A. SERVICE SPECIFICATION

Service	**OUTCOMES BASED CARE SUPPORT AND ENABLEMENT**
Authority Lead	**NOTTINGHAM CITY COUNCIL AND NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP**
Period	The anticipated start date for the contract is from 1st March 2018 onwards – 28th February 2023. (With provision to extend for 4 Years)
Summary of Service	Care Support and Enablement provides Outreach and Accommodation based services for citizens with a range of disabilities and/or complex needs. Citizens who are eligible for Nottingham City Council Social Care, Joint Funded packages of care (Inc. S117 Aftercare) or NHS Continuing Healthcare (*see Appendix A: NHS Funded Care – Supported Living)*, will be enabled to achieve "Progression" and "Recovery" outcomes and increase their ability to live independently in the community.

1 Background and Context

1.1 National / Local context

Nottingham City Council currently provides a range of care and support to vulnerable adults in a variety of ways. Care Support and Enablement (CSE) is one of those key quality services that is available. The principle of a life independent of services and social care intervention is better than a life dependant on statutory support is being embedded across the Adult Social Care system.

Our ambition is to enable service users to maximise their independence, to realize quality of life outcomes and for services to deliver value for money. Outcomes focused services will be commissioned and designed to support personalisation:

- For citizens with mental health needs this will be based on a ***"Recovery"*** outcomes model, which will aim to provide a time-limited intervention.
- For other citizens whose needs are likely to be more permanent, such as citizens with learning disabilities, the model will be based on ***"Progression"*** outcomes.

Care Support and Enablement is care and support delivered in services users' homes or in the community. Services are defined as:

- **Outreach**
  Provides a single person with support for their daily living activities and to access community services in line with the social model of disability (without night cover).

- **Accommodation Based**
  Provides a single and shared person service with night cover. Staff are required to be on-site either during the day/night or both or have access to a 24 hour on-call service.

Providers will be required to have the specialist skills and knowledge to meet the needs of the following service user groups, who are eligible for the Council's social care services and NHS joint funded packages of care as outlined in Appendix A:

1. Adults with physical and sensory impairments, some of whom also have an acquired brain injury/cognitive impairment *(hyperlink)*
2. Adults with mental health needs. *(hyperlink)*
3. Adults with learning disability *(hyperlink)*
4. Adults with autism *(hyperlink)*
5. A small number of citizens, mainly with a learning disability and/or autism, with very high needs, who challenge services due to complex care needs.

The following link provides further information about the needs of each group: Joint Strategic Needs Assessments for Nottingham City. *(hyperlink)*

There are also a number of statutory requirements, guidance and best practice; Providers are required to meet them all in order to support the delivery of high quality services including, but not limited to:

- Care Act 2014.
- Health and Care Act 2012.
- NHS Five Year Forward View 2014.
- Care Standards Act 2000.
- Care Quality Commission National Standards.
- Mental Capacity Act, 2007.
- Safeguarding Vulnerable Adults Act 2006
- Transforming care: A national response to Winterbourne View Hospital, 2012 – key national organisations made a commitment to challenge the way services were being commissioned and delivered.
- See also the National Transforming Care Plan, the National Service Model and Building the Right Support October 2015.
- The Equality Act 2010.

In addition, all Providers are required to be in support of the Dignity in Care Campaign led by the Social Care Institute for Excellence.

The Care Act 2014

Under the Care Act, local authorities have responsibilities which include ensuring that citizens who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs.
- Can get the information and advice they need to make good decisions about care and support.
- Have a range of provision of high quality, appropriate services to choose from.

- Have access to information and advice about services in a range of formats.
- Have an individual care plan to meet their needs.
- Have access to a personal budget, via a direct payment, if they require one.
- Have access to advocacy if they do not feel able to adequately express their views.

Additionally, the Act gives local authorities responsibilities to assess carers' needs and to put in place a care plan to meet identified needs.

The Care Act 2014 legislates to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent citizens developing needs for care and support or delay people deteriorating such that they would need more acute and ongoing care and support or be admitted to hospital.

Integrated Personal Commissioning

Integrated Personal Commissioning (IPC) is a partnership programme between NHS England and the Local Government Association. It is a pillar of the NHS Five Year Forward View, and supports the improvement, integration and personalisation of services, building on learning from personal budgets in social care and progress with personal health budgets.

Through IPC, individuals, their carers and families can take an active role in their health and wellbeing, with greater choice and control over the care they need through personalised care planning and personal budgets.

Alongside this, IPC also supports citizens to develop their knowledge, skills and confidence to self-manage their care, through stronger partnerships with the voluntary and community sector, community capacity building and peer support.

ASCOF

The Adult Social Care Outcomes Framework (ASCOF) for 2016/17 will be used to provide local priority setting and care and support service outcomes, focusing on four domains:

1. Enhancing quality of life for citizens with care and support needs.
2. Delaying and reducing the need for care and support.
3. Ensuring that citizens have a positive experience of care.
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

Nottinghamshire Sustainability and Transformation Partnership

The Nottinghamshire Sustainability and Transformation Plan 2016-21 details the joint approach to the delivery of health and social care provision over the next five years across all of Nottinghamshire, including Nottingham City. It outlines five high impact areas which are:

1. Promote wellbeing, prevention, independence and self-care.
2. Strengthen primary, community, social care and carer services.
3. Simplify and improve urgent and emergency care.
4. Deliver technology enabled care.
5. Ensure consistent, evidence-based pathways in planned care.

A key focus of the plan is to shift provision from the acute sector to the community. The delivery of timely and effective Care Support and Enablement is key to this approach.

The focus of delivery in Nottingham will be via the Greater Nottingham Partnership which incorporates Nottingham City and South Nottinghamshire supporting a unified approach to delivery of services across this footprint.

Nottingham Plan to 2020

The following highlights our key priorities:

- Create neighbourhoods in which citizens want to live.
- Support families in helping their children realise their potential.
- Enable citizen to access employment.
- Make Nottingham a safer place.
- Help citizens to be healthier (including improving mental health).

NHS Nottingham City Clinical Commissioning Group Business Plan 2017-19

NHS Nottingham City Clinical Commissioning Group (CCG) is committed to achieving its ambition through:

- Prevention of avoidable illness through the identification of citizens at high risk of poor health and targeted advice to support lifestyle changes.
- Providing quicker access to diagnosis and treatment, which will provide better detection of symptoms and earlier diagnosis. The aim is to improve access to services and provide an integrated approach to mental and physical health.
- To support self-care and empower citizens using services to manage their own health needs through improved provision of information, advice and education, increased personal health budgets and better use of technology.

Along with reducing health inequalities another key ambition is to improve the number of years citizens in Nottingham live in good health. This will be accomplished through commissioning effective services and empowering citizens using services to take responsibility to improve their own health. This will have a positive impact in improving the lives of the citizens using services in Nottingham, *(including citizens who access Northeast, Northwest and Rushcliffe CCG services)* and help NHS Nottingham City CCG maintain sustainable services into the future through reducing demand for NHS services.

2 Key Service Outcomes

2.1 Vision

Nottingham City's vision and approach to commissioning and delivery of adult services has shifted from residential services to increasing supported living environments and options. The focus is for individuals to maximise their independence through the achievement of outcomes, enabling them to live their life of choice fully in the community.

CSE forms part of the Adult Social Care strategy and pathway of enabling support, empowering people to live a fulfilling and rewarding life.

Nottingham City therefore wants to establish an Approved Accredited Provider list, of Providers who are innovative and want to work proactively to deliver effective, efficient and affordable CSE services.

Central to the vision for CSE is to provide high quality personalised services that encourages self-management, prevents future escalation, focuses on increasing and strengthening skills, utilising appropriate tools and resources to achieve quality of life outcomes. Successful Providers will challenge how people are supported.

- For citizens with mental health needs this will be based on a *"Recovery"* outcomes model, which will aim to provide a time-limited intervention.
- For other citizens whose needs are likely to be more permanent, such as citizens with learning disabilities, the model will be based on *"Progression"* outcomes.

This new approach will enable Providers to offer person-centred support, whilst being able to creatively deliver flexible, responsive services that are solution focused, efficient and cost effective. E.g. Working in partnership across sites to share staff for shared activities, or for the provision of night time support. *(see para 3.3.9)*

CSE will enable people to:

1. Manage and maintain their known needs;
2. Transition from an unsettled residence to a settled place in the community;
3. Access to contribute and participate in their local community;
4. Develop and strengthen their skills and knowledge to be self-sustaining, this includes where there is capacity to learn new skills;

5. Proactively identify life changes early and develop strategies to meet the needs;
6. Access mainstream services and local community and leisure services;
7. Exercise their rights of the Equality Act and transform services, individuals, staff, systems and processes.

Please note that where any of the current Service Providers are successful in tendering for this Accredited Provider list, there is no intention to award any of their existing business to an alternative Provider. However, where any Service Providers are unsuccessful, the Council will work with the service user(s) to understand the options available to them, which may result in choosing a different Provider from the Accredited Provider List.

2.1.1 New Accommodation based projects (Schemes)

Enabling citizens to live in settled accommodation with their own tenancy augments Nottingham City's vision to maximise independence. It is envisaged new supported living accommodation will continue to be required to support the delivery of CSE.

Nottingham City want to work with property developers, and/or CSE Providers who can work with housing partners to develop new supported living accommodation.

2.1.2 Personalisation

Nottingham City is committed to enabling service users to have choice and control and for services to be tailored to meet their needs, rather than delivered in a one-size-fits-all fashion. Service users will be supported to plan their services utilising:

2.1.3 Direct Payments/Personal Health Budgets

Direct Payments have been available to adults for 20 years. Successive governments have promoted the use of Direct Payments for service users. Providers will support service users to use their Direct Payments on services that they may provide.

NHS Nottingham City CCG provides personal health budgets and is working with Nottingham City Council to jointly fund packages of care. This may also be via a Direct Payment.

2.1.4 Individual Service Funds (ISF)

In accordance with the Care Act 2014, Nottingham City Council aims to make the offer of Individual Service Funds (ISF) a reality. An Individual Service Fund enables people to have control over their personal budget (PB) and their support without the responsibility of managing the money themselves. The Service Provider agrees to manage the personal budget on the person's behalf and to only spend it in the way agreed and described in their Support Plan. It does not go into a pooled budget unless this is agreed as part of a shared funding arrangement. An ISF allows service users (family/carers/advocates as appropriate) greater choice and control over the support provided and a transparent relationship with their Service Provider. It offers the potential for people's budgets to be used more flexibly, to see how their money is spent and decide how any surplus is used.

A pilot is currently underway and Nottingham City Council will expect Providers to work in partnership to support this initiative moving forward. Further information on this initiative will be shared with Providers during the life of this contract.

2.2 Core Operational Principles of Care Support & Enablement

The core principle of CSE is to provide a holistic supported living environment for service users, but is not a prescriptive model of service design and can look very different for different people.

CSE provides the tools and resources for service users to live their chosen lifestyles. Providers will enable service users to increase their independence and remain able to live within their communities by developing existing skills or acquiring new living skills, through appropriate risk taking, increasing their opportunities for education and employment, and ultimately to meet their desired outcomes as detailed within their ***Individual Support Plan*** and ***Person Centred plan***.

Providers are required to develop resilience, identify prevention and early intervention and make them central within the following principles:

a) Secure tenure and tenancy

Nottingham City Council is committed to ensuring service users have security of tenure/residence in their usual accommodation in the medium to long term. CSE services will be commissioned independently to accommodation.

Current providers who become accredited, who are also the landlord must note Nottingham City's preferred commissioning model, and intention; however, the focus will be to ensure the service user retains their tenancy.

If a CSE service is not well-matched for the service user, the Care Manager will work with the Provider to resolve the issue before a decision is made to replace the CSE support Provider. There is the potential for shared accommodation to have multiple providers. Providers are required to work in partnership and ensure service users receive a smooth, efficient service.

b) The individual is at the centre of service planning

Service principles are required to be based on a person-centred approach and include:

- Rights
- Independence
- Choice
- Inclusion

This includes all the rights associated with 'ordinary living' including the right for service users to follow their chosen lifestyles, communication, health plans etc.

Individual Support Plans will be developed collaboratively with the service user and capture care and support needs and projected outcomes, using accessible communication tools.

c) Individual skills are maximised

Recovery/Progressive outcome focused assessments will be used to identify service users' goals, aspirations, and accountable/SMART outcomes. Individual goals will include the ability to develop and acquire the skills, knowledge, take responsibility and increase confidence and financial situation, so they can live as independently as possible.

d) Individuals are supported to live a fulfilling life, experience new opportunities through an approach which both manages risk and utilises appropriate risk taking

Service users' opportunities and choices will be maximised, and Providers will support individuals to develop confidence and skill in making choices.

- For citizens with mental health needs this will be based on a ***"Recovery"*** outcomes model, which will aim to provide a time-limited intervention.
- For other citizens whose needs are likely to be more permanent, such as citizens with learning disabilities, the model will be based on ***"Progression"*** outcomes.

Service users must have choice regarding their living arrangements and life-style. They will have autonomy within their own household, creating their own atmosphere and sense of ownership.

With choice, there will be some increased actual or perceived risks. Providers must recognise that appropriate risk taking is an intrinsic aspect of independent living and that service users should be empowered to take well informed risks that will provide opportunity for the service user to learn, grow and develop skills that will enhance their independence and widen their opportunities.

Robust risk assessment and management plans will be integral to support planning processes. Staff will work with service users to identify potential risks and agree ways of minimising them.

Service users will be enabled to access independent advocacy if needed to assist them in making choices.

e) Recognising and nurturing relationships
Service users are to be supported to develop a variety of relationships, including maintaining current relationships that are appropriate and acceptable to the individual. Providers need to be attuned to a service user's need for socialisation and be proactive in facilitating this where appropriate. This includes respecting and recognising the important role carers and families make and ensuring their views are considered.

f) Good quality of life achieved through a focus on Health and Wellbeing
The service will promote the physical and mental health of service users offering emotional support and enabling citizens to develop personal resources to deal with life changes, stresses and crises. The following objectives must be considered within the outcomes based model of recovery or progression within the ISP:

- Meeting the service user's mental and physical health, social, personal and cultural needs as identified through the NHS continuing healthcare or mental health after-care process;
- Providing services that take into account the service user's mental capacity and their personal circumstances, e.g. safeguarding issues with relatives and carers;
- Ensuring that service users are supported so that they are able to access local health and social care services, where this is identified as appropriate to their needs;
- Ensuring that Service user's mobility is optimised, within a risk assessed framework;
- Providing a range of treatment and care, to promote, maximise, and wherever possible, sustain quality of life for service users;
- Providing access to social, occupational, vocational and meaningful activities as appropriate, in line with the service user's care needs, and which enhances the quality of their lives.

g) Respect and dignity
The service will work in ways that enable service users to develop self-respect and feel valued members of the community.

h) Privacy
Providers will respect a service user's right to privacy and confidentiality.

i) Equalities and Diversity

Providers are required to be proactive in meeting the statutory requirements of the Equalities Act 2010 to ensure both organisational practice and service delivery is run in a non-discriminatory manner that recognises the value of diverse staffing and service user profiles.

Support will be tailored to the religious, cultural and ethnic needs of the service user, and supported to develop an understanding and appreciation of their personal and wider history and heritage.

j) Social Value
Services are required to contribute to the wider community to assist in the development of the economic, social, and environmental wellbeing of the local area.

2.3 Sustainability

Providers are encouraged to deliver services in line with the principles in The Nottingham Business Charter to '*Be Environmentally Responsible'*.

The Provider should actively consider how delivery of CSE services will be more sustainable. This should include:

- Sourcing supplies locally.
- Setting up plans to better facilitate walking, cycling or the use of public transport, as opposed to cars.
- Encouraging staff to use more sustainable transport and offering training, safety awareness and information in this regard. http://www.ridewise.org.uk/ride/
- Exploring options to offer a 'Cycle to Work' scheme for staff to purchase bikes through salary sacrifice.
- Giving staff information in relation to Citycard cycle hire.
- Taking all reasonable steps to minimise any adverse impacts on the environment.
- Demonstrating progress on climate change adaptation, mitigation and sustainable development, including performance against carbon reduction management plans.

3 Scope

3.1 Aim

The aim of Care Support and Enablement services are to:

- Achieve "progression" and "recovery" person centred outcomes;
- Promote and maximise service users' independence;
- Support good value for money.

CSE service providers will be required to work with service users who live in supported living settings to develop existing skills, and acquire new skills. Activity must be delivered with service users, *(not for them)* as indicated in their Individual Support Plan (ISP).

Providers will be required to have the specialist skills, and demonstrate sound knowledge to deliver outcomes based CSE service/s to service users who are aged 18 years and over, live in a supported living setting or have an ordinary residence in Nottingham City or Nottinghamshire county boundary. Service users will be eligible for social care services and will be registered with a Nottingham City or Nottinghamshire County GP (including Northwest, Northeast, Rushcliffe CCG's) who meet the eligibility criteria for NHS continuing healthcare with one or more of the following needs:

1. Adults with Physical and Sensory Impairments, some of whom also have an acquired brain injury/cognitive impairment
2. Adults with Mental Health needs.
3. Adults with Learning Disability
4. Adults with Autism
5. A small number of citizens, mainly with a learning disability and/or autism, with very high needs, who challenge services due to complex care needs.

In addition, providers will be required to cater for citizens using services who may have a combination of the above needs.

Delivery of a seamless transition for young people between 16 years and 18 years old from children's to adult's services will be required. Accredited Providers where agreed by the Adult Social Care team will be required to deliver an appropriate service to young people prior to them reaching 18 years. This approach will enable young people to commence identifying and achieving progression or recovery outcomes to maximize their independence.

3.2 Service Description / Pathway

Accredited Providers will be commissioned to deliver Outcomes based *(recovery and progression outcomes)* Care Support and Enablement consisting of 4 Lots:

a) Outreach (Lot 1)
Provides a single person with support for their daily living activities and to access community services in line with the social model of disability *(without night cover).*

b) Enhanced Outreach (Lot 2)
As per Lot 1 - The following criteria must also be met for services to be deemed Enhanced Outreach services:

- Any citizen requiring a specialist communication such as British Sign Language (minimum Level 2, preferably Level 3), Makaton or Deafblind Manual/Block in order to achieve their outcomes and goals.

c) Accommodation based services (Lot 3)
Provides a single and shared person service with night cover and staff are required to be on-site either during the day/night or both or have access to a 24 hour on-call service. Outcomes based CSE will be linked to the management of Accommodation based services; there is also a requirement for Shared services to be flexible and responsive to meet person-centred individual needs within the pricing envelope.

d) Enhanced Accommodation based services (Lot 4)
As above for Lot 3, and all of the following criteria must be met for services to be deemed Enhanced:

Individual Requirements	Service Requirements
1. Individual has a primary support need and additional complexities that challenge the physical, environment and social requirements of a service. This could have resulted in the property requiring specialist adaptation; *or in having to regularly purchase new equipment or undertake repairs.* 2. Following a Positive Behaviour Support Restraint programme, two or more carers are required. 3. Risk Assessments must be evidenced within the ISP/Care and Support Plan and clearly outline the mitigating plan with additional costs, which would support the enhanced rate being considered. *(ASC Panel will need to verify this is above the standard requirement.)*	1. Joint funded Packages where Health contribute 50% or over. 2. Identified support workers working with the service user receive Specialist Behaviour Support training and supervision, *(which is updated annually)* 3. This training will be evidenced in the service user's Individual Positive Behaviour Support Plan, which identifies key specialities requiring specific training/refresher training and achieved outcomes. 4. Staff receive Positive Behaviour and Active Support case supervision, relevant to a service user, to support service risk management, manage and reduce anxiety and high staff turnover.

3.3 Service Delivery

Accredited Providers will offer person-centred support that is dynamic and creative to service users who live or have an ordinary residence in Nottingham City or Nottinghamshire County boundary and eligible to the services as outlined at 3.2 enabling them to maximise their independence.

Within these settings Providers are required to demonstrate that they are:

- Proactive in problem solving;
- Engaging with multi-disciplinary teams including psychologists'/Community teams/psychiatric support
- Monitoring patterns of behaviour and take early intervention and preventative action, through engaging with Health and Social Care managers as appropriate;
- Brokering the right support to build resilience and maintain independence;
- Identifying when to seek Health and Social Care input and interventions for services and support that have been brokered;
- Setting goals that enable an individual to be more independent and have a fulfilling life.

- Operating from a holistic, person-centred perspective.

3.3.1 Supporting a service user in their own home and in the Community

The Provider will deliver the following activities, as determined by service users' Individual Support Plan and Person Centred Plan. *The following requirements will be applicable to the delivery of all CSE Services:*

Support Activities

Providers are required to deliver the following activities with the service user not for them, unless otherwise indicated in their Individual Support Plan: *(see Appendix 1 for a full outline)*

a) Practical daily support
b) Personal care
c) Support in healthcare
d) Management of Challenging Behaviour
e) Positive Behaviour Support/Active Support
f) Risk management
g) The management of physical Interventions
h) Management of money
i) Engagement and access with the local community and mainstream services
j) Transport and travelling
k) Waking nights

3.3.2 Individual "Recovery" and "Progression" Services/Outcomes

Fundamental to the delivery of CSE services is an outcome based model, outcomes are the impacts or end results of services on a person's life.

Outcomes focussed services will be commissioned and designed to support personalisation:

- For citizens with mental health needs this will be based on a ***"Recovery"*** outcomes model, which will aim to provide a time-limited intervention.
- For other citizens whose needs are likely to be more permanent, such as citizens with learning disabilities, the model will be based on ***"Progression"*** outcomes.

Appendix 2 provides an outline of the roles and responsibilities and performance targets. (*See Appendix 2 Outcomes Model)*

In line with the Care Act 2014, outcome focussed services must promote the individuals well-being in relation to their:

- Personal dignity (including treating the individual with respect);
- Physical and mental health and emotional well-being;
- Protection from abuse and neglect;
- Control over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
- Participation in work, education, training or recreation;
- Social and economic well-being;

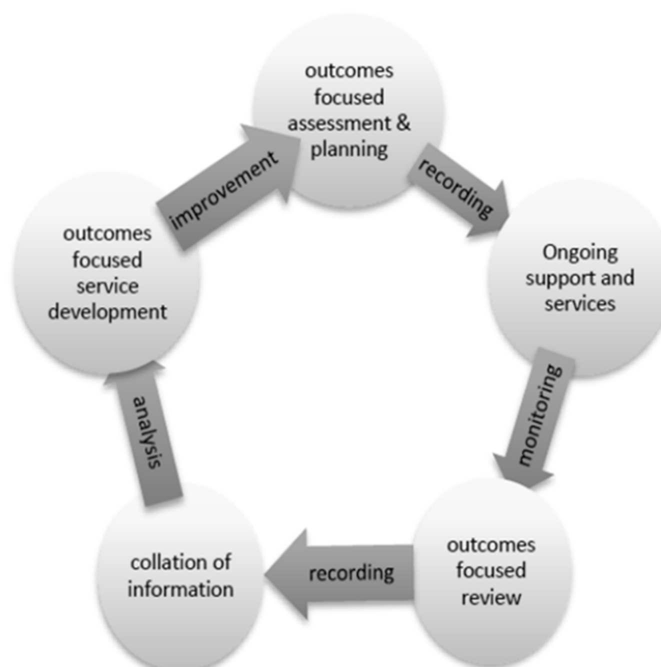
- Domestic, family and personal relationships;
- The suitability of their living accommodation;
- Contribution to society.

The **NHS Outcomes Framework Domains & Indicators** are:

Domain 1	Preventing people from dying prematurely	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in a safe environment and protecting them from avoidable harm**	**X**

This approach represents a shift in the relationship between the Commissioners, the Service Provider and the service user. The roles, responsibilities and activities require an outcome focused approach built on a foundation of trust and strengthened through working in partnership, good communications and engagement.

See diagram below:



'Outcome focused' means putting the person at the centre, identifying what is important in their life, ensuring that everyone is working together to achieve the same purpose of maximising the person's independence and quality of life.

'Personal outcomes' is a way of describing what matters to the service user, and an outcomes focused plan is the written record, setting out what the service user is aiming for, and the actions required to achieve the outcomes.

An outcome based Support Planning and Recording and Tracking system is crucial to realising the impact of services for service users, also for analysis for service improvement.

3.3.3 24/7 Tool

Nottingham City Council uses a Care and Support Planning Tool called 24/7 Grid which provides citizens with a clear understanding of how their Personal Budget is being used. It will be a requirement that Providers will be able to work with this tool as part of ensuring a Person Centred Strengths Based approach. Work will be undertaken with Providers to support this new approach.

3.3.4 Outcomes-Based Measurement Tool

Providers will be required to use an evidenced based tool e.g. Outcome STAR, capable of setting, tracking and measuring impact and change required for services to achieve “recovery” and “progression” outcomes.

Outcomes measurement tools will be accessible, have the capacity to support service users to be central and engaged with setting, measuring and celebrating their quality of life goals and achievements as agreed in the Individual Support Plans.

3.3.5 Recognising the Importance of Carers and Family Members

Providers must aim for services to engage and consult with carers and family members, whilst ensuring the respect for the service users right to choose who is and isn’t involved in their day to day service delivery.

The role and responsibility of all agencies involved in the service user’s support (for example health professionals, Local Authorities and the Service Provider) should be clearly recorded in Support Plans.

In addition, service configuration, hours of service delivery, the use of any shared hours and any change to such matters should be fully explained to carers and family members as appropriate.

3.3.6 Individual Support Planning and Risk Assessments

Following an assessment and determination of eligibility in line with the Care Act, the Adult Social Care team will develop a Care and Support Plan that will be outcomes focused. The Plan will detail the identified needs and how the needs will be met, and will state the outcomes that the service user wishes to achieve in day-to-day life as identified in the assessment process. Their aspirational wellbeing, what the service user wants to change to increase their independence and quality of life should also be recorded.

The Provider shall conduct a needs and risk assessment on each individual, this shall include a fire risk assessment. Any decision taken by the Provider precluding a service user being involved in an activity due to a perceived risk shall be clearly documented and justified.

Support planning documentation will include Health Action Plans and will identify professionals involved and the frequency of their inputs / support. It will focus on improving a service user’s health, personal development and social wellbeing.

The Provider will help to build a healthy professional relationship between the care workers and the service user, supported by a robust key worker system to support person centred planning. Specific plans relating to enhanced needs and personal development will specify the inputs and interventions of different staff members and multi-disciplinary team professionals to support positive outcomes for individuals.

The Provider will be required to develop and maintain Individual Support Planning documentation, which will include person-centred information in relation to assessments including:

- Needs to be met;
- Health Action Plan;
- Risk Assessments;
- Positive Behaviour plan or equivalent;
- Outcomes Plan – outlining how SMART progression and recovery outcomes will be achieved;
- Daily living routines/choices/preferences.

Once all assessments are complete the Service Provider will ensure all areas of need and support along with outcome expectations are part of the Individual Support Planning documentation, and outline:

- The activities to be undertaken by support workers;
- When they shall be carried out?
- Who shall carry them out?

A Person Centred Approach with expertise in Person Centred Planning (PCP) is mandatory to ensure service users' wishes and preferences are recorded and supported.

All assessments and development of Support Plans will involve and be agreed by the service user, their family as appropriate and where appointed, independent advocates / Independent Mental Capacity Advisor (IMCA). The written documentation will be made available in accessible format and use the chosen communication method of the individual.

Individual Support Plans and Person Centred Plans must be reviewed continuously as a mainstream process, with involvement of the individual's circle of support, as a minimum on an annual basis and with a minimum of six monthly interim reviews. Any changes must be clearly recorded.

Individual Service Plans will have a named officer of the Service Provider, with delegated responsibility to be accountable for liaison and communication with the Adult Social Care team, and to lead on the achievement of desired outcomes during the periods between reviews.

3.3.7 Managing Challenging Behaviour

The Provider must have a policy that takes account of all relevant legislation and guidance and good practice, to positively engage and support service users who show any behaviour that challenges. This policy will take account of all relevant legislation, guidance and good practice including the Human Rights Act 1998, and the Mental Capacity Act 2005.

Behaviours that challenge must be considered in terms of the way the service is delivered, the context of the environment in which it occurs, and the needs of the service user. The Provider will ensure that the service is delivered in such a way, to provide sufficient structure and consistency to promote an environment, which supports positive behaviour.

The service user should have an individualised plan, which sets out both proactive and reactive strategies to manage challenging behaviours. Best practice dictates this should be framed within a behavioural model; and written with the advice of a specialist practitioner in the field of challenging behaviour.

All incidents of physical intervention used within the organisation must be formally recorded.

Concerns regarding ongoing disruptive behaviour, or risks to the service user or others, a high incidence of physical intervention being used with an individual, should be brought to the attention of the Adult Social Care team and discussed with the appropriate professionals.

Service users who exhibit severe challenging behaviour must be referred to their social worker and/or community care coordinator who may refer them to the Intensive Community Crisis Assessment and Treatment Team (ICATT) if appropriate for a review of their challenging behaviour management strategy.
Discontinuation of the service will occur if all other demonstrable efforts to resolve issues have been unsuccessful. The Service Provider and Commissioner will work together to take steps to resolve issues as and when they arise; however the Commissioner will have the final say in whether or not the individual's needs can continue to be met in the environment.

Where an individual exhibits behaviour that cannot be managed in such a way as to safeguard them or other individuals the Provider may need to access emergency support as available under the Mental Health Act. The provider is expected to demonstrate a sound and current working knowledge of this Act. *(See Appendix 1 Care Activities d-g Management of Challenging Behaviour.)*

3.3.7.1 Positive Behaviour Support/Active Support

PBS is a framework for developing an understanding of behaviour that challenges, rather than a single therapeutic approach, treatment or philosophy. It is based on an assessment of the broad social, physical and individual context in which the behaviour occurs, and uses this information to develop interventions. The overall goal of PBS is to improve the person's quality of life and of those around them, thus reducing the likelihood of challenging behaviour occurring in the first place. The framework is made up of ten core elements (Gore et al. 2013) each of which should be included and visible if a service is providing PBS.

The PBS framework is a key quality driver for services being commissioned as part of the Transforming Care partnership.

3.3.8 Flexibility in Service Delivery (inc Banking of Hours)

The Provider will be required to ensure that the service can be delivered with flexibility.

The Provider will be required to ensure that the total number of hours commissioned for service users each week are utilised in a way that ensures that services are in accordance with their Support Plan. However, following approval from the Care Manager the way the service is provided can be varied by the Provider as per the individual's needs that particular week. In doing so, this will allow greater flexibility in allowing more hours one week and less hours another week, for example banking hours to support service users to go on a holiday. Where hours are purposefully banked, the reason and extent of this should be given to carers and family members as appropriate.

A record must be retained for service auditing/reviewing purposes.

3.3.9 Night-time Support, On-call Arrangements and Emergencies *(including Waking Nights)*

In all cases 24 hours a day support is required to ensure there is capacity to meet the needs of service users. This may incorporate the appropriate use of an on-call provision (24 hours a day, 7 days per week including weekends and Bank Holidays) ensuring management support is available for Staff.

a) <u>Waking Night</u>

A waking-night service will require the employee to be awake for the duration of the shift. This will be paid at the hourly rate specified within the Pricing Schedule. No additional

payment will be made by the Council should a service user require assistance during the night.

Night time support will generally cover the hours of 10:00pm until 8:00am (*minimum of 8 - hours)* unless specified within an individual's support plan.

Sleep—Ins in the old contract will be eliminated, Nottingham City Council will work with providers to find alternative solutions.

- *Providers are encouraged to look at creative solutions for night-time cover across services. Overnight support may be shared between multiple service users, schemes and locations. The onus will be on the Provider to ensure this model of delivery is safe and must be agreed with the Care Manager in advance.*

On call solutions may need the Provider to involve other professionals such as Health Workers or the Emergency Duty Social Work Team ***(0115 876 1000)****.*

The Provider will be required to note patterns of on-call need for individuals and to discuss with the Care Manager whether this indicates a need to adjust normal commissioned hours for the service user.

3.3.10 One to One Support
Nottingham City Council and/or NHS Nottingham City CCG may commission one to one support for service users following an assessment of need by the service user's Social Worker and / or Nurse Assessor.

One to one support is defined as one appropriately trained and competent member of staff to one service user for a specified number of hours each day or specified days. The member of staff is required to keep the individual within sight at all times and have an awareness of any risks identified in the Care/Support Plan.

The member of staff should not be responsible for any other service user or be engaged with any other tasks in the home during the specified time. There should be cover provided when the member of staff is on a break so that the individual is always supported by one member of staff within the specified times. Where possible there will be consistency of staff providing the one to one support.

One to one support can be commissioned to support a service user to manage behaviours through engagement and to enable the service user to improve their life skills and support independence this could be within the home environment or in the community. Any identified outcomes from one to one support must be clearly recorded in the service users Care/Support Plan.

All one to one support that is delivered must be recorded in full and be in line with the service user's needs identified in their Care/Support Plan. This must include any episodes of behaviour that challenges, what were the triggers and how this was managed along with any identified outcomes that have been achieved. Where there is a risk that a service user could make an attempt to harm themselves or others or where there is an immediate risk of absconsion the staff member must be within intervention distance at all times. Records need to be made available as part of any review of the service user's needs and will be used to support any future funding.

When there is a change of shift, there must be a robust handover to the next member of staff picking up any one to one support. This must include any relevant information including the current mood, behaviour of the service user and what triggers or de-escalation techniques used

by the staff member handing over. During handover, the service user must continue to receive their one to one by an identified member of staff until the handover is complete.

3.3.11 Information about the Service to service users

The Provider shall ensure service users and (where appropriate) their carers and family members, receive appropriate information (in a format accessible to the service user) about the services that shall be provided to them. The Provider will ensure appropriate communication approaches are used. This will be informed by the person's communication passport or similar document.

Information should include the following elements:

- When the services shall start;
- How long the services shall be provided for or how long they are likely to be provided for;
- The name of support workers who shall be delivering the services and a description of the means of identification that the support workers shall show to the individuals to identify themselves;
- How to make a complaint and the way in which the Provider shall progress the complaint;
- How to initiate a review of their support arrangements and the date of their next review;
- The Provider's address and telephone number including the out-of-hours telephone number.

3.3.12 Holidays

The Care Manager will only consider funding additional support hours during a holiday break in exceptional circumstances and where the Provider has clearly demonstrated that measures have been put in place to bank hours to support the holiday. In addition, the Care Manager will have assessed the holiday as a need for the service user.

In the event of this the Care Manager will expect the Provider to assist service users to explore opportunities of funding for holidays/trips (e.g. group holidays with shared support, seeking additional funding from charities etc.), and where necessary and with their agreement, the service user contributing towards the cost of any additional support hours that may need to be provided whilst on holiday. Where service users are being asked to contribute towards their holiday, clear agreement from them will need to be obtained. Where they lack capacity to such a decision a relative or advocate should be consulted on the proposal as part of the best interest decision process.

3.4 Additional Requirements for Shared Accommodation Services

The Provider will ensure that support staffing levels can be maintained to facilitate a shared service, reflective of the support requirements outlined within ***Individual Support Plans*** to ensure the overall service needs and service user outcomes are met.

3.4.1 Matching and suitability for shared accommodation

Care Managers will ascertain at the assessment phase whether a service user wishes to live in a shared accommodation.

The Provider will establish compatibility criteria outlining similar preferences with the existing service users to ensure effective matching takes place; and will be responsible for minimising interruptions during the move. This includes identification and reduction of the risk of de-stabilising their home.

Where possible the Provider must involve the existing service users with the selection of a suitable housemate.

3.4.2 One to one support

3.4.3 1:1 staff being clearly recorded on the staff rota above the core staffing in group situations, identifying at all times who is the responsible staff member *(see section 3.3.10).***Payment of household amenities in shared accommodation**

Providers will be required to show the full calculation of shared services and the breakdown of individual contributions towards the costs of household overheads and amenities (gas, electric, water, telephone), where this cost is not offset through Housing Benefit in a manner that is accessible to both the service users and the Care Manager.

Copies of all invoices should be retained and records of all service user contributions should be kept in such a way as to allow any necessary auditing, both by the Provider and authorised officers of Nottingham City Council and NHS Nottingham City CCG (CCG).

All household financial arrangements should be renegotiated before any new tenants move in and agreed by all service users.

3.5 Record Keeping

The Provider will ensure appropriate records are maintained and available to Nottingham City Council, NHS Nottingham City CCG or agents acting on their behalf, including but not limited to:

- Running records.
- Care plans/Individual Support Plans.
- Activity plans.
- Risk assessments and management plan.
- Financial transactions undertaken on behalf of people using services.
- Monitoring and review of person-centred care plans.
- Any assistance with medication or other health related tasks where this has been identified in the Care Plan.
- Delivery of first aid.
- Preparing reports for and attending reviews of people using services.
- Health and safety audits.
- Staff rosters.
- Visitor’s book.
- Safeguarding referrals.

In addition, the Provider will keep and make available to Nottingham City Council, NHS Nottingham Clinical Commissioning Group or agents acting on their behalf, upon request:

- Details of all staff employed (including volunteers) and staff changes.
- Staff records including training, induction and supervision.
- Records of all financial transactions carried out on behalf of people using services.
- Details of all complaints received and actions taken.

- Records of all accidents/incidents involving staff/people using services with follow up risk assessments and records of actions taken.
- Health and Safety audits.
- Staff team meetings and resident/relative meetings.
- Medication Administration Record sheet (MAR).
- Information on any past or current criminal convictions of staff identified on the enhanced DBS Check.

Monitoring of progress against Individual Support Plan goals will be undertaken as part of the scheduled review of Care Plans with the designated Care Manager.

Nottingham City Council and/or NHS Nottingham City CCG may monitor the service on an annual basis and request information quarterly in line with Schedule 4 of this contract.

3.6 Review of Care Packages

Nottingham City Council and NHS Nottingham City CCG may work with Providers towards them achieving ‘trusted reviewer’ status which could support Providers to review packages of care annually.

See Appendix A paragraph 2.2.c for reviews of NHS funded packages.

Nottingham City Council will from time to time undertake targeted reviews of packages to ensure they are appropriate to meet assessed eligible need. Based on these reviews, the packages will be increased or decreased accordingly. We expect Providers/support workers to work proactively with “Reviewing staff” to support these reviews.

3.7 Employment and Staff Practices

3.7.1 Recruitment

The Provider:

- Must follow all relevant employment legislation.
- Will ensure that identification is carried by staff at all times and must show:
  - A photograph of the staff member;
  - The name and signature of the staff member;
  - The name of the Provider and a telephone number that can be used to verify this information;
  - Expiry date of I.D (I.D. badges should be updated annually.
- Must comply with the requirements of the Equalities Act 2010, Nottingham City Council’s Equality and Diversity Policy and keep themselves up to date on any subsequent amendments to equality legislation.
- Will employ sufficient numbers of suitably qualified staff to enable it to carry out the service and continue to meet demand. This will include ongoing contingency arrangements in case of sickness, annual leave and holiday periods. Planning arrangements will be made available to Nottingham City Council staff on request.

- Must ensure that there are sufficient numbers of staff who are trained and available to commence service delivery from the contract start date.
- Must employ staff who are able to communicate effectively with the people they will be delivering the service to. These staff should be able to speak English and/or the first language of the person to whom they are delivering services *(however recording must be in English).*
- Will ensure that all staff have a written job description.
- Will ensure all staff are employed on fair and appropriate terms and conditions. This includes ensuring workers are being paid ***as a minimum*** (as appropriate) the National Living Wage, are paid for travel time and are reimbursed for any expenses outlaid during the working period. ***As a minimum*** statutory sick pay and holiday pay are required to be paid separately from basic pay to all employed staff. All staff will be offered a contract with a guaranteed number of hours, although staff may opt to work on a zero hour's basis.

The Provider must have a robust ***pre-employment process*** to include:

- Checks to confirm staff identity and to ensure staff are entitled to reside and work in the United Kingdom.
- A minimum of two references are obtained, one of which must be from a previous employer.
- Enhanced DBS check to work with adults and children is undertaken prior to care delivery and, if not clear, a robust risk assessment is in place which is reviewed regularly.
- All new staff undertake a robust induction process.
- Taking appropriate measures against any unauthorised or unlawful processing of personal data, and against the accidental loss or destruction of or damage to such personal data having regard to the state of technological development, the nature of the data to be protected and the harm that might result from such unauthorised or unlawful processing, accidental loss, destruction or damage.
- Taking steps to ensure the reliability of staff who will have access to personal data, and ensure that those staff are aware of and trained in the policies and procedures identified in the ***Data Protection Act 1998***, and the upcoming ***General Data Protection Regulations 2018*** (GDPR).

Providers are encouraged to make use of the Nottingham Jobs service to support with recruitment. Nottingham Jobs was established by Nottingham City Council in 2012 as part of its Economic Development service to help employers deliver local employment and training obligations, secured through planning and procurement conditions. It is integrated with Job Centre Plus (DWP) employer teams as part of Nottingham's 2013 'City Deal' with the government, providing employers with a single public-sector recruitment service, supporting people into work.

Nottingham Jobs delivers a high quality free-of-charge account management, workforce development and recruitment service to employers across the Nottingham area that Providers of homecare will be able to access. Benefits of this include:

- The key services for this activity are well established and the team has core expertise in this area.

- Vacancy management. Free recruitment services for employers with advertisement and promotion of vacancies via the website www.nottinghamjobs.com, as well as via Jobcentres and partner organisations.
- Targeted recruitment – managed recruitment including pre-employment training and greater involvement of employers.

Providers will be encouraged to sign up to the Nottingham Business Charter. It sets out how Nottingham City Council expects commissioned Service Providers to maximise their positive impact on the economic stability of the local area by maximising social value through delivery of contracts.

Call **0115 876 4508** or email jobs.hub@nottinghamcity.gov.uk for more information.

3.7.2 Supervision

The Provider:

- Shall ensure that all staff receive as a minimum monthly planned and structured supervision.
- Shall ensure that supervision procedures include the requirement for supervisory staff to undertake observation of staff practice on a regular basis.
- Will undertake spot checks of workers lone working in the community to monitor quality, standards and implementation of required policies.

3.7.3 Staff Training

In order to ensure a responsive service is provided to people using services the Provider must ensure the following in relation to their workforce:

- Undertake the Care Certificate if not already completed.
- For all staff an introduction and “getting to know the person” is carried out and will familiarise the staff member with the Care Plan of the person using services.
- All staff are effectively integrated into their organisation. Staff will be made aware of the aims and objectives of the organisation, and of their position within the organisational structure.
- Staffing arrangements will provide sufficient flexibility to enable adjustments to respond to changing need and make best endeavours to enable continuity of staff delivering care and support to people using services.
- All staff involved in the provision of the services are fully trained and receive regular ongoing training and development (including refresher training) timetabled in advance to meet the current and future needs of people using services.
- Accurate and up to date training records are maintained and made available to authorised officers of Nottingham City Council and NHS Nottingham City CCG upon request for quality monitoring purposes.
- Staff have in place a continuing professional development plan that is relevant to the role, setting and the needs of the people using services and their families and carers.
- Should it be necessary for the Provider to use temporary, agency or bank staff, the Provider will ensure that staff have received relevant training and have the relevant knowledge, skills and experience to support the person using services. Temporary, agency or bank staff will be subject to the same checks as permanent staff. An induction into the service will be required.

- The Provider should ensure the best possible continuity and consistency of care through the provision of excellent working conditions in order to minimise staff turnover.
- Staff undertake safeguarding, medication and infection control training annually.
- Staff receive training in how to support people using services who have dementia.
- The recruitment process takes into account the values of potential care workers as well as their skills and experience.
- Staff are trained in relation to their understanding of the Mental Capacity Act and how this impacts on how they deliver care and support.
- Where the staff are required to use medical devices the Provider shall ensure such staff have received appropriate and up to date training in their safe use. The Provider shall contact the NHS District Nursing Team for any advice and training that may be required in specific instances.
- All staff will receive specific training around end of life care. This should be refreshed annually.
- All staff will receive training in offering support to people using services to keep them safe at times of extreme weather incidents such as heatwaves and during the winter.

3.7.4 Support Workers and Individuals

If a service user is unwilling to allow a support worker to provide support, the Provider shall as soon as reasonably practicable contact the service user and take appropriate action to resolve the situation. In the event that the service user requests that the Provider supplies an alternative support worker the Provider shall use all reasonable endeavours to comply with the request. The Provider is required to investigate the reasons for such requests, and notify the Care Manager and carers/family members as appropriate.

Where possible the Provider shall inform the service user in advance if the support worker who normally delivers the service is unavailable to do so. A reason for the cancellation shall be given and an alternative support worker supplied. Advocacy support may be accessed to resolve the situation if necessary.

3.7.5 Managing Risks

The Provider shall immediately inform the Health and Care Point or designated Care Manager, (if the service user has one), if they have any reason to believe that an individual is at risk through self-neglect or as a result of their behaviour or lifestyle, or because of the actions or behaviour of others.

3.7.6 Respecting individuals' homes

Provider staff are guests in the service user's home. As a consequence, staff will be unable to eat the individual's food or drink without the service user's permission.

The Provider shall not show groups of people or individuals around service users' homes unless at the agreement of the people living there.

The Provider shall ensure that houses used are not marked or otherwise identified in any way that might institutionalise them.

Some consumables in the house will be shared by individuals and Provider staff e.g. soaps and toilet rolls. The Provider is required to contribute towards the purchase of such items.

3.7.7 Managing Service user Finances

Any support given to the service user to enable them to manage their own money should take the Guidance on Managing the Service users Finances *(see Appendix 3*) into account. The use of advocacy, appointeeship and Power of Attorney as well as the creation of a package of support around finances should be carefully considered and in line with Care and Support Plans.

3.7.8 Appropriate Motor Insurance

The Provider must satisfy itself that staff who may use their cars for work purposes have a current driving license, have taken out appropriate motor insurance and hold an MOT certificate if relevant. The Service Provider will ensure that a copy of the support worker's current valid insurance certificate is held on the staff file.

4 Health and Safety

Nottingham City Council accepts its duty under the Health and Safety at Work Act 1974 and is committed to providing and maintaining safe and healthy working conditions and appropriate welfare arrangements for all of its employees. It also accepts its duty under The Act to other persons using its buildings and facilities or affected by work carried out by, or on behalf of, Nottingham City Council.

The Service Provider shall:-

1. Ensure they (and any sub-contractors) deliver their services in accordance with the Health and Safety at Work Act 1974 and all associated legislation. This should include, but not be limited to, the premises and any associated equipment where the services are carried out.

2. Ensure they (and any sub-contractors) are competent to carry out their services (including health and safety duties), as detailed above.

3. Confirm that it complies with its statutory requirements as indicated (see schedule 1 listed below*). The Client shall retain the right to request this information at any time. Upon this request, the Service Provider shall provide the necessary information within 5 working days.

*Schedule 1

1. Health and Safety Policy & Arrangements.
2. Risk Assessments (relevant to the contract).
3. Asbestos management plan.
4. Fire risk assessment and log book/record of tests.
5. Legionella risk assessment and log book/record of tests.
6. Certificate of the fixed electrical installation.
7. Record of portable electrical appliance tests.
8. Gas safety certificate.
9. Lifting Operations & Lifting Equipment certificates.
10. Work equipment inspections.
11. Site inspection reports.
12. Health and Safety complaints/accidents/incidents are investigated.

5 Applicable Service Standards

5.1 Equality Act

It is the responsibility of Providers working on behalf of Nottingham City Council to actively meet the Public Sector Equality Duty of the Equality Act 2010 as it relates to the nine protected characteristics.

The Public Sector Equality Duty requires that in the exercise of any functions 'due regard' must be exercised to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
- Advance equality of opportunity between people who share a characteristic and those who do not.
- Foster good relations between people who share a characteristic and those who do not.

This can be evidenced by:

- Promoting equality of access to services and of employment opportunity.
- Ensuring effective data capturing and analysis of service provision.
- Conducting Equality Impact Assessments (EIAs) on policies, procedures and services.

It is required that services have a clear published plan of action to achieve the equality principles in the equality duties.

5.2 Care Act 2014

The Provider will adhere to the legislative requirements of the Care Act 2014 and in relation to safeguarding, be familiar with the statutory safeguarding requirements of the Act.

5.3 CQC registration requirements

Under the Health and Social Care Act 2008, Providers of health and Adult Social Care services must, by law, register with CQC if they carry on a regulated activity. If a Provider carries out a regulated activity without being registered, they may be prosecuted and liable to a fine.

Where a regulated activity is carried out, from the commencement of the service, the Provider is required to ensure that the service is registered with the Care Quality Commission (CQC). Registration must continue throughout the duration of this Contract. The Provider is required to comply with the section 20 Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Where Providers are appropriately registered, people who use those services can expect the service to meet essential standards of quality and safety that respect their dignity and protect their rights.

5.4 NICE Guidance

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. Providers should be able to demonstrate regard to NICE guidance and quality standards when planning and delivering care to residents as part of a general duty to secure continuous improvement in quality.

5.5 Mental Capacity Act and Deprivation of Liberty Safeguards

The Provider shall work within the principles of the Mental Capacity Act (2005) and the Mental Capacity Act 2005 Code of Practice to understand best practice and in particular best interest decision making in regard to that legislation.

The Provider will be required to understand their responsibility under the Deprivation of Liberties Safeguards (DOLS) addendum to MCA and the Deprivation of Liberty Safeguards Code of Practice.

The Provider will have a policy in place in line with the MCA and DOLS Codes of Practice.

Information should routinely be provided to service users, their families and friends about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Information must be included about the right of a concerned person to bring to the Provider's attention that there should be an application for a Deprivation of Liberty authorisation, and what else they could do if the Provider did not agree.

The Provider should have a system in place to ensure that the role of representative under Deprivation of Liberty Safeguards is carried out adequately in line with the guidance in the Deprivation of Liberty Code of Practice 7.25 – 7.28.

The Provider should have a procedure in place that identifies:

- How restraints are recorded to ensure that they are in a service user's best interests in each case;
- How to identify when these restraints constitute a Deprivation of Liberty in line with current case law and guidance;
- Whether they have taken all practical and reasonable steps to avoid deprivation of liberty;
- When to implement an Urgent Authorisation;
- How to apply for a Standard Deprivation of Liberty Authorisation;
- Who would be the authorised applicant (the Registered Manager in a care home);
- A prompt response to eligible persons concerned that there may be a Deprivation of Liberty;
- How to implement any conditions;
- How and when to request a review of a standard authorisation;
- How they would monitor and record the representatives contact with the person;
- What governance processes are in place to evaluate the procedures, duties, referral rates and authorisations

5.6 Communication

The Provider is required to provide staff who can support and promote a total communication environment using a range of methods, both verbal and non-verbal, based on individual need. The Provider should have regard to an individual's Communication Plan.

Support workers should have the capability and skills to communicate and articulate issues service users have raised at multi-disciplinary meetings.

CSE Providers should follow the Five Good Communications Standards as developed by the Royal College of Speech and Language Therapists. (*Follow the link for further information)*

5.7 Safeguarding Adults and Child Protection Procedures

Safeguarding the citizens who use services and planning to maintain their safety and wellbeing should be a core element of the services delivered by the Provider.

The Provider will fulfil their responsibility to safeguard the citizen using services from potential neglect and abuse and adhere to the legislative requirements set out in the Care Act 2014.

The Provider should sign up to and be familiar with the Nottingham and Nottinghamshire Multi Agency Safeguarding Vulnerable Adults Procedure and the Nottinghamshire Multi Agency Safeguarding Vulnerable Adults Guidance and their responsibilities detailed within these.

The Provider should ensure the following:

- Citizens who use the services are protected from abuse and neglect, and their human rights are respected and upheld.
- All employed staff or volunteers have undertaken an enhanced Disclosure and Barring check.
- If the employee or volunteer has lived outside the United Kingdom of Great Britain and Northern Ireland for more than two years (cumulatively or continually) from the age of 16 years upwards, the Provider shall also undertake additional checks equivalent to an enhanced Disclosure and Barring check or obtain a certificate of good conduct from the appropriate embassy and/or police force and/or obtain references and carry out background checks in respect of such person before allowing them to perform the services under this agreement .
- The Provider must have a policy and system in place to ensure full compliance with legislative requirement set out in the Health and Social Care Act 2008.
- The Provider will have a clear and accountable procedure for following up staff concerns about the wellbeing of service users. This should include a risk assessment of other citizens the staff member may have had contact with. The procedure should make it explicit regarding the process of referring staff to regulatory bodies should allegations of abuse or neglect be upheld.
- The Provider should be aware of their Duty of Candour responsibilities as set out in CQC regulations.
- Safer recruitment procedures should be adhered to and should include agency staff commissioned by the Provider.
- All safeguarding referrals should be logged and outcomes recorded. There should be evidence that the service user and / or their advocate is informed of the referral.
- The Provider should establish internal safeguarding policy and procedures as appropriate to the size of the organization which are in accordance with the Care Act and local Adult Safeguarding procedures, including clear reporting arrangements.
- Nottingham City Council requires Providers to co-operate with investigations of abuse, including appropriate representation at Nottingham City or Nottinghamshire County Council safeguarding meetings. Providers should submit action plans in response to recommendations arising from safeguarding investigations as required.
- Nottingham City Council requires Providers to contribute to all major incidents which require multi agency review and safeguarding adults review processes when instigated by the Nottingham City and Nottinghamshire Adults Safeguarding Board.

Providers should also have in place a specific children's safeguarding policy in line with Interagency Safeguarding Children Procedures of the Nottinghamshire Safeguarding Children Board and the Nottingham City Safeguarding Children Board.

5.8 Medicine Management

5.8.1 Medication

The Provider will ensure that staff who provide support with any aspect of the medication administration process are appropriately trained and competent to do so. Such staff will receive accredited and appropriate training in the safe handling of medication, and will have their competency in practice assessed annually or sooner if required (e.g. after an error).

The Provider ensures the continuity of medication for service users through effective communication and co-ordination.

5.8.2 Administration of Medication

The Service Provider will ensure that (a) there are policies and procedures in place for medicines management (b) staff adhere to those policies and procedures, or where applicable, obtaining supplies of medicines, receipt, recording (on MAR sheets and Care Plans), storage (including refrigerated items), handling, administration and disposal of medicines in accordance with:

- The Handling of Medicines in Social Care Settings by The Royal Pharmaceutical Society of Great Britain 2007 or subsequent revisions;
- The Clinical Commissioning Group (CCG) Standard Operational Procedures (Procedural Guidance) and CCG Medicines Management Competency Assessments;
- Professional advice documents produced by the Care Quality Commission, (or its predecessor, the Commission for Social Care Inspection), including Medicine Administration Records (MAR) In Care Homes and Domiciliary Care,
- The Misuse of Drugs Act 1971 (Modification) Order 2001.

The Service Provider’s policy and procedures for medicines management will, wherever possible be agreed by and made available to all GP’s providing services to the service user.

The Service Provider will seek information and advice from a pharmacist regarding medicines policies and medicines dispensed for individuals.

The Service Provider’s policy for medicines administration will include procedures to ensure that service users are able to take responsibility for and self-administer their own medication if they wish, within a risk management framework and the Service Provider’s policies and procedures will protect service users in doing so.

Prescribed medication will be administered in a format suitable for the service user, with the service user’s consent where the individual has capacity to do so. The Service Provider will have procedures for dealing with verbal orders from prescribers; giving medicines to service users with difficulties in swallowing; for covert administration and crushing tablets; expired medicines and for adverse drug reactions.

The Service Provider will ensure that staff monitor the condition of the service user on medication and will prompt a medication review with the GP if there are concerns relating to use of medicines.

Medicines prescribed for individual service users will not be supplied, dispensed to or used by any other person.

The Service Provider will have procedures to safely manage the transfer of medicines when a service user transfers to another health / social care setting; or returns from hospital stays.

Where applicable the Service Provider will make the necessary arrangements in accordance with procedure for the disposal of medical waste to the pharmacy.

The Service Provider will have procedures in place to deal with errors or incidents relating to any aspect of medicines management.

The Service Provider must ensure that staff are appropriately trained in all aspects of safe handling and use of medicines appropriate to their role and that staff training must be documented. Staff must be competent in undertaking the medicines related tasks delegated to them and appropriate competency assessments must be in place.

The Service Provider will maintain adequate records including, but not limited to:

a) A medication profile for each service user;
b) Medication administered per service user (except those for self-administration);
c) Medicines that the service user stores and self-administers (following a risk assessment).

The Provider shall ensure all support workers are trained, and comply with ***infection control procedures.***

Providers are required to facilitate access to Nottingham City CCG Medicines Management Team in carrying out medicines audits in Service Provider agencies that provide services to service users in Nottingham City on behalf of Nottingham City Council and NHS Nottingham City CCG.

5.9 Hospital Admissions

Hospitalisation – The Provider should notify the allocated care manager or duty point from the relevant locality team of the hospital admission on the next working day. If there is no planned return to the service, notice will be given to the Provider.

Where a Service User is admitted to hospital from an accommodation based scheme the Council will continue to pay their contribution to the **shared costs** from the date the Service User is admitted.

Where a Service User has **one to one** support in addition to shared hours these will be paid for up to 24 hours following admission. Any additional one to one payments beyond 24 hours will be an exception and in agreement with the care manager.

Where the service user is in receipt of Outreach support payment will be made for up to 24 following admission.

5.10 Whistle Blowing

The Provider must have a whistle blowing procedure in accordance with the Public Interest Disclosure Act 1998. The following aims should be incorporated:

- To encourage staff to feel confident in raising concerns and to question and act upon concerns about practice.
- To provide avenues for staff to raise concerns in confidence and receive feedback on any action taken.

- To ensure that staff receive a response to their concerns and that they are aware of how to pursue them if they are not satisfied.
- To reassure staff that they will be protected from possible reprisals or victimisation if they have a reasonable belief that they have made any disclosure which is in the public interest.
- To ensure that whistle blowing is covered as part of the staff induction process and continued to be discussed as part of Team Meetings and Supervision processes.
- To ensure staff have access to information at all times by displaying information in areas accessed by staff.

5.11 Other Provider Obligations

a) Directors/ Managers of service

The Provider shall advise Nottingham City Council of any changes to the persons named as the Director/major shareholder/person carrying on the business of the Provider and the manager or person in control of the day-to-day management of direct service provision.

We expect the Manager of the service to have a relevant qualification in social work, occupational therapy, nursing or management (Diploma in Management Studies, NVQ Level 4/5) or equivalent qualifications, but must have the relevant experience and skills of working to support and enable citizens with learning disabilities, autism, mental health, physical or sensory impairment or acquired brain injuries.

The Director and Manager may be the same person, however where a separate Manager is employed to take day to day control, there is no requirement for Director/shareholders to have direct experience of care / support work.

In the event of absence of the Manager or person in day-to-day control, cover arrangements acceptable to the Commissioner shall be in place. If the Manager is anticipated to be absent for more than 14 days, Nottingham City Council shall be informed, with details of the cover arrangements. Any planned or unplanned absence of the Director or person carrying on the business expected to last for 28 days or more shall be notified to Nottingham City Council with details of the cover arrangements.

b) General Welfare Concerns

Whilst delivering support and care, both in the home and in the community, any concerns regarding the wellbeing of the service user should be reported to the Care Manager. In the same way, should a service user fail to attend a pre-arranged appointment this should always be followed up and again, if necessary, the concerns should be reported to the Care Manager.

c) Relationship With Housing Provider/s

The Provider will be required to co-operate and work closely with relevant housing providers for the benefit of service users. It will be necessary where relevant for the provider to enter into management agreements and/or referral protocol with the housing provider, which will set out the responsibility for services of each party.

d) Partnership Working

Partnership working is fundamental for achieving the requirements of this specification. Providers are required to enter into a genuine spirit of partnership, and must endeavor to maintain a positive relationship with all stakeholders, including positive cooperation during service transfer periods.

The Provider must work with the following services/Providers: *(note this is not an exhaustive list)*

- GPs;
- Intensive Community Assessment and Treatment Team;
- Supported Living placements in Nottingham City or within the Nottinghamshire County boundary– (e.g. Care Homes Team, Continence Advisory service, Tissue Viability Nurses, Continuing Care Team, End of Life service, Dietetics);
- Supported Living placements in other areas – local community health services as appropriate to the resident's needs;
- Local hospitals for any admissions and subsequent discharge to the supported living placement.

e) Arrangement for Variation to The Specification

Nottingham City Council and NHS Nottingham City CCG may from time to time vary this Specification. Any variation will be carried out in consultation with the Provider.

6 Quality Assurance and Contract Monitoring

Nottingham City Council and NHS Nottingham City CCG are committed to commissioning high quality services which support the delivery of health and social care outcomes.

The Provider shall at all reasonable times during the contract period allow authorised officers of Nottingham City Council and NHS Nottingham City CCG or agents acting on their behalf, access to all documents relating to the performance of the service under the contract.

The Provider will meet representatives of Nottingham City Council, NHS Nottingham City CCG or agents acting on their behalf, to review performance of the contract, including complaints and compliments, the views and comments of the citizens who use services and their carers and family, and staff expertise.

The Provider is required to demonstrate to Nottingham City Council, the NHS Nottingham City CCG or an agent acting on its behalf, that it has a commitment to providing recovery and progression outcomes quality services and ensuring customer satisfaction. In order to do this the Provider will have developed a quality assurance system, which continuously reviews and improves the standards of service delivery. Such a system will include but not be limited to the following:

- Ensuring that the service is registered with CQC for the duration of this contract where the service is delivering a regulated activity;
- Ensuring that the service receives and maintains a CQC rating above inadequate. Seeking the views of service users, families and advocates. This will include an annual survey in line with performance management and local quality requirements;
- Checking that the specified services are consistently being delivered efficiently, effectively and sensitively, taking account of the needs of citizens using services and their preferences;

- Ensuring that appropriate changes are promptly made where services are not consistently being delivered efficiently, effectively and sensitively, taking account of the needs of service users and their preferences;
- Regular monitoring and evaluation of complaints, concerns, safeguarding alerts and investigations in addition to the requirements of the Provider's complaints procedure;
- An annual review of performance and customer satisfaction with the services provided, with outcomes identified and associated action plan;
- Participating in any independent quality assurance process;
- Equality and diversity and health and safety are embedded in service delivery and procedures followed as appropriate.

The Provider is required to ensure that it has a safeguarding policy in place that aligns with and makes reference to Nottingham and Nottinghamshire Multi-Agency Safeguarding Vulnerable Adults Procedure for Raising a Concern and Referring.

6.1 Inclusion of service users and family carers

As part of these processes, the Provider will be required to:

- Work with a service user's family carers, Care Manager and advocates to develop, implement and evaluate improved outcomes (and indicators) for the individual;
- Work with the Care Manager to ensure that the agreed programme of support for the service user, as set out in his/her Support Plan, is being implemented;
- Acknowledge that Nottingham City Council or NHS Nottingham City CCG may make arrangements to independently monitor the quality of the service provided by direct contact with individuals;
- Give Nottingham City Council and/or NHS Nottingham City CCG any information reasonably required for monitoring the performance of the service, preparation of local authority reports, government statistics or information required to respond to enquiries/ complaints from Councillors or members of the public, or which is necessary for the performance of the Commissioner's statutory responsibilities.

The Provider will be required to demonstrate internal quality monitoring mechanisms that assist in the ongoing delivery of value for money, and that are designed to identify and address falling standards.

6.2 Performance and Local Quality Requirements

Performance indicators are required for the Council to understand and benchmark performance across the Care Support and Enablement delivery system.

Performance will be monitored and assessed as outlined in Schedule 4 of the NHS Standard Contract 2017/18 and 2018/19 Particulars (Shorter Form).

The service will work to deliver the following key outcomes for citizens:

Key Performance Indicator	Method and Frequency of Measurement
Outreach	

Citizens with mental ill-health are enabled to better manage their own care and support needs and • 50% are able to exit the service following a period of 6 months • 95% of citizens still supported by the service after a period of six months require less assistance from the service (equivalent to a reduction of 30% of their recovery outcome individual package of support agreed on entry to the service)	Quarterly monitoring return **Action Plan to address concerns.** Where unresolved, further action can be taken at the discretion of the commissioner under GC9, GC16 and GC17 of this contract.
• 95% of citizens with a long-term disability including learning disability and physical and sensory impairment are enabled to better manage their own care and support needs and • Require less assistance from the service (equivalent to a reduction of 10% of their progression outcome individual package of support agreed on entry to the service) following a period of 6 months.	Quarterly monitoring return **Action Plan to address concerns.** Where unresolved, further action can be taken at the discretion of the commissioner under GC9, GC16 and GC17 of this contract.
Accommodation Based	
• 95% of citizens with a mental ill-health are enabled to manage their own care and support needs with less assistance from the service (equivalent to a reduction of 30% in funding of their recovery outcome individual package of support agreed on entry to the service) following a period of 6 months.	Quarterly monitoring return **Action Plan to address concerns.** Where unresolved, further action can be taken at the discretion of the commissioner under GC9, GC16 and GC17 of this contract.
• 95% of citizens with a long-term disability including learning disability and physical and sensory impairment are enabled to better manage their own care and support needs with less assistance from the service (equivalent to a reduction of 10% in funding of their progression outcome individual package of support agreed on entry to the service) following a period of 6 months.	Quarterly monitoring return **Action Plan to address concerns.** Where unresolved, further action can be taken at the discretion of the commissioner under GC9, GC16 and GC17 of this contract.

All full list of quality requirements and measures applicable to the service is detailed in Schedule 4 of the NHS Standard Contract 2017/18 and 2018/19 Particulars (Shorter Form).

7 Provider Base and Contact

It is a requirement for all Providers to have an office base with staff to be able to manage services within the City or County boundary. If this base is not within the County boundary, clear procedures must be in place to ensure that staff are appropriately supported in service delivery and citizens using services experience good customer service.

The Provider shall not use service users' homes for business meetings. Reviews may take place in service users' homes only with consent of the individual.

8 Population Covered, Eligibility and Exclusion Criteria, Target Groups

As per the model, as outlined below Nottingham City Council and NHS Nottingham City CCG expects the Provider to accept referrals:

- For citizens living within the Nottingham City or County boundary or for NHS Continuing Healthcare funded packages, the citizen is registered with a Nottingham City or Nottinghamshire County GP, (Inc. Northeast, Northwest, Rushcliffe CCG's) where occasionally the citizen's home address may fall outside of the County boundary.
- For citizens who have been assessed as needing a package of care by Nottingham City Council or NHS Nottingham City CCG. This will include more complex needs including health provision as detailed above and where more than one carer may be required to provide safe support.

9 Advertising the Service

The Provider is required to list this service on the Nottingham City Council and NHS Nottingham City CCG's health and social care directory entitled www.asklion.co.uk. The Provider is also encouraged to add any other services or activities offered to Nottingham citizens. For further information please contact asklion@nottinghamcity.gov.uk

10 Days/Hours of Operation

- 24 Hours a day, 7 days a week.

11 Referral – For the Placement of Service users

Following the identification of the need for an Outreach or Accommodation based CSE service *(Single or Shared),* Accredited Providers will be selected using the following criteria For the placements of citizens:

- Citizen choice
- Citizen need

- Creativity of care
- Location
- Required outcomes

12. Transition to the new Contracting Model

12.1 Transitions Model

- CSE services will be delivered by approved Providers on the “Accredited Provider List” from 1st March 2018.
- All Providers of current business will have to go through the Accreditation process in order to be awarded a contract, and to be considered for new business.
- There will be **No SPOT** Contract. Any Providers currently delivering services under a spot contract will need to go through the Accreditation process to be awarded a contract with effect from 1st March 2018. The terms of the new contract will supersede any previous contracts.
- All new business will be contracted at the new outcomes model rate.
- Historic business will be paid at the new rate and are required to be delivered using the Outcomes model (*recovery and progression outcomes see Appendix 2. Outcomes Model)*. A review will be undertaken to ascertain services have transitioned to the new Outcomes Delivery Model.

13 Funding Arrangements

Pricing Model

Outreach CSE

Standard rate	**£14:60ph**
Enhanced rate	**£18:00ph**

Accommodation Based CSE

Standard rate	**£15:10ph**
Enhanced rate	**£18:50ph**
Waking Nights	**£10:70ph**
Enhanced Waking Night	**£14.10ph**

All pricing will be fixed for the duration of the Accreditation with an annual inflationary review in accordance with the terms and conditions of the contract. This rate will incorporate travel time and travel costs.

The first review in relation to inflation will take effect from March 2019.

Appendix A

NHS Funded Care – Supported Living *(including NHS Continuing Healthcare)*

1. Population Needs

1.1 National/local context and evidence base

This appendix, covers placements in supported living environments that are funded by the NHS under eligibility for NHS continuing healthcare or any health funded element of a joint funded care package; as set out in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2012 and any subsequent updates), excluding funded nursing care. It will also apply to placements funded by the NHS, in full or part, under relevant sections of the Mental Health Act 1983 and as further amended by the Mental Health Act 2007, in particular for section 117 after-care.

NHS continuing healthcare is a package of care which is arranged and funded by the NHS. In a care home the NHS pays the care home fees inclusive of board and accommodation.

National guidance was published in 2007 which sets out a single, National Framework for determining eligibility for NHS continuing healthcare. The National Framework was updated in 2012 and can be accessed here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

2 Scope

2.1 Eligibility

People registered with a Nottingham City or Nottinghamshire County GP (including Northeast or Northwest and Rushcliffe), who meet the eligibility criteria for NHS continuing healthcare and have their care package provided in the community.

2.1.1 Any acceptance and exclusion criteria and thresholds

Acceptance or exclusion is based on the CCG's decision regarding eligibility for NHS continuing healthcare in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, or the CCG's decision regarding funding under section 117 of the Mental Health Act 1983 for after-care services.

2.2 NHS Continuing Healthcare Service Description/Care Pathway

NHS continuing healthcare is a package of care arranged and funded by the NHS for citizens assessed as eligible under the National Framework for NHS Continuing Healthcare & NHS-funded Nursing Care. Assessments are carried out by a multi-disciplinary team (MDT) led by a Nurse Assessor from CityCare. The MDT makes a recommendation to NHS Nottingham City CCG (the CCG) who makes the final eligibility decision for continuing care.

Upon making a decision that a person is eligible the CCG has commissioned CityCare to arrange a care package to meet the eligible person's identified needs. This specification relates to care packages arranged in supported living environments only.

Joint Funded care packages are for those service users who do not meet the eligibility threshold for NHS Continuing Healthcare, but have nursing needs and other needs with a health element. These packages are jointly commissioning by NHS and Local Authority to meet assessed health and social care needs. The Local Authority will fund the placement and make arrangements to re-charge an agreed proportion to the CCG. Where Funded Nursing Care is agreed, the CCG will directly fund this to the provider as part of the agreed joint package of care.

Section 117 after-care is a package of care that is jointly commissioned by the NHS and Local Authority to meet assessed after-care needs following discharge from a relevant section of the Mental Health Act. The Local Authority will fund the placement and make arrangements to re-charge an agreed proportion to the CCG.

a. Pre-assessment and Admission

Unless the eligible service user is already living in supported living, the Provider will complete a pre-placement assessment to determine whether they can meet the service user's needs and aspirations. The Provider's assessment and outcome will be submitted to CityCare within 48 hours so that placement can be arranged.

The individual continuing healthcare needs of the eligible service user will be documented by the Nurse Assessor and will be clearly communicated to the Provider. The Provider will produce an initial care plan within 24 hours of admission that accurately reflects the identified needs of the eligible service user. A full care plan will be produced within 7 days of admission.

On confirmation of the service user's admission, the CCG will complete an "Individual Service user Placement", confirming the weekly fee, and send it to the Provider for signature and return. This will advise the provider of the service user's unique QA reference number to use on future correspondence.

Where any additional support for one to one care is required in excess of Bands A, B or C by the eligible service user's case manager that the additional support is necessary to meet the service user's assessed needs. The Case Manager will present the need for additional funding to the CCG and confirmation of the CCG's agreement or otherwise will be communicated to the provider by letter.

Top-up fees will only be permitted for services that the CCG agrees are not related to the service user's care needs. Top-up fees are for extra services chosen by the service user. They are strictly forbidden where the provider feels there is a gap between the contract price and the price the Provider wishes to charge.

b. Service user Needs and Outcomes

The Provider will support the needs and required outcomes detailed in Table 1 below. These are based on the care domains in the Decision Support Tool with additional requirements concerning end of life care and general well-being.

Table 1: Indicative list of needs, outcomes and activities the Provider must support/undertake which include but will not be limited to:

Need	Outcomes	Indicative Activity
Behaviour	• Service user's capability towards positive behaviours is maximised	• Ensure a strategic prevention approach to behaviour deterioration
		• Establish communication points and reporting lines to ensure expectations of both Service user and carer are clear where possible
		• Ensure care plans and records accurately reflect positive behavioural strategies
		• Ensure access to services as appropriate
Cognition	• Service user's cognitive capability is maximised	• Ensure a cognitive assessment is completed on admission. Monitor and review as appropriate
		• Ensure staff understand individual service sser's cognitive needs
		• Ensure staff utilise cognitive support tools for individual service users such as access to a clock and calendar (TV / radio if possible) as appropriate

Need	Outcomes	Indicative Activity
		• Encourage service user's representatives to visit and bring in Service user's personal possessions, e.g. photographs • Ensure the service user's individual activity programme is tailored to meet the service user's needs and prevents isolation • Ensure access to specialist services, as appropriate
Need	**Outcomes**	**Indicative Activity**
Emotional & psychological needs	• Service users are supported in achieving optimal level of psychological and emotional wellbeing. • There is Service user opportunity for meaningful occupation and engagement • Privacy and dignity is maintained at all times	• Provide links to social facilities and arrangements • Provision of an appropriate activities plan and equipment to support activities • Actively consult Service users as part of activity planning • Regularly review service user engagement in activities and provide additional support to facilitate service user involvement as required • Support service user with life changing events as required • Ensure staff have the skills to recognise depression and its effects on behaviour and refer to GP • Support and promote service users existing and new relationships, including partners, families and friends • Support shopping / purchases as required, e.g. family gifts, clothes
Communication	• Service user has the opportunity to express needs and choices through their preferred or an appropriate method • Optimisation of verbal and non-verbal communication skill • Privacy and dignity is maintained at all times	• Ensure a communication assessment is completed on admission. Monitor and review as appropriate • Ensure staff have communication skills relevant to meeting service user needs • Ensure information is provided to Service users in the appropriate format • Ensure staff are able to respond to verbal and non-verbal cues and make best use of relevant communication aids
Mobility and Falls	• Mobility is maximised at a level which is appropriate relative to the ability of the service user • To minimise the risk of falls • Privacy and dignity is maintained at all times	• Ensure a mobility assessment (including a falls risk assessment) is completed on admission. Monitor and review as appropriate • Implement fall prevention strategies as appropriate • Ensure a manual handling risk assessment is completed and reviewed as appropriate • Enable safe service user moving and Service Provider handling provision • Ensure access to a range of suitable equipment, that is maintained and replaced as appropriate
Nutrition – food & drink	• Service user enabled to maintain a balanced and nutritious diet in accordance with NICE guideline CG32 • Service user is enabled to maximise their own potential to feed themselves (i.e. not assisted solely in order to save time) • Privacy and dignity is maintained at all times	• Ensure an assessment of nutritional needs is completed on admission using the Malnutrition Universal Screening Tool (MUST) or equivalent recognised tool. Monitor and review as appropriate • Support service user by offering nutritious diet • Ensure adequate hydration is maintained at all times • Ensure that a policy is in place which ensures that any change in service users' weight or dietary intake is responded to appropriately, and in a timely manner • Manage the use of enteral feeds as appropriate • Ensure that food/drink is available at flexible times and locations and is in accordance with service user preferences • Ensure request for referral to specialist services is made where appropriate • Ensure appropriate supervision and assistance as necessary
Elimination & continence management	• Continence is promoted and optimised • Privacy and dignity is maintained at all times • Skin integrity is maximised	• Undertake a continence assessment on admission, develop a continence plan and monitor and review as appropriate • Ensure request for referral specialist continence services as appropriate • Recognise normal patterns and act on abnormal occurrences seeking specialist advice as required

	• Risk of infection is minimised	• Monitor for and act on any infection

Need	Outcomes	Indicative Activity
Skin (including tissue viability)	• Skin integrity is optimised with active service user input as appropriate • Privacy and dignity is maintained at all times	• Ensure an assessment of skin integrity is completed on admission, and include any care required to maintain healthy skin. Monitor and review as appropriate • Ensure an assessment of pressure ulcer risk is undertaken on admission and is reassessed regularly and prompt recognition of and action as a result of any changes to pressure ulcer risk factors according to local guidance. • If a service user is at risk of pressure ulcer development a pressure ulcer prevention plan must be devised, implemented and evaluated • Ensure that skin care and wound management is evidence based and in line with current wound and skin care formularies and treatment/management regimes are clearly recorded in care plans • Ensure that all wound and skin lesions are assessed and documented • Ensure request for referral to specialist services using the identified referral criteria • Ensure that staff access pressure ulcer prevention training • If a stage 3 or above develops then the Provider must complete an RCA and submit a copy to the CCG (Nursing Homes only)
Breathing	• Airway integrity is maintained and breathing is optimised • Respiratory risk is minimised • Negative impacts of respiratory dysfunction on daily living are minimised • Privacy and dignity is maintained at all times	• Where appropriate, ensure a breathing assessment is completed on admission. Monitor and review as required • Utilise appropriate equipment to support service user breathing as prescribed, e.g. nebulisers and tracheotomy equipment • Ensure staff are appropriately trained and competent in the use of any equipment
General Well Being/Clinical Condition	• To ensure existing and emerging clinical conditions are managed appropriately • To ensure service user lives well until they die	• Ensure an assessment is carried out in conjunction with the information from GP and other services on admission • Ensure regular review is carried out or as symptoms change • Ensure that any changes in condition (physical and psychological) are responded to appropriately and that actions taken are clearly recorded in care records
Medication and Symptom Control	• Medication is provided in a safe and timely manner in order to optimise the care and clinical condition of the service user • Service users are advised of the purpose of medication and actively engaged in the decision making and review of it • Privacy and dignity is maintained at all times • Service user's pain levels are reduced and comfort optimised • The negative impacts of pain on the service user's daily life is minimised.	• Ensure a pain assessment is completed on admission. Monitor and review as appropriate • Ensure a range of communication skills are utilised to assess the characteristics of pain, e.g. location, severity on a scale of 1 – 10, type, descriptors frequency, precipitating factors, relief factors • Administer analgesia as prescribed and monitor effect using pain assessment tool • Utilise appropriate non-pharmacological methods to reduce pain and discomfort • Maintain prompt access to all required medication, including self-medication where appropriate • Ensure appropriate recording of medication and escalation of non compliance • Inform the service user and their representatives (as appropriate) of any likely side effects of medication • Monitor the side effects of medication and refer to the appropriate prescriber. • Work with the specialist care teams to anticipate service user requirements prior to immediate need • The Provider must have a robust medication policy in place • Ensure that medication information is available in an accessible format focused on the service user e.g. pictorial, tape, Braille, translated

		• Ensure that medication administration is in accordance with prescriptions and in line with the medication policy

c. Reviews

Each eligible service user will be reviewed 3 months after the eligibility decision and at least annually thereafter. The review will be completed by the MDT to assess the service user's needs and make a recommendation to the CCG regarding eligibility for NHS continuing healthcare. The Provider is required to take part in the MDT, ensuring all relevant care documentation is available for the MDT's reference and to contribute to the discussions and recommendation.

d. Case Management

Each eligible service user will be allocated a Case Manager from either CityCare's Continuing Care Team or Nottinghamshire Healthcare Trust's Dementia Outreach Team who will, in addition to the above reviews, visit the service user quarterly, or more frequently if required, to ensure the service user is receiving the care they were assessed as needing. The Provider will ensure that the Case Manager has access to the service user and all care records as requested, and will liaise fully with the Case Manager to discuss the eligible service user's ongoing needs.

e. Cessation of NHS Funding

NHS Funding will cease in the following circumstances:

- Death of the eligible service user (funding will be paid to date of death plus 2 days)
- Eligible service user permanently leaves the Provider premises – funding will end on the date the service user leaves for whatever reason
- Upon review the service user is no longer eligible for NHS continuing healthcare or section 117 after-care funding, the CCG will give a 28 day notice period applicable from the CCG's decision date that funding will end

f. 4 weeks from a hospital admission date (see Hospital Admissions below)**Death of an eligible resident**

In the event of an eligible service user's death, the Provider will notify:

- The service user's next of kin/representative immediately
- The CCG by telephone or e-mail within 24 hours of occurrence. E-mails should not include any person identifiable information and the provider should use the QA reference number only.
- CQC where required to do so

In the cases of a sudden or unexpected death the Provider will notify the CCG immediately.

The Provider will make arrangements with the service user's next of kin/representative to collect their belongings. Where there is no next of kin/representative, the Provider will contact the Local Authority to request arrangements for both removing the personal effects and arranging the funeral.

The Provider will ensure that the service user's medicines are retained for a period of 7 days in case there is a coroner's inquest.

g. Hospital Admissions

The Provider must inform the CCG of any hospital admissions within 48 hours of admission, and the subsequent discharge date within 48 hours of the service user's return. Where the service user is initially expected to return to the supported living environment the CCG will continue to fund the placement, with the exception of any separate one to one funding which will not be funded during the hospital admission period, for a maximum of 4 weeks. If an eligible service user remains in hospital after 4 weeks, the case manager will make a recommendation to the CCG regarding funding the care home bed for a longer period if this is felt appropriate. Otherwise the funding will cease at the end of the 4 week period. The CCG is not required to give any further notice.

If it is known at the outset that the service user will not return to the care home following a hospital admission, the CCG will fund the placement for the day of admission plus 2 days.

Appendix 1

Details of Care Support and Enablement Activities

a) Practical daily Support (*including support with housing related issues – Not Exhaustive)*

- Getting to know individuals during any period of transition into supported living;
- Help settling in new tenants;
- Support with household budgeting, including help with correspondence, and the payment of bills;
- Prompting and supporting with practical household tasks e.g. general cleaning;
- Prompting and supporting with laundry tasks;
- Assistance in developing domestic/life skills;
- Assistance in developing social skills/behaviour management including supporting citizens to develop social networks within the community and elsewhere;
- Advising on aids/equipment;
- Assisting individuals to access education, employment or community based activities;
- Help in liaising with other agencies e.g. health professionals, social work staff;
- Maintaining the personal safety and security of individuals;
- Support in accessing information (e.g. local/national news);
- Support in maximising welfare benefits and referring to specialist agencies where necessary;
- Emotional support and advice;
- Supporting individuals to access counselling as appropriate;
- Helping to liaise with the Registered Social Landlord or landlord on issues such as maintenance/repair/ improvement work to the home;
- Advice on transport methods and arrangement of transport;
- Supervising and monitoring of medication e.g. prompting the individual to take medication which has been prescribed and dispensed into individual doses;
- Support to plan and prepare meals; including addressing the principles of a healthy diet;
- Assisting an individual with their mobility, such as accompanying individuals in the community, including shopping;
- Practical support to help deal with emergencies;
- Supporting individuals to access advocacy support where appropriate;
- Supporting individuals to develop social networks and to maintain current friendships and family relationships.

b) Personal Care

The tasks undertaken shall include those that could be given by a caring relative or friend but excludes nursing care, (which is the responsibility of the Health Service). Tasks include:

- Assisting the individual to get up and get dressed or undressed and to go to bed;
- Assisting the individual to wash, shower or bath including washing of hair and oral hygiene;
- Assisting the individual with their toilet/continence requirements;
- Assisting with meal preparation;

- Helping the individual to eat their food or take a drink;
- Assisting an Individual with their mobility needs.

In certain situations it may be acceptable for staff to physically assist an individual to take medication e.g. by placing it on the tongue. This would require:

- An explicit account of the procedure in the relevant individual's Support Plan;
- Proper briefing/training of the staff concerned by health care staff;
- The informed consent of the Individual (following relevant Department of Health guidance on Consent in place at the time).

c) Support in Healthcare

The Provider will ensure that comprehensive healthcare checks of the individual are regularly carried out and the relevant services provided as necessary.

The provider will work in a coordinated approach with other health professionals including Health facilitators, community nurses, acute liaison nurses and other allied health professionals to ensure citizens achieve Health and Wellbeing outcomes for the citizen.

Support workers will be expected to:

- Support those eligible for an annual health check to attend and ensure that any identified health issues are fed into health action plans;
- In partnership with other health professionals, contribute to the development of individual health action plans and ensure these are kept up to date and are relevant in citizens' lives;
- Support the individual in attending GP, hospital, dental appointments, optician etc when/if required;
- Ensure that health needs are included in Support Plans;
- Promote the importance of and support individuals to maintain good health
- Assist with accessing information on health related matters;
- Support during periods of challenging behaviour, episodes of mental health difficulties and periods of illness;
- Support in managing continence issues;
- Support individuals to access other health services as necessary.

d) Management of Challenging Behaviour

Challenging behaviour must be considered in the context of the environment in which it occurs, the way the service is organised and the needs of the individual. The service provider must have a policy to positively engage and support individuals who show challenging behaviour. This policy will take account of all relevant legislation, guidance and good practice including the Human Rights Act 1998, and the Mental Capacity Act 2005. Information should routinely be provided to individuals and their representatives, families and friends about these acts.

Providers are expected, where appropriate, to engage fully with carers and family members regarding any episodes of challenging behaviour. All policies, procedures and terminology used should be clearly explained to the individual and anyone involved in their care.

The Service Provider must be aware of and have plans for known challenging behaviour in the Individual's Support Planning documentation. All reasonable endeavours will be undertaken to avoid discontinuation of placement for the Individual. However if this cause of action is required as a result of challenging behaviours providers must demonstrate how they have worked proactively, with appropriate intervention from partners to manage and resolve issues or at best minimise the challenge.

e) Positive Behaviour Support (PBS)

In line with national priorities, a CSE service will be required to evidence that:

- All support staff receive competence based in-house training in PBS refreshed at least annually.
- All support staff with a leadership role (shift leaders, frontline managers) have completed, or are undergoing, more extensive training in PBS which includes practice-based assignments and independent assessment of performance.
- All staff with a role (which may be peripatetic or consultant) in respect of assessing or advising on the use of PBS with individuals have completed, or are undergoing, externally-validated training in PBS which includes both practice and theory based assignments with independent assessment of performance at National Qualifications Framework Level 5 or above.
- All staff involved in the development or implementation of PBS strategies receive supervision from an individual with more extensive PBS training and experience. Staff in consultant roles are supervised by an individual (within or outside the organisation) with a relevant postgraduate qualification, e.g. applied behaviour analysis, positive behaviour support, clinical psychology.
- Where physical intervention is used, all staff receive regularly updated training (at least annually) in a suitably accredited physical intervention training programme.
- The organisation has plans for the flexible deployment of suitably trained staff to support an individual during a period of crisis.

f) Active Support

The Service will provide an Active Support model of care and must be able to provide evidence that:

- Service users participate in meaningful activities for the majority of their time and are supported to engage as fully as possible in the activities of daily living through an active support model with personalised daily and weekly objectives, planned routines and timetables.
- Information is collated on levels of engagement with active support and this information is used to chart progress and review support arrangements.
- Support staff have timetabled responsibility for providing active support to named citizens.

g) The Management of Physical Interventions

The Service may be provided to service users who can present profound challenging behaviour and behaviour which poses risks to themselves, staff, others and the environment. A duty of care may require physical intervention by the Provider. This shall always be as a last resort and not as a matter of course and form part of a positive person centred behaviour support plan.

The following checklist shall serve as a framework for the Provider to consider issues around physical intervention. This check list is not exhaustive for each and every occasion the Provider may become involved in where physical intervention may be used, and so should be used in conjunction with national guidance. (DOH 2002 Guidance on the Use of Restrictive Physical Interventions, Mansell 2007, BPS and Royal College Guidelines 2007.)

The Provider will ensure they are satisfied that:

- There is a written plan agreed by the multi-disciplinary team in respect of each service user detailing in what circumstances physical intervention will be implemented, and ensuring that it forms part of an hierarchical response, clearly detailing proactive and reactive approaches, identifying early warning signs, triggers and clear ways of responding to behaviour from warning signs through to crisis and recovery;
- The intervention is required, and the rationale provided by those proposing physical intervention is sound;
- The intervention is legal and training provided by an appropriately accredited organisation, which can only be implemented by staff who have received training and who have been judged by training service providers as being competent to use;
- The intervention is safe;
- Other less restrictive/intrusive interventions have been tried and proven to be non-effective;
- The techniques being employed are fully described within an individual support plan which has been agreed as necessary and appropriate by relevant professionals, the Service user, their family and advocate, and consent or best interests are clearly recorded;
- The need to intervene will be reviewed after each episode formally with the Multi-Disciplinary Team;
- The intervention is the least restrictive possible option under the circumstances;
- Active alternative least restrictive options have been and continue to be considered;
- The intervention is part of a holistic behaviour management strategy which seeks to bring about change in a more positive manner;
- The monitoring recording and reporting mechanism in place is appropriate and in line with national guidance and that it is being used openly and honestly by staff involved. Audit of physical intervention records should be at least 6 monthly. Clear systems need to be in place to monitor physical intervention usage;
- The view of the individual wherever possible regarding options about which strategy they prefer should be sought. Pain will not be used intentionally as part of the procedure. A debriefing protocol for Service users and staff should be in place and audited for its effectiveness;
- The intervention is occurring within a clear policy context, particularly in regard to the Mental Capacity Act. The policy should identify methods of physical restraint used and clearly outline training and update requirements which should be annual;
- Value base and ethical considerations have featured as part of the individual's plan. Physical intervention training should always be based on person centred approaches;
- That an individual's ethnicity, gender, and disability have been regarded as part of the planning process. Physical interventions and safeguarding issues should form part of all staff supervision agendas;
- The training of staff is appropriate to the individual, is reviewed and updated and being provided by an appropriately accredited training agency.

h) Engagement and access with the local community and mainstream services

Each individual requires a wide range of age-appropriate, meaningful activities for daytime and evenings. Providers are required to work with individuals and their supporters, utilising person centred approaches, to raise the individual's awareness to the range of opportunities available, in their local community, so they are enabled to access and assist real choice.

i) Transport and travelling

The service will assist individuals in being able to access a range of transport options, from public transport to individual provision. Support workers must enable individuals to use all ordinary forms of transport which maximise independence, are value for money and are appropriate to the journey and the person, as identified in their individual Support Plan and associated risk assessment. The risk assessment should consider the number of support staff needed when considering public and private transport.

If individuals choose to use their Disability Living Allowance Mobility component towards the running of a vehicle, the vehicle will only be for the use of the individuals. It will not be for use by the Core Provider to carry out its own activities. A detailed log will be kept of all use of the vehicle, and a record of all individual contributions. Copies of all documents relating to the arrangement are to be kept at the individual's home.

It is anticipated that support workers using their cars to take individuals to places will be an option only where a taxi would be the only viable alternative. Individuals must be enabled to walk, use buses, taxis, etc. with support if necessary. If it is agreed for staff cars to be used they must have appropriate vehicles and appropriate car insurance and be driven by citizens with a full licence. A mileage rate should be agreed as company policy and service users informed of the mileage rate. Receipts must be issued and full records kept for any money paid to the company by the service user for transport. Money should not be paid directly to the carer providing the transport by the service user.

Appendix 2 Outcomes Based Model

1. Individual Outcome based Support Planning and Recording system

An Outcome based Support Planning and Recording system will be the key to realising the impact of services for citizens. This approach will require the activities of the provider and social care teams to be outcome focused and strengthened through working in partnership, good communications and engagement, tracking and recording, and analysis for service improvement. See diagram below:

The following tables outline the roles, responsibilities and activity required to achieve Individual outcomes for each element of the CSE model:

- Community Outreach CSE
- Accommodation Based CSE
- Shared Accommodation Based CSE

Community Outreach CSE				
Activity	**Whose Responsibility**	**Tools required**	**Expected Outcomes**	**Performance Indicator**
1. Assessment of Needs with the individual, circle of support and family	Social worker	Person centred Assessment tools	Identify current needs and opportunities for Progression and Recovery outcomes important to the individual Draft “Care & Support Plan” with proposed Progression and Recovery Outcomes	• Internal ASC audit processes
2. Service requirement shared with Accredited Providers using agreed process for Expression of Interest and selection.	Social worker	CSE Placement process	Identify a suitable provider capable of achieving agreed Outcomes within the Pricing model contained in the service specification.	• No. of providers that respond, validating Accredited provider list is fit for purpose. • Internal ASC audit processes

3. Agree “Individual Support Plan” with the selected provider	Social Worker	Person centred Individual Support plan (ISP) capable of recording Outcomes	Agreed Progression and Recovery Outcomes, stating service start date and expected date of achievement	• Internal ASC audit processes • 100% of ISP state Outcomes to be achieved
4. Recording Individual Support Plan Liquid Logic	Social worker	Liquid Logic CPLI	Additional Needs and Outcomes, Proposed Start and End dates recorded	• Internal ASC audit processes
5. “6 week Service Review” *Statutory Care Act requirement*	Provider	Outcomes STAR or equivalent tool	Ascertain whether Progression and Recovery Outcomes are achievable Take appropriate action as agreed with the social worker;	• Contract Review o Number of 6-week reviews undertaken • Subject to audit at request of commissioner.
6. Reviews undertaken as identified in Individual Support Plan	Provider	Outcomes STAR or equivalent tool	Ascertain whether Progression and Recovery Outcomes are achievable Take appropriate action as agreed with the Commissioner	• Will be subject to audit at request of commissioner. • Contract Review o Recording of outcomes using appropriate tools; o Achievement of Outcomes; o Timely reviews and Number of packages that end on time;
7. Notification of met Outcomes	Provider	Evidence in ISP Service user input using accessible communication tools	Service user Positive impact Automatic Reduction in service package via Liquid Logic Cost saving	• Contract Review • 50% of citizens with MH are enabled and no longer require a service; • 95% of citizens with MH are enabled and require less assistance, equivalent of a 30% reduction in their care package;

				• 95% of citizens with a learning disability or a long-term physical or/sensory impairment are enabled and require less assistance, equivalent of a 10% reduction in their care package; • Positive Service user feedback • Appropriate Outcomes and communication tools • Timely notification of outcomes • Budget reductions.
8. Notification of Unmet Outcomes 1 month prior to service end date	Provider	Evidence in ISP Service user input using accessible communication tools	There are 3 potential impacts from unmet outcomes: a. Renegotiated time frame for achievement of Outcomes; b. Renegotiated service package and timeframe for achievement of Outcomes; c. New CSE provider identified	• Contract Review • 50% of citizens with MH are enabled and no longer require a service; • 95% of citizens with MH are enabled and require less assistance, equivalent of a 30% reduction in their care package; • 95% of citizens with a learning disability or a long-term physical or/sensory impairment are enabled and require less assistance, equivalent of a

				10% reduction in their care package; • Positive Service user feedback • Appropriate Outcomes and communication tools • Timely notification of outcomes • Budget reductions. • Unmet outcomes will result in full review provider contract.

Accommodation Based CSE				
Activity	**Whose Responsibility**	**Tools required**	**Expected Outcome**	**Performance Indicator**
1. Assessment of Needs	Social worker	Person centred Assessment tools	Identify current needs and opportunities for Progression and Recovery outcomes important to the individual Draft "Care & Support Plan" with proposed Progression and Recovery Outcomes	• Internal ASC audit processes
2. Service requirement shared with Accredited Providers using agreed process for Expression of Interest and selection.	Social worker	CSE Placement process *CSE Portal (TBC)*	Identify a suitable provider capable of achieving agreed Outcomes within the Pricing model contained in the service specification.	• No. of providers that respond, validating Accredited provider list is fit for purpose. • Internal ASC audit processes
3. Create Individual Support Plan	Social worker	Person centred Individual Support plan capable of recording Outcomes	Agreed Progression and Recovery Outcomes, stating service start date and expected date of achievement	• 100% of ISP state Outcomes to be achieved

				• Internal ASC audit processes
4. Recording Individual Support Plan Liquid Logic	Social worker	Liquid Logic CPLI	Additional Needs and Outcomes, Proposed Start and End dates recorded	• Internal ASC audit processes
5. Statutory Care Act requirement - 6 week Review	Provider	Outcomes STAR or equivalent tool	Ascertain whether Progression and Recovery Outcomes are achievable Take appropriate action as agreed with the social worker;	• Contract Review o Number of 6-week reviews undertaken • Subject to audit at request of commissioner.
6. Reviews undertaken as identified in Individual Support Plan	Provider	Outcomes STAR or equivalent tool	Ascertain whether Progression and Recovery Outcomes are achievable Take appropriate action as agreed with the Commissioner	• Will be subject to audit at request of commissioner. • Contract Review o Recording of outcomes using appropriate tools; o Achievement of Outcomes; • Timely reviews and Number of packages that end on time;
7. Notification of met Outcomes	Provider	Evidence in ISP Service user input using accessible communication tools	Service user Positive impact Automatic Reduction in service package via Liquid Logic Cost saving	• Contract Review • 95% of citizens with MH are enabled and require less assistance, equivalent of a 30% reduction in their care package; • 95% of citizens with a learning disability or long-term physical /sensory impairment are enabled and require less

				assistance, equivalent of a 10% reduction in their care package; • Positive Service user feedback • Appropriate Outcomes and communication tools • Timely notification of outcomes • Budget reductions.
8. Notification of Unmet Outcomes 1 month prior to service end date	Provider	Evidence in ISP Service user input using accessible communication tools	There are 3 potential impacts from unmet outcomes: d. Renegotiated time frame for achievement of Outcomes; e. Renegotiated service package and timeframe for achievement of Outcomes; f. New CSE provider identified	• Contract Review • 95% of citizens with MH are enabled and require less assistance, equivalent of a 30% reduction in their care package; • 95% of citizens with a learning disability or long-term physical /sensory impairment are enabled and require less assistance, equivalent of a 10% reduction in their care package; • Positive Service user feedback • Appropriate Outcomes and communication tools • Timely notification of outcomes • Budget reductions.

Shared Accommodation Based CSE *(Inc. New Projects/Schemes)*				
Activity	**Whose Responsibility**	**Tools required**	**Expected Outcome**	**Performance Indicator**
1. Assessment of individual Needs	Social worker	Person centred Assessment tools	Identify current needs and opportunities for Progression and Recovery outcomes important to the individual Draft "Individual Support Plan" with proposed Progression and Recovery Outcomes	• Internal ASC audit processes
2. Identification of suitable "Matches" of Needs for shared service	Supported Living coordinator/Social Worker	Individual needs assessment Matching tool for shared services	Outline for service, summarising service and accommodation needs	• Internal ASC audit processes
3. Mini Competition for new projects/schemes. Service requirement shared with Accredited Providers using agreed process for Expression of Interest and selection.	Supported Living coordinator /Social Worker	CSE Placement process *CSE Portal*	Identify a suitable provider capable of achieving agreed Outcomes within the Pricing model contained in the service specification.	• Internal ASC audit processes
4. Create Individual Support Plan	Supported Living coordinator/ Provider	Person centred Individual Support plan capable of recording Outcomes	Agreed Individual Progression and Recovery Outcomes stating start and expected date of achievement Agreed shared service outcomes stating start and expected date of achievement	• 100% of ISP state Outcomes to be achieved • Internal ASC audit processes
5. Recording Individual Support Plan Liquid Logic	Social worker	Liquid Logic CPLI	Additional Needs and Outcomes, Proposed Start and End dates recorded	• Internal ASC audit processes

6. Statutory Care Act requirement - 6 week Review	Provider	Outcomes STAR or equivalent tool	Ascertain whether Progression and Recovery Outcomes are achievable Take appropriate action as agreed with the social worker;	• Contract Review ○ Number of 6-week reviews undertaken • Subject to audit at request of commissioner.

7. Reviews undertaken as identified in Individual Support Plan	Provider	Outcomes STAR or equivalent tool	Ascertain whether Progression and Recovery Outcomes are achievable
			Take appropriate action as agreed with the Commissioner
				• Will be subject to audit at request of commissioner.
				• Contract Review
				  ○ Recording of outcomes using appropriate tools;
				  ○ Achievement of Outcomes;
				• Timely reviews and Number of packages that end on time;

8. Notification of met Outcomes	Provider	Evidence in ISP Service user input using accessible communication tools	Service user Positive impact Automatic Reduction in service package via Liquid Logic Cost saving	• Contract Review • 95% of citizens with MH are enabled and require less assistance, equivalent of a 30% reduction in their care package; • 95% of citizens with a learning disability or a long-term physical or/sensory impairment are enabled and require

				less assistance, equivalent of a 10% reduction in their care package; • Positive Service user feedback • Appropriate Outcomes and communication tools • Timely notification of outcomes • Budget reductions.
9. Notification of Unmet Outcomes 1 month prior to service end date	Provider	Evidence in ISP Service user input using accessible communication tools	There are 3 potential impacts from unmet outcomes: g. Renegotiated time frame for achievement of Outcomes; h. Renegotiated service package and timeframe for achievement of Outcomes; i. New CSE provider identified	• Contract Review o Positive Service user feedback o Appropriate Outcomes and communication tools o Timely notification of outcomes o Budget reductions.

Appendix 3

Guidance on Managing Service user Finances

Aim: The service user finances are kept safe, spent in a way that reflects individual choice and are fully accounted for.

The starting assumption should always be that a person has capacity in line with The Mental Capacity Act. Any support given to the service user to enable them to manage their own money should take this into account. The use of advocacy, appointeeship and Power of Attorney as well as the creation of a package of support around finances should be carefully considered taking into account the following issues:

- Person Centred planning
- Legal aspects and Rights
- Capacity presence/absence
- Best Interests
- Duty of Care
- Good Communication
- Risks
- Health and Safety

The following protocol offers some guidance to Providers regarding the drawing up of their own policies and procedures relating to service user finances.

1. The Provider has in place a clear policy for reporting all allegations of financial irregularity in line with Nottinghamshire Safeguarding Adults' Policy, Procedure and Guidance. Where there are concerns about the way the service user is managing their own finances, relevant stakeholders should be informed with a view to a multi-disciplinary approach to supporting the service user. Where a crime has been committed (for example theft) actions should be taken immediately to consider the reporting of the incident to the police.

2. The Provider has a policy and procedure for the protection of the service user finances which meets National Minimum guidance. Accurate records are kept of any financial transaction undertaken involving the service user money.

3. Staff are made aware of policy and procedure during induction and supervision.

4. The Provider has a policy and procedure relating to professional boundaries for staff which includes, as a minimum, guidance on NOT:

   a) Accepting gifts or cash (beyond a very minimum value)

   b) Using loyalty cards except those belonging to the service user when shopping with the service user

   c) Making personal use of the service user's' property e.g. telephone

   d) Involving the service user in gambling syndicates (e.g. national lottery) (NB this does not prevent the service user choosing to enter a syndicate with other service user's and being supported to do so but staff should not be part of this syndicate)

   e) Borrowing or lending money

   f) Selling, trading or disposing of goods belonging to the service user

g) Selling or trading goods or services to the service user

h) Incurring a liability on behalf of the service user

i) Taking responsibility for looking after valuables on behalf of the service user (NB this relates to individual staff and does not preclude the provider from making arrangements with the service user for storing valuables as long as appropriate recording and insurance is undertaken)

j) Taking any unauthorised person (including children) or pets into the service user home without permission of the service user, their relatives or representatives and the manager of the service.

k) Being able to be a beneficiary of the service user's Will or playing any part in the Will making procedure of any service user.

5. The Provider works to ensure that the service user receives their maximum entitlement to benefits in conjunction with the care co-ordinator. Support staff are made aware of benefit entitlement and the need to ensure any changes in circumstances or changes to the service user's benefits are referred on to managers to take up advice if required. The Provider refers on to more specialist financial advisors where appropriate – e.g. income maximisation, financial advice around inheritance, appeals etc.

6. The service user is supported to understand their income and their outgoings. Staff support the service user to take responsibility for their own money and the Service user is encouraged to manage their own money within a risk assessment framework. The Provider will work alongside a multidisciplinary approach to ensure that the service user is not at risk through inappropriate spending. Staff support the service user with budgeting and following up on any advice received from specialist advisors.

7. The Care and Support Plan identifies how the service user's finances will be managed, i.e. what they can do for themselves and the areas where they may require support. A decision making agreement is recommended, outlining clearly the role of family etc. (NB this may also be useful in other areas aside from finance), which should be reviewed at least annually involving all relevant parties. A comprehensive risk assessment informs the plan. Where there are issues relating to capacity, clear documented evidence is maintained regarding how decisions have been reached. The use of advocates may be required in some circumstances.

Points 8 to 18 should be included as part of an overall policy and applied for individuals as applicable, in accordance to their individual support plans.

8. The service user or appointee to be able to access any records kept about their finances.

9. The Provider has a system in place for undertaking spot checks on records of the service user's finances. Any discrepancies of over £5 to be overseen and/or investigated by a senior manager. In addition, ad hoc auditing by Regional Manager plus an annual audit of finances by Head Office. Requests for withdrawals of an amount above the usual spend for an individual, (this should be indicated in Individual Support Plans) should be authorised by an appropriate manager – however, Providers should consider how this authorisation may be made at short notice to ensure the service user is not prevented from accessing their own money

as required. Attention should also be paid to the appropriateness of any spending during this audit.

10. Bank accounts.
    Wherever possible each service user will have their own bank account. Where this is not possible a risk assessment will be undertaken and the arrangements for managing the service user finances will be recorded in the care and support plan. Where barriers to accessing a bank account have been encountered this should be addressed in a support plan with a view to ensuring the person is able to open an account where they choose to have one.

11. PIN numbers.
    Providers have a procedure on the safe use/storage of debit cards and pin numbers by staff in situations where staff are supporting the service user to manage their finances. This is to include restricted staff access to PIN numbers; PIN numbers and debit cards to be kept separately. Providers to explore with the service user the opening of a savings account to reduce access to large amounts of money. Other options can be considered such as using the Money Carer Foundation.

12. Individual cash balances.
    Individual records are kept rather than shared accounts. Receipt book/ Small Cash Needs sheet is used to record monies coming in/out. A method of staff signing for transactions is agreed depending on the amount of the transaction and the capacity of the individual to sign for themselves. Itemised receipts should be kept, where appropriate and where it is not clear from the receipt what the money has been spent on, this should be noted on the back of the receipt. It may not always be possible to obtain receipts (e.g. in the pub, trip to the fair) but expenditure should still be accounted for in the receipt book. Management audits should include particular attention to none receipted items. If the purchase has been made using a card rather than cash, the receipt should be logged so that it can be checked against bank statements.

13. The Service user/appointee is made aware of any charges made by the Provider (including rent and bills) and a clear breakdown of any charge should be provided. Records should be kept and made available to the service user (receipts being provided for payments made). This also applies to any loans made to the service user.

14. The service user is advised of the consequences of not having contents insurance. Where the service user wishes it, the Provider should enable them to take out a policy and explain the extent /terms of the cover.

15. Providers assist the service user to make an inventory of their possessions. This helps to prevent potential abuse as well as being useful for insurance claims etc. All loss or damage to property whilst the service user is being supported must be recorded. It is also recommended that any loss or damage to property noticed by staff or reported by the service user is also recorded.

Outings and Activities

Care & Support Plans should explore options for promoting independence and having alternatives to staff accompanying the service user on activities wherever possible.

Where the service user requires support to undertake an outing, activity or holiday the following principles should be applied.

16. Outings and activities.

a. The frequency of meals out/trips/activities should be addressed via the individuals support plan taking into account issues such as health, social inclusion, service user choice and service user finances.

b. Managers should be aware of whether support is being delivered according to the support plan. This would address the potential for abuse (e.g. staff making decisions about outings, may be easier to go out for a meal than help someone cook it, rather than the service user) OR flag up the need for a review of the support plan.

c. The Provider should look for innovative ways of reducing the cost of any staff activity or transport costs (this principle should also be applied to helping the service user get the ‘best deal’)

17. Staff costs.
The progression model of care supports service users to be involved in the community and engage in social events. It is no longer acceptable for a service user and worker to just go out for a meal as an activity. This would be an exception to the rule and not the ‘normal’ approach to ensuring service users are supported in the community. A clear rational as to why this has occurred must be recorded and in line with the principals below:

a. Where staff are accompanying the service user out for a meal or a trip, it is anticipated that, in most cases, the service user will have to make a contribution towards the cost. However, basic principles should be drawn up for staff around how much it is acceptable to spend in various situations. (E.g. staff should always try to have the cheapest meal option, only have one soft drink etc.) This may vary depending on the service user and their choices of outing so where there is any variance from the basic principles, this should be agreed with the service user before the trip is undertaken.

b. Any costs to the service user should be discussed with the service user as part of the planning process for the activity. If the service user lacks capacity staff should agree an activity with the Service, but must agree any staff costings with the person’s appointee.

c. The basic principles agreed by the Provider should be accessible to the service user at all times and may be requested as part of any individual expression of interest.

18. Transport.

a. The service user to be enabled to use public transport where appropriate and feasible and supported to access bus passes etc.

b. Where staff use their own cars to transport the service user they shall have appropriate insurance cover.

c. The service user may be asked to pay a ‘mileage’ contribute, towards the cost of petrol/car maintenance for the journey undertaken. Details of how the

mileage cost is made up should be agreed in a formal policy. Records of any charge made to the service user to be kept.

19. Holidays.
In advance of any holiday it is recommended the Provider prepares proposed costing for the holiday, identifying any staff costs, i.e. holiday, transport, subsistence. Core Contract on how these will be met to be reached in advance of the holiday with service user, representative and care coordinator. Information to be retained as an audit trail.

a. The Provider to support the service user to explore a range of holiday options, including short breaks and assisted holidays.

b. This may be with family or friends, on their own or, where there are no other options available or the service user chooses, with direct support from the Provider.

c. The service user should be assisted to budget for holidays and make realistic choices regarding what they can afford or where they may need to ‘cut back’ on day to day expenses in order to be able to afford a bit more.

d. It is not unreasonable to expect the service user to pay for a flight or basic accommodation costs for a support worker if other options have been fully explored. However, the Provider should ensure the ‘best deal’ is sought.

e. The service user should NOT be expected to pay for all food or drinks for support staff whilst on holiday. Acknowledgment of the usual costs for staff of providing their own meals and drinks should be balanced with any additional cost of having to buy them ‘away from home’. Agreement regarding an appropriate level of contribution from the service user should be made. This may vary depending on whether the service user wants to eat out and needs support to do so or whether the staff member would be able to cook for themselves etc.

f. Additional staffing requirements for a facilitated holiday are negotiated between the service user and Provider. It is recommended that providers consider an hourly rate equal to the cost of the direct support only (i.e. wages, NI, Pension) for these additional hours.