SCHEDULE 1 – CARE & SUPPORT IN SUPPORTED HOUSING - SERVICE SPECIFICATION

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| **1.0 Introduction** |
| * 1. This schedule sets out the specification for a new care and support Service 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.   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.   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.   4. The Service will place an emphasis on recovery and moving on to independent accommodation or less intensive forms of support wherever possible. |
| 1. **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)[[1]](#footnote-1)   * 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 landlord and the Service 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.   1. 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; * Have identified, 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.   1. The Service may also be provided in circumstances where the Authority exercises it 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.   2. 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.   3. The Service will be commissioned by the Authority or any organisation acting on its behalf under the Authority's power to delegate its functions.   4. The Service may also be provided to individuals entitled to receive NHS continuing healthcare. In which case, the package will be commissioned by any of the Lancashire Clinical Commissioning Groups via the Midlands and Lancashire Commissioning Support Unit.   5. 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.   6. The Service shall be delivered within Lancashire County Council boundaries subject to the geographical zone(s) appointed to. However, there may be a small number of exceptional occasions when it is requested to provide Services outside of these boundaries. |
| 1. **Service requirements** |
| **3.1 Regulatory and legal**  The Service Provider must be registered with the Care Quality Commission (CQC) to provide personal care prior to commencement of any contract and will maintain registration throughout the duration of the 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 Schedule. The Provider must comply with all relevant legislation that relates to the operation of their business.  *The following will be included in the contract:*  *(The Provider must not have an overall rating of 'Inadequate' or is found to be in breach of Care Quality Commission (Registration) Regulations 2009 or Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)*  *Where a provider has a rating of 'Requires Improvement' they will be required to provide mitigating evidence, explaining the position and remedial actions implemented.*  The Service provided under this Schedule 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 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 * 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 * Service Users’ individual assessed needs and outcomes and any subsequent assessment, Care and Support Plan or review documentation * The Driving up Quality Code 2013 * Any future legislative changes or changes to National Minimum Standards that determine the standard of care to be delivered.   **3.2** **Client groups**  The primary client groups served by this specification are:   * Learning disabilities (including with a forensic history) * Autism * People with mental health needs (including with a forensic history) * Physical disability * Sensory impairment * People with dementia   Other client groups which may receive this Service include:   * Young people 16+ with long term care and support needs transitioning to adulthood.   The Authority 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 are being considered in terms of high level significant complex needs in addition to a learning disability and/or mental health.  The Service will be delivered via the following service models:   * Support to individuals which may include the provision of personal care. * Shared support to two or more individuals which may include the provision of personal care. * Overnight support to individuals or groups which may include the provision of personal care. * Community Support Networks. * Support to access employment, education or other vocational activities.   **3.3 Key principles**  This set of principles must apply to all contact between Service Users and their carers:   * Be independent. * Be regarded and treated as individuals. * Make choices for themselves. * Be treated in an equal and fair way. * Be treated with respect, dignity and confidentiality. * Access specialist support to realise potential. * Receive non-judgemental support. * Reducing reliance on paid for services. * Providing efficient, effective and responsive processes. * Involving service users and carers in Quality Assurance.     In addition the Service Providers must:   * Treat Service Users as individuals and protect each Service User's dignity, privacy and independence. * Enable each Service User to maintain direct control over their recovery journey. * Enable each Service User to reduce anxiety, build resilience and increase confidence to live independently. * Acknowledge and respect each Service User's gender, sexual orientation, age, ability, race, religion, culture and lifestyle and or other protected characteristics. * Maximise Service Users' self-care abilities, independence and well being. * Give Service Users flexibility and choice to plan their support to achieve their outcomes. * Recognise Service Users' individuality and personal preferences. * Provide support for informal carers and recognise the rights of other family members. * Acknowledge that each Service User has the right to take risks in their lives and to enjoy a lifestyle of their choosing. * Provide protection to each Service User who needs it, including a safe and caring environment. * Provide a consistent and high quality Service which is person-centred, flexible, reliable and responsive. * Prevent or delay the requirement for more intensive care and support services.   The service model must be constituent with the key principles of the Mental Capacity Act 2005 and the associated code of practice, which includes:   * + a presumption of capacity   + individuals being supported to make their own decisions - ensuring access to advocacy service for those who may require this   + least restrictive option - Support and interventions: should always be provided in the least restrictive manner and should promote independence. If an individual must 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, in line with *Positive and Proactive Care*, Department of Health 2014   + the Service 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.   **3.4 Service Outcomes**  The focus of the Service must be firmly on individuals making choices, taking control, social inclusion and wellbeing.  To achieve the Service outcomes the Service Provider will:   * Provide a suitable and safe environment that meets the needs of each Service User. * Continue to provide recovery focussed support Service where the Service User feels safe, respected and is treated with dignity. * Ensure the Service will promote recovery and the wellbeing of the Service User which encompasses improving activities of daily living in a way which promotes the Service User’s health; choice; control; independence; self-reliance and improvement to the Service User’s quality of life. * Cooperate with discharge planning for patients with the NHS, CCGs and other NHS agents. * 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. * Enable the service user to meet all identified needs within the Service User’s individualised Care and Support Plan. * Deliver evidence based and outcome focused care. * Ensure that the nutritional and hydration needs and preferences of the Service User are met * Support the Service User to live as healthy and independently as possible irrespective of their condition/circumstance. * Meet all identified outcomes within the Service User’s individualised Care and Support Plan. * Enable the Service User to exercise personal choice and control over their life. * Enhance the quality of life of the Service User. * Assist and enable the Service User to access other services as required. * Where appropriate, enable the Service User to die with dignity in a manner that supports their wishes along with their cultural and spiritual beliefs. * To individualise care and support planning to enhance coping strategies and build on strengths and potential, with promotion of choice and focus on independence. * Assist with moving on to other more suitable accommodation where the need for support changes or no longer exists.   The Service Provider must, where appropriate, use a positive behavioural support framework for developing an understanding of a Service User's challenging behaviour where applicable and for use this understanding to develop effective support. It must include:   * Personalisation of both assessment and support arrangements. * Systematic assessment of the 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. * Attention to the broader context to ensure that other factors influencing the Service User’s behaviour are properly understood. * Development of both proactive and reactive support arrangements. * How to prevent the Service User’s challenging behaviour as much as possible, through the provision of a more helpful and less challenging environment. * Developing the Service User’s competencies to ensure that their capacity to influence the world is less restricted. * 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. * Avoidance of support arrangements that punish the Service User in any way or create unnecessary restrictions on their freedom of movement and choice.   The Service Provider is required to ensure that where appropriate, there is an up to date written, individualised behaviour support plan that includes:   * Relational support requirements. * Proactive strategies. * Reactive strategies. * Monitoring and review arrangements.   The Service Provider is required to ensure that appropriate referrals are made to the Court of Protection for authorisation of a Deprivation of Liberty;  The Service Provider must make reasonable adjustments and develop the most effective ways of understanding and communicating individuals’ experience, help others to understand them and find ways of responding. Sustainable improvements in communication and swallowing require a strategic approach to building capacity and capability across services.  **Promote the independence of Service Users through an enabling approach:**   * Support Service Users to regain skills and gain confidence to achieve greater independence in their day to day living. * Support Service Users to remain in the community and prevent, reduce or delay the need for more intensive care and support by building resilience. * Support programmes of reablement and recovery, education, training and employment * Motivate and facilitate Service Users to develop or maintain skills related to activities of daily living, for example washing, dressing, feeding, toileting, bathing and mobility. * Encourage Service Users to acquire or maintain skills relating to areas of non-personal care, for example, shopping, cooking and cleaning. * Support Service Users to access and encourage best use of assistive technology, such as community equipment and telecare to support activities of daily living. * The Service Provider will support flexible innovative individualised solutions for Service Users. This is especially important for those with dual diagnosis – this often is mental health and substance misuse either drugs or alcohol. * Support Service Users to develop problem solving Skills and coping strategies. * The Service Provider will work with Service Users and their care coordinator/social worker to develop and respond to relapse prevention plans, which aims to empower the individual and their Service Provider to facilitate detection and treatment of relapse. * The Service 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. The Service Provider will set out the actions that need to be taken to overcome these barriers and record in the Service User's Care and Support Plan. * The Service Provider must use a strengths approach to supporting positive change around Service User led outcomes and priorities. * Where appropriate, use the Recovery Star as a framework (or other appropriate alternative) for a strengths approach to supporting positive change around Service User led outcomes and priorities. * The Service Provider must work with other agencies to prevent inappropriate admissions to hospital at the point of crisis.   **Support Service Users to achieve the outcomes in their Care and Support Plans and to maximise independence**   * Support Service Users to achieve the outcomes identified within their Care and Support Plan. * Continuously review and record the achievement of, and progress towards, outcomes, enabling Service Users to gain greater independence and contribute to informing annual reviews. * Work with families and other services so that they understand the approach to maximising independence. * Support Service Users to maintain their tenancy/licence to occupy agreement.   **Support Service Users to engage with family/friends, their interest and community services**   * Support Service Users to sustain significant relationships, including with family and informal carers. * Encourage and support Service Users to participate in their community and to use community resources and facilities. * Support Service Users to develop confidence in their own ability to engage with hobbies/interests and to access their wider community e.g. employment, volunteering. * Support Service Users to communicate and engage positively with others in a way which is appropriate to their personal preference and lifestyles. * Support Service Users to identify and report hate crime and to develop approaches to minimise the impact.   **Support Service Users to improve their mental health and wellbeing**  The Service Provider will be required to recognise specific mental health needs, including those associated with dual diagnosis, and develop approaches to respond to these and provide:   * A flexible, person centred, empathetic, non- confrontational and non- judgemental approach, which is important for maintaining an appropriate intervention programme. * Trusting supportive relationships with clinical or social work professionals. * A shared understanding. * Optimism and building motivation to deal with substance problems and other associated difficulties. * An Understanding of the chronology of the disorders, but maintaining a holistic focus in addressing the substance misuse, psychological, social and physical health problems. * A problem solving approach. * A harm reduction approach to substance misuse in the first instance. * Advice and information about the impact of substance misuse and support access to specialist services. * Support to Service Users to maintain their health and personal hygiene. * Enablement to Service Users to sustain improvements to their health. * Promotion of healthy eating and hydration with Service Users. * 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, 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. * Support to Service Users to access their GP, dentists, opticians, chiropodists and wider healthcare services etc. * Support to Service Users to comply with medication regimes including supporting self-administration. * Encouragement to Service Users to use self-care programmes for long term health conditions. * Support to Service Users to make informed decisions about the management of their care and treatment, using appropriate information including risks and benefits. * Support for the early diagnosis and treatment of mental health difficulties, in particular dementia. * Support to Service Users to alleviate their loneliness and isolation. * Support to Service Users have an active part in the content and implementation of their health action plan (where required). * Support to Service Users to access appropriate sexual health advice and services.   **Support Service Users to stay safe and take a positive approach to risk, rights and responsibilities:**   * 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. * Support Service Users to maintain accommodation. * Enable Service Users to exercise their Voting Rights. * Support Service Users to fulfil their role within their families, e.g. celebrations/significant events.   **3.5 Types of care and support tasks**  The Service required will be set out as part of Service Users' agreed outcomes based and person-centred Care and Support Plans. Therefore, the following list of types of care and support tasks required is not intended to be exhaustive or needed in all cases, and should not preclude creative solutions which may better suit an individual where it is part of their agreed Care and Support Plan. Such requirements that the Service Provider must provide must include:  **Support**  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. Support may also be commissioned based on agreed outcomes for the Service User.  **Overnight Support to individuals or groups**  Support might include waking night support, sleep in support or on call systems, or a combination of these models. Support may be delivered flexibly in supported housing or across a number of properties, available peripatetically. The Service 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. Overnight support may require a smooth transition into day time support, and the Service Provider will be required to facilitate effective partnership working with Service Users, carers and other agencies as required to manage this change.  **Care tasks**  Personal care and support is defined by the CQC as physical assistance given to a person and in connection to the following types of tasks:   * Direct assistance with, or regular encouragement, to perform tasks of daily living. * Providing advice and support on self-care. * Regular encouragement to dress, undress and supporting choice of what clothes to wear for the day. * 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 Care Worker has received the appropriate training and been deemed competent. * Support with the safe disposal of clinical waste * Assistance when and where required:   + to get up or go to bed;   + assistance with transfers from or to bed/chair/toilet;   + 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);   + support with using the toilet, including necessary cleaning and safe disposal of waste/continence pads (including in relation to the process of menstruation);   + empty or change catheter or stoma bags and associated monitoring and;   + assistance with skin care such as moisturising very dry skin.   **Other support that promotes wellbeing and self-care of the person**   * Regular prompts to take or safely administer prescribed medication in accordance with agreed protocols and CQC standards. * Assistance with putting on appliances with appropriate training, for example leg calliper, artificial limbs and surgical stockings, and assistance with visual and hearing aids. * 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. * Eating and drinking (including the administration of parenteral nutrition), including any associated kitchen cleaning and hygiene. * Support access to activities including employment, education and voluntary work. * 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.   **Other support that promotes safeguarding**   * Identification, and mitigation of any immediate risk and reporting of possible safeguarding adults concerns. * Identification, and mitigation of any immediate risk and reporting of possible safeguarding children concerns. * Identification, and mitigation of any immediate risk and reporting of possible domestic abuse or hate crime.   **Escorting and social activities**  Supporting and facilitating access to social, vocational and recreational activities as stipulated in the Care and Support Plan, including but not limited to:   * Support to develop structured daytime routines including accessing employment opportunities * Support to attend appointments which promotes the Service User's continued health and wellbeing * Assisting to access local community based services * Supporting Service Users to participate in appropriate physical activity * Supporting people to events at night beyond 9pm as and when required in agreed routine * Helping Service Users to make their way to places and to assist in road safety and learning routes.   **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 care home or supported accommodation the Service 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 Service Provider may also:   * make beds and change linen; * dispose of household and personal rubbish; * assist with laundry; * clear areas of any potential slip or trip hazards; * identify and mitigate as far as possible any hazards or risks around the household * and other household tasks the Service User requires in order to maintain their home.   **3.6 Supported Housing based requirements**  Service Users supported by this service have accepted that some of their support will be shared and will be delivered by the Service Provider based at the property or group of properties sharing support and have agreed to contribute towards the cost of this support.  Support workers will be in the building at times when they are assessed as needed, the Service provider will complete risk assessments to manage times when Service Users may be unsupported or have some of their needs via assistive technology The Service Provider will provide a support service to Service Users to manage their tenancy includingProviding support to assist in the resolution of disputes with other Service Users and/or neighbours on an informal basis.Providing support to Service Users to enable them to live in the accommodation in accordance with the terms of the tenancy agreement. Service Providers will:   * Ensure that there are robust arrangements in place; for example a Management Agreement which clearly establishes roles and responsibilities between the Service Provider and Housing Provider. * The Service Provider will ensure that there are appropriate protocols and procedures in relation to the following:   + Supporting Service Users to sign up to, maintain their Tenancy /licence Agreements using advocacy services where needed.   + If required the Service Provider will assist the Authority in the making of an application to the Court of Protection for an order authorising the tenancy.   + Completing and submitting Housing Benefit documentation (or its replacement) and resolving any issues e.g. backdated claims in relation to Benefits.   + Reporting of repairs.   + On site Housing Management functions and activities.   + Ending tenancies/licences and facilitating move on where the service is no longer needed   + Any other activity as agreed with the Housing Providers that would form part of the Management Agreement.   The Service 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.  The Housing Provider will provide information to the Service Provider and Service Users of their operating arrangements for dealing with emergency housing repairs or other emergencies, which may also require an out of hours assistance.  The Service Provider will be required to review themselves against REACH: Support for living an ordinary life: Service review – Pavilion Publishing and Media Ltd and its licensors 2013.  **3.7 Service availability and flexibility**  The Service 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 Service Provider will not operate on a reduced basis over periods of public holidays or festivities unless the Service User is able to receive informal support from family and friends to meet their needs during periods for public holidays.  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 Authority unless the Authority agrees the Service Provider will manage a personal budget on behalf of the Service User or the Service User themselves is directing their own care and support.  The Service Provider must:   * Be able to accept all referrals through effective management of referrals, workforce capacity and staff rostering/coordination. * Report to the Care Navigation Service on a regular basis to confirm the availability and capacity of the Service including any unexpected vacancy or change in individual circumstances. * Provide a timely response to the Care Navigation Service Oracle Sourcing System to respond to requests for Supported Housing packages. * Ensure that there is the necessary workforce capacity to accept and commence care and support over weekends/Bank Holidays if required. * Encourage reductions in care and support needs where safe to do so and/or where independence permits. * Minimise the number of different Support Workers delivering care and support to the Service User to promote consistency and continuity. * Ensure that there is a match between Service Users' needs and the skill sets, knowledge and competency of Support Workers. * Undertake Service User risk assessments prior to commencement of the Service and produce and plan to manage these. * Ensure the Service is delivered in accordance with the Service User's Care and Support Plan and personalised outcomes.   The Service Provider will be flexible and responsive in:   * Its approach to Service provision * Dealing with a Service User's fluctuating needs and supporting the individual outcomes of the Service User.   **3.8 Care and support planning**  The Service Provider may, without reference to the Authority, mutually agree day to day changes with the Service User 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 Service Provider is required to:   * 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. * Consult the Authority 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. * Inform the Authority 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. * 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 Service Provider. * 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. * Develop a Care and Support Plan within 6 weeks, to include the Service User and contain clear goals and identify how the outcomes will be achieved within a specified timeframe, where appropriate. * 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 and maximise their independence.   **3.9 Keeping Service Users informed and in control**  The Service 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 user friendly, clear and understandable and include the following:   * Statement of purpose. * Contact details for the Service including out of hours and emergency contacts. * Service provision details. * The contingency arrangements in the event of Service interruption. * Safeguarding information. * How to access the Service Provider's most recent CQC inspection reports. * Complaints procedure.   The Service 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.  The Service Provider should give Service Users choice regarding the specific Support Worker who provide the Service and the opportunity to meet new Support Workers prior to providing the Service.  **3.10 Recording**  With the Service User's knowledge, the Service 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):   * Assistance with medication, including time and dosage on a medication chart. * Other requests for assistance with medication and action taken. * Details of any change in the Service User's circumstances, health, physical condition or care and support needs. * Any accident, however minor, involving the Service User and/or staff. * Any other untoward or serious incidents (e.g. emergencies or safeguarding issues).   **3.11 Out of hours service**  The Service Provider must ensure that at all times outside of normal office opening hours there is a dedicated responsible person(s) with sufficient knowledge and training to be a point of contact to respond to enquiries and emergencies from Service Users, Support Workers and the Authority. The Service Provider will ensure the out of hours contact service has telephone and email capabilities as a minimum. The out of hours contact details must be clearly communicated to all Service Users and other appropriate people who may to need to contact the Service Provider out of hours.  **3.12 Business transition**  The Service Provider must cooperate with the Authority and outgoing provider to take a lead and proactive role to the Service transfer, which may include but is not limited to:   * Ensuring Service continuity for current Service Users and the new arrangements are established in a safe, timely and sensitive manner. * Managing any workforce transfers as required under TUPE legislation and ensuring the approaches to recruitment, retention and training are robust during the transition. * Working with the Authority and Service Providers to develop and implement a clear and effective communication strategy. * Ensuring information, finance, premises, management and other systems are in place. * Appointing a designated lead contract manager to provide a readily available contact point for the Authority throughout this phase.   **3.13 Referrals and commencement of the Service**  The Service Provider will receive and respond to referrals/mini competitions using the Oracle Sourcing system and must keep a record of any occasional referrals received outside of this process e.g. direct from the Authority's social work staff, Emergency Duty Team, care package restarts by NHS staff upon hospital discharge.  **Transition pathway**  The Service Provider must work with education and health services to ensure a smooth transition to Adult Services. Young adults typically 16+ with long term care and support needs may find their needs can be met by a Service Provider/s delivering under this Schedule. It is envisaged this will be on a case specific basis.  The Service Provider will comply with the requirements of the Children and Families Act 2014. Part 3 of the Children and Families Act places a duty on the Authority 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 plan (EHC plan).  There is scope to make use of EHC plans as a basis for arranging and agreeing support for young people with ongoing care and support needs in adulthood. In these situations, the plans must identify which aspects of the plan are being met by the Care Act.  Therefore, the Service Provider will be required to vary their current CQC Statement of Purpose to enable them to provide support to young people. This is to remove the potential for any gap in provision of care and support as people move from children's to adult social care.  The Service Provider will be required to provide information on the availability of the Service to enable young people and their families to plan ahead.  The Service Provider must ensure that all Services provided meet these requirements where appropriate and comply with the following main principles**:**   * High expectations and aspirations for what children and young people with Specialist Educational Need and Disabilities can achieve, including paid employment, living independently with choice and control over their lives and support and participating in society * Education, health and social care partners collaborate so that a coordinated and tailored support can be provided to children, young people and families * Clarity of roles and responsibilities to ensure that collaboration goes hand in hand with accountability to fulfil duties.   **3.14 Partnership working**  Partnership working is at the heart of successful delivery of the Service. This applies to the relationship between the Authority and the Service Provider, but also with other significant agencies supporting Service Users.  The Service Provider must cooperate and work in partnership with other organisations or individuals to: promote the wellbeing of Service Users; signpost the Service User to other relevant services; contribute to the prevention, reduction or delay of the development of Service Users' needs; and improve the quality of person-centred and joined-up care and support, including the outcomes Service Users achieve. The Service Provider must work with the community health teams, and other partners to prevent inappropriate admissions to hospital at the point of crisis.  This includes, but is not limited to, the following partners:   * CQC * General Practitioner (GP) Practices * Community Mental Health Teams / Services * NHS Trusts * Clinical Commissioning Groups (CCGs) * 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 * Children and Young Peoples Services to ensure a smooth transition to Adult Services*.*   The Service Provider must make appropriate use of local networks for information, advice and advocacy to ensure that a Service User's needs are met holistically and resources are used effectively.  **3.15 Risk assessment and management**  The Service Provider must have a Risk Management Policy, and must operate systems to ensure it can complete an assessment of risk and provide a risk management plan where necessary on all aspects of tasks carried out by its staff. A copy of the policy must be available to the Authority on request.  **For Staff**  The Service Provider must maintain clear policies, procedures and guidance for all staff on safety precautions that must be taken relating to risk, including lone working, and will ensure that staff are familiar with the guidelines and their application in the work situation. The policy must be comprehensive and include care tasks, community based activities, moving and handling, use of equipment and environmental hazards. The Service Provider must have clear monitoring procedures to ensure its staff work to these standards.  **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. 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 and Support Plan for staff reference, and for inspection by the Authority if required. Risk assessments must be reviewed as changes arise, and in line with good practice guidance. All Support Workers must have access to the risk assessment and have read and understood its content prior to undertaking any care provision.  In relation to Service Users who present challenging behaviour, the Service Provider is required to ensure that there is a written, individualised behaviour support plan for Service Users requiring them that includes:   * Relational support requirements * Proactive strategies * Reactive strategies * Monitoring and review arrangements.   **For Housing**  Whilst the Housing Provider must have appropriate measures in place to deal with its Landlord responsibilities, the Service Provider has a duty of care when operating within the property.  In meeting their respective obligations, both the Housing Provider and the Service Provider will need to produce and review, risk assessments relating to all aspects of landlord functions and responsibilities. These risk assessments must be made available to the Service Provider on request and copies should be held on site at each property.   As a minimum these must include:   * Fire and personal evacuation plans. * Any other risk assessments required during the course of carrying out its functions which may affect the building or buildings related control measures.   **3.16 Health and safety**  To ensure staff are informed and deal confidently with accidents, injuries and emergencies, the Service Provider is required to ensure that:   * 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. * There is a detailed policy covering the risks and support for lone workers. * Infection control procedures are in place when a Support Worker or Service User has a known transmittable disease or infection. * Protective clothing is worn where appropriate. * Procedures for managing violence and aggression to staff are in place. * One or more competent persons, depending on the Service provided, are nominated to assist in complying with health and safety duties and responsibilities, including:   + identifying hazards and assessing risks;   + preparing health and safety policy statements;   + introducing risk control measures;   + providing adequate training and refresher training;   + ensuring all records relating to health and safety are accurate and kept up to date. * Any accidents or injuries to a Service User that require hospital treatment or GP attendance are reported to the Service Provider's Service Manager and noted on the Service User’s care records * All staff know the Service Provider's procedures for dealing with emergencies. * All staff have first aid training and manual handling training where appropriate. * Identity cards are available for Support Workers. * 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.   **3.17 Health/medical care**  The Service 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.  The Service Provider will support the health care of the Service User under the direction of their GP, District Nurse, Community Matron, other health care professional or Community Health Team. Where the meeting of these need have been specifically agreed and where the relevant Support Workers has received appropriate training and have been deemed sufficiently competent by a health care professional. This will not ordinarily include any care requiring a medical or professional qualification, but will require appropriate training. A record of all applicable training shall be maintained by the Service Provider.  The Service 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 Service Provider's policies and procedures and are up to date with appropriate training and are assessed as being sufficiently competent.  The Service 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. and set out actions that need to be taken to overcome these barriers, and record in the Service User's care records.  **3.18 Supporting the wider care system**  The Service Provider must contribute to prevention strategies which are aimed at:  Reducing numbers of unplanned admissions to hospital and supporting the safe and timely discharge of patients from hospitals.  Keeping people in community settings rather than institutional care and support.   * Engaging and participating in developing integrated care pathways. * Identifying and meeting the needs of vulnerable Service Users at the earliest possible stage. * Reporting any observed poor and/or unsafe care.   The Service Provider will work closely with local organisations, across the health and social care system to continually improve the Service to Service Users, in accordance with identified 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.  The Service Provider will be required to assist when care and support is coordinated by a health professional. As such, the Service Provider will liaise with adult social care services, community mental health and therapy teams, voluntary agencies, acute trusts and other professionals and agencies to ensure seamless nursing and personal care provision to Service Users.  **3.19 Social value**  The Service 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 Authority's social value policy[[2]](#footnote-2), the Service Provider must work with the Authority to enhance the social value associated with this service in terms of sustainable employment and investment in the workforce.  The Service 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 Service Provider will work with the supported employment service or other local employment initiatives to enable the Service User to seek and maintain employment. |
| **4. Workforce requirements** |
| **4.1 Data and intelligence**  The Service Provider shall register with the Skills for Care National Minimum Data Set for Social Care (NMDS-SC) and complete the following:   * The NMDS-SC organisational record and update this data at least once per financial year. * Fully complete the NMDS-SC 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 Service Provider shall retain records that ensure they can demonstrate their performance under this contract. Records will show resource inputs, organisational processes and outcomes related to the Service and Service Users.  The Service Provider must participate in any survey of Adult Social Care employees organised by the Authority or Skills for Care and actively encourage its staff based in Lancashire to respond.  The Service Provider will be required to provide to the Authority, as required and within reason, additional workforce-related data not covered by the NMDS-SC and other established methods of data collection.  **4.2 Planning and management**  The Service Provider must identify a suitable person or persons with full knowledge and understanding of workforce issues pertaining to the delivery to be responsible for workforce planning for the Service.  The Service Provider must develop workforce plans 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 contract.  Specific plans must be developed for the following:   * Recruitment and Retention. * Management of sickness and other absences. * Learning and development.   The Service Provider should develop separate documents for the following:   * Succession plans for key management posts and/or posts requiring scarce skills. * Specific plans for issues identified locally/organisationally.   The Service Provider must have in place an effective sickness absence management and monitoring system, and must inform the Authority at the earliest opportunity if staff absence will impact upon their ability to deliver the Service.   * 1. **Social Care Commitment**   To demonstrate its commitment to delivering quality care and support, the Service Provider is expected to make and maintain the Social Care Commitment[[3]](#footnote-3).   * 1. **Staff supervision and annual appraisals**   The Service Provider must ensure that all staff have regular, planned and documented supervision sessions at a minimum every 3 months.  The Service Provider must ensure that all staff have a documented annual appraisal and a plan for learning and development.  The Service Provider must ensure that staff know when and how to raise an issue, comment, concern or complaint with their manager.   * 1. **Leadership and management**   The Service Provider must be able to evidence that it is developing effective leadership at all levels of the organisation by encouraging and supporting staff to develop leadership skills and competencies through training, supervision and reflective learning.  The Service Provider must be able to evidence that its managers, including registered managers, hold or are working toward the appropriate management level qualification as recommended by Skills for Care, and continue to refresh their learning regularly.  The Service Provider must ensure that individual Registered Manager(s) complete the Manager Induction Standards within six months of taking up a management role.   * 1. **Enabling care and support**   The Service Provider must ensure that learning and development activities for Support Workers focus on maintaining and promoting independence. Support Workers should be confident in enabling people 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.   * 1. **Core skills, induction and the Care Certificate**   The Service Provider must ensure that all staff possess the core skills their role requires.  The Service Provider must be able to evidence that at recruitment they have assessed the core skills of 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[[4]](#footnote-4).  The Service Provider must ensure that all Support Workers are supported to overcome any cultural communication differences between themselves, Service Users, carers and other professionals.  The Service Provider must ensure that all Support Workers receive a thorough induction to their new role, the organisation and the care sector.  The Service Provider must ensure that all new Support Workers achieve the Care Certificate within the time period defined by Skills for Care.  The Service Provider must be able to evidence that they are working to bring all 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.   * 1. **Qualifications and learning**   The Service Provider must ensure that its staff are supported to maintain their 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, the Service 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 new and existing staff). * Level 2 Diploma in Health and Social Care.   **Generic**  The Service Provider must ensure that all staff have access to learning and development opportunities which enable them to meet the needs of all those using the Service. The learning requirements of staff are therefore expected to go beyond the level of induction and the Care Certificate.  The Service Provider will be expected to work within the Skills for Care Common Core Principles for Dementia[[5]](#footnote-5):  The Service 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:   * Communication * Working with carers * The Mental Capacity Act 2005 and consequent deprivation of liberty safeguards * Safeguarding adults * Combating loneliness and isolation * Challenging behaviour * Dementia care * Assistive technology * Continence care * Falls prevention * Skin care * Strokes * Dignity in care * The requirements and responsibilities under the Equality Act 2010 and the Human Rights Act 1984.   1. **Specific skills and knowledge**   The Service Provider must ensure that all staff have access to learning and development opportunities which enable them to meet the needs of all those using the Service. The learning requirements of staff are therefore expected to go beyond the level of induction and the Care Certificate.  In addition, the Service 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 deliver of the Service:   * Person Centred and Recovery Based Approaches/values based practice * The Mental Capacity Act 2005 and consequent deprivation of liberty safeguards * The Mental Health Act 1983 and 2007(Specifically including conditionally discharged patients and CTO’s) * Safeguarding adults * Carers’ awareness, assessment and support * Challenging behaviour * Positive behavioural support and standards of good practice * Epilepsy and behaviour, autism, borderline personality disorder, anxiety disorders and other mental health issues; self-injury * Speaking up, empowerment, advocacy and how people who use the Service are involved. * Dementia Care * Supporting people with learning disabilities * Combating loneliness and isolation * Working with carers * Mental Health * Autism * Assistive technology * A flexible, person centred, empathetic, non-confrontational and non-judgemental approach, which is important for maintaining an appropriate intervention programme * A recovery based approach * Trusting and supportive relationships with clinical or social work professionals * Support to give Service Users the motivation to deal with substance problems and other associated difficulties * An understanding of the chronology of the disorders and maintaining a holistic focus in addressing the substance misuse, psychological, social and physical health problems * A harm reduction approach to substance misuse in the first instance * Advice and information about the impact of substance use.   The Service Provider must use a positive behaviour support framework for developing an understanding of a Service User's challenging behaviour. It must include:   * Personalisation of both assessment and care and support arrangements. * Systematic assessment of the Service User’s behaviour. * Attention to the broader context to ensure that other factors influencing the individual’s behaviour are properly understood. * Development of both proactive and reactive support arrangements. * Preventing the Service User’s challenging behaviour as much as possible through the provision of a more helpful and less challenging environment. * Avoiding support arrangements that punish the person in any way or create unnecessary restrictions on their freedom of movement and choice.   The Service Provider will ensure Support Workers receive specialist training in autism and the Support Worker will be able to:   * 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 * Support families and friends, and make best use of their expert knowledge of the Service User * Recognise when a Service User with autism is experiencing stress and anxiety and support them with this * Recognise sensory needs and differences of a Service User with autism and support them with this * Support the development of social interaction skills * Provide support with transitions and significant life events * Understand the issues which arise from co-occurrence of mental ill health and autism.   1. **Business continuity**   The Service Provider shall ensure that it has a business continuity plan to ensure the delivery of the Service is continuous and consistent for the benefit of Service Users. The Service Provider must ensure that the business continuity plan is able to deal with the following non-exhaustive list of issues that could impact upon the delivery of the Service:   * Inadequate staffing levels/Staff absences. * Financial resource management. * Administration and management. * Core IT system failure. * Adverse weather conditions e.g. snow, flooding. * Pandemic. * Complaints and regulatory intervention. * Business transfer or sale. |
| **5. Quality and safeguarding** |
| **5.1 Quality standards and assurance**  The Service must be provided by appropriately qualified/experienced staff, in line with the standards set by the CQC.  The Service Provider must ensure that they meet the registration requirements for delivery of the appropriate regulated activities and must include correct information within their Statement of Purpose submitted to CQC. The Service Provider must not have an overall rating of 'Inadequate' or part of the report is found to be in breach of Care Quality Commission (Registration) Regulations 2009 or Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.  Where a provider has a rating of 'Requires Improvement' they will be required to provide mitigating evidence, explaining the position and remedial actions implemented.  The Service Provider should understand NICE guidance[[6]](#footnote-6) and quality standards[[7]](#footnote-7) on Home Care and Transition between inpatient hospital settings and community or care home settings for adults with social care needs[[8]](#footnote-8) and operate the Service in line with evidence and recommendations contained within them. The Service Provider should also adhere to the Skills for Care Code of Conduct for Healthcare Support Workers and Adult Social Support Workers in England[[9]](#footnote-9).  As part of an approach to continuous quality improvement, including promoting better terms and conditions for Support Workers, the Service Provider must:   * Commit to and implement stages 1 and 2 of Unison's ethical care charter[[10]](#footnote-10) on commencement of the first year of the Framework with the exception of the requirement relating to zero hours contracts. * Ensure that from the commencement of the second year of the Framework 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 * Cooperate to explore the feasibility of implementing stage 3 within future frameworks.   To support the Service Provider in reducing the use of zero hour contracts in place of permanent contracts, except in circumstances where a Support Worker specifically requests to be employed on such terms.  The Service Provider must be committed to achieving and maintaining high quality services. This will be a key factor in their own business success, for the Service Users they support and also in the achievement of the success of the wider care system.  The Service Providers must ensure that continuous quality improvement systems are in place to ensure the Service is run in the best interests of Service Users, demonstrates the quality and consistency of information, measures Service User outcomes and ensures that risks to Service Users are minimised. As part of the Service Provider's approach to continuous improvement, the Authority encourages the use of the Care Improvement Works guides, tools and resources produced by Skills for Care and the Social Care Institute for Excellence.  The Service Provider must use an outcome focussed framework for a strengths based approach to supporting positive change around Service User led outcomes and priorities e.g. the Recovery Star for adults managing their mental health.  The Service Provider must have quality assurance and monitoring systems, which seek the views and experiences of Service Users, carers and health and social care professionals, to enable a realistic assessment of the Service provided.  The Service Provider will be expected to follow the Skills for Care 'Principles to Practice'[[11]](#footnote-11) 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 Service Provider's quality assurance system must demonstrate:   * Measurable organisational improvement. * The quality and standards of the Service provided. * Training that provides staff with the skills and tools to promote quality improvement. * Staff are empowered and supported to make positive changes. * Positive attitudes and working relationships. * Early warning systems. * Learning from complaints, serious incidents and safeguarding alerts/investigations. * Continuous building on good practice. * Introduction of new procedures.   The Service Provider will be required to cooperate with the Authority in evaluating and improving quality, not only of the care to individual Service Users but also compliance with the Framework Agreement, and in improving the quality of the Service.  The Service Provider must have a clear set of policies and procedures to support good practice and meet the requirements of legislation and this specification. These policies and procedures should be dated and monitored as part of the Service Provider’s quality assurance system. They should be reviewed at a timescale that is appropriate to the content of the policy and at least annually.  The Service Provider must ensure that all policies and procedures in place have a person centred emphasis, which promote feedback of Service User experience, and which ensure safe and appropriate working practices.   * 1. **Complaints, concerns and compliments**   The Service Provider must have a written complaints, concerns and compliments policy and procedure in place in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16. The Service Provider must take all reasonable steps to bring the arrangements to the attention of Service Users in an understandable way and keep a complete record of all complaints made by Service Users, or their representatives and subsequent investigations.  The Service Provider shall record sufficient detail of complaints and compliments, which will include the:   * Date and time it was received. * Name of the person making the complaint/compliment. * Nature of the complaint/compliment. * Names of the staff involved. * Timescales for remedial action to be taken. * Action taken to remedy the complaint. * Date and time when the remedy was completed.   The Service Provider will acknowledge the complaint on receipt and will provide a comprehensive reply within 30 working days of the complaint being received providing remedial actions if required. The response must include details of how the complaint may be escalated if they are not satisfied with the outcome.  The Service Provider will be required to evidence to the Authority the learning from complaints and actions taken as a result to improve the quality of the Service and experience for Service Users.  A record of compliments received should be retained by the Service Provider and shared with all staff to promote good practice and an understanding of what can make a difference to Service Users.   * 1. **Safeguarding**   The Service Provider must ensure that robust arrangements are in place to safeguard Service Users from any form of abuse or exploitation as detailed in Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including physical, financial, psychological or sexual abuse, neglect, discriminatory abuse, self-harm, inhuman or degrading treatment through deliberate intent, negligence or ignorance.  The Service Provider has a responsibility to safeguard Service Users in accordance with CQC Essential Standards Outcome 7 and the Care Act 2014, and comply with the government guidance: Working Together to Safeguard Children 2015.The Service Provider must have in place policies and procedures for identifying and dealing with the abuse of vulnerable people which are complementary to the Pan Lancashire Policies and Procedures for Safeguarding Adults[[12]](#footnote-12) and Children[[13]](#footnote-13)(This includes the two unitary Authorities). The Service Provider must have in place policies and procedures for identifying and dealing with the abuse of vulnerable adults which are complementary to the agreed Multi-Agency Safeguarding Adults Policy and Procedures.  The Service Provider must also comply with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 – Duty of Candour to ensure its safeguarding practice promotes openness, transparency and trust.  The Service Provider must ensure that policies and procedures are covered in induction and fully understood by staff. All staff must be given an initial understanding of their safeguarding duties within their first week of employment. Comprehensive training on awareness and prevention of abuse must be given to all staff as part of their core induction within 3 months and updated at least annually. In addition, update training will be provided in light of new policies and procedures introduced either locally or nationally.  The Service Provider will minimise the risk and likelihood of incidents occurring by:   * Ensuring that staff and Service Users understand the aspects of the safeguarding processes that are relevant to them. * Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed. * Ensuring that Service Users are aware of how to raise concerns of abuse. * Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern. * Having effective means of receiving and acting upon feedback from Service Users and any other person. * Having a whistleblowing policy and procedure in place. * Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:   -having clear procedures followed in practice monitored and reviewed, and take account of relevant legislation and guidance for the management of alleged abuse;  -separating the alleged abuser from Service Users and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the Service Provider;  -reporting the alleged abuse to the appropriate authority ;  -reviewing the Service User's Rehabilitation Care and Support Plan to ensure that they are properly supported following the alleged abuse incident.   * Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance. * Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local Authority policies. * Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding. * Taking into account relevant guidance set out by the CQC. * Ensuring that those working with Service Users wait for a full Disclosure and Barring Service disclosure before starting work. * Training and supervising staff in safeguarding to ensure they can demonstrate the necessary competences. |
| **6.0 Performance management** |
| The Authority is establishing a new Performance Framework for Supported Housing services. All Service Providers offered places on the Framework will have to comply with requirement to provide information in the following key areas:  **Service Requirements**  KPI 1 Service User outcome measures (Outcomes being achieved)  KPI 2 Health Action Plans  **Workforce Requirements**  KPI 3a Staff Training – General  KPI 3b Staff Training – Specific  **Quality and Safeguarding**  KPI 4 Quality check visits  KPI 5 Experience of people who use services: Complaints and Concerns  KPI 6 Experience of people who use services: Compliments  **Adult Social Care Outcomes**  KPI 7 Supporting people to obtain or retain employment  The detailed descriptions of above key performance indicators are set out in annex 1. |

1. <http://www.thinklocalactpersonal.org.uk/_assets/MakingItReal/MIRHousing.pdf> [↑](#footnote-ref-1)
2. <http://www.lancashire.gov.uk/media/898255/approved-social-value-policy-and-framework.pdf> [↑](#footnote-ref-2)
3. <https://www.thesocialcarecommitment.org.uk/> [↑](#footnote-ref-3)
4. <http://www.skillsforcare.org.uk/Recruitment-retention/Values-based-recruitment-and-retention/Values-based-recruitment-and-retention.aspx> [↑](#footnote-ref-4)
5. <http://www.skillsforcare.org.uk/Documents/Topics/Dementia/Common-core-principles-for-dementia.pdf> [↑](#footnote-ref-5)
6. <https://www.nice.org.uk/guidance/ng21> [↑](#footnote-ref-6)
7. <https://www.nice.org.uk/guidance/qs123/chapter/using-the-quality-standard> [↑](#footnote-ref-7)
8. <https://pathways.nice.org.uk/pathways/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs> [↑](#footnote-ref-8)
9. <http://www.skillsforcare.org.uk/Documents/Standards-legislation/Code-of-Conduct/Code-of-Conduct.pdf>. [↑](#footnote-ref-9)
10. <https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf> [↑](#footnote-ref-10)
11. <http://www.skillsforcare.org.uk/Documents/Topics/Mental-health/Principles-to-Practice-good-mental-health.pdf> [↑](#footnote-ref-11)
12. <http://plcsab.proceduresonline.com/chapters/contents.html> [↑](#footnote-ref-12)
13. <http://panlancashirescb.proceduresonline.com/> [↑](#footnote-ref-13)