

Bristol City Council



Specification for the provision of Community Support Services

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Part A: Context

A.1 Introduction

A.2 Aims of the Specification

A.3 Eligibility

A.4 Armed Forces Community Covenant for Bristol

This document is Bristol City Council's (BCC) specification for the commissioning and purchasing of adult social care Community Support Services and additional background to this specification can be found in Appendix 1. It sets out the requirements for Community Support Services and BCC's expectations for the delivery of service. All providers will be required to deliver Community Support Services in line with this specification until further notice. Providers will be assessed on their service delivery against this specification. However, it is acknowledged that packages of care will vary and not all requirements will be applicable to every service user; an individual's needs will be clearly identified in their support plan. Additionally, this specification is intended to support the transition to outcomes focused care and support. It aims to clearly define expectations whilst still permitting flexibility in delivery, in order to meet the needs and outcomes of individuals.

Community Support Services (CSS) in Bristol are social care support services for adults (18+ years) with statutorily assessed eligible social care needs, including but not limited to those with learning disabilities, physical disabilities, sensory impairments, mental ill health, older people, acquired brain injury and carers.

CSS aims to maximise independence and wellbeing and enable individuals to remain in their own home or in supported accommodation within the community, avoiding residential or hospital settings, where appropriate and for as long as possible. This includes services provided directly to individuals but also to their carers, to enable them to take a break from their caring role. The promotion of services within community settings is a key driver for change in the Care Act and in national Transforming Care policy, for example 'Building the Right Support – developing Community Services'. In order to meet the requirements, providers are expected to have, and to continue to develop and expand, strong local networks and knowledge of available local services that can help maximise an individual's independence.

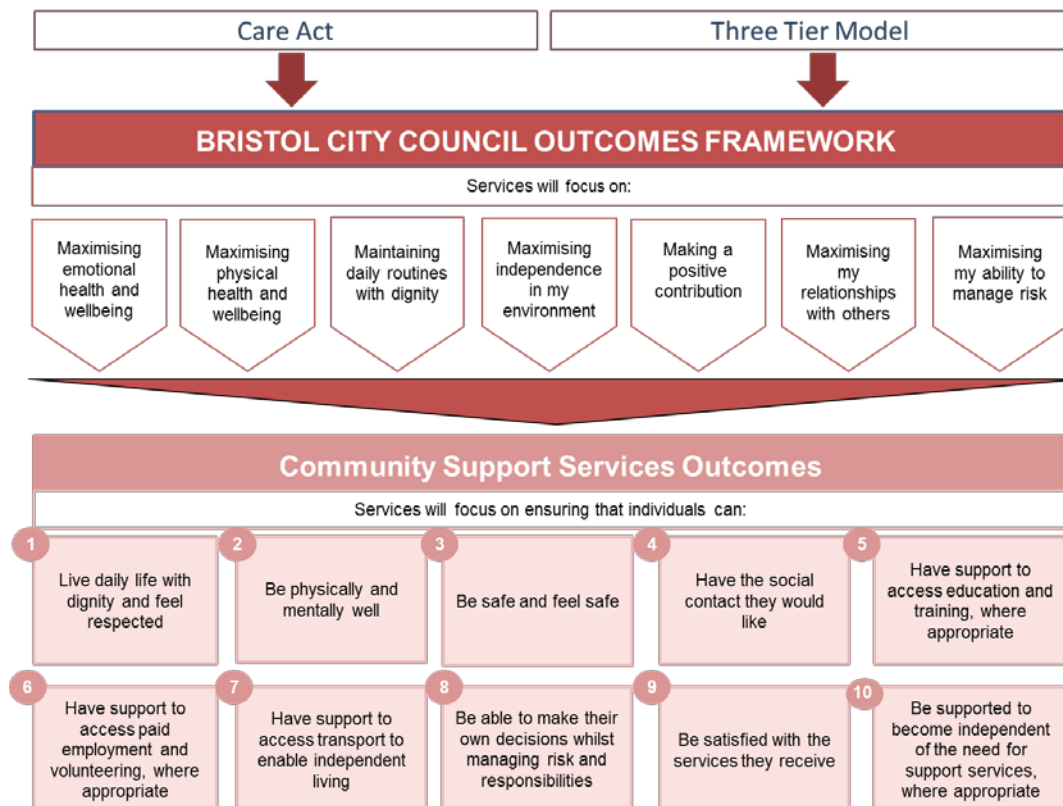
Adult social care Community Support Services include a range of activities that meet differing levels of need, for example:

- Support with household tasks to enable independent living and/or support to maintain tenancies
- Support to attend learning, training and employment related support
- Support to enable progression towards greater independence
- Assistance to build and maintain social networks and relationships and attend activities in the local community

- Support to enable individuals to maximise their income, which may include submitting claims for relevant benefits, reporting changes of circumstances and generally managing benefits claims
- Support for carers to enable them to continue in their caring role.

Community Support Services can be provided in isolation or in conjunction with other services, such as Clinical Commissioning Group (CCG) commissioned health services and other services commissioned or provided by BCC and key partners in the Bristol, such as housing, transport and education and training.

It is essential that providers of CSS transition away from traditional activity focused social care packages to more innovative, personalised and outcomes focused services. A key element of this is enabling individuals to access other services and facilities within their local community to support their independence and able them to be active local citizens. As outlined in the CSS strategy and in the body of the document, the CSS outcomes sought in addition to individual service user outcomes are shown below.



Within this specification, there are four categories of Community Support Services:

- **Supported Living** – Support provided within someone’s home to enable and maintain independent living, where the tenancy and support are intrinsically linked. Supported living, as described in this specification, tends to be accommodation support alongside support with non-domestic tasks. The provider may or not be the Landlord alongside the service provider but the tenancy and support will be intrinsically linked.
- **Support to access the community** – this support provided out in the local community or support provided in someone’s home focused on house/domestic related tasks where the individual is the owner or tenant of their own home and the service provider is not the Landlord.
- **Day services** - this is support provided in the local community, usually building based day support
- **Time for you carers services**– this is support to enable carers to take a break from their caring role and/or to provide them with the support they need to continue in their role, such as befriending.

Services will be commissioned depending on a service user’s assessed band of CSS need, recognising that the level of need and complexity within the service user group varies. Supported living and support to access the community will have four bands of BCC defined need: Standard, Intermediate 1, Intermediate 2 and High, recognising variation in need within these categories. For day services there will be two bands of need (Standard and Intermediate) whereas time for you carers services will have one band of need, recognising that there is currently less variation in need across the client group and the differences that are prevalent can be captured within the identified bands.

The need bands typically align with the level of intervention a service user requires. Other factors also influence a service user’s band such as level of risk. BCC have created a tool for social care practitioners to be used alongside the support planning process. This tool will serve to allocate service users’ needs to a band for the purposes of commissioning appropriate CSS packages. In some instances a service user may be allocated more than one band per support plan depending on their needs. This tool can be found in Appendix 5.

To support the delivery of improved services that can meet demand, BCC will continue to work with the market to ensure that there is a diverse and vibrant local market and gaps in provision can be identified, to support continual market development. BCC commissioners will review the service and existing provision against identified need on a periodic basis and inform providers of the

outcomes, to enable further business development and to share market intelligence transparently with all providers to provide a fair and equitable opportunity for business development. One of the key gaps identified in the public consultation was the gap in services for the transition to adulthood and this will be an area of focus for further market development work. Providers of CSS may therefore wish to consider providing a service to under 18s to support this aim.

This service specification document sets out the following:

- **Context** within which the services are being commissioned
- **What we are commissioning** (definition of the service categories and a description, the high level quality standards and price ranges and descriptors for each)
- **Service and quality standards** – applicable to all service categories
- **Service outcomes** – applicable to all service categories.

A.2

Aims of the Specification

This specification sets out BCC's requirements for the provision of Community Support Services and describes the service user outcomes and service and quality standards required from commissioned providers. This specification is applicable to all services and client groups.

Bristol City Council aims to:

- Maximise independence and to meet agreed service user outcomes and needs
- Enable individuals to remain in their own home or supported accommodation within the community
- Transition from an activity focussed approach to an outcomes focussed approach to wellbeing and maximised independence
- Commission quality services that offer value for money.

A.3**Eligibility Criteria**

The national eligibility criteria as set out under the Care Act (2014), sets a minimum threshold for adult care and support and carer support. All local authorities must enable needs to be met at this minimum level. The threshold is based on identifying how an individual's needs affect their ability to achieve relevant desired outcomes and the impact their needs have on their physical and mental wellbeing. The Care Act eligibility threshold will be used to establish critical and substantial unmet eligible needs that BCC has a duty to meet, either directly or by enabling another organisation to meet an individual's needs. Once eligible needs are identified, BCC will take steps to meet those needs in a way that supports the individual's needs being met and agreed outcomes.

A.4**Armed Forces Community Covenant for Bristol**

On June 23rd 2014, BCC and Bristol CCG signed the Bristol Armed Forces Community Covenant. This is a voluntary statement of mutual support between the civilian community and the local Armed Forces community in Bristol. This Bristol initiative reflects the government's tri-service Armed Forces Covenant. This reflects government policy to improve the support available for the Armed Forces community.

The Bristol Covenant builds relationships and local support between the council and other organisations, the bases and the charities that support in-service and ex-service personnel and their families.

It is not intended to give preferential treatment to the Armed Forces community, but to ensure that they do not suffer detriment because of their service to our country. Members of this community can experience a range of challenges. For instance, when a member of the Armed Forces is drafted to a new post at short notice, the families will have to find accommodation and the children change schools quickly. The council is keen to ensure parity of outcome for the armed forces community with our other residents. There are many independent charities that provide specific support for the armed forces community and the provider is expected to support the council by signposting these services to qualifying residents.

Further information about the Covenant can be found at; <https://www.bristol.gov.uk/armed-forces-community-covenant>

Part B: Services

B.1. Overview

B.2: Supported Living

B.3: Support to access the community

B.4: Day Services

B.5: Time for You Carers services

This specification includes the quality standards for four services that are commissioned under this contract. Those services are:

- Supported Living
- Support to access the community
- Day Services
- Time for you carers service

This section includes:

- A definition of the service
- A description of what the service should do in order to enable service user and carer outcomes
- The quality standards that commissioners expect within these services
- Needs bands/price bands per service user

Providers will be assessed on their ability to meet all requirements within this specification. However, it is acknowledged that packages of care will vary and not all requirements will be applicable to every service user; an individual's needs will be clearly identified in their support plan. The specification also aims to provide flexibility, to enable providers to transition to more outcomes focused care and support.

Each service is assigned a needs band or bands. Each needs band relates to a price range. The need bands are aligned with the level of intervention a service user requires and other determining factors such as levels of risk presenting with different support packages. BCC have not provided a definition of these bands as the CSS pricing tool will be used to assign a band or bands to a service user needs. The CSS pricing tool will be reviewed over the course of the life of the framework and may be subject to change.

	Description	Link to CSS Outcomes
Definition of service	<ul style="list-style-type: none"> Support provided with accommodation. The support provider delivers the accommodation and the support. 	
Description of service	<ul style="list-style-type: none"> Support provided in accommodation, which is commissioned as part of a support package. The support and landlord function can be commissioned in two different ways: <ul style="list-style-type: none"> The landlord is separate to the support provider. In this instance the provider is required to have a partnership with a landlord (private or registered social), which details the arrangements and responsibilities of the partnership. Where this is the case, a joint working agreement must be in place before a service can be commissioned. The landlord is also the support provider Typically support should be provided within the service user's accommodation. Support may be provided outside of a service users home if it is stipulated in the service users support plan and is connected to maximising their independence, for example, supporting a service user to leave their home to go shopping within the local community. Support to enable service users to develop independent living skills and to manage and live well within their home and local community. Types of activities may include but is not limited to independent living skills associated with maintaining a home, maximising income, securing employment and/or exploring opportunities within the community. Duration of support (and therefore the service) can vary depending on service user need. The individual rate is the cost to deliver the service to that individual service 	Be physically and mentally well

	<p>living in their accommodation (e.g. rent, service charge etc) decisions around finances are well documented and that service users are supported, where appropriate to maximise independence around their finances.</p> <ul style="list-style-type: none"> • Support that enables service users to gain and maintain independent living skills associated with maintaining accommodation. This may include, though is not limited to promoting skills for daily living, self-care, timekeeping and managing personal relationships. • Support that empowers service users to take control of their accommodation choices and where appropriate support that empowers service user to consider their future accommodation options. • Service users are supported with shopping for household items and gain skills to do so independently within the local community, where appropriate. • Service users are enabled to take responsibility for their food choices and are prompted to consider healthy food options where appropriate. Consideration should also be given to locally sourced food and to culturally appropriate choices. • Support to enable service users to live well in their home environment. This may include, though is not limited to, enabling service users to take care of their home surroundings. • Support to enable service users to manage their physical and mental health needs so that they can live well in their accommodation. • Support to help service users manage any conflict that occurs between different individuals in a shared accommodation setting, to seek resolution. Where the issue(s) cannot be resolved, the provider must ensure that it has reasonable process to support the move on and should commence discussions with BCC regarding a transition of a service user to alternative accommodation. • Providers are expected to work with BCC and an individual's friends and family, to carefully plan and manage the transition of service users in and out of shared accommodation where this is an outcome of the individual. This is in order to manage the impact on the individual moving but also other individuals 	
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	<p>within the shared accommodation.</p> <ul style="list-style-type: none"> Providers are expected to discuss the action to be taken with regard to an individual's possessions in the event that they leave the accommodation and cannot be contacted. Providers and BCC will agree a course of action based on the particular individual circumstances. 	
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How services will be priced

As part of the social work assessment process the appropriate need band (which links to specified price ranges) will be identified by a practitioner based on the individual's needs. For some individuals all the care and support hours they require may be within the same band, whereas for others they may receive some hours at one band and some at a higher/lower band. BCC has identified price ranges for each band of need, calculated on an hourly rate. The price band tool can be found as Appendix 5.

Needs band for supported living

There will be four needs bands for supported living:

- Standard
- Intermediate 1
- Intermediate 2
- High

In addition, if sleep in and/or waking night is required this will be identified in an individual's support plan and a separate rate will apply. BCC has identified a cap that the price cannot exceed, and providers are expected to price accordingly based on the level of need of the individual. The caps stated are intended to be reflective of a 1:1 rate.

The price ranges associated to these bands are associated to the individual care and support service commissioned. The cost of rent and service charges are separate and should not be included within the hourly rate.

The hourly rate should include all costs associated with the delivery of the commissioned service, including but not limited to, staff handovers, staff supervision and any back office administration associated with the delivery of the service. The price ranges and sleep in/waking night caps can be found in Appendix 4.

	Description	Link to CSS Outcomes
Definition of service	<ul style="list-style-type: none"> Support to live in the local community in order to maximise service user independence and wellbeing. 	
Description of service	<ul style="list-style-type: none"> A service that goes to the service user and enables them, where appropriate, to access support in the local community to meet their agreed outcomes. Activities may include recreational, leisure, social and sports; access to education, employment and training; volunteering and; support to access and sustain paid employment. Additionally the service may be focused on supporting an individual to gain lifelong skills to enable progression to greater independence, for example, support to enable independent living skills associated with living well within the home. The service can be delivered to the service user on an individual basis or the service can be delivered on a shared basis, depending on the service users' needs and outcomes. Personal care can be delivered by the provider but only if stipulated on the service users support plan and if the provider can demonstrate that they meet the personal care requirements. Where applicable providers should be accredited and registered with the Care Quality Commission. Duration of the service can vary depending on service user need. 	

<p>Quality standards commissioners expect within the service</p>	<ul style="list-style-type: none"> • Support that enables service users to access the community in order to meet their agreed outcomes within their support plan. • Support that enables service users to gain and maintain independent living skills in the local community. This may include, though is not limited, to promoting skills for daily living, self-care, time keeping, managing personal relationships. • Support to build / maintain purposeful community links to facilitate inclusion in the wider local community. This may include though is not limited to, leisure and vocational activities. • Service users and their families and carers (as appropriate) are involved and have a voice in decisions made which impact the support they receive to access the community. This may include, though is not limited to, decisions around how shared support hours are used. • Service users are supported to understand the costs associated with accessing activities in the local community. The provider must, where appropriate, ensure that decisions around finances are well documented and that service users are supported, where appropriate to maximise independence around their finances. If the service user is under Court of Protection, the provider must work in partnership with the deputy, where appropriate, in order to support management of service users' finances. • Support that empowers service users to take control of their interactions within the local community and ensuring that they understand the risks and responsibilities associated with the decisions and choices that they make. Where service users lacks capacity to make informed decisions, the provider is required to work in partnership with the other relevant parties. It is the provider's responsibility to ensure that risks are appropriately communicated, actions are documented and risks are mitigated, with the involvement of the service user and other relevant parties 	<p>Be able to make their own decisions while managing risks and responsibilities</p> <p>Have the social contact they would like</p> <p>Be physically and mentally well</p>
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	(i.e. family and carers), where appropriate. <ul style="list-style-type: none"> • Healthy food choices should be promoted where appropriate. Consideration should also be given to locally sourced food and to culturally appropriate choices. • Support to enable service users to manage their physical and mental health needs so that they can live well in their local community. 	
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How services are priced

As part of the social work assessment process the appropriate need band will be identified by a practitioner based on an individual's needs. For some individuals all the care and support hours they require may be within the same band, whereas for others they may receive some hours at one band and some at a higher/lower band. BCC has identified price ranges for each band of need, calculated on an hourly rate. The price band tool can be found as Appendix 5.

The needs bands for support to access the community are:

- Standard
- Intermediate 1
- Intermediate 2
- High

In addition, if sleep in and/or waking night is required this will be identified in an individual's support plan and a separate rate will apply. BCC has identified a cap that the price cannot exceed, and providers are expected to price accordingly based on the level of need of the individual. The cap stated is expected to be the maximum 1:1 rate; shared support should be priced accordingly.

The hourly rate should include all costs associated with the delivery of the commissioned service, including but not limited to, staff handovers, staff supervision and any back office administration associated with the delivery of the service.

The price ranges and sleep in/waking night caps can be found in Appendix 4.

	Description	Link to CSS Outcomes
Definition of service	<ul style="list-style-type: none"> Support provided within the community with access to a base which service users may access if stated on their support plan. 	
Description of service	<ul style="list-style-type: none"> A service provided with access to a base or location to meet agreed service user outcomes. Activities may include recreational activities, social interaction, learning, receipt of a meal made in the building. Additionally the service may be focused on supporting an individual to gain lifelong skills to enable progression to greater independence. The hourly rate should include reasonable activity costs and consideration can be given to requesting a service user top up payment for more specialist and bespoke activities. Typically, the cost of materials for activity should be funded by the service user (e.g. paints for an arts class). This service may be provided during the week or at weekends and may be a daytime service or offered in the evenings. Personal care can be delivered by the provider but only if stipulated on the service users' support plan and if the provider can demonstrate that they can meet personal care requirements. Duration of service can vary depending on service user need. The support package will be inclusive of transport if the individual requires this and it is identified in their support plan. Providers will be required to include transport costs within the hourly rate and offer an appropriate transport option for the individual where this is required and where it is a service that the provider offers. 	

	<ul style="list-style-type: none"> The service may be offered from the physical base for the majority of time or may be offered in the community with a return to the base for set periods as required, for example, between activities. The requirements will be specified in the individual's support plan. 	
Quality Standards commissioners expect within the service	<ul style="list-style-type: none"> Support that enables, where appropriate, service users to access community assets from a base in order to meet their agreed outcomes. Community assets may include, though not limited to, education, employment, training, work experience and volunteering etc. The amount of time the service user needs to access the base will vary based on their needs and individual outcomes. Support that enables service users to gain and maintain independent living skills in the community. This may include, though is not limited, to promoting skills for daily living, self-care, timekeeping and managing personal relationships. Support to build / maintain purposeful community links to facilitate inclusion in the wider community. This may include though is not limited to building and sustaining leisure and vocational activities. Service users and their families and carers (where appropriate) are involved and have a voice in decisions made which impacts on the support they receive to access the community. Service users are supported to understand the costs associated with accessing activities in the local community. The provider must, where appropriate, ensure that decisions around finances are well documented and that service users are supported, where appropriate to maximise independence around their finances. If the service user is under Court of Protection, the provider must work in partnership with the deputy, where appropriate, in order to support management of service users finances. Support that empowers service users to take control of their 	<p>Be able to make their own decisions while managing risks and responsibilities</p> <p>Have the social contact they would like</p> <p>Be physically and mentally well</p>

	<p>interactions within the local community. Providers should take all reasonable action to ensure, as far as possible, that service users understand the risks and responsibilities associated with the decisions and choices that they make. Where a service user lacks capacity to make informed decisions, the provider is required to work in partnership with the other relevant parties. The provider is responsible for communicating risks appropriately, documenting actions and mitigating risks, with the involvement of the service user and other relevant parties, where appropriate.</p> <ul style="list-style-type: none"> • Healthy food options should be promoted where appropriate. Consideration should also be given to locally sourced food and to culturally appropriate choices. • Support to enable service users to manage their physical and mental health needs so that they can live well in their community. 	
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How services should be priced

As part of the social work assessment process the appropriate need band will be identified by a practitioner based on the individual's needs. For some individuals all the care and support hours they require may be within the same band, whereas for others they may receive some hours at one band and some at a higher/lower band. BCC has identified price ranges for each band of need, calculated on an hourly rate. The price band tool can be found as Appendix 5.

The needs bands for day services are:

- Standard
- Intermediate

The hourly rate should include all costs associated with the delivery of the commissioned service, including but not limited to, staff handovers, staff supervision and any back office administration associated with the delivery of the service. The price ranges can be found in Appendix 4.

	Description	Link to CSS Outcomes
Definition of service	<ul style="list-style-type: none"> A service that provides a short break or additional support for carers, such as befriending or additional advice, to enable the person cared for to remain in their own home. 	
Description of service	<ul style="list-style-type: none"> A service that enables the carer to take a break by providing cover arrangements for the cared for person. A service that supports a carer, for example, by providing befriending or additional advice and guidance to help them in their caring role. The duration of the service can vary depending on the carer's need. This service is delivered on an individual basis and may involve going to the carer's home or providing support to the carer in the community depending on their needs. Personal care can be delivered by the provider but only if stipulated on the service users support plan and if the provider can demonstrate an ability to meet the requirements. Where appropriate the provider should be registered with CQC. 	
Quality Standards commissioners expect within the service	<ul style="list-style-type: none"> Support that enable carers to take a short break from their caring role or receive access to activities that help them meet agreed outcomes within their support plan. Support to build / maintain purposeful community links to facilitate inclusion in the wider local community. This may include though is not limited to, leisure, vocational activities and support to retrain. Ensuring that carers and the cared for are involved and have a voice in decisions made which impact the service they receive to access the community. 	<p>Be able to make their own decisions while managing risks and responsibilities</p> <p>Have the social contact they would like</p>

	<ul style="list-style-type: none"> • Support that takes into account both the carers and cared for support plans with regards to the delivery of care. • Support that empowers carers to take control of their interactions within the community. • The provider is expected to have sound understanding of other carer services, information, advice and guidance and signpost to them where appropriate • The provider is required to understand the needs of the individual being cared for whilst the carer takes a break if this is the service they choose. It is the expectation of the provider to regularly review this with the service user and their carer when required. • The provider is responsible for ensuring that the carer is informed if the individual being cared for presents any additional needs. • Assistance to build personal networks with others that have a shared experience, for example through a befriending service. This may be the carer or cared for. 	Be physically and mentally well
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How services will be priced

There will be one price band for time for you carers services. Providers will be required to submit a price that falls within the identified price range as part of the mini-competition stage via the DPS. The hourly rate should include all costs associated with the delivery of the commissioned service, including but not limited to, staff handovers, staff supervision and any back office administration associated with the delivery of the service. The price band tool can be found as Appendix 5. The price range can be found in Appendix 4.

Part C: Quality Standards Expected

- C.1: Leadership, Management and Accountability
- C.2: Recruitment, Staff Development and Training
- C.3: Travel
- C.4: Communication
- C.5: Safeguarding
- C.6: Equalities
- C.7: Confidentiality & Privacy
- C.8: Medication
- C.9: Health and Safety
- C.10: Behaviour that Challenges Services
- C.11: Restraint/Physical Intervention
- C.12: Financial Protection & Maximising Independence
- C.13: Personal Care
- C.14: Risk Assessment
- C.15: Complaints, Comments and Compliments

1. A Disclosure and Barring Service (DBS) check has been carried out for all staff (where applicable) in the last three years and the reference number can be provided for all leaders and managers involved in the delivery of the service.
2. An accountable senior member of staff is contactable at all operational times.
3. The responsible manager/person is able to evidence they have experience/training and/or a working knowledge and understanding of people with social care needs, for example, people with physical or sensory impairments, learning difficulties, mental health problems, long term conditions or who may need end of life care. They have an understanding of the personalisation agenda in promoting choice and control.
4. Agreed key performance indicators (KPIs) are in place to enable internal and external assessment of the operational and financial performance of the organisation, with follow up action taken where required with relevant reports/minutes of meetings available.
5. The roles and responsibilities of the manager and senior staff are clearly defined. Performance is monitored via a performance management processes through a structure of line management.
6. There are management policies and procedures in place and staff receive appropriate training to implement these. Training prepares and supports staff to carry out their role effectively, develop their potential and secure good practice in service delivery.
7. A process for continual staff development exists that encourages staff and managers to jointly identify learning needs. This provides accountability and enables quality commitments to be met more effectively.
8. The organisation encourages improvement and innovation in the delivery of CSS to better meet service user's needs, including the adoption of national initiatives and guidance.
9. Any changes to service provision are subject to the agreed systems of change management, including discussions with the service user. There is effective communication and training programmes are implemented to develop staff competence to provide changes in service delivery following service reviews, and both staff and service users are involved in the changes implemented.
10. There is a business continuity plan in place that is reviewed annually to accommodate any changes that may affect the continuation of service provision.
11. Contingency plans for CSS include provisions to ensure continuity of services, if key members of the staff team are not available.
12. The responsible manager/person is trained and skilled in emergency planning and ensures all key staff are trained and made aware of what to do in the event of an incident, in line with manager's induction standards by skills for care.
13. Risk control measures are appropriate in respect of the business and organisational reputation, and for the range of services provided.
14. There is a regular review of the effectiveness of risk control measures, including the risk for service users and staff.

15. The organisation has implemented a systematic and robust approach to audit; with a responsible person or persons identified. This should include regular sample audits of all care notes/logs documentation, spot check visits and obtaining service user feedback.
16. The organisation must be able to evidence that effective checks are carried out on all forms of communication with both staff and service users, so communication is effective and is responded to appropriately. The organisation is required to evidence how it maintains up to date records, for example telephone numbers and contact details e.g. by reviewing contact details at the point of review.

C2

Recruitment, Staff Development and Training

1. Any staff employees or volunteers working with service users or having access to service users' data, must undergo checks through the Disclosure and Barring Service at the appropriate level prior to commencement of employment.
2. The decision rests with the employer as to whether to employ a person who's DBS (Disclosure and Barring Service) checks reveals a conviction or other information. A risk assessment should be undertaken with the provider being mindful of their overarching responsibilities for the welfare of the people who use their services. This risk assessment and decision to employ should be fully documented and held on the staff member's file for future reference.
3. The provider will take all reasonable action to mitigate against significant delays in recruiting staff to key posts.
4. Where volunteers are recruited, selection will be according to the skills and ability they have to perform the required tasks. The individual should receive a full induction to the service and be offered training to address any areas for development.
5. The provider will develop and implement a structured induction process in place that applies to all new staff. This should be linked to National Standards (e.g. the Care Certificate – skills for care). In addition there should be a basic training programme for staff or volunteers that is appropriate to the needs of the service users and delivered within an agreed period of taking up appointment.
6. The provider will undertake a Training Needs Analysis for each new member of staff and this will be incorporated into the staff training and development plan.
7. Staff have the necessary knowledge, skills and experience to deliver the services that the provider states will be provided. The required knowledge, skills and experience are matched to the needs of each service user. In particular support workers will have the necessary training, experience, skills, competencies, personal qualities and caring attitudes to enable them to meet the needs of individual service users supported by the provider.

8. Providers will ensure that where a service user has complex needs, (e.g. moderate or severe dementia, learning difficulties, is recovering from a mental illness etc), all support workers allocated to provide support to the service user are competent and have received the necessary training to effectively provide the support required.
9. Individual staff training needs will be reviewed at least annually and this will consider the need for refresher training. This will be incorporated into the staff development and training programme.
10. Staff will receive regular training to carry out all aspects of their role, including, where relevant to their role:
 - a. Administration of medication, where applicable
 - b. Communication Skills
 - c. Working with Behaviour that Challenges
 - d. Equalities and Diversity awareness / including LGBT Training
 - e. First Aid
 - f. Food Hygiene, where applicable
 - g. Health & Safety
 - h. Safeguarding Adults
 - i. Providing personal care (if this is appropriate to the provider offer and scope)
 - j. Risk assessment and management
 - k. Person-centred care and support
 - l. Mental Capacity
 - m. Specialist training as required for specific care groups
11. The provider's induction and basic training programmes will be submitted to the Council on request.
12. The provider will provide regular supervision to all staff and volunteers working for the organisation and appraise the standard of practice at least annually.
13. The provider will consider ways to promote the recruitment of staff from within the local area wherever possible and appropriate. This may include but is not limited to, local apprenticeship schemes, advertising vacancies with local agencies and on local online forums and/or work experience opportunities.

1. The provider delivers support to make service users aware of appropriate travel options and documents these.
2. Where any transport is provided by the provider or a third parties as part of the service, the provider must ensure that the required legal and safety standards are met.
3. Where support workers use their own vehicles to transport service users, the provider will ensure that the support worker has a full valid driving licence and that appropriate checks are in place to identify any changes, that all vehicles used are clean and fully maintained with a valid MOT certificate if needed and that the insurance held by the support worker is correct and specifically covers the relevant business uses including the transportation of service users. Evidence that the provider has carried out regular checks will be provided to the Council on request.
4. The provider will develop adequate and reliable contingency procedures are in place in case of accident or breakdown while transporting service users.
5. Where the support worker is required to drive the service user's vehicle, it is the provider's responsibility to ensure that the correct insurance is in place and appropriate consent is obtained. Evidence that appropriate insurance is in place and consents obtained will be available to the Council on request.
6. If additional mileage above that already included in the hourly rate is required in order to meet the service users assessed needs, the provider will contact the Council and seek approval to incur additional expenditure. Where additional mileage above that already included in the hourly rate is required in order to meet non-assessed need, funding arrangements are to take place outside of this contract. The support worker must not enter into a separate agreement with the service user for additional mileage to meet non-assessed need unless this has been approved by a manager or accountable person.
7. Bristol's Road Safety Strategy identifies work related driving as a key segment to support the reduction of casualties on the local roads. The provider will formally make all employees using vehicles as part of their employment aware of their responsibility to drive in a safe and legal way adhering to all speed limits and provisions of the Highway Code and deal proactively with any complaints against an individual's driving. The use of telemetrics in vehicles as part of this approach can motivate drivers and encourage better driving, and help reduce costs and pollution, so providers are encouraged to consider this where appropriate.
8. The provider will consider sustainable forms of travel wherever possible and appropriate to the individual, for example, walking or car sharing.

Communication

1. The provider will ensure that all staff are sufficiently competent in the English Language to enable them to read and understand all plans and documentation relating the service user.
2. Service users will be supported to access and use specialist individual communication aids as prescribed.
3. Support workers are aware of the preferred communication methods of service users and communicate in a method and language of the service users' choice; they are appropriately trained and knowledgeable with the necessary communication skills.
4. Providers, working with the Council and other relevant agencies, will support and enable service users to access a friend, relation or adviser of his/her own choice to act as an advocate and have the facility to pursue matters on their behalf, where this is appropriate to the service being provided
5. In line with service user wishes, as agreed in their support plan, the provider will keep the service users' family and / or friends informed of any relevant information in relation to the service user's support.

Safeguarding

1. The provider has a clear and accessible whistle blowing policy that is reviewed regularly; as a minimum annually. This should be promoted within the organisation and shared with service users. The provider will make all staff aware of the duties relating to Safeguarding under the Care Act 2014.
2. The provider has a clear process for recording allegations of abuse, alongside robust documentation to support this.
3. The provider is subject to the safeguarding duties under the Care Act 2014 including ensuring that:
 - a. Alerts are made in a timely way, appropriate to the level of urgency and risk
 - b. Alerts contain all relevant information with regard to any allegation made to enable any investigation can be conducted comprehensively
 - c. Alerts are made to the relevant agencies
 - d. Any relevant external agencies are informed
 - e. Service users are asked to consent to an alert being made, where they have capacity to do. Reasons for over-riding consent, for example that others may be at risk, must be explained to the service user
 - f. Dignity, choice and respect for the service user is maintained throughout any investigation and they are informed of the outcome
 - g. The Council's safeguarding process is followed, which may include participation in safeguarding strategy meetings and producing written reports of safeguarding investigations.
4. The provider will provide an overview of policies and procedures in the staff induction and take all reasonable efforts to ensure that the content is fully understood by staff. All staff will have an initial understanding of Safeguarding duties under the Care Act 2014 within their first week of employment. Comprehensive training on awareness and the prevention of abuse should be given to all staff as part of their core induction within three months and updated at least every two years. In addition, update training will be provided in light of new policies and procedures introduced either locally or nationally.
5. The provider will work with the Council and other relevant agencies to support service users who do not have capacity to access an independent advocate where required and where this is possible. For example, the provider may signpost the service user to local organisations that can provide independent advocacy.
6. If a provider has reason to believe that a service user is at risk, either through self-neglect or as a result of behaviour/lifestyle, the actions or behaviour of others and/or their physical environment, they will follow the published Safeguarding Adults procedures and demonstrate an ability to learn from Serious Case Reviews to improve practice.

Equalities

1. Providers must comply with the Equality Act 2010 and assist BCC as required with its compliance with the public sector equalities duty. This should include compliance relating to the recruitment and selection of staff.
2. Providers must make their own written policies covering equal opportunities, anti-discriminatory practice and harassment available to staff.
3. Recruitment and selection policies must aim to eliminate discrimination in recruitment procedures and the policy must explicitly state that providers are working towards such an approach. Policies will be in accordance with guidance from the Equalities and Human Rights Commission.
4. All staff must receive equalities training and be familiar with the relevant policies.
5. Providers will support staff to understand, and be sensitive to, the particular needs of minority groups. Where necessary training will be provided to equip staff with the skills to deliver the service in a culturally sensitive way.

Confidentiality and Privacy

1. The provider will take all appropriate measures to maintain service users' privacy in accordance with the Data Protection Act, Freedom of Information Act, the Mental Capacity Act, and the provider's confidentiality policy.
2. The provider will have written policies concerning the management of information in accordance with the 1998 Data Protection Act and will collect evidence that staff have received appropriate training.
3. Service users and their carers/representatives will be made aware of the need to hold records of their individual information and the appropriate process for accessing the information. Records will be confidential and stored securely. Access to individual records will only be permitted in controlled circumstances.
4. The provider will handle a service user's personal information appropriately and respect confidentiality.
5. The provider shall obtain and record permission from service users in order to share confidential information about them, unless existing legislation or guidance states otherwise.
6. Service users will have the right to receive a copy of any information held about them in the provider's files, provided that this does not breach third party (e.g. GP) or legislative guidelines. Further information is available from the Information Commissioners Office.
7. Service users will be able to discuss their needs in confidence and privacy with a member of the providers staff if they wish to, where appropriate. Confidentiality will be maintained unless there is a duty of care to take action.
8. Service users can be confident that staff will not speak publicly about them unless it has been agreed with the service user beforehand, for example, this may relate to sharing information in a newsletter or in the form of a case study.
9. Discussions about a service user's personal care and other sensitive matters must be held in private.
10. Copies of the providers' policies and procedures on confidentiality, including the process for dealing with breaches of confidentiality, will be available to service users and their representatives if requested.
11. The Provider will report any breaches of service user personal data to the Council as soon as possible and have in place a procedure for dealing with the investigation of data breaches. The provider will work with BCC to assess the impact of the breach in considering whether it needs to be reported to the Information Commissioner's Office.

1. The provider will have a clear, written policy and procedure in place which is adhered to by all staff and includes:
 - a. The circumstances in which support workers may or may not be involved in prompting or administering service users to take medication and the extent to which this is permitted. The policy should require that only trained, competent and confident support workers are assigned where the administration of medication is required. The policy should also enable support workers to refuse to administer medication if they have not received suitable training and/or do not feel competent to do so.
 - b. The limitations of assistance with prescribed and non-prescribed medication, and which tasks a support worker must have specialist training in before undertaking.
 - c. The arrangements necessary to secure the safe handling and administration of medication.
 - d. The records to be maintained where support workers support service users to take medication.
2. Support workers will receive training in the policy, procedures and the administering of medication during their induction and on an ongoing basis. The medication training provided will match the complexity of the category of medication administration or technique required.
3. The provider will have a formal procedure to assess whether support workers are sufficiently competent in medication administration before being assigned to a task where this is required, and will undertake regular competency appraisals.
4. The provider will establish a process to record all medication errors made by support workers so that reasons for errors are monitored and changes to procedures can be made to affect a programme of continuous improvement, to reduce future medication errors.
5. Service users will be assisted to maintain responsibility for their own medication wherever possible.
6. The provider will make arrangements for service users to take any necessary medication in a way that respects their dignity and privacy, ensuring compliance with the organisations medication policy and will monitor adherence to this.
7. The service user, or their representative, must agree to allow a support worker to administer medication and their consent should be documented in the provider's support plan. If a service user is unable to communicate informed consent, the provider should use all best endeavours to seek confirmation from the prescriber that the treatment is in the Best Interest of the individual following Mental Capacity Act and Best Interest requirements as appropriate.
8. Administration of medicine may include some or all of the following:
 - a. Any physical assistance to assist the service user with the process, for example the selection and preparation medicines for immediate administration, including selection from a monitored dosage system or compliance aid
 - b. When the support worker selects and measures a dose of liquid medication for the service user to take
 - c. When the support worker applies a medication patch to the skin, medicated cream/ointment, inserts drops to ear, nose

- or eye and administers inhaled medication
- d. When the support worker puts out medication for the service user to take themselves at a later (prescribed) time to enable their independence.
- 9. The provider's support plan should determine and document the following:
 - a. The nature and extent of support and/or assistance that the service user needs to manage their medication
 - b. Details of arrangements for medication storage in the person's home and access by the service user, relatives or friends
 - c. A statement of the service user's consent for the support worker to assist with medication.
- 10. Where service users are unable to manage their own medication the provider will have a safe and secure system for the storage of service users' medication.
- 11. The provider should record the date and time of medication being prompted, administered or refused and also identify the support worker completing the record (for example on a Medication Administration Chart).

1. The provider will develop and implement systems and procedures to comply with the requirements of Health and Safety legislation. Copies of policies and procedures will be available to the Council on request.
2. Providers will have a policy on the provision and wearing of protective clothing which will be provided to all staff as necessary.
3. Building on from the risk assessment undertaken as part of the assessment, providers should conduct risk assessments on activities, environments, manual handling and the risks to the service user maintaining their independence prior to the commencement of any service. The assessment will consider the potential risks to service users and staff in delivering the support package and must contain a balance that accounts for a service user's personal choices and freedoms. The risk assessment will be updated annually or more frequently if required.
4. All staff will be informed of emergency procedures. Providers will ensure a competent person is on call and contactable at all times when support staff are on duty.
5. If undertaking support with domestic tasks, on behalf of the service user, the provider should carry out COSHH assessments to establish a list of safe products that staff can use to carry out these tasks, if appropriate to the service being delivered.
6. There are systems in place to control the spread of infection, in line with relevant regulation and published professional guidance.
7. The provider must report any work related deaths and certain work-related injuries, cases of disease and near misses involving your employees wherever they are working to RIDDOR.
8. Providers are required to comply with current food hygiene standards and regulations when staff are required to handle and prepare food for or with the service user.
9. The provider will keep accurate and up to date organisational records relating to health and safety matters.
10. Providers are required to develop and implement a Lone Working policy, to minimise the risk to staff working alone. Where staff work alone with a service user a risk assessment must be undertaken which specifically address the risks faced by lone workers. The Lone Working policy must be brought to the attention of every employee or volunteer.
11. The risks to staff associated with working in other people's homes must be assessed by providers periodically; at least annually.
12. Where a service user requires support that involves moving and handling, the provider will ensure that those support staff receive appropriate training. Moving and handling is delivered in a way where staff communicate with the service user throughout, and uphold the dignity, privacy and safety of the service user.

Behaviour that Challenges Services

1. Providers will have a policy and procedure in place relating to dealing with challenging behaviour that sets out how to avoid the need for restraining measures and sanctions by using positive behavioural support techniques and risk management strategies, as cited by BILD or equivalent bodies. Staff will be made aware of the policy and procedure in their induction, including an awareness of the purpose of it, and trained how to implement it.
2. Providers will seek to manage the risks associated with challenging behaviour to prevent the need for restraint as far as possible
3. Some service users may present behaviour that challenges the service being provided. It is essential that a risk assessment is undertaken with such service users, to evaluate the potential for harm to the service user and staff. The provider should develop a clear procedure to deal with such behaviour, in partnership with other agencies involved so a clear and consistent approach is adopted. The procedure developed should take into account all information in the service user's Assessment Summary and be detailed in the providers' support plan.
4. In determining the approach to managing challenging behaviour, providers should consider the service user's emotional and physical needs and warning signs and 'trigger' points which result in particular behaviour. Providers should undertake careful planning and consider staff skill sets (for example skills in listening, diversion and defusing challenging incidents) to avoid problematic situations where possible.
5. Providers should consider any additional staff training and support needs and what support and guidance can be offered from other specialist professionals, for example psychologists.
6. Providers will adopt any Good Practice Guidelines that are introduced by the Council or other relevant public body in promoting positive engagement with people who may find services hard to engage with.
7. Providers are required to record any staff injuries that occur as a result of challenging behaviour.

Restraint/Physical Intervention

1. The provider will have a policy and procedure in place that is compliant with the Mental Capacity Act 2005 including Deprivation of Liberty requirements from April 2009 and best practice. All staff will receive training on the implementation of this policy and procedure during their induction.
2. The provider will have a pro-active approach to behaviour that challenges which minimises the need for restraining measures. Support from appropriate professionals should be sought at the earliest opportunity.
3. A service user with complex needs and whose assessment indicates, anticipates or requires the use of restraint will have received information from the Council detailing the nature, frequency, and duration of incidents and the appropriate measures to be employed to deal with them.
4. Any restraint used must be proportionate to the likelihood and seriousness of the harm that may result if no restraint was used. The minimum level of restraint necessary should be used and for the shortest time possible.
5. Where restraint is anticipated or required the Council will provide information that includes protocols and plans for the restraint that has been agreed. This information will be shared with the provider and service user. The Council and the Provider will agree to jointly review the plans and protocols on a regular basis and, in particular when circumstances indicate that a review is required. The provider will incorporate these details into their care planning process and risk assessments. Providers will deliver and implement the necessary training to staff, to enable adherence to the jointly agreed plans and protocols. The decision to use restraining measures must be recorded in the provider's support plan specifying:
 - a) A review date for all restraining measures employed
 - b) The need to be met, or the objective of employing restraining measures
 - c) The restraining measures to be employed (nature, frequency of application, duration etc)
 - d) The circumstances restraining measures are to be employed and by whom.
6. Staff may only employ restraining methods after they have received training from appropriately skilled professionals. Where a provider considers employing restraining techniques they must ensure that any course/training they intend to provide to staff is undertaken with a specialist accredited training provider.
7. The provider will regularly check and monitor the use of restraining activity. The provider will inform the Council and the service user's representative in writing within one working day when restraining measures have been employed if they exceed that described within the service user's assessment summary or the providers support plan, or where restraint is not mentioned within a plan.
8. The provider's manager is responsible for the use of protective measures involving the use of restraint. Where the provider's manager believes that longer term measures should be considered, this should be assessed with the relevant social worker and the service user's GP, or other appropriate health professionals. The outcome should be recorded in a revised Council

assessment summary and providers' support plan. Routinely, responsibility may be delegated down the management line, but whenever the use of restraint is employed, it must be reported to the person in charge as soon as possible and noted in the service user's records.

9. The provider will maintain a written record of all occasions where restraint is used and the record will be made available to the Council on request.
10. Tying people to restrain movement by whatever means is prohibited. Any discovered breach of this rule should automatically involve disciplinary action on the part of the provider.
11. The use of medication as a restraint should only take place with the agreement of the service user's medical practitioner. The minimum amount of medication necessary should be used and it should be proportionate to the risk of harm and be reviewed regularly as part of the care planning process.
12. Service users may have various drugs prescribed for chronic conditions or recurrent illnesses. The side effects of some of these may have a disabling effect on the recipient which result in the need for restraint. Such changes must be noted and referred for medical or nursing advice.
13. Where physical intervention is required for service users with Learning Difficulties and those on the Autistic spectrum, the intervention must comply with the guidelines issued by the Department of Health in 2002, and any subsequent reviews.

1. Providers will have written policies and procedures in place for staff on the safe handling and service user's property.
2. Staff must exercise due care in handling service users' money and any paperwork associated with finance and personal property. Any money handled due to support with the collection of benefits, purchase of shopping or payment of bills must be accounted for with the service user at the time. A record signed and dated by the support worker must be kept for review by the service user, their carer/representative, the provider and the Council if required.
3. Service user's money shall typically be kept separately from the support worker's personal money at all times, unless the support plan identifies a need to support the individual to manage their money and this is clearly evidenced and documented. Unless specified in the individual's support plan, service user's money should not be saved up and kept in a support worker's or the provider's bank account, or held at the provider's office. The Council acknowledges that this may be required on occasion and this should be agreed with the Council and recorded in the assessment summary and the provider's support plan.
4. Support workers will not make personal use of the service user's property, for example a telephone, except in the case of emergency.
5. The provider, support workers, other staff, or their families, must not become involved in any personal financial transaction with any service user, including the sale or purchase of goods/services and the borrowing or lending of money or goods.
6. Staff will not involve the Service User in gambling or gambling syndicates, e.g. National Lottery.
7. Staff will not incur a liability on behalf of a service user.
8. Staff may take responsibility for looking after any valuable items on behalf of a service user on occasions where this is necessary but providers must ensure this is clearly documented.
9. The provider will make good any loss to the service user caused by the negligence, or any other action, of any of their staff. The provider must ensure that adequate insurance (insurance type and level as described in the Contract) and any other necessary arrangements are in place for this purpose.
10. Support workers and other staff will be bound by a policy regarding the refusal of gifts, except for token gifts (for example low value consumables) which must be declared and recorded by the provider. Staff will not advise about service users' wills, nor act as a Witness to a service user's will, a Trustee or Power of Attorney on behalf of a service user.
11. The provider will have policies and procedures in place to prevent staff from obtaining personal benefit when working with vulnerable people. This may be in the form of a documented risk assessment addressing the potential for personal benefit through abuse. For example, abuse may include the provision of financial advice, Power of Attorney or handling a service user's money.
12. The provider will have a policy and procedure for the investigation of allegations of financial irregularities and the involvement

of the police, the Council and other professional bodies as required.

13. Where a service user does not have the mental capacity to make informed decisions relating to spending their personal allowance, and there is no family or other advocate to support the service user, the provider will not support the Service User to make purchases over the sum of £200, or such other amount as detailed in the Service User's Assessment Summary, without gaining approval from the Council's Team Manager or the Council's Receivership Officer.
14. Staff will be made aware of benefits available to individuals and where to find assistance regarding claims
15. Staff will receive training on how to provide general support and/or signpost individuals with benefit claims and maximising their income, to support service users to access available central government funding is accessed where individuals are eligible and this is appropriate and relevant to the service being delivered.
16. Providers may be required to look after a service users' personal bank account. Providers should ensure that this requirement is included in the individual's support plan and appropriate records are maintained.

1. As part of some CSS packages, a service user may also require some personal care. If the predominant need is for personal care, the service will be commissioned under the homecare contract. If the predominant need is for CSS with elements of personal care, this will be commissioned via the CSS contract.
2. Where a personal care need is identified within an individual's support plan, only providers assessed as meeting the required minimum standards for personal care will be able to submit an offer for this package of care. These providers will be required to be registered with the Care Quality Commission to deliver personal care, where this applies to the category of care and the environment in which personal care is being delivered.
3. Providers will be required to deliver a package of care which includes some personal care in a way that supports the achievement of CSS outcomes and those of the individual service user, as detailed in this document.
4. The support plan should be used as the basis of delivery for the service. However, the delivery of personal care should include:
 - Providing stability for a service user to meet their personal care needs e.g. getting dressed
 - Providing support so the service user can increase their level of independence, where appropriate, and undertake tasks for themselves
 - Identifying any assistive technology to help reduce dependency where this is appropriate
5. Personal care tasks should be carried out in a way that is respectful and maintains an individual's dignity. In addition to the CSS outcomes and over-arching quality standards, with regards to the delivery of personal care providers are required to:
 - Provide service users with the assistance they need to maintain a standard of hygiene that they are satisfied with and the comfort and dignity that complies with their wishes as far as possible, regardless of any mental impairment that may lead to the service user being less aware of their preferences
 - Ensure that service users receive appropriate 'moving and handling' assistance, delivered by staff who communicate clearly and respectfully with the service user throughout and act always to uphold the dignity, privacy and safety of the service user
 - Give service users the choice of which gender of staff they require and the provider will make all reasonable efforts to accommodate these wishes. Service user choice will be evidenced
 - Service users will be treated with respect, which includes the appropriate use of language, tone and body language that will vary depending on the service user
 - Where required, service users will be assisted with eating and drinking in a dignified and safe manner, ensuring service users are positioned appropriately and have access to appropriate eating/drinking aids to promote

independence

- Document service users' wishes, preferences and priorities with regard to the support they need in order to retain and develop their sense of dignity and personal identity
- Respect cultural preferences in the delivery of personal care and in particular food and drink that meet cultural preferences.

6. Discussions about a service user's personal care and other sensitive matters must be held in private and take into account cultural boundaries.

7. Providers should remain vigilant to signs of personal neglect and take appropriate action if concerns are raised.

C14

Risk Assessment

1. Providers are expected to use or incorporate BCC's risk assessment proforma (see Appendix 6) into their risk assessment process for CSS service users.
2. An individual risk assessment will be required for each individual and this will need to be reviewed and updated on a regular basis.

Complaints, Comments and Compliments

1. The provider's complaints and compliments procedure must be simple, well publicised and available in a format that is accessible to all service users, to enable an individual/someone acting on their behalf to make a complaint or express a concern regarding the service provided. This procedure must allow for complaints to be made on equalities grounds.
2. The provider's complaints procedure will contain the information necessary to enable the service user to make a complaint to the local Commissioning Organisation and the Local Government Ombudsman / Health Service Ombudsman.
3. The provider's complaints procedure must set out timescales for investigating a written complaint and for providing a written response to the complaint that states the outcomes of the investigation.
4. Providers will maintain a log of complaints, concerns and compliments showing:
 - a. Date complaint / concern was received.
 - b. The name and address of the service user.
 - c. The name and address of the complainant (where different).
 - d. The nature of the complaint / concern / compliment.
 - e. The response to the complaint / concern / compliment and the date issue
 - f. The complainant's level of satisfaction with the outcome of the complaint and the way in which it is investigated.
 - g. The date when the commissioning organisation was informed of the complaint.
5. Where the service user remains dissatisfied following a complaint investigation, the provider will inform the service user of the Council's complaints procedure and offer any assistance required to enable the service user to make a complaint via this route.
6. The log of complaint and copies of the providers' letter of response to complainants must be made available for inspection by the Council at any time. The log of the complaints and an analysis of the complaints and their outcomes must be provided to the Council on request.
7. Providers should notify the Council's Complaints Team of complaints and response within five working days of finalising the complaint.
8. Providers will co-operate fully in any investigation conducted by the Council under its complaints procedure.
9. Providers will comply with the regulations for handling complaints set out in the Local Authority Social Services and National Health Service Complaint (England) Regulations (2009).

Part D: Service Outcomes

D.0: Overview of Outcomes

D.1: Live daily life with dignity and respect

D.2: Be physically and mentally well

D.3: Safe and feel safe

D.4: Have the social contact they would like

D.5: Access to purposeful activities which link to the community and may involve education, training, employment, voluntary work and lifelong learning opportunities

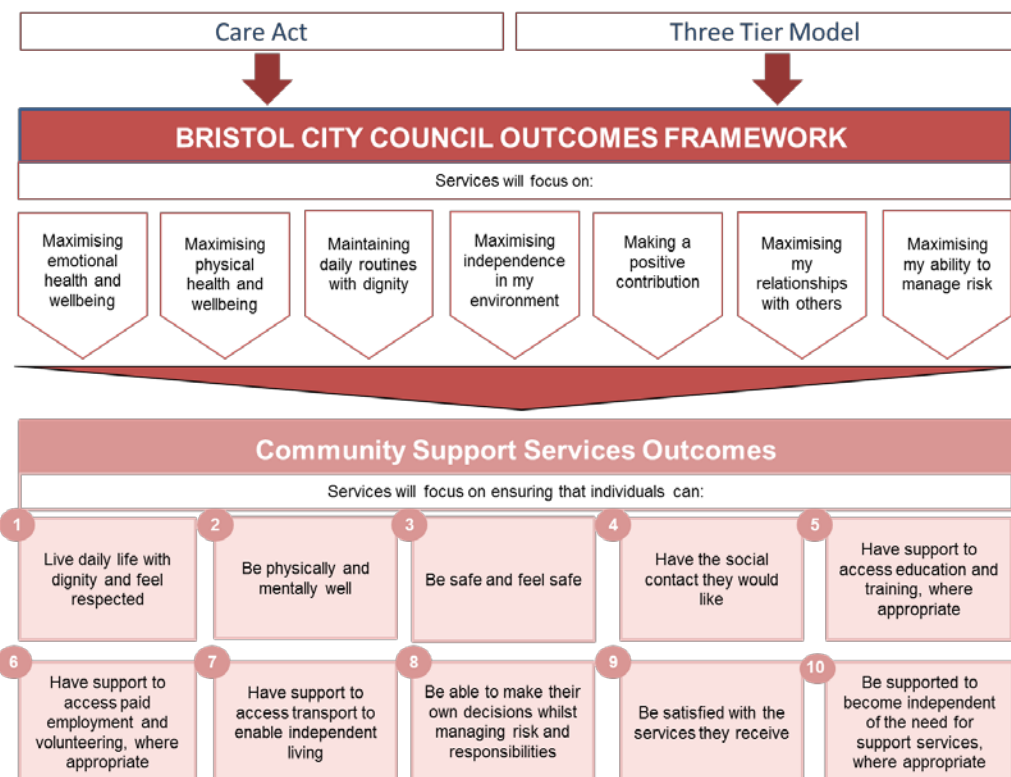
D.6: Enabling independent living through access to travel

D.7 Able to make their own decisions and manage risks and responsibilities

D.8 Satisfied with the services they receive

Providers of Community Support Services will be required to meet the Bristol City Council (BCC) outcomes for all adult social care services. In addition, BCC has developed a set of Community Support Services outcomes that are specific to this service that the Council will monitor performance against, alongside the specific outcomes identified by service users and carers.

The outcomes have been developed by the Council and consider the Care Act requirements and BCC's Three Tier Model (please refer to Appendix A and the CSS Strategy for further details). It is acknowledged that it may be achievable for some service users to meet all the outcomes outlined, whereas for others it may be more appropriate to target achievement of a selection of the outcomes depending on the individual's need. The outcomes will apply to all CSS categories of care: supported living, support to access the community, day services and time for you carers services.



D.1: Live daily life with dignity and respect		Examples of Evidence
Service User Outcome:		
Service users feel they are respected, their dignity and privacy is upheld in the way they feel is right. Service users are supported to achieve and maintain their maximum level of independence which is appropriate to them.		
<i>'I can maintain my identity'</i>		
Service Outcome:		
The service actively promotes dignity, respect and independence. Services enhance the quality of people's lives, so that they can live as independently as possible with as little intervention as possible.		
No	Signposts	
1.	The provider will support service users to make informed choices and that these are clearly communicated to relevant parties and that selected choices will be reviewed regularly.	✓ Service user support plan
2.	The provider will deliver regular training to staff, which will include appropriate attitude and communication skills.	✓ Accident / Incident forms
3	The provider will support service users to maintain their gender, sexual, cultural, religious, and spiritual identity.	✓ Risk assessments
4.	The provider will arrange, wherever possible, for a consistent member of staff to work with the service user.	✓ Risk plans
5	The provider will undertake Risk assessments and manage the identified risks appropriately using a risk plan approach. The implications of the risk assessment will be communicated with the service user.	✓ Staff meeting minutes
6	The provider will help service users to actively participate in support planning, using a person centred approach. The Provider will develop a personalised support plan that is agreed with the individual and reviewed regularly. The Provider will consider the views of the individual's family/carer as appropriate.	✓ MCA protocol
7	The provider will use a strengths based approach, ensuring that the service user is aware of opportunities available to fulfil their potential and supported to access these.	✓ Staff training plan / and attendance
8	All staff will receive training on the Mental Capacity Act (MCA) and have a sound working knowledge of this.	✓ Observation of practice (internal provider quality assurance)
9	The provider will have a clear MCA protocol in place where decisions and issues can be discussed, logged and actioned. Best practice should be shared with the team.	✓ Handover / staff communication records
10	The provider will ensure that a training plan is in place for all members of staff, proportionate to the work the individual does. The provider will be able to demonstrate that their staff team have regular and appropriate training.	✓ Observation of practice (commissioning organisation quality assurance)
		✓ Staff interviews
		✓ Management interviews
		✓ Service user feedback
		✓ Support feedback
		✓ Job Descriptions

D.2: Be physically and mentally well

Service User Outcome:		Example of Evidence
Service users are physically and mentally as well as they can be. They have knowledge about how to maintain their health and about how to reduce and recover from ill health.		
<i>“I am as physically and mentally healthy as possible”</i>		
Service Outcome:		
The service works within the ethos of prevention. Providers actively promote physical and mental wellbeing, and support Services Users to lead a healthy lifestyle, with early access to appropriate services before reaching a crisis point.		
No	Signposts	
1	The provider will support service users to register with a GP and a dentist where appropriate. The provider will also arrange access to primary and secondary health care, as appropriate.	
2	Through the support planning and review process the provider will work with the service user to recognise barriers to physical and mental wellbeing, and identify the tools that may be used in achieving better health outcomes.	
3	The provider will signpost service users where appropriate to enable them to access other services that may positively impact their physical and mental health (such as access to substance misuse services)	
4	When supporting service users who have been detained under the Mental Health Act (1983) and are eligible for section 117 aftercare, the provider must assess whether they are able to adequately meet the service users’ needs	
5	The provider will support service users to access information about maintaining and improving mental and physical health.	
6	The provider will work with other services that can contribute to the delivery of improved physical and mental health outcomes.	
7	The provider will encourage service users to follow professional health and medical advice.	
8	The provider will promote healthy lifestyle choices and activities. The provider will advise service users of activities that are available in their local community, such smoking cessation and walking for health.	
9	The provider will promote information and support groups that provide information about living a healthy lifestyle.	

- ✓ Service user care and support plan
- ✓ Daily recording in care and support plan
- ✓ Service user Life Story / Map of Life
- ✓ Key Worker allocation
- ✓ Activities timetable / log / record of involvement
- ✓ Service user meeting minutes
- ✓ Support network meeting minutes
- ✓ Handover / staff communication records
- ✓ Staff interviews
- ✓ Management interviews
- ✓ Service user interviews and feedback
- ✓ Support network interviews and feedback
- ✓ Risk assessments

D.3: Safe and feel safe		Examples of Evidence ✓ Service user support plan ✓ Reviews of support plan ✓ Risk assessments ✓ Safeguarding/Whistle-blowing Policy ✓ Service user feedback ✓ Staff interviews ✓ Staff induction plan ✓ Staff training plan/attendance ✓ Safeguarding log ✓ Management interviews ✓ Support network feedback ✓ External organisations input log
Service User Outcome:		
Service users have control of decisions about their life and the services they receive. They have access to resources to support them to meet the outcomes agreed in their support plan and are able to exercise control over all aspects of the service they receive. Services are responsive to individual needs and preferences. Service users live their everyday lives confidently with strategies to help them to manage this in a positive and safe way. 'I feel safe' and 'I am listened to'		
Service Outcome:		
The service works alongside service users to help them to be safe and feel safe.		
No	Signposts	
1	Through the support planning, safeguarding, risk assessment and management process the provider will work with the service user to develop practical strategies to enhance safety and feelings of safety.	
2	The provider will promote and provide an organisational ethos and service environment where Service Users are able to express when they do not feel safe.	
4	The provider will have a clear and accessible Safeguarding and whistle-blowing policy in place. Service Users will be provided with appropriate information about this and know how to report concerns.	
5	The provider will train staff on Safeguarding and the whistle –blowing policy and encourage behaviour in accordance with these policies.	
6	The provider will link with external organisations to provide information that will help to increase safety. This may include, though is not limited to, the fire service, police and Neighbourhood Partnership Boards. In addition the provider will signpost individuals, where appropriate, to community safety training.	

D.4: Have the social contact they would like		Examples of Evidence
Service User Outcome:		
The service user will be satisfied with the level of social contact that they have. <i>'I have social contact and positive activity'.</i>		
Service Outcome:		
The service promotes appropriate social contact for service users.		
No	Signposts	
1	The provider will explore options for social contact with service users.	
2	Through the support planning process, the provider will help to facilitate social contact in discussion with service users.	
3	The provider will link in to mainstream groups in the community, as well as specifically commissioned groups, and peer groups, to promote and facilitate appropriate social contact, and help service users to socialise with their contemporaries.	
4	The provider will make best use of technology (e.g. Internet) to support and enable service user to access appropriate social contact opportunities.	
5	The provider will ensure, through their processes and practice, that Safeguarding, Risk assessment and Risk plans are completed, used, and regularly reviewed.	
6	The provider will have active policies in place that define clear boundaries to support appropriate and healthy relationships between the provider staff and service users.	

D.5: Have support to access purposeful activities which link to the local community and may include education, training and lifelong learning opportunities		Examples of Evidence ✓ Service user support plan ✓ Accident / Incident forms ✓ Risk assessments ✓ Risk plans ✓ Staff meeting minutes ✓ MCA protocol ✓ Staff training plan / and attendance ✓ Observation of practice (internal provider quality assurance) ✓ Handover / staff communication records ✓ Observation of practice (commissioning organisation quality assurance) ✓ Staff interviews ✓ Management interviews ✓ Service user feedback ✓ Support feedback ✓ Job Descriptions
Service User Outcome:		
Service users will know what education and training opportunities are available to them and how these can be accessed. Service users will be more confident in exploring, setting and achieving their aspirations for education and training. <i>'I have opportunities to learn'</i>		
Service Outcome:		
The service signposts service users to meaningful and purposeful activities in the community and provide accurate information and supports Service Users to access education and training.		
No	Signposts	
1.	The provider will explore what service users' aspirations are in achieving meaningful purposeful activity in the community, in addition to education and training in the support planning and review process.	
2.	The provider will signpost and support service users in accessing purposeful activity in the local community.	
3.	The provider will promote education and training and other purposeful activity (e.g. activities that work towards independence by developing core skills).	
4.	The provider will have accessible information for service users on how to access education and training and other relevant purposeful activities to promote progression towards greater independence.	
5.	The provider will signpost the service user and support them to access education and training organisations that can provide accurate information on the impact of education and training on their benefits, so that service users can make an informed decision.	
6.	The provider will keep up to date with, and engage in education and training and voluntary opportunities in the city linked to Cities of Service and Learning City initiatives. http://www.citiesofservice.org/ http://learningcities.uil.unesco.org/about-us/learning-cities	

D.6: Enabling independent living through access to travel		Examples of Evidence ✓ Service user support plan ✓ Accident / Incident forms ✓ Risk assessments ✓ Risk plans ✓ Staff meeting minutes ✓ MCA protocol ✓ Staff training plan / and attendance ✓ Observation of practice (internal provider quality assurance) ✓ Handover / staff communication records ✓ Observation of practice (commissioning organisation quality assurance) ✓ Staff interviews ✓ Management interviews ✓ Service user feedback ✓ Support feedback ✓ Job Descriptions
Service User Outcome:		
The service user will use appropriate travel options in order to live as independently as possible. This may mean use of public transport, community transport, their own private transport (e.g. Motability) or transport provided by the CSS provider. <i>'I can get from place to place independently'</i>		
Service Outcome:		
The service will support service users to access appropriate travel options, always trying to maximise the person's independence balanced with safety.		
No	Signposts	
1.	Service user to be given a choice of travel options that are affordable	
2.	Service user to be given the choice to arrange their own travel options if they wish.	
3.	The provider will promote the travel options that are available for Service Users to enable them to make a decision.	
4	The provider will keep apprised of current travel options and promote these options to Service Users. The options may include walking, public transport, taxis, the various Community Transport providers, dedicated hospital or supermarket transport or access to bicycles.	
5	The provider will signpost and support service users to access welfare benefits, where applicable, that may enable them to have their own independent transport.	
6	The provider will have accurate information available to service users on transport timetables and accessibility options, such as Safe / Better Journey Cards.	
7	The provider will complete Safeguarding and Risk assessment plans and actively support the use and regular review of these, taking action where appropriate if staff are found to not be adhering to this.	
8	The provider will support service users to access 'travel buddies' as appropriate.	

D.7: Able to make their own decisions and manage risks and responsibilities		Examples of Evidence <ul style="list-style-type: none">✓ Service user support plan✓ Reviews of support plan✓ Risk assessments/ plans✓ Safeguarding log✓ Incident / accident forms / audits✓ Health and safety policy / log✓ Service User feedback✓ Staff interviews✓ Management interviews✓ Support network feedback✓ Training plan/attendance log
Service User Outcome:		
Service users are empowered to make their own decisions in their daily lives.		
<i>'I have as much choice and control as possible over my life'</i>		
Service Outcome:		
The service works with service users to support them to make informed decisions and that risks are understood and mitigated. Services users understand and are able to manage their responsibilities with appropriate support as required.		
No	Signposts	
1	The provider will provide a consistent approach in the exploration of decision making processes, ensuring that service users understand consequences and can make informed decisions.	
2	Through the support planning, safeguarding, risk assessment and management process the provider will work with the service user to identify and mitigate risk.	
3	The provider will use appropriate formats to communicate the decisions reached and discuss these with Service Users to provide clarity before any action is taken.	
4	The provider will demonstrate how decisions were reached and maintain a record of the rationale for decisions, taking into consideration rights versus risks. The provider will document the agreed responsibilities for both the provider and service users.	
5	The providers will have a good working knowledge of the Mental Capacity Act in relation to day to day decisions. Providers will have clear protocols in place where decisions/issues can be discussed, logged, actioned, and best practice shared across the organisation.	
6	The provider's risk assessment process must be robust and comply with the service specification requirements.	
7	The provider will deliver regular Safeguarding training to all staff members and organisational leadership will take all reasonable action to embed that learning into practice.	
8	The provider will comply with Bristol City Council's Safeguarding policy as set out under the Care Act 2014. When completing a risk assessment, the provider must incorporate the BCC standard template in relation to decision making (please see Appendix 6).	

D.8: Satisfied with services they receive		Examples of Evidence ✓Service user support plan ✓Reviews of support plan ✓Service user feedback ✓Support network feedback ✓Service user meeting minutes ✓Complaints policy ✓Support network feedback ✓Staff interviews ✓Examples of service user suggestions informing service development ✓Examples of the complaints process in action
Service User Outcome:		
Service users and their support/network are encouraged and enabled to give their views about the services they receive. <i>‘I am satisfied with the service I receive’</i>		
Service Outcome:		
The service has policies and procedures in place to manage complaints and suggestions from service users and their support network, to promote and enable service user satisfaction with the services that they receive.		
No	Signposts	
1	The provider will promote a culture of openness within their organisation, enabling service users to express their complaints and suggestions.	
2	The provider will provide a complaints procedure in a format that is accessible to service users and their support network.	
3	The provider will inform service users and support networks, as appropriate, of the outcome of their complaints, in a timely manner and in accordance with the complaints policy.	
4	The provider will have an agreed process for service users to make suggestions to inform service development. This will be communicated to service users in a timely and consistent manner.	
5	The provider will proactively seek and record service user’s views on the service they receive. This will be done on an agreed regular basis in an appropriate and accessible format.	
6	The provider will assess service user satisfaction on a regular basis, at a minimum annually.	

D.9: Enabled to become independent of support services where appropriate		
Service User Outcome:		Examples of Evidence ✓ Service user support plan ✓ Review of support plan ✓ Risk assessment/plan ✓ Risk assessment review ✓ Move on plan ✓ Team meeting minutes ✓ Staff interviews ✓ Service user feedback ✓ Support network feedback ✓ External organisations meetings and activities timetable
Service users are enabled to move forward with their lives independently. For some this may mean ongoing regular support that has reduced overtime to the lowest level of intensity, which enables service users to maintain the progress that they have achieved. There should also be appropriate flexibility to increase the level of support an individual receives in the event of a crisis, to support them to regain independence and prevent the need for a hospital admission.		
'I can do more things on my own without support'		
Service Outcome:		
The service uses a planned approach in supporting service users to reach the level of independence that is right for them.		
No	Signposts	
1	Through the support planning, safeguarding, risk assessment and management process the provider will work with the service user to identify opportunities and mitigate risks to independence. This will include helping service users to identify what they would like and supporting them to achieve it.	
2	The provider will review and discuss support plans with service users with a view of working towards agreed outcomes. This will be in a responsive and timely manner, identifying stepping stones to reaching agreed outcomes, agreeing key milestones, recording the distance travelled and exploring any barriers to appropriate independence.	
3	The provider will work with the service user to discuss move on options and, where appropriate, develop and agree a realistic move on plan in partnership with BCC. The provider will clearly communicate the plan to the relevant parties.	
4	The provider's support planning process consistently reviews a service user's ability to move on to greater independence.	
5	The provider will signpost and support service users to explore and use mainstream groups, peer groups and activities in the community to maximise independence.	
6	Where a service user wants to be more independent or reach more outcomes than their support plan identifies, the provider will work with service users on how they can meet the outcomes that they have identified independently.	
7	The provider will work with service users so they understand, as far as possible, that their role is to enable move on towards greater independence where appropriate. The provider will discuss this regularly with all service users and explore all available options.	

Appendix 1: Additional Context & Background

1.1 Context

1.2 Care Act

1.3 Three Tier Model

1.4 Principles of CSS Commissioning

1.5 CSS Pathway

1.6 Partnership Working

Bristol City Council (BCC) currently commissions over 100 different providers to deliver CSS to approximately 1,245 service users at an estimated cost of £16m per annum. Due to increasing current and projected future demand for social care services and significant financial pressures arising from local government funding cuts, this level of spend is unsustainable. Additionally the social care landscape has undergone significant change since the service was last commissioned, following the introduction of the Care Act and a transition within BCC to a “Three Tier Model” of social care. This aims to maximise independence by enabling individuals to be supported to access ‘help to help yourself’; ‘help when you need it’ and ‘help to live your life’.

This is underpinned by a strengths based approach to social care assessments by social workers starting from a premise of what individuals can do rather than what they cannot do. It also works to the assumption that someone’s independence should be maximised where possible. People with learning difficulties, physical disabilities and mental ill health generally want to live their lives as independently as possible without the need for permanent external support. For some, a level of ongoing support will always be needed, but for the majority of individuals, the expectation should be that over time support packages will reduce as independence increases and outcomes are met.

It needs to be recognised, however, that there will always be individuals who will require a level of ongoing support to manage their risk of harm to themselves or community members, or due to the severity of their disability. There also needs to be an acknowledgment that the costs of CSS services will differ for different levels of need and services required to meet these needs.

An increasing number of service users are also choosing to manage their own care through a Direct Payment (DP), which will result in a reduction in the provision commissioned directly by BCC over time. There is also an ongoing commitment from BCC to work with the market to develop this for those service users and carers who chose to direct their own care. This sets the context for Community Support Services and the service specification has taken this into account.

Introduced in April 2015, the Care Act 2014 builds on recent reviews and reforms within health and social care for adults. It sets out a range of new duties and responsibilities for local authorities and partners, and new rights for service users and carers. The Care Act aims to ensure:

- Clearer, fairer care and support
- Improved wellbeing – physical, mental and emotional, of both the person needing care and their carer
- Prevention and delay of the need for care and support
- Individuals are in control of their own care

The provision of Community Based Support Services must comply with the Care Act (2014). In particular:

A greater focus on wellbeing – the Care Act introduces a new statutory principle of individual wellbeing. This refers to physical, mental and emotional wellbeing and all social care services must focus on improving an individual's wellbeing.

Prevention – there is a requirement for local authorities to proactively prevent, reduce or delay the need for care and support for local people. Community Support Services must therefore work with individuals to reduce and/or maintain their ongoing support needs.

Diverse care markets – the Care Act requires a diverse local marketplace to enable individuals to access high quality services and be able to exercise choice in the service they receive.

Safeguarding – the duty to protect individuals from neglect and abuse has been strengthened and safeguarding must form a core element of every service

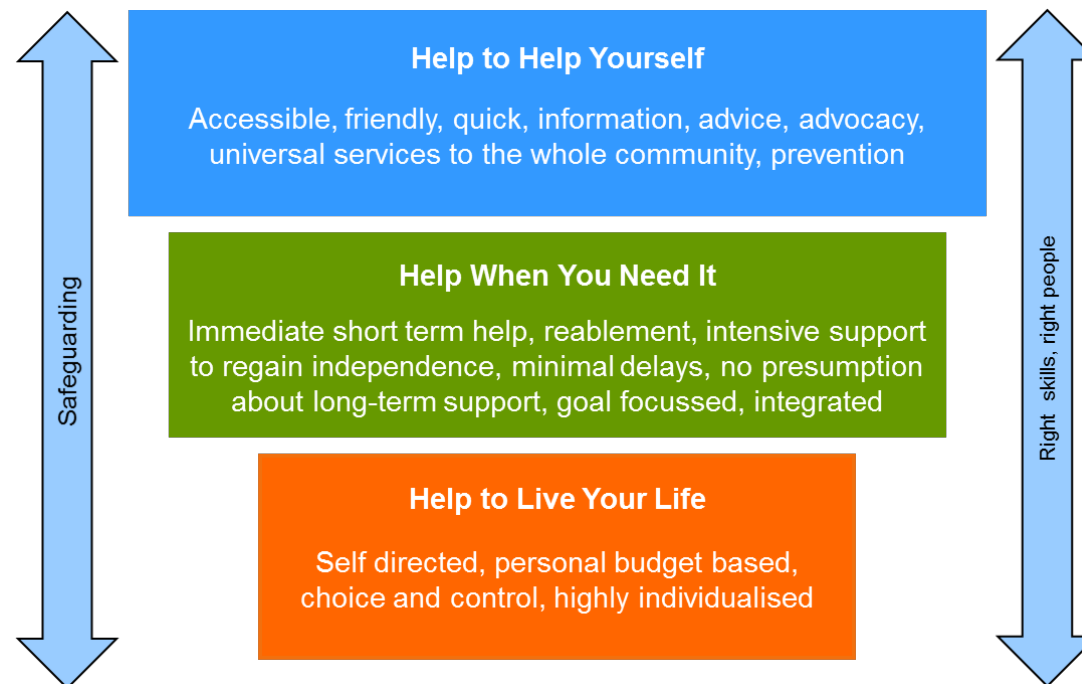
Support for Carers – the Care Act offers greater statutory support to informal Carers, to enable them to continue caring for their loved ones in the community.

Transition to Adulthood - The Care Act includes a refreshed duty on Local Authorities to plan appropriately for transition to adulthood for young adults at 18. The Children and Families Act 2014, which includes SEND reforms 0-25, is the key statutory guidance on longer term preparing for Adulthood planning for young adults.

1.3

Three Tier Model

BCC's vision is to commission support services that maximise an individual's wellbeing and independence by providing appropriate and flexible levels of care and support at the right time, right place, at the right quality and cost. To underpin this, there need to be changes in carer management and social work practice. BCC is working to a new 'strengths based' approach to social care assessment and planning, which considers what the individual can do for themselves firstly to support the ethos of maximising independence. BCC's Three Tier Model of Support is outlined below:

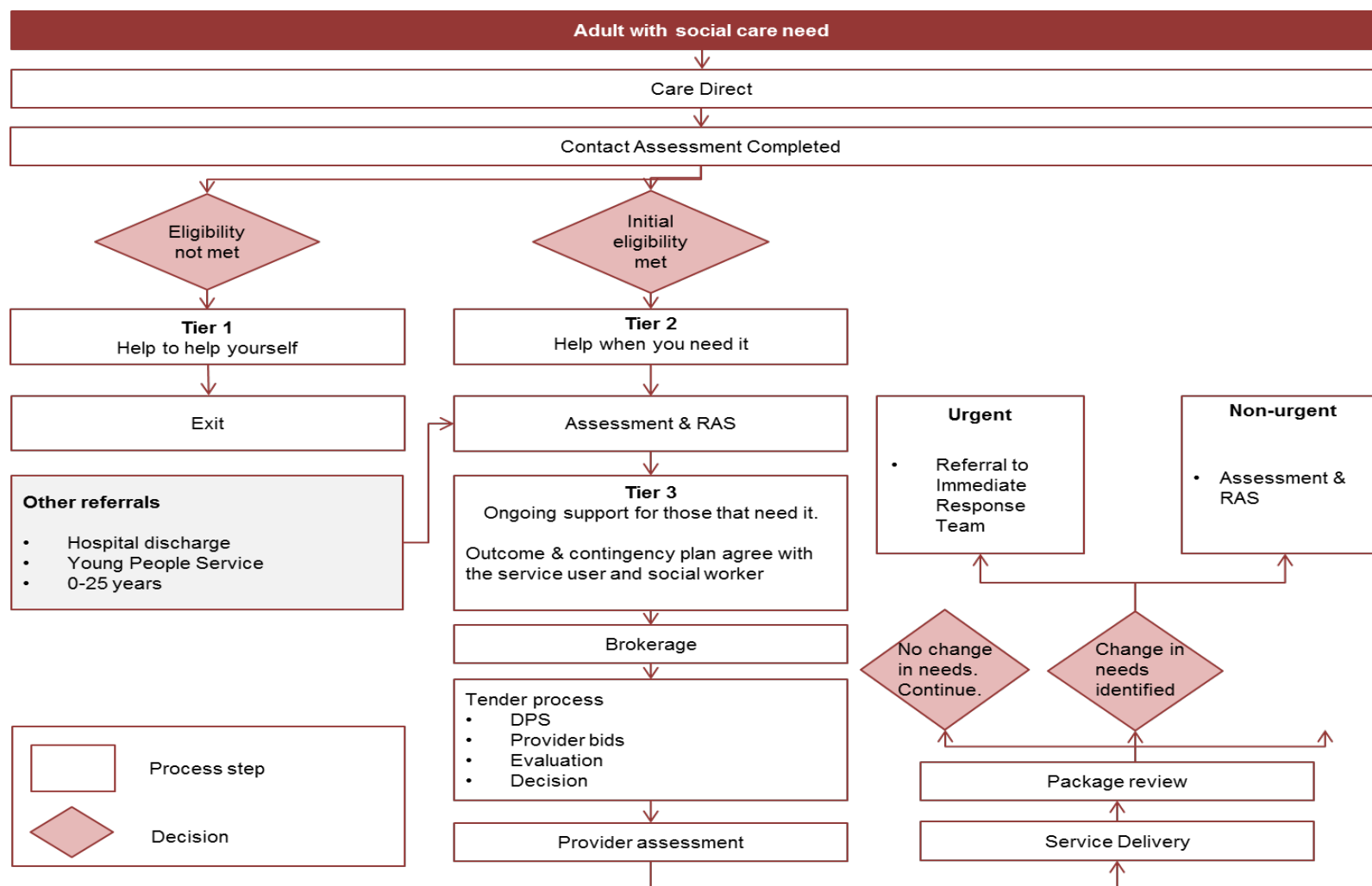


There are 10 key principles that underpin this commissioning process and this service specification:

- 1 Focus on outcomes and maximising independence
- 2 Quality support that meets needs and agreed service user outcomes, and that service users and carers are satisfied with
- 3 A focus on prevention and early intervention
- 4 Strengths based approach to assessing needs and outcomes – starting from a position of what someone can do, and will be able to do for themselves, with appropriate levels of support
- 5 Adaptable, flexible and inclusive services that can meet changing needs and agreed outcomes
- 6 Purposeful activities that meet outcomes, including supporting people into education, employment and training
- 7 A diverse market of good quality providers across CSS services, to reflect the diversity of the city
- 8 Services that signpost onto other services and activities in communities
- 9 Value for money services (economic, efficient and effective services)
- 10 Transparent pricing structure for CSS services, with price better linked to need and agreed outcomes

Fundamental to meeting the requirements outlined in this document is the local network and connections of providers within Bristol and the commitment of providers to continue to develop and expand their knowledge of services available within the local community, in order to promote greater independence.

1.5 Community Support Services Pathway



BCC is the sole commissioner of adult social care CSS. However, there is strong strategic alignment to health based commissioning undertaken by Bristol Clinical Commissioning Group (CCG) given the aspiration to support people in the community and prevent unnecessary hospital admissions and delayed discharge. CSS will therefore be delivered alongside a number of other services, for example mental health services and re-ablement.

Providers will be required to work collaboratively with other organisations, such as Bristol Clinical Commissioning Group, further education colleges, employment support agencies, voluntary and community sector organisations and Voscur (the lead organisation representing the interests of voluntary and community sector organisations in Bristol), to support individuals to achieve their outcomes. In addition, providers may be required to work with other council services, such as Public Health, Housing, Children's Services, Transport and partnership boards.

BCC will continue to work with partners throughout the duration of the commission and contract to:

- Assess needs and seek to be responsive to changes in need
- Look systemically at what is being commissioned for what purpose, for whom and where
- Assess the supply of CSS services and other associated support
- Share relevant information and key objectives whenever possible
- Avoid duplication and fill joint gaps
- Share training opportunities and best practice
- Maximise resources and identify better, more efficient ways of doing things
- 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
- Promote partnership working at all levels of the organisation
- Enable service user and their families/carers to contribute to partnership working
- Develop contracts that are flexible enough to enable providers to be responsive to service users' changing needs and priorities.

As part of the requirement to work effectively with other organisations providers will be required to:

- Attend the monthly CSS Provider Forum which is co-chaired by providers and BCC and attended by CCG representatives
- Actively participate in local community networks and engage with other groups and organisations in the local community, which will include signposting service users to other resources in their community that may support them to meet their outcomes
- Utilise BCC's Information, Advice and Guidance portal to ensure that there is optimal access to and usage of information about what is on in local communities and the City to broaden the experience of CSS service users and their access to non-social care activities.

Further information about CSS can be found in the CSS Strategy:

www.bristol.gov.uk/csscommissioning

Appendix 2: Accommodation Standards

2.1 Accommodation Standards

This appendix is only applicable to providers of supported living. Whilst the accommodation will be commissioned separately from the care and support element of the package and performance monitoring will take place outside the scope of the CSS contract, BCC recognises that the accommodation is a key part of the service an individual receives and is intrinsically linked to their CSS package and such, has set out the accommodation standards expected.

Supported living providers are required to:

- Self-certify that the properties and management of their properties comply with the West of England rental standards.
- Where the landlord is separate to the support provider, a joint working protocol and service level agreement is in place that sets out the roles and responsibilities of the partnership.
- Ensure that the accommodation remains affordable as far as possible based on factors within the provider's control. Where it has been identified by the provider or other relevant parties that accommodation costs prevent access to employment, the provider is expected to contact the Council to explore alternative provision that may remove this barrier.
- Keep apprised of changes made by central government welfare reform regarding the supply and provision of supported accommodation. Where changes in policy take place that impact commissioned provision, providers must inform BCC through the procedures set out within the contract.
- Operate their business structures in a way that covers costs in the event of voids. BCC is not liable for any voids unless stated within the contract for accommodation provision.
- Ensure that routine repairs and maintenance to the accommodation are carried out promptly

West of England Rental Scheme Standards

For Landlords

A written tenancy agreement provided with required information.

Membership of an approved Tenancy Deposit Protection scheme

Meets our minimum property standard (see checklist)

Fit and Proper Person declaration completed

A commitment to undertake regular training to keep up to date with relevant laws

For Letting Professionals

As for landlords and;

Membership of an approved Agents Redress Scheme

Compliance with trading laws and the [Competition and Markets Authority Guidance for Letting Professionals](#).

If your answer is in a grey shaded box the property <u>may</u> not meet the minimum legal requirements so you should take action to make sure the property is compliant with the law.			X
1. Planning	Do you have the correct planning permission for the current use of the property? Some newly shared houses may need planning permission.	Yes or N/A	No
2. EPC	Does the property have a current Energy Performance Certificate (EPC)?	Yes	No
	Is the EPC band F or G?	Yes	No
3. Heating	Does the property have a fixed heating system (i.e. gas boiler and radiators, or storage heaters) in good repair, with sufficient power output to heat all bedrooms and any lounges, a timer or programmer and a device to control room temperature – e.g. thermostat?	Yes	No
	Is the heating easily controllable by the tenant?	Yes	No
4. Food safety	Does the property have adequate; hot and cold water, a surface to prepare food, food storage and provision for cooking and refrigeration?	Yes	No
5. Insulation	Do the windows and doors appear to be in good repair and free from excessive draughts?	Yes	No
	If there is a loft or loft room is it insulated sufficiently, (100mm minimum if gas central heating or 200mm minimum if electric heating)?	Yes or N/A	No
6. Fire	If there are shared communal parts (Halls Stair landings, shared Kitchens or Living rooms etc.) a written Fire Safety Risk Assessment is required. Has a written Fire Safety Risk Assessment been completed?	Yes or N/A	No
	For houses occupied by a family - Does the property have a mains operated fire alarm system, or 10 year life sealed battery smoke detectors in hallways and landings on each level?	Yes or N/A	No
	For 3 storey family houses – does the property have mains wired interlinked smoke detectors located in the ground floor hall, first floor landing and second floor landing?	Yes or N/A	No
	For shared houses or bedsit accommodation – Do fire precautions meet requirements of LACORS guidance on Fire Safety?	Yes or N/A	No
7. Gas	Is there a satisfactory current Landlord Gas Safety certificate for all gas appliances provided? Expiry date:	Yes	No
8. Solid fuel/Oil	Evidence of servicing and maintenance of all solid fuel appliances by a HETAS/OFTEC engineer within the last 12 months.	Yes or N/A	No
	Is there a Carbon Monoxide alarm in each room with a solid fuel appliance?	Yes or N/A	No
9. Electricity	In the last 5 years has the property have a current satisfactory electrical condition report which indicates that the property is free from dangerous or potentially dangerous faults? <i>A legal requirement in a House in Multiple Occupation expected to be required by law for all rental property.</i> Expiry Date:	Yes	No
	On a visual inspection of the electrical installation and appliances, are there any obvious hazards such as broken or loose sockets, burn marks, unavoidable overloading, exposed wires or live conductors, cracked or broken light pendants, sockets too close to water.	Yes	No
10. Security	Do the windows and doors appear to be in a good condition and can they be adequately secured?	Yes	No

11. Condensation & Mould	Is there sufficient ventilation in the kitchen, bedrooms, living room and bathroom (An operable window or mechanical extract fan in a kitchen or bathroom)? In some cases you may need secure means of ventilation such as trickle vents.	Yes	No
	Is there extensive black mould growth in any room ?	Yes	No
12. Personal Hygiene	Is there at least one inside flushing toilet in working condition?	Yes	No
	Is there a wash hand basin with hot and cold running water in the same room as each toilet?	Yes	No
	Is there at least one bath with hot and cold running water or a shower cubicle with a working shower?	Yes	No
13. Furniture	Does any furniture and soft furnishings supplied comply with the legal fire resistant standard? E.g. Sofas, mattresses must have labels proving they comply.	Yes or N/A	No
14. Falls	Is the property free from tripping and falling hazards? E.g. Stairs with no hand rails, raised and uneven floor surfaces, windows that should have window restrictors to prevent falls.	Yes	No
15. Asbestos	If there are any shared common parts to building has a competent person assessed whether there are any Asbestos containing materials that you need to manage?	Yes or N/A	No
16. Repair	Is the property in a reasonable state of repair ?	Yes	No
17. HMO	If the house or flat is shared by 3 unrelated people is it well managed (decoration, cleanliness, maintenance, equipment and facilities in good working order, common parts free from obstruction)?	Yes or N/A	No
	Are there an adequate number of amenities for the number of occupiers (i.e. bathrooms, toilets and kitchens)? Please note it is a criminal offence if HMO Management Regulations are not met unless the manager has a reasonable excuse.	Yes or N/A	No
18. Licensing (mandatory)	If the house or flat is (1) three or more storeys, (2) occupied by five or more unrelated people who (3) share facilities with others then it is likely to require a licence. If yes do you have or have you applied for a licence?	Yes or N/A	No
19. Licensing (discretionary)	If the accommodation is within an area subject to a discretionary licensing scheme, does it need a licence? If yes, do you have or have you applied for a licence?	Yes or N/A	No
	If the accommodation is within an area subject to a discretionary licensing scheme, does it need a licence?	Yes	No
	If yes, do you have or have you applied for a licence?		
20. Overcrowding	Will the number of people occupying meet the bedroom standard? One bedroom for up to two persons, two bedrooms for up to four persons, three bedrooms for up to six persons or four bedrooms for up to seven persons.	Yes	No
	Is the living area big enough space for the household occupying to carry out normal activities including space for a child to carry out educational activities like homework?	Yes	No
	Do the bedrooms meet or exceed an area of 6.5 m ² (Single) and 9.5m ² (Double)	Yes	No

Appendix 3: Glossary of Terms

3.1 Glossary of Terms

Term	Definition
Advocate	http://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/inclusion-empowerment-human-rights/types.asp
Assistive Technology	Assistive technology or adaptive technology (AT) is an umbrella term that includes assistive, adaptive, and rehabilitative devices. AT promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with, the technology needed to accomplish such tasks
BCC	Bristol City Council
BCCG	Bristol Clinical Commissioning Group
Care Act	http://www.scie.org.uk/care-act-2014/
Care Direct	Care Direct is a service run by the council for vulnerable adults, older and disabled people, their family, friends and carers. It provides information about - and access to - social services, benefits and other resources
Carer	An individual who looks after Family members, partners or friends in need of help because they are ill, frail or have disability. (Social care institute of excellence)
Comment	A suggestion or observation about services provided
Commissioning Strategy	A commissioning strategy provides a long-term, guiding and co-ordinated plan to achieve outcomes desired on the basis of national legislation and strategy as well as local needs. It explains not only why we are doing it but how

Support to access the community	Support provided in the community. This may include support with accommodation based tasks where the service provider is not the Landlord.
Complaint	An expression of dissatisfaction or disquiet in relation to an individual citizen about the actions, decisions or apparent failings of a service
Compliment	A positive remark about a service or an individual
Contact Assessment	Assessment carried out with direct contact with the individual at the first point of contact
COSHH	Control of Substances Hazard to Health
Council	Bristol City Council
Council Assessment Summary	A summary of the assessment carried out by the Council
CQC	Care Quality Commission
CSS	Community Support Services
Data protection act	https://www.gov.uk/data-protection/the-data-protection-act
DBS	Disclosure Barring Service
Deprivation of Liberty act 2005	http://www.scie.org.uk/publications/ata glance/ata glance43.asp
DPS	A dynamic purchasing system is similar to a framework agreement with the exception that potential suppliers can apply to join at any time during the lifetime of the DPS. The DPS is set up with a specific set of requirements which can then be broken down in to individual categories
Equality Act 2010	http://www.legislation.gov.uk/ukpga/2010/15/contents
ETE	Education, Training and Employment
Freedom of information act	http://www.legislation.gov.uk/ukpga/2000/36/contents
LGBT	Lesbian, Gay, Bisexual and Transgender
Lone Working	http://www.hse.gov.uk/pubns/indg73.pdf
MAR chart	Medication Administration Record
MCA	Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents
National Standards	Best practice guidance for engagement between communities and public agencies
Needs	A thing that is wanted or required
Outcomes	End result, consequence

Performance Indicator	Succinct measures that aim to describe as much about a system in as few points as possible and help us understand a system, compare it and improve it
Personal care	Personal care includes assistance with dressing, feeding, washing and toileting, as well as advice and psychological support.
Personalisation	Putting people at the centre of the process identifying their needs; is not just about personal budgets, but about achieving choice and control in many ways and in different settings, including basic needs such as being able to access public transport if you are disabled.
Provider	An organisation which provides a service or commodity.
Providers support plan	The details of the care/support required and the way the service user's assessed needs are to be met.
Risk assessments	Document detailing the control of risks and reasonable steps taken to prevent harm
Safeguarding	Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.
Service user	Individuals who are eligible to access CSS services
Service user review	A formal assessment of a service user's support plan with the intention of instituting change if necessary
Service user support plan	A summary of your assessed needs, your outcomes and how you want to use your personal budget to achieve these outcomes
Signposting	Informing, advising or guiding SU onto another support service,
Stakeholders	In the context of this service specification, stakeholders is an all encompassing term which may refer to service users and their support network, care home providers, the Local Authority, NHS Bristol, Social Workers, General Practitioners and other health professionals.
Strengths based approach	Strengths-based practice or approach is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets
Sustained paid employment	Paid employment for a duration of at least 3 months
Tender	a written or formal offer to supply goods or do a job for an agreed price

Three tier model?	BCC's model of support to support the ethos of maximising independence. Incorporates 3 levels of support ranging from universal & short term to highly individualised services.
Training needs analysis	Training needs analysis identifies training needs at employee, departmental or organisational level in order to help the organisation to perform effectively.
Trustee	Any person who holds property, authority, or a position of trust or responsibility for the benefit of another
Whistle-blowing policy	Whistle Blowing involves a person or group of people who tell someone in authority (i.e. the Local Authority, NHS Bristol, the Care Home Manager or the Care Quality Commission) about alleged dishonest or abusive practices occurring in a care setting.

Appendix 4: Price Ranges

4.1 Price ranges

As outlined in the body of this document, during the service user assessment process the practitioner will identify the appropriate need band for an individual. There will be a dialogue with providers, where appropriate, about an individual's needs. For some individuals all the care and support hours they require may be within the same band, whereas for others they may receive some hours at one band and some at a higher/lower band. BCC has identified price ranges for each band of need, calculated on an hourly rate. Providers will be required to submit a price that falls within the identified price range as part of the placement process via ProContract.

There is a maximum of four need bands. The number of needs bands for each service differs. Typically most services bands correlate with provider staffing ratios. Typically the standard band will be used where services are commissioned on a shared basis with a staffing ratio which is less than 1:1, Intermediate 1 and 2 will be used where services are commissioned with a staffing ratio of 1:1 and High will be used where services are commissioned with a staffing ratio greater than 1:1.

Other factors as well as staffing ratios will influence the selection of a band for each service user. The pricing tool in Appendix 5 demonstrates what factors will be considered in determining the need band, for example, support ratios and the level of risk presenting. The level of support required and the specialist nature of this will be less at the lower end of the need bands and within the specified range.

In addition, if sleep in and/or waking night is required this will be identified in an individual's support plan and a separate rate will apply. BCC has identified a cap per night that the price cannot exceed, and providers are expected to price accordingly based on the level of need of the individual. The cap stated is expected to be the maximum 1:1 rate; shared support should be priced accordingly.

Supported Living Price Ranges		
Price Band	Low Cost of Band (per hour)	High Cost of Band (per hour)
Standard	£2.85	£6.25
Intermediate 1	£13.00	£15.50
Intermediate 2	£14.00	£17.50
High	£24.05	£30.50

Support to access the community		
Price Band	Low Cost of Band (per hour)	High Cost of Band (per hour)
Standard	£2.47	£6.25
Intermediate 1	£13.00	£15.50
Intermediate 2	£14.00	£17.50
High	£24.05	£30.50

Day Services		
Price Band	Low Cost of Band (per hour)	High Cost of Band (per hour)
Standard	£2.50	£5.93
Intermediate	£5.74	£15.75

Time for You Carers Services		
Price Band	Low Cost of Band (per hour)	High Cost of Band (per hour)
Intermediate	£12.00	£14.00

Price caps (per night)	Cap*
Sleep in	£74
Waking night	£140

**The cap is the maximum price payable for a sleep in/waking night. The stated cap reflects the maximum payable on a 1:1 basis. If the requirement is for a shared sleep in/waking night providers are expected to price for this accordingly and should note that the rate submitted will be added to the hourly rate to calculate a total weekly cost to enable comparison between providers.*

Appendix 5: Price Band Tool

5.1 Price band tool

CSS Support Planning Tool

Accommodation Based Services

Scoring Instructions

1. Support Ratio: Based on the Descriptors, mark the category of Staff Ratio for Service user with a '1'.
2. For the remaining descriptors mark as many categories as you can based on the most recent assessment/Support plan for weekly support.
3. Repeat the exercise for each package of care (for instance if the individual has shared care for x hours and 1:1 on x hours)
4. Complete the Assessment Sign off.

LAS Reference	
New client? Y/N	

Descriptors	Intra-descriptors	
Support Ratio	Shared support up to 1:3 ratio/ Telephone monitoring support. Shared support 1:2 ratio. 1:1 support required. 2:1 support required.	
Risk Consider; * Drug use * Lifestyle * Self-harm * Mental Health	Specific individual Risk-Assessment required and updated Annually. Requires Shared Staff support to mitigate risk/Back office support. Requires 1:1 Staff intervention to mitigate risk due to unpredictable behaviour. Requires 1:1 Staff intervention to mitigate risk. Dedicated on-call back up support. Requires 2:1 Staff intervention to mitigate risk. Requires 2:1 Staff intervention to mitigate risk. Dedicated on-call back up support.	
Personal Care	Service user requires occasional verbal prompts for personal care. Service user requires regular, repeated verbal prompts in regard to their personal care. Service user requires repeated verbal prompts and 1:1 supervision in relation to personal care needs Service user requires 1:1 physical support. Service user requires 2:1 physical support.	
Transport	Service user needs staff input to plan new journeys. Service user requires shared support to use public transport independantly and/or monitoring. Service user requires 1:1 support to use public transport for most journeys. Service user requires 1:1 support to use public transport for all journeys. Service user requires 1:1 support. Transport needs can only be met by private car or adapted vehicle. Service user requires 2:1 staffing. Transport needs can only be met by private car or adapted vehicle.	
Community Consider; * Language barrier * Cultural needs * Isolation	Service can access universal provision from his or her local area with shared ratio support. Service user requires shared support to use public transport and/or monitoring. Service user requiring 1:1 support to access the Community Service requires 1:1 support + back office and/ or Manager support. Service user requires 2:1 support. Service user requires 2:1 support + back office and/ or Manager support.	
Choices Consider; * Health * Finance	Service user requires weekly prompts and checks to ensure they are making safe choices Service user requires daily prompts and checks to ensure they are making safe choices Service user requires 1:1 support in decision making support to ensure their safety and well-being Service user requires 1:1 support in decision. Service user actively placing themselves at risk	
Stability/Engagement	Under assessment/Unsettled Placement/Hard to reach Service user	
Specialist Training	Specialist training required i.e Behaviour management	

Assessment Record

1. Record the Banding, Total number of hours (Weekly), Your Name/Position and LAS reference.
2. IF the service user has varying Staffing ratio's, complete the assessment for the next ratio in the next row

Score 0
Banding

Banding	Total Hours	Name and Position
Total	0	

Banked hours Assessment Record

Banked hours are to account for a service user whos package of support needs to be increased for short periods of time to ensure the stability of placement and the safety of the individual. This section will require a counter-signature from a Team manager. Please see Guidance notes.

Banding	Total Hours	Name and Position	Team Manager
Total	0		

Appendix 6: BCC Risk Proforma

6.1 BCC Risk Proforma

CENTRAL SAFETY SECTION RISK ASSESSMENT PROFORMA

Dept:

Date of Assessment : Assessed by :

Section :

Review dates
(max 24 months)
date one- date
two

SECTION 1

What is the Task/Activity or Workplace Environment You Are Assessing?	What Hazards Are Present or May Be Generated?	Who is affected or exposed to hazards?	What is the Potential Severity of Harm (<i>Risk Rating</i> <i>Matrix Table</i> <i>1</i>)?	What Precautions are Already in Place to Either Eliminate or Reduce The Risk of an Accident Happening (Existing Controls)?	What is the Likelihood of harm occurring? (<i>Risk Rating</i> <i>Matrix Table 1</i>)?	What is The Risk Rating (See Note <i>Below &</i> <i>Risk Rating</i> <i>Matrix</i> <i>Table 2</i>)

NOTE: If the risk rating is either High, Very High, Medium or Low proceed to section 2. If the risk rating is No Significant Risk no further action is required.

Section 2 - ACTION PLAN

<u>What is the Hazard You Need to Control ?</u>	<u>What Additional Precautions do You Need to Either Eliminate the Risks or to Reduce the Risk to:</u> <u>at Least the MEDIUM RISK RATING or Ideally the LOW RISK RATING.</u>	<u>Who is Responsible For Implementing These Controls?</u>	<u>When Are These Controls to be Implemented (Date)?</u>	<u>When Were These Controls Implemented (Date)?</u>

RISK RATING MATRIX
(Notes To Aid Completion Of The Risk Assessment Format)
Table 1

Potential Severity of Harm	Meaning	Likelihood of Harm	Meaning
Fatal/Major Injury	Death, major injuries or ill health causing long-term disability/absence from work.	High Likelihood	Occurs repeatedly / event only to be expected
Serious Injury	Injuries or ill health causing short-term disability/absence from work (over three days)	Possible	Moderate chance/could occur sometimes
Minor Injury	Injuries or ill health causing no significant long-term effects and no significant absence from work	Improbable	So unlikely that probability is close to zero

Table 2

Risk Rating - Degree of Injury by Likelihood/Probability			
	High Likelihood	Possible	Improbable
Fatal/Major Injury	Very High Risk	High Risk	Medium Risk
Serious Injury	High Risk	Medium Risk	Low Risk
Minor Injury	Medium Risk	Low Risk	No Significant Risk