SCHEDULE 1:

Service Specification

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Table of Contents

1. Definitions

Accessible Information	Accessible information is information that people can understand and that is presented in a way that meets their communication needs. It can include, but is not limited to, Easy Read, braille, audio, Makaton and Social Stories.
Acquired Brain Injury	An injury to the brain that is not hereditary, congenital or degenerative.
Adult	A person aged 18+.
Asset Based	A form of assessment and support planning that looks at what people have, rather than what they lack, making use of their existing skills, knowledge and relationships.
Audit	A visit (or series of visits) to a service conducted by the Council's Integrated Commissioning Team, to check contractual requirements and produce a report on the findings. (also see Focussed Audit)
Autistic Spectrum Condition	A lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them.
Communication Passport	Person centred booklet that supports Service Users, who cannot easily speak for themselves, to present information important to them in an accessible way e.g. how they prefer to communicate, activities they enjoy, people that are important to them.
Community Support	Support delivered in a community setting by a carer or support worker.
Complex / Challenging Behaviour	Behaviour is challenging if it causes harm to the person or others, or if it stops them fulfilling some aspect of their lives e.g. A Service User cannot go to college because they show aggressive behaviour.
Contract Review	A meeting led by the Lead Commissioner, usually held Annually, which looks at performance against the contract of larger groups of services with one organisation, or a high value Service Contract.

Day Activities / Opportunities	Activities that take place in the community that Service Users can participate in
Dementia	A syndrome caused by a number of progressive disorders that affect memory, thinking, behaviour and the ability to perform everyday tasks.
Desk Top Review	A desk top review conducted by the by the Council's Integrated Commissioning Team, of information held and received about a service. The outcome determines the level of subsequent monitoring required of that service.
Direct Payments	Funding provided by the council directly to a Service User that allows them to plan and manage their own support and to buy services or employ people to support them in everyday life.
Easy Read	'The presentation of text and pictures in an accessible, easy to understand format. It is often useful for people with learning disabilities, and may also be beneficial for people with other conditions affecting how they process information.
Eligible person	A person who has been assessed by the Council under the *Care Act 2014* as being in need of care and support from Adult Social Care.
Enhanced Housing Management	See Intensive Housing Management.
Focussed Audit	A visit (or series of visits) to a service conducted by the Council's Integrated Commissioning Team, to check contractual requirements in specific areas only, and produce a report on the findings. (also see Audit)
Health Action Plan	An accessible plan developed with a person with a learning disability that contains information about their health needs, ways they can stay healthy and help them can access.

Health Charter	The Health Charter is designed to support social care providers to improve the health and well-being of people with learning disabilities, thus improving people's quality of life generally. Providers sign up to the Health Charter and using a self-assessment tool can evidence how they are working to improve health outcomes for people with learning disabilities.
Home Care	Care received by a person in their own home provided by a service registered with CQC to deliver personal care. It may include but is not limited to assistance with dressing, feeding, washing and toileting, as well as advice and psychological support.
Home	A person's home is where they ordinarily live.
Hospital Passport	An accessible document used to inform staff in a hospital about a person's health needs and also provide information about the person themselves e.g. how they communicate, things they like and dislike, people who are important to them.
Independent Service Fund	A personal budget paid to a provider chosen by a service user to arrange their care and support.
Intensive Housing Management or Enhanced Housing Management	The services within supported housing a) related to the maintenance and upkeep of the property and communal areas, and b) the provision of advice on tenancy issues / housing need (including signposting to other advice agencies).
Learning Disability	Learning Disability refers to; - A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) along with: - a reduced ability to cope independently (impaired social functioning; and - Where the onset of disability which started before adulthood and had a lasting effect on development.

Makaton	A language programme using signs and symbols to help people to communicate. It is designed to support spoken language as the signs and symbols are used with speech, in spoken word order.
Mental Health Needs	Needs related to any mental health illness.
Personal Budget	A Personal Budget is a sum of money allocated to a Service User as a result of an assessment of their needs. The amount of money awarded is based on eligible need at the time of assessment.
Personalisation	Ensuring people in receipt of social care services have choice and control over the service they receive.
Physical Disability	A physical impairment that has a substantial and long term negative effect on a persons ability to undertake normal activities
Positive Behaviour Support	A multi component framework that views challenging behaviour as functional, rather than as deviancy, a diagnosis, a mental health condition or deliberate attempt by the Service User to cause problems for themselves or others.
Provider	The Contractor who is providing the Service to the Service Users.
Sensory Impairment	Vision, hearing or multi-sensory impairment.
Service Users	People in receipt of the service.
Service User Outcomes	The goals and aspirations of Service User
Social Care Needs	Needs identified by the Council under the *Care Act 2014*.
Social Stories	**Social stories are short descriptions of a particular situation, event or activity, which include specific information about what to expect in that situation and why. They are mostly used to support people with ASC.**
Supported Living /Accommodation	A range of supported accommodation options that enable Service Users to live, socialise, learn and work in the community and hold a tenancy in their own home.

Support with Personal Care	Support from a carer for activities such as washing, toileting, dressing (see Home Care)
Support Plans	Plans developed with a Service User that detail the outcomes they want to achieve and the support that will be provided to them to achieve their goals
Transforming Care	Refers to the Transforming Care Agenda, the current local plan for the transformation of care for people with Learning Disabilities and Autism.
Value for Money	The best use of resources to achieve economy, efficiency and effectiveness

2. Acronyms

ASB	Anti-Social Behaviour
ASC	Adult Social Care
ADASS	Directors of Adult Social Services
BHCC	Brighton and Hove City Council
BILD	British Institute of Learning Disabilities
BSL	British Sign Language
CCG	Brighton & Hove Clinical Commissioning Group
CLDT	Community Learning Disability Team
CQC	Care Quality Commission
IHM	Intensive Housing Management
KLOE	Key Lines Of Enquiry
KPI	Key Performance Indicators
LGA	Local Government Association
PBS	Positive Behaviour Support

3. Introduction

3.1 This specification outlines the aims, objectives and expected outcomes of the support and care services to be provided to people with Learning Disabilities, and / or Autistic

Spectrum Condition, and / or Complex/Challenging Behaviour and / or complex physical health needs, who may also have personal care needs.

3.2 Where Service Users have personal care needs, the Service Provider shall deliver care services that are registered in accordance with the requirements of the Care Quality Commission, or any successor organisation. In addition, the Service Provider must comply with the Fundamental Standards of Care as defined by the Care Quality Commission as appropriate to the Service delivered.

3.3 The service will be delivered according to the principles of the Transforming Care Agenda, with particular reference to:

- 'Building the Right Support – A National Plan to develop community services and close in patient facilities for people with a learning disability and / or autism who display behaviours that challenge, including those with a mental health need' (2016);

- 'The National Plan – Supporting people with a learning disability and / or autism who display behaviours the challenge, including those with a mental health need (2016);

3.4 This Service Specification sets out the minimum requirements and Service Providers will be required to meet the individual needs of Service Users in a flexible and adaptable way that supports Service Users in achieving the outcomes set out in their individual Care and Support plans.

4. Aims and Objectives of the Service

4.1 The overall aim for services provided under this Specification is to provide a range of **Community Support options** that enable Service Users to continue living in , and accessing, the community.

4.2 The Service will be delivered to meet the outcomes specified in the Individual Support Plans which will be agreed at the outset of each placement and will be revised as necessary as the outcomes are amended or achieved. Service success will be defined in terms of outcomes for people who rely on care and support.

4.3 The Service Provider will provide flexible care and support solutions and will work in partnership with Service Users, families, commissioners and care professionals to ensure that as the Service User's outcomes are achieved the Service adapts according to need and if appropriate the Service Provider shall assist Service Users to transition to a more appropriate setting.

4.4 Services shall minimise admissions of Service Users to institutions such as hospitals, the criminal justice system and residential care.

4.5 Services shall work with partners to ensure effective communication, co-ordination and collaboration.

4.6 Services shall make effective use of community and leisure activities by linking Service Users into local services.

4.7 Services shall deliver a service which represents good Value for Money for the Council;

4.9 Services shall adhere to the 5 Key Lines of Enquiry (KLOE) as set out by the Care Quality Commission, which are:

- Safe
- Effective
- Caring
- Responsive
- Well Led

5. Service User Eligibility

5.1 This service is for Adults who are Eligible for Adult Social Care Support and have been assessed as requiring Community Support.

5.2 The range of Service User needs includes; Learning Disability, Autistic Spectrum Condition, Physical Disabilities, Acquired Brain Injury, Sensory Impairment or Mental Health Needs and personal care needs.

5.3 Service Users may have additional needs such as behaviours that challenge, mental health needs or physical health needs

6. Referrals

6.1 All referrals will be made by the Council.

6.2 The assessment procedure carried out by the Council will identify the type of Accommodation and Support that is most suitable to meet the Service User's needs and identified outcomes.

6.3 Referrals will be made via the *ADAM* dynamic purchasing system. Service Providers must be enrolled on the *ADAM* system to receive referrals.

6.4 At the current time the procurement system is only able to facilitate the purchase of the services directly between Adult Social Care and Providers. In the future, it is intended that services under this Specification will also be purchasable via Direct Payment, Personal Budget or Individual Service Fund.

7. Service Level

7.1 The Service will provide the Services for each and every Service User in accordance with the Service Agreement used to make the referral and their individual Support Plan. The Service Provider will have the skills and relevant experience to deliver in a competent and efficient manner, social and personal support to Service Users, including the delivery of an appropriate person centred care plan for individual Service Users and risk assessments ensuring the general well-being of Service Users. Appropriate risk management guidelines are to be put in place and provision made to ensure the guidelines are in place and implemented.

7.2 The Service will offer appropriate levels of social and personal support to the Service User as determined by their assessed needs, being mindful of the need to promote the Service User's independence, and being sufficiently flexible to allow for variations in Service User need.

7.3 The Service will offer appropriate recreational and social activities to the Service User as prescribed within the provisions of The Care Act (2014), the Fundamental Standards (CQC) and the Individual Support Plan.

7.4 The Service Provider shall allocate a suitably qualified and experienced named key worker for each Service User, who will act as a point of contact between all appropriate parties. For the purposes of this Service Specification, a key worker is an individual worker, matched with a Service User, whose role is to ensure the Service User is able to contribute meaningfully to their agreed Person Centred Plan and /or act as an advocate for them in making decisions, as appropriate about all aspects of their care.

8. PBS Accreditation

8.1 The Service will be required to complete a PBS Organisation Self Assessment form if they wish to become an Accredited PBS provider.

8.2 Self Assessment forms will be assessed by the Commissioning & Performance Team and the Behaviour Support Team to confirm accreditation.

8.3 Services that are accredited will be able to include confirmation of their accreditation when bidding on packages of support on the *ADAM* system.

8.4 Packages of care that require high levels of PBS and restrictive interventions may only be available to Services who have completed the accreditation process.

8.5 Services that wish to complete the process can do so by contacting the Commissioning & Performance Team.

9. Assessment of Needs

9.1 The Council's Assessment Team will be responsible for assessing an individual's suitability for placement in this service.

9.2 Service Users placed in the service will have the agreed level agreed funding authorised by the Council, or CCG, prior to the placement.

9.3 Following referral by the Council, the Service Provider's Service Manager will implement the Service Provider's assessment procedure and liaise with the relevant parties. The Service Provider's assessment will confirm that the Service Provider can accept the Council's referral.

9.4 The Service Provider will monitor all referrals to ensure adherence to Equal Opportunities

9.5 The Service Provider has the right following assessment to refuse to accept a referral. The Service Provider must notify the appropriate Assessment Team in writing as to the reasons.

10. Support and Person Centred Planning

10.1 The Service Provider must assess continuously throughout the placement in order to identify and assist each Service User to meet his/her needs to ensure that he/she can enjoy as fulfilling a life as is possible.

10.2 A written Care and Support Plan for each Service User will be provided by the Assessment Team. The Plan will be outcome focused and will identify the services and any special staffing support, e.g. 1:1, that must be provided by the Service Provider to meet the Service User's assessed needs. The Service User's key worker will work with the Service User to fulfil the Support Plan. Appropriate records relating to the development of Support Plans and the outcomes achieved, will be maintained, and must be available for the Service User in an accessible format, and be open for inspection. The Service User will be advised of this requirement. Contact with family and friends will be promoted as appropriate.

10.3 The achievement of the outcomes set out in the Care Act 2014, will be fundamental in the delivery of the service and will help inform Individual Support Plans:

- Maintaining a habitable home environment;
- Managing and maintaining nutrition;
- Managing toilet needs;
- Maintaining personal hygiene;
- Being appropriately clothed;
- Developing and maintaining family or other personal relationships;
- Making use of necessary facilities or services in the community;
- Accessing and engaging in work, training, education or volunteering;
- Carrying out any caring responsibilities for a child; and

- Being able to make use of your home safely.

10.4 Activities undertaken to meet Service User Outcomes may include, but are not limited to:

- Developing a PBS plan with the Service User;
- Completing the PBS organisation self-assessment;
- Developing a Health Action Plan with the Service User;
- Developing a Hospital Passport with the Service User;
- Developing a Communication Passport with the Service User;
- Sensory support;
- Specialist communication support appropriate to Service User's needs (e.g. social stories, Makaton, BSL);
- Support with substance misuse issues;
- Support with mental health issues;
- Support with physical health needs;
- Developing daily living skills (e.g. cooking, cleaning, being more independent with personal care, budgeting, shopping, nutritional advice);
- Support with personal care (registered services only);
- Establishing and maintaining a tenancy or licence (e.g. understanding tenancy or licence agreement, rights and responsibilities, repairs, dealing with neighbours, ASB procedures);
- Enabling Service Users to maximise their income;
- Attending appointments (e.g. medical, bank, council);
- Enabling Service Users to access appropriate health services (e.g. annual health checks, health screening);
- Enable Service Users to develop peer support networks;
- Enabling Service Users to access work, training, learning or volunteer opportunities;
- Enabling Service Users to seek out new experiences and activities;
- Enabling Service Users to share activities with friends as appropriate;
- Enabling Service Users to build confidence and maximise their potential for independence;
- Enabling Service Users to access activities in mainstream services of their choosing;
- Enabling Service Users to develop the tools to manage in the community with less support from formal support services;
- Enable Service Users to move on from this service to a mainstream or lower support service;
- Enabling Service Users to manage their emotional and behavioural needs that may impact on their ability to access to the community;
- Enabling Service Users to build confidence and maximise their potential for independence;
- Enabling Service Users to access advice and information services in the community;

- Enabling Service Users to access advocacy services as required;
- Support to link in with specialist services as required e.g. substance misuse services, mental health services;
- Work in partnership with criminal justice agencies to identify support needs and reduce risk of offending or victimisation;
- Supporting Service Users to remain safe from abuse and hate crimes in their communities e.g. mate crime, disability hate crime.

10.5 The Service Provider shall develop and agree a written Person Centred Plan for each Service User in accordance with the Fundamental Standards of Care as specified by the Care Quality Commission or any successor organisation as applicable. Relevant staff will have received appropriate training in order to complete and update the Person Centred Plan, which will be reviewed at least every six months or sooner should the Service User's needs change during that time. Copies of the completed Person Centred Care Plans will be available for inspection at each Service User's review. It is, however, recognised that some people using the service may choose not to have a person centred plan and evidence of this choice should be made available. Where a Service User already has a person centred plan produced by another service (for example they are moving from another Service Provider), it is expected that the Service Provider would contribute to its development and review.

10.6 The Service Provider will review jointly with the Council, each Service User's individual needs within six weeks of the commencement of the service and at a minimum of a one-year interval thereafter.

10.7 Reducing health inequalities is a key target within the Transforming Care Agenda and as such Service Providers are required to ensure that all service users are supported to have an Annual Health Check and to develop a person-centred Health Action Plan in conjunction with their registered GP.

11. Service User Involvement and Consultation

11.1 The Service Provider must have clear written policies setting out their commitment to Service User led care practices and the inclusion of Service Users in designing, delivering, developing and reviewing services.

11.2 The Service Provider must make use of the most effective and appropriate means of communication with Service Users, taking into account individual Service Users communication needs. Service Providers must be able to employ different approaches to communicate with Service Users to ensure inclusion e.g. Easy Read, Makaton, Social Stories. Service Providers must keep evidence of consultation with Service Users and their families and any actions taken as a result of consultations and engagement.

12. Review of Individual Service Agreements

12.1 In the event of a significant change in an individual Service Users needs the Service Provider will request a review of need by the Council's relevant Assessment team who will respond in a timely manner.

12.2 A significant change in need can be either an increase or decrease in need.

12.3 Examples of a significant increase in needs might include exclusion from a day centre, loss of mobility or significant change in behaviour or other change resulting in the need for additional staff support.

12.4 Any increase in the package of care must be agreed by the Council before any expenditure is committed, and a variation to the individual's Support Plan and Contract, as necessary, will be raised.

12.5 Examples of a significant decrease in needs might include no longer using additional 1:1 hours provided when support needs were higher, no longer requiring additional support to access the communityor other change resulting in less need for staff support.

12.6 Any reduction in the package of care must be agreed by the Council, and where necessary a variation to the individual's Support Plan and Contract will be raised.

12.7 Contracted hours will be measured via the KPI workbook (Schedule 2). There will be an allowable variance of + or – 10% in hours being delivered.

12.8 Where more hours are being delivered than are contracted the service will absorb this cost.

12.9 Where less hours are being delivered than are contracted the council will absorb this cost except in the following circumstances:

a) The variance is greater than 10%;
b) The variance is regular to the extent that it clearly shows contracted hours are not required at the level set

12.10 In the event of 12.9 a or b occurring, the Service Provider shall inform the Commissioning and Performance team outside of the usual reporting mechanism to request an urgent review.

12.11 Fee increases and deductions will take effect from the point that the change in need was identified.

12.12 In the event of an urgent request from the Service Provider to the appropriate Assessment Team for a changed service to reflect urgent changed needs of a Service User already in receipt of care, the Service Provider's Registered Manager and/or Care

Co-ordinator and the Council's Assessment team will exercise the greatest flexibility and commitment possible to meet the urgent request (with the proviso that extraordinary financial arrangements may be required) having regard to the needs of the other Service Users using the Services.

13. Equal Opportunities

13.1 The Service Provider in delivering the service shall comply with all non-discrimination and equality of opportunity legislation, codes of practice and the Equal Opportunities section of the Terms and Conditions.

14. Staff

14.1 All staff must be provided with a comprehensive induction to the service covering skills required to obtain a Care Certificate and appropriate training within twelve weeks of joining the service. The Care Certificate needs to be delivered in a context relevant to the service and job role and must be fully recorded.

14.2 On completion of the Care Certificate all care practitioners should be offered the opportunity to achieve a recognised vocational qualification. Practitioners should be expected to achieve Level 2 Diploma within 2 years of appointment.

14.3 All staff must receive all relevant training relating to the challenging needs, health needs and clinical diagnosis of the Service Users being supported within six months.

14.4 The Service Provider must keep up to date training records for all staff and management.

14.5 Staff learning and development must be regularly reviewed, updated and adjusted to meet the changing needs of the people using the service. Training may include, but is not limited to:

- Positive Behaviour Support (or equivalent), to include functional assessments, developing intervention and behaviour support plans;
- Care/support planning and recording;
- Communication with Adults with a Learning Disability as relevant to service;
- Safeguarding adults, Mental Capacity Act, DoLS;
- Restrictive physical interventions;
- Person centred active support;
- Mental health;
- Autistic Spectrum Condition;
- Health & Safety, Risk assessment, Safe handling of medication, Moving and handling, First Aid, Food safety, Food & Nutrition, Infection control;
- Epilepsy;
- Postural care;
- Dysphagia;
- Plus any other training as identified for CQC registered services under Regulation 22 of the Health & Social Care Act 2008 (Regulated Activities) regulations 2009 and as described by Skills for Care

14.6 The Service Provider will provide or arrange for the provision of technical support and advice i.e. around care and treatment in addition to providing regular supervision of staff. Opportunities to debrief and access counselling, will be provided as necessary;

14.7 An annual review of Continued Professional Development should be undertaken by he registered manager (or appropriate line manager) as part of each care practitioner's annual appraisal. The overall workforce plan as well as individual learning and development plans should be used to identify and record the further skills and qualifications needed by practitioners and how they are to be met;

14.8 The Manager must undertake relevant training to maintain and improve knowledge and skills and contribute to the learning and development of others. A Registered Manager should hold one of the following qualifications:

- Registered Manager's Award (RMA) ;
- An NVQ Level 4 in Leadership and Management for Care Services **plus** a relevant care qualification ie NVQ Level 4 in Health and Social Care/relevant nursing, physiotherapy or occupational therapy qualification and registration/ relevant social work qualification and registration with the GSCC
  Or
- Be registered on the Level 5 Diploma in Leadership for Health and Social Care and Children and Young People's Services, choosing one of the following pathways:
- Management of Adult Services
  Or
- Management of Adult Residential Services

15. Partnership Working

15.1 The Service Provider must provide access to and communicate regularly as required with other key professionals involved in the care of the particular Service User.

15.2 The Service Provider must attend local forums with other providers to share best practice and knowledge, agree common quality standards and disseminate information on training, national events and research. Local forums include the Learning Disability Provider Forum, the Care Home Forum and the Positive Behaviour Support Network.

16. Quality Standards and Controls

16.1 The Service Provider will actively encourage all staff to help Service Users to be as independent as possible in their daily lives;

16.2 The Service Provider will comply with any relevant regulations as set out by the Department of Health and/or as monitored by the Care Quality Commission or any successor organisation as applicable.

16.3 Quality Controls will include the following components:

- The Service Provider will be registered and inspected by the Care Quality Commission;

- The Service will be monitored by the Council's Integrated Commissioning Team (this may be in the form of a Desk Top Review or Focussed Audit);
- Annual service monitoring by the Service Provider's Service Manager and the respective teams focusing on both systems and individual outcomes;
- Where required, the Service Provider will deliver an Annual Report to the Council's Commissioning and Performance Team to inform a Contract Review meeting (see **Schedule 3**);
- Regular provision of information, including KPIs, when requested, to the Council's Commissioning and Performance Team.

17. Business Support Services

17.1 The Service Provider must ensure that all support services required to support the running of the service that they are responsible for e.g. cleaning, accounting and management are delivered to a recognised professional standard and/or accepted good practice.

17.2 Records including accounts and receipts for all financial transactions for each Service User will be kept by the Service Provider and monitored by the Service Provider's Registered Manager or other Senior Manager and shall be audited professionally. Such records and accounts for each Service User shall be accurate, and made available to the Council, the Service User and their carer/advocate if appropriate and available for external audit upon request.

17.3 Service Users unable to administer their own financial affairs will have an appointee approved by the DWP.

18. Contract Monitoring

The Services provided under this Specification will be monitored and assessed for success according to two variables;

- Key Performance Indicators; and
- Service User Outcomes.

18.1 **Key Performance Indicators (KPIs)** provide the Council with key data that is used to determine how well Providers meet the contracted performance outcomes and quality standards. A list of KPIs grouped under key outcomes, which is a combination of service specific and combined KPIs aligned across services, is attached to the Contract as **Schedule 2**, alongside guidance and a template for returns.

The Council is building robust methods of benchmarking across our Health & Adult Social Care services, so aspirational targets have been set. These will be reviewed alongside contract performance, and agreed between the Council Commissioning and Performance Manager and the Providers.

18.2 **Service User Outcomes,** as referred to in section 10 above, will be defined when the Service Agreement is first agreed between the Council and the Provider. These outcomes

and their measurement will relate specifically to the Service User, and in a large number of situations they will relate directly to the outcomes identified on a Service User's Support Plan.

18.3 A KPI workbook (**Schedule 3**) will be established for Providers to return annual and quarterly data as specified in the guidance.

An outline of Schedules to the Contract is below: