

**Bath and North East Somerset Council and Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board**

# Service Specification for the provision of Care and Support for Adults with a Learning Disability and /or Autism in Supported Living Housing Scheme -Hygge Park & Sulis Down

**July 2023**

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# Introduction

This Service Specification describes the minimum requirements for the provision of care and support for adults with a learning disability and/or autism in two supported living housing schemes. It sets out all the important elements of that Service that must be delivered by the awarded Provider and will apply until further notice. However, the Council may from time to time vary this Specification, in partnership with the awarded provider. Any variation shall only be carried out after consultation and shall be recorded in writing.

The types of Service that might be commissioned for people with learning disabilities and/or autism by the Council and BSW ICB are described in this Specification, and it forms a part of the Contract between the Council and the Provider. This Specification should be read in conjunction with the Terms and Conditions of the Contract.

The two supported living housing schemes outlined below will provide 10 additional homes for individuals within Bath & North East Somerset who require this type of provision. The two schemes are:

* Hygge Park, Keynsham

Landlord: Curo Group

The development will provide 6 x 1 bed flats. Three on the ground floor will be wheelchair accessible. Five of these flats will provide own front door homes, and the 6th flat (one on the ground floor) will be used as a communal space for tenants to socialise. A room in this flat will provide a staff space and sleep-in space for the core provider.

* Sulis Down, Bath

Landlord: Bromford Group

The development will also provide 6 x 1 bed flats. The three on the ground floor will be wheelchair accessible, and five of these flats will provide own front door homes with the 6th offering communal space for tenants to socialise. A room in this flat will provide a staff space and sleep-in space for the core provider.

The Council will have a nominations agreement with both landlords for tenant referrals and void liability. The tenants will need to apply for and be in receipt of housing benefit to cover the weekly rent and all tenants will be responsible for their own utility bills via their benefits and for furnishing their homes. This provides residents with security of a quality local home, supports the reduction of younger adults being placed in more restrictive care home settings, and encourages building independent living skills for these individuals and the opportunity to be part of local communities.

The awarded core provider will have a partnership agreement with each landlord that outlines roles and responsibilities related to the building for each scheme.

This Specification has been developed in consultation with local Providers and people with learning disabilities and/or autism who use the related services. It takes into account national and local priorities and reflects the principles of the Transforming Care Service model for people with learning disabilities and/or autism as set out in ‘Building the Right Support’.

<https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

# B&NES Council & Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board Partnership

Bath and North East Somerset Council (B&NES Council) and Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (BSW ICB) have formed a partnership to work together towards integrated health and social care services for adults and children in Bath and North East Somerset.

B&NES Council and BSW ICB have a shared legal duty to operate a Health & Wellbeing Board and to publish a Joint Health & Wellbeing strategy.

The Health & Wellbeing Board is the body responsible for improving the health & wellbeing of people in Bath & North East Somerset. It provides shared leadership and is the centre point of our local health & social care system.

The Joint Health & Wellbeing Strategy sets out how the Health & Wellbeing Board will improve health and wellbeing and reduce inequalities in Bath & North East Somerset. Its focus is on encouraging people to stay healthy, improving the quality of people’s lives, and on making sure that everyone has a fair chance of living well.

More information about the strategy can be found at:

[www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-](http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board) [partnership/health-and-wellbeing-board](http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board)

B&NES Council and BSW ICB wish to commission a range of services to meet the needs of people with learning disabilities and/or autism who have support needs and are no longer able to live at home or in their own accommodation without support.

B&NES Council and BSW ICB have a responsibility to deliver services in line with Best Value Statutory guidance to ensure that people benefit from good quality services that are good value for money and cost effective within the current limited financial resources.

This service directly supports the wider determinants of health, in line with Strategic Objective 1 in BSW ICB’s Integrated Care Strategy by providing good quality housing and helping residents to develop independent living skills.

# Requirements of the Regulator

The Care Quality Commission (CQC) Fundamental Standards for health and social care underpin the requirements of this Specification and the Provider must carry out Services in accordance with those Standards (or any successor Standards). The Provider must be registered with the CQC for Homecare Services and deliver Services in accordance with CQC’s registration requirements for supported living, complying with all relevant regulations and best practice guidelines.

Service Providers will inform Commissioners when a regulatory inspection has taken place and will share the result of the inspection, positive or negative. The Service Provider will notify the Commissioners of any Regulator Warning Notices placed on the Service/Service Provider regarding the Service Provider and/or its associated activities. The Service Provider will also inform Commissioners of any advice/comments received from the regulator. The regulator can place fines or formal warnings on a Service Provider to suspend or cancel its registration, the Commissioners will be informed of any such activity by the Service Provider and a failure to do so will mean that Commissioners will seek to recoup costs and damages incurred from the Service Provider and may terminate the contract without notice.

The Service Provider must keep the Commissioners informed of Registered Manager vacancies and any fines this attracts from the regulator. The Service Provider must inform the Commissioners when new Registered Managers are appointed.

# Definition of Services Covered within this Specification

The Services described by this Specification are those provided to adults with learning disabilities and/or autism who require assistance and support in all or part of their lives.

Supported Living Housing Schemes comprise of individual flats for each occupant and usually will include a shared communal area, where activities may be delivered and people who use the service have an opportunity to socialise with other people.

The landlord is separate to the support provider. In this instance the provider is required to work with a landlord and detail the arrangements and responsibilities of each partner. A Partnership Agreement will be in place to support this. The support for people using the service will align with the below

1. **Description of Service**

* Support to enable service users to develop independent living skills and to manage and live well within their home and local community. 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
* When a service user has made a choice to move into a Supported Living Housing Scheme, the support element of a person’s offer involves ‘Core Shared Support’ commissioned by B&NES Council. Everyone living in that particular building receives access to Core Shared Support from staff to enable them to meet their identified outcomes and to ensure they are able to live ordinary lives.
* If a service user chooses to reside in a Supported Living or Shared Housing Accommodation, they will not have a choice of Service Provider for their ‘Core Shared Support’ but will use the care and support provider appointed by the Commissioners to the accommodation. However, service users will be supported to choose the type of service(s) they wish to meet any additional, identified individual needs for 1:1 support in line with Care Act requirements.
* The Service Provider is required to develop a vibrant and diverse community that maximises the use of communal areas, by providing a range of activities and events that will benefit and be informed by the wishes and needs of the people living at each scheme or in their own home.
* The service should consider using assistive technology where this can lead to greater levels of independence for the individual/ decrease dependency on staff
* Examples of support may include Personal budgeting and finances, paying bills, sending letters, independent living skills, including housekeeping skills, shopping for, planning and cooking meals, enabling access to education, employment and training, emotional and wellbeing support, securing employment and/or exploring meaningful opportunities within the community.
* Hours & ratio of support (and therefore the service) may increase or decrease depending on service user /assessed need. These are defined in three ways:
* One to One Support - staffing support deployed to meet the needs and outcomes of one person at a time. Individual hours of support required during day hours (07.00 and 22.00 daily) and on occasions outside these time parameters.
* Core Shared Support - shared between a group of people, which will be predominantly accommodation based but will also include group-based support in the community e.g., shopping, social activities. Shared day time support hours (07.00 and 22.00 daily)
* Individual and shared night support – may include the provision of night support/on call support or use of Assistive technology.
* Support to enable service users to remain safe from harassment, abuse, discrimination, and exploitation, including hate crime and mate crime, within the home and in the local neighbourhood from neighbours, members of the local community and/or visitors to their home.
* Regulated 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 and is registered with the Care Quality Commission.
* The service will establish, monitor, implement and update effective and robust emergency protocols to be applied on an individual and shared living basis.
* On-call support will be flexible and creative to meet people’s needs and support the minimisation of paid support by giving individuals a range of transitional options that may replace face to face support including access to Assistive Technology, such as using video call options on smart phones/tele care options should be considered. This approach would also be expected to be used to support independence, manage positive risk, and make best use of limited resources.

Quality standards commissioners expect within the service:

* Support that enables service users to meet their agreed outcomes within their support plan.
* Make all reasonable efforts to secure compatibility when considering placement opportunities for new service users moving in a new accommodation setting with agreement from commissioners and the housing provider.
* The Landlord in partnership with the Provider will ensure that all necessary arrangements are in place before a service user moves into the property, such as but not limited to, ensuring that the property is in a reasonable condition and ensuring that the tenancy agreement is available in a format suitable to the service user needs.
* Support individuals to secure any additional furniture and household items that they require in order to live in the accommodation.
* Service users are involved and have a voice in decisions made which impact their lives in their accommodation. This may include, though is not limited to, decisions around shared household tasks, communal living arrangements and responsibilities associated with the tenancy.
* Support that enables service users to understand their role and responsibility as a tenant within their accommodation.
* For individuals lacking mental capacity to sign a tenancy agreement; either an individual with lasting power of attorney for property or financial affairs will support the tenant in this process, or the individual’s allocated social care practitioner will support an application to the Court of Protection for either a specific order to deal with the tenancy matter, or seek the appointment of a Court deputy who will have power to sign a tenancy agreement on the tenant’s behalf: this will usually be a family member or the local authority. In no circumstance will the landlord sign on behalf of the tenant.
* 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 home and promote 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 and the tenant chooses to move or the landlord issues notice to the tenant, the provider must ensure that it has reasonable process to support the move on and should commence discussions with the Council regarding a transition of a service user to alternative accommodation subject to the tenancy rights of the tenants involved.

# Aims and Objectives of the Service

The aim of the Service is to maintain or improve the quality of life for the people they support. The Service will do this by providing person centered support to people in line with the person’s own identified needs and wishes.

The Provider will deliver the Service with the concept of “wellbeing” at its core, in line with the provisions of Sections 1 and 2 of the Care Act 2014.

Wellbeing is ‘a broad concept.’ It is described as relating to the following areas in particular:

* personal dignity (including treatment of the individual with respect)
* physical and mental health and emotional wellbeing
* protection from abuse and neglect
* control by the individual over their day-to-day life (including over care and support provided and the way they are provided)
* participation in work, education, training, or recreation
* social and economic wellbeing
* domestic, family, and personal domains
* suitability of the individual’s living accommodation
* the individual’s contribution to society

Service Providers will ensure that they understand that wellbeing as a concept applies to all areas of a person’s life, not only to one or two. Therefore, using a holistic approach to ensure a clear understanding of the person’s needs and views is vital to identifying and defining wellbeing in each case.

The Service shall promote the maximum level of independent living achievable by the persons using the Service. People will have access to services which enable them to benefit from the same community, leisure, and education opportunities as anyone else. This means following individual interests, undertaking activities that have a purpose, doing things that are right for them personally, meeting local people and developing friendships and connections.

The Service will promote choice and control for the individual in their everyday working practices in line with the Mental Capacity Act 2005 and will understand the importance of empowering people to have control in their own lives through the choices they make.

People with learning disabilities and/or autism may choose to plan what is important to them now and in the future through Person Centred Planning (PCP). Person Centred means activities which are based upon what is important to a person from their perspective and which contribute to their full inclusion in society. PCP is a process for continual listening and learning. It is a way of assisting people with learning disabilities and/or autism to work out what they want, the support they require and the help they need to make sure they are in control of their lives.

Person centred approaches are ways of commissioning, providing, and organising services rooted in listening to what people want, to help them live in communities as they choose. Person centred approaches look to mainstream services and community resources for assistance and do not limit themselves to what is available within specialist learning disability/autism services.

Family members, friends, and advocates must be respected by the Service Provider as expert partners in a person’s care. They should have the opportunity to be involved in planning and making decisions if the person wishes them to be. Where there is an apparent conflict of interest between a person and family members, or perceived risk to safety and well-being these must be managed within the legal framework and local policy regarding safeguarding, mental capacity and decision making.

# Outcomes Based Approach

An outcome-based approach shifts the focus from tasks and processes to the impact of these on the people receiving support. Success by achievement of individual outcomes will be evidenced primarily, but not exclusively, by the care and support plan, the satisfaction levels of people and their carers, their experiences in the Service, and the impact on their wellbeing.

Achievement of the individual outcomes identified in the person’s care and support plan shall ensure that people:-

* + are valued – involved, more in control, listened to, told what is happening, given choices and at the center of what is happening to them;
  + retain their strengths and independence – ensuring that an individual’s quality of life is maintained by keeping active and alert, maintaining mobility/physical health, maintaining hygiene, maintaining social contact and keeping safe and secure;
  + are supported through change - e.g., post-operatively, at the end of their lives, and in situations where poor care or self-neglect has resulted in a decline in their independence;
  + are safe – services are well managed and provided by staff who work competently with people because they are appropriately trained and supervised to take person centred approaches.

# Working in Partnership

The best outcomes for people using the Service will be obtained when the Provider, Landlord and other relevant agencies are working effectively in partnership. The Provider will have access to, and be expected to collaborate with external professional’s support services of various kinds when required and will:

* + Actively seek external professional support in situations where they feel this is required;
  + Maintain open and honest communications with all relevant professionals involved in the person’s support;
  + Allow and facilitate reasonable access for the purpose of assessment intervention and monitoring, and agree and undertake any action arising;
  + Offer innovative approaches to help the person achieve their personal outcomes through service design, review, and delivery, and the use of assistive technology where appropriate.

# How People Access the Service

Access to the Service is based on assessed need. The link below provides information on how to make a referral for assessment to access services, as well as detailed information about the assessment process.

[http://www.bathnes.gov.uk/services/care-and-support-and-you/how-arrange-care-](http://www.bathnes.gov.uk/services/care-and-support-and-you/how-arrange-care-and-support/what-assessment) [and-support/what-assessment](http://www.bathnes.gov.uk/services/care-and-support-and-you/how-arrange-care-and-support/what-assessment)

# Support Planning and Needs Assessments

Following a referral, an assessment of the needs of the person(s) wishing to receive a Service will be carried out by HCRG Care Group under the locally delegated arrangements with the Council and ICB, and in line with the B&NES Care and Support Assessment and Eligibility Policy and the Care Act 2014.

Following the assessment, the Council will provide information to the person about the range of care and support options available, based on their assessed eligible needs in line with the National Eligibility Criteria as set out in the Care Act 2014.

The choice of support package is made by the person themselves where possible and where appropriate in consultation with his/her family or representative.

A care and support plan for each person is drawn up between them and the Council, in consultation (where appropriate) with their carers and in line with the B&NES Care and Support Planning Policy.

Care and support plans will identify the nature of the specific provision needed, including the amount, frequency, and duration of support. They may cover general health and social needs and will be designed to promote positive outcomes for the person.

The care and support plan is part of the contract documents and will form the basis for the Provider’s Support Plan.

It is recognised that needs change, often quickly, and following the commencement of support by the Provider, the Provider is responsible for the monitoring and amendment of the Provider’s support plan and other records as necessary to provide appropriate care and support for the person at all times. The Provider will notify the Council of changes in care and support needs and if the change is significant, the Council will consider whether an urgent review of the person’s care needs is required.

An assessment of the needs of new and prospective person is undertaken by the Provider prior to the provision of a support service being commenced by people who are trained to do so.

The Provider shall ensure that all support planning and support delivered is carried out in line with the Mental Capacity Act and clearly documented.

Best practice guidance can be sourced <http://www.scie.org.uk/>

The Provider, in consultation with the person, their family/ carers and any other significant people that the person may want to include will draw up a detailed plan of support (Provider Support Plan) to reflect the person’s ongoing care needs as described in the Council’s Care and support Plans. The Provider will ensure that this is reviewed, monitored, and evaluated regularly.

The Council’s Care and Support plan will specify when the person’s needs should be reviewed by the Council under the delegated arrangement with HCRG Care Group as the Prime Provider, but it will not be less frequently than every year. The Provider of the Service will contribute to these reviews.

# Service Delivery

The Provider is responsible for the day-to-day delivery of the person’s support in line with the Council’s Care and Support plan and the Provider’s identified service model.

Section 12 sets out the key outcomes that people who use services for people with learning disabilities and/or autism have identified as being important to them in the delivery of their care and support and are based around 6 key themes. Providers are encouraged to develop their own approach to meeting these outcomes involving the people who use the Service to the maximum extent possible.

# Outcomes

1. **My private space is my own. This includes my belongings, like furniture, clothes, and money.**
   * My private space is respected. This means the people who support me knock and ask my permission to come in
   * If I live with other people, I am supported to keep my space private from the people I live with. I am offered a key to my room and supported to use it. This means I can lock my room and keep my things safe
   * I am able to choose what my private space is like inside and out. This means choosing how it will be decorated, choosing my furniture, and choosing what my garden is like as much as possible
   * If I live with other people, I am supported to understand that some decisions about our home are joint decisions. This might be done through regular house meetings
   * If I live with other people my personal belongings are treated as my own and not as shared property, unless I choose for this to happen
   * I am supported to keep my money in my chosen safe place when I am at home and out in the community – this might include my own bedroom, my wallet or my pocket. My money should not be kept in a communal safe unless there is a clear reason, or this is my choice.
   * My money is my money only and not treated as shared money.
   * I am supported to be as independent as possible with my money. This might mean having a plan in place to help me increase my money skills.
   * Clear information is given to me about when I am expected to pay for my support worker for coffees, trips and activities etc.

# I make choices and am in control of my own life: This means allowing me to take risks and make mistakes.

* + I am able to take risks and make mistakes. Information is given to me in a way that I prefer, and I am supported to understand it. This means that I am making an informed decision. I am able to make this decision even if my support staff disagree with it.
  + The staff who support me will have a very good understanding of the Mental Capacity Act and will be aware of this when supporting me to make decisions.
  + The people who work with me are there to support me to be actively involved

in decisions about my life. They are not there to make decisions for me. If it is found that I am lacking the ability to make some decisions about my life through a Capacity Assessment there should be a best interest meeting to establish what is best for me. This meeting should involve Advocacy and my family – if this is what I want.

* + I am supported to make choices about my life. This includes day to day choices such as what I eat, when I go to bed, how I spend my time, as well as the bigger decisions like where I live and how I spend my money.
  + I have a decision-making profile that I have been involved in writing. This will help staff know how to support me to make a decision.
  + I am supported by staff that I choose. This means involving me when new staff are being recruited in a way that means something to me.
  + I am given the opportunity to be included in delivering inductions for new staff, introducing them to where I live, who I am and how best to support me.
  + Staff who support me are given the right training to support me safely.

# I am able to keep myself well and healthy: This means making informed choices about my lifestyle, treatments and medicines

* + I am supported to access my local health services. This means my GP, Dentist, Optician, and any other professionals that I need input from.
  + I get offered an annual health check and am supported to understand why it is important. Information from my annual health check is put into a health action plan.
  + I am supported to maintain good oral health in a way that is comfortable for me. Staff are aware of the impact of poor oral health and support me to avoid this.
  + Staff support me with bowel management in a way that suits me. This may mean supporting me with personal care or just providing me with information.
  + I am supported by medical professionals in a way that suits me. This means sharing information. I am made aware of this, and I understand why it is important. I have a person centred hospital passport to aid this.
  + If I take medication, I am supported to understand what it is for and the side effects.
  + I am provided with information about how to keep myself healthy and well. This includes my physical, mental and emotional wellbeing. It is about more

than what I eat and what exercise I do.

* + I am supported to manage my medication in a way that is safe for me.
  + I am given information about the end of life and I am able to make choices about what I will want now and in my future. My choices at end of life are just as important as my choices now. Any choices I make about my end of life are respected where possible when I die.

# I feel safe at home and in my community.

* + I feel safe in my own home – this includes the people I live with, the people I’m supported by and the space I live in.
  + I am supported to use and get to know my local community so that I feel safe going out in my local community with or without support.
  + I understand what abuse is and feel comfortable speaking up. Information about abuse is given to me in a way I can understand.
  + The staff who support me understand what safeguarding is and receive training in this.
  + I am protected from the risk of abuse both at home and in my community.
  + I am supported to live in and maintain a safe environment at home that promotes my independence and choice.

# My voice is heard: This means having my communication respected and my views and opinions listened to.

* + If I need, I will have a communication passport or profile that’s person centred so that the people who support me know how to communicate with me.
  + Where I have a communication need my staff will be trained to communicate with me, depending on what I need.
  + All information is given to me in a way that I can understand it.
  + I will have support from speech and language therapy if I need it.
  + I will be included in all meetings that are about me. I will have a say in when and where the meetings will be and who comes to the meetings. The meetings will be carried out in a way that I can understand.
  + I am able to make a complaint if I am not happy. Information on how to make a complaint should be available to me in a way that I understand. I feel confident that my complaint will be listened to and responded to in confidence.
  + I am listened to, and my wishes are acted upon, this can be small things on a daily basis or bigger things.
  + I know that any information about me is to be kept confidential and that it can’t be shared with other people without my knowing ‘consent’. I know that I am able to see this information at any time.
  + It’s my right to benefit from the support of an independent Advocate to ensure my voice is listened to/heard when needed. This is a statutory duty where the person would have substantial difficulty in representing themselves and there is no suitable person to represent them.
  + I should be made aware of Advocacy services that I can access if I wish in my

local area, such as peer Advocacy groups.

* + I receive regular person-centered reviews of my support with the people who support me and anyone else important in my life outside of my annual social work review. A person-centered review is a meeting led by me, as much as possible, to look at the things that are working and not working in my life. The meeting will take place in a place that I feel happy and in a way that I understand. I can request this if I want without waiting for my support workers to arrange it.

# I have my own life: This means doing the things that other people do and living the way that I want.

* + I am encouraged and supported to access my local community for example clubs, activities, shops, bars, and restaurants. I am supported to go where anyone goes, and not to always use ‘services’ that work with people with disabilities.
  + I am able to go out when I want to and not when my supporter or Service that supports me says I can go out. Staff working hours need to be flexible around when I want to go out and do things.
  + I am given the opportunity to use public transport. This includes training opportunities so I can travel independently with confidence or accessing services to help me learn these skills.
  + I am supported to help me to reach my own full potential by learning new skills and knowledge. This could mean developing my skills with the help of my support worker, trying new activities, or undertaking a course.
  + I am supported to try to work towards, apply for and secure paid employment if I wish. Just because I have a disability does not mean I can’t work.
  + I have support to understand about sex, relationships, and staying safe. This support is provided in a way I can understand and delivered by someone I feel comfortable with.
  + I am able to see my friends at my home, their home and other places in the community. I am able to make new friends.
  + I am given the opportunity to go on holiday, even if this means I have to save for a period of time. I understand that I have to pay and what I am paying for including my staff support. I get to choose the staff who support me on my holiday as I have paid for it.
  + I am supported and enabled to take risks and make mistakes. My support Provider recognises that risk assessments are person centred to me and are about helping me achieve something rather than preventing me from doing something.
  + If I wish, I am supported to practice my religion and follow my cultural beliefs. This might include diet, clothing etc. which reflect the cultural lifestyle as well as visiting places of worship.

# Support to People with Complex Behaviours

“Children, young people, and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe, and rewarding lives” - Transforming Care National Service Model Vision Statement 2015

The Provider will support people with a learning disability and/or autism who have mental health and or complex and challenging needs in a community setting, avoiding the need for unnecessary mental health inpatient placements. Providers of services for people with complex behaviours form part of the collaborative whole systems approach in achieving this.

# Behaviours that Challenge

Some people with a learning disability and/or autism display behaviours that challenge.

‘Behaviours that challenge’ is not a diagnosis and is used to refer to behaviours that may provide a challenge to the services, family members or carers or to the person themselves. It is recognised that this behaviour may serve a purpose for the person.

The Provider shall ensure the application of good practice as set out in the National Institute for Health and Care Excellence (NICE) guidance in Challenging Behaviour and Learning Disabilities prevention and interventions for people with learning disabilities whose behaviour challenges which can be found here:

[https://www.nice.org.uk/guidance/ng11/resources/challenging-behaviour-and-](https://www.nice.org.uk/guidance/ng11/resources/challenging-behaviour-and-learning-disabilities-prevention-and-interventions-for-people-with-learning-disabilities-whose-behaviour-challenges-pdf-1837266392005) [learning-disabilities-prevention-and-interventions-for-people-with-learning-](https://www.nice.org.uk/guidance/ng11/resources/challenging-behaviour-and-learning-disabilities-prevention-and-interventions-for-people-with-learning-disabilities-whose-behaviour-challenges-pdf-1837266392005) [disabilities-whose-behaviour-challenges-pdf-1837266392005](https://www.nice.org.uk/guidance/ng11/resources/challenging-behaviour-and-learning-disabilities-prevention-and-interventions-for-people-with-learning-disabilities-whose-behaviour-challenges-pdf-1837266392005)

The Provider shall ensure that:-

* + - Assessment of risks will address risk to self, risk to others and risk from others;
    - There are clear links between assessment of the person’s needs and

associated risks and their support/risk management plans;

* + - Assessments balance promotion of independence with effective risk management.

The Provider shall ensure that their approach focuses on person-centred and positive support to people whose behaviour challenges services and ensure that staff are suitably trained and competent in those practices.

The Provider will have an in-depth knowledge of the Mental Capacity Act and Best Interest Processes for people with a learning disability and/or autism.

Behaviour support shall be planned in a way that reduces the likelihood of challenging behaviour happening, identifies early warning signs and shows how to support service users in a way that suits them. Additional useful information and best practice guidance can be sourced from The British Institute of Learning Disabilities (BILD) and the Challenging Behaviour Foundation –

<http://www.bild.org.uk/capbs/capbs/>

<http://www.challengingbehaviour.org.uk/information/information.html>

<https://www.skillsforcare.org.uk/Developing-your-workforce/Care-topics/Supporting-people-with-challenging-or-distressed-behaviour/Supporting-people-with-challenging-or-distressed-behaviour.aspx>

The Provider, in partnership with the multi-disciplinary team, shall ensure that people with behaviours that challenge will have a behaviour support plan which will be based on an assessment carried out by a clinical psychologist, behaviour specialist, and/or other professional, and put in place by the Provider.

The behaviour support plan will identify the behaviours to be addressed as well as an assessment of risk. The behaviour support plan will be developed with the person and others involved in their life based on what is important for the person and an assessment of risk. An understanding of the reasons for these behaviours shall be determined with the person and others involved in their life.

The plan shall consider all aspects of the person’s life to include how meeting their support and care outcomes and their physical, mental, social, and emotional wellbeing has an impact on their behaviour.

Interventions used shall be the least restrictive possible and any physical restraint and medical intervention shall be a last resort.

The Provider will ensure there is evidence of on-going multi-disciplinary working and effective liaison with specialist services.

The behaviour support plan shall be recorded to ensure all those providing support use a consistent approach including:-

* + - a description of the person’s challenging behaviour;
    - a summary of the most probable reasons underlying the person’s challenging behaviour and known triggers;
    - proactive and preventative strategies;
    - reactive strategies;
    - incident briefing;
    - monitoring and review arrangements;
    - who was involved in devising the plan.

Separate plans will be devised as necessary for specific situations (e.g., car journeys, around food).

Plans shall be reviewed and updated on a regular basis and at other times when there is a change that may impact on them or an incident of challenging behaviour.

# Support to People with Forensic History

Some people with learning disability and/or autism may have behaviours that can be described as challenging (for example, who present an active and high risk to others/members of the public or themselves). Where this behaviour has led to contact with the criminal justice system, or where there is risk of this (i.e., relating to behaviours which could be construed as an offence or are viewed as pre-cursors to more serious offending behaviours) where applicable the Provider will have in place enhanced measures in addition to 10a above.

Where applicable the Provider will work collaboratively with a range of other services/agencies (such as the police, MAPPA, Complex Health Needs Services, the Courts, MARAC) with a focus of reducing/preventing behaviours leading to contact with the criminal justice system.

Where applicable the Provider will ensure that staff are appropriately trained and will have:

* + - Knowledge, skills and capability to work with people with a learning disability and/or autism with a forensic history;
    - Knowledge and skills to conduct thorough assessment of risk (including risk to others and to self) and in the management of risk;
    - The ability to recognise and manage emerging risks and to provide interventions to reduce risks to self and others;
    - Knowledge, skills and experience in using a range of different strategies to engage and maintain engagement with people to achieve positive outcomes;
    - Knowledge and understanding of the criminal justice system and other

agencies.

# Support to People with Profound and Multiple Learning Disabilities and/or Autism and Complex Needs (PMLD)

People are considered to have PMLD when they have more than one disability, the most significant of which is a profound learning disability. Many will have additional sensory or physical disabilities, complex health needs or mental health difficulties.

Best practice guidance for supporting people with PMLD can be found here: <http://www.pmldlink.org.uk/wp-content/uploads/2017/11/Standards-PMLD-h-web.pdf>

The Provider shall ensure that where the Service supports people with profound and multiple disabilities and complex needs that staff receive bespoke specialist training to support this such as postural care, safe eating and drinking, use of specialist equipment in manual handling and non-formal communication as examples to ensure that they can meet their individual needs.

End of life plans are in place for people with PMLD that have been developed in consultation with the person, their family and any other significant or relevant person. This are kept updated on a regular basis. For more information refer to section 15.2. DNACPR (Do not attempt cardiopulmonary resuscitation) plans are only in place as appropriately agreed in line with the Mental Capacity Act 2005 and the best interest decision making process.

Special consideration is given to people’s communication. Staff are trained in methods of communication that best match people’s needs and abilities.

Clear communication plans are in place documenting how best to support people to communicate their views and wishes.

The Provider will ensure that staff are aware of and respond appropriately to indicators that the person may be in pain, discomfort, or distress. This will be clearly documented in people care and support plans.

The Provider is responsible for ensuring that the environment where people live is appropriate and responsive to their needs and that people can easily access their home environment.

Staff will be trained and able to safely support people with eating and drinking difficulties. Guidance put in place by the local Speech and Language team will be clearly embedded in a person’s support plan and adhered to by staff.

# Support to People with Epilepsy

Where the Provider supports people with epilepsy, they will ensure that staff are sufficiently trained and that their competencies are checked regularly.

Where specialist training is identified as a need to provide safe support the Provider ensures that this is undertaken by the staff team.

The Service will work in collaboration with the local epilepsy specialists to ensure that clear support guidance is in place and that any Epilepsy Management Plan put in place by professionals is followed.

Where measures are identified and put in place to reduce risk for people with epilepsy these are adhered to by the Service.

# Support to People to Manage their Physical Health

People should be provided with the right support to maintain their physical health, this might be full support to manage their health including support to medical appointments, providing information to the person, or staff having a general awareness of what good health looks like for people and being able to identify any changes and inform the relevant people.

# Oral Health

The provider should ensure that staff have a good awareness of the benefits of good oral health and the possible impact of poor oral hygiene. More information and guidance has been provided by the National Institute for Health and Care Excellence (NICE)

[https://www.nice.org.uk/guidance/ng48/resources/oral-health-for-adults-in-care-](https://www.nice.org.uk/guidance/ng48/resources/oral-health-for-adults-in-care-homes-pdf-1837459547845) [homes-pdf-1837459547845](https://www.nice.org.uk/guidance/ng48/resources/oral-health-for-adults-in-care-homes-pdf-1837459547845)

[https://www.nice.org.uk/guidance/qs139/resources/oral-health-promotion-in-the-](https://www.nice.org.uk/guidance/qs139/resources/oral-health-promotion-in-the-community-pdf-75545427440581) [community-pdf-75545427440581](https://www.nice.org.uk/guidance/qs139/resources/oral-health-promotion-in-the-community-pdf-75545427440581)

# Constipation

People with learning disabilities have been found to be more likely to suffer from constipation than people without learning disabilities. Staff supporting people with learning disabilities should be aware that they’re at a higher risk of having constipation as they may be unable to communicate this. It is essential to be aware of the signs and symptoms.

Public Health England has released guidance for Providers and services who support people with learning disabilities. The Provider should ensure that all staff have a basic awareness of the causes and indicators of constipation and the potential impact on a person.

[https://www.gov.uk/government/publications/reasonable-adjustments-for-people-](https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/constipation) [with-learning-disabilities/constipation](https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/constipation)

# Screening and Immunisations

People with learning disabilities and /or autism are entitled to health screenings and immunisations and should be offered these in line with national programmes.

Where people receive support from the Provider to manage their physical health, they should be supported to make an informed decision about receiving these and this decision making process clearly documented. Where a person lacks capacity to make this decision the Mental Capacity 2005 and Best Interest process should be applied and documented.

# Support to People as they get Older

The Provider must give consideration to people’s needs as they get older and be aware of their changing health and support needs which are a result of the persons ageing process rather than their disability.

The Provider will ensure that the staff team are able to identify a change in need and will provide the appropriate training where applicable.

Key areas that Providers must give attention to are

* + Changes in a person’s mobility and the need for equipment aids.
  + Identifying hearing and vision loss.

Information around key indicators for hearing and vision loss and practical steps to helping someone can be found through –

[www.sense.org.uk](http://www.sense.org.uk/) <https://www.sense.org.uk/olderpeople>

* + Continence.
  + Skin integrity and pressure area prevention and care.

Information about prevention and care can be found in the NICE guidelines <https://www.nice.org.uk/guidance/cg179>

The Provider is responsible, along with the person’s social worker for identifying when and if the Placement and Service Model is no longer able to meet the needs of the person due to a change in need as a result of ageing.

# Dementia

It has been found that people with learning disabilities are at a greater risk of developing dementia as they get older compared with the general population. For people with Down’s syndrome, the risk of developing dementia is significant and increases with age.

The Provider must ensure that appropriate training is sourced and delivered to their staff teams that reflect the degree of involvement in supporting people with dementia and those at risk of developing dementia.

Special consideration should be given to ensuring staff are skilled and confident in identifying early indications and taking appropriate action.

# End of Life Planning and Support

As people get older it is expected that the Provider will support them to think about what they would like when they die. End of life plans are put in place where appropriate with people, their families and anyone else they would like involved. These plans are reviewed on a regular basis.

Where people require end of life or palliative care, an assessment will be co- ordinated by an appropriately trained nurse to assess whether it is appropriate for that care to be provided by the existing Provider or elsewhere.

All deaths will be managed with dignity and propriety and people’s spiritual needs, rites and functions should be observed. There will be systems in place to ensure, when death is expected, the person does not die alone unless it is their wish.

More information on end-of-life care and planning can be found here:

[https://www.nice.org.uk/guidance/qs13/resources/end-of-life-care-for-adults-pdf-](https://www.nice.org.uk/guidance/qs13/resources/end-of-life-care-for-adults-pdf-2098483631557) [2098483631557](https://www.nice.org.uk/guidance/qs13/resources/end-of-life-care-for-adults-pdf-2098483631557)

The Provider will be aware of the Learning Disabilities Mortality Review Programme being run by Bristol University and commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England.

The aim of the programme is to identify good practice and learning to reduce the number of premature deaths for people with a learning disability.

<http://www.bristol.ac.uk/sps/leder/>

The Provider has a responsibility to notify a death to the programme where necessary and will cooperate in any reviews of deaths when asked.

Following the end of the programme the Provider will be expected to follow local processes established by the Council and the ICB for reporting a death of a person with a learning disability.

# Services for People with Autism

There are particular processes required to achieve good outcomes for people with an Autism Spectrum Condition.

The Service Provider must provide:

* + detailed and specific structures to achieve social interaction, communication and independence skills;
  + highly planned and structured activities;
  + consistency and stability in the environment and in all communications;
  + continuous motivation and positive interaction;
  + specialised training for Staff in interaction programmes and ongoing training to reinforce and update the specialist skills required.

Training must provide staff with the ability to support people with autism and must include as a minimum:

* + Awareness of the ‘triage of impairments’ that distinguish a person with autism;
  + understanding and interpreting the verbal or non-verbal communications of a person with autism;
  + interpreting situations, events and concepts, into language that can be understood by a person with an autism condition;
  + sensitivity in the recognition of anxiety levels;
  + managing and reducing behaviour that challenges;
  + the value of repetitive reinforcement;
  + using structure to compensate for a lack of motivation;
  + The importance of an appropriate environment.

# Medication Management

Where the Provider is contracted to provide support to people with their medication there are clear policies and guidance in place to do so safely which demonstrate recognised best practice.

Registered care home provisions should adhere to best practice guidance as set out by the National Institute for Health and Care Excellence (NICE) guidance:

[https://www.nice.org.uk/guidance/qs85/resources/medicines-management-i n-care-](https://www.nice.org.uk/guidance/qs85/resources/medicines-management-in-care-homes-pdf-2098910254021) [homes-pdf-2098910254021](https://www.nice.org.uk/guidance/qs85/resources/medicines-management-in-care-homes-pdf-2098910254021)

NICE guidance for managing medication in the community can be found here:

[https://www.nice.org.uk/guidance/ng67/resources/managing-medicines-for-adults-](https://www.nice.org.uk/guidance/ng67/resources/managing-medicines-for-adults-receiving-social-care-in-the-community-pdf-1837578800581) [receiving-social-care-in-the-community-pdf-1837578800581](https://www.nice.org.uk/guidance/ng67/resources/managing-medicines-for-adults-receiving-social-care-in-the-community-pdf-1837578800581)

People are supported to manage their medications in a person-centered way that suits them. If they have been deemed unable to manage their own medications, then this is supported within the Mental Capacity Act 2005 and best interest processes and clearly documented.

The policies will make it clear who is accountable and responsible for using medicines safely and effectively in the care home. The policies will be evidence based and include the principles of:-

* Sharing information about a person’s medicines including when they transfer to another care setting;
* Accurate and up to date recording keeping and MAR charts;
* Identifying, reporting and reviewing medicines-related problems;
* Keeping people safe (safeguarding);
* Medication review;
* Safe handling of medicines and controlled drugs including ordering, storage and disposal;
* Self-administration;
* Care home staff administration of medicines including ‘when required’ medication;
* Staff training and competence requirements;
* Covert administration;
* Homely Remedies/Minor Aliments;
* Palliative care;
* Monitored Dosage Systems and Compliance Aid.

Information and advice will be sought from the pharmacist or other medical professionals where appropriate in relation to administering, monitoring, and reviewing medication.

The Provider shall ensure that they have an up-to-date list of past and present medications for each person at the point that the Service begins.

The Provider shall support people to take medicines independently where possible or administer medicines when they are unable to do so.

Records should include details of any Capacity Assessments and Best Interest decisions made on behalf of any person lacking capacity to consent to medication.

Any arrangements for covert medication must be made in accordance with Mental Capacity Act guidance and clearly documented.

Self-administration will be undertaken within a risk management framework and suitable lockable facilities provided.

People’s medication will be reviewed with their General Practitioner annually.

Medication Administration Records (MAR charts) will be audited monthly by the Provider to provide an audit trail of stock control and storage of medicines including monitored dosage systems and evidence that correct procedures have been followed.

Additional audits will include monitoring the administration, recording and disposal of medicines. Audits should be robust and comprehensive and identify that measures are in place to ensure safe practice such as:-

* + The use of photographs to identify that medicines are being administered to the right person;
  + Specimens of staff signatures to identify care staff or the Registered

Nurse responsible for the administration of medication;

* + The correct and accurate completion of MAR charts;
  + Satisfactory procedures for transcribing medication onto MAR charts and recording dosage changes onto MAR charts which include obtaining countersignatures from another registrant or competent health professional.

The Provider shall have arrangements in place to record and report medication related incidents including findings of their service review and lessons learnt in order to reduce the risk of repetition.

People will be notified of any errors in relation to the administration of their medication or their representative.

# Assistive Technology

Assistive technology plays a part in supporting independence for people with learning disabilities and/or autism. It can reduce some of the risks associated with living independently and reduce the amount of supervision required.

The provider will support the use of assistive technology for individuals when necessary. The provider will engage with assistive technology if appropriate to enhance a person’s support package and increase their independence.

# Staff Training and Employment

* The Provider must have evidence of ongoing supervision/monitoring available as part of the contract monitoring requirements.
* The Provider will endeavour to meet the Service User’s reasonable preference about the choice of staff supporting them.
* The Provider will employ and deploy with effect from the start date and throughout the Contract period:

* A Care and Support Manager to act as the Responsible Individual/ Registered Manager who must have an appropriate professional qualification validated by and in accordance with the Care Quality Commission (CQC) requirements;
* Sufficient Staff to ensure compliance with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fundamental Standards (2014);
* Sufficient staff to ensure compliance with the requirements of the Care Act 2014 and Care Quality Commission (CQC) fundamental care standards;
* A staff training and development programme to ensure all staff can deliver an individualised service consistent with the latest statutory requirements, guidance and best practice. In addition to general care training, other training shall be specifically targeted to the client group and focus on issues arising in the service.

* The staff training and development programme is likely to include but not be limited to:
* An understanding of and ability to work in a person centred way;
* The ability to use a wide range of communication techniques including alternative augmentative communication;
* An understanding of and ability to work with people who have learning disabilities, autism, physical disability, dementia, an end-of-life plan, or other additional health conditions e.g., epilepsy, personality disorder, substance misuse, or mental health;
* An understanding of the general and specific health needs of people who have additional physical and sensory disabilities;
* An understanding of the emotional needs and wellbeing of people who may be using the Service, including understanding feelings and the importance of love;
* Developing local community networks to facilitate the integration and inclusion of people who use this Service;
* Health and Safety issues, e.g. manual handling, risk assessment, the control of infection, fire prevention and evacuation;
* All relevant policies, rules, procedures and standards as required by CQC registration standards and the Commissioners;
* The need to maintain the highest standards of care, courtesy and consideration;
* The need to carry out duties in a respectful manner without inconvenience to the person supported.

The Council expects the Provider to pay their staff in line with the real Living Wage and will discuss and monitor this through contract monitoring meetings.

# Key Performance Indicators

A number of key performance indicators (KPI’s) and performance measures have been identified which will be used to assess the performance of the Service, alongside the delivery of the outcomes highlighted in Section 12. This information will be gathered on a quarterly basis, at the time of the contract monitoring review and will refer to the previous quarter.

Consistent underperformance against KPI’s and/or performance measures may result in default procedures.

|  |  |  |  |
| --- | --- | --- | --- |
|  | KPI | Frequency | Target |
| 1 | Completion of quarterly contract monitoring workbook information (Schedule 7 to the contract) | Quarterly | 100% |
| 2 | Completion of two case studies evidencing how the service has supported individuals to meet Key Outcomes (Schedule 8 to the contract) | Quarterly | 100% |
| 3 | Number of people who have had their care package reduced as a result of increased independence | Annually | 50% indicative |
| 4 | Attendance at partnership meetings with other stakeholders including the scheme landlord  *Meeting frequency set by commissioners* | Quarterly | 100% |
|  | | | |
|  | Performance Measures | Frequency | Target |
| 1 | Number of support plans reviewed in the last 12 months  *Expressed as a percentage* | Annually | 100% |
| 2 | Number of people with completed hospital passports, reviewed in the last 12 months.  *Expressed as a percentage* | Annually | 100% |
| 3 | Number of people who have received an annual health check in the last 12 months.  *Expressed as a percentage* | Annually | 100% |
| 4 | Number of people in paid employment or a voluntary post  *Expressed as a number* | Quarterly | 80% indicative |
| 5 | Number of Core Shared Support and one to one hours delivered each month | Quarterly | 95% |
| 6 | Meaningful engagement and views of individuals to influence and shape service development | Quarterly | 100% |
| 7 | Feedback gathered in the last 12 months from staff, families, and people who use the service shows a positive, satisfied response; | Annually | 80% |
| 8 | Number of social, recreational, and educational activities held in communal facilities, including:  - How many people attended from the scheme  - How many people attended from outside the scheme | Quarterly | Minimum of two activities per week  60% attendance indicative |

Social Value & Climate Commitments

The Provider will be able to evidence delivery of social value commitments and climate commitments as pledged in their tender submission on request but no less than an annual basis.

The Provider will record information on:

1. The number of People who use the service who are enabled to be involved in volunteering activities and how these activities support greater social value, such as helping a neighbour.
2. Activities provided by the service that contribute to the community, such as inviting community members to activities within the supported living hub to reduce social isolation
3. Activities provided by the service that contribute to the environment and climate emergency, such as community litter picking.