INVITATION TO TENDER

To be awarded a place on a Pseudo Dynamic Purchasing System – under the light touch regime

For the Provision of Specialist Provider Services

Schedule 3 Service Specification

Tender Reference: DN667265

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1. Glossary of Terms

1:1 Support	These hours are commissioned in accordance with the social workers assessment of eligible needs. This includes activities outside of a service such as shopping, travelling, going to groups and appointments etc. The person should have choice on who provides their support, which could be via a direct payment, the core provider, or another provider via a managed service. This includes: • Any specific requested therapies or interventions brought in to meet an individuals need. • Any additional specialist training required for staff to meet the individual need. This must be over and above any mandatory training required for safe working in the service as per the Service Specification.
Adult Social Care Outcomes Framework (ASCOF)	ASCOF is used both locally, regionally and nationally to measure progress against key priorities and strengthen transparency and accountability. Importantly, it measures how well care and support services achieve the outcomes that matter most to people. The ASCOF also sets outcomes-based priorities for care and support, focused around 6 key objectives for people who draw on care and support, unpaid carers and professionals who provide care and support (Quality of life, Independence, Empowerment, Safety, Social connections, Continuity and quality of care)
Advocate	Someone who can support an individual to understand the care and support process, understand and ensure an individual's feelings are heard and noted, make and challenge decisions around care and support, stand up for and their rights. An advocate can Independent Advocate (Family, friend, neighbour etc) or where appropriate could be an Independent Mental Capacity Advocate.

Assessment	Process whereby an individual with presenting needs is identified and evaluated by the Operational Team in order to assess what assistance should be provided in order to identify which specified outcomes would support the individual's capacity to live a full and independent life.
Assistive Technology	Products or systems that support and help individuals with disabilities, restricted mobility, or other impairments to perform functions that might otherwise be difficult or impossible. These devices support individuals to improve or maintain their daily quality of life by easing or compensating for an injury or disability.
Brokerage Team	Are a team within the Partnerships and Commissioning Team who are responsible for the sourcing and securing of services for individuals who request a commissioned service from the council. Their purpose is to work in partnership with providers, operational teams, and individuals to source the most suitable service.
Best Value Duty	The Commissioner is required to ensure public funds are spent economically, efficiently, effectively, and equitably to achieve high quality services for the individuals who use or are placed in a commissioned service.
Commissioner	A representative of a Local Authority or Clinical Commissioning Group who is responsible for the contractual element of the arrangement to purchase services from a Provider.
Continuing Healthcare	NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. This may not cover everything being delivered as part of a package of care. CHC is the statutory responsibility of the ICB.
Care Inspectorate Wales (CIW)	Care Inspectorate Wales oversees the registration of regulated services in Wales. They will inspect services regularly to provide assurance that a good quality service is being provided. Some services under this framework may be registered with the CIW.
Core/Shared Support	It is building-based support, formed by calculating the minimum staffing necessary to manage risk and meet needs across a group of individuals within a given setting. This includes admin and office tasks outside of direct support but does not involve support outside of the scheme. Core/Shared Support could be used for Supported Living Services or Day Services.

Care Quality Commission	The Care Quality Commission is the independent regulator of health and adult social care in England. They will inspect services regularly to provide assurance that a good quality service is being provided.
Day Services	A Day Service can be a buildings based or community-based service, offering activities that reflect the interests of those individuals attending either as a group or individually. A day service can provide support flexibly and is not limited to normal 9am – 5pm operating hours. The service to be provided in accordance with local authority support plan provided by social services. The service will enable individuals to benefit from community, leisure, education, training and employment opportunities and support to achieve and maintain maximum possible independence.
Direct Payment	This is a payment made directly to an individual from the Council onto a direct payment care, these payments will allow the individual greater choice and flexibility in the way they arrange their services with providers.
Integrated Care Board (ICB)	Integrated Care Boards will be established in the NHS from the 01 July 2022, and it will be a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities. The ICB has taken all of the responsibilities of the CCG including delivering Continuing Healthcare Services. For South Gloucestershire Council, NHS Bristol, North Somerset and South Gloucestershire ICB is the designated ICB.
Individual/s	The person for whom the service is provided.
Individual's Information Guide	Information produced by the provider about their organisation and services for the individual and or their representative to have.
Individual Service Fund	An Individual Service Fund (ISF) is one way of managing a personal budget, where someone who needs care and support (and/or their family, advocate, or carer) chooses an organisation to manage the budget on their behalf and works with them to plan care and support services and activities that will help them to achieve their identified outcomes.
Joint Funding	Where the Council and ICB jointly fund the individuals package of care or placement outside of S117 responsibilities. This may mean a joint review of the package or placement from the Operational staff of each authority.

Local Authority support plan	The document completed by the relevant operational team which sets out the services required to achieve the individuals specified outcomes
Link Officer	The link officer is the individual from the Commissioning Team who will liaise with the provider to oversee the contract and manage quality assurance.
Mentoring	Mentoring services will be designed for adults who may have physical impairments, learning difficulties, autism, mental health diagnosis, sensory impairment, and/ or behaviours that challenge to spend time in the company of people other than their primary carers. Mentors are expected to share their knowledge, skills, and experience to assist others to progress in their own lives and careers and to motivate and empower individuals to identify their own issues and goals and helping them to find ways of resolving or reaching them within set and agreed timescales. Individuals will have opportunities to a service which enables them to benefit from community, leisure, education, training, and employment opportunities.
Moving on plan	A plan devised to provide a smooth transition from one service to another or onto independence. A Moving on plan is distinctly different from what is commonly known as a “transition plan”. In a transition plan The Care Act 2014 states that local authorities (councils) must carry out needs assessments for children, children's carers and young carers where there is a likely need for care and support after the child in question turns 18, and a transition assessment would be of 'significant benefit'.
Multi-disciplinary team	Multi-Disciplinary Teams (MDTs) are the mechanism for organising and coordinating services to meet the specified outcomes of individuals**.**
National Institute for Health and Care Excellence (NICE)	The National Institute for Health and Care Excellence is an independent organisation responsible for driving improvement and excellence in the health and social care system.
Operational staff	A member of the staff working for either the Council, Health or Social Care Team who is responsible for assessing, monitoring and/or co-ordinating the individuals care and support.
Outcomes	Describes what an individual wants to achieve to attain maximum wellbeing. These are realistic goals that individual’s accessing a service can work towards with support.

Person-centred	Being person-centred is about focusing support on the specified outcomes of the individual. Ensuring that people's preferences, needs and values guide decisions, and providing support that is respectful of and responsive to them.
Person centred plan	The detailed plan drawn up by the individual and the provider detailing how the Support Service will meet the individuals specified outcomes and how support will be provided on a day-to-day basis to achieve the aims, objectives and outcomes specified.
Power of attorney	There are three different definitions of Power of Attorney: • Power of attorney: This covers decisions about your financial affairs and is valid while you have mental capacity. It is suitable if you need cover for a temporary period (hospital stay or holiday) or if you find it hard to get out, or you want someone to act for you. • Lasting power of attorney (LPA): An LPA covers decisions about your financial affairs, or your health and care. It comes into effect if you lose mental capacity, or if you no longer want to make decisions for yourself. You would set up an LPA if you want to make sure you're covered in the future. • Enduring power of attorney (EPA): EPAs were replaced by LPAs in October 2007. However, if you made and signed an EPA before 1 October 2007, it should still be valid. An EPA covers decisions about your property and financial affairs, and it comes into effect if you lose mental capacity, or if you want someone to act on your behalf.
Progression	A process of development and growth towards maximum possible independence and wellbeing.
Provider	The organisation who provides the support that is commissioned by South Gloucestershire Council, either directly or via Direct Payments and Individual Service Funds.
Positive risk	Positive risk taking is a process which starts with the identification of potential benefit or harm. The desired outcome is to encourage and support people in positive risk taking to achieve personal change or growth. Positive risk management does not mean trying to eliminate risk. It means managing risks to maximise people's choice and control over their lives.
Recovery	No longer having symptoms of a condition or, having the ability to manage these symptoms to enable progression towards maximum possible independence and wellbeing.

Regulated activity (CQC)	Regulated activities are listed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They include but are not limited to: • Personal care, • Service for person who requiring nursing or personal care, • Service for persons who require treatment for substance misuse. • Treatment of disease, disorder, or injury. • Assessment or medical treatment for persons detained under the Mental Health Act 1983.
Regulated Services (CIW)	Regulated Services are listed as part of the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 and include but are not limited to: • Care home services • Secure accommodation services • Residential family centre services • Domiciliary support services
Section 117	Section 117 of the Mental Health Act states that aftercare services are services which are intended to meet a need that arises from or relates to an individual's mental health problem and reduces the risk of readmission to hospital. Section 117 places a legal duty to provide health and social care support to an individual once they have left hospital. Usually funding for S117 is split between the Local Authority and ICB.
Shared support	Shared support is less common and is where one or more staff member/s support more than one person with activities inside or outside of a supported living scheme. Similar to and also known as Core Support.
Strengths-based approach	Strengths-based practice is a collaborative process between approach the person being supported and those supporting them, allowing the parties to work together to determine an outcome that draws on the individual's strengths and assets.
Supported living	For the purpose of this Framework, the definition of 'Supported Living' will be to support individuals through a journey of recovery or development to develop independent living skills and to live as independently as possible in their home and local community. Supported Living support will be outcomes focussed and will have a joined-up approach to quality assurance and monitoring.

Support worker	The worker or volunteer employed or instructed by the provider to work with a specific individual. Also known as staff.
Unpaid carer	A carer is anyone, including children and adults, who looks after a family member, partner or friend who relies on that help because of illness, frailty, disability, a mental health problem or addiction. The Care Act defines a "Carer" as "Somebody providing any unpaid necessary support."
Wellbeing	Wellbeing is defined within this framework as: • 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.

2. Introduction

South Gloucestershire Council wants to deliver a difference for individuals accessing Specialist Provider Services. The Specialist Provider Framework is a new approach to commissioning services for adults (and children 16 years or over where applicable) who may have (but not limited to) Learning Difficulties, Autism, Mental Health Diagnosis, Physical Impairments, Sensory Impairment, and/or Behaviours that Challenge. Providers may be commissioned directly or via direct payment or Individual Service Funds held by the individual and these arrangements are both in scope of this framework.

This Framework is a part of the Adult Social Care pathway under the Council's responsibilities through the Care Act (2014). The approach is underpinned by a clear emphasis on progression and recovery based on identified outcomes from a Care Act assessment. Recovery is defined as no longer having symptoms of a condition/diagnosis or having the ability to manage these symptoms to enable progression towards maximum possible independence and wellbeing.

Progression is the process of development and growth towards maximum possible independence and wellbeing, and we will work in partnership with specialist provider services to support individuals to develop confidence, skills, connections, and knowledge to move along this process of change. We understand that progression for some individuals will vary, and the pathway will be determined by their needs.

For some individuals, Specialist Provider Services may be commissioned as part of a recovery from an illness or injury, and this too would be a process of progression. An outcome is the result or effect of an action or event, we will commission specialist provider support to work with individuals to achieve these identified outcomes and progress towards the maximum wellbeing and independence.

The Provider will have the capacity, skills, and expertise to deliver services designed to meet the requirements and specified outcomes as stated in the individual's Local Authority Support Plan underpinned by the core values set out in Appendix 1. There will be sufficient competent staff to ensure the specified outcomes of all individuals are safely met. Where appropriate the provider will utilise specialist services for specific activities.

We are working towards aligning the cost of commissioned services, Direct Payments and developing the use of Individual Service Funds in response to the Government white paper "People at the Heart of Care", to ensure parity, consistency and transparency.

We are also aiming to promote and embed the use of Individual Service Funds to enable individuals to have more choice and control in how they work towards and achieve their outcomes. We are seeking providers with the passion, commitment, and skill to offer personalised and tailored support options. This may mean that providers will be offering support planning, ongoing support management and coordination, sub-contracting arrangements, personalised staff recruitment and also delivering support.

This Service Specification describes the minimum requirements for the provision of Specialist Provider Services (or Services) for adults (and children 16 and over where applicable) placed under this contract and outlines the delivery requirements of that provision.

This document sets out the elements of the service that must be delivered by the Provider that will apply under these contract terms. The commissioner may review and vary this specification. Any variation shall only be carried out after engagement and consultation with the Provider and shall be recorded in writing and updated documentation sent to the Provider.

The aim of the service specification is to set out the requirement/expectations for service delivery within a Provider setting for adults or those in transition to adult services (16 years or older), in order to help meet individuals' specified outcomes either on a long- or short-term basis.
The relevant, underpinning legislation and guidance that inform and influence this specification includes but is not limited to:

- The Care Act 2014 2014
- Liberty Protection Safeguards - Mental Capacity (Amendment) 2019
- Data Protection Act 2018

- SEND Code of Practice 0-25 2015
- Preparing for Adulthood as part of
- Children and Families Act 2014
- The National Health Service Commissioning Board and CCG groups (Responsibilities and Standing Rules) Regulations 2013
- Mental Capacity Act 2005
- Equality Act 2010
- The Human Rights Act 1998
- The Mental Health Act 1983
- Down Syndrome Act 2022 (legislation.gov.uk)
- Autism Act 2009 (legislation.gov.uk)
- National framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)
- NICE | The National Institute for Health and Care Excellence
- Health and Social Care Act 2012
- People at the Heart of Care, Adult Social Care Reform White Paper
- Commissioning services for people with a learning disability framework (skillsforcare.org.uk)
- Commissioning services for autistic people (Dept. of Health & Social Care
- Adult social care outcomes framework 2023 to 2024: draft handbook of definitions - GOV.UK (www.gov.uk)
- Building the Right Support for People with a Learning Disability and Autistic People Action Plan - July 2022 (publishing.service.gov.uk)
- Good Lives: Building Change Together – Learning Disability England
- Introduction to supporting adults with a learning disability to have better lives framework | Local Government Association
- Draft quality of life framework - Care Quality Commission (cqc.org.uk)

Any updates or changes to legislation of guidance included within the framework will supersede the above links.

This service specification schedule is part of the framework agreement and should be adhered to alongside the terms and conditions and all other schedules and documentation.

2.1. Individuals

For the purposes of this specification, individuals are defined as:

- Adults (aged 18 years and older)
- Children in transition into adult services (aged 16 and older) who may be moving on from education or care services and leaving their family home and into adult specialist services for the first time.

2.2. Minimum service requirements for providers

Where regulated activity is part of the individuals wider local authority support plan the provider and/or its subsidiary company acting must be registered with the Care Quality Commission (CQC) to deliver regulated activity, Care Inspectorate Wales (CIW) for regulated services, Office for Standards in Education (OFSTED) for regulated services, or any authority that may replace them.

All services will be provided in accordance with the requirements of the CQC, CIW, the Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation of the Care Quality Commission (Registration) Regulations 2009, complying with all relevant regulations, best practice guidelines and the Children's and Families Act 2014. Reports, assessments, statutory notices, and quality ratings issued by the Commission or any other regulatory body (e.g., H&S executive) should be copied to the Council and will be taken into account for monitoring and compliance purposes.

For those providers who are not regulated by any official body the minimum service requirements would be included within this framework and we would work in partnership to maintain quality and standards.

3. Service Specific Descriptions

3.1 Supported Living

For the purpose of this framework, the definition of 'Supported Living' will be to support individuals through a journey of recovery or development to develop independent living skills and to live as independently as possible in their home and local community. Supported Living Support will be outcomes focussed and will have a joined-up approach to quality assurance and monitoring. Individuals will have opportunities to access a service which enables them to benefit from community, leisure, education, training, and employment opportunities.

3.1.1 Types of settings that supported living might take place under this framework

3.1.2 Support provider with separate scheme-based landlord

Where the service is managed by a scheme-based landlord and any support provision is provided by a separate provider with an arrangement between the landlord and support provider or an independent support provider of the persons choice. The tenancy under this arrangement is between the individual and the landlord.

Where the landlord of a supported living scheme does not provide direct care/support they should provide emergency on call provision if an external agency is providing the one-to-one support.

3.1.3 Support provider as both landlord and support provider

Where the landlord and support provider own/lease the service and also provide the onsite care/support. The tenancy under this arrangement is intrinsically linked, but for the purposes of the Specialist Provider Framework, the tenancy is viewed

separately and is a separate tenancy agreement between the individual and the landlord.

3.1.4 Support provided when living independently.
This is where an individual lives in their own property or lives with a friend or family member and is in receipt of supported living support. This is also known as Community Based Support or Community Outreach Support.

3.1.5 Supported Living (General)
Where the supported living provider and the Landlord are two separate organisations, it is important to gain clarity and understanding of the roles of each, to support an individual achieving the most fulfilling and independent life as possible. For all supported living services where the landlord is a social landlord, CQC registered setting, or where the landlord and service provider are the same (or part of the same) organisation, we have created a template Service Level Agreement that providers may wish to use. (Please see Appendix 4)

For private landlords, we would expect best endeavours were made to utilise this or a something similar.

For Landlords, there are legal requirements and standards for safe service. Central Government have published guidance on "How to Let" and "How to Rent", this includes information for both landlords and tenants. Under The Assured Shorthold Tenancy Notices and Prescribed Requirements (England) Regulations 2015 landlords have a legal obligation to provide a copy of the How to Rent booklet to each tenant (How to let - GOV.UK (www.gov.uk)).

For properties rented as shared houses (HMO's) they must meet The South Gloucestershire Council amenity and size standards, and if occupied by 5 or more people in 2 or more households will require an HMO licence. Details of licensing and requirements for both licensable and non-licensable properties can be found on our website. Licensing of houses in multiple occupation (HMO) | South Gloucestershire Council (southglos.gov.uk)

South Gloucestershire Council strongly advise Landlords to join a Landlord's Association, who provide legal support and training to ensure landlords stay up to date with changes. The West of England has a rent with Confidence scheme, and we would advise that landlords join one of the associations accredited under the scheme. There is also a simplified minimum standard tick sheet on the website, but higher standards may be required depending on the property type.
For any further information from the South Gloucestershire Council Private Sector Housing Team please contact: psechousing@southglos.gov.uk

3.1.6 Specialised Supported Housing
Specialised Supported Housing is defined within the Government's Policy statement on rents for social housing (2020) as supported housing:

- Which is designed, structurally altered, refurbished, or designated for occupation by, and made available to, residents who require specialised services or support in order to enable them to live, or to adjust to living, independently within the community;
- Which offers a high level of support, which approximates to the services or support which would be provided in a care home, for residents for whom the only acceptable alternative would be a care home;
- Which is provided by a private registered provider under an agreement or arrangement with a local authority or a health service (within the meaning of the National Health Service Act 2006);
- For which the rent charged, or to be charged, complies with the agreement or arrangement mentioned in paragraph (c); and
- In respect of which at least one of the following conditions is satisfied:
  i. there was no, or negligible, public assistance, or
  ii. there was public assistance by means of a loan (secured by means of a charge or a mortgage against a property).

The Council may wish to engage with identified housing associations, and providers to develop Specialist Supported Housing for individuals depending on the demands required to.

Across all Supported Living Schemes, the Provider should notify the Council when an individual being supported has completed all of their goals identified or in some cases is not progressing towards completing their goals, so a review of the service can take to ascertain ongoing suitability for the service. The Provider where this is applicable should be contacting the operational teams to request a review of the service.

3.2 Mentoring Services

Mentoring Services will be designed for adults who may have physical impairments, learning difficulties, autism, mental health diagnosis, sensory impairment, and/ or behaviours that challenge to spend time in the company of people other than their primary carers. Mentors are expected to share their knowledge, skills, and experience to assist others to progress in their own lives and careers and to motivate and empower individuals to identify their own issues and goals and helping them to find ways of resolving or reaching them within set and agreed timescales. Individuals will have opportunities to a service which enables them to benefit from community, leisure, education, training, and employment opportunities.

- The Provider will provide a high-quality provision for the individual who can be confident of the level of skills and expertise of the provision.

- The Provider will offer a reliable, stable but flexible provision with a high level of good practice.

- The Provider will work in partnership with the Council to ensure that the outcome-focused plan for the individual is implemented and monitored together

with the individual, family carers, or known representatives (as appropriate), the Council and the service provider.

- The Provider will ensure that the provision is creative, innovative so that individuals are safe but also have opportunities to challenge themselves, acquire as much independence as possible.

- The Provider shall keep full and appropriate records in relation to the provision of the service and at the Council's request shall make them available for inspection by the Council and/or provide copies of the records to the Council.

- The Provider will ensure that the service meets the needs of all those individuals currently receiving the service.

- When a new service for an individual is commissioned (either via direct commissioning, direct payments or when developed individual service funds) a review of the progress of the service will take place within the first three months to ascertain ongoing suitability for the service to continue based on progression of outcomes. The provider should actively be seeking for these reviews to take place within the first three months of the service starting and contacting the operational teams about arranging these reviews.

- The Provider should notify the council when an individual being supported has completed all of their goals identified or in some cases is not progressing towards completing their goals, so a review of the service can take to ascertain ongoing suitability for the service. The support provider where this is applicable should be contacting the operational teams to request a review of the service.

3.2.1 Other Forms of Mentoring Support

The Council also defines Job Coaching (supporting an individual towards gaining employment) and Employment Support (supporting an individual to maintain employment, whether paid or unpaid) within Mentoring.

3.3 Day Services

A Day Service can be a buildings based or community-based service, offering activities that reflect the interests of those individuals attending either as a group or individually. The service can provide support flexibly and is not limited to normal 9am – 5pm operating hours. The service to be provided in accordance with local authority support plan provided by social services. The service will enable individuals to benefit from community, leisure, education, training and employment opportunities and support to achieve and maintain maximum possible independence.

A Day Service should not automatically be viewed as a service for life, but as a step towards independence. It is therefore vitally important that services are clear as to what they offer, who is eligible and appropriate, and what outcomes can be expected. The service will work in partnership with the Council to support individuals to meet their defined outcomes.

3.4 Community Based Support

Community Based Support includes supporting the individual to live at home (whether this is their own home, living with their family or sharing with others).

Community Based Support can include both regulated and non-regulated services to support an individual towards achieving their outcomes. Types of Community Based Support can include:

- Homecare support – support to remain at home which may include personal care support and medications prompting.
- Community Outreach – support to access the local community including; local amenities, support to use public transport, support to access to appointments etc.
- Supported Living 1 to 1 support – specific support to an individual to support towards outcomes.

4 Aims and Objectives of Service Delivery

The aim of the service is to maintain or improve the quality of life for individuals supported under this contract. The service will do this by providing person-centred support to individuals according to the individual's wishes and specified outcomes. Outcomes must be co-produced by individuals, in partnership with operational staff, advocates, family and friends. Outcomes should be person centred and driven by an individual's aspirations so that they are meaningful, achievable, and able develop and change over time to enable an individual to achieve maximum wellbeing and independence. (See Appendix 5 for further definitions)

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. The Provider will provide high quality, reliable, consistent support that enables individuals to increase choice and control over their daily lives, to achieve and maintain maximum possible independence and a sense of belonging.

The Provider shall promote the maximum level of independent living skills achievable by the individuals accessing the provision (and supporting individuals to access other services). Individuals will have opportunities to a service which enables them to benefit from community, leisure, education, training, and employment opportunities. This means engaging with the individual, undertaking activities that have a purpose towards progression of outcomes.

The Provider will promote choice and control for the individual in their everyday working practices in line with the Mental Capacity Act 2005 or any replacing legislation and will understand the importance of empowering an individual to have control in their own lives through the choices they make by:

- Achieving specific outcomes identified in the individual local authority support plan
- Being valued by being at the centre and involved, have more control, listened to, informed of what is happening, given choices, and treated with respect
- Retaining their strengths and independence by ensuring that an individual's quality of life is maintained by keeping active and alert, maintaining mobility/physical health, maintain hygiene, maintaining social contact and keeping safe and secure
- Being supported through change by transitioning into a different service (Or support to manage current tenancy) setting where appropriate, post-operatively, at the end of their lives, in situations where post care or self-neglect has resulted in a decline in their independence and increasing independence levels
- Being safe by having services that are well managed and provided by staff who work competently with individuals because they are appropriately trained and supervised to take person centred approaches.

4.1 Person-Centred Plan

The Provider will draw up a Person-Centred Plan (to be reviewed by the Council on request) which has been fully discussed and agreed with the individual, their unpaid carer, and any other professional/s (as appropriate) in an accessible manner that ensures the plan is collaborative and understood. The Person-Centred Plan will consider the individual's aspirations and personal goals, specified outcomes, choices, and preferences in relation to the way in which support is provided and their own chosen lifestyle.

The Person-Centred Plan will refer to the means of empowering, facilitating choice, regaining, or acquiring skills and/or maintaining existing skills. The person-centred plan will clearly define the service to be provided by the service provider showing how the service will be delivered to meet assessed outcomes and how the service will promote independence and support individuals to live a fulfilled life making the most of their capacity and potential.

The Provider will ensure that the person-centred plan provided is accessible compatible and supports the outcomes identified in the individual's local authority support plan. Information from the Local Authority Support Plan and the Provider's Person-Centred Plan will be made available to support workers so that they are aware of; any specific needs, the activities they are required to undertake, the purpose of the activities, the frequency and duration agreed, the outcomes to be achieved and any applicable time frames.

The Provider will have in place a means of recording actions taken to meet the outcomes, and staff will record the acquisition of new skills and the achievement of goals by the individual. Once these goals have been met the local authority support plan will be revisited to set new goals in collaboration with the identified operational staff.

The Provider will ensure that sufficient information is held and made available in the to enable the service to be delivered in accordance with the local authority support plan, the Provider's Person-Centred Plan and all documents relevant to the individual. All information needs to be stored securely and in accordance with the General Data Protection Regulations 2018 or any act that may replace it.

Where appropriate, the Person-Centred Plan will outline the views and needs of unpaid carers. If these views and needs conflict with those of the individual, the individual's wishes will take precedence wherever possible. All views will be recorded on the providers support planning system.

The Provider will ensure that the allocation of commissioned hours will be utilised across the full period of the support (i.e., 3 to 12 months or longer) flexibly (on agreement with the Council and the current payment mechanisms) to support the individual to achieve the identified their outcomes. The Provider will work collaboratively with all key stakeholders to support the individual's progression to achieve identified outcomes. The Council wants to work with the Provider to develop flexible use of commissioned hours, however, may be restricted due to the Council's payment mechanism in the first year of the Framework.

5. Referrals and Exit Process

5.1 Eligibility and Access to the Service

Services provided under this contract and service specification will be for adults and children (aged 16 years or older where applicable) with eligible health and social care needs whose assessments and Local Authority Support Plans identifies that their specified outcomes can be best met by a Specialist Provider Service which is funded by social care either on a long-or-short-term basis.

5.2 Referral Process and Supported Living Directory

5.2.1 Referral Process

The social worker, on completion of a Care Act assessment with individuals (family, friends, and unpaid carer's) will have an agreed local authority support plan. The social worker would then liaise with the South Gloucestershire Council Brokerage Team to source an appropriate available service taking into account the best value for the Council and individual.

The Brokerage Team will source the most appropriate service/s for the individual by working in partnership with providers on this framework. This information would then be shared with the individual (and advocate). The opportunity to visit services may be available to help in the decision-making process. (See appendix 6 for the brokerage/commissioning process). The Provider should develop and maintain strong working relationships with the Brokerage Team (and vice versa) to support individuals where possible based on their own vacancies across any of the service areas.

5.2.2 Supported Living Directory

The Council would like to keep an updated record of Supported Living vacancies within the Provider or service to support the brokerage referral process. Providers may be asked on a monthly or quarterly basis by the Specialist Team to confirm what vacancies they have in their service to inform the brokerage team and market intelligence. The Specialist Team will keep a record of these vacancies and share with the Brokerage Team accordingly.

The Council will also use the Supported Living Directory to arrange for the annual monitoring reviews and or tri-party meetings to review services accordingly. The Council will request this information initially from Providers when they tender for this framework and then ask for an update on this on a monthly or quarterly basis.
The Council reserves the right during the contract term to widen the Directory to include other services and their vacancies should this be required to support the brokerage process or market intelligence.

5.3 Out of Area Placements

An out of area placement is where an individual's care and support is delivered in a local authority area, but is commissioned by either a different local authority, or an ICB not associated with the local authority area where the individual has been placed.
All out of county providers will need to be on the Specialist Provider Framework for South Gloucestershire Council to commission a service with them.

For the purpose of this Framework an out of area placement is a service commissioned outside of the South Gloucestershire Council area/boundary determined by the location of which the support is being provided to the individual i.e., a Supported Living Scheme based in another local authority area and the individual is registered to live there and support is provided in this scheme.

Working together the Local Government Association, Southwest ADASS, NHS England, Health and Social Care Commissioners, parent carers and people with lived experience have developed guidance and checklists to support improvements to the out of area placement process for when people move around the Southwest. The tools have been developed for use by commissioners, frontline practitioners, providers, parent carers and people with lived experience of a learning disability.

Providers are expected to adopt the Provider Guidance and Provider Checklist for placements that are made into their Service from a local authority or CCG which is not their host authority.

South Gloucestershire Council is looking to secure a good quality service with progressive outcomes for all South Gloucestershire individuals irrelevant of where the service is based.

Guidance for Providers.pdf

Checklist for Providers.pdf

5.4 Joining the Service

Providers must have a clear process to ensure individuals starting to be supported by the service are well informed and are able to ask questions to ensure a seamless move into the service.

5.4.1 Working with Other Teams in the Council

Following an assessment of a Child or Young Person with Special Education Needs and/or disabilities (SEND) requires social care and support, this is provided by Children's Operational Team until they reach the age of 18. For Adults over the age of 18, this care and support will usually be provided by the 16-25 team within the 0-25 Social care service which sits in the Children's Department.

The Council has designated Preparing for Adulthood & Transition to Independence Teams, who will also work with individuals to support them through the transition from children to adult services and support them with achieving specific goals/outcomes. Providers may be required to work in partnership with this team to support the individual.

5.5 Exiting the Service

The Provider will work collaboratively with relevant partners/individuals to support a seamless progression to either independence or to a new service.

After constantly supporting an individual for a period of time where all outcomes in the local authority support plan are on track to being achieved, the final outcome may need to be "moving on plan" onto independence as part of the local authority support plan in collaboration with operational staff, wider South Gloucestershire Council teams, other relevant health and community partners and family/friends to give individuals necessary support to move onto independence and avoid individuals remaining in the scheme solely under a tenancy.

If the individual transfers to an alternative service outside the specialist provider service, during the notice period prior to the individual's departure and up to and including the day of the departure, the Provider shall provide the individual with all reasonable practical assistance to ensure a smooth transition to the new service. The service will work collaboratively with relevant partners to support a seamless progression to the new service.

Examples of exits include (but not limited to):

Planned

- Outcomes have been achieved and the individual moves onto independence or another setting.
- Reassessment takes place and individuals needs require different service
- Individual chooses to move away

Unplanned

- Notice is served on tenancy (either by landlord or individual) (where appropriate a Tri party approach to supporting the individual to maintain tenancy)
- Individual is no longer present to receive support.
- Admission to another setting (examples include but not limited to, Hospital admission, Respite Care, Rehabilitation Care, and or Prison)
- Individual passes away.

For unplanned exits from a service, the Provider would need to make the operational team and commissioning team aware of this within one working day.

6. Strength Based Approach

The Provider will be expected to adopt a strengths-based approach. This is a collaborative process between the individual, supported by the service, and those supporting them, allowing all parties to constantly work together to achieve the individual's outcomes in a way that draws on the strengths and assets. Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services.

A strengths-based approach to support, starts with the skills and resources the individual has, or can develop, with support from the service, social networks, and communities to enable the individual to deal with challenges in life in general, and achieving their desired outcomes.

The service will enable and support individuals to do things for themselves wherever possible, with the aim that they become more than passive recipients of support. In order to do this, it is fundamental that support staff and or practitioners establish and acknowledge the capacity, skills, knowledge, network, and potential of both the individual and the local community.

6.1 Care Act 2014 Eligible Outcomes

The Care Act 2014 has introduced a responsibility for local authorities to promote an efficient and effective market for care and support services in their areas. Market shaping and commissioning activity should focus on outcomes and the wellbeing of users, promoting quality, sustainability, and choice in services, engaging with providers and members of the local communities. It also provides the legislative framework that puts people in control of their care and support and provides the mechanism through which the quality of support provision will be improved.

Services will be commissioned and delivered in partnership with the Council to embed the ethos of an outcome focused approach and building on opportunities to:

- Empower providers to work with individuals in an enabling way.
- Give the individual the opportunity to receive support that is flexible and tailored to meet their individual specified outcomes.
- Give support workers increased job satisfaction.

- Reduce the long term, high volume traditional packages of care.

Examples of outcomes, underpinned by the key principles in the Care Act 2014 might include (but not limited to):

Promoting wellbeing

- Individuals are supported to develop and maintain family or other personal relationships.

Promoting Independence

- Individuals are supported and encouraged to live as independently as possible e.g., with daily tasks, being part of their community, good nutrition, fitness, and mental health. Approaches to health that respect individual's choice whilst offering and encouraging a 'healthy lifestyle' where this is appropriate.

Promoting Dignity and Respect

- Individuals are given choice and control over their support and living arrangements wherever possible.
- Services take account of individual personalities, lifestyles, interests, physical and mental health needs, and will be designed to address the specified outcomes of the individual person taking into account their age, gender, ethnicity, language, religion, culture, and sexuality.

Providers should also consider evidencing the following:

- How the individual has settled and integrated into the service, positive and negative impacts should be included.
- Comprehensive Person-Centred Plan demonstrating how the identified outcomes will be met, by whom and in what time frame.
- What progression can be expected, and the timescale identified.
- What reduction in support can be expected and the timescale identified.
- How innovation will be embedded in the support delivery.
- How the individual will be supported to engage further with their community and family networks.

6.2 Prevention

One of the overarching aims of The Care Act is to prevent, reduce or delay needs for care and support. The South Gloucestershire Council Plan includes Priority no.2 "Identifying and supporting those most in need and helping people to help themselves" where the commitment is "We will shift the balance of support towards prevention".

South Gloucestershire Council is working in partnership with the Integrated Care Board on prevention. Together we have identified opportunities to increase a preventative approach, these opportunities are:

- Throughout all the stages of someone's life (taking a life course approach)
- During people's contact and interaction in and with their own communities

- During people's contact with the services, they use
- Methodically and in a way that improves the lives of people who might benefit the most.

6.3 Individual Outcomes – Assessment
An individual's outcomes are identified through the needs assessment and as set out in an individual's local authority support plan. The focus of the assessment is on the individual's needs and how they impact on their wellbeing and the outcomes they want to achieve.

Providers will be expected to evidence as part of the quality assurance process how they have measured, developed, progressed, and met an individual's outcomes by implementing a person-centred plan to reach identified outcomes with an initial baseline to work from.

6.4 Individual Outcomes – Person-Centred Plan
An individual's outcomes are set out in their local authority support plan, and it is the expectation that providers will build on the initial outcomes identified, by working with the individual and their existing network.

Providers will need to demonstrate the difference the support makes to an individual, including how they are constantly supporting the individual to work towards specified outcomes.

The aim for the service is to be proactive and flexible in meeting the person's changing needs and identifying a range of ways to meet the individuals agreed specified outcomes in their local authority support plan. The provider will be expected to increase or decrease the service in order to meet an individual's fluctuating needs in relation to specified outcomes. Individuals will have opportunities to a service which enables them to benefit from community, leisure, education, training volunteering and employment opportunities by accessing and integrating into the local community.

Where an individual's needs have changed the provider will contact CSOdesk@southglos.gov.uk or 01454 868007 (Adult Care) immediately to enable a review and agree any changes required.

For any urgent safety matters the provider will ensure that the individual is safe and free from harm and then immediately contact CSOdesk@southglos.gov.uk or 01454 868007 (Adult Care, Monday – Friday) or outside of working hours the Emergency Duty Team on 01454 615165 for a discussion.

Where an individual has met an identified outcome and support can be reduced the Provider is expected to notify the CSODesk@southglos.gov.uk or call 01454 868007 (Adult Care, Monday – Friday) so a new assessment can be completed, and a new local authority support plan can be developed which may include a change in

services where appropriate. New outcomes may also be identified at this assessment for the Provider to support the individual to work towards.

7 Person-Centred Requirements

7.1 Person Centred Support

The service will promote and embed person-centred support as standard practice, so that individuals are treated as individuals with unique backgrounds, qualities, abilities, interests, preferences, and needs.

The individual will be allocated a support worker who understands their individual needs and preferences and who liaises regularly (ideally at least weekly) with the individual's support network to:

- Provide information that supports individuals and their support network, to understand the support they will receive, and how to make decisions about it, and understand any limitations.
- Enable individuals to maximise their independence for themselves where possible, taking a reablement, enablement and recovery approach.
- Encourage and support individuals and their support network to be involved in the day-to-day workings of the home.
- Ensure that the views and wishes of individuals/families/representatives are at the centre of any decisions about the delivery of the individuals support as long as they fit with the individuals' specified outcomes that have been identified and do not compromise the individual's health and safety.

The Provider will conduct the appropriate risk assessments for each individual and put in place risk management plans if required. The risk assessment/risk management plan will consider the potential risks of an activity or task to:

- Individuals and staff.
- Other individuals within the service.
- The wider public when out in the community.
- Risks associated with different environments.

When delivering support, all risk assessments must contain a balance that accounts for an individual's personal choices and freedoms. The risk assessment will be updated at least annually or more frequently as required.
Provision is made for ensuring individuals can access information, guidance, and support to use domestic appliances safely.

Providers must ensure that each individual has more than one support worker who provides their support to ensure that support can still be provided in cases of holiday or sickness and to avoid an individual becoming overdependent on one person.

7.2 Positive Risk Management

The Provider will recognise the individual's right to take risks to extend opportunities and independence and will ensure that individuals are able to choose the risks they want to take and be given support to understand the full implications of their choices.
Individuals will be assisted to understand the possible consequences for themselves and others of their choices, and be supported to take responsibility for their actions, and decisions recorded. For individuals with capacity to make decisions around risk, views from family, friends, unpaid carers etc can only be included if the individual has agreed to this.

Individuals will be fully involved in formal risk assessments for everyday service activities (including managing complex and challenging behaviour), carried out by trained staff, offering a balance between individual needs and preferences and the needs of other users and staff.

To assist individuals in making decisions around risk, providers should carry out a capacity assessment in line with The Mental Capacity Act and where someone is deemed to lack capacity involving a variety of people as set out in the legislation. The people involved will depend on the decision being made and may include (but not limited to) an independent advocate, independent mental health advocate (IMCA), health professionals, social care professionals, family, and unpaid carers.

The Provider's staff will continually monitor risks, make assessments, and take appropriate action as required.
Copies of risk assessments will be made available to individuals, their representatives (advocate, family, unpaid carer etc), commissioners, and operational teams and or any other professionals/stakeholders on request.

The Principles of the Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS) and Mental Capacity (Amendment) Act (2019) (Liberty Protection Safeguards (LPS) can be found in Appendix 7.
Here are some useful guides from the Department of Health around managing positive risk:

2D8BF51C.pdf

7FB4458A.pdf

7.3 Partnership Working

The best outcomes for the individual using the service will be obtained when the Provider and others involved with the individual are working effectively in partnership. The Provider will have access to, and be expected to collaborate with external professionals, support services and other agencies 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 individual's support.

- Facilitate appropriate access for the purpose of assessment intervention and monitoring and agree any action/s arising.
- Offer innovative approaches to help the person achieve their personal outcomes through service design, review and delivery and the use of assistive technology or equipment where appropriate.
- Creative and proportional support is key to achieving outcomes therefore consideration of least restrictive approaches and the use of assistive technology where appropriate must be evidenced.
- Work with all relevant professionals in line with a multi-disciplinary team approach.
- Build and maintain a positive and professional relationship with social workers, commissioners, brokerage, local support services (that meet the need of the individual) and the local Integrated Care Board.
- Participate in multi-disciplinary team meetings or any other relevant meeting which discusses the local authority support plan/specified outcomes of the individual.
- Understand the local preventative and blue light protocols under Transforming Care and participate in these arrangements when necessary. *(Note: These may differ in different counties)*
- Be aware of and participate in the LeDeR review programme which is a service improvement programme learning from the lives and deaths of people with a learning difficulty or autism where required.
- Supply any requested information by health and social care and share in a timely manner.
- Participate in local, regional, and national forums as required.
- Where an individual has multiple providers supporting them, provider must work across providers and services to support the individual.

For each of the requirements above, the Provider will be responsible for identifying the most appropriate person to attend or be involved.

7.4 Community Engagement

Individuals will receive the support they need to foster and maintain friendships and networks in their local community according to their wishes. Individuals will be encouraged and enabled to make use of public and community transport as appropriate. This support and enabling may not mean that the Provider will accompany the individual into the wider community.

To promote community inclusion, the Provider will seek opportunities for joint working with other agencies, voluntary and community groups to identify opportunities for the involvement of the individual in their community as required. Providers will signpost individuals to appropriate community services.

7.5 Providing Transport to Individuals

Providers should support people to arrange transport as independently as possible. The Provider should not be liable for costs incurred as the individual should be

paying at point of access unless these costs have been covered in the local authority support plan.

Where support workers use any vehicle to transport individuals the provider will ensure the support worker has a relevant full valid driving licence, that all vehicles used are well maintained and has valid MOT, and that the appropriate insurance is held. Evidence that the Provider has carried out regular checks will be provided to the Council on request. The Provider will ensure adequate and reliable contingency procedures are in place in case of accident or breakdown while transporting Individuals.

Where the Provider offers transport, the Provider shall ensure all vehicles used are suitable for the individual's needs.

The Provider will carry out risk assessments for individuals accessing any type of transport (pool vehicles, support worker cars, taxis, or other public transport etc).

7.6 Individual's Financial Protection

Providers will support individuals to manage their own money in a way that enables the individual to exercise choice, control, and an awareness of any consequences, to achieve identified outcomes from an assessed need. The Provider will have a process in place to support people to manage their money. The Council would support individuals and providers to look for independent financial appointees separate from their service provider.

Where an individual does not have capacity (following a mental capacity assessment by the Council) and there is an assessed need, there should be a financial appointee/deputyship in place for finances, the Provider will support these mechanisms accordingly.

There must be robust policies and procedures to support appropriate financial management.

Any concerns around financial abuse should follow Safeguarding procedures.

7.7 Communication

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 to an individual's service, accurately update daily records and logs and communicate verbally effectively with the Individual or any third party.

Staff are aware of the preferred communication methods of individuals and communicate in the method and language of the individual's choice; staff will be appropriately trained and knowledgeable with the necessary communication skills to ensure any language barriers or communication issues are minimised.

Staff should seek to use language and expressions that are readily understandable and appropriate to individuals. Where appropriate digital communication should be used.

Individuals will be supported to communicate at the speed and in the style they wish.
Individuals' person-centred plan will contain a record of any communication assistance needed, (ideally in the format of a communication passport) and this will be regularly reviewed and updated.

The Provider will ensure all services; aids and equipment are available to assist an individual's communication as identified in the person-centred plan.
Individuals will be supported to access and use specialist individual communication aids as prescribed by the Council, Occupational Therapy or Speech and Language Services unless the item is privately purchased.

Individuals will be supported to prepare for important events, (e.g., a review), and have time to communicate their feelings, views, and answers.
Individuals will be able to ask family, friends, unpaid carers, or others to help staff in listening and understanding their views.

Individuals shall have access to 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. (This may include the involvement of the advocate in individuals' local authority support plan or the provider's person-centred plan reviews) as a 'suitable person' in accordance with the Care Act 2014).

If an individual requires an advocate but does not have a person in their life that can fulfil this role, then a formal advocate will be appointed by the Council. The Provider will co-operate with any recognised advocate and assist the advocate in providing a service to the individual.

Access to interpreters should also be available to those who would benefit from this facility, including profoundly deaf people, and this should be provided at times of assessment and review. Where appropriate, the cost of providing an interpreter will be met by the council. Any requests for funding must be agreed by the council prior to use.

The Provider will make referrals to appropriate community services (for example but not limited to; Community Learning Difficulty Teams, Mental Health Services and Community Nursing) in partnership with the individual's General Practitioner, to support individual outcomes where appropriate.

7.8 Assistive Technology

Assistive Technology plays a significant role in supporting independence and wellbeing for individuals. The Provider will maintain up to date knowledge of Assistive Technology and support and facilitate the use of assistive technology for individuals when beneficial for an individual or for individuals within a specific specialist provider service. The Council will pay for any assistive technology that has been assessed under the Care Act (2014) by operational staff and identified as an appropriate way of achieving identified outcomes. The Provider will engage with Assistive Technology where appropriate to achieve an individual's outcomes and increase their independence and decrease their reliance on other services (such as waking or sleeping night support).

The Provider must allow and enable all Assistive Technology arranged by the Council and Providers must not purchase/or support individuals to purchase any equipment/aids that have been assessed under the Care Act by operational staff and identified as an appropriate way of achieving identified outcomes without prior agreement of the Council.

Although regulated care home settings are expected to have Assistive Technology, Providers are not expected to have Assistive Technology unless already agreed with the Council for use in their Supported Living Scheme. If an individual requires specific equipment, this is funded by health or social care via the commissioned ICES (Integrated Community Equipment Service). All equipment except wheelchairs are loaned to the individual and maintained and repaired by the equipment provider. Referrals to ICES can be made via operational teams or local community health teams.

Please see appendix 8 for examples of how Assistive Technology can support independence and wellbeing.

7.9 Equipment and Consumables

The Council and the ICB have a local agreement for the ICB to provide individuals with continence products for those they deem to be clinically eligible following an assessment. Where such need is identified, individuals will not be charged by the provider for such products. Personal hygiene products will be funded from the individual's personal allowance.

Where equipment is loaned to an individual within a service it will be maintained and repaired by the Community Equipment Provider. Therefore, it is essential that the Provider keeps a log of all loan equipment that has been provided, to support the equipment provider in locating items of equipment when this is required. Providers may be subject to an annual loan equipment audit to confirm what loan equipment is on site and still required. Loan equipment must be properly cared for and returned when no longer needed by the individual to who it was prescribed. Loan of equipment will be in line with the council's policy and is available on request.
When the Provider is expecting the individual to provide any furniture, white or brown goods etc. or equipment privately this must be made explicit to the individual at point of support planning before placement.

The Provider is not expected to store items of equipment other than those that have been identified to meet a need of an individual.
In a service with shared facilities the Provider will provide and maintain all items supplied as part of the scheme. In services with individual flats furnishing and provision and maintenance of white and brown goods etc., are normally the responsibility of the individual unless otherwise specified in the tenancy agreement.

Any equipment used in connection with the provision of the service must be regularly maintained in accordance with the manufacturer's requirements and PAT tested.

The wishes of the individual not to use equipment should be respected. However, the Provider is expected to explain the reasons for the use of equipment to individuals and the likely risks associated with not using the equipment and to undertake a capacity assessment.

If the individual continues to refuse to use the equipment and particularly in circumstances where the individual lacks mental capacity to fully understand the consequences of their decision, the support worker should act to minimise the risk to themselves, and the individual and the allocated operational staff should be notified immediately to consider whether a reassessment is required in such circumstances. If the support worker feels they are not able to manage the relevant task or tasks without risk to themselves or the individual, then the support worker should not attempt to do so without seeking advice from their line manager. The Provider must not attempt to support in an alternative way (not using the equipment) without Council or other professionals' agreement.

Providers should ensure all support workers working with the individual are appropriately trained to use the identified equipment or consumable and regular checks on their competencies are completed in line with the Provider's Policies and Procedures.

7.10 Environment and Building

The services delivered will provide an environment that is positive, empowering and which validates the strengths of everyone. The Provider will ensure that the physical environment reflects the distinctive needs of the individuals who use the service. The Provider will:

- Provide standard equipment and adaptations that one might reasonably expect to facilitate the promotion of independence and the safe moving and handling of individuals.
- Provide a range of opportunities for social interaction and so that individuals have the ability to be independent with tasks where appropriate.
- Provide reasonable access to facilities. (e.g., quiet lounge for physiotherapy or occupational therapy activities provided by in-reach community services).
- Support individuals to have three meals each day at appropriate intervals: morning, midday, and evening, at least one of which will be a cooked meal.
- Ensure that the building and infrastructure are fit for enabling digital connectivity (internet/Wi-Fi/devices) and supporting moving and handling equipment for those who also require physical support as per section 7.3
- Provide a building that can support moving and handling equipment for those who require physical support.
- The building is kept to a good standard and the provider continues to work with the Landlord to identify improvements needed.

7.11 Meeting an Individual's Diverse Needs

The service will be inclusive responding sensitively and appropriately to the diverse needs of the individuals. This includes ensuring that the service is accessible and

can adapt to meet a broad range of needs irrespective of an individual's race, gender, disability, religion/belief, sexual orientation, age, gender reassignment, pregnancy & maternity, marriage & civil partnership.

Staff will be properly trained in anti-discriminatory practice and equality issues, so they can ensure individuals can access and participate in their community networks.

8 Health and Social Care

8.1 Health Needs

The Provider will ensure that individual's health needs are addressed, and support is offered in accessing the full range of healthcare services as identified in the individual's local authority support plan. Individuals will be helped to understand where possible how to stay healthy, including their emotional and mental wellbeing, and are encouraged and supported to do so.

Individuals will be supported to register with a local General Practitioner, Dentist, and Optician. Staff will take a proactive approach to supporting people to manage their health and wellbeing by informing and encouraging individuals to access preventative healthcare such as screening, immunisation, and regular check-ups (including eye, hearing, dental, general health). Staff will be trained in spotting the signs of deterioration and know how to escalate it.

8.1.1 Annual Health Checks and Hospital Passports

The provider will support and encourage individuals with a Learning Disability and/or Autism to access Annual Health Checks and obtain a Hospital Passport. (See Appendix 9 for more information around Annual Health Checks and Hospital Passports)
Annual NHS Health Checks for people aged over 14 years with a learning disability | South Gloucestershire (southglos.gov.uk)

Please find below, Healthwatch South Gloucestershire, Annual Health Check, "Your checklist" (Easy Read) to support individuals around annual health checks.

244AE6E6.pdf

The Provider will promote good physical, emotional and mental wellbeing and where possible prevent the need for hospital admissions. Staff will ensure that general wellbeing is regularly included as part of conversations/interactions (using accessible language/Easy Read) and regular observations to look out for any changes/signs of deterioration, to ensure that any issues such as cancer, respiratory, constipation, obesity, diabetes, dehydration, pain etc. can be identified early, and preventative action taken to avoid escalation and preventable deaths. *(A useful example is constipation, where a LeDeR annual report identified that 80% of people had constipation as a factor in their death).*

F02DDA04.pdf

Source:

LeDeR reviews have evidenced that applying the Mental Capacity Act 2005, to physical health issues is a significant factor in reducing or preventing avoidable deaths in people with a learning disability.

Staff will support and encourage individuals to contact health (and social care where appropriate) professionals and support individuals to arrange and attend all health checks. Health Action Plans should be accessible to individuals and any actions identified will be written into the individual's person-centred plan and staff will support them to work towards achieving them. Here is a useful document from NHS BNSSG ICB to support individual's Health Action Plans.

Health Action Plan V5 FINAL blank.pdf

Staff will discuss any concerns they have about individual's health and well-being with the individual before involving any other agency or unpaid carer/family member. If these concerns indicate any potential abuse of the individual, then these must be reported through Safeguarding Adults and Children arrangements where appropriate.

8.2 Medication

The Provider will have a clear, written medication policy in line with NICE guidance – Managing Medicines for adults receiving social care in the community and procedures in place which is adhered to by all staff and includes:

- The extent and circumstances in which support workers may or may not be involved in prompting or administering individuals to take medication. The policy should ensure that only trained, competent and confident support workers are assigned where medication is required, and it should enable support workers to refuse to administer medication if they have not received suitable training and/or do not feel competent to do so.
- The limitations of assistance with prescribed and non-prescribed medication and which tasks a support worker must have specialist training in before undertaking.
- The arrangements necessary to ensure the safe handling and/or prompting of medication.
- The records to be maintained where support workers support individuals to take medication.
- Staff will ensure that arrangements are in place for individuals to take any necessary medication in a way that respects their dignity and privacy and complies with the organisation's medication policy.

8.2.1 Medication for Regulated Providers

- Services registered with the Care Quality Commission (CQC) or Care Inspectorate Wales (CIW) will have their medication policy reviewed and monitored as part of the regulatory inspection function

- Providers are expected to be compliant with CQC/CIW requirements on Medication Administration.

- Providers must have insurance that covers support to prompt or administer medication

- Any medicinal prompting/preparation must be recorded in a Medication Administration Records Chart (MARs Chart).

All staff working within the service 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.

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.
The Provider will ensure that minimal medication errors occur, but should an error occur a root cause analysis is undertaken with clear mitigating actions identified and refresher training is undertaken. The Provider will ensure that CQC/CIW and local safeguarding policies are adhered to in relation to medication.

The individual, or their representative must agree to have a support worker administer medication and consent should be documented in the provider's person-centred plan. If an individual is unable to communicate informed consent, the prescriber must indicate formally that the treatment is in the Best Interest of the individual following Mental Capacity Act and Best Interest requirements as appropriate.

Administration of medicine may include but not limited to:

- Any physical assistance to assist the individual with the process for example the selection and preparation of medicines for immediate administration, including selection from a monitored dosage system or compliance aid.
- When the support worker selects and measures a dose of liquid medication for the individual to take. Where support workers are required to do this the provider will ensure that they have the appropriate training and supervision in place and that their medication policy and insurance covers them to complete this task.
- 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. Where support workers are required to do this the provider will ensure that they have appropriate training and supervision in place and that their medication policy and insurance covers them to complete this task.

- When the support worker puts out medication for the individual to take themselves at a later (prescribed) time to enable their independence.

The provider's person-centred plan should determine and document the following:

- The nature and extent of support and/or assistance that the individual needs to manage their medication.
- A current list of prescribed medicines for the individual, including the dose and frequency of administration; method of assistance; and arrangements about the filling of compliance aids if these are used and that these are in line with your medication policy and management oversight.
- A statement of the individuals consent for the support worker to assist with medication.

Non-regulated providers would not be expected to administer medication and may be asked to prompt the individual to take their medication in line with their local authority support plan.

8.3 STOMP – Stopping Over Medication of People with a Learning Disability, Autism or both.

STOMP stands for stopping over medication of people with a learning disability, autism, or both with psychotropic medicines. It is a national project involving a number of different organisations which are helping to stop the overuse of these medicines. STOMP is about helping people to stay well and have a good quality of life.

Psychotropic medicines affect how the brain works and includes medicines for psychosis, depression, anxiety, sleep problems and epilepsy. Sometimes they are also given to people because their behaviour is seen as challenging.

Individuals with a Learning Disability, Autism or both are more likely to be given these medicines than other people.

These medicines are right for some individuals. They can help individuals to stay safe and well. Sometimes there are other ways of helping individuals, so they need less medicine or none at all.

Providers are expected to support the aims and principles of stopping the over medication of people with a learning disability, autism, or both with psychotropic medication (known as STOMP). The Provider shall therefore:

- Encourage each individual to have regular medication reviews.

- Ensure that any health professionals involve the individual, their circle of support and staff in decisions about their medication; and

- Be informed about non-drug therapies and practical ways of supporting individuals so they are less likely to need as much medication, if any.

- Be prepared to be involved in any STOMP service reviews that may be initiated by local health services.

8.4 Delegated Healthcare Interventions
Support Workers/staff may be asked to carry out healthcare interventions that are delegated by a registered healthcare professional such as a nurse, nursing associate or occupational therapist. These are usually called 'delegated healthcare interventions' and are often specific clinical interventions that support people's care and independence.

Skills for Care and the Department of Health and Social Care (DHSC) are working in collaboration with partners to develop guiding principles to support consistent, safe and effective delegation of healthcare interventions to social care workers across residential and community settings, including the personal assistant (PA) workforce. Initial guidance and more information on this work can be found here:

Skills for care - Delegated-healthcare-interventions

Providers should ensure all support workers working an individual is appropriately trained in the delegated healthcare intervention and regular checks on their competencies are completed in line with the Provider's Policies and Procedures.

8.5 Enteral Feeding
Support workers may be required to support individuals with enteral feeding in the administration of nutrition, flushing of the enteral tube before and after nutrition but will not be expected to administer medication via an enteral tube unless this is performed by a qualified and competent member of staff. This will be based on individuals needs and discussed with the Provider.

Before supporting an individual with enteral feeding, the provider will ensure that appropriate training has been delivered by the relevant health training provider who will retain clinical responsibility for the process and for monitoring this aspect of care with support, if necessary, from the enteral feed provider. Providers will ensure that regular competency assessments are carried out on all staff supporting people with enteral feeding tubes.

The Provider will ensure that they have received relevant contact information for raising issues concerning enteral feeding from the enteral feed provider, including for outside of normal office hours and that workers are equipped to recognise and deal with any issues that require escalation to health services.

8.6 Dietary Needs
If appropriate, the individual's dietary requirements and preferences will be discussed and recorded in their person-centred plan.
Where the Provider is preparing meals and snacks for individuals the menus will reflect preferences, cultural and medical needs. A varied and nutritional range of meals that promotes healthy eating will be agreed with the individual.

All support workers will have received training in food hygiene and food and drink will be prepared and served in line with current food hygiene standards and regulations. Where necessary providers will seek professional specialist advice regarding specialist dietary requirements or difficulties with eating and/or drinking and will work in conjunction with them to ensure appropriate equipment and support is available to individuals who require it.

Staff will be ready to offer prompting/assistance with eating and drinking where necessary. Support will be offered discreetly, sensitively, and individually in a manner that respects the individual's dignity and wishes.
Individuals will receive support to monitor the intake of food or drink where required and the provider will ensure appropriate recording procedures will be in place.

8.7 Dysphagia
Dysphagia is the medical term for swallowing difficulties. Some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all. Other signs of dysphagia include (but not limited to):

- Coughing or choking when eating or drinking
- Bringing food back up, sometimes through the nose
- A sensation that food is stuck in your throat or chest.
- Persistent drooling of saliva
- Being unable to chew food properly.
- A gurgly, wet-sounding voice when eating or drinking.

Over time, dysphagia can also cause symptoms such as weight loss and repeated chest infections. The Provider will ensure staff have a good understanding of Dysphagia with adequate training and will ensure individuals are supported to eat and drink safely and appropriately.

209A70AA.pdf

Dysphagia and people with learning disabilities - GOV.UK (www.gov.uk)

8.8 End of Life Care
The Provider will work within NICE's guidelines and local end of life pathways for end-of-life care to ensure that the physical, emotional, and spiritual needs of individuals are met and that they live out their lives in as dignified and peaceful a manner of their choosing.

Service delivery will be managed in accordance with "One Chance to get it Right", where possible, and individuals and their family members are involved in the assessment and planning of their End-of-Life Care. To meet the individuals wishes in the event of death, an advance Person-Centred Plan should be in place that is linked to the GP records and is clearly documented in the individual's support plans.

End of life plans that are in place for individuals with profound and multiple learning disability (PMLD) will be developed in consultation with the person, their family and any other significant or relevant person and will be kept updated on a regular basis.

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. DNACPRs should be highlighted to any medical personal who attend if individual becomes ill - anyone with capacity can agree a Do Not Resuscitate and does not necessarily need a best interest decision.

End of life care support may be provided by a number of community services (GP, District nurses, hospice etc.) to support the decisions made by the individual. A change in setting and services may be required depending on the needs of the individual.

Support workers are expected to have a good understanding of End-of-Life Care (appropriate to their role and service being provided) and will support the individual as required towards the end of their life.

Continuing Healthcare Fast Track referral can be applied for by a relevant health professional to support the individual. Should an individual receive confirmation of Continuing Healthcare Fast Track then the responsibility for their care and support arrangements will transfer to the NHS BNSSG ICB and or the host ICB where the individual's GP is registered.

8.9 Positive Behaviour Support

Positive Behavioural Support (PBS) is about values and rights for people with disabilities. It looks at why people behave the way they do. It aims to improve quality of life for individuals and the people who live and work with them.

Providers (where applicable depending on the individuals they are supporting) will take a proactive approach to supporting people with behaviours that challenge. This may include:

- Strong emphasis on person-centredness/Quality of Life
- Functional assessment
- Strong and accessible communication and planning
- Preventative rather than reactive
- Understanding behaviours (predisposing factors, presenting issues, precipitating factors, perpetuating factors, protective factors)
- Short term and long-term goals
- Multi-disciplinary
- One assessment that is enduring and reviewed (evidence of progression towards goals/reduction in incidents of behaviour of concern)
- Flexibility
- Direct involvement of individuals, family, carers, advocates, in developing responses / strategies. (Co-production)
- Behaviour assessment

- Crisis management.

UK PBS Alliance “What does good PBS look like now?”

53495B1E.pdf

Supporting people with challenging or distressed behaviour (skillsforcare.org.uk)

8.9.1 BNSSG Intensive Positive Behaviour Support Project (IPBS) – Flourishing Lives

NHS BNSSG Integrated Care Board has awarded Bristol City Council, as the lead partner in a joint project on behalf of Bristol City, North Somerset and South Gloucestershire Councils, in partnership with the ICB. This is specifically to establish and evaluate a 2-year pilot project offering Intensive Positive Behaviour Support (IPBS) to adults with Learning Disabilities / Autism, following a successful pilot for children.

- IPBS is a person centred, evidence-based framework for supporting people with learning disabilities (PWLD) and autism with behaviour that is viewed by services to challenge.
- The overall aim of Intensive Positive Behaviour Support (IPBS) is to improve the quality of a person’s life and that of the people around them. This includes children, young adults and older people.
- IPBS provides the right support for a person, their family and friends to help people lead a meaningful life and learn new skills without unnecessary restrictions. It is not simply about getting rid of what is seen to be problematic behaviour

The Pilot is due to run from 2023 to 2025. The Council will liaise with specified providers to be a part of the pilot based on the individuals they are supporting. Once the Pilot has completed any learning or useful information will be shared with the Provider on this framework to help develop the PBS support, they may provide to individuals.

8.10 Behaviours that Challenge

Some individuals with physical impairments, learning difficulties, autism, mental health diagnosis, sensory impairment 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 support workers or to the individual themselves. It is recognised that this behaviour may serve a purpose for the individual and often is a method of communication.

The Provider shall ensure the application of good practice as set out in the NICE guidance in Challenging Behaviour and Learning Disabilities prevention and interventions for individual with learning disabilities whose behaviour challenges which can be found here:

The provider shall ensure that:

- An assessment of risks will address risk to self, risk to others and risk from others.
- There are clear links between assessment of the individual's specified outcomes and associated risks and their support/risk management plans.
- Assessments balance promotion of independence with effective risk management.
- Staff should have received appropriate training (in additional to normal induction training) and competency regularly checked to enable them to safely support the individuals
- The Provider is aware of the referral route for the Community Learning Difficulties Team/Speech and Language Therapy Team and engages and supports any referrals.

The Provider shall ensure that their approach focuses on person-centred and positive support to individuals whose behaviour challenges services and ensures 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 individuals with a Learning Disability and/or Autism or poor mental health.

Behaviour support shall be planned in a way that reduces the likelihood of challenging behaviour happening, identifies early warning signs and shows how best to support individuals 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:

- bild.org.uk

- Challengingbehaviour.org.uk

The Provider shall ensure that individuals with behaviours that challenge will have a behaviour support plan which may be based on an assessment carried out by a clinical psychologist or behaviour specialist or 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 individual'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. Where interventions are used these should be evidenced by best practice and developed according to local policy as well as being clearly recorded in the individual's person-centred plan.

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 individual challenging behaviour
- A summary of the most probable reasons/antecedents underlying the individual 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.

8.11 Support to Individuals with Forensic History

Individuals 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 7.7 above.
Where applicable the provider will work collaboratively with a range of other services/agencies (such as the Police, Multi-Agency Public Protection Arrangements, Complex Health Needs Services, the Courts, Multi-Agency Risk Assessment Conference) 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 individuals 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 individual to achieve positive outcomes
- Knowledge and understanding of the criminal justice system and other agencies.

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

Individuals 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 diagnosis.

Best practice guidance for supporting individual with PMLD can be found here:

105DB77D.pdf

The Provider shall ensure that where the service supports individuals 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 specified outcomes.

Special consideration is given to individuals' communication. Staff are trained in methods of augmentative communication that best match individuals needs and abilities.

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

The Provider will ensure that staff are aware of and respond appropriately to indicators that the individual may be in pain, discomfort, or distress. This will be clearly documented in the individuals person centred plan.

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

Staff will be trained and able to safely support individuals with eating and drinking difficulties. Guidance put in place by the local Speech and Language services (or other services as applicable) will be clearly embedded in an individual's person centred plan and adhered to by staff.

8.13 Support to Individuals with Epilepsy

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

Where bespoke 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 an individual with epilepsy these are adhered to by the Provider.

8.14 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).

Oral health for adults in care homes.pdf

Oral health promotion in the com

8.15 Constipation

Individuals with Learning Disabilities have been found to be more likely to suffer from constipation than an individual without learning disabilities. Staff supporting individuals with learning disabilities should be aware that they are 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 individuals 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.

Constipation and people with learning disabilities - GOV.UK (www.gov.uk)

8.16 Screening and Immunisations

Individuals are entitled to health screenings and immunisations and should be offered these in line with national programmes. Individuals with learning disabilities and/or autism should receive an annual health check.

Where individuals receive support from the Provider to manage their physical health, they should be supported to make an informed decision about receiving these and the 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.

Health screening for people with learning disabilities | South Gloucestershire (southglos.gov.uk)

8.17 Support to Individuals as they get older

The Provider must give consideration to an individual's needs as they get older and be aware of their changing health and support needs which are a result of the individuals 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 an individual'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 – 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

The Provider should notify the allocated social worker or link officer where the placement or service model is no longer able to meet the individual's specified outcomes.

8.18 Dementia

It has been found that individuals with learning disabilities are at a greater risk of developing dementia as they get older compared with the general population. For an individual with Down's syndrome, the risk of developing dementia has been found to be 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 individuals 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.

8.19 Services for Individuals with Autism

There are particular processes and services required to achieve good outcomes for individuals with an Autism Spectrum Condition. Providers must deliver appropriate levels of staff training and awareness.

The service provider must provide:

- Detailed and specific structures and provision 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
- Bespoke training for staff to enable them to support an individual on how to support and manage their autism appropriately.

Training must provide staff with the ability to support individuals 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 an individual with autism.
- Interpreting situations, events, and concepts, into language that can be understood by an individual with an autism condition.
- Sensitivity in the recognition of anxiety levels.
- Managing and reducing challenging behaviour.
- The value of repetitive reinforcement.
- Using structure to compensate for a lack of motivation.
- The importance of an appropriate environment.

8.20 Sexual Health and Relationships
To support individuals to have access to education and information on key sexual health issues such as consent, managing emotions and parenting, and to support individuals to develop and maintain positive and healthy relationships.

9. Provider Responsibilities

9.1 Requirements
The Provider will ensure that there are sufficient staff who are appropriately trained and experienced to deliver the stated aims of the service and this specification. Staffing arrangements will be sufficient to meet specified outcomes, and the overall needs of the service.

The Provider will ensure that staff have the necessary training, personal qualities, values, and caring attitudes to enable them to relate well to individuals. The provider will conduct regular reviews of staffing levels and resources and is encouraged to complete and return the Adult Social Care Workforce Data Set (ASC-WDS), on an annual basis via this link. Providers will ensure that identification documents are checked, and that staff have the right to remain and work in the UK. The Provider will monitor staff retention rates and offer appropriate benefit packages, incentives, and training to minimise staff turnover.

9.2 Safer Recruitment

Any staff, employees or volunteers working with individuals must have the right to work in the UK under relevant immigration law undergo checks made through the Disclosure and Barring service at the appropriate level. Providers must complete these checks for all new staff and volunteers joining their organisation.

The decision rests with the employer as to whether to employ a person whose disclosure reveals a conviction or other information but must not use anyone who is on the lists of individuals considered unsuitable to work with vulnerable children, young people, or adults in the performance of the service.
The Provider must be mindful of their overarching responsibilities for the welfare of the individual who use their services, and the guidance issued by CQC/CIW (the regulatory authority) on safe recruitment practices where applicable. In the event of failure to comply with these procedures the Council reserves the right to require the employee to be withdrawn and an acceptable person substituted.

Providers must issue their own written policies covering equalities, diversity and inclusion, anti-discriminatory practice, and harassment. Recruitment and selection policies must aim to eliminate discrimination in recruitment procedures. Policies must explicitly state that providers are working towards such an approach. Policies will be in accordance with the Commission for Race Equality Code of Practice. All support workers must receive equality, diversity and inclusion training and be familiar with the above policies.

Providers will establish if gender specific staff are required when personal care is needed to meet an individual's support needs. The Provider will ensure that there are no avoidable delays in recruiting staff to key posts.

Providers will only employ 'fit and proper' staff who are able to provide support appropriate to their role. Providers must operate robust recruitment procedures, including undertaking any relevant checks. Providers must have a procedure for ongoing monitoring of staff to make sure they remain able to meet the requirements, and providers must have appropriate arrangements in place to deal with staff who are no longer fit to carry out the duties required of them.

The Provider will check and verify the employment history as set out in the requirements under regulation 19 of Health and Social Care Act 2014 2008 (Regulated Activities) Regulations 2014. Providers will encourage and support staff to access all relevant vaccinations as part of their responsibility for everyone's health and wellbeing.

Providers must obtain two references for potential employees one of which must be the current or most recent employer. Providers must check the validity of any reference by phoning to check the details provided.
Any gaps in employment must be checked.

9.2.1 Better Hiring Toolkit for Care

The free toolkit provides simplified guidance to support employers with obtaining and providing effective references and conduct information. With social care staff and

volunteers providing support for some of the most vulnerable people, the toolkit is focused upon the safety of:

- the people employers are entrusted to care for
- the staff who carry out these roles.

The Better Hiring Toolkit can be found below:
Better Hiring Toolkit (betterhiringinstitute.co.uk)

9.2.2 Recruiting Staff from Overseas

For providers who are recruiting staff from overseas to ensure staff capacity can meet service requirements, overseas staff should apply for a "Health and Care Worker visa". The Government guidelines for the Health and Care Worker Visa can be found here:

Health and Care Worker visa: Overview - GOV.UK (www.gov.uk)

9.3 Agency workers

The Provider will keep the use of agency staff to a minimum to ensure continuity of support. Where agency staff have to be used, the service is responsible for ensuring that they are fully vetted, appropriately trained about the needs of those they are supporting, and they are appropriately supervised. Where possible the Provider will use the same agency workers for consistency of support to the individual/s.

9.4 Staff and Volunteer Development and Training

All managers of the service will be suitably experienced and/or qualified in order to effectively run the service.

Where regulated services are being provided within the service the manager of the service will have registered manager status with CQC/CIW. The manager will be responsible for overall day to day management of the service will hold a QCF Level 5 Diploma in Leadership and Social Care or another recognised equivalent qualification. If the manager is new to post without an appropriate qualification, then they must be working towards their qualification within 3 months of appointment and have completed it within 2 years.

Where regulated services are not being provided within the service, the manager must have at least a level 3 qualification (and be working towards a level 5 qualification) and/or equivalent operational experience in Management, Social Care, Health settings, Education settings, and or the Voluntary/Community Sector.

Volunteers will be recruited according to the skills and ability they must perform the required tasks and will receive a full induction to the service and training will be provided to address any skills shortfall. If volunteers are providing regular direct support, then they must be DBS checked to the required level based on the support being provided and monitored/ supervised in-line with paid support staff. Clear guidance should be given to volunteers about their roles and responsibilities.

The Provider will ensure provision of a structured induction process, which is linked to National Standards (e.g., Skills for Care - Common Induction Standards), is completed by all new staff, and a basic training programme for staff or volunteers appropriate to the needs of the individual group, within an agreed period of taking up appointment.

The Provider will undertake a training needs analysis for each new member of staff or volunteer, and this will be incorporated into the staff and volunteer training and development plan which will be reviewed annually.

9.4.1 Staff and Volunteers working with Individuals with Learning Disabilities and or Autism

Where the service is supporting an individual with a Learning Disability, the support worker will complete the LD Induction Award (LDIA) or an equivalent qualification and their training needs will be assessed against the Learning Disabilities Core Skills Education and Training Framework.

Where a Provider is supporting an individual with a Learning Disability, they will reference the Core Capabilities Framework for Supporting People with a learning disability to support development and planning of the workforce and inform the design and delivery of education and training programmes.

7251EA66.pdf

Where a Provider is supporting an individual with autism, they will reference the Core Capabilities Framework for Supporting Autistic People to support development and planning of the workforce and inform the design and delivery of education and training programmes.

26258098.pdf

From 1 July 2022, all health and social care providers registered with CQC must ensure that their staff receive training in how to interact appropriately with people who have a Learning Disability and Autistic individuals, at a level appropriate to their role. This new legal requirement is introduced by the Health and Care Act 2022.

9.4.2 Oliver McGowan Training

From 1 July 2022, all health and social care providers registered with CQC must ensure that their staff receive training in how to interact appropriately with people who have a Learning Disability and Autistic individuals, at a level appropriate to their role. This new legal requirement is introduced by the Health and Care Act 2022.

South Gloucestershire Council would also expect all providers (including non-regulated providers) to ensure that their staff receive the Oliver McGowan Mandatory Training and work in compliance with the relevant code of conduct and Skills for Care Frameworks.

Oliver McGowan Training can be accessed here - The Oliver McGowan Mandatory Training on Learning Disability and Autism

9.4.3 RESTORE2 Training

Recognising when an individual's health is deteriorating is vitally important to avoid further deterioration and preventable deaths. The West of England Academic Health Science Network provides free training resources for providers on spotting signs of deteriorating health. The resources for this free training can be found here:
Free RESTORE2 training for care providers to spot deterioration

9.4.4 Mandatory Training

Staff will receive all mandatory training to carry out all aspects of their role. The need for refresher and updating training is identified at least annually and incorporated into the staff development and training programme. Where staff are required to support individuals with specific needs, they will have additional training to enable them to competently support that individual. The Provider's training programmes will be submitted to the council on an annual basis (or on request).
The Provider will ensure that all relevant staff are thoroughly compliant with the use of use of all equipment and assistive technology.

The Provider may be able to apply for Workforce Development Funding via Skills for Care to support specific training programmes as required - Workforce Development Fund (skillsforcare.org.uk).

The Provider will ensure that all staff receive supervision sessions at least every 8 weeks and have their standard of practice appraised at least annually.

The Provider will be fully responsible for costs relating to recruitment and training.

The Provider should set and ensure clear responsibilities and boundaries, so that support can be delivered appropriately, effectively, and safely. The Provider shall ensure it has in place a policy that clearly defines the boundaries and conduct of all staff and volunteers.

The Provider will have written disciplinary procedures which deal with circumstances where the behaviour or actions of an employee are considered unsatisfactory; or arrangements where such behaviour or action from volunteers needs to be dealt with in a similar way.

9.5 Safeguarding

9.5.1 Leadership and Accountability

There is clear leadership and accountability by the provider for Adult and Children's Safeguarding. The Provider will identify a named professional with lead responsibility for safeguarding adults and children. The provider will address safeguarding adults and young people as core business and central to the practice of all staff.
The Provider will ensure that there is an effective system for identifying and recording all safeguarding concerns and enquiries, including where appropriate a separate record of concerns and enquiries relating to Continuing Health Care (CHC) and young people under the age of 18 (where applicable).

The Provider will have internal quality assurance and monitoring arrangements in place to assure itself that safeguarding systems and processes are working effectively and that practices are consistent with safeguarding guidance and the Mental Capacity Act (2005) and Working Together (2015). This includes ensuring there is an effective system for monitoring complaints, adverse incidents, individuals feedback and human resource functions in order to identify any concerns indicating neglect, abuse, or harm, whether this is intentional or unintentional.
The Provider will ensure that, when a safeguarding alert or enquiry relates to their own service that the incident is immediately reported in accordance with the council's safeguarding procedures. The Provider will ensure that all its services are closely monitored for issues which may compromise the safety of vulnerable adults such as the level of needs of the individuals being supported, staffing and skill mix, team cultures and leadership capability.

The Provider will ensure that written information is available to the public and people using their services. This information describes safeguarding and how safeguarding referrals can be made and will be available at all times in all areas.

See appendix 10 for a useful flow chart on deciding if you need to raise a safeguarding concern to the local authority/Multi-Agency Safeguarding Hub (MASH). This is from the Local Government Association "Understanding what constitutes a safeguarding concern and how to support effective outcomes" framework.

Understanding what constitutes a safeguar

9.5.2 Safeguarding Adults

The Safeguarding Adults Standards are informed by legislation and guidance, most significant of which is the Care Act (2014). Providers will be expected to adhere to all new legislation and statutory guidance.

According to the Care Act, Safeguarding duties apply to:

- Any person who is aged 18 or over
- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- And is experiencing, or at risk of, abuse or neglect
- And as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

The following six principles from the Care Act apply to all settings and should inform the ways in which professionals and other staff work with adults.

- Empowerment – adults at risk are supported to make their own decisions.
- Prevention – It is better to take action before harm occurs.
- Proportionality – The least intrusive response appropriate to the risk presented.
- Protection – Support and representation for those in greatest need.
- Partnership – Local solutions through services working with their communities.
- Accountability – Accountability and transparency in delivering safeguarding.

According to the Care Act, the following categories constitute abuse (but not limited to):

- Physical abuse
- Domestic violence – this includes 'honour' based violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery (and human trafficking)
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

9.5.3 Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS).
The Provider must be able to demonstrate compliance with the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (awaiting confirmation from Government when it will apply from). The five statutory principles of the MCA (below) will underpin provider practice and decisions made for those who lack capacity.

- Every adult has the right to make their own decisions and must be presumed to have capacity unless it can be proven otherwise
- An individual must be given all practicable help to make their own decisions
- Every adult has the right to make what, to other people, may seem like unwise decisions. An unwise decision does not equate to lacking capacity
- Anything done for on behalf of somebody lacking capacity must be done in their best interests
- Anybody making a decision on behalf of somebody who lacks capacity must consider the least restrictive approach and must act in a way that least restricts the person's rights and freedom.

The Provider will ensure their MCA Policy aligns with their Safeguarding Adults Policy and all other relevant policies including research. Copies of policies will be published on the provider's website and be made available to the Council on request.

The Provider will ensure that their staff are aware of the role of an Independent Mental Capacity Advocate (IMCA), Care Act advocate, Independent Mental Health Advocate, and when the relevant advocate must be involved in decision making. All records demonstrate consideration of least restrictive treatment options in the person's best interest during the delivery support.

If restraint is used, this will be appropriate, reasonable, and proportionate to the level of risk, justifiable, respects dignity and protects human rights. Consideration of the Deprivation of Liberty Safeguards (DOLS) should be evident.

In any instances where support delivery requires restriction /restraint this is supported by a risk assessment and support plan which is regularly reviewed and includes consideration of Deprivation of Liberty Safeguards (DOLS) or Liberty Protection Safeguards when it is introduced.

9.5.4 Children's Safeguarding

The term 'child/ children' will be used in these standards to cover all children and young people up to their 18th birthday. These standards are informed by legislation and statutory guidance. All providers of services will be expected to comply with all statutory / national guidance related to safeguarding children, this includes:

- Children Act 1989.
- Children Act 2004.
- Working Together to Safeguard Children 2015.
- Care Quality Commission Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment - Health & Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13.

There are ten core Safeguarding Children Standards:

- Governance and Commitment to Safeguarding Children.
- Policy, Procedures and Guidelines.
- Appropriate Training, Skills, and Competences.
- Effective Supervision and Reflective Practice.
- Effective Multi-Agency Working.
- Reporting Safeguarding Children Serious Incidents & Incidents.
- Engaging in Serious Case Reviews.
- Safe Recruitment and Retention of Staff.
- Managing Safeguarding Children Allegations Against Members of Staff.
- Engaging Children and their Families.

It is the providers' responsibility to provide assurance that they meet the safeguarding children's standards and demonstrate that robust governance structures and systems are in place in line with Working Together to Safeguard Children 2015.

9.5.5 Adult Safeguarding Policies and Procedures

The Provider will have adult safeguarding policies and procedures which reflect The Care Act (2014) and South Gloucestershire Council's Safeguarding Adults Policy. It should be reviewed and updated every 3 years.

All Adult Safeguarding, Mental Capacity and Consent policies and procedures will be reviewed at least every 3 years and will be aligned to safeguarding legislation, national policy/guidance, local multi-agency safeguarding procedures and any host Commissioning authority safeguarding requirements.
The Provider will have a restriction and restraint policy consistent with Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health, 2014).

Provider safeguarding policies and procedures will provide staff with clear guidance on how to recognise and refer adult safeguarding concerns and all staff will have access to the guidance and know how to use it.

The provider will have an up-to-date Whistle-blowing procedure which is compliant with the Public Interest Disclosure Act 2013. This Whistle Blowing Procedure will also reference to the local multi-agency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies (for providers that work with the South Gloucestershire are neighbouring local authority area only).

9.5.6 Children's Safeguarding Policy and Procedures

The Provider will have a children's safeguarding policy and procedure where young people are supported in the service and will ensure all staff are aware of the safeguarding children's policy and any relevant guidance or procedures.
The Provider will have a Safeguarding Children Policy which is revised 3 yearly and reviewed annually to ensure continued compliance with national and local guidance.
The Provider Children's Safeguarding Policy will include information on child sexual exploitation (CSE including children associated with gangs or at risk of exploitation), female genital mutilation (FGM) domestic abuse (DA) and local escalation and reporting protocols.

The Provider will have appropriate operational procedures and/or guidance, which are in line with the Southwest Child Protection Procedures (SWCPP).
All of the procedures should make reference to and comply with the Southwest Child Protection Procedures. Links to internal procedures, Southwest Child Protection Procedures should be readily available to staff via their website.

9.5.7 Recruitment and Employment

The Provider should demonstrate that:

- Recruitment procedures protect and safeguard vulnerable adults and children and safer recruitment policies are followed.
- Safe and appropriate staffing levels are maintained.
- The recruitment policy is reviewed at least once every 3 years.
- All staff with responsibility for recruiting and interviewing staff are appropriately trained.

- Recruitment policies and practices meet the council's employment check standards for all eligible staff. This includes staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students, and trainees. This will include relevant staff having an up-to-date Disclosure and Barring Service (DBS) check and having received two written references before a person commences work with an adult with support needs.

All staff employed in professional roles must be registered with the appropriate registration body and aware of the expectation of their relevant body regarding safeguarding. Employment practices meet the requirements of the DBS and referrals are made to the DBS when necessary.

All job descriptions and employment contracts (including volunteers, agency staff and contractors) include an explicit responsibility for safeguarding adults and children.

All allegations of neglect or abuse against members of staff (including staff on fixed term contracts, temporary staff, locums, agency staff, volunteers, students, and trainees) are referred into the council's safeguarding adults or children's procedures as appropriate.

To undertake safeguarding enquiries where asked to do so including those into allegations/complaints/concerns/incidents where a member of staff may have neglected, harmed, or abused an individual.

The Provider must demonstrate they have safe recruitment procedures that protect and safeguard children in line with the Council's Safeguarding Procedures.

9.5.8 Appropriate Training, Development, and Competencies

The Provider will have a safeguarding training matrix and ensure that all staff attend safeguarding adults and children's training commensurate with their roles.
The Provider can identify the Safeguarding Adults and Children's training needs for their workforce (including volunteers, contractors, and temporary staff) and can provide evidence of all staff adult safeguarding training. This will be reported to the providers link officer as per the KPI's in section 9 of the quality assurance schedule.

All Safeguarding Adults and Children training are delivered by suitably qualified and experienced trainers and is formally evaluated. All staff are trained to appropriate levels according to their role and responsibility in line with the host local authorities' Safeguarding Adult and Children's requirements. All staff attend update training on safeguarding at least every 3 years.

The Provider will ensure that all staff are appropriately supported and supervised when undertaking any aspect of the safeguarding process. The Provider will have an induction process in place for all staff that includes a mandatory session that provides key adult and children's safeguarding /child protection information and appropriate action to take if there are concerns.

The impact of training on practice should be evaluated to determine its effectiveness. An appropriate method of evaluation should be developed. The Provider will ensure all staff have access to safeguarding supervision and reflective practice.

9.5.9 Multi-Agency Working

The Provider will:

- Ensure that all staff are aware of the need for inter-agency information sharing and adhere to information sharing protocols.
- Actively support adult safeguarding enquiries/procedures e.g., attendance by appropriate representative at strategy or planning meetings.
- Contribute to multi-agency audits, enquiries and Safeguarding Adults Reviews including producing individual management reports (IMR's) when required.
- Consider the organisational implications of any Safeguarding Adults and Children's Review to ensure that lessons are learnt, and appropriate improvements are implemented and evaluated across the providers services.
- Contribute to the LeDeR process when required.
- Effectively utilise and promote the 'passports' for all individuals with one e.g., Learning Disability passports.

9.5.10 Serious Incidents

The Provider will maintain a policy and procedure for Serious Incidents and incidents will be reported and investigated in line with the 'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation' (NRLS 2010).
Where there is an unexpected death or serious harm to an individual and abuse or neglect may be a factor, this will be referred into Adult or Children's Safeguarding procedures in addition to being reported as a Serious Incident.
The Provider must make the Council aware of any case which it considers will be in the public interest or may generate media attention.
The Provider will engage as appropriate in any Serious Case Reviews and has adopted the learning from both national and local Serious Case Reviews.

9.5.11 Managing Safeguarding Allegations against Members of Staff

The Provider must report incidents where it has been identified that a member of staff has behaved in a way that has or may have harmed an adult or young person, acted inappropriately towards an adult or young person, or committed a criminal offence against or related to an adult or young person.

The Provider must have a process in place for managing allegations; this can be included in the safeguarding adults or children policy. The Provider must have a designated officer and a deputy to whom allegations should be reported and who will support any investigation.

The Provider must ensure their designated officer reports all allegations to the designated officer for allegation (DOFA)/ local authority designated officer (LADO) as detailed in the Southwest Child Protection Procedures (SWCPPs).
The Provider must inform staff during their induction period of this policy and how to access it and report any concern.

9.5.12 Provider Responsibilities

The Provider will participate as required in local meetings to act as partners with local community care and health care purchasers to jointly deliver services.
The provider will be required to attend and participate in monitoring meetings with council representatives on request and attend provider meetings on a single and joint basis when required.

In line with Government agendas and good practice, the council is committed to the provision of outcome-based services that meet an individual's needs and enable the individuals full involvement in when and how their support is provided.
Providers will ensure staff understand, and are sensitive to, the needs of individuals from minority groups. Where necessary training will be provided to ensure support is delivered in a culturally sensitive way.

The Provider will work positively with operational staff, health and other professionals or stakeholders involved in the individual to support the individual to meet their identified outcomes.

9.5.13 Engaging with Individuals and their Carers

The Provider must be able to evidence that they have engaged with individuals and parent/carers and or person known to them about the quality and delivery of their service provision.

9.5.14 Using Audits for Quality Assurance

The Provider should develop an annual programme of audits of key policies and procedures to ensure compliance and individual's safety. For instance, 'procedures for managing individuals' money'**.** The outcomes of these should be discussed with the council authority who will carry out the monitoring and quality visit.

9.5.15 Safeguarding Adults - Multi – Agency Policy and Reporting (BANES, Bristol City, North Somerset, South Gloucestershire, and Somerset)

The Provider should produce their own guidelines that are consistent with the Multi-Agency Safeguarding Adults Policy and local area procedures. These should set out the responsibilities of staff, clear internal reporting procedures, and clear procedures for reporting to the local Safeguarding Adults process. In addition, provider organisations' internal guidelines should cover a whistleblowing policy which sets how to work within best practice as specified in contracts, how to meet the standards in the Health and Social Care Act 2008 (Health and Social Care Act 2008 (legislation.gov.uk) and the Care Quality Commission Regulations 2009 (Care Quality Commission (Registration) Regulations 2009, how to fulfil their legal obligations under statutory processes, robust recruitment arrangements, and training and supervision for staff.

Full copy of the Policy can be found here: Joint Safeguarding Adults Policy FINAL June 2016 (southglos.gov.uk)

The Multi- Agency Procedures (updated July 2019) and Process for raising concerns can be found here: Multi-Agency-Procedures-2019.pdf (southglos.gov.uk)

Do I need to raise a safeguarding concern to the local authority flow chart can be found here - Do-you-need-to-raise-a-safeguarding-concern-to-the-local-authority

If providers are unsure about raising a concern the Council's First Contact Desk can be contacted during office hours on 01454 868007 or EDT outside of office hours on 01454 867916. Or if an out of area commissioned service, then the provider would need to contact their host local authorities Safeguarding Team on their contact details found on their website.
For further information on the Councils Safeguarding Adult Board advice and guidance pages when working with Adults can be found here: I work with adults | Safeguarding South Gloucestershire Safeguarding (southglos.gov.uk)

The Provider should welcome Safeguarding Referrals and follow up action as an opportunity to improve service delivery.

9.6 Complaints and Compliments
The Provider will have a compliments and complaints procedure which is simple, well publicised and in a format accessible to all to enable individuals, or someone acting on their behalf, to make a complaint or suggestion in relation to services they receive.

Providers will establish in advance a procedure for examining individual's complaints which will meet the statutory requirements. Individuals must be informed of the means of registering a complaint. The procedure will show how complaints are dealt with, how individuals' views are taken into account, how individuals are informed of the outcome of a complaint and any timescales. Where the individual remains dissatisfied following a complaint the provider will inform the individual of the Council's complaints procedure.

Providers will maintain a log of compliments, complaints and concerns showing:

- Date compliment, complaint/concern is received.
- The nature of the compliment, complaint/concern.
- The response to the compliment and complaint/concern. (If it is a complaint a response, including timescales, should be in writing, and the date of the response letter should be included in the log, with brief details of the outcome.)
- The level of satisfaction of the complainant.

The log of complaints will be available for inspection to the Council at any time. The log of complaints and an analysis of complaints and their outcomes must be provided on request to the Council.

The Provider will collate the information from complaints annually to identify any trends which may impact on services and share the results with the commissioner on request. Evidence of learning should be made available, and any actions taken as a consequence. All staff must be aware of the complaints procedure and how to respond to a complainant. Complaints are handled promptly and courteously.

The Provider should welcome complaints and feedback as an opportunity to improve service delivery.

The Provider will ensure that copies of the original complaints and compliments, and the responses are sent to the local authorities designated officer in line with the quality assurance monitoring process.
Any serious complaints must be shared with the Council Link Officer as soon as possible (and no later than one day)
Depending on the nature of the complaint, the escalation processes in the quality assurance document will be followed as appropriate.

Complaint type	Detail		Possible escalation
High level complaints Safeguarding/Safety/Harm *(Where someone may be at risk of, or experiencing harm/abuse)*	- This type of complaint may follow the Emergency or direct escalation process within the quality assurance documents.	→	Emergency or direct
Medium level complaints *(Where clarity needs to be sought and or/action required)*	-This type of complaint may require a visit/meeting (or bringing a review meeting forward)	→	Direct
Low level complaints *(Where clarity and/or action may be required and can be checked in due course)*	-This type of complaint may require no immediate action and/or may be an item to note for the next review meeting.	→	Standard

The Council will allocate a theme to each complaint regarding a service, in line with the CQC approach to categorising complaints which we feel is a good approach to improving how we use the intelligence from concerns and complaints to better understand the quality of support; and to look at how well providers handle complaints and concerns to encourage improvement. These are:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

(Please see appendix 11 “Complaints Matter from CQC)
For further guidance around complaints please see Local Government and Social Care guidelines for complaints:
Resources for care providers - Local Government and Social Care Ombudsman

9.7 Administrative Systems

The Provider will have effective administrative systems in place that ensure the provision of good support services. Providers will have in place monitoring arrangements, agreed with the commissioners, that accurately record service inputs and outcomes delivered to individuals. Managers will appreciate the importance of effective administrative systems. The Provider will have in place effective business and financial planning, budget monitoring and financial control systems.
The Provider shall be able to directly communicate with the council by all normal business methods of communication i.e., phone and email between the hours of 08.45 – 17.00, Monday to Thursday and 08.45 – 16.30 Friday (excluding bank holidays) and the Emergency Duty Team outside of normal working hours.

9.8 Accessible Information Standard

The Care Act 2014 details specific duties for local authorities with regards to the provision of advice and information, which includes the requirement that,
“Information and advice provided under this specification must be accessible to, and proportionate to the needs of, those for whom it is being provided.”
The Standard applies to all providers of NHS and publicly funded adult social care. As such, it is a requirement that your organisation can demonstrate that it is meeting the Standard.
The Council has a responsibility to ensure that all commissioned service providers are meeting this requirement.” This section should be implemented in support of section 7.7.

9.8.1 What is the Accessible Information Standard?

The ‘Accessible Information Standard’ – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing, and meeting the information and communication support needs of patients, individuals, unpaid carers, and parents, where those needs relate to a disability, impairment, or sensory loss.

9.8.2 Who is responsible?

The Standard applies to service providers across the NHS and adult social care system. Commissioners of NHS and publicly funded adult social care must also have regard to this standard.

9.8.3 How will it be implemented?

Effective implementation will require such organisations to make changes to policy, procedure, human behaviour and, where applicable, electronic systems.

9.8.4 Why is it needed?

Successful implementation will lead to improved outcomes and experiences, and the provision of safer and more personalised services to those individuals who come

within the Standard's scope. More information can be found here - England.nhs.uk - access-info-spec.

9.9 Sustainability

South Gloucestershire 2036: A Great Place to Live and Work is the South Gloucestershire Council Sustainable Community Strategy which was updated in 2016. The values underpinning this are:

- Find simple and effective ways of working together that improve efficiency, make the most of resources and ensure value for money.
- Ensure social, economic, and environmental well–being is embedded in all decisions
- Promote a greater understanding and mutual respect between different sectors and sections of the community; empower all people to participate and become involved in decisions which affect the area
- Ensure resources are used wisely, become carbon neutral, prevent pollution and waste, and conserve and enhance the environment for future generations.

9.9.1 The Council's Procurement Strategy – Sustainability

The South Gloucestershire Council Procurement Strategy 2020 – 2023 builds on this with two key themes of:

9.9.2 Theme 2: Social Value

The Social Value Act 2012 requires the Council to "consider, prior to undertaking the procurement/commissioning process, how any services procured might improve economic, social, and environmental well-being". The Council will have a consistent, measurable and 6 best practice approach to using procurement spend to deliver broader value to our residents, the local economy, and the environment.

To measure social value, South Gloucestershire Council uses a set of targets, outcomes, and measures (TOMs) which are a National standard set by the Social Value Portal, however, the TOMs that have been selected for South Gloucestershire Council were done so by a panel from South Gloucestershire Council. They were selected from the larger list in order to meet specific Council policies and objectives.

The social value targets, outcomes and measures can be found here:

ITT Schedule__-
Social Value TOMs _

Note: Within the social value TOMS the word "Local" means within the West of England Combined Authority Area The West of England Combined Authority

9.9.3 Theme 7: Climate Emergency

In July 2019 South Gloucestershire Council declared a Climate Emergency and pledged to provide the leadership to enable South Gloucestershire to become carbon neutral by 2030. The Council also adopted a Climate Change Strategy in November 2018 which was updated to reflect targets set out in Climate Emergency declaration. The strategy's vision is: "A climate resilient South Gloucestershire with a thriving low carbon economy and lifestyle reflected in our travel, homes, businesses and

communities and where nature can flourish." The Council spends around £200m per year with suppliers and many of the services that we provide are delivered through these suppliers.

There is therefore a huge opportunity for the Council to work in partnership with providers to support the Council's Resolution and Strategy.
Target outcomes

- Spending decisions that consider and minimise whole life cycle Co2e emissions associated with the delivery of goods, works and services.
- Spending decisions that consider and improve the resilience of Council services and infrastructure, to the impacts of a changing climate.
- Suppliers, who embrace the aims of the Council's Environmental Policy, Climate Change Strategy and Climate Emergency declaration and by doing so promote higher environmental standards between businesses and other customers.

Appendices

Appendix 1

Core Values

The service will be provided in accordance with the values that are fundamental to all social care services provided or arranged by South Gloucestershire Council's People Department:

1. **Dignity and Independence:**

People should be treated with dignity and respect. Support should be personalised, enabling the person to achieve their goals and spirations. Services will be aimed at enhancing the quality of people's lives, so that they can live as independently as possible with as little intervention as possible.

2. **Participation:**

It is our aim to listen to what individuals ask for and to try to meet those requests by offering individuals choice and control wherever possible, over their own support services; it is the individual who should make decisions about every aspect of their life. Any decisions about support should be in line with the Mental Capacity Act. People should be supported to make their own decisions and, for those who lack capacity, any decision must be made in their best interests involving them as much as possible and those who know them well.

3. **Valuing People:**

We believe that the quality of social services is heavily influenced by the many staff who provide them. We believe that it is essential to recognise the right to dignity, self-esteem, safety, health, and welfare of our individuals and all those engaged to work with them.

4. **Equality and Rights:**

Services will be sensitive to the needs and wishes of individual and take into account an individual's disability, age, sex, sexual orientation, culture, race, language, or religion. The Department is working towards equal opportunities for staff as well as for individuals.

5. Local Accountability:

Wherever possible, services will be supplied, and decisions made at the most local level possible in response to local needs.

Information: Information will be made publicly available about the services which may be arranged by the council; what is possible and not possible to supply; and the ways in which help can be requested.

6. Working Together:

Those providing services will work together with all Operational Staff, Commissioners, relatives, unpaid Carers, and staff from other providers in order to deliver services more effectively and sensitively to individuals.

Agency Staff and Bank Staff:

There should be minimum reliance of agency staff but where they are used there should be consistency of workers or are specialist staff to meet an individual's assessed outcomes.

Continuity of Care:

Providers should look to promote continuity of staff to support individuals.

Appendix 2

Quality Assurance schedule

DN667265. DPS
Appendix 2 Quality As

Appendix 3

Pricing Methodology Guidance

DN667265. DPS
Appendix 3 Pricing M

Appendix 4

Tri Party Agreement for Supported Living Scheme

Tri-Party Agreement for *insert scheme address* Supported Living Scheme

This Agreement is between:

Landlord (name and address)
Support Provider (name and address)
South Gloucestershire Council

1. Purpose of the Agreement

The overall aim of the partnership is to provide people with support and service that meets their needs and enables them to progress towards the most fulfilling and independent life possible. This Agreement is intended to:

- Clarify the roles and responsibilities of the parties
- Set out working practices and expectations around access to the scheme and tenancy sustainment
- Support effective communication and relationships between the parties

2. Overview of the Scheme

Insert scheme name is a supported living scheme for people with insert description of individual's needs (for example low/moderate/high/multiple and complex needs - learning difficulties, mental health needs, autism).
The scheme has insert property description and number of units (e.g., self-contained flat suitable for one person, 3-bed shared house with each room having an ensuite-bathroom).
The scheme has 24/7 core support with one worker on site to ensure emergency and planned day time support and sleep-in night cover *change description as applicable*. The support provision is based in and operated from insert where support provision operated from, e.g., ground floor bedroom, flat within block.

When an individual moves into the scheme they will be issued by Landlord name with an assured shorthold tenancy agreement *amend as appropriate e.g., licence agreements* which will be reviewed after insert number months and can become an assured tenancy.

Enhanced housing management will be provided by the landlord insert landlord name. It will remain the responsibility of the landlord to ensure that all properties are offered to let in an acceptable and legally compliant state of repair, including up to date checks and certification.

3. Eligibility

To meet the aims and objectives of the scheme, there is a need to maintain a balanced mix of individuals. Level of need is determined by the amount of care and support hours an individual requires. The scheme is to support individuals through a journey of recovery or development to develop independent living skills and to live as independently as possible in their home and local community.

To be eligible, applicants must:

- Have funding agreed for the care and support offered at the scheme and as required by the applicant as described in their up-to-date local authority support plan.

- Have eligible care and support needs which have been assessed by the Council's Adult Care Team or 0 – 25 Team in accordance with its duties under the Care Act 2014 and set out in a local authority support plan, which will be appropriately met by the scheme.

- Understand what it means to have a tenancy and their rights and responsibilities under their tenancy agreement. If the applicant has been assessed as not being able to understand this, there needs to be a formal authorisation from the Court of Protection in place, at the time of tenancy sign-up, for a named Deputy or Power of Attorney to sign on their behalf.

As a general rule applicants whose care and support needs have been assessed as only being able to be met in residential or nursing care will not be eligible for supported living. An applicant should have mental capacity regarding their care and service needs on entry, but based medical or other professional opinion, should **not have on entry to the scheme**:

- A level of learning difficulty, physical or mental health need exceeding that which can reasonably be met by the care and support provision within a supported living environment.
- A requirement for specialist health services which cannot be provided in a community setting.
- A level of learning difficulty, physical or mental health need which is likely to cause serious disruption or risk to themselves and/or other tenants.

3.1 Assessment information

Assessment information will include:

- Up-to-date information on an applicant's personal care and support needs, full information on health, social needs, family support, any relevant issues regarding lifestyle, culture, or religion.
- Information about how care and support needs are currently being met including information from any health professionals involved in their care, paid and unpaid carers and other key professionals.
- Clear measurable outcomes including realistic achievable targets; the person's own aspirations and wishes.
- Relevant risk assessments.
- Full information about the applicant's personal financial circumstances and capabilities, including any entitlement to benefits.
- Any community equipment, adaptation, or assistive technology needs.
- If the person has an EHCP, Education colleagues to provide a report with up-to-date information:
    - The current education situation.

- Details of the planning for future provision, outcome of any local or out of county consultations, and any education funding decisions.
- Views of young person and/or family about any future education decision.
- Copy of EHCP.

4. Access to the scheme:

1. When a vacancy arises or is due to arise due to an existing tenant giving notice, the landlord must inform the Council (the HomeChoice team and the Brokerage team) and the core support provider within three working days, to give the Council the maximum time possible to nominate individuals to fill the vacancy and maximise the opportunity for consecutive tenancies.
2. Upon receipt of notice from the landlord, the Brokerage team will provide the details of an applicant to both the Landlord and the support provider within five working days. The applicant will have been assessed as potentially benefitting from a move to the scheme and be eligible to live there.
3. The Landlord will liaise with the individual's social worker to facilitate a visit to the scheme to meet both the Landlord and core support provider.
4. All Parties (the individual, the social worker, the support provider, and the Landlord) must come to an agreement on whether the scheme is suitable and meets the needs of the nominated individual.

4.1 Expectations of applicants upon acceptance to the Scheme

- A home visit will be arranged to meet the applicant and their representative to complete a 'Getting to Know You' form and to collect information relevant to the tenancy.
- 4 weeks rent to be paid in advance.
- The individual will be ready and able to sign the tenancy, or, as detailed above for formal authorisation from the Court of Protection in place for a named Deputy or Power of Attorney to sign on their behalf.
- Housing Benefit/ Universal Credit application to be well underway by the tenancy sign-up date.

4.2 Appeals and complaints

- Applicants who are not successful for the offer of a tenancy at the scheme should be contacted by the brokerage team or relevant social work team supporting their application to discuss the reasons for this and other supported living opportunities.
- Complaints relating to either housing or care & support assessments will be dealt with by South Gloucestershire's Children, Adults and Health Complaints Department.

5. Payment of core support costs

The core support provided at the scheme is 112 hours per week and 7 sleep-in nights *change as applicable*. The core support costs are split equally between

the residents at the scheme. In the event of a vacancy, the core support costs shall be split between the remaining residents at the scheme until the vacant flat is occupied.
All parties agree to work in accordance with the terms of this agreement, in line with the shared goal of delivering a responsive and high-quality service.

Signed:
Provider:
Landlord:
Council:

Appendix 5

Outcomes definitions

1. The Care Act (2014)

"Desired outcomes (of the individual): these are the outcomes a person wishes to achieve in order to lead their day-to-day life in a way that maintains or improves their wellbeing."

2. Social Care (Wales)

"Personal outcomes describe what a person wants to achieve."
"Personal outcomes are not services or resources.

Some examples of services and resources are:

- A person might attend a parenting group
- have a walk-in shower fitted
- receive a home care service
- These are the things the person does or is provided with (the inputs) to help the person to achieve their outcomes, but they are not an outcome in themselves."

Appendix 6

Brokerage Referral Process

Appendix 2 -
Brokerage Referral Pr

Appendix 7

Mental Capacity Act & Liberty Protection Safeguards Principals

Mental Capacity Act (2005)

Principle 1: A presumption of capacity
Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

Principle 2: Individuals being supported to make their own decisions
A person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

Principle 3: Unwise decisions
People have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

Principle 4: Best interests
Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

Principle 5: Less restrictive option
Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

Deprivation of Liberty Safeguards (DoLS)

- The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only.
- The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.
- Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.
- The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.
- Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation.
- There are **six assessments** which have to take place before a standard authorisation can be given.

- If a standard authorisation is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend.
- Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs).

Mental Capacity (Amendment) Act (2019) (Liberty Protection Safeguards (LPS).

The Council is still awaiting the Government to confirm when Liberty Protection Safeguards will supersede the Mental Capacity Act. Once it has been confirmed the below will be applicable.

Key changes introduced by the Liberty Protection Safeguards

1 Three assessments will form the basis of the authorisation of Liberty Protection Safeguards:

- A capacity assessment
- A 'medical assessment' to determine whether the person has a mental disorder
- A 'necessary and proportionate' assessment to determine if the arrangements are necessary to prevent harm to the person and proportionate to the likelihood and seriousness of that harm

The assessment process will be embedded into existing care planning (for example under the Care Act 2014) and it will be easier to use existing valid assessments, where reasonable and appropriate.

Local authorities and NHS bodies will be 'Responsible Bodies' under the Liberty Protection Safeguards. Responsible Bodies will organise the assessments needed under the scheme and ensure that there is sufficient evidence to justify a case for deprivation of liberty. Ultimately, the Responsible Body is responsible for authorising any deprivation of liberty in certain settings.

2. Greater involvement for families

There will be an explicit duty to consult those caring for the person and with those interested in the person's welfare. There will be an opportunity for a family member or someone else close to the person, if they are willing and able, to represent and support the person through the process as an "appropriate person". Family members or others close to the person will also be able to raise concerns throughout the process and in response to any authorisation.

3. Targeted Approach

Where it is reasonable to believe that a person would not wish to reside or receive care or treatment at the specified place, or the arrangements provide for the person to receive care or treatment apply mainly in an independent hospital, the case must be considered by an approved mental capacity professional (AMCP). This provides an additional protection.

The Responsible Body may also refer other cases to the AMCP. The AMCP can accept those referrals and consider those cases too.

The AMCP will review the information on which the Responsible Body relies, meet with the person if appropriate and practicable, and complete consultation if appropriate and practicable with:

- the person
- Anyone named by the person as someone who should be consulted
- Anyone engaged in caring for the person
- Anyone interested in the person's welfare
- Any attorney of a lasting power of attorney (LPA) or an enduring power of attorney (EPA)
- Any deputy appointed by the Court of Protection
- Any appropriate person
- Any independent mental capacity advocate (IMCA)

4. Extending the scheme to and 16 and 17-year-olds

Currently, when a 16 or 17-year-old needs to be deprived of their liberty, an application must be made to Court of Protection. Under the Liberty Protection Safeguards, Responsible Bodies can authorise the arrangements without a Court order. This will deliver more proportionate decision-making about deprivation of liberty and minimise potential distress and intrusion for young people and their families.

4.1 Extending the scheme to Domestic Settings

The Liberty Protection Safeguards will apply to individuals residing in domestic settings who need to be deprived of their liberty. Domestic settings include:

- the person's own home and family home
- Shared Lives
- Supported Living

This change ensures that all individuals who need to be deprived of their liberty will be protected under the Liberty Protection Safeguards, regardless of where they reside, without the need to go to court.

5. NHS ICBs, NHS Trusts and Local Health Boards as Responsible Bodies

The Liberty Protection Safeguards creates a new role for ICBs and NHS trusts in authorising arrangements. In England, if the arrangements are mainly taking place in an NHS hospital, in most cases the Responsible Body will be the 'hospital manager' (which in most cases will be the NHS trust responsible for that hospital).
In Wales, in most hospital cases the Responsible Body will be the local health board.
If the arrangements that result in a deprivation of liberty are being carried out mainly through NHS CHC, or the equivalent in Wales, the Responsible Body will be the relevant CCG in England or the local health board in Wales.

Appendix 8

Assistive Technology


Assistive Technology South G


Assitive Technology.pdf


Story of Difference - Echo Show (Promp


Story of Difference - Miss Ravi.pptx


Story of Difference - Security.pdf

Appendix 9

Annual Health Checks

- Learning disabilities - Annual health checks - NHS (www.nhs.uk)
- Annual health checks and people with learning disabilities - GOV.UK (www.gov.uk)
- Your Annual Health Check - what it is and why it is important. - YouTube
- Annual NHS Health Checks for people aged over 14 years with a learning disability | South Gloucestershire (southglos.gov.uk)

Hospital Passports

- Learning disabilities - Support if you are going into hospital - NHS (www.nhs.uk)
- Bristol Royal Hospital for Children | University Hospitals Bristol NHS Foundation Trust (uhbristol.nhs.uk)
- Learning Disabilities | Royal United Hospitals Bath (ruh.nhs.uk)
- Learning Disabilities (waht.nhs.uk)
- Print (gloshospitals.nhs.uk)
- My-Health-Passport-Easy-Read-v2-April-2021-Printable-Version.pdf (ghc.nhs.uk)

Autism Hospital Passport.pdf


NAS Hospital Passport - template.p

Invitation to tender

Deciding if you need to raise a safeguarding concern to the local authority/Multi-Agency Safeguarding Hub (MASH)

Appendix 10

Are you concerned that an adult is at risk of or is experiencing abuse or neglect?
What types of abuse or neglect are concerned about?
Have you had a conversation with the adult about the concerns?
Have you sought the views and wishes of the adult?*
Are there any immediate risks to the adult or to others including children?
Have you discussed and agreed next steps with the adult? *
Have you provided advice, information or signposted the adult?

a) Does the adult have needs for the care and support (whether or not the authority is meeting any of those needs) and b) Is the adult experiencing, or at risk of, abuse of neglect? Section42(1) (a) & (b) Care Act 2014

YES

If you have reasonable cause to suspect that the adult meets the criteria (a) and (b) have you discussed with the adult about raising a safeguarding concern? Does the adult wish to raise their own concerns? Do they need support to do this?

Does the adult want a safeguarding concern to be raised?

YES Raise a safeguarding concern

NO

HOWEVER raising a safeguarding concern may be justified e.g. where there is a vital risk to the person or others, where there is a public interest consideration or issue, or where a best interest decision needs to be made (where the adult lacks capacity to make the decision). Then proceed with raising a safeguarding concern. Record rationale for decision making.

UNSURE

Who else can you talk to within your organisation? Can you seek advice from others outside of your organisation or consider seeking advice from the local authority?

If the outcomes of these discussions give you reasonable cause to suspect s42(1) (a) & (b) – raise a safeguarding concern to the local authority/MASH.

If you have enough reasonable cause to suspect (b) but you are still unsure about (a), raise an adult safeguarding concern. The local authority information gathering responses, under s42(1) will help make a decision.

YES Raise a safeguarding concern

NO

If the concerns are not (a) and (b) what further support, advice, information or signposting can you offer the adult?

*There may be circumstances where the safety of the adult or yourself prevent this from happening. If you still have concerns about abuse or neglect and it is not possible or within the scope of your role to have a conversation with the adult, then if in doubt continue with the process and raise a safeguarding concern.

Appendix 11

Complaints Matter (CQC)

CQC Complaints Matter.pdf