Service Specification

for

Care and Support Framework for Adults with a Learning Disability and/or Autism across Bournemouth, Christchurch and Poole

2019-2024

Schedule 1 – Part 1

SERVICE SPECIFICATION – CARE AND SUPPORT FRAMEWORK FOR ADULTS WITH A LEARNING DISABILITY AND/OR AUTISM 2019-2024

CONTENTS:

Schedule 1

SERVICE SCHEDULES:

Service Schedule Part 2 - Lot 1 General Care and Support

Service Schedule Part 2 - Lot 2 Complex Health

Service Schedule Part 2- Lot 3 Behaviours that challenge services/Mental Health/Autism

Service Schedule Part 2 - Lot 4 Forensic/ Risk of Offending/Risky Behaviour

Service Schedule Part 2 – Lot 5 Supported Living Schemes

APPENDICES:

Appendix 1 – Bill of Rights Charter

Appendix 2 – Principles for Person Centred Practice for People with Learning Disabilities and/or Autism across Bournemouth, Christchurch, Poole and Dorset

Appendix 3 – LD Services Relationship Guidance 2016

Appendices 4a & 4b – Adult Social Care Medication Management Policy and Guidance, Borough of Poole and Bournemouth Borough Council 01 August 2017

Appendix 5 - Multi Agency Safeguarding Adults Policy

Appendix 6 – Working Together to Safeguard Children 2015

Appendix 7 – Working Together to Safeguard Children Update 2018

Appendix 8 - Care and Support Tasks

Appendix 9 – Positive Behavioural Support (PBS) Coalition UK – Competency Framework (2015)

Appendix 10 – Legislative And Policy Framework

1. VISION

1.1 The Big Plan for Dorset 2018 – 2021 www.poole.gov.uk/bigplan identified the following vision based on what people with a learning disability want:

1.1.1 Everyone with a learning disability is treated with dignity and respect

1.1.2 Services make sure that people with learning disabilities and their families are at the centre of everything they do

1.1.3 People have choices and rights and are responsible for their lives

1.1.4 People's lives getting better, with services supporting them to reach their hopes and dreams

1.2 The Big Plan 2018-21 continues to support the Pan Dorset Bill of Rights for people with a learning disability, (Appendix 1). All Providers are expected to sign up to this charter and ensure that in the delivery of services these rights are upheld at all times.

1.3 As part of the work of the Dorset Transforming Care Partnership in response to Building the Right Support, (2015) a set of principles for person centred practice has been co-produced to help underpin how people with a learning disability and/or autism should be supported, (Appendix 2). All Providers are expected to follow these principles when delivering services under this framework.

2 DEFINITIONS AND INTERPRETATIONS

2.1 Any reference to Commissioner(s) and Providers includes employees of those organisations. Any reference to Providers includes voluntary and private sector organisations and individuals with designated responsibility under the Health and Social Care Act 2008 and the Care Act 2014.

2.1.1 **Abuse -** Describes a single action or repeated action or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to a person including physical, emotional, financial, sexual, racial abuse, neglect and abuse through the misapplication of drugs.

2.1.2 **Adult at risk** - Refers to any person aged 18 years and over who:

- May have need for care and support (S9 (1) Care Act 2014
- Or as a Carer may have need for care and support either now or in the future (S10 1(a)
- Is experiencing, or is at risk of, abuse and neglect and as a result of those needs cannot protect themselves.

2.1.3 **Assistive Technology -** An umbrella term that includes assistive, adaptive, and rehabilitative devices for older people or those with

disabilities and includes the process used in selecting, locating, and using them.

2.1.4 **Business Continuity Plan -** A document that contains critical information on what the business needs to remain operational when faced with unexpected and adverse events including staff shortages.

2.1.5 **Care Act 2014 -** The Care Act 2014 came into force in April 2015. Local Authorities and Clinical Commissioning Groups have a range of new duties and responsibilities under the Care Act. Some of these new duties will impact organisations that provide care and support services.

2.1.6 **Care and Support -** This may include a number of tasks to support an individual to meet their outcomes, both at home and in the wider community, (see Appendix 8 for further examples)

2.1.7 **Care Diary -** This document is completed by the Social Worker/Care Manager, and is a daily record of the tasks to be carried out by the Provider where a more traditional package of support is required. It should be read in conjunction with the Care and Support Plan, and used to develop the Provider's Support Plan in partnership with the Individual**.**

2.1.8 **Care Quality Commission (CQC) -** The organisation that is responsible for the registration and regulation of health and social care in England in accordance with the Care Act 2014.

2.1.9 **Care and Support Plan -** Following a social care assessment and a determination of eligibility the Care and Support Plan is agreed between the social care practitioner and the Individual. It highlights the outcomes that have been agreed that impact significantly on the Individual's well-being. The Plan will periodically be reviewed by the local authority. The Care and Support Plan provides the starting point for discussion between the Provider and the Individual in how these outcomes will actually be met by the care provided.

2.1.10 **Care and Support Worker -** Refers to the Provider's employees who provide the care and support service to Individuals in their own homes. This includes any staff employed by sub-contractors of the Provider who have been approved by the Commissioner(s).

2.1.11 **Carer/Informal Carer -** A person of any age who provides or intends to provide on-going unpaid support to a partner, child, relative or friend. Without this help the health and wellbeing of the cared for person could deteriorate because of disability, a serious health condition, mental ill health or substance misuse. The carer may live with or apart from the cared for person. Services provided by the NHS may also be in place.

2.1.12 **Continuing Health Care -** Refers to a package of continuing care that is commissioned (arranged and funded) on behalf of the NHS. Continuing Care refers to care that is extended over a period to a person aged 18 or over, (or child aged 16-18 for the purposes of this framework), to meet physical and/or mental health needs which have arisen because of disability, accident or illness.

2.1.13 **Commissioned Health Outcome Plan/Health Care Plan-** The Agreed Commissioned Health Outcome Plan identifies the needs/outcomes of the patient, how these are to be met and the services required to meet those needs. This can be primary, secondary or commissioned care or family involvement.

2.1.14 **Commissioner(s) -** The current Commissioner(s) are Bournemouth Borough Council, Borough of Poole and NHS Dorset Clinical Commissioning Group and their staff and nominated representatives tasked with purchasing/funding care and support for individuals under this framework. From 1 April 2019 the local authority Commissioners will be replaced by the new Bournemouth, Christchurch and Poole Local Authority.

2.1.15 **Community Adults Asperger's Service (CAAS)** - Dorset Healthcare Service offering a wide range of services to people with a diagnosis of an autism spectrum condition (Asperger's Syndrome or High Functioning Autism).

2.1.16 **Community Learning Disability Teams (CLDT's)** – specialist joint services with a range of health and social care professionals who support people with learning disabilities. These professionals are employed by both Dorset HealthCare University NHS Foundation Trust and local Commissioners(s).

2.1.17 **CPA – Care Programme Approach -** The Care Programme Approach is used in secondary mental health care to assess, plan, review, and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics.

2.1.18 **Direct Payment -** A payment of part or all of a personal budget directly to an Individual or their representative in order for them to arrange their own care and support.

2.1.19 **End of Life Care -** This term refers to generalist care provided to people who are expected to die within the next twelve months, and includes those who are expected to die imminently. Any palliative care provided during this time is considered to be end of life care, although this is of a specialist nature and would be provided by the NHS.

2.1.20 **Guidance -** Any health and social care guidance (including Cabinet Office guidance), direction or determination which the Commissioners and/or Provider have a duty to have regard to, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Provider by the Commissioners and/or Department of Health.

2.1.21 **Individual (Service User) –** A person receiving the care delivered by the Provider, in accordance with the Framework Agreement, Service specification and related documents appended to the Agreement. Any reference to the Individual shall, where appropriate, include the Individual's duly authorised representative.

2.1.22 **Review -** A formal review undertaken by the Commissioner' social care practitioner/case coordinator with the Individual, (their family as relevant), and the Provider to discuss and review the Individual's current needs and any aspect of the service provided. Following the Individual Review, the Individual's Plan will be updated.

2.1.23 **Individual Service Fund (ISF) -** This is a more flexible type of 'managed' budget, as the Individual chooses the provider and works with the Provider to agree how the care will be provided. The local authority pays the Provider directly so the Individual is relieved of the responsibility of managing the budget.

2.1.24 **Infection Control -** This term relates to the policies and procedures that together provide guidelines to minimise the risk of spreading infection.

2.1.25 **Intensive Support Team** – Is a specialist service provided by Dorset HealthCare University NHS Trust. It supports Adults with a learning disability aged 18 or over, and the support offered is for a time limited period. The team works in conjunction with the community Learning Disabilities Teams, The IST provides specialist assessments to Adults with Challenging and complex needs. The support may be in the form of consultancy, preventative or Proactive working.

2.1.26 **Key Worker -** The Officer of the Commissioner(s) (for example Social Worker, Care Manager, Clinical Case Manager) responsible for ensuring that the assessed outcomes identified by the Individual that maintain or improve their wellbeing are met.

2.1.27 **Managed Budget -** When the local authority manages the individual's personal budget, and commissions specific services and support for the person under a contract with a provider.

2.1.28 **Medication -** A Drug or other form of medicine that is used to treat or prevent disease.

2.1.29 **Moving and Handling Plan -** A document which is specific to an Individual who requires assistance with their transfers and/or walking. The document specifies the number of staff, any equipment and the procedures to be followed when care staff and /or carers are assisting the individual to move. This plan shall be completed following an assessment by a person with specialised knowledge of moving and handling techniques, for example an occupational therapist or back care advisor.

2.1.30 **Multi-disciplinary team -** A multi-agency team that spans both health and social care and typically will be made up of social workers, occupational therapists, physiotherapists, nurses and other clinicians who are all involved in the care of the Individual.

2.1.31 **MUST (Malnutrition Universal Screening Tool) -** A five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition) or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

2.1.32 **National Framework for NHS CHC -** Sets out the principles and processes of the National Framework for NHS Continuing Health Care and NHS-funded nursing care.

2.1.33 **National Minimum Wage -** The minimum rate that an employee can earn in an hour.

2.1.34 **NHS Continuing Health Care -** Care that is arranged and funded solely by the NHS where it has been assessed that the person's primary need is a health need and eligibility determined against criteria as detailed in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care July 2009.

2.1.35 **Outcomes -** The end result of the service provided by a Provider, which can be used to measure the effectiveness of the service. An outcome may be a service outcome which is applicable to all Individuals, or an individual outcome which pertains to the Individual and is identified in the Individual's Care and Support Plan/Health Outcome Plan.

2.1.36 **Personal Budget -** An indicative amount of funding allocated to an individual following an assessment of needs to determine the way money is spent to meet his or her care needs. This can be taken as a commissioned service, ISF, Direct Payment, or a combination.

2.1.37 **Personal Health Budget -** A personal health budget is an allocation of CCG resources that Individuals can use to meet their health and well-being goals in new and innovative ways that do not rely on

commissioned services. It does not cover an individual's entire NHS care. (GP services, A&E, and inpatient care, are excluded).

2.1.38 **Provider –** The organisation providing the Care and Support Service and includes employees, agents and volunteers of that organisation. This may include sub-contractors who are approved by the Commissioner(s).

2.1.39 **Provider Review -** Review carried out as necessary by the Provider and the Individual to consider any aspect of the Individual's care and support and the delivery of the Service.

2.1.40 **Provider Support Plan -** The Provider Support Plan, is drawn up by the Provider in partnership with the individual and their circle of support as appropriate, states the tasks that will be undertaken to meet the individual's outcomes as defined in the Commissioner's Care and Support Plan/Health Outcome Plan.

2.1.41 **Re-assessment -** Formal re-assessment of needs undertaken by the Commissioner.

2.1.42 **Recording and Reporting -** All aspects of recording, reporting and sharing of information for services provided under this specification. Information may be required in various formats including digital and on-line.

2.1.43 **SALT (Speech and Language Therapy) -** Treatment provided by allied health professionals to support and care for adults and children who have difficulties with communication, or with eating, drinking and swallowing.

2.1.44 **Service Review -** Arrangements made by the Commissioners and the Provider to consider any aspect of the Agreement or the performance of the service.

2.1.45 **Service User (Individual) –** A person receiving the care delivered by the Provider, in accordance with the Agreement, Service specification and related documents appended to the Agreement. Any reference to the Individual shall, where appropriate, include the Individual's duly authorised representative.

2.1.46 **Skills for Care -** A national organisation responsible for providing training to employees providing social care services.

2.1.47 **Sleep-In Night Care** - Is the service provided between the hours of 10:00pm and 7:00am, (9 hours) where the Care and Support Worker sleeps in the Individual's home and will immediately respond to any request for assistance. The service may include personal care, enabling and domestic tasks. The sleep-in night Care and Support Worker may be disturbed up to twice per night before the service is

regarded a "waking night". Care and Support Workers can expect to be provided with a bed in a separate room and to be able to go to bed by midnight.

2.1.48 **Supported Assessment -** A professional process undertaken by the Key Worker with the Individual to identify their needs and the outcomes they wish to achieve within the context of their situation.

2.1.49 **Social Care Commitment -** A commitment to the public that care and support services will always be supported by skilled people who treat them with dignity and respect. Employers commit to give their workers the development /training they need and staff commit to put social care values into practice within their daily work.

2.1.50 **Transition –** Refers to period of time between Child and adulthood, where a Young person moves from children to adults services, typically between 16 - 18 years. Although transition planning can start earlier from 14 years.

2.1.51 **Universal Services -** Refers to services that are available to all individuals across Dorset and which can be accessed directly without the involvement of the Commissioner(s).

2.1.52 **Waking Night Care -** The service provided between the hours of 10.00 pm and 7.00 am where the Care and Support Worker must remain awake and vigilant throughout their shift to undertake any care needs that may arise including quiet domestic tasks.

3 INTRODUCTION

3.1 Bournemouth Borough Council and Borough of Poole, working in partnership with NHS Dorset Clinical Commissioning Group, (hereafter referred to as the Commissioner(s)) are tendering these services in preparation for the new Bournemouth, Christchurch and Poole local authority from 1 April 2019.

3.2 This tender is being carried out in agreement with Dorset County Council in respect to Christchurch.

3.3 This service will cover individuals eligible for services under this specification who are ordinarily resident in, or are the responsibility of the Bournemouth, Christchurch and Poole Commissioners on or after 1 April 2019, (hereafter referred to as BCPC).

3.4 This document sets out the service specification relating to the provision of care and support for adults aged 18 years and over, or young people aged 16 and over, coming through transition into adult services with a Learning Disability and/or Autism.

3.5 This document sets out the service specification, community and individual outcomes and quality standards which apply to the provision of care and

support to persons who are funded either solely or jointly, by the Commissioner(s).

3.6 It describes the key features of the service being commissioned and the expectations of the partners involved. This Specification should be read in conjunction with the terms and conditions of the contract agreement and the contract appendices.

3.7 This Service Specification is for the provision of care and support services to support people to live independently within their own home and to access their community.

3.8 It is recognised that individuals will be living in a variety of accommodations, e.g. supported housing, rented accommodation, owned home, with family and/or friends and for the purpose of this contract arrangement, these accommodations shall be defined as the individuals' own home.

3.9 The Commissioner(s) are seeking to commission care and support services for any individual with a Learning Disability and/or Autism who is entitled to receive services under:

3.9.1 The Care Act (2014)
3.9.2 Children's and Families Act (2014)
3.9.3 Joint funding under NHS Section 117, (Mental Health Act 1983)
3.9.4 National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care October 2018 (Revised)
3.9.5 National Framework for Children and Young People's Continuing Care (2016).

3.10 This Service Specification also details the quality standards the Commissioner(s) expect care and support Providers to deliver to individuals who are self managing their own care services, (whether through a Personal Budget or other means).

3.11 The Commissioner(s) are committed to working with Providers in a spirit of consultation, co-operation and partnership to ensure that appropriate services are available to meet the needs of young people and adults aged 16 years and upwards with Learning Disabilities and or Autism and their families.

3.12 Adult Social Care (ASC) Services, Community Learning Disability Teams (CLDT's) and the Commissioning Partner(s) are fulfilling their Obligations and Duties under The Care Act 2014 and Children's and Families Act 2014, for the provision of 'welfare services' to disabled persons and to carry out an assessment of the persons needs for those services and then decide whether the individual's needs call for the provision by them of a service.

3.13 Under Section 6 of the Care Act, the local authority Commissioner(s) will assume responsibility for meeting the care costs of those individuals ordinarily resident in their authority who are entitled to public financial support and who need support to live independently in their own home.

3.14 NHS Dorset Clinical Commissioning Group is fulfilling their Obligations and Duties under the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care October 2018 (Revised) and Mental Health Act 1984.

3.15 This specification reflects national policy, advice, guidance, and sets out the philosophy and care standards to be adhered to in the provision of such care, (Please refer to Appendix 10).

3.16 The Commissioner(s), in partnership with individuals and Providers, have an outcome based approach to the commissioning and provision of services which is reflected in this Service Specification.

3.17 By signing up to a "Partnership Approach", the Commissioner(s) and the Provider are making a commitment to:

i) Share key objectives.
ii) Collaborate for mutual benefit.
iii) Communicate with each other clearly and regularly.
iv) Be open and honest with each other.
v) Listen to, and understand, each other's point of view.
vi) Share relevant information, expertise and plans.
vii) Avoid duplication wherever possible.
viii) Monitor the performance of both/all parties.
ix) Seek to avoid conflicts, but where they arise, to resolve them quickly at a local level, wherever possible.
x) Seek continuous improvement by working together to get the most out of the resources available and by finding better, more efficient ways of doing things.
xi) Share the potential risks involved in service developments.
xii) Promote the partnership approach at all levels in the organisations (e.g. through joint induction or training initiatives).
xiii) Have a contract, which is flexible enough to reflect changing needs, priorities and lessons learnt, and which encourages individual participation.

4 CLIENT GROUPS

4.1 In respect to adults with a Learning Disability the Valuing People (2001) definition of an individual with a Learning Disability includes the presence of:

- a significant reduced ability to understand new and complex information to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.

4.2 In respect to adults with Autism, the National Autistic Society definition describes Autism as a lifelong developmental disability that affects how an

individual communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition, which means that, while all individuals with autism share certain areas of difficulty, their condition will affect them in different ways. Asperger's Syndrome is a form of Autism and for the purposes of this specification the term Autism will include this group.

4.3 A significant number of individuals accessing these services are likely to have complex needs, which could include, but are not limited to:

- 4.3.1 Over or under sensitivity to sounds, touch, tastes, smells, light or colours.
- 4.3.2 A range of vision, hearing or movement impairments.
- 4.3.3 Mental Health needs
- 4.3.4 Conditions such as epilepsy and diabetes
- 4.3.5 Difficulty communicating and typically express themselves through non-verbal means.
- 4.3.6 Swallowing difficulties, peg feeding or specialist dietary requirements
- 4.3.7 Social interaction difficulties including making friends, understanding social rules, understanding what other people are thinking and feeling
- 4.3.8 Social communication, including understanding what is said, making conversation, understanding gestures, taking things literally
- 4.3.9 Social imagination including problem solving, fixed interests, anxiety at change
- 4.3.10 Behaviours that challenge services, including self-injurious behaviour.
- 4.3.11 Eating disorders.

4.4 Service Users with a Learning Disability and or Autism who are also under Multi-Agency Public Protection Arrangements (MAPPA) may be supported under this Framework, (Lot 4).

4.5 The Care and Support Framework aims to support the five at risk groups within Transforming Care with the introduction of separate Lots. The Lots contained under the framework have been developed following consultation with providers, professionals, people with learning disabilities and/or autism and family carers.

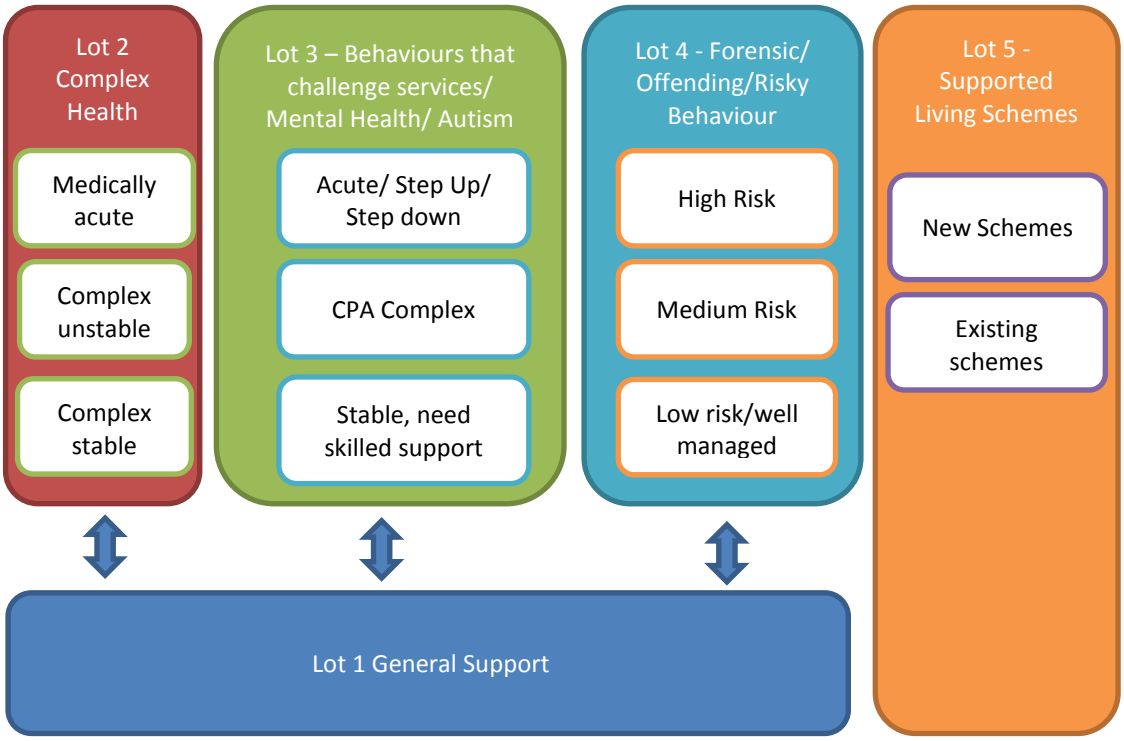
5 FRAMEWORK OVERVIEW

5.1 This overarching service specification underpins the expectations for providers delivering services across all the five Lots proposed, (see figure 1 below).

5.2 In addition to this service specification are individual service schedules relating to each Lot.

5.3 Regardless of which Lot(s) a Provider sits within, they must adhere to the conditions within this generic specification in addition to any Lot specific conditions contained within each Lot specific service schedule.

Figure 1



5.4 Each Provider can choose which Lots they wish to apply for in order to deliver services under this framework.

5.5 Each provider will be assessed for each Lot they apply for in its own right. Consequently, a Provider may be accepted on to all, some, or potentially none of the Lots they apply for.

5.6 With the exception of Lot 1, the number of Providers within each Lot has been limited as detailed in the Invitation to Tender document, to ensure there is sufficient business and to enable the Commissioner(s) to work more closely with a defined provider market.

5.7 This is a flexible framework enabling Providers to re-apply for specific Lots when the Commissioner(s) identify a need as detailed in the Invitation to Tender document

5.8 This is a declared rate framework:

5.8.1 Those delivering support to Individuals under Lot 1 will be paid at the Standard declared rate as quoted in the Framework Agreement - Schedule 2.

5.8.2 Those delivering support to Individuals under Lots 2, 3 and 4 will be paid at the Complex declared rate as quoted in the Framework Agreement - Schedule 2.

5.8.3 Those delivering support to Individuals under Lot 5 will be paid at either rate based on the complexity of Individuals within each supported living scheme, as determined through the assessment process.

5.9 Individuals requiring support will be identified at the assessment and Personal Budget approval stage as to which Lot they will sit under and consequently which Providers the Brokerage Teams will approach to deliver support.

5.10 If at the Care Brokering stage a Provider challenges the proposed Lot when initially assessing a client for support then this will be reviewed by the appropriate Team Manager/Practice Lead.

5.11 If an individual's needs change a Provider can request a reassessment of their needs and a revaluation of which Lot the Individual should be supported under.

5.12 Individuals with an existing package of care have been initially assessed by the Community Teams to agree which Lot each Individual will fall under when the Framework commences. This will be reviewed prior to contract commencement to reflect any changes in need.

5.13 There will be an opportunity for Providers to make a case where they dispute this assessment, post contract start.

5.14 In addition, the framework will include the facility for negotiated time–limited rates. This will be for clients within Lots 2 – 5 for those experiencing the upper tiers above of:

5.14.1 Lot 2 - Medically acute
5.14.2 Lot 3 - Acute/Step Up/Step Down from specialist LD hospital admission
5.14.3 Lot 4 - High Risk
5.14.4 Lot 5 - where an in individual falls under any of the above three upper tiers within a supported living scheme setting

5.15 Negotiated rates will be based on clear evidence and agreement between the Provider and the Commissioners that any one or more of the following is required:

5.15.1 Need for more senior staff to initially deliver care and support to individual
5.15.2 Individual requires additional management oversight than would be expected for a Lot 2,3 or 4 Individual
5.15.3 Agreement reached to commission additional specialist clinical or behavioral management services, over and above those offered as a specialist Lot 2, 3, or 4 Provider.

5.16 The declared rate will be inclusive of travel time and mileage incurred by staff to and from visits and any handover time required between staff.

6 AWARD CRITERIA

Lot 1

6.1 Existing contracted care and support Providers already delivering individual care packages who are successfully awarded to this Framework Agreement will be permitted to continue delivering these packages under the new terms and conditions of this Framework Agreement at the rates set out in Schedule 2 Pricing Schedule.

6.2 Existing individual support packages currently delivered by Providers who are not successful in joining this new Framework Agreement will be offered to all Lot 1 Providers contracted under this new Framework Agreement as follows:

6.2.1 Individual package of care – allocated on a first provider to respond basis

6.2.2 Collection of Individual packages – allocated through a process of mini competition.

6.3 New support packages starting after this Framework Agreement has commenced will be offered to all Lot 1 Providers contracted under this new Framework Agreement and will be allocated to the first provider to respond.

Lots 2, 3 and 4

6.4 Existing contracted care and support Providers already delivering individual care packages who are successfully awarded to Lot's 2, 3 or 4 under the Framework Agreement will be permitted to continue delivering these packages that fall under each respective Lot under the new terms and conditions of this Framework Agreement at the rates set out in Schedule 2 – Pricing Schedule.

6.5 Existing contracted care and support Providers already delivering individual care packages who meet the minimum criteria for Lots 2, 3 or 4, but do not rank high enough to successfully awarded to Lots 2, 3 or 4, will be permitted to continue delivering these packages under the new terms and conditions of this Framework Agreement at the rates set out in Schedule 2 – Pricing Schedule, as long as they have been accepted onto the Framework under another Lot. However, they will not be able to bid for new packages of care and support under Lots 2, 3 and 4.

6.6 Existing individual support packages currently delivered by Providers who are not successful in joining Lots 2, 3 or 4 under this new Framework Agreement and who also do not meet the minimum criteria, will be offered to the

respective Lot 2, 3 or 4 Providers contracted under this new Framework Agreement through a process of mini competition.

6.7 New support packages starting after this Framework Agreement has commenced will be offered to all Lot 2,3 and 4 Providers contracted under this new Framework Agreement through a process of mini competition.

Lot 5

6.8 In order to be eligible to deliver services under LOT 5, the Provider must also be successful in the award of at least one other LOT (1, 2, 3, and 4).

6.9 Existing contracted care and support Providers already delivering named schemes who are successfully awarded to Lot 5 of this Framework Agreement will be permitted to continue delivering these schemes under the new terms and conditions of this Framework Agreement at the rates set out in Schedule 2 – Pricing Schedule.

6.10 Existing named schemes currently delivered by Providers who are not successful in joining Lot 5 under this new Framework Agreement will be offered to the highest rank scoring Lot 5 Provider, and then in rank order thereafter if not accepted.

6.11 Any new Lot 5 services shall be let through a process of mini competition tender through the procurement portal.

All Lots

6.12 Information regarding staff considered eligible for TUPE will be shared when recommissioning any existing packages of care and support.

6.13 A 3-month transition phase post contract start has been allocated to manage any recommissioning of existing packages/schemes.

7 QUALITY STANDARDS AND SERVICE OUTCOMES

7.1 ‘The Big Plan 2018- 21’, the Bournemouth and Poole Health and Social Care Commissioning Strategy for people with a Learning Disability builds on the previous Big Plan 2012-15 and strongly aligns with the principles ‘Building the Right Support’, (2015) and ‘Supporting Individuals with a learning disability and/or autism who display behaviour that challenge, including those with a mental health condition – A Service model for Commissioners of Health and Social Care Services, (2015).

7.2 Whilst it is essential that the focus of the service delivery is on individual outcomes as described in the Individual’s Support Plan, the Commissioners also need to ensure that its Service outcomes are met.

7.3 The Provider will operate a Statement of Purpose and individuals guide which reflects the philosophy as detailed above and which sets out:

- The aims and objectives of the agency.
- The nature of the services provided.
- The name and address of the registered Provider.
- The relevant qualifications and experience of the registered Provider and manager.
- The range of qualifications of the care and support Workers supplied by the agency.
- The parameters of the service, including terms and conditions including referencing the precedent of the Commissioners terms and conditions for publically funded individuals.
- Specific reference to support for young people between 16-18yrs, (where applicable).

7.4 The following service outcomes have been identified in respect to national policy and best practice guidance, The Big Plan 2018-21 and Bill of rights Charter.

Outcome 1 - Rights, Respect, Privacy and Dignity – Individuals and their carers are treated equally, with dignity, respect and compassion. Individuals and their carers are free from discrimination.
The Provider shall:
1. Demonstrate a commitment to fair access, diversity and inclusion, and will ensure individuals are well-informed about their rights and responsibilities. 2. Ensure personal matters are dealt with sensitively and confidentially 3. Ensure each individual's personal space and belongings are respected by the staff that supports them and other individuals 4. Be sensitive to the age, gender, racial, ethnic, physical ability, sexual orientation and cultural needs of individuals and ensure they are supported by individuals who understand their needs and demonstrate this through their practice. 5. Demonstrate how complaints are dealt with, a timescale for responses and how individuals are informed of the outcome (in line with the Commissioners standards). 6. Support individuals to access independent advocacy where this is required. 7. Help individuals understand the care and treatment choices available to them. 8. Ensure at all levels individuals are supported to make informed decisions

about their life.

Outcome 2 – Maintaining my tenancy and my home – Supporting Individuals to maintain their new home.

The Provider shall:

1. Work with the housing landlord to support individuals to maintain their tenancy, (in line with the Commissioners policy and procedures).

2. Support individual's to manage their finances and all bills associated with their tenancy.

3. Support individual's to access advice and guidance in relation to their housing benefits.

4. Support individual's to raise any issues/concerns around the maintenance of their flat directly to the housing landlord and arrange suitable access for repair.

5. Work with the Individual to understand the task of being a responsible neighbour.

Outcome 3 - The right care and support when I need it – Ensuring services can meet the needs of the local population, in particular those who display behaviours that challenge services. Promoting a philosophy of 'Just Enough Support' with a focus on developing and maintaining skills and promoting independence, choice and control.

Individuals receive care and support that meets their needs and achieve their personal outcomes.

Individual Outcomes will be either:

Change Outcomes e.g. to enable 'John' to become independent in self care, Or

Maintenance Outcomes e.g. to assist 'John' in maintaining his level of self care.

Individuals are able to make informed decisions about the care and support they receive and are involved all aspects of the service that directly impact upon them, e.g. recruitment and training of staff.

The Provider shall:

1. Increase the number of individuals who are supported to live independently in the community.

2. Increase the number of individuals to become more independent and less reliant on services.

3. Work with the Commissioners to make the best use of Assistive Technology to promote independence and minimise risk.

4. Positively engage with every individual and their circle of support, (as appropriate), including carers, family, friends, advocates and other professionals.

5. Work with the individuals to draw up a Provider Support Plan to identify how the individual outcomes in Commissioners Assessment and Support Plan are to be met.

6. Make appropriate use of individual centered planning tools and approaches.

7. Ensure Individuals have access to information about their care and support in a format they can understand. Make appropriate use of Communication passports for Individuals with communication difficulties.

8. Support Individuals in achieving their outcomes through the care and support being delivered.

9. Ensure staff promote choice, but in the context of advocating behaviours that will support the Individual to maintain their health, social and economic wellbeing and preserving staff's overall duty of care.

10. To continually monitor and review goals with Individuals and play an active part in the Commissioners formal review process. As a minimum the support plan is to be updated six monthly.

11. To evidence clearly the outcomes achieved in each Individual's case recordings and support plan documentation. Copies of review documentation will be sent to the Commissioners.

12. Ensure a personalised approach to supporting individuals is explicitly included in induction and basic training and care workers shall be able to demonstrate their understanding.

13. To ensure staff are properly trained and work with individuals appropriately in respect to the Mental Capacity Act 2005 and consequent Deprivation of Liberty Safeguards, (DoLS).

14. Take a positive approach to risk management, ensuring that staff are

appropriately trained to assess risks and record and implement and review appropriate strategies to manage risk. At a service level these should be routinely audited for quality assurance purposes.

15. Ensure that staff will work with the Commissioners and other professionals to ensure Behaviour Support Plans are used effectively to support individuals. This will include adhering to plans which have been developed by staff within or linked to the CLDT's or Intensive Support Team (IST).

16. Involve individuals in recruitment and decisions around which staff support them. Work to identify people with similar interests to those they will be supporting.

17. Involve individuals and their families, representatives and/or wider circle of support in staff training as appropriate.

18. Ensure that services are delivered in such a way that enables the individual to feel control that their views and feelings are listened to and valued.

Outcome 4 - Having a Good Life – Supporting Individuals to be part of their community, to maintain and build new relationships and access social, leisure, education and employment opportunities.

The Provider shall:

1. Discuss with the individual, when developing the Provider Support Plan, whether there are opportunities to engage the Individual in the community, and realise any opportunities to make a positive contribution and experience fulfillment where appropriate.

2. Support Individuals to maintain links with their families, friends and wider circles of support.

3. Support individuals to make the most of their local community and access universal services, including public transport.

4. Support individuals to access employment, education or training, where appropriate.

5. To make best use of support available within the community that in turn may reduce a reliance on commissioned care.

6. Have clear policy and procedures for staff to support Individuals with learning disabilities and/or autism in respect to both friendships and

relationships of a personal and sexual nature Staff to be aware of the local LD Services Relationship Guidance 2016, (Appendix 3).

7. Organise service provision in a way that help's Individual's social contacts, for example not designing shift patterns that curtail Individual's social lives.

8. Consider giving support to voluntary sector initiatives that promote full social lives and networks.

9. Be sensitive to different approaches from different cultural groups.

10. Where commissioned, support Individuals who are parents in their parenting role.

Outcome 5 - Improved Health and Well being – Individuals are supported to look after their health, including managing medication, good nutrition, accessing mainstream and specialist health care services.

The Provider shall:

1. Support individuals in attending annual GP health checks and routine health screening as required by:
    a. Helping individuals understand the importance of an annual health check;
    b. Supporting them to fill out the pre-health check questionnaire;
    c. Arranging for someone who knows the individual well to go with them to the health check;
    d. Working with the CLDT, Intensive support Team (IST), CHAD, specialist health staff and GP practice to put in place any reasonable adjustments necessary (such as longer appointment times) for the individual to have a successful health check;
    e. Maintaining their Yellow Health Books.

2. Yellow Health Books and Health Action Plans can be a helpful way of supporting individuals to understand about their health. They should be updated after a health check, screening, or other health appointment, (e.g. dentist, dietician). Providers will ensure that the individual knows about and attends any follow-up appointments and referrals.

3. Support individuals in accessing universal and specialist healthcare services when needed and support the use of the Pan Dorset 'This is me - My Care Passport'.

4. The Provider shall ensure that Medication is administered in line with the requirements of the Care and Support Plan/Health Outcome Plan/Service Delivery Plan and the Commissioner's Medicines Guidance (Appendix 4).

5. Support staff are often the first to notice changes which may indicate a health problem. Providers need to ensure that support staff receive training so that they can recognise and report health needs.

6. Provide information to the Case Manager or relevant team when a significant health event has occurred.

7. Ensure Care Workers support individuals to understand more about their bodies and general health issues.

8. Ensure that individuals have accessible information and support to understand lifestyle choices with regard to diet and exercise.

9. Where service provision involves meal preparation or support to prepare meals, Care Workers shall be aware they have a responsibility to promote an Individual's access to a balanced, varied and healthy diet, and to ensure food is fresh and in date for healthy consumption

10. Care workers need to be able to recognise if an individual is underweight or overweight and seek medical advice and inform the Case Manager or relevant team. Where required individuals must be weighed regularly and an annual MUST assessment carried out.

11. Support individuals to maintain good oral health, linking closely with specialist oral health services in line with the Oral Care Pathway, where required and identifying a local Oral Health Champion.

12. Support individuals to access general health promotion initiatives regarding tobacco, alcohol, substance misuse and sexual health in the same way as the general population, using accessible information if needed.

13. Where applicable work with the Commissioner's staff in supporting people to develop a 'My End of Life Plan'.

14. Have a policy to ensure that wherever possible individuals, who have been recognised as being near the end of their life, are supported to stay at home to die if this is their express wish and appropriate. Achievement of this objective will be subject to the input of a range of Health and Social Care staff and the Provider shall contribute to this package of care as necessary. Any staff deployed to deliver services to individuals at the end of their lives is appropriately trained and skilled to do so.

15. Work with Commissioner(s) to implement the NICE Guidance Care and support of people growing older with learning disabilities (April 2018)

Outcome 6 - Keeping Safe – Individuals are safeguarded from abuse and experience effective, safe and appropriate care and support. Individuals are supported to learn about keeping themselves safe.

The Provider shall:

1. Ensure that the Principles of Safeguarding are embedded in all aspects of their service delivery, policy and procedures, recruitment, staff training, supervision and quality assurance. The Provider will ensure that all staff act in accordance with the Pan Dorset Multi-Agency Safeguarding Adults Policy and Procedures, (Appendix 5) and adhere to the 'Working Together to Safeguard Children – March 2015 and 2018 update, (Appendices 6&7)'.

2. Ensure the Provider's staff recruitment policy will evidence how new staff will have the aptitude and skills to deliver the outcome identified above.

3. Ensure the Provider's staff induction and on-going training and supervision programme ensures that staff are appropriately trained and supported to deliver the outcome identified above.

4. Ensure Care workers actively demonstrate an awareness of the above in the delivery of services and this is evidenced through individual and carer feedback, quality assurance activity and direct service monitoring.

5. Operate a proactive policy for ensuring that the welfare of individuals is safeguarded and all alerts are reported in line with the Policy and procedures above. The Provider will work in partnership with the Commissioners to ensure timely resolution of any safeguarding issues, individuals are safeguarded from any form of abuse or exploitation including physical, verbal, financial, psychological, sexual abuse, neglect, discriminatory abuse or self-harm or inhuman or degrading treatment through deliberate intent, negligence or ignorance in accordance with written policies and procedures.

6. Ensure the health, best interests and rights of individuals are safeguarded by maintaining a record of key events and activities in the home including:

    - The Commissioners Support plan.
    - The Provider's Support plan.
    - Risk assessments and action plans, including manual handling, as appropriate.
    - A record of each visit – this record may be used as a means of establishing deterioration or improvement in the individual's condition and may be referred to at reviews.

7. Ensure that all recording of this type is appropriate and that confidentiality is maintained at all times.

8. Ensure all records shall be accurate, factual, objective, concise and

relevant and will provide evidential records of the care that is being provided. Records shall be used as a means of communication between the Care Workers and others involved in the care package. The Commissioners shall have access to these records on request.

9. Ensure any individual, or their relative or representative acting on their behalf, refusing to have records kept in their home is requested to sign and date a statement confirming the refusal and this shall be kept on their individual file at the Provider's premises*.*

10. Regularly monitor and evidence the use and quality of documentation in the Individual's home as part of their quality assurance activities.

11. For individuals who needs challenge services the Provider will take ownership and provide leadership to staff in the implementation of Positive Behaviour Support.

12. Ensure care workers will work proactively with individuals to support them in taking steps to understand potential risks and to safeguard themselves. The Provider will ensure staff are competent to fulfill this role.

13. Please refer further to Outcome 7 in respect to Provider's responsibilities in respect to the recruitment of staff.

14. The Commissioners reserves the right to require the immediate removal of a member of staff in the event of any evidence of criminal activity or any other activity which may present risk to individuals. Notwithstanding that the Provider may have carried out their own assessment in relation to the risk presented by the member of staff.

15. Have a Whistleblowing Policy in place and evidence that all staff are aware of its existence and can access it.

Outcome 7 – Support for my family – Family and other informal carers are supported in their role and involved where appropriate in decision making.
The Provider shall:
1. Communicate effectively and in a timely manner with families. 2. Identify who is within each individual's circle of support and involve as appropriate family members/ informal carers in the decision making process. 3. Ensure that staff treat family members and informal carers with dignity and respect at all times. 4. Support carers' emotional and mental wellbeing through the provision of

good quality, reliable, consistent and responsive support which enables them to feel confident that their cared for individual will be treated with dignity, respect and kindness, their needs met and outcomes achieved.

Outcome 8 – Becoming an Adult – Young people are supported as they progress in to adult life with services focussed on ensuring a well planned and smooth transition.
The Provider shall:
1. Work with Commissioners, young people and their families to plan from as early as 16 years, where an individual has been identified as requiring services as an adult. 2. Be aware of, and comply with all legislation specific to supporting a young person from 16 years. 3. To work collaboratively with schools where a young individual is still in education to ensure coordinated approach to education, health and care outcomes. 4. Ensure compliance with CQC when delivering regulated care to individuals between 16-18 years and that the Services registration include age range within its Statement of purpose.

8. GEOGRAPHICAL LOCATION, OFFICE LOCATION AND AVAILABILITY

8.1 The Provider will cover the geographical area of Bournemouth, Christchurch and Poole in its entirety.

8.2 The Provider will also cover the wider county of Dorset for a small number of individuals who remain ordinary residents of BCPC, but live in wider Dorset. It is not expected that additional travel time and mileage costs will be incurred by the relevant commissioner.

8.3 The Provider is required to fully operate this service from a CQC registered office to be ideally situated within the Bournemouth, Christchurch or Poole area, or at least within a 10 mile radius.

8.4 If the Provider does not have a registered office that meets these criteria at the point of award, the successful Provider must work to register a local office within six months of securing a first package of care. The Provider must agree with CQC that they are able to deliver services from any proposed interim office.

8.5 A contact telephone number shall be made available to both the Commissioners, the individuals using this service (and their circle of support

as appropriate) and be appropriately staffed 24/7, 365 day per year (366 days in a leap year). It is important that the person answering the call(s) is appropriately trained to deal with potentially urgent and emergency situations, which may involve signposting to a more senior manager within the organisation who can respond effectively to the situation.

9. SERVICE DESCRIPTION

9.1 The Services will be available during the day typically between 7am – 10pm, 365 days per year, (366 days in a leap year). As a general rule support workers should not work outside these hours, although in some instances these times may be extended based on the agreed outcomes for individuals, as determined through the assessment process.

9.2 These Services will also be available at night typically, between 10pm and 7am, 365 days per year, (366 days in a leap year). Services during these hours will be either waking night support, or sleep in support.

9.3 The Services will provide both 1:1 care and support and shared care and support, e.g. care and support shared between Individuals.

9.4 Individuals with higher needs may require higher ratios of staffing, for example 2:1 or 3:1 support (please refer to Pricing Schedule).

9.5 The Services will achieve a primary objective of enabling people to remain living at home and maintain a good quality of life.

9.6 The Services must be person-centred, flexible and responsive ensuring that all individuals are able to exercise choice and control over the services that they receive and regarded as equal partners in the choosing how their care is delivered.

9.7 The Services are to support a culture of outcome identification and flexible working to achieve these outcomes. The Provider will deliver against an individual's personal budget allocation.

9.8 The Personal Budget represents an allocation of time assessed as required for each individual. However, the focus for service delivery is on achieving outcomes for individuals and moving away from a practice of 'time and task'.

9.9 Individuals who choose to manage their Personal Budget by way of a Direct Payment, or are eligible for a Personal Health Budget, will be able to purchase services direct from the Provider under this contract.

9.10 Whilst Services will be directly commissioned as a Managed Budget. Over the length of the Agreement the Commissioner(s) intend to explore the introduction of Individual Service Funds (ISF) with Providers as part of the development of the Services.

9.11 There is an expectation that Providers will work in close liaison with Individuals to develop a Provider Support Plan in an appropriate, timely and accessible format showing how the requirements of the relevant Commissioners Assessment and Support Plan will be met.

9.12 Services provided must meet the essential care requirements which may be identified in the individual's Support Plan but must also be flexible to fit in with the lifestyles of individuals.

9.13 The service provision must be able to take account of any changes to an individual's routine and also short term changes in health.

9.14 It is recognised, however, that the provision of truly flexible services may prove difficult within the constraints of available funding, staff rotas and call times. Consequently the Provider will be creative when considering how they configure services to maximise their capacity to be flexible.

9.15 The care and support tasks to be undertaken with and for individuals are likely to include the following. However, this is not an exhaustive list, nor needed in all cases, but will depend on the individual outcomes identified in the individual's Assessment and Support Plan.

- Personal Care Tasks
- Enabling Tasks
- Domestic Care
- Housing Related and Finance tasks
- Night Care
- Community Activities
- Emotional and Behavioural Support
- Providing a safe environment

Further information on these tasks is available in Appendix 8.

9.16 The Provider will work closely with the Commissioners to agree the use of assistive technology systems both in the home and the wider community to help promote independence, reduce the need for unnecessary support and minimise risk.

9.17 Service provision shall enable individuals to make decisions about what they do and how they do them that might involve a degree of risk. The Provider must have arrangements in place that can identify and manage risk appropriately to enable individuals to take risks but within a framework that minimises those risks.

10. SERVICES FOR CARERS

10.1 Included in this specification are the requirements to deliver a home based support service as set out in the Framework Agreement's Service Schedule Part 2 - Lot 1 – General Support.

11. ACCESSING THE SERVICE

11.1 An individual with a primary diagnosis of a Learning Disability, who may also have Autism, will be supported through the CLDT's and when required the Intensive Support Team (IST).

11.2 An individual who has Autism only will be supported through the Adult Social Care Services Locality Teams and should also be known to the Community Adult Asperger's Service.

11.3 Please refer to the Framework Agreement's Schedule 3 Referral Process and Order Form for further information on accessing the service for all Commissioners.

12. MENTAL CAPACITY

12.1 The Provider will comply at all times with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards in the provision of the Services. The Provider shall ensure that the Services are provided to an individual in such a way as does not deprive the individual of his liberty unlawfully.

13. PROVIDER OBLIGATIONS

13.1 The Provider shall provide the Services in accordance with its obligations under this Framework Agreement and with all the skill, care and diligence to be expected of a competent Provider of services of this type.

Staffing

13.2 The Provider shall ensure that sufficient numbers of individuals of appropriate ability, skill, knowledge, training or experience are available, so as to properly provide and to supervise the proper provision of the Service.

13.3 Staffing should be adequate to support individual needs and to provide continuity and consistency of service.

13.4 The Provider will ensure staff are regularly supervised and appraised on an annual basis.

13.5 The Provider will ensure Individuals are cared for by individuals who understand their communication needs and demonstrate this understanding

through their practice. Care workers shall be able to communicate effectively and appropriately with individuals.

13.6 Ensure staff are provided with suitable protective clothing, where required and the issue of any necessary equipment in which to safely perform their duties. ID badges to be renewed three yearly as a minimum.

13.7 Ensure that a senior member of staff is available to the Commissioner(s) staff for training with regard to each individual's needs, including but not exclusive to moving and handling, health management, positive behaviour support and risk management. This training will then be cascaded to the relevant care and support staff.

13.8 Ensure staff terms and conditions reflect the value of staff retention to provide consistency of care.

Recruitment

13.9 The Provider's staff recruitment policy will evidence how new staff will have the aptitude and skills to meet the needs of the Individuals they are supporting.

13.10 The Provider's recruitment process will evidence that staff are appropriately vetted in respects to their suitability to work with vulnerable individuals. When recruiting Care Workers, the Provider shall ensure that at least two appropriate written references are taken up one of which must be from the individual's last employer, and shall demonstrate the means by which the suitability of all Care Workers has been assessed. If the last employer was not engaged in the social care industry, then a further reference should be sought from their last care employer if appropriate.

13.11 Ensure staff shall go through a full recruitment process including completion of an application form which provides complete employment history (including month as well as year of employment), and addresses any gaps in employment history. Evidence of ID to include Photo ID.

13.12 Ensure that all staff are legally entitled to work in the United Kingdom.

13.13 The Provider must ensure that all managers, staff and volunteers that engage with individuals or have access to individual records are fully checked under DBS Procedures and the Provider is in receipt of a cleared DBS in line with the requirement of the Call off Contract at clause 10.2.

Practice Standards

13.14 Ensure all risk assessments are carried out by a trained and qualified person of the Provider. Where required such individuals should work in conjunction with other professionals who are involved in assessing the care and support needs of the client.

13.15 The Provider shall ensure every individual receives visits according to the frequency and duration recorded in the Care and Support/Health Care Plan, and the service shall be performed to the standard required by this Specification.

13.16 The Commissioner(s) reserve the right to withhold payment for any Services that are unrecorded in the Care and Support/ Health Care Plans.

13.17 The Provider's Staff shall arrive at the agreed time as specified in the Care and Support/Health Care Plan or as agreed directly with the Individual. Persistent failures to arrive at the agreed time may give rise to adjustments in any payment due.

13.18 The Provider shall make every effort to contact the Individual to inform them where staff are going to be late, and the alternative arrangements where applicable. Where Care Workers are late and the Services are not provided for the contracted period of time an adjustment shall be made to the payment due.

13.19 The Provider shall ensure that the Individual is notified in advance, where possible, if the regular Care Worker is unavailable or, if an emergency as soon possible. Every effort shall be made to promote consistency of carers, using substitute Care Workers that are trained to the agreed standards where necessary.

13.20 The Provider staff shall not throw personal items of the Individual away, with the exception of domestic refuse.

13.21 Where the Provider uses equipment belonging to the Individual they shall do so in a considerate and appropriate manner. They shall inform the Individual of any equipment that is damaged or unsafe and shall not be required to use such equipment.

13.22 The Provider shall promote the health and well-being of Individual in receipt of Services by upholding and implementing best practice in hygiene and in infection control procedures.

13.23 The Provider shall ensure the names of care staff who attend the Service User are recorded legibly in the delivery Care Plan.

13.24 The Provider shall ensure that care staff do not arrange substitute staff or changes in personnel to cover absences themselves.

13.25 The Provider shall provide safe storage for an individual's medication and ensure staff comply with the Adult Social Care Medication Management Policy Borough of Poole and Bournemouth Borough Council 01 August 2017, (Appendix 4a and 4b).

13.26 The Provider shall as part of their obligation to notify CQC of any statutory notices immediately forward a copy of such notice in writing by post to the

Service Improvement Team, Commissioning and Improvement – People Services, Borough of Poole, Civic Centre, Poole, Dorset BH15 2RU or by email to serviceimprovementteam@poole.gov.uk.

13.27 All records shall be accurate, factual, objective, concise and relevant and will provide evidential records of the care and support that is being provided in response to meeting individual's assessed need and outcomes. Records shall be used as a means of communication between the Care Workers and others involved in the care package and as evidence in respect to assessing individual's eligibility for Social Care or Health funding. The Commissioners shall have access to these records on request.

13.28 Care must be taken by the Provider to ensure that all recording of this type is appropriate and that confidentiality is maintained at all times in line with the requirements of the General Data Protection Regulations 2018.

13.29 Any individual, or their relative or representative acting on their behalf, refusing to have records kept in their home is requested to sign and date a statement confirming the refusal and this shall be kept on their personal file at the Provider's offices. Records of tasks and/or interventions undertaken will be held in the Provider's offices. The Provider will have a process in place to ensure that any staff providing care/support has access to these records to enable them to provide a safe service.

13.30 The Provider shall operate a staff code of conduct, which all staff must be aware of and adhere to at all times.

13.31 Written records demonstrating compliance with all of the requirements above shall be held by the Provider on a personal staff file for each employee. The Provider shall ensure that all employees are requested to give consent for their staff file to be accessed as required by the Commissioner(s) to carry out Service Monitoring and evidence in writing where this has been refused.

13.32 The Provider shall comply with any programme of continuous improvement that has been agreed and reviewed with the Commissioner(s)

13.33 The Provider shall regularly monitor the use and quality of documentation in the Individual's home as part of their quality assurance activities.

13.34 All parties involved in the service shall demonstrate a strong commitment to partnership working.

13.35 The Provider must evidence a culture of consistently achieving good practice and commitment to the ongoing improvement of services.

13.36 The Provider must operate a quality assurance and improvement framework which actively uses intelligence and feedback from individuals, families and their wider circle of support in respect to this service on a routine basis. This should also include feedback from the Commissioner's Contracts Team and Service Improvement Team, and other professionals involved in care of

individuals, as well as learning from good practice at national, regional and local level. The Provider will publish their findings and make this available to the Commissioner(s) upon request.

13.37 The Provider will work in partnership with Commissioner(s) in the event of the Commissioner(s) transferring packages to an alternative service Provider as a result of a safeguarding or other issue which in the opinion of the Commissioners place(s) individuals at risk to their health and wellbeing.

13.38 The Provider will engage in Provider/Commissioner(s) meetings/Forums as reasonably requested in the spirit of service improvement and positive communication.

13.39 The Provider will specifically be required to send an appropriate management representative to the Bournemouth, Christchurch and Poole Learning Disability Provider Forum (3 meetings per year), if delivering services locally under this framework.

14. TRAINING

14.1 The service Provider will work with other agencies including the Commissioner(s) to support development and deliver training for individuals with learning disabilities, family, carers and staff teams. The service Provider must have in place appropriate training programmes for all staff groups which include mandatory and up to date training and support for continuous professional development.

14.2 Prior to commencement of duties all care staff shall have participated in the Skills for Care Common induction – Care Certificate, as detailed below and will have been signed off by the Provider as being competent to deliver services under this contract.

- Standard 1 Understanding your role
- Standard 2 Your personal development
- Standard 3 Duty of care
- Standard 4 Equality and diversity
- Standard 5 Work in a person centred way
- Standard 6 Communication
- Standard 7 Privacy and dignity
- Standard 8 Fluids and nutrition
- Standard 9 Awareness of mental health, dementia and learning disability
- Standard10 Safeguarding adults
- Standard 11 Safeguarding children
- Standard 12 Basic life support
- Standard 13 Health and safety
- Standard 14 Handling information
- Standard 15 Infection prevention and control

14.3 To accommodate gaps in staff training and ensure all learning disability knowledge skills are completed, it is recommended that the Provider refers to the following:

- Skills for Care – Ongoing Learning and Development in Adult Social Care, key learning outcomes.
- Skills for Care – Learning Disability Core Skills Education and Training Framework.

14.4 The Provider is responsible for ensuring the competence of the member of staff deployed to meet the needs of the individual prior to commencement of duties.

14.5 Management staff must have the aptitude, skills, knowledge and experience required to act as leaders within the Care Sector. All Managers shall comply with National training requirements in relation to achievement of the previous Registered Managers Award, Level 5 Diploma in Leadership for health and Social Care and Children and Young Persons' Services – Management of Adult Services or any subsequent replacement or amendment.

14.6 Managers must complete Safeguarding Adults for Managers of Provider Services in line with the Pan Dorset Multi-Agency Safeguarding Adults Policy and Procedures and undertake refresher training every (3 years).

14.7 The Provider will evidence through its quality assurance processes that all staff have completed the required training to meet the needs of the clients they are supporting and that their ongoing competence in respect to this training is routinely monitored and reviewed.

14.8 The Provider should not overly rely on e-learning; ensuring face to face delivery of training is provided where staff competence is paramount to the safety of individuals and themselves.

14.9 The Commissioner's Learning and Development Team can provide support and advice on standards required with mandatory training.

15. QUALITY ASSURANCE, SERVICE REVIEW AND MONITORING INFORMATION

15.1 It is a mandatory requirement that all Providers will be registered with the Care Quality Commission (and any successor body); to include specific provision for 16-18 year olds in their registration and their Statement of Purpose. The Provider will maintain registration throughout the duration of this 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.

If the Provider fails to perform to a satisfactory level they will trigger the requirement for a contract review and a monitoring exercise will be undertaken that will result in an agreed action plan for improvement, in accordance with the Call off Contract clause 40 – Termination on Default.

15.2 The Provider and their staff are required to evaluate their standards of care and support practice regularly. The performance management and monitoring of the Framework Agreement shall be the responsibility of the Lead Commissioner, working in conjunction with the other Commissioner(s). Monitoring of the services shall be conducted by the Commissioner's Commissioning and Improvement – Service Improvement Team; in consultation with the Provider, Individual, Carer/Representative, (where appropriate), CLDT, Community Adult Asperger's Social Worker or Locality Teams.

15.3 The Commissioner(s) and the Provider shall be jointly responsible for quality assuring and monitoring the effectiveness of the services provided in meeting the specified outcomes. The Provider will at all times co-operate with the Commissioner(s) monitoring requirements.

15.4 The Provider shall have an effective system for Quality Assurance based on the outcomes for individuals, in which standards and indicators to be achieved are clearly defined and monitored on a continuous basis by care and support staff and their line-managers.

15.5 The Provider is responsible for supervising the activities of all Care Workers and for monitoring and reviewing the effectiveness of their own working arrangements. This includes the effects of the work undertaken on Care Worker's health with particular regard to physical or mental strain. The Provider shall continually assess staff competence and ability to undertake the work required, in addition to undertaking regular supervisions and annual appraisals.

15.6 The Provider will ensure that individuals and carers are integral to the process of quality assurance and the Provider will learn from and improve service provision based on the direct feedback of Individuals. The Provider shall develop innovative methods of engaging with Individuals and carers to contribute to their quality assurance process.

15.7 The Provider shall attend Contract Review Meetings as and when they are reasonably required to do so, as outlined in the following clause 16.

15.8 The Provider shall be a crucial partner in the completion of individual service reviews and will be required to coordinate reviews on receipt of reasonable due notice by the Commissioner.

15.9 The Commissioner(s) shall also carry out regular service monitoring, this can be either announced or unannounced (being mindful of all clients and their specific needs), to ensure that the quality standards required under this contract are adhered to. The Commissioner(s) monitoring activity may include:

15.9.1 Accessing any available information which gives an indication of the quality of the service, including CQC reports, individual Service Reviews, complaints and compliments and Monitoring reports from other Local Authorities and/or the NHS;

15.9.2 Visiting individuals to observe the quality of care provided or discuss their experience of receiving services. The Provider may or may not be advised that these visits are to take place;

15.9.3 Seeking feedback from individuals and their representatives, other professionals and agencies involved in their care regarding the quality of service provided;

15.9.4 Discussing with Care Staff their experience of working for the Provider.

15.10 The Commissioner(s) may share information regarding the Provider's service standards, including contract monitoring reports, with other public bodies including the CQC, the NHS, and other local authorities and with individuals who are considering purchasing care services from the Provider, in line with the General Data Protection Act requirements.

15.11 As the service develops, performance reporting shall be reviewed to meet need and agreed between the Commissioner(s) and the Provider.

15.12 The Provider shall also compile and maintain such information as the Commissioner(s) may reasonably require enabling the Commissioner(s) to evaluate the Service using any local Performance Indicators that may be developed and introduced following consultation with Providers.

15.13 The Provider shall produce for the Commissioner(s) any other information that the Commissioner(s) may reasonably require relating to the Service provided under this Agreement including information on and the names of individuals.

15.14 In accordance with the provision of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Social Care Act 2012. The Provider shall allow members of the Local Healthwatch to inspect Services commissioned by the Commissioner(s) under this Framework Agreement, so as to enable members of the community to contribute their views in relation to health and social care service development and delivery.

16. CONTRACT MANAGEMENT

16.1 Authorised Representatives

16.1.1 The Council's initial Authorised Representative will be confirmed upon award of the Framework Agreement.

16.1.2 The Provider's initial Authorised Representative will be confirmed upon award of the Framework Agreement.

16.2 **Key Personnel**

16.2.1 The following Key Personnel shall be responsible for managing the contract which shall include monitoring contract compliance, all financial and operational aspects of the Services, and the standards of the Services provided with particular emphasis on quality:

The Council's Key Personnel:

Key Personnel	Post Title	Key Role
Authorised Officer – Jonathan O'Connell	Principal Officer - Joint Commissioning Learning Disabilities & Mental Health	To approve funding for the Services; and ensure that the Services are meeting service delivery objectives in line with the Council's priorities
Email address: jonathan.oconnell@poole.gov.uk Tel: 01202 261144		
Contracts Officer – Alison Pagram	Contracts Manager and/or Contracts Officer	To manage the Contract and make decisions about the provision of the Services. (i) managing and administering the Contract; (ii) arranging payment for the Services; (iii) monitoring the Provider on a periodic basis to ensure that the Contract is adhered to; (iv) ensuring that the information requested from the Provider, as detailed in Service Agreement, is provided by the Provider at the time specified.
Email address: a.pagram@poole.gov.uk Tel: 01202 261146		
Operations Link Officer – Anna Keegan	Integrated Team Manager – Community Learning Disability Teams	(i) the first point of contact for the Provider on a day-to-day basis; and (ii) responsible for evaluating the Services to ensure that the objectives of this Contract are met.

Email address: a.keegan@poole.gov.uk Tel: 01202 605858		
Ewa Johnson Service Improvement Manager	Service Improvement Manager and/or Service Improvement Officer	for arranging and/or carrying out the monitoring of the Services using various approaches depending on the purpose of the monitoring, e.g. routine monitoring visit, or a visit instigated as a result of a specific concern regarding the quality of the service being provided by the Provider.
Email address: e.johnson@poole.gov.uk Tel: 01202 261176		

16.2.2 The Provider shall promptly give notice to the Commissioners of the identity of the Provider's Contract Manager appointed to manage the Services and any replacement. Any Contract Manager shall be appropriately qualified and/or experienced for their responsibilities in relation to the Service.

16.2.3 The Provider shall also notify the Commissioners of all other Key Personnel acting on behalf of the Provider in administering, managing and delivering these services.

16.2.4 The Provider and Commissioners shall take appropriate steps to confirm the preferred communication and other procedures at the outset of the Framework Agreement.

16.3 **Meetings**

16.3.1 Prior to the start of the Framework Agreement and for the first 6 months after, Implementation Meetings shall be held to monitor progress of the Provider's Implementation plan for mobilising the service provision.

16.3.2 The Commissioners Contracts Officer shall be responsible for planning and organising the Implementation meetings, which the Provider's Authorised Representative (and other Provider Key Personnel as deemed appropriate by the Provider) will be required to attend. The Contracts Officer shall be responsible for minuting the discussions, agreed actions and outcomes arising.

16.3.3 Contract review meetings for Providers assigned to Lots 1,2,3 and 4 will be arranged at least annually as a combined meeting, and individual provider meetings may also be held on a more frequent basis. The Commissioners Contracts Officer shall be responsible for planning and organising these meetings and minuting the discussions, agreed actions

and outcomes arising. (See also Section 15.9 in regards to service monitoring arrangements.)

16.3.4 Thereafter, contract review meetings for Providers assigned to Lot 5 shall be held on a six monthly basis between the Provider and the Commissioners. The Commissioners Contracts Officer shall be responsible for planning and organising these meetings and minuting the discussions, agreed actions and outcomes arising.

16.3.5 The Commissioners Contracts Officer shall issue an agenda and the minutes from the previous contract review meeting 5 working days prior to the next scheduled review meeting.

16.3.6 As a minimum, the Provider's Authorised Officer, the Commissioner's Authorised Officer and Contracts Officer should attend meetings.

16.3.7 The purpose of these contract review meetings shall be to:-

(i) monitor, review and evaluate the performance of the Provider against the Service Specification (Schedule 1) and relevant Appendices;

(ii) monitor, review and evaluate all financial and operational aspects of the Service;

(iii) evaluate and review the information reported by the Provider in accordance with the Service Specification.

(iv) ensure that the data to be produced in accordance with the Service Specification has been reported accurately and that targets have been achieved. If targets are not achieved, a plan of action will be agreed between the parties.

(v) measure the outcomes against the Services Specification and discuss and identify areas for improvement or more focus;

(vi) provide an opportunity for the Provider and the Commissioners to openly discuss any areas for future development, gaps in provision, current barriers to success, etc;

(vii) at the Contract Review Meeting which is held nearest to the date which is 12 months before the Framework Agreement expiry date, discuss the arrangements for decommissioning.

16.3.8 The Commissioners shall agree a standard Agenda for the Contract Review and plan meetings with the Provider at the onset of the Contract.

16.4 **Reports**

16.4.1 For each Contract Review meeting, the Provider will supply the Commissioners with the following reports:

16.4.1.1 a service report for LOT 5 which covers the service activity for the previous six month period. This should include the information agreed at the onset of this Agreement; and

16.4.1.2 a financial report for LOT 5 which details the expenditure for the project for the previous six month period with a comparison against the relevant scheme service schedule.

16.4.2 These reports will be provided at least 5 working days prior to the scheduled Contract Review meeting for the Commissioners to consider before the meeting.

16.5 **General**

16.5.1 Any costs incurred by the Provider in attending any meetings shall be at the Provider's expense.

17 SERVICE DEVELOPMENT

17.1 This Service is being developed at a time of significant change with the contract commencing as the new Bournemouth, Christchurch and Poole Council comes in to being. As such, it is essential that the Commissioner(s) and Provider are committed to working together in the spirit of mutual co-operation and trust in developing these services and taking them forward during the period of the contract.

17.2 As a learning organisation, the Provider will be required to proactively collect and analyse information on outcomes for the Individuals in order to inform their understanding of best practice and service development.

17.3 The Provider shall be willing to share and actively disseminate best practice and information on needs and outcomes.

17.4 There is a commitment from the Commissioner(s) to explore how the LD Provider Forum can be used to celebrate success within the sector following feedback from the workshop in Feb 2018.

17.5 Exploring the introduction of Individual Service Funds will be progressed as an area for Service Development in the life of this agreement.

17.6 The Commissioner(s) shall work with Lot 1 Providers to ensure individuals requiring smaller packages of support receive the care they need will also be progressed.

17.7 The Provider shall be willing to assist the Commissioner(s) in planning for future service demands and also be prepared to participate in programmes to

build capacity amongst Providers adding value to future commissioning decisions.

17.8 During the period of this Framework Agreement, the Commissioner(s) and Provider shall work together to develop the nature and delivery of the Service to reflect the needs of individuals to access service and the agreed priorities for the Commissioner(s). Any other changes to Services or how they are delivered shall be negotiated between the Parties, including any associated changes to the price.

18 PROTECTED PACKAGES

18.1 The Commissioners may, in some cases, exercise the right to protect payment for packages of care (protected hours). The length and value by which a package of care may be protected will be determined on a case by case basis. The Commissioner's Brokerage Team will advise the Provider when a package of care is to be protected, and for how long the package of care will be protected.

18.2 Where a package of care has been protected, the Provider shall restart the care on the requested date and if possible, using the same care workers. If the Provider cannot restart a protected package of care on the requested date, the Commissioner will not pay the Provider for the protection period, and will reclaim if already paid the cost of the protected care hours.

18.3 Where an Individual's package of care is protected while they are in hospital and the Provider is informed the Service User will not be returning home, the Provider must notify the Commissioner immediately. The package of care shall terminate on the day that the Provider or Commissioner received notification from the hospital that the Service User will not be returning home.

18.4 The Provider shall provide appropriate care to meet the needs of all referred Service Users at home; however, exceptional circumstances may arise whereby the Provider is unable to meet the needs of a Service User. In this eventuality, the Provider must alert, and give notice to the Clinical Continuing Healthcare Team/Care Management Team as soon as possible to facilitate the sourcing of alternative care and to mitigate any disruption in service to vulnerable Service Users.

18.5 For Individuals funded through Continuing Health Care please refer to NHS CHC Memorandum of Agreement for Protected Payments, (please refer to the Pricing and Payment Schedule).

19 EMERGENCIES

19.1 The Provider shall notify the Keyworker immediately when a Service User is considered to be in need of urgent attention from other services, or is at immediate risk, after ensuring the relevant emergency service is summoned.

19.2 The Provider shall report any failure by care staff to gain access to the Service User to the Social Worker/Care Manager/Clinical Case Manager, or if outside normal office hours, by referral to the Emergency Out-of-Hours Service/Clinical Continuing Healthcare Team.

19.3 The Provider shall immediately report any changes/concerns in the Service User's circumstances or other concerns that the care staff may have about a Service User to the Continuing Healthcare Team/Care Management Team, or if outside normal office hours, to the Emergency Out-of-Hours Service.

19.4 The Provider shall allocate additional care time to ensure the Service User's health and safety where a Service User's needs have changed due to sudden illness or unforeseen circumstances. This extra care will be at the discretion of the Provider and must be in proportion to the nature of the emergency. The need for this additional care and the amount of care given must be discussed with the commissioner(s) on the same day, or the next working day if this is not possible.

20 PROVIDER BUSINESS MANAGEMENT

20.1 The Provider shall manage the service in a business-like manner, demonstrating a sound financial base and meeting all contractual obligations to the highest standard.

20.2 The Provider shall provide information to the Commissioner on the financial security of the business when requested.

20.3 The Provider shall ensure their staff in senior positions within the organisation have the knowledge, skills and competence to undertake this Specification to ensure high standards of care provision for Service Users and Carers.

20.4 The Provider must understand the nature and purpose of the Service it is providing, in particular the varying needs of Service Users, and that this is fully conveyed and understood by its employees.

20.5 The Provider shall ensure the Management Structure of the Service is robust, flexible, and responsive to changing needs, circumstances and demands. There will be a strong commitment to leadership within the organisation, business direction and oversight to keep abreast of national and local best practice initiatives in care.

20.6 The Provider shall ensure all staff, comply, uphold and maintain legislative requirements, employment practice, policies and procedures at all times.

20.7 The Provider must inform the Service Commissioner of any changes relevant to this Contract, including changes of personnel and/or address.

21 BUSINESS CONTINUITY PLAN

21.1 The Provider shall have a robust business continuity plan in place to reduce the risk of service disruption to vulnerable Service Users. As a minimum, this plan will record resources and risk, and consider:

- A risk assessment that identifies five levels of impact from an insignificant disruption to one of significance.
- The minimum number of people required to deliver the Service
- The critical times to deliver the Service
- The premises where the Service is delivered from
- Business Continuity and control measures in the event of an emergency or power failure

(This list is not exhaustive)

21.2 Where business continuity arrangements are not predicted to be temporary, or where an Individual would be put at risk because of the Business Continuity arrangements, the Provider and the Commissioner will work together to agree a way forward.

21.3 The Provider shall work collaboratively and positively with the Commissioner(s) to promote the status of the domiciliary care sector and so improve the retention and recruitment of care workers. This may involve working collectively with other Providers in the sector on joint projects to improve quality, address workforce issues, or develop services.

21.4 The Provider shall invest time and resources in proactively working to recruit and retain staff to meet the predicted increase in capacity requirements.

22 THE MANAGEMENT OF POTENTIAL RISKS AND DISRUPTIONS

22.1 The Provider shall receive information, from the Commissioner(s), about measures required to manage the risk or hazard, including the involvement of carers and any other relevant people in the Service User's life. Actions shall be taken to mitigate risk and the Care and Support Planning process will record whether this will create a significant impact on the Service User's well-being. Where concerns remain the Provider shall work with the Service User to look for solutions and notify the relevant Commissioner of any significant changes made to the service.