Agenda item

Cabinet – 14 February 2018

Procurement of supported living framework for complex needs and mental health

Portfolio: Councillor D Coughlan

Related portfolios:

Service: Adult Social Care

Wards: All

Key decision: Yes

Forward plan: Yes

1. Summary

1.1 The Community Based Services framework (CBS) went live on the 03rd April 2017 following a comprehensive procurement exercise delivering domiciliary care to people with a range of needs, including complex needs:

- learning disability including co-morbidities
- autism
- physical disability
- sensory impairment
- mental health (functional illness and dementia)

However there remains a gap in the market for supported living services where care and support is shared across a scheme. Unfortunately the existing framework does not allow for the flexibility to share costs for multiple users sharing the same property and so there is a need to complete a supplementary procurement exercise to address this gap. Children's Services, within this new Supported Living Framework will be seeking a support provision for 16-17 yr olds with a range of complex and personal care support needs.

1.2 The existing arrangements for supported living care services for adult clients are managed through the Council's Transitional 4 contracts which are due to expire on 30 June 2018 but have the option to extend if required. The relevant Transitional 4 Contracts will need to be extended to allow the existing care arrangements to continue up until the care provision can be transferred to those providers who are successful under the new fully compliant supplementary framework agreement tendering exercise.

2. Recommendations

2.1 That approval is given for the Council to undertake a tender process for Community Based Services in order to create a supported living framework contract for adults and young people with complex care needs who live together in supported living accommodation, with the contract to run for up to five (5) years (3+1+1) from 01 October 2018 to 30 September 2023.

2.2 That approval is given for the Council to exercise its existing unilateral contractual right with supportive living providers only to extend their current transitional 4 contracts for a further 9 months from 1st July 2018 to 31st March 2019 to ensure sufficient time for completion of the tendering exercise, award of the supported living framework agreement and the transfer of work from the outgoing transitional 4 supported living contractors to the successful tenderers (where applicable). Children's Services will not access the extended contracts but will seek to engage with new providers from 01 October 2018.

2.3 That delegated authority to approve the award of the contracts following completion of the procurement exercise and sign all associated procurement recommendation reports, agreements and other documents associated with the procurement is approved in favour of both the Executive Director of Adult Social Care and Executive Director of Children's Services in consultation with the Portfolio Holders for Adults and Children's Social Care.

3. Report detail

3.1 The Community Based Services framework (CBS) went live on the 03rd April 2017 following a comprehensive procurement exercise delivering domiciliary care to people with a range of complex care needs. However, the terms and conditions of the framework and pricing model are not compatible with the supported living model of care, where support and costs are shared between multiple service users living in the same property.

3.2 The Care Act 2014 sets out the Councils' statutory duties to deliver and manage a local market of providers that can provide a range of health and social care services in line with the customers' assessed needs. The current 'Transitional 4' contracts are used to secure the delivery of the care services which are required in order to manage the diverse needs of adults with complex needs and mental health across supported living, these contracts are due to expire on 30 June 2018.

3.3 The Care Act 2014 sets out the Councils responsibility to meet the eligible needs of the local adult and young people population with complex and mental health needs. The Council has a duty to facilitate a market place of providers who have the ability to meet the diverse range of needs of those who require care and support. The new framework agreement for supported living and shared accommodation services will support to address the Council's responsibilities under the Care Act 2014.

3.4 Supported Living services provide care and support to adults with complex care within their own home. The person will have a tenancy agreement with a landlord (or an implied agreement with the landlord where they lack capacity) for

the accommodation. The care is delivered by a separate organisation which provides the accommodation. This can allow the individual to change their accommodation or care without the other being affected. Young people aged 16-17 yrs. may receive council funding for both private accommodation and care support costs. There may be some young people where the CCG will also contribute to the costs of their service.

3.5 A framework agreement will be commissioned which will include the following service lots allowing the Council to meet its statutory duty under the Care Act 2014:

Lot 1 – Learning disabilities including co-morbidities
Lot 2 – Autism
Lot 3 – Physical disability
Lot 4 – Sensory impairment
Lot 5 – Mental Health (functional illness)
Lot 6 – Mental Health (dementia)
Lot 7 - 16 -17 year olds with complex needs

3.6 It is therefore proposed that a supplementary Community Based Services tendering exercise is undertaken to secure the provision of care to people with a range of complex care needs in supported living, where the level of care provision and the costs payable by the Council, can be adjusted upwards and downwards in a flexible and financially viable way to reflect the changes arising from incoming and outgoing tenants during the term of the contract. The arrangements will ensure that the Council continues to meet its obligations under the Care Act 2014. The tendering exercise will also allow the Council to address gaps within service provision across complex care.

3.7 As already stated, the existing contract arrangements for the provision of care for complex care cases in supported living are purchased and managed through the current ‘Transitional 4’ contracts and these are due to expire on 30 June 2018. The Council does however have a contractual right to further extend these arrangements by up to another nine months from 1 July 2018. The waiver of the Council’s Contract Rules which was granted by the Council’s Executive Director of Social Care to authorise the extension arrangements is however subject to Cabinet first giving its approval to the exercise of the right to extend. This requirement was imposed because of the possibility that any further extension may be vulnerable to challenge on the basis that the extended contracts are not being put in place via either a compliant procurement or a compliant modification process under the Public Contracts Regulations 2015. However, this is considered to be a low risk in relation to the Transitional 4 contractors that support adult service users in supported living, because the Council will also simultaneously be undertaking a fully rule compliant tendering exercise with a view to new contracts being awarded with services commencing from 1 October 2018.

3.8 It is anticipated at the time of drafting this report the Council will need to extend the existing Transitional 4 Contracts (for complex care cases in supported living) so that these continue until such time as the care provision can be transferred to the successful tenderers under the new framework agreement that are awarded pursuant to the tendering exercise. This will inherently involve an overlap

between the two sets of contracts, although the intention is to keep this to the minimum period necessary to secure the completion of a carefully planned and managed transfer process.

3.9 Therefore Cabinet's approval is sought to authorise the exercise of the Council's right to extend the Transitional 4 Contracts for those providers that serve complex care cases in supported living, by nine months from 1 July 2018 to 31 March 2019. The Council will reserve the right to terminate each extended Transitional 4 Contract by serving at least one week's notice on the relevant contractor if their workload reduces to zero cases prior to the expiry of the extended contract period (i.e. so that the Transitional 4 Contracts can be brought to an end at the earliest opportunity).

3.10 This Supported Living Framework will improve the transition experience for complex 16-17 yr. olds as they mature into adulthood. Children's Services would consider LAC children who might require this specialist provision. These children would be complex LAC children with special educational needs transitioning from a looked after care environment such as foster, residential or hospital setting into a form of independent accommodation.

4. Council Corporate Plan priorities

The commissioning of the framework for supported living and shared accommodation services is in line with the following Council corporate priorities:

- Make a positive difference to the lives of Walsall people: Increasing independence and improving healthy lifestyles through meeting the eligible care and support needs of local residents

- Safe, resilient and prospering communities; Walsall is a clean, safe and healthy place, with the right housing to meet need. Vulnerable adults are supported to meet their housing needs and responsibilities through support provided by providers who have been commissioned to meet their needs by the Council.

5. Risk management

5.1 There is a risk of challenge from Care Provider's to the temporary transitional 4 contract extension arrangements on the basis that they are not a compliant procurement under the Public Contracts Regulations 2015. However, this risk should be largely mitigated by the Council by simultaneously undertaking the compliant tendering exercise for supported living services with a view to contracts being awarded from 1 October 2018.

5.2 There is risk to the continuity of services if approval is not secured for the undertaking of the proposed tendering exercise. for supported living services. There is potential that services will have to be delivered via non-compliant temporary, short term spot purchase contracts and the Council will be exposed to legal challenges if contracts are awarded outside of a compliant procurement process and possible cost pressures by providers imposing increases. This risk is however minimised by the extension of transitional 4 contracts to 31 March 2019 whilst the procurement for the agreement of supported living and shared accommodation services is procured.

5.3 The domiciliary care services which are provided under the transitional 4 contracts allow care and support to be shared across individuals within the same shared accommodation scheme. This provides the residents with a consistent approach to their care needs as support is delivered by the same provider and staffing group. In addition these arrangements provide the Council with significant efficiencies through the cost of the support being shared by the residents, as opposed to residents purchasing this individually. If the Council is unable to continue to purchase services through these arrangements then there will be significant financial risk as efficiencies will not be achieved across placements.

5.4 There is no identified risk to any young people as none currently receive services from the transitional contracts being considered for extension.

6. Financial implications

The funding for supported living is not a separate identifiable budget but sits within the domiciliary care budget, which for 2017/18 is £29.182m gross and £25.091m net.

For Children Services, any support costs would be from the Looked After Children's budget or Short Breaks budget for this provision and detailed in their statutory case review.

7. Legal implications

7.1 The views and comments of Legal Services have been taken into account in the drafting of this report.

7.2 The proposed tendering exercise will be undertaken by the Council in accordance with the requirements of the Public Contracts Regulations 2015 and the Council's Contract Rules.

7.3 Any **personal care** provider for young people is required to be registered with the Care Quality Commission (CQC).

8. Procurement Implications/Social Value (if applicable/remove if not)

8.1 Reasons for going out to tender are as follows:

I. The model is changing
II. The value is above the applicable EU threshold
III. Change affects one or more wards of the borough

8.2 Providers local to Walsall will be delivering services to the people of Walsall; people living in Walsall will be employed to work for the organisations delivering the services. Landlords and providers of services will be paying taxes into the local authority.

9. Property implications

There are no property implications because service users will have individual tenancy agreements with landlords that are not within the scope of (or affected by) the supported living tender.

10. Health and wellbeing implications

10.1 Supported living services support people with disabilities to live as independent lives as possible. Providers work in a person-centred manner maximising opportunities for people whilst facilitating access to mainstream services limiting social isolation and facilitating positive participation within communities.

10.2 Providers support people to access primary and secondary health services as appropriate to ensure that preventative and targeted health interventions are provided in a timely manner to meet people's needs.

11. Staffing implications

The Council does not and will not be guaranteeing levels of business for providers that deliver care services to service users with complex care needs in supported living, as the demand for services is not consistent. Providers will resource services based on the eligible assessed needs of the individual which will be reviewed annually. The Council does not directly employ staff for these services and the employment responsibilities are with the supported living provider.

12. Reducing inequalities

Consideration has been given to the Councils responsibility under the Equality Act 2010. The Council's duty to meet people's eligible needs will remain the same under the extended Transitional 4 Contracts and the framework contracts that are awarded pursuant to the proposed supplementary tendering exercise.

13. Consultation

13.1 A number of workshops have been delivered engaging with the market to inform the supported living tender. A broad range of providers attended the workshops and provided feedback on the challenges they face within the market and opportunities where services could be improved with the right infrastructure.

Some of the key themes raised were as follows:

- Managing voids within shared accommodation, both housing and managing the cost of care where services are shared
- Retainer fees for care when people are admitted to hospital allowing for quicker discharges from acute and mental health services
- National living wage and sleep In allowances in line with guidance from HMRC and employer liabilities

13.2 The feedback was collated and will be used to inform the drafting of the tender documentation; the Council will be seeking to review how some of the key challenges faced by stakeholders could be mitigated. Further engagement was

carried out with stakeholders and health colleagues to develop the services specification.

Stakeholder consultation dates:

- Supported living providers workshop, (6th July 2017)
- Supported living providers workshop, (10th July 2017)
- Professionals workshop, (24th July 2017)
- Stakeholders and health colleagues (16th November to 01st December 2017)

Background papers

Appendix A - Service Specification Supported Living Services Lots 1 to 6 for people with complex needs (learning disabilities inclusive of co-morbidities, autism, physical disability, sensory impairment, mental health (functional illness), mental health (dementia)

Appendix B – Service Specification Supported Living Services Lot 7 for 16 to 17 year olds with Complex Needs (learning disabilities, autism, physical disability and mental health)

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2 February 2018

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2 February 2018

Appendix A

Walsall Council

Supported Living Service
Specialist Service Specification 1, Schedule A5

Service Specification	**Adults with Complex Needs** **Lot 1: Learning Disabilities including Co-Morbidities** **Lot 2: Autism** **Lot 3: Physical Disability** **Lot 4: Sensory Impairment** **Lot 5: Mental Health (Functional Illness)** **Lot 6: Mental Health (Dementia)** **Lot 7: 16 – 17 year olds with Complex Needs**
Duration of Work	**Date TBC 2018 to Date TBC 2021 (3 Year Contract)**

1.0	**PEOPLE WITH COMPLEX NEEDS**	
1.1	This specification covers Adults with Complex care needs, including people with the following conditions:	
	1.1.1	People with Learning Disabilities including Co-Morbidities
	1.1.2	People with Autism
	1.1.3	People with Physical Disabilities
	1.1.4	People with Sensory Impairments
	1.1.5	People with Mental Health (Functional Illness)
	1.1.6	People with Mental Health (Dementia)
	1.1.7	16 – 17 year olds with Complex Needs
1.2	The provider must understand that this schedule refers to a range of multiple and additional needs service users may have, including individuals with profound and multiple disabilities and those who present with challenging behaviours.	
2.0	**OBJECTIVES**	
2.1	The provider shall use its reasonable endeavours to achieve the following outcomes for each service user:	
	2.1.1	to promote and improve independence
	2.1.2	to maintain a tenancy and reduce homelessness
	2.1.3	to develop a stable lifestyle
	2.1.4	to access other appropriate services
	2.1.5	to promote social inclusion and community involvement
	2.1.6	to improve health and wellbeing
	2.1.7	to maintain and/or improve quality of life
	2.1.8	to avoid crisis, accident & emergency and specialist hospital admissions
	2.1.9	to reduce hospital bed blocking by providing a safe and supported environment for swift hospital discharge
	2.1.10	to support service users to access and maintain employment, training, volunteering and educational opportunities

3.0	**CORE SERVICE PRINCIPLES**	
3.1	In delivering the service, the provider will adhere to the following principles:	
	3.1.1	To promote each service user's quality of life and enable community participation and maximise independence. The provider will create linkages that allow the service user's needs to be addressed holistically, in an environment which is appropriate to the service user.
	3.1.2	To deliver the outcomes identified in each service user's care plan. It is expected that each outcome will have a set timeframe attached, within which the outcome should be achieved or reviewed. The provider will also monitor, review and amend service outcomes with the individual service user, their carer and their care manager/social worker.
	3.1.3	To promote the reablement and enablement of each service user. The Department of Health definition of reablement is: "the use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on reabling people within their homes so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing care"
	3.1.4	To support service user to maintain and strengthen relationships with their family, guardians, friends, carers and partners
	3.1.5	To support service users to access vocational, education, social, recreational and other interests. The provider will support to enhance a service users personal growth and development
	3.1.6	To ensure staff have the necessary skills to include service users with cognitive or communication difficulties in decision making
	3.1.7	To support the development and maintenance by service users of positive relationships within the immediate neighbourhood / community
	3.1.8	To ensure service users with complex needs are signposted or referred to an independent advocate if required
	3.1.9	To ensure where appropriate equipment, telecare and telehealth is used to support individuals, staff are trained to use the equipment safely and appropriately. Where there are concerns/issues identified about pieces of equipment / telecare the provider will contact the supplier e.g. Integrated Community Equipment Service (ICES), Telecare/Telehealth Service or the manufacturer if equipment was purchased independently
	3.1.10	To support the improvement of each service users health and wellbeing whilst reducing the likelihood of a hospital admission
	3.1.11	To promote each service users quality of life and enable their community participation and maximise their independence
4.0	**COMPLEX CARE NEEDS**	
4.1	The provider shall deliver the service to (but not limited to) service users that express the following type of needs:	
	4.1.1	people who are challenging services
	4.1.2	people who have a history of assault, violent and aggressive behaviour to others
	4.1.3	people who have a history of arson
	4.1.4	people who are on the sex offender register
	4.1.5	people who significantly self harm
	4.1.6	people who have a history of addictive behaviour
	4.1.7	people who have historically attempted suicide
	4.1.8	people who have personality disorders

	4.1.9	people who have a period of poor mental health
	4.1.10	individuals subject to Care Treatment Orders, Guardianship, Restriction Orders and Section 117 aftercare;
	4.1.11	individuals who may also be overseen by National Offender Management Service, MAPPA, Ministry of Justice and Leaving Care Teams;
	4.1.12	individuals stepping out of the judicial system and who may have criminal convictions;
	4.1.13	people who have an acquired brain injury
	4.1.14	people who have a spinal injury
4.2	The provider will work holistically with all stakeholders that are involved with each service user's care and treatment.	
4.3	The provider will ensure that a comprehensive range of assessments including but not limited to Behaviour Support Plans, Occupational Therapy Assessments, are triangulated against each service user's care pathway.	
4.4	The provider will ensure that staff are qualified to manage service users with behaviours that challenge, which may include positive behaviour management techniques that support to reduce the occurrence, severity or impact of behaviours which challenge.	
4.5	**Challenging Behaviour**	
	4.5.1	A person's behaviour can be defined as challenging if it puts them or those around them (such as their carer) at risk, or leads to a poorer quality of life. Behaviours that challenge can include aggression, self harm, destructiveness and disruptiveness
	4.5.2	These service users will need to be reviewed regularly to ensure the most independent options are explored
	4.5.3	The provider will ensure staff are qualified to manage people with behaviours that challenge which may include positive behaviour management techniques that support to reduce the occurrence, severity or impact of behaviours which challenge
	4.5.4	The provider will ensure staff are appropriately trained in behaviour management techniques and will have the ability to apply these within their working practices
	4.5.5	The provider will be able to support service users who present with verbal and physical aggression, self injurious behaviour, non-compliance with medication and treatment for physical health needs
	4.5.6	The provider will encourage the service user to maximise social capital – the support system of friends and family who may know the service user and their usual behaviour
	4.5.7	The provider will be able to demonstrate ongoing risk assessment and management which is reviewed regularly
	4.5.8	
5.0	**STAFF SKILLS SET FOR PEOPLE WITH COMPLEX NEEDS, CONTINUING HEALTH CARE (CHC) / END OF LIFE DELIVERY**	
5.1	The provider will ensure Staff whom it deploys to provide CHC for service users who have complex needs are:	
	5.1.1	nurses registered with the Nursing and Midwifery Council where required
	5.1.2	willing to undertake any training and education relating to the assessment of the service users before commencement of service provision
	5.1.3	demonstrate source of registered training with regard to the Mental Capacity Act 2005 and Adult Safeguarding (with at least three yearly updates)
	5.1.4	are provided with training with regard to the Mental Capacity Act 2005 and Adult Safeguarding (with at least 3 yearly updates)
	5.1.5	receive training on infection prevention and control
	5.1.6	Have an awareness of their limitations and when to seek guidance and support from healthcare services (escalation)

5.2	The provider will ensure service users have a relevant and current care plan which is updated by the service provider if any changes to their condition or care provision occur. If there is no change to condition or care provision then their care plan must be reviewed at least annually by the provider	
5.3	The provider will ensure line managers/co-ordinators have assessment and care planning skills and accept responsibility for completing and updating each service users care plan	
5.4	The provider will ensure that any service user in receipt of waking night sits have care staff who undertake the constant monitoring of their health condition in the same room (or otherwise via direct observation of the service user in question) and who remain alert at all times while they are on duty	
5.5	**End of Life**	
	5.5.1	The provider must comply with the requirements of paragraphs 5.1 to 5.4 (inclusive) and the following requirements:
	5.5.2	The provider will ensure all staff have undertaken training relating to palliative and end of life care with evidence of competency
	5.5.3	The provider will update and review each service users care plan as their needs and condition changes
5.6	**Accessible Information Standard**	
	5.6.1	The provider will follow the Accessible Information Standard, formally known as (DC1605 Accessible Information). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.
6.0	**ELIGIBILITY CRITERIA**	
6.1	The provider will provide the service for the benefit of all adults who reside in the Borough of Walsall (and/or who have a Walsall registered GP for CHC eligible service users) and who have been assessed by the Authority as eligible to receive the service in their own home	
6.2	**Exclusions**	
	6.2.1	A service user will not be entitled to access the service if their personal circumstances falls outside those stated in paragraph 6.1 above, or if they do not fall within any of the complex care categories which are listed in paragraph 1.1 above
7.0	**HOURS OF SERVICE AVAILABILITY**	
7.1	**Core hours**	
	7.1.1	The provider will refer to each service user's care plan to identify the core hours of the care service to be provided for them
	7.1.2	Where applicable to the service the provider will ensure the service is available within the contracted area throughout seven (7) days a week, fifty two (52) weeks per year, twenty four (24) hours each day throughout the agreement term after the service commencement date
7.2	**Contact details**	
	7.2.1	The provider will operate a 24 hour staffed telephone line and will ensure that service users and/or their advocates and the Authority are aware of the telephone number(s) in case of an emergency or crisis event in relation to the service
8.0	**SERVICE DELIVERY**	
8.1	This specification is applicable to all the complex needs groups identified in this specification for the service	

8.2	The provider will deliver services with an emphasis on reablement and promoting independence	
8.3	The provider will support (firstly) service users who may have been subject to long stays in hospital, and (secondly) service users who have had a continued period of admission and discharge from hospital (revolving door)	
8.4	The provider will deliver the services which are identified within each service user's care plan which may include:	
	8.4.1	Support with key daily living requirements e.g. nutrition, continence, medication and tissue viability
	8.4.2	The ability to maintain and strengthen relationships with family, guardians, friends, carers and partners
	8.4.3	Support to access vocational, education, social, recreational and other interests and support to enhance a service users personal growth and development
	8.4.4	The development and maintenance of positive relationships within the immediate neighbourhood / community
	8.4.5	Support to develop money management skills, living skills and promote social inclusion
8.5	The provider will measure each service users progress through their care pathway with a defined tool	
8.6	The provider will work holistically with all stakeholders involved with each service users treatment	
8.7	The provider will ensure the service user has access to the Community Health Teams where appropriate	
8.8	Where the provider is unable to complete the necessary treatment then a referral will be made by the provider to the appropriate service for continuation of their care	
8.9	The provider will ensure that people with complex care needs are signposted or referred to an independent advocate if required	
8.10	The provider will provide a rehabilitation model of care that will support a service user to recover from a period of ill health whilst developing / maintaining skills to live independently.	
8.11	The provider will support each service user to improve their health and wellbeing whilst reducing the likelihood of their hospital admission / re-admission	
8.12	The provider will support each service user to achieve their own recovery, without creating dependence, or enable each service user to achieve the maximum level of self reliance as possible	
8.13	The service provided will be matched as closely as possible to the requirements of each service user to enable them to lead as fulfilling a life as possible	
8.14	The provider will ensure that where appropriate they use equipment, telecare and telehealth to support individual service users. The provider must ensure that their care staffs are trained to use equipment safely and appropriately. Where there are concerns/issues identified about pieces of equipment / telecare the Service Provider should contact the supplier (e.g. Integrated Community Equipment Service (ICES), Telecare/Telehealth Service) or the manufacturer if the equipment was purchased independently.	
8.15	The provider will ensure where applicable that each service user's long term health conditions / needs are monitored and managed. This includes referring them to appropriate community resources.	
8.16	The provider will ensure that each service user is supported to access a comprehensive annual health check from their General Practitioner	
8.17	The provider shall be able to support service users who present verbal and physical aggression, self injurious behaviour, absconding, non compliance to medication and treatment and physical health needs.	
8.18	The provider will support each service user to develop emotional control and coping strategies.	

8.19	The provider shall be able to demonstrate ongoing risk assessment and risk management in relation to the service (which is reviewed regularly).	
8.20	The provider will demonstrate staff understand the use of good practice in the delivery of care to service users by:	
	8.20.1	Use of recovery star type documents
	8.20.2	Involving each service user and their family/carer in planning their care
	8.20.3	Adopting person centred care principles and choice
	8.20.4	Promoting dignity in care principles
	8.20.5	Using nutritional screening tools e.g. MUST, weight and fluid charts
	8.20.6	Enabling access to training and volunteering
	8.20.7	Promoting physical health as well as mental wellbeing
	8.20.8	Empowering service users to embark on varied activities planned on a daily basis both within their home and in their wider community
	8.20.9	Working in partnership with other agencies to enhance each service users recovery and life opportunities
	8.20.10	Encouraging re-learning of skills by service users where possible
	8.20.11	Improving the knowledge of service users, carers and staff about complex needs and providing them with appropriate information
	8.20.12	Using outcome based interventions with service users
9.0	**FREE FROM HARM**	
9.1	**People are safe and care is always delivered in their best interests**	
	9.7.1	Provider will ensure service users lives are free from fear, abuse and neglect
	9.7.2	The provider will ensure the service user is protected from abusive practices and ensures service user safety
9.2	**Mental Capacity Act and Deprivation of Liberty Safeguards**	
	9.2.1	The provider will ensure that assessment of capacity relating to making specific decisions is based on a functional test of capacity
	9.2.2	The provider will ensure that decisions taken by staff on behalf of a service user are demonstrably in the service users best interests and have taken into account • The individuals past and present wishes and feelings • Any belief and values which would have influenced their decision • The view of their support network and other professionals
9.3	**Health and Wellbeing**	
	9.3.1	The provider will ensure that service users reach their potential for independence, good health and wellbeing by receiving the health care and medication they need in a pro-active way to manage their health, delivered by experienced and qualified professionals
	9.3.2	The provider will ensure the service user is supported to access primary and secondary care e.g. General Practitioners (GP's) and Dentists
	9.3.3	The provider will ensure that the health needs of each service user are proactively managed through regular review of needs, liaison with external health professionals and delivery by competent health staff. Unnecessary hospital admissions are avoided through management of health and wellbeing needs.

Additional Information – Client Group Specific

Lot 1: People with a Learning Disability including Co-Morbidities

10.0	**PEOPLE WITH LEARNING DISABILITY (Includes behaviours and a range of co-morbidity health needs)**	
10.1	The provider will deliver services to service users with learning disabilities across the spectrum of need.	
10.2	The provider will ensure that, where applicable, it is able to meet the needs of people who present across the spectrum of medically diagnosed disabilities and syndromes.	
10.3	Service users with learning disabilities shall be supported by the provider to have an annual health check in accordance with the Cardiff Health Check tool with their GP.	
11.0	**STAFF SKILLS SET FOR LEARNING DISABILITIES SERVICE DELIVERY**	
11.1	The provider will ensure that staff who are deployed to provide care to any service user who has a learning disability:	
	11.1.1	are qualified to /or working towards at least Qualification and Credit Framework (QCF) Health and Social Care Diploma Level 2 within twelve (12) months of the Agreement Commencement Date;
	11.1.2	are experienced in working with service users with a broad spectrum of Learning Disabilities from low level to complex and challenging behaviour, forensic background, people discharged from low, medium, high secure hospitals, people stepping down from assessment and treatment services, people with Learning Disabilities who are sectioned under the Mental Health Act (dual diagnosis), dementia, Learning Disabilities and Autism, co-morbidity, complex health needs;
	11.1.3	are trained and have an awareness around epilepsy, diabetes and autism and where appropriate have the skills and training to manage people that present challenges to services;
	11.1.4	are trained and have an awareness around the Mental Health Act and demonstrate the necessary skills to support service users that have a forensic background;
	11.1.5	are trained to assume that different service users have capacity in differing levels and act accordingly;
	11.1.6	demonstrate an ability to (firstly) support service users to re-integrate back into the community following a hospital stay and (secondly) to prevent people from offending / re-offending and (thirdly) provide rehabilitation to service users that have offended;
	11.1.7	(for service users who are stepping back into community services from hospital) are recovery focused, so that clear relapse plans and protocols are in place to ensure that Service Users are prevented from re-offending and their care is coordinated within a Multi Disciplinary approach;
	11.1.8	are adequately trained in conflict resolution, positive risk management techniques and behaviour management;
	11.1.9	are able to manage crisis situations and ensure appropriate steps are taken to resolve or manage the presenting situation;
	11.1.10	are able to provide emotional support, therapeutic input;
	11.1.11	are well trained in proactive behavioural management and ensure where appropriate robust behaviour management plans are implemented and have appropriate training to support Service Users that present with challenging behaviour (i.e. MAPPA or alternatives);
	11.1.12	work within a Multi Disciplinary approach and ensure care is coordinated;
	11.1.13	demonstrate a level of flexibility to ensure that care and support is delivered within a person centred approach and meets the needs of the individual within a least restrictive manner;

	11.1.14	are well trained in the management of actual and potential aggression;
	11.1.15	are trained and work to the philosophy of enabling the service users for whom they provide care to be in control and also work alongside such service users to either retrieve lost skills or to build on their existing skills and maximise their independence.

Lot 2: People with Autism

12.0	**PEOPLE WITH AUTISM**	
12.1	The provider shall deliver services to service users who are on the Autism Spectrum Disorder, who can present in the following ways:	
	12.1.1	have difficulty with social communication, interaction and imagination
	12.1.2	have Aspergers Syndrome
	12.1.3	have high functioning Autism
	12.1.4	have additional needs (i.e. mental health, physical disabilities and sensory impairments);
	12.1.5	have Classic or Kanner Autism
	12.1.6	have Persuasive Development Disorder
12.2	The provider will be able to demonstrate that it meets, or is working towards, nationally or internationally recognised autism specific quality standards.	
12.3	The provider will ensure where applicable that it is able to meet the needs of service users who present with varying medically diagnosed syndromes.	
13.0	**STAFF SKILLS SET FOR AUTISM SERVICE DELIVERY**	
13.1	The provider will ensure that staff who are deployed to provide care to any service user who has Autism:	
	13.1.1	use appropriate communication skills when supporting a person with autism
	13.1.2	support families and friends and make best use of their expert knowledge of the person
	13.1.3	recognise when a person with autism is experiencing stress and anxiety and support them with this
	13.1.4	recognise sensory needs and differences of a person with autism and support them with this
	13.1.5	support the development of social interaction skills
	13.1.6	provide support with transitions and significant life events
	13.1.7	understand the issues which arise from co-occurrence of mental ill health and autism
	13.1.4	are trained and have an awareness around autism and demonstrate the necessary skills to support service users that have a forensic background;
	13.1.5	are trained to assume that different service users have capacity in differing levels and act accordingly;
	13.1.6	are adequately trained in conflict resolution, positive risk management techniques and behaviour management;
	13.1.7	are able to manage crisis situations and ensure appropriate steps are taken to resolve or manage the presenting situation;
	13.1.8	are able to provide emotional support, therapeutic input;
	13.1.9	are well trained in proactive behavioural management and ensure where appropriate robust behaviour management plans are implemented and have appropriate training to support service users that present with challenging behaviour (i.e. MAPPA or alternatives);
	13.1.10	work within a multi disciplinary approach and ensure care is coordinated;
	13.1.11	demonstrate a level of flexibility to ensure that care and support in delivered within a person centred approach and meets the needs of the individual within a least restrictive manner;
	13.1.12	are well trained in the management of actual and potential aggression;

Lot 3: People with a Physical Disability

14.0	**PEOPLE WITH A PHYSICAL DISABILITY**	
14.1	The provider shall deliver the service to people with physical disabilities/impairment across the full spectrum of need.	
14.2	The provider shall acknowledge that people with physical disabilities may have challenges / require support with areas including:	
	14.2.1	mobility
	14.2.2	manual dexterity
	14.2.3	physical co-ordination
	14.2.4	continence
	14.2.5	ability to lift, carry or otherwise move everyday items
	14.2.6	speech, hearing or eyesight
	14.2.7	memory or ability to concentrate, learn or understand
	14.2.8	perception of risk and physical danger
	14.2.9	access to services and facilities including community, mainstream and specialist resources
14.3	The provider will acknowledge that no one definition of physical disability covers the full range of conditions that constitute a physical disability. However to give an indication of the complex nature and range of physical disabilities that are covered by this specification the list includes (but is not exhaustive of) the following neurological conditions:	
	14.3.1	Neurological conditions resulting from damage to the brain, spinal column or nerves, caused by illness or injury. Examples include: • Acquired Brain Injury (ABI) – i.e. an injury caused to the brain since birth. There are many possible causes, including stroke, haemorrhage, infection, hypoxic/anoxic brain injury and tumour. • Traumatic Brain Injury (TBI) is if the head receives a severe blow or jolt, for example in an accident, fall or assault, the brain can be damaged. Spinal Injury.
	14.3.2	Conditions such as Duchenne Muscular Dystrophy and Cerebral Palsy.
	14.3.3	Neuro-degenerative conditions, such as multiple sclerosis and motor neurone disease, which affect people mainly in adulthood and will cause deterioration over time.
14.4	The provider will ensure it is able to meet the needs of service users who present with varying medically diagnosed syndromes; some of which will be uncommon and will require the provider to gain awareness and knowledge about the specific syndrome/ condition in question.	
15.0	**STAFF SKILLS SET FOR PHYSICAL DISABILITY SERVICE DELIVERY**	
15.1	The provider will ensure staff who are deployed to provide care to any service user who has a physical disability have also undertaken the following (and ongoing refreshers):	
	15.1.1	disability awareness
	15.1.2	deaf and hearing loss awareness
	15.1.3	visual impairment awareness
	15.1.4	dual sensory loss awareness
	15.1.5	adult safeguarding
15.2	The provider will ensure staff are qualified to/working towards at least Qualification and Credit Framework (QCF) Health and Social Care Diploma Level 2 within 12 months of the agreement commencement date	
15.3	The provider will ensure staff undertakes any requisite training and education relating to the assessed needs of the service users before commencing the provision of care e.g. mental capacity, condition specific training, deaf blind communication and guide	

15.4	The provider will ensure staff have the knowledge and experience in working with service users with a broad spectrum of physical disabilities and sensory impairments from low to complex needs and related enablement	
15.5	The provider will ensure that staff receive training and work to the philosophy of enabling the service users for whom they provide care to be in control and also work alongside such service users to either regain their skills or to build on their existing skills in order to maximise their independence;	
15.6	The provider will ensure that staff are aware of the progressive nature of some physical disabilities and that the service users in question will need to be regularly reviewed to account for this and outcomes amended in line with their changing needs and aspirations;	
15.7	The provider will ensure that staff are trained in specific progressive conditions such as Muscular Dystrophy (MD), Multiple Sclerosis (MS), Spinal Injury, Motor Neurone Disease (MND) and Huntington's Disease (HD) so that any service user who has any such condition has their care delivered appropriately and particularly in the context of palliative care.	
15.8	The provider will ensure that staff are trained and have an awareness around Epilepsy, Diabetes and Autism and where appropriate have the skills and training to manage people that present challenges to services,	
15.9	The provider will ensure that staff who are deployed to provide care to any service user who is either deaf and/or deaf blind:	
	15.9.1	are experienced in communicating in deaf blind manual and communicator guidance and have a nationally recognised qualification
	15.9.2	have at least a level 2 certificated and accredited qualification in British Sign Language (BSL)
	15.9.3	work within a Multi Disciplinary approach and ensure each service user's care is coordinated;
	15.9.4	demonstrate a level of flexibility to ensure that care is delivered within a person centred approach and meets the needs of each individual service user in the least restrictive manner.

Lot 4: People with a Sensory Impairment

16.0	**PEOPLE WITH A SENSORY IMPAIRMENT**	
16.1	The provider will ensure that the physical environment (particularly in community supported living) meets the needs of service users who have a sensory impairment. This includes appropriate lighting, contrasting colours on walls and floors, raised tactile signage (Braille, Moon, Symbols) and assistive technology to alert service users who have a hearing impairment	
16.2	The provider will ensure that where appropriate it has a range of sensory equipment and assistive technology to support and re-enable service users - e.g. text phones, magnifiers, speaking items such as clocks, flashing lights etc. It is not always appropriate for the provider to supply all of the items required so they must refer the individual for specialist support such as low vision clinics, rehabilitation officers, or specialist third sector providers to access specialist resources.	
16.3	As detailed in the skills required for delivery of these services, information and communication is critical to the delivery of the service with staff being appropriately skilled and trained to ensure communication is appropriate and of a high standard.	
16.4	Where an individual service user lives in their own home in the community, where appropriate a referral should be made for an assessment of their sensory needs to ensure any suitable equipment is provided.	
15.4	The provider will ensure staff are qualified to manage service users with behaviours that challenge, which may include positive behaviour management techniques that support to reduce the occurrence, severity or impact of behaviours which challenge.	
17.0	**STAFF SKILLS SET FOR SENSORY IMAPIRMENT SERVICE DELIVERY**	
17.1	The provider will ensure staff who are deployed to provide care to any service user who has a physical disability have also undertaken the following (and ongoing refreshers):	
	17.1.1	Disability awareness
	17.1.2	Deaf and hearing loss awareness
	17.1.3	Visual impairment awareness
	17.1.4	Dual sensory loss awareness
	17.1.5	Adult safeguarding
17.2	The provider will ensure staff are qualified to/working towards at least Qualification and Credit Framework (QCF) Health and Social Care Diploma Level 2 within 12 months of the agreement commencement date	
17.3	The provider will ensure staff undertakes any requisite training and education relating to the assessed needs of the service users before commencing the provision of care e.g. mental capacity, condition specific training, deaf blind communication and guide	
17.4	The provider will ensure staff have the knowledge and experience in working with service users with a broad spectrum of physical disabilities and sensory impairments from low to complex needs and related enablement	
17.5	The provider will ensure staff receive training and work to the philosophy of enabling service users for whom they provide care to be in control and also work alongside such service users to either regain their skills or to build on their existing skills in order to maximise their independence;	
17.6	The provider will ensure staff are aware of the progressive nature of some physical disabilities and the service users in question will need to be regularly reviewed to account for this and outcomes amended in line with their changing needs and aspirations;	
17.7	The provider will ensure staff are trained in specific progressive conditions such as Muscular Dystrophy (MD), Multiple Sclerosis (MS), Spinal Injury, Motor Neurone Disease (MND) and Huntington's Disease (HD) so that any service user who has any such condition has their care delivered appropriately and particularly in the context of palliative care.	

17.8	The provider will ensure staff are trained and have an awareness around Epilepsy, Diabetes and Autism and where appropriate have the skills and training to manage people that present challenges to services,	
17.9	The provider will ensure staff who are deployed to provide care to any service user who is either deaf and/or deaf blind:	
	17.9.1	are experienced in communicating in deaf blind manual and communicator guidance and have a nationally recognised qualification
	17.9.2	have at least a level 2 certificated and accredited qualification in British Sign Language (BSL)
	17.9.3	work within a multi disciplinary approach and ensure each service user's care is coordinated;
	17.9.4	demonstrate a level of flexibility to ensure care is delivered within a person centred approach and meets the needs of each individual Service User in the least restrictive manner.

Lot 5: People with Mental Health (Functional Illness)

18.0	**MENTAL HEALTH (FUNCTIONAL ILLNESS)**	
18.1	This specification applies to adults who have been diagnosed with a functional mental health illness (or similar conditions that have been formally assessed by an appropriate clinician) including the following conditions (without limitation): • Anxiety and panic disorders • Eating disorders • Depression • Psychotic disorders • Impulse control and addiction disorders • Bipolar disorders • Obsessive compulsive disorder (OCD) • Post-traumatic stress disorder (PTSD) • Personality disorder	
18.2	The provider will understand that this specification for service users with a functional mental health illness, refers to a range of multiple and additional needs that some service users for the mental health (functional illness) service may have, including individuals with profound and multiple disabilities and those who present with challenging behaviours referred to as “Complex Care”.	
19.0	**STAFF SKILL SET FOR MENTAL HEALTH (FUNCTIONAL ILLNESS) SERVICE DELIVERY:**	
19.1	The provider will ensure staff who provide care to any service user who has a functional mental health illness:	
	19.1.1	are operating to CQC standards of its workforce requirements;
	19.1.2	are qualified to /or working towards at least Qualification and Credit Framework (QCF) Health and Social Care Diploma Level 2 within 12 months of contract award;
	19.1.3	are able to complete a structured induction process (currently CIS, common induction standards, soon to be replaced by the Care Certificate) and a training programme for Staff or volunteers which focuses on and is appropriate to the needs of the Service Users;
	19.1.4	are aware of the main sub-types of functional illnesses which are listed in Paragraph 1.1 of this Schedule;
	19.1.5	have an understanding of the most common causes of ‘Functional Mental Health Illnesses’ as follows: • **Biological Factors:** genetics (heredity); infections; brain defects or injury; prenatal damage; substance abuse; nutrition. • **Psychological Factors:** severe psychological trauma suffered as a child, such as emotional, physical, or sexual abuse, an important early loss, such as the loss of a parent, neglect, poor ability to relate to others • **Environmental Factors:** death or divorce, a dysfunctional family life feelings of inadequacy, low self-esteem, anxiety, anger, or loneliness, changing jobs or schools, social or cultural expectations, substance abuse by the person or the person's parents

	19.16	have a good understanding of the behaviours and symptoms which are associated with Functional Mental Health Illness as follows: • anxiety; • agitation; • depression; • verbal aggression; • physical aggression; • calling out or shouting; • culturally inappropriate behaviour; • sexually inappropriate behaviour; • visual and auditory hallucinations and responding; • risk behaviours.
	19.1.7	are able to demonstrate the use of appropriate interventions associated with managing Functional Mental Health Illness such as: • use of recovery star or similar; • use of ABC charts and guidance; • good communication; • identification of triggers; • establishing a routine; • distraction; • exercise; • encouraging participation in activities; • requesting GP assessment and treatment of physical ill health/pain.
	19.1.8	are aware of the risks and side effects of using antipsychotics.
	19.1.9	complete a risk assessment that includes anti ligature audits for all users at risk of self-harm or suicide.
	19.1.10	are aware of the following publications to inform the planning and delivery of each Services User's Care: No health without Mental Health No health without mental health (dh_12 Closing the Gap Closing_the_gap_V2_-_17_Feb_2014.pdf

Lot 6: People with Mental Health (Dementia)

20.0	**MENTAL HEALTH (DEMENTIA)**	
20.1	This specification covers adults diagnosed with a dementia that has been formally assessed by an appropriate clinician. The most common dementias are: • Alzheimer's disease • Vascular dementia • Mixed dementias • Dementia with Lewy Bodies • Frontotemporal dementia • Parkinson's disease dementia •	
20.2	The provider must understand this specification refers to a range of multiple and additional needs that some service users for mental health (dementia) SLHS may have. People with dementia often have co morbidities and they are more vulnerable e.g. three times more likely to fall, five times more likely to develop a delirium associated with an infection and are likely to have associated behaviours that challenge. Providers should ensure they understand these additional needs.	
21.0	**STAFF SKILL SET FOR MENTAL HEALTH (dementia) SERVICE DELIVERY:**	
21.1	The provider will ensure staff who provide care to any service user who has dementia:	
	21.1.1	are operating to CQC's standard of its workforce requirements.
	21.1.2	are qualified to /or working towards at least Qualification and Credit Framework (QCF) Health and Social Care Diploma Level 2 within 12 months of contract award
	21.1.3	complete a structured induction process (currently CIS, common induction standards, soon to be replaced by the Care Certificate) including a training programme for Staff or volunteers which focuses on and is appropriate to the needs of the Service Users.
	21.1.4	are aware of the main sub-types of dementia listed in 1.1.
	21.1.5	have an understanding of the most common causes of 'Behavioural and Psychological Symptoms of Dementia' ("BPSD") as follows: • Fear • Pain • Effects of medication • Boredom • Environmental factors e.g. noise, heat, cold • Environment changes e.g. changing room, new home • Changes to routine • Poorly fitting clothing • Sleep disturbance • Sensory impairment • Communication difficulties • Delirium • Co-morbid mental health issues e.g. depression • Progression of dementia

	21.1.6	have a good understanding of the behaviours which are associated with BPSD as follows: • Anxiety • Agitation • Wandering (not usually aimless) • Verbal aggression • Physical aggression • Calling out or shouting • Following/shadowing • Culturally inappropriate behaviour • Sexually inappropriate behaviour • Hallucinations
	21.1.7	are able to demonstrate the use of appropriate interventions in the Home associated with managing BPSD such as: • Use of ABC charts and guidance • Good communication • Identify triggers • Establishing a routine • Distraction • Exercise • Encouraging participation in activities • Requesting GP assess and treatment of physical ill health/pain • Use of the Abbey pain scale
	21.1.8	are aware of the following publications to inform the planning and delivery of the services users care/support: Awareness of the DoH publication *Living Well with Dementia: a National Dementia Strategy (2009)* Awareness of the DoH publication *Nothing Ventured, Nothing Gained: Risk Guidance for People with Dementia (2010)* Awareness of NICE publication *Dementia: Supporting People with Dementia and their Carers in Health and Social Care (2006)* Awareness of NICE publication: *Mental wellbeing of older people in care homes (2013)* Awareness of Skills for Care publication *Supporting People in the Advanced Stages of Dementia (2013)*
	21.1.9	have a working knowledge of the most common drug groups used in the treatment of mental health and dementia, their indications for use, forms (e.g. liquid), and common side effects: • Antipsychotics • Antidepressants • Anxiolytics • Hypnotics • Mood stabilisers • Acetylcholinsterase inhibitors (dementia drugs)

	21.1.10	Behaviour that Challenges In addition to the BPSD requirements listed in Paragraphs 6.1.5 to 6.1.7, the provider will also ensure that its Staff have training in management of actual or potential aggression (MAPA) techniques or similar training and are familiar with assessing for BPSD and delirium as these are often misdiagnosed as a progression of dementia
	21.1.11	Assessment Tools The provider will ensure its staff utilise tools to assist with the assessment of pain, delirium and behavioural issues in relation to each service user (where applicable)

Appendix B - Lot 7: Supported Living - Specialist Service for 16/17 Year Olds with Complex Needs (including Learning Disabilities, Autism, Physical Disability and Mental Health)

Service Profile	
Service Name	Supported Living - Specialist Service for 16/17 Year Olds with Complex Needs (including Learning Disabilities, Autism, Physical Disability and Mental Health)

Introduction

The provision of supported accommodation services for all children aged 16-17 years old for whom the Local Authority has a statutory duty, including young people who are looked after, and/or leaving care and/or homeless and/or who are known to the youth offending service and/or are either at risk of offending, and/or the edge of custody, and/or released from custody.

Young people are safeguarded from harm, with their development, wellbeing and life chances promoted. We will achieve this by working openly with young people, their families (where possible) and collaboratively with partners.

Young people are supported to bring about change, in solution-focused ways, building on their strengths, so that they can maximise opportunities to improve their life chances, benefit from good parenting, consistent boundaries, emotional warmth and are equipped with life skills and resilience.

Young people are supported to re- build, maintain and enhance family and social networks (wherever possible), reducing social isolation and building resilience.
Young people in care and care leavers receive stability through high quality provision and care planning from local authorities and their partners, acting collaboratively as corporate parents.

Service Description	
Service Name	Supported Living - Specialist Service for 16/17 Year Olds with Complex Needs (including Learning Disabilities, Autism, Physical Disability and Mental Health)
Type of service	To provide accommodation and support to 16/17 year olds with complex needs and help them to maintain a tenancy, improve health and wellbeing and promote independence.
Service Description	

Services provided	To deliver short term / brief interventions to include:
	• Risk Assessment
	• Accommodation & Support for 16/17 year olds with;
	  • Complex Needs
	  • Learning Disabilities
	  • Autism
	  • Physical Disability
	  • Mental Health

Service delivery location	Walsall and surrounding area
Service availability (times) & access	Flexible hours – according to need.
Duration of Service	Up to the age of 18
Service Availability	
Primary Service User group	The provision of supported accommodation services for all children aged 16-17 years old for whom the Local Authority has a statutory duty, including young people who are looked after, and/or leaving care and/or homeless and/or who are known to the youth offending service and/or are either at risk of offending, and/or the edge of custody, and/or released from custody
Age	16/17
Ethnic or Culturally-Specific Group Supported	As required
Language(s) Supported	As required
Religions Supported	As required
Referral Routes	- Placement Team – Children Services - Money, Home, Job
Additional Information	

1. The Service

1.1 The outcomes and service requirements specified will be applied in the context of, and as relevant to, any special conditions agreed between the Parties and as set out in the IPA for the Young Person in question.

1.2 The Provider must provide safe accommodation for those aged 16/17 years old who may be vulnerable and have specific needs including, but not exclusively;

Learning disabilities	• Across the spectrum of need
Autism	• difficulty with social communication, interaction and imagination • Aspergers Syndrome • high functioning Autism • additional needs (i.e. learning disabilities, mental health, physical disabilities and sensory impairments); • Classic or Kanner Autism • Persuasive Development Disorder
Physical disability	• mobility • manual dexterity • physical co-ordination • continence • ability to lift, carry or otherwise move everyday items • speech, hearing or eyesight • memory or ability to concentrate, learn or understand • perception of risk and physical danger • access to services and facilities including community, mainstream and specialist resources
Mental health	• Anxiety and panic disorders • Eating disorders • Depression • Psychotic disorders • Impulse control and addiction disorders • Bipolar disorders • Obsessive compulsive disorder (OCD) • Post-traumatic stress disorder (PTSD) • Personality disorder

1.3 The Provider must be able to provide emergency and/or short stay supported accommodation.

1.4 The Provider must be able to provide therapeutic or specialist supported accommodation.

1.5 This Service Specification is generic and relates to the provision of Support in all Accommodation, therefore, the outcomes, service requirements and performance indicators which are set out in section ?? shall apply in the context of and as relevant to:
(1) the specific conditions of the Accommodation in question;
(2) the specific conditions which have been agreed between the Council and the Provider in relation to the provision of Support to each Young Person as set out in their IPA and Individual Placement Agreement Variation (IPAV).

1.6 The Provider will work to ensure that progress achieved by individual young people can be sustained to optimise their life chances and future choice of accommodation/transition.

1.7 The service shall operate flexibly to meet the specific and changing needs of individual young people. The type of supported accommodation shall reflect the differing stages through a pathway from prevention, access, progression and move on to independence or return to family, with an expectation that the needs will reduce over time as the young people become more independent

1.8 The Service shall operate a flexible approach to the need for emergency or short term placements and where possible offer an emergency out of hours placement service within the limitations of the Providers resources and should be agreed with the Council on an individual basis.

1.9 Where additional services are required, then this should be detailed in the Individual Placement Agreement Variation (IPAV) form.

2. Referrals

2.1 The Council shall:

a. Initially make a referral to the Provider by sending the Council's referral form for the Young Person in question, via ?? or electronic mail, which will be sent to the Provider by the Council to an email address nominated by the Provider, at any time, on any day;
b. Ensure that the referral information is current, accurate and sufficient for the Provider to make a judgement about the Young Person's needs in matching with its Accommodation and Support provision, and respond to further enquiries/clarification from Providers.
c. Ensure that each referral form states:
    i. Accommodation and support applicable to the Young Person in question;
    ii. The number of support hours required
    iii. Approximate date of commencement of the Service or Placement of the Young Person in question;
    iv. The name and contact details of the Authorised Officer who is responsible for making the referral.
    v. If in an emergency state the timescales i.e. same day or within 48 hours.
    vi. Provide a profile of the young person and include specific needs, risks and offending behaviours.
    vii. Ensure that all referrals include the young person's initials and a unique reference number for that young person and that this is quoted in all correspondence.
    viii. Provide an indication of the age of the young person by year and part year.
    ix. Ensure that the Provider is aware of the name of the Case Managing Social Worker/Personal Advisor allocated to an individual young person and to update the Provider on any changes in Case Manager as the key point of contact in relation to the individual placement

2.2 The Council's decision to place a Young Person will be based on a current assessment of their needs and other documentation relating to the Young Person in question including (without limitation):

a. their Pathway Plan or Care Plan (as applicable),
b. a risk assessment which takes into account any indicators of risk including challenging behaviour;
c. their Health Plan (if any);
d. any other information from other relevant agencies (e.g. CAMHS, Sustain, etc.).
e. Suitability of location
f. Experience and qualifications of staff meeting the needs of the young person.
g. The Service meeting the specific needs of the young person

2.3 If the referred Young Person is to be placed with another Young Person, then the Council shall ensure that its relevant Authorised Officer discusses with the Provider any impact of placing the Young Person in question with another Young Person and any likely effect on the physical, emotional or social well being of that Young Person or any Young Person already occupying the Accommodation. No shared placements to take place until all parties are in agreement and this is confirmed by all parties in writing.

2.4 Following the confirmation of the Placement of an individual Young Person with the Provider, each of the Parties shall comply with the requirements in relation to the IPA for the Young Person in question, by returning the fully completed and signed IPA within the 14 days of issue.

3. Placement in Accommodation

3.1 Prior to the commencement of the Placement of a Young Person in any Accommodation, the Provider shall (as a minimum):

a. Allocate a Support Worker to act as the 'key worker' for each Young Person in question, and the name of the key worker provided to the young person, Social Worker/Personal Advisor or other appointed person from the Council;
b. If more than one support worker on a regular basis then one must be a named 'key worker' for the young person
c. Where the referral timescale for the Young Person in question allows, arrange:
    i. for the key worker to visit the Young Person in question in their current place of residence;
    ii. for the key worker to work with the Young Person in question and their social worker/personal adviser (as applicable) to agree a Support Plan to link with the IPA;
    iii. ensure that, where applicable, the young person is aware of the need to contribute a weekly sum to the provider towards utilities
    iv. at least one introductory visit by the Young Person in question to the Accommodation in order to
        1. Introduce the Young Person to all members of Staff and any other Young People living at the Accommodation (where applicable);
        2. Familiarise the Young Person with the Accommodation and their own personal space within it and any associated communal areas and to make the Young Person aware of facilities within the immediate locality of the Accommodation.
        3. Familiarise the young person with any documentation including the Welcome/ information pack provided
        4. If placing in a shared accommodation undertake a risk impact assessment with any other current occupants.

3.2 The Council shall ensure that the social worker/personal adviser (as applicable) or other named person identified by the Council visits the Young Person in question at the Accommodation:

a. on the day of the commencement of the Young Person's Placement, and;
b. within seven (7) days of the commencement of the Young Person's Placement;
c. then regularly and as a minimum in line with statutory requirements
d. an 'occupancy agreement' (in a form which shall be approved by the Council (acting reasonably)) is signed by the Young Person in question and the Provider, with the Young Person retaining a copy. A copy must also be forwarded electronically to the Social Worker/Personal Advisor or other appointed person from the Council.
e. the Young Person in question is made aware of any health and safety issues in a form that can be clearly understood by the Young Person in question, recognising any disability and language barriers.
f. the property has been fully inspected by the Provider and all gas, electrical safety, smoke and carbon monoxide alarms and fire safety checks have been carried out and that the property is fully furnished and equipped as per the core cost specification

3.3 The Provider shall forward a copy of the signed 'occupancy agreement' which has been entered into by the Provider and the Young Person in question to the allocated Case Managing Social Worker/Personal Advisor within seven (7) days of its completion.
No Occupancy Agreement should infer any Landlord and Tenant Relationship.

3.4 The Council has a duty to minimise the number of moves a Young Person experiences and the disruption, however, if it is clearly evident that the Placement is not suitable and cannot achieve the intended outcomes for the Young Person in question, this must be determined and acted upon in accordance with the Conditions of Contract.

4. Provision of the Services to Individual Young People

4.1 Throughout the Placement of each Young Person in their Accommodation, the Provider shall work with the Council to assist in the implementation of their individual Pathway Plan, including (as applicable) their Care Plan, Education plan and health plan (if any) and shall prepare and provide written 4 weekly progress reports, to be sent electronically on a 4 weekly cycle to the Case Managing Social Worker/Personal Advisor. Along with any assessments on each individual Young Person for the purposes of planning meetings, safeguarding meetings, Review Meetings, court proceedings, monitoring, and any other documentation which is required by the Council from time to time during their Placement with the Provider. The Provider shall also participate in the preparation of any other reports as required from time to time by the Council. The 4 weekly reports are to include detail as per the Core Cost Specification, which will include recording any missed support sessions and the reasons for this along with the start time and end times of each support session.

4.2 The Council shall ensure that each Young Person's social worker/personal adviser (as applicable) co-ordinates how services will be provided for the Young Person in question, developing constructive professional relationships, in order that all agencies recognise their important investment in enabling the Young Person in question to succeed as they make their transition to adulthood by working in partnership with the support worker and their local knowledge.

4.3 The Provider shall also work in partnership with the Council:

a. to ensure that the assessed needs of each Young Person are based upon all relevant and up-to-date information;
b. to monitor the needs of each Young Person and address any changes in their needs and to advise the Social Worker/Personal advisor of any changes promptly via telephone if urgent, or via email;
c. to review each Young Person's Support Plan twenty-eight (28) days after the commencement of their Placement and thereafter in accordance with statutory guidance throughout their Placement and to feedback any changes to the Social Worker or Personal Advisor, via email.
d. to discuss and resolve any concerns there may be for the young person if they feel the young persons are not met and challenge the Council if they consider this is the situation.
e. Enables a young person to achieve the primary aim for them to gain the necessary skills to live independently at 18.

5. Duty of Care

5.1 The Provider shall have a duty of care for each Young Person from the time that the Provider collects or receives the Young Person in question until such time that the Young Person in question leaves the Placement and the IPA expires or is terminated.

6. Notice of Termination of Placement/IPA's/IPVA's

6.1 The Parties shall act at all times in relation to the Contract and each IPA in good faith in order to meet the needs of the Young Person. When an IPA is to be terminated, both Parties to the IPA shall support a smooth transition of the Support and Accommodation arrangements for each affected Young Person.

6.2 An IPA may end by the expiry of the framework period specified in the IPA or by termination on the following periods of notice in writing by either Party to the IPA, IPAV as detailed ????

7. Staff Training

7.1 The Provider shall ensure that at least 80% of staff who work with young people are qualified to at least level 3 NVQ/QCF or equivalent in a subject related to, or transferrable to, the needs of young people aged 16 and 17. Those staff not qualified should be working towards a related QCF qualification and complete within 18 months of commencement of their role as support staff.

7.2 The Provider shall ensure that its Staff are trained to understand and be sensitive to the diverse cultural, religious and ethnic needs of Young People and shall provide guidance on use of translation and interpreting services where necessary.

7.3 The Provider shall ensure that its Staff receive appropriate training and maintain a record of all training which is provided or arranged by it for each member of its Staff from time to time during the Framework period. Appropriate training shall include (but not be limited to) the following:

a child protection (safeguarding);
b health and safety and first aid;
c managing difficult and emergency situations;
d food handling (where appropriate);
e substance misuse, including both legal and illegal drug use and alcohol;
f equality and diversity;
g working towards an appropriate qualification at level 3 Quality and Credit Framework (QCF) Diploma or above (or its equivalent)
h Child Sexual Exploitation
i Missing Children
j Mental Health
k Behavioural Issues
l Offending behaviour
m Self Harm
n Prevent Agenda
o Domestic Violence
p Human Trafficking/Modern Slavery

7.4 The Provider shall ensure that its Staff are familiar with the Provider's policies and procedures via ongoing supervision and training.

8. The provision of Accommodation

8.1 All properties within which Accommodation is located must comply with the Management of Houses in Multiple Occupation (England) Regulations 2006 and the Housing Act 2004 standards.. Details of ownership of the Accommodation and person(s) responsible for repairs must be disclosed, on demand, both to the Council and to local housing authority department officers responsible for enforcement

8.2 The Provider shall provide suitable Accommodation for the provision of the Services, ensuring that the property within which the Accommodation is located includes:

External

a. a safe, well lit and easily accessible entrance;
b. clean tidy, well lit and maintained communal areas;
c. gardens/yard and paths which are clear from rubbish and overgrown vegetation, shrubs or trees;
d. gates and fences in functional good order;

e. a washing line or rotary dryer
f. free from rubbish

Internal

a. external doors fitted with a 5 levered mortice deadlock or multipoint locking system with an internal thumb turn;
b. windows in good state of operational repair and any windows above ground level that could present a danger to a Young Person fitted with a restrictor mechanism to limit the opening to no more than 100mm;
c. adequate fixed heating sufficient to heat the Accommodation with a timer/thermostat;
d. where feasible and appropriate, prepay/card/key meters;
e. decoration of walls, ceilings and woodwork to be clean and free from obvious marking and dirt, and any wallpaper to be securely fixed and in good order;
f. free from any damp, mould and condensation;
g. adequate insulation to ensure a warm comfortable home;
h. hot water cylinders which are foam lagged or fitted with insulation jacket; an adequate number of power points throughout;
i. any glazed doors must have either Georgian wired glass, or be glazed with safety glass or safety film applied;
j. hardwired or non replacement battery smoke alarms to meet current standards and in converted houses or above commercial premises electronically operated interlinked smoke alarms;
k. kitchen units, including work surfaces and any appliances supplied, which are free from defects and are clean and free from excessive wear;
l. have the number of kitchen units and work surfaces stated in the Core Cost Specification for Fully Furnished and Equipped Accommodation (Appendix 4), and which are sufficient for the number of occupants;
m. suitable floor coverings throughout the Accommodation with bathrooms, toilets and kitchens which are free from defects and clean and free from excessive wear;
n. curtain rails/poles, curtains or blinds fitted to all windows with the exception of the kitchen where blinds only should be fitted;
o. bathroom and toilet facilities sufficient for the number of occupants;
p. bathroom facilities, including toilet, bath, shower and wash hand basin free from defects and in good working order;
q. furniture and equipment as listed in the Core Cost Specification for Fully Furnished and Equipped Accommodation which are clean, of good serviceable condition and conform to current BS standards where appropriate;
r. (where applicable) an appropriate common seating or kitchen area suitable for the number of occupants and accessible at all times;
s. suitable laundry facilities to suit the level of occupancy.

8.3 The Provider shall implement a regular programme of maintenance for the Accommodation and all equipment, fixtures and fittings therein, to ensure that the same are safe, clean, in good working order and otherwise well maintained at all times;

8.4