Plan and personalised outcomes.
xi. The Service will not create more vacancies without a business case demonstrating an overall plan unless this is planned in conjunction with the Council.

3.8 Keeping Service Users informed and in control

3.8.1. The Provider must supply Service Users with reliable and timely information via an information pack when the Service commences and update the information pack as required to ensure the Service User is kept informed and involved in their support. The information pack should be in plain English, be available in formats that suit Service Users with different communication or capacity needs, and include the following:

a. Statement of purpose.
b. Contact details for the Service including out of hours and emergency contacts.
c. Service provision details Core, Individualised and Neighbourhood supports.
d. The contingency arrangements in the event of Service interruption.
e. Safeguarding information.
f. How to access the Provider's most recent CQC inspection reports.
g. Complaints procedure.

3.8.2. The Provider must keep Service Users informed in advance and involved in decisions about any planned long term changes to their Service and, as far as possible, unavoidable short term changes to their Service, including changes to the Service User's regular Support Worker and/or changes to the Care and Support Plan.

3.8.3. Once the core support has been established the Provider should give Service Users choice regarding the specific Support Worker who provides the Service and, where possible, the opportunity to meet new Support

Workers.

3.9 Recording

3.9.1. With the Service User's knowledge, the Provider must ensure that Support Workers note progress in relation to delivery of the Care and Support Plan including details of any significant occurrence. Records should include (where appropriate):

a. Assistance with medication, including time and dosage on a medication chart.
b. Other requests for assistance with medication and action taken.
c. Details of any change in the Service User's circumstances, health, physical condition or care and support needs.
d. Details of any change in the Service User's circumstances that prompt the need for a risk assessment review.
e. Any accident, however minor, involving the Service User and/or Support Worker.
f. Any other untoward or serious incidents (e.g. emergencies or safeguarding issues).

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

3.10 Out of hours service

The Provider must ensure that at all times outside of normal office opening hours (9am to 5pm) there is a dedicated responsible person(s) with sufficient knowledge and training to be a point of contact to respond to enquiries and emergencies from Service Users, Support Workers and the Council to provide advice, information or direction to keep Service Users safe from avoidable harm. The Provider will ensure the out of hours contact service has telephone and email capabilities as a minimum. The out of hours contact details must be clearly communicated to those who may need to use them.

3.11 Care and support planning

The Provider may, without reference to the Council, mutually agree with the Service User minor changes to their direct care and support provision and minor revisions to the direct care and support elements of the Service User's Care and Support Plan. The changes made still need to meet the needs identified in the Care and Support Plan. In agreeing any such changes the Provider is required to:

a. Ensure that such changes are in keeping with the objectives of the Care and Support Plan and continue to meet the Service User's assessed needs and identified outcomes in a safe way.
b. Ensure that all support changes are within the personal budget, reduce or manage risk and are legal.
c. Consult the Council if the Service User wishes to use funds within their personal budget for an outcome that has not been identified within the Care and Support Plan.
d. Inform the Council if a Service User's support needs reduce or if the Service User's needs increase and cannot be met within the existing care package and Care and Support Plan.
e. Update the Service User's Care and Support Plan so that it remains current and reflects the actual support that is being provided by the Provider.
f. Consult with the Service User's carer/representative/advocate where they would have substantial difficulty in agreeing such changes, including those who lack mental capacity.
g. Develop an initial Care and Support Plan within 2 weeks with all risk assessment and other key safety information competed within a 1 week, of a Service User moving into shared supported housing or an apartment to include the Service User and contain clear goals and identify how the outcomes will be achieved within a specified timeframe, where appropriate. This will be reviewed after 6 weeks and adjusted to reflect the presenting need.
h. Ensure that the Care and Support Plan is provided in a way that reflects the Service User's level of engagement, strengths, abilities and interests and enables them to meet their needs.

3.12 Contingency

3.12.1.The Council and the Provider will consider the Service User's care & support history to take account of potential needs, fluctuation of needs (frequency & degree to determine a flexible, responsive care & support plan, with associated any requirement and agreement for contingency strategies and plans).

3.12.2.This will take into account what fluctuations might be reasonably expected, based on experience of others with a similar condition, or life circumstances to mitigate the impact of the fluctuation, preventing or delaying, as far as possible, the development or escalation of further needs in the future.

3.12.3.The Council agrees the outcomes the Provider is required to support for each Service User. The Provider has the flexibility to arrange Care and Support services when they are needed in line with the agreed Care and Support Plan this may result in an agreement between the Provider and Service User to reduce and increase levels of support to enable Service Users to participate in planned events.

Examples of a Contingency are:

i. Continue existing arrangements for safeguarding people.
ii. Managing responses to fluctuating needs
iii. Manage known risks including behaviours which challenge
iv. To support periodic events eg attending social event

3.12.4. The sum of a provider's claims for payment in any financial year cannot exceed the value of one week of care and support (i.e. 1/52nd of the annual cost of care and support for the individual).

3.12.5 The Provider shall agree to take responsibility for arranging the provision of Contingency services as required by the Service Users Care and Support Plan and are responsible for claiming Contingency Hours in a timely manner.

3.12.6 The Councils and onward Providers Care and Support plan will reflect a Contingency plan including the actions to be taken if a predictable anticipated risk takes place which requires the Provider to deliver additional support. The Provider is required to maintain a record of the number of hours used under this Contingency provision in accordance with KPI 5.

3.13 Managing Individual Service Funds – Managing Money

3.13.1. Where a Service User chooses to take payment of some or all of their Personal Budget via an Individual Service Fund, the Provider will manage the Individual Service Fund in accordance with the Service User's agreed Care and Support Plan. The Provider will provide direct care and support identified within the Service User's Care and Support Plan in a flexible and person-centred way to meet their individual needs and outcomes.

3.13.2. Where the Service User chooses to take payment of some of their Personal Budget as a Direct Payment, the Provider will assist the Service User to manage their money in accordance with the service user's agreed Care and Support Plan.

3.13.3. The Provider will ensure that the Service User retains the maximum degree of choice, control and flexibility over how the Provider provides direct care and support within the Care and Support Plan using funds. To meet this expectation, the Provider will need to communicate with the Service User on an ongoing basis to agree the details of care and support provision in relation to service inputs (service times and tasks) to meet agreed Care and Support Plan outcomes as flexibly as possible.

3.13.3. In agreeing with a Service User any changes to their care and support arrangements, the Provider must have regard to the requirements set out in 3.11 above.

3.13.4. The Provider may agree to directly contract external formal paid for Services and/or Informal Services and universal support on the behalf of Service Users using funds from within their Individual Service Fund provided these arrangements are documented within the Service User's Care and Support Plan. Where the Provider does so, it will be responsible for monitoring and managing any such services, and will be the contracting party to all such contracts and agreements.

3.14 Business transition

The Provider must cooperate with the Council, work with outgoing Providers and under the direction of the Council take a lead and proactive role to the service transfer, including but not limited to:

a. Ensuring Service continuity for current Service Users and the new arrangements are established in a safe, timely and sensitive manner.
b. Managing any workforce transfers as required under TUPE Regulations and ensuring the approaches to recruitment, retention and training are robust during the transition.
c. Working with the Council and outgoing Providers to develop and implement a clear and effective communication strategy to ensure information is managed to provide continuity of care to Service Users throughout the hand over period.
d. Ensuring information, finance, premises, management and other systems are in place.
e. Appointing a designated lead contract manager to provide a readily available contact point for the Council throughout this phase.

3.14.1. The Provider must also cooperate with the Council and incoming Providers in circumstances where existing Service Users' Care Packages need to be transferred to another Provider.

3.14.2 The Provider must produce and maintain an implementation and mobilisation plan for the entirety of the transition phase. This will cover changes in the delivery hours and the key activities to achieve the required volume in a planned way. It will include details such as:

- Recruitment, induction and retention of staff
- Any management restructure required
- Any capital expenditure e.g. IT systems, additional offices.

3.15 Referrals and commencement of the Service

The Provider will in the main receive and respond to referrals to match to vacancies in shared households or apartment schemes from and to the Council's Care Navigation Service using the Oracle Sourcing system or equivalent. Care and support for new services will be sourced via mini competitions or direct award.

The Provider must keep a record and report these to contract management of any occasional referrals received outside of this process e.g. direct from the Council's social work staff, Emergency Duty Team.

3.16 Transition pathway (requirements if the Provider has chosen to provide the Service to young people as they transition to adulthood)

Young adults typically 16+ with long term care and support needs may find their needs can be met by a Provider/s delivering under this Schedule. It is envisaged this will be on a case specific basis.

3.16.1 Part 3 of the Children and Families Act places a duty on the Council to develop for children and young people with more complex needs, a coordinated assessment of needs and a new 0 - 25 Education, Health and Care (EHC) plan and the Provider is expected to assist the Council in the development of such a plan. The Provider must comply with the requirements of the Children and Families Act 2014 and work with education and health services to ensure a smooth transition to Adult Services. Where appropriate, the Provider must make use of

EHC plans as a basis for arranging and agreeing support for young people with ongoing care and support needs into adulthood. The Provider must contribute to meeting these aims:

i. High expectations and aspirations for what young people with Specialist Educational Need and Disabilities including those with a diagnosis of an Autistic Spectrum Disorder (including autism, high-functioning autism and Asperger syndrome).can achieve, including paid employment, living independently with choice and control over their lives and support and participating in society
ii. Education, health and social care partners collaborate so that coordinated and tailored support can be provided to young people and their families
iii. Clarity of roles and responsibilities to ensure that collaboration goes hand in hand with accountability to fulfil duties.

3.17 Risk assessment and management

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

3.17.1 For Staff

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

3.17.2 For Service Users

Responsible risk taking is a normal part of living. Service Users must not be discouraged from participating in activities solely on the grounds that there is an element of personal risk. Service Users must be encouraged to discuss and judge risk for themselves and make their own decisions where the safety of others is not unreasonably threatened and where the Service User has the mental capacity to do so.

a. Where a Service User lacks mental capacity, a best interest decision must be made, recorded and retained. A risk assessment must be undertaken in all circumstances where a risk has been identified and maintained on the Service User's care records for staff reference, and for inspection by the Council if required.

b. Risk assessments must be reviewed as changes arise, and in line with good practice guidance. All Support Workers must have access to the risk assessment and have read and understood its content prior to undertaking any care provision. Refer to section 3.5.9.2 above

3.17.3 For Housing

Whilst the Housing Provider must have appropriate measures in place to deal with its landlord responsibilities, the Provider has a duty of care when operating within the property.

In meeting their respective obligations, both the Housing Provider and the Provider must produce and review risk assessments relating to all aspects of landlord functions and responsibilities.

3.17.3.1 New accommodation will meet nationally recognised standards e.g. lifetime homes or equivalent to ensure accommodation is suitable to manage the life course changes anticipated to be required for Service Users with disabilities and care and support needs.

3.17.3.2 For existing property:

"The property" should meet the requirements of the Decent Homes standards. The property must be warm, weatherproof and have reasonably modern facilities:

- A reasonably modern kitchen (20 years or less)
- Kitchen with adequate space and layout
- A reasonably modern bathroom (30 years or less)
- An appropriately located bathroom and w/c
- Adequate insulation against external noise
- Adequate size and layout of common area in block of flats
- Provide a reasonable degree of thermal comfort through effective insulation and effective heating system

A home lacking in two or few of the above is still classes as 'Decent'

A Housing Provider cannot make a home 'Decent' against the tenants wishes (waiver should be signed)

"the property" must "have in place":

- A valid gas safety certificate (annually)
- A valid electrical safety certification (every 5 years with PAT test annually)
- An up to date 'Fire Risk Assessment' for the shared property (not apartments)

The Provider must ensure that they have copies of relevant risk assessments. As a minimum these must include:

a. Fire and personal evacuation plans and associated arrangements
b. Any other risk assessments required during the course of carrying out its functions which may affect the building or buildings related control measures.
c. Assessment of risks in respect of the application of Decent Homes standards[1] by the Provider and Housing Provider.

3.18 Health and safety

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

a. There is a comprehensive health and safety policy with clear written procedures for the management of health and safety, which comply with all current and relevant Health and Safety legislation, and define individual and organisational responsibilities
b. There is a detailed policy covering the risks and support for lone workers
c. Infection control procedures are in place when a Support Worker or Service User has a known transmittable disease or infection
d. Protective clothing is worn where appropriate
e. Procedures for managing violence and aggression to staff are in place
f. One or more competent persons, depending on the Service provided, are nominated to assist in complying with health and safety duties and responsibilities, including:
g. Identifying hazards and assessing risks;
h. Preparing health and safety policy statements;
i. Introducing risk control measures;
j. Providing adequate training and refresher training; and,
k. Ensuring all records relating to health and safety are accurate and kept up to date.
l. Any accidents or injuries to a Service User that require hospital treatment or GP attendance are reported to the Provider's Service Manager and noted on the Service User's care records .

[1] https://www.gov.uk/government/publications/a-decent-home-definition-and-guidance

m. All staff know the Provider's procedures for dealing with emergencies.
n. All staff have first aid training and manual handling training where appropriate.
o. Identity cards are worn by Support Workers.
p. They promote an understanding of the risk of fire and other hazards among their staff and the Service Users they support. This will particularly apply to those whose behaviour or environment may pose particular fire risks e.g. smoking or open fires. This will include taking account of advice from, and agreements reached with, the Lancashire Fire and Rescue Service to ensure risk assessments are completed and advice is followed.

3.19 Health/medical care

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

3.19.1. Where the meeting of health care needs has been specifically agreed by a health clinician, the Service Provider will support the health care needs of the Service User under the direction of the clinician.
3.19.2. When the relevant Support Workers have received appropriate training and have been deemed sufficiently competent by a health care professional to complete health care clinical activities and actions e.g. administer rescue medication for epilepsy or managing the nutritional needs of individuals via a peg or button. This will not ordinarily include any care requiring a medical or professional qualification, but will require appropriate training and refresher training. A record of all applicable training shall be maintained by the Provider.
3.19.3. The Provider must ensure that Support Workers who are required to assist Service Users to take prescribed medication, as directed by the prescriber, receive appropriate instruction and written guidance. This will be in accordance with the Provider's policies and procedures and supported by appropriate training and assessment of staff competency.
3.19.4. The Provider must sign up to the Public Health England and VODG (the Voluntary Organisations Disability Group) updated Health Charter 2017 - Tackling health inequalities for people with learning disabilities and pledge to adhere to a clear framework for improving practice, they have not already done so.
3.19.5. The Provider will liaise will hospital service team when a Service User is admitted to hospital to receive health care to determine if reasonable adjustments are required by the medical team to meet the needs of Service Users during their health care interventions.
3.19.6. The Provider may be asked to continue to deliver care and support during a period of hospitalisation this will need to be agreed by the hospital service as they will be required to authorise the funding of this care.

3.20 Partnership working

Partnership working is at the heart of successful delivery of the Service and the Provider must work in collaboration and develop effective working relationships with key local partners; this applies to the relationship with the Council, but also with other significant agencies supporting individuals, including other services commissioned by statutory organisations.

The Provider must cooperate and work in partnership with other organisations or individuals to: develop robust information-sharing arrangements; signpost the individual to other relevant services; contribute to the prevention, reduction or delay of the development of individuals' needs; and improve the quality of person-centred and joined-up support.

The Provider must work with the community health teams, and other partners to prevent inappropriate admissions to hospital at the point of crisis:

e.g. Fire safety - personal evacuation plans which set out how evacuation from buildings will be managed providing assurance to the fire service, landlord and Service User.

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

- CQC
- General Practitioner (GP) Practices

- Community Health Services
- Community Mental Health Teams / Services
- NHS Trusts
- Clinical Commissioning Groups (CCGs)
- North West Ambulance Services
- Lancashire Fire & Rescue Service
- District/Borough Councils
- Voluntary, community and faith sector organisations
- Other Registered Care Providers
- Carers' Services
- Family members/informal carers
- Health practitioners to manage and minimise the risks for Service Users with swallowing assessments and identified needs in this area
- CAMHS and Family Services to ensure a smooth transition to Adult Services.

The Provider must make appropriate use of local networks to obtain information and resources, including advice and advocacy, to ensure that Service Users' needs are met holistically and resources are used effectively.

3.21 Supporting the wider care system

3.21.1 The Provider must contribute to prevention strategies developed by Public health England, the Local Authority and NHS commissioners which are aimed at:

i. New initiatives to change behaviour, increasing public awareness of risk factors and health promotion, especially with vulnerable groups.
ii. Reducing numbers of unplanned admissions to hospital.
iii. Supporting the safe and timely discharge of patients from hospital.
iv. Keeping people in community settings rather than institutional care and support.
v. Developing integrated care pathways.
vi. Identifying and meeting the needs of vulnerable Service Users at the earliest possible stage.
vii. Reporting any observed poor and/or unsafe care.

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

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

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

In these circumstances, the Provider may be asked to:

a. Take urgent actions in partnership with other organisations.
b. Reprioritise delivery of the Service.
c. Flex their workforce and the Service.
d. Increase welfare checks in neighbourhoods.

3.22 Social value

The Provider must give consideration to the employment needs within their local community when recruiting and selecting staff and as such must give consideration to how their recruitment processes support the local economy.

In accordance with the Council's social value policy[6], the Provider is expected to meet the following social value outcomes:

- More local people in work.
- Thriving local businesses.
- Responsible businesses that do their bit for the local community.
- A local workforce that is fairly paid and well supported.
- Communities supported to help themselves.
- A reduction in poverty, health and education inequalities.
- Reduction in costs by investing in prevention.
- Protecting our environment and reducing climate change.

The Provider will work with the community and voluntary sectors to ensure that people who use the Service are signposted to support which address all identified needs.

The Provider will work with the supported employment service or other local employment initiatives to enable Service Users to seek and maintain employment.

4.0 Workforce requirements

4.1 Data and intelligence

The Provider shall register with the Skills for Care Adult Social Care Workforce Data Set (ASC-WDS) previously National Minimum Data Set for Social Care (NMDS-SC) and complete the following:

- The ASC-WDS organisational record and update this data at least once per financial year
- Fully complete the ASC-WDS individual staff records for a minimum of 90% of staff, including updating these records at least once per financial year
- Apply for funds to support workforce development from Skills for Care.

The Provider shall retain records that ensure they can demonstrate their performance under this Service Contract by using templates and or systems as directed by the Council. Records must be fully compliant with the Data Protection Act 1998, Caldicott Guidance and Practice and Information Commission Guidance and Practice.
In relation to overall compliance, the provider will be expected to:

i. Comply with the contract management strategy that support this specification. The provider will ensure that all parts of the system keep within any national and locally set targets.
ii. Provide financial, performance and governance (inc. safeguarding) functions. An important element of this will be the collection, collation and reporting of whole supply chain.
iii. Make full use of performance information as part of continuous service development.
iv. Assist commissioners in servicing strategic commissioning functions.

Records will show resource inputs, organisational processes and outcomes related to the Service and Service Users.

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

The Provider will be required to provide to the Council, as required and within reason, additional workforce-related data not covered by the ASC-WDS and other established methods of data collection.

[6] http://www.lancashire.gov.uk/council/strategies-policies-plans/corporate/approved-social-value.aspx

4.2 Planning and management

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

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

Specific plans must be developed for the following:

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

The Provider should develop separate documents for the following:

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

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

4.2.1 Staff supervision and annual appraisals

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

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

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

4.2.2 Leadership and management

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

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

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

4.2.3 Enabling care and support

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

4.2.4 Core skills, induction and the Care Certificate

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

The Provider must be able to evidence that at recruitment they have assessed the core skills of Support Workers and that they are supported in further developing their core skills. As such, a values based recruitment and retention process should be adopted to create and maintain a workforce which embraces workplace values in line with national guidance[7].

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

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

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

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

4.3 Qualifications and learning

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

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

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

Registered Managers

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

Support Workers

Care Certificate for staff new to health and social care.
Level 2 Diploma in Health and Social Care.

From time to time partners (other Providers, NHS bodies) of the Council may offer free training. Partners often incur significant expense and planning overheads to provide training in this way and consequently the Provider is expected to demonstrate reasonableness in accessing the training and ensuring staff attendance.

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

4.3.1 Specific skills and knowledge

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

The Provider will be expected to work within the Skills for Care Common Core Principles for Dementia where appropriate[8]:

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

a. Communication
b. The Mental Capacity Act 2005 and consequent deprivation of liberty safeguards
c. Safeguarding adults
d. Combating loneliness and isolation
e. Fire safety in a community setting
f. Challenging behaviour
g. Assistive technology
h. Continence care
i. Falls prevention
j. Dignity in care
k. The requirements and responsibilities under the Equality Act 2010 and the Human Rights Act 1984
l. Working with carers - carers' awareness, assessment and support.
m. Promoting the choice, wellbeing, self-care and safety when supporting people with personal relationships and sexuality

In addition, the following non-exhaustive list of specific skills and knowledge are relevant to the delivery of the Service:

i. Person Centred and Recovery Based Approaches/values based practice
ii. Speaking up, empowerment, advocacy and how people who use the Service are involved
iii. The Mental Capacity Act 2005 and consequent deprivation of liberty safeguards
iv. The Mental Health Act 1983 and 2007(Specifically including conditionally discharged patients and CTO's)
v. Valuing People (2001) and Valuing People Now (2009)
vi. Supporting people with learning disabilities and or autism
vii. Supporting people with Mental Health
viii. Supporting people with physical Disabilities including skin & postural care
ix. Positive behavioural support and standards of good practice using a British Institute of Learning disabilities (BILD) accredited Physical Intervention Model
x. Epilepsy and behaviour, autism, borderline personality disorder, anxiety disorders and other mental health issues; self-injury
xi. Dementia Care
xii. A flexible, person centred, empathetic, non-confrontational and non-judgemental approach, which is important for maintaining an appropriate intervention programme
xiii. A recovery based approach
xiv. Multi-Disciplinary working and practice - Trusting and supportive relationships with clinical or social work professionals
xv. An understanding of the chronology of the disorders and maintaining a holistic focus in addressing the substance misuse, psychological, social and physical health problems
xvi. Support to give Service Users the motivation to deal with substance problems and other associated difficulties
xvii. An abstinence and recovery approach to substance misuse in the first instance

[8] http://www.skillsforcare.org.uk/Documents/Topics/Dementia/Common-core-principles-for-dementia.pdf

xviii. Advice and information about the impact of substance use.

The Provider must identify and train and refresh the workforce to enable the use of a positive behaviour support framework in responding to the needs of a Service User with challenging behaviour/s. See section 3.5.9.1 above

The Provider will ensure Support Workers receive specialist training in autistic spectrum disorders and the Support Worker will be able to:

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

4.4 Business continuity management

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

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

4.4.2 The business continuity plan must include:

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

a. Premises
b. People
c. ICT Hardware & Software
d. Telecommunications equipment
e. Vehicles
f. Suppliers/Contractors
g. Any other critical equipment/supplies.

4.4.3. Identification and assessment of risks that could limit the availability of the above resources and potentially lead to a disruption in the delivery of services
Appropriate continuity solutions should an impact be experienced
Supporting information such as key contact numbers, generic and hazard specific action plans, incident management procedures.

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

4.4.5 The Provider shall also develop and maintain and implement a Business Continuity Plan which shall include (without limitation) the following:

a) plans to explore use of temporary management resources from the Council to assist the Provider to maintain Services provision;

b) plans to be developed by both Parties for any wider assistance available to maintain the provision of Services;

c) procedures and evidence to be provided by the Provider confirming that any regulatory bodies have been informed and approve the temporary measures being utilised to maintain service provision;

d) plans to provide the Council with reasonable access to Service Users records pertaining to the Agreement to allow confirmation of the details of

the provision of Services to individual Service Users and establish if any local arrangements have been agreed between the Service User and the Provider for the manner and timing of the service they receive; and

e) plans to provide such data required in respect of Service Users to assist in the potential reallocation of service provision to the Successor Provider.

Upon exit, and pursuant to clause 18 of the agreement to which this Schedule relates, should the Provider fail to provide to the Council all material information and data relating to the delivery of the Services to the Service User, the Council will have the right to immediately access the Provider's premises to obtain the information required and the Provider will be obligated to assist in all material ways in order for the Council to obtain the information required in an efficient manner.

5.0 Quality and safeguarding

5.1 Quality standards and assurance

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

The Provider must ensure that they meet the registration requirements for delivery of the appropriate regulated activities and must include correct information within their Statement of Purpose submitted to CQC. The Provider must at all times achieve and maintain Good or Outstanding overall ratings from CQC inspections. In the event the Provider fails to achieve this, the Applicable Terms of the Approved Provider List and provisions of clause 7 of the Service Contract shall apply.

The Provider should understand NICE guidance[9] and quality standards[10] on Home Care and Transition between inpatient hospital settings and community or care home settings for adults with social care needs[11] and operate the Service in line with evidence and recommendations contained within them. The Provider should also adhere to the Skills for Care Code of Conduct for Healthcare Support Workers and Adult Social Support Workers in England[12].

As part of an approach to promoting better terms and conditions for Support Workers, the Provider must:

i. Commit to and implement stages 1 and 2 of Unison's ethical care charter[13] on commencement of the first year of the Services Agreement with the exception of the requirement relating to zero hours contracts
ii. Ensure that from the commencement of the second year of the Services Agreement they do not use zero hours contracts in place of permanent contracts, unless a Support Worker specifically requests to be employed on such terms due to their personal wishes and circumstances; and
iii. Cooperate to explore the feasibility of implementing stage 3 within future contracts

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

The Provider must ensure that continuous quality improvement systems are in place to ensure the Service is run in the best interests of Service Users, and demonstrates the quality and consistency of information, measures

[9] https://www.nice.org.uk/guidance/ng21 https://www.nice.org.uk/guidance/cg142
[10] https://www.nice.org.uk/guidance/qs123/chapter/using-the-quality-standard
[11] https://pathways.nice.org.uk/pathways/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs

[12] http://www.skillsforcare.org.uk/Documents/Standards-legislation/Code-of-Conduct/Code-of-Conduct.pdf.
[13] https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf

Service User outcomes and ensures that risks to Service Users are minimised. The Council encourages the use of the Care Improvement Works guides, tools and resources produced by Skills for Care and the Social Care Institute for Excellence to maintain CQC ratings, and collaboration with Approved Provider List requirements Partners to share good practice and learning.

The Provider will be expected to follow the Skills for Care 'Principles to Practice'[14] which defines the principles and the key areas to support good mental health.

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

The Provider's quality assurance system must demonstrate:

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

The Provider will be required to cooperate with the Council in evaluating and improving quality, not only of the care to individual Service Users but also compliance with the Service Agreement, and in the Annual Service Development Plan to improve or maintain the quality of the Service.

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

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

5.2 Complaints, Concerns and Compliments

The Provider shall ensure that it has in place a written compliments procedure in addition to a written complaints procedure that complies in all respects with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309 and any other applicable legislation from time to time in force (the "Complaints Procedure").

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

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

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

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

The Provider shall acknowledge all complaints and concerns immediately upon receipt and will provide a comprehensive reply within 28 days of the complaint being received.

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

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

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

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

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

5.3 Safeguarding

The Provider must ensure that robust arrangements are in place to safeguard Service Users from any form of abuse or exploitation in accordance with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Care Act 2014, and the government guidance: Working Together to Safeguard Children 2015. The Provider must have in place policies and procedures for identifying and dealing with the abuse of vulnerable people which are complementary to the Pan Lancashire Policies and Procedures for Safeguarding Adults[15] and Children[16].

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

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

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

a. Ensuring that staff and Service Users understand the aspects of the safeguarding processes that are relevant to them
b. Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed
c. Ensuring that Service Users are aware of how to raise concerns of abuse
d. Having effective means to monitor and review incidents and demonstrate the Service recognises when further action is required to manage and respond, concerns and complaints that have the potential to become an abuse or safeguarding concern

[15] http://plcsab.proceduresonline.com/chapters/contents.html
[16] http://panlancashirescb.proceduresonline.com/

e. Having effective means of receiving and acting upon feedback from Service Users and any other person to make changes to the way/s in which care and support is delivered
f. Having a whistleblowing policy and procedures in place
g. Having a medicines management policy and procedures in place
h. Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:
    I. having clear procedures that are followed in practice, monitored and reviewed, and take account of relevant legislation and guidance for the management of alleged abuse
    II. separating the alleged abuser from Service User and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the Provider
    III. reporting the alleged abuse to the appropriate authority
    IV. reviewing the Service User's Care and Support Plan to ensure that they are properly supported following the alleged abuse incident
i. Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and take any necessary action to ensure compliance
j. Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and having safeguarding policies that link with the Council's policies
k. Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding
l. Taking into account relevant guidance set out by the CQC
m. Ensuring that those working with Service Users wait for a full Disclosure and Barring Service disclosure before providing the Service
n. Training and supervising staff in safeguarding to ensure they can demonstrate the necessary competences.

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

Appendix 1

Housing, Care and Support Specification within a Supported Housing Environment

		Responsibility of Support Provider	Provided via Core Service and/or Individual Planning Time	Provided via Planned Support Time
	Personal Care	✓		✓
	Health and Well Being	✓	✓	✓
	Practical Support	✓	✓	
	Planned Purposeful Activities	✓	✓	✓
	Social Networks and Relationships	✓	✓	✓
	Financial Planning and Budgeting	✓		
	Personal Administration	✓	✓	✓
	Welfare, Emergencies and ad hoc support	✓	✓	
	Managing own home	✓	✓	

Apartment Based Scheme

	Practical Support	**Responsibility of Support Provider**	**Provided via Core Service and/or Individual Planning Time**	**Provided via Planned Support Time**
	Supporting tenants to develop skills to access finances and benefit entitlement	✓	✓	✓ Specified time-limited intervention as part of agreed skills acquisition
	Supporting tenants to plan and complete shopping	✓	✓ Planning	✓ main shop
	Supporting tenants to plan and prepare meals	✓	✓ Advice, prompt, reminder, or encouragement needed	✓ Preparation of meals
	Providing advice and practical support with changing bedding	✓	✓	✓

			Advice, prompt, reminder, or encouragement needed	Practical support needed to acquire a skill or complete task
	Supporting tenants to use household IT and entertainment systems when part of planned activities	✓	✓ Short intervention to assist with usage of equipment	✓ Specified time-limited intervention as part of agreed skills acquisition
	Providing advice and practical support with washing up	✓	✓ Advice, prompt, reminder, or encouragement needed	✓ Practical support needed to acquire a skill or complete task
	Providing advice and practical support with food storage	✓	✓ Advice, prompt, reminder, or encouragement needed	✓ Practical support needed to acquire a skill or complete task
	Providing advice and practical support with laundry, vacuuming and ironing	✓	✓ Advice, prompt, reminder, or encouragement needed	✓ Practical support needed to acquire a skill or complete task

	Personal Care	**Responsibility of Support Provider**	**Provided via Core Service and/or Individual Planning Time**	**Provided via Planned 1 to 1 Support Time**
	Supervision and physical assistance with moving and handling needs	✓	✓ Additional person support to meet an ad hoc need requiring 2 to 1 support	✓ Physical assistance required to meet the assessed need
	Supervision and physical assistance with washing, undressing, dressing, bathing, support to use the toilet	✓	✓ Advice, prompt, reminder, or encouragement needed or Additional person support to meet an ad hoc need requiring 2 to 1 support	✓ Physical assistance for an assessed need
	Supervision and physical assistance with ensuring adequate nutrition including meal planning, preparation, cooking and if required support with eating and drinking	✓	✓ Menu Planning	✓ Physical assistance required to meet the assessed need
	Supervision and physical assistance to go to bed / get out of bed	✓	✓	✓

			Additional person support to meet an ad hoc need requiring 2 to 1 support Or support during night hours	Physical assistance required to meet the assessed need
	Providing a response to regular or unpredictable care needs and developing contingency plans for when additional support is required	✓	✓	

Core Support- Day

The Service will provide physical, emotional and social care support (including personal care) and associated domestic services to groups of people with identified Care and Support needs in supported housing. The Service will support individuals to enhance their quality of life and to develop and maintain maximum independence.

The identified need and specific outcomes for individuals and the group and contract value and duration will be specified at mini competitions and call off arrangements.

Core Support - Night

Support might include waking night support, sleep in support or on call systems, or a combination of these models (including personal care). Support may be delivered flexibly in supported housing or across a number of properties, available peripatetically. The Provider may be required to work in partnership with other agencies, including those providing assistive technology solutions.

The identified needs and specific outcomes for individual(s) and contract value and duration will be specified at mini competitions and call off arrangements.

Agreed changes to night support may require a smooth transition into day time support, and the Provider will be required to facilitate effective partnership working with Service Users, carers and other agencies as required to manage this change.