SALFORD CITY COUNCIL AND NHS SALFORD CLINICAL COMMISSIONING GROUP

INTEGRATED HEALTH AND SOCIAL CARE COMMISSIONING JOINT COMMITTEE (ICJC)

AGENDA ITEM NO 7

Item for Decision

INTEGRATED COMMISSIONING JOINT COMMITTEE (ICJC): 9 May 2018

| REPORT OF:     | Judd Skelton                      |
| DATE OF PAPER: | May 2018                          |
| SUBJECT:       | Learning Disability Supported Tenancy Tender |
|                | Moving on Up Project Tender       |
| IN CASE OF QUERY | PLEASE CONTACT: | Kerry Thornley |
PURPOSE OF PAPER:

The purpose of this ICJC paper is to present two draft contract specifications to ICJC members for final approval prior to commencing the tender process.

1. The Learning Disability Supported Tenancy Contract Specification, and
2. Moving on up Project (MOUP) for young people with ADHD and/or ASC

(please note that appendices will be added as tender documents are developed. Contract monitoring is still in development with the ICO and will be added prior to tender)

Summary (1): The Learning Disability Supported Tenancy Service Specification
This service specification has been a collaborative approach with service users, their families and staff working in schemes. It also incorporates the GM standards developed as part of the work carried out to develop the flexible purchasing system for LD. This is traditional supported tenancy for people with Learning Disabilities but incorporates some key factors that People and their families told us were important to them; such as friendships, relationships and being part of their own community. The network consists of 60 properties, supports approximately 170 people and has a contract value of around £7.8m.

This contract will be procured using the GM LD Flexible Purchasing system that supports ethical and social value. Conditions applied in the homecare tender re: employment conditions and min pay will be replicated in this tender.

Summary (2): Moving on up Project (MOUP)
This service specification is derived from a 3yr project and was initially developed as a pilot to reduce the impact of a number of young people in transitions, with high cost packages of care, but who did not fit traditional service models. This pilot has been successful, securing financial savings and is being developed as a tender opportunity. There are different levels/elements to this service, which is reflected in the detail of the specification.

The main house accommodates 4 people, but more are supported in the community as they move on to greater independence, and we plan to increase this element going forward. 17 young people have accessed this service so far, the overall cost is changeable and specific to the group of individuals accessing support at one time. The current cost is £354,049.

The main outcomes from this service are: People self-managing their own conditions; achieving greater independence and reducing reliance on paid support.

Though this is procured and managed as part of the LD/Complex needs service – with the core/background cost coming from this budget, people accessing this provision do not have an LD and the individual budgets are often part of integrated social care teams.

Engagement has led to further elements of the service being written in much more detail for clarity, which has subsequently been moved to an appendices for information purposes.

The contract will be procured using the GM LD Flexible Purchasing system that supports ethical and social value. Conditions applied in the homecare tender re: employment conditions and National Living Wage will be replicated in this tender.
Further explanatory information required

<table>
<thead>
<tr>
<th>HOW WILL THIS BENEFIT THE HEALTH AND WELL BEING OF SALFORD RESIDENTS?</th>
<th>By supporting people with LD, ASC and ADHD safely in the community.</th>
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<tbody>
<tr>
<td>WHAT RISKS MAY ARISE AS A RESULT OF THIS PAPER? HOW CAN THEY BE MITIGATED?</td>
<td>NA</td>
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<tr>
<td>WHAT EQUALITY-RELATED RISKS MAY ARISE AS A RESULT OF THIS PAPER? HOW WILL THESE BE MITIGATED?</td>
<td>Quality of service is to be addressed as part of the tender process and proposed ongoing monitoring</td>
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<tr>
<td>DOES THIS PAPER HELP ADDRESS ANY EXISTING HIGH OR EXTREME RISKS? IF SO WHAT ARE THEY AND HOW DOES THIS PAPER REDUCE THEM?</td>
<td>NA</td>
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<tr>
<td>PLEASE DESCRIBE ANY POSSIBLE CONFLICTS OF INTEREST ASSOCIATED WITH THIS PAPER.</td>
<td>NA</td>
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<tr>
<td>PLEASE IDENTIFY ANY CURRENT SERVICES OR ROLES THAT MAY BE AFFECTED BY ISSUES WITHIN THIS PAPER:</td>
<td>NA</td>
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Footnote:

Members of ICJC will read all papers thoroughly. Once papers are distributed no amendments are possible.
## Document Development

<table>
<thead>
<tr>
<th>Process</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
<th>Comments and Date (i.e. presentation, verbal, actual report)</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Public Engagement (Please detail the method i.e survey, event, consultation)</td>
<td>x</td>
<td></td>
<td></td>
<td>Engagement with users of the service and their families, wider LD population, and staff through face to face engagement in all cases as well as online survey for staff who could not attend</td>
<td>Collaborative work to develop the specification.</td>
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<td>Clinical Engagement (Please detail the method i.e survey, event, consultation)</td>
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<td>Has ‘due regard’ been given to Equality Analysis (EA) of any adverse impacts? (Please detail outcomes, including risks and how these will be managed)</td>
<td>x</td>
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<td>Engagement with people with LD took place as part of the development of this service. Advocates and carers were also included in this to ensure that people accessing the service were not experiencing any adverse impacts</td>
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<td>Legal Advice Sought</td>
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<td>Presented to any other groups or committees, including Partnership Groups (Please specify in comments)</td>
<td>x</td>
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<td></td>
<td>Report/specifications went to ICAB 20.03.18</td>
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Note: Please ensure that it is clear in the comments and date column how and when particular stakeholders were involved in this work and ensure there is clarity in the outcome column showing what the key message or decision was from that group and whether amendments were requested about a particular part of the work.
Section 1 – Introduction

1. Nature of the Service

1.1 The purpose of this Service Specification is to describe the key features of the Learning Disability Supported Living Services.

1.2 The Service Specification should be read in conjunction with the terms and conditions that form the body of the Contract.

2. National/Local Context and Drivers

2.1 National Context:
- Our Health, Our care, Our Say (2005)
- Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care (2007)
- A Vision for Adult Social Care: Capable Communities and Active Citizens (2010)
- Think Local Act Personal (2011)
- Valuing People
- Valuing People Now
- Raising our Sights (2010)
- All Together Now (2010)
- Just Enough Support Principles
- Care Act 2014
- Mental Capacity Act 2005
- LD Professional Senate 2015
- Death by Indifference 2007
- CIPOLD (2013)
- LeDeR (Learning Difficulty Mortality Review Programme)
- Transforming Care 2012
- Building the Right support 2015
- Accessible Information Standards

2.2 Regional Context:
The Greater Manchester Commissioning for Reform Strategy sets out the key role commissioning will play in delivering our ambition for place-based, whole-system reform. In order to do this we need to embed a new approach, one which ensures that our reform principles are drivers of our commissioning activity.
The principles that underpin our approach to reform are:
- Use of an Asset Based approach that recognises and builds on the strengths of people, families and our communities rather than focusing on the deficits.
- Flexible approach / response to support and prevent escalation.
- Behaviour change in our communities that builds independence and supports residents to be in control
- Integrated services that place people, families, communities at the heart
- A stronger prioritisation of wellbeing, prevention and early intervention
- An evidence based understanding of risk and impact to ensure the right
Supported Living is a service which is ideally suited to development which follows these commissioning principles and can champion our ongoing dedication to the delivery of place-based services across Greater Manchester. We want Supported Living services which are based in the heart of our communities, that offer true choice and control of support and help people achieve and maintain independence.

To achieve this ambition, Greater Manchester Combined Authority (GMCA) wants Supported Living services which take an asset-based approach to service delivery, focusing on the personal and social strengths of the person and what they can do for themselves, or others, as the starting point for achieving their outcomes and promoting independence. Enabling people to become independent as possible. We want to move away from ‘deficit’ models of care and support which focus on meeting a person’s ‘needs’ to a service which understands the person’s personal goals and helps them to achieve positive, meaningful outcomes. The service will ensure that people have access to the information they need to make informed choices, enabling them to decide the types of support they receive, where and when they receive it and who they receive it from. The service will also have a strong focus on promoting wellbeing; ensuring people have the support to be physically, mentally and emotionally able to exercise their choices. This combination of choice and wellbeing will help support people to achieve independence, giving them the platform to realise their goals, pursue their interests and live a meaningful life as an active part of their community.

As well as building on people’s personal and social assets, the service will also build relationships and work in partnership with a wide range of local community assets to assist in achieving positive outcomes for people. In building these relationships the provider will also engage in promoting social cohesion in the community, building capacity and capability for support and inclusion of people with learning disabilities.

This specification is to be read in conjunction with both the specification for the GM Learning Disability and Autism Ethical Dynamic Purchasing System, the Framework Agreement and contract terms and conditions.

2.3 Local Context:

- Salford services are now delivered as part of an Integrated Care Organisation (ICO). The ICO delivers contracts from a joint health & social care budget with the aim of meeting people’s needs more efficiently and effectively.
- People have told us that they feel safe living in a supported environment because of the model and staffing that are present.
- Salford has long held an ambition for people with Learning Disabilities to live in an ordinary house, on an ordinary street, with their own front door. Supported Lives is part of this vision.
- Salford also believes in People having ordinary lives, friends and relationships. Providers of supported lives are vital in helping People to have the best chance to be part of their local community.
- Under this contract Support should be provided in both the home and community.
- It is expected that community support will be covered under this locality Intervention at the right time.
contract, for people who are living in your area.

- Using a network/locality model will enable staff/Providers to identify where people have common interests and provide support for People to achieve their ambitions. Staff at these services should use support effectively to meet needs more efficiently.
- There is an expectation that Providers will ensure that they have extensive knowledge of their local area, activities, groups and other opportunities so that this information can be disseminated to People and also use this to provide a good service and meet people’s desired outcomes.
- People will be enabled to meet their potential and have as much choice, freedom and independence as possible.
- Whilst maximising independence/ability to make informed choices is important this shouldn’t be at the detriment of the individuals’ health & wellbeing.
- People’s mental capacity to make choices will be supported and where appropriate will be enabled to make informed and proportionate choices, in an accessible format.
- Positive risk taking policies and processes should be used to support People to achieve their aspirations and build natural support/friendships.
- Effective, regular, positive communication is essential to achieving the outcomes required for individuals’ and Providers are expected to ensure that good relationships exist with family carers, the Community Learning Disability Team (CLDT), other Supported Lives locality Providers, community services and all agencies involved in a Person’s care.

3. Partnerships

3.1 The Authority wishes to work in partnership with the Provider in delivering a high quality of service to its Service Users.

3.2 The Service must be developed flexibly and creatively to meet the needs and wishes of Service Users, Carers and stakeholders, in partnership with them.

3.3 It requires a co-ordinated and collaborative approach with other Providers, and community provision to ensure that a comprehensive range of services is available at the most appropriate times. An expectation is placed on the Provider to actively liaise with other agencies involved in the care and support of Service Users to support this approach. It may also involve Service Users receiving support and encouragement to enable them to take advantage of a broad range of opportunities, as citizens of their community.

3.4 Attendance at the Provider Forum is essential and representation must be at the appropriate level in order for this to be effective. This would be specified as the Contract Manager, and meetings are held quarterly.

3.5 The Provider will cooperate with the landlord(s) and any other appropriate agencies, especially around safeguarding issues.

3.6 Other expected partnerships are listed below (not exhaustive):
3.7 Families are a key partner and should be valued. For many people the relationships they have with family members are the most important in their lives. Even into adulthood many people seek the counsel of their parents or siblings when making important decisions. This is the same for people with learning disabilities. If they want to involve their families in their decisions, small or large, they should be supported to do so. Alternatively, there are some people who may not wish to involve their families and their wishes should be adhered to.

3.8 Providers must ensure that a regular Carer Forum is put in place to ensure continued dialogue.

4. Overview of the Service

4.1 This service will be provided to adults, who are ordinarily resident in Salford, with a Learning Disability, who have been assessed (By Salford CLDT) as requiring a Supported Lives service. The Service will support People to live a good life, and be as independent and fulfilled as they are able.

4.2 This will be achieved through the provision of support in the person's own home and local community, which allows them to build or maintain their independence; in many cases, moving someone on to greater independence.

4.3 The Service will connect people into their local communities, ensure they have choice and control over their own lives, and can build friendships and relationships in a meaningful way.

4.4 The Service will provide support as detailed in individual's support plans, and deliver on the duty under the Care Act 2014, and Mental Capacity Act.

4.5 The Service will be delivered flexibly and efficiently for up to 24hrs a day, 7 days a week and 365 days a year. This may be via direct staffing (waking night or sleep in) on using technology and on call; as dictated by the needs of People residing at each address.

4.6 Providers need to be aware of the criteria and process of the Moving on Panel (See supporting tender documentation) This process is used to manage voids and improve outcomes for people, so that they can achieve greater independence. The panel also assists with compatibility, and Providers should play an active role in both developing the processes and proactively managing voids/compatibility on an ongoing basis.
4.8 Providers must actively support the functions of the Moving on Panel; including supporting people to move into or on from accommodation, appropriately.

4.9 Providers must support people with their tenancies; in fulfilling their own obligations as tenants, and supporting them to access the right support (advise, repairs etc) from landlords.

Section 2 - The Service

5. The Service(s)

5.1 People may live on their own or with others in the same accommodation. The properties in each locality where people are receiving support will be known as schemes.

5.2 This contract includes a number of schemes under one Locality. There will be 6 Localities, which will form separate lots in this tender. Details of which, will be provided in the tender pack.

5.3 Properties are separate to the support which allows for new properties to be added into a Locality, and old properties to be discontinued throughout the course of the contract. Packages of community support and increased support to manage a crisis situation in your Locality is also a requirement of the contract. The Provider must provide adequate staffing and support to all schemes in their Locality and offer flexibility when required.

5.4 The Service will be provided 24hrs, 7 days a week, 365 days a year. The Provider will meet the needs of each person, as specified in their support plan.

5.5 Services are commissioned using block/background hours and individual hours of support to meet specified, defined outcomes; individual hours are to be used flexibly and creatively. The Authority and the Provider will work together to ensure the most effective and efficient ways of delivering people’s support plans, respecting the choices of the individual.

5.6 Delivery of sleep in or waking night provision should this be required; this is arranged as appropriate for specific people/schemes.

5.7 The level of support can be reviewed at any point by the Authority as and when needs change. The Authority will review needs periodically to ensure that needs are correctly identified and are being met effectively. Providers have a responsibility to refer into the team where there is significant changing need that needs to be reflected in the support provided; such as admission to hospital and the need for discharge planning.

5.8 Informal/natural support should be encouraged where safe and appropriate and staffing should be maximised to ensure the delivery of each person’s daily and weekly programmes effectively and efficiently. This should include supporting service users together where interests and activities are mutual – cross provider support should be considered.
5.9 The Provider will need to ensure that staff are of high quality with appropriate training and experience (as detailed in section 7.10), and the ability to build good relationships to make sure that they understand the People they support, what is important to them, their personal strengths and ambitions. Staff should support People to identify opportunities and take positive risks to enable them to try new things and build a better life.

5.10 Resilient and robust management structures should be in place for each locality contract to ensure that appropriate decision making and support to staff and service users is available at all times.

5.11 The Provider will be required to have a local (Salford registered) office base.

6. Aims of the Service

Supported Lives services aims to deliver effective, efficient and safe care and support in a person’s own home and in the local community, to allow People to build and maintain their independence and have good lives. The service will ensure that people have choice and control over their lives, that they have good relationships with families, friends and staff, and that they are able to spend their time purposefully and enjoyably.

6.1 Working together:
- Supported lives aims to bring People together, which will require different schemes/Providers to work together to look at opportunities to support People support to socialise, and build friendships.
- Both within a locality and across Salford, Providers should build and expand on existing elements of good practice to create a culture of working together for the benefit of People.
- Sharing knowledge and building networks to offer all people with Learning Disabilities opportunities that are already available locally.

6.2 Fulfilling aspirations:
- Information should be offered to all People in Supported Lives schemes to expand knowledge on what is available and possible.
- Tenancies for Supported Lives schemes should not always be considered as permanent/fixed. Like anyone else a Person’s wants and needs may change over time and information should be readily available with regard to how a Person may move to a different scheme, or move to more independent living, should this be required to meet their outcomes.
- Providers should find out what is important to People, what they enjoy, what interests they have, what their strengths are and assist them in developing their aspirations.
- Providers should work imaginatively; aiming to create a model of support that assists in helping someone achieve goals; this will include setting up opportunities and removing barriers to access, and identifying how this can be sustained through independently or by using natural support and community assets.
6.3 Support:
- Active Support principles should be implemented in Supported Lives schemes (See Appendix)
- A capacity / independence building approach should be taken in the delivery of required/essential care. Support may be provided by a person, adaptation or assistive technology.
- People should be supported to develop skills so that they can do as much as they are able to do for themselves. Where support is needed, this should be done in a way that works for the individual and gives as much autonomy and dignity as is possible. Total communication approaches must always be used.

6.4 Promoting physical & mental health and wellbeing:
- Reducing health inequalities for people with Learning Disabilities.
- Ensuring that health appointment including annual health checks and relevant cancer screenings are attended.
- Ensuring any barriers to accessing health services should be escalated and addressed through the Providers management structures. If not resolved this should be reported to the CLDT.
- Ensuring that people are identified as having a Learning Disability and/or Autism with Primary and Secondary health services to ensure that reasonable adjustments are provided.
- To ensure the representative at the Locality Provider Forum cascades, collates and actions information given and requested.
- Supporting People to self manage their own physical health as much as possible and make healthier choices.

7. Delivery of Support

To achieve this, the Provider will need to ensure that housing and the local environment improve people’s ability to live independently; ensuring that homes and support are well designed, accessible and flexible to meeting each person’s needs. The Provider will use collaborative ways of working that support people to actively engage in the design, delivery and evaluation of their services. The Provider will also demonstrate approaches which enable staff to work in creative, person-centred ways, underpinned by the organisational systems and effective Management structures to support and sustain this. The provider will ensure active, ongoing evaluation to ensure needs / presentation changes are tracked, identified and responded to; including reporting this to the CLDT.

7.1 Culture and Quality:
- Organisational culture is the base from which ‘good’ or ‘excellent’ starts. We want services which have a strong person-centred culture, both in terms of the people who receive support and with the staff which deliver it. We need providers who develop their staff through training, mentoring and supervision to become strong leaders who can ensure high standards are maintained and promoted.
- We would require as a minimum providers who have:
  - A clear process in place for consulting with people and their families about their care needs.
  - A structured feedback process which helps the service develop.
  - An approach to training staff which focuses on continuous improvement and...
quality.


✓ Operate robust personalised risk management systems which update and refine individual Provider Support Plans on a continuing basis.

✓ Adheres to local safeguarding policies and procedures for children and vulnerable adults; demonstrate expertise in the operation of the Mental Capacity Act, Deprivation of Liberty Safeguards and Best Interests practices.

✓ Supports people to manage their own safety and security both inside and outside of the home.

✓ Communicates changes in need to the relevant professionals and CLDT.

7.2 Asset Based Approach:

✓ An asset based approach recognises and builds on a combination of the human, social and physical capital that exists within local communities.

✓ We want a service which uses asset-based practice as a collaborative process between the person and the service, which allows them to work together to achieve positive outcomes by drawing on the person’s strengths and assets.

✓ To successfully do this, staff need to develop quality relationships which respect the elements that the person receiving support brings to the process. This way of working promotes opportunities for people to have a say, and shape their own services and support.

✓ The service will also act as a facilitator in linking up with the social assets each person has, including support from family, friends, health professionals, community groups and voluntary organisations.

✓ We want providers developing a strong working knowledge of what is available in the area and developing partnership with other local providers’ for putting in the asset based approaches section.

7.3 Health and Care

✓ Support will be provided to register with the local GP and access local community health services. This will include support to access annual health checks and other health/medical appointments, including, but not limited to Doctors, dentist, opticians, podiatry, auditory.

✓ To deliver the Health Charter social care providers: https://www.vodg.org.uk/publications/health-charter-for-social-care-providers/

✓ Support will begin with the assumption that the person is best-placed to judge their own well-being, but family and independent advocates will be involved where appropriate.

✓ To ensure that services and staff support the Positive Behaviour Support Competence Framework. See: http://www.skillsforcare.org.uk/Documents/Topics/PBS/Positive-behavioural-support-competence-framework.pdf

✓ Support will ask for and respect the person’s views, wishes, feelings and beliefs.

✓ Staff will establish, communicate and respond to the person’s preference in respect of how, when and by whom personal care is provided.

✓ The Service will take an enabling approach to ensuring that an person’s personal care needs are met, encouraging and supporting the person to do as much as possible for themselves – maintaining, regaining or developing their abilities.

✓ Staff will ensure that all assistance and support with personal care is given in a discreet and dignified manner, in particular toileting, bathing, washing, dressing,
eating, drinking, and supporting with mobility. This must be specified in the Providers Support Plan.

- The Provider will check regularly with people whether they are happy with how their personal care needs are being met.
- Support will help people to monitor (and record, if appropriate) their own health and well-being, through regular health checks, making referrals and seeking advice and support as necessary.
- People should be supported to learn how to manage their own physical health as much as possible; learning what is good and bad for health and enabling People to make healthier choices.
- Support will encourage and promote healthy lifestyle choices, including diet, sleep patterns, activities and exercise.
- Support will encourage and promote positive mental health using the national guidance of the five ways to wellbeing.
- The Service will have staff that are able to support people with planning, buying and cooking health meals.
- The Service will promote and support access to health services, including other community providers ensuring that reasonable adjustments are made to take account of person anxieties, fears or phobia. Support staff will escalate and seek appropriate advice if they come across barriers to this.
- Staff will follow a detailed, documented Provider Support Plan with clear information that will guide them to have an understanding of people’s conditions. Induction and training will support the knowledge and expertise required. Additional training requirements should be highlighted to the CLDT.
- The Service will work closely with any health professionals involved to support delivery of medicines, treatments and therapeutic programmes. Administration of medication must be delivered in accordance with the local medication protocol that is currently in development.
- The Service will continue to develop and maintain and deliver Health Action Plans; or Education, Health and Care Plans with support as required from the CLDT.
- The Service, supported by the relevant clinicians, will be able to demonstrate expertise in supporting people with a wide range of physical and mental health needs, plus supporting people with pre and offending behaviours.
- Up-to-date Provider Support Plans and reviews are essential to this support.

7.4 Communication:

- Providers must be able to use a wide variety of communication methods (as set out in the Total Communication policy) to support People in expressing their needs and preferences, to ensure that they can contribute fully to all planning and decision-making that concerns them. Staff should receive adequate training and support for using these methods.
- Promote a culture which maximises customer’s choice and control, through training, supervision, role modelling, and monitoring.
- Promote a culture that values the contribution of family carers. Communication with family carers is an important two way process; information should be provided to families (with consent of the person supported, in line with Mental Capacity Act, Human Rights Act and Data Protection) and families can be a useful source to get information from. Views should be sought and families should be engaged, where appropriate.
- Implement person-centred planning systems that:
support service users to develop and express their needs and preferences
support the continuity of relationships with family and friends and develop new ones.
record and communicate those needs and preferences
monitor and review person-centred plans
Use and support the use of TEC (Technology Enabled Care)
Support with the appropriate use of regular technology, such as tablets and applications that can support independence
Observes the accessible information standards

✓ Communication with staff regarding key information; ensuring information, issues and drivers are cascaded down through all services.
✓ Mechanisms for staff feeding information up to managers effectively too.

7.5 Independence:
✓ The Service will deliver support within a culture of promoting independence, ensuring that their workforce has the appropriate values and attitudes, knowledge and skills, training and supervision.
✓ Staff will ensure that people have choice and control over their own lives through consultation, supported decision making and access to advocacy where necessary.
✓ Staff will promote people’ positive sense of identity and self-esteem
✓ Staff will build understanding of the person, including their history and future ambitions as well as understanding their day to day needs for support.
✓ Staff will support people to build and maintain friendships and relationships, supporting them to access this natural support, as appropriate, and as part of their independent leisure time.
✓ The Service will support service users to develop weekly programmes and activity plans that facilitate development and independence, building time in for an enabling approach to be implemented whilst avoiding providing support when it is not needed. This is likely to involve careful assessment of risk and testing out, for example, identifying times and/or circumstances where no support is required.
✓ Encourage people to consider the choices available to them and the implications of their choices, taking account in particular of potential risks.
✓ Operate robust personalised risk management systems which update and refine person support plans on a continuing basis, including risk assessments that support positive risk taking.
✓ Staff and people are encouraged to take positive risks in order to achieve outcomes.
✓ The Service will implement systems for continually reviewing support arrangements to ensure that they remain the most effective in promoting or maintaining independence for the person.
✓ The Service ensures that people have access to assistive equipment and Technology Enabled Care which can help maximise their independence.
✓ Where appropriate, staff will support people to move on to more independent living options.
✓ Ensure people are supported to manage their own affairs including all correspondence.
✓ All the above should adhere to the principals of the mental capacity act, ensuring least restrictive practise and proportionate decisions.
7.6 Finances and Property

- To support people regarding managing their money and accessing appropriate benefits where the person has the potential to undertake this role and there is no need for an appointee.
- Support people's control over their own money and resources so that they are enabled to manage money, budgets, letters etc as much as they are able to. Where support is needed this takes account of the Person’s preferences and wishes in how their money is spent and their financial responsibilities.
- Facilitate and explain decision-making regarding household financial management where resource and/or responsibilities are shared between people in the household.
- Assist people to maximize their income and manage their finances, where necessary, offering guidance and support in respect of income (including access to benefits), expenditure and the safe keeping of money whilst minimising the risk of financial abuse.
- The Service will have robust financial policies and procedures.
- The Service will support tenants in their relationship with their landlord, from tenancy sign up to protecting their rights and supporting them to meet their responsibilities as tenants, and providing liaison with the landlord to ensure any repairs etc are carried out in a timely fashion.
- The service must maintain a housing management agreement with the landlord or their agent.
- Act as appointee for the purposes of the DWP where this is judged by the Authority to be in the best interests of the person and in some cases as a deputy for the purposes of the Court of Protection.
- Robust policies and procedures, will include record keeping and auditable information that should be made available on request.

7.7 Safeguarding and Behaviour Management:

- Adhere to local safeguarding policies and procedures for children and vulnerable adults;
- All levels of management will attend training in “Safeguarding Vulnerable Adults in Salford”, as provided by the CLDT.
- Support people with any requirements under the Mental Health Act in line with associated regulations and guidance.
- Support people to manage their own safety and security both inside and outside the home.
- The Service and Staff will ensure that any restraint or physical intervention complies with Salford’s and GM Positive Behaviour Support Strategy and is only used in line with person plans, developed by the multi-disciplinary team and signed by the Authority’s care manager or team leader.
- The Service will work closely with the members of the multi-disciplinary team to assess, monitor progress and revise plans accordingly.
- Demonstrate expertise in the operation of the Mental Capacity Act, Deprivation of Liberty Safeguards and Best Interests practices.
- Access to an independent advocate is arranged and supported where appropriate.
7.8 Social Inclusion:

- Support people to maintain and develop (or rekindle) their social networks with natural relationships beyond professional and paid support, by promoting and facilitating where necessary positive contact with family and friends.
- Ensure that staff role-model interaction that enhances people’s confidence and self-esteem, through positive relationships both inside and outside their home;
- Facilitate contact with neighbours, local shops, leisure services and community groups, so that people can participate in the local community in a way that suits their needs and preferences.
- Ensure that staff support appropriate online behaviours and online safety for those wishing to access social media and other technology to maintain and enhance relationships.
- An intention that People become more independent of support in this area in the future.
- Enabling People to have freedom and the ability to enjoy a wide range of experiences; whilst learning about risk and how to look after their own safety as much as possible.
- Ensuring that People are aware of their own behaviour and are supported to manage this for themselves and understand the consequences.
- People are supported in the least restrictive way that is possible and safe.

7.9 Technology Enabled Care:

There continues to be developments in the field of Technology Enabled Care which are ideal both for the realisation of GM Commissioning Principles and for the delivery of Supported Lives Services.

- It is expected that the Provider will, in partnership with the CLDT, be able to evidence and execute a plan to develop the use of Technology Enabled Care in the delivery of this Service. Uses of Technology Enabled Care may include (but are not limited to);
  - Managing the support network around the person
  - Improving access to advice and support
  - Supporting people to access primary and secondary care
  - Support in managing medication where appropriate
  - Maintaining and/or improving person’s independence
  - Maintaining and/or improving person’s social participation
  - Reducing/removing night support where appropriate and safe to do so

- The Authority will support the Service in accessing any GMCA wide or borough-wide licences to Technology Enabled Care and offer support and advice in the development of new Technology Enabled Care options where appropriate. The Provider will be required to show a tangible/evidence based willingness to use Technology Enabled Care to improve outcomes for person’s who receive Supported Living services.

7.10 Staffing, Management, Training & Supervision:

- Services should operate 24/7; this will entail a combination of staffing presence, on call and technology, as appropriate and agreed for each service and individual.
- The model of staffing should ensure that optimum hours are used to make sure
that services are effective and avoids staff burnout, minimise use of agency staff usage and ensure flexibility in services.

- Staff should be trained to work in a person centred way and designed to avoid People becoming over reliant on staff/particular staff.
- Ethical care and value based recruitment practices are expected.
- Providers must ensure that their induction for new starters meet the requirements of CQC. Which supports the use of the Skills for Care lead care certificate and use this as the basis for staff induction especially when staff are new to the role.

Specifically this must include:

- Medication administration and recording
- Adult Safeguarding
- Whistle blowing policy


- As well as training as staff start as new employees then their continuous development.
- Staff must access the following mandatory training and updates as required within 6 months of commencing employment:

Mandatory:

- Understanding Learning Disabilities
- Friendships and Relationships
- Autism Awareness,
- Breakaway training (This training must be delivered and updated using a BILD accredited model)
- Active Support
- Positive Behaviour Support (including understanding behaviour and developing PBS plans)
- Awareness of Mental illness and people with LD
- Health needs of people with a learning Disability
- Training for Managers
- Person centred planning and thinking
- Autism Triad workshop and developing strategies
- Physical Intervention training (This training must be delivered and updated using a BILD accredited model)
- Total Communication (Induction and co-ordinators training available)
- Dysphagia training
- Epilepsy and safe administration of rescue medication
- Bereavement Training
- Leadership training (for specific roles, as appropriate)

This is not an exhaustive list and staff may require additional specific training around the needs of the people they support.

- Some of the above training will be provided by the CTLD, and staff must attend as required. There will be no charge for staff working in a Salford commissioned service for the training provided by CTLD.
- Management should be in place to offer a robust structure; including maintaining a regular scheme presence to retain operational oversight, as well as quality
checking service and making decisions where required. On call arrangements should be a robust and effective part of this structure.

- Use of Community team staff as a level of Provider management must be avoided. As important partners, the CLDT will be responsive and flexible with appropriate requests e.g. facilitating a hospital discharge. Contact with community team staff must constitute part of the Provider’s escalation processes that includes all lines of their own Management team.
- It is important that appropriate staff supervision is provided; providing a safe and confidential place for staff at regular intervals. This should form part of ongoing staff development and appraisal processes.

7.11 Referral Route and Nomination Rights: Referrals will be made by the CLDT, as part of the ‘Moving on Panel’ process. Nomination rights are held by the council as defined in the ‘Nomination Rights’ documentation. Both will be attached to the tender documentation.

8. Service Flexibility

8.1 Flexible and innovative approaches to service delivery are necessary to allow for reaction to the changing needs and demand of People.

The portability of support will enable People to be supported in the best place; allowing people to achieve more by extending services into the community and to move on, if required, to meet their aspirations.

Being creative and flexible with support hours will help People to achieve their ambitions; using an asset based approach to make this sustainable without paid support in the longer term.

Section 3 - Requirements for the Provision of the Service

9. Staff training

9.1 The Authority requires that, when delivering the Service to Service User, the Provider ensures that:

(i) The highest standards of protection are afforded to vulnerable people and are adhered to throughout the term of the Contract.
(ii) There is an appropriate match between individual Worker and staff skills, knowledge and competency and the individual needs of the Service User.
(iii) It minimises the need for change and provides a consistency in the number of Workers providing support to an individual.

9.2 The Provider must maintain a detailed record; containing relevant information concerning the individual’s care and support and actions taken in its delivery and the time of service delivery and be updated on a regular basis.

9.3 Please see Section 7.10 for a list (not exhaustive) of mandatory training to be covered by the Provider’s induction training and annual training.
Section 4 – Contract Monitoring

10. Purpose and Method of Contract Monitoring

13.1 The purpose of Contract Monitoring is to ensure that the specified services:
   • are delivered in accordance with this Contract.
   • are effective in delivering outcomes that enable People to live good lives, as independently as possible.
   • demonstrate continuous improvement.
   • provide value for money.

10.2 Contact Monitoring will take place through a combination of provider self-monitoring, regular contract meetings, appraisal visits and consultation in order to demonstrate service delivery meets the strategic requirements and are delivering to the contract specification.

11. Service Performance Monitoring

11.1 The Provider will be required to submit a Performance Workbook on a quarterly basis. This will be submit one week following the end of each quarter, and an audit trail will be maintained so that the information can be verified.

11.2 The following indicators may be measured:
   • Rates of staff recruitment and retention
   • Agency staff usage
   • DBS at recruitment and expiry/ renewal
   • Management of staff (supervisions, observations and appraisals)
   • Use of hours – activities and opportunities offered
   • Staff training and qualifications
   • Satisfaction of People in Supported Lives and their families
   • Quality of service (Quality Framework to be developed)
   • Outcomes for Individuals (Outcomes measurement tool to be implemented) – submission quarterly.
   • Complaints / Safeguarding
   • Attendance at Provider Forum
   • No of Carer Forums held
   • No of service user forums held
   • Service Usage

11.3 Other key performance indicators may be agreed between the Provider and the The Authority.

12. Outcomes Monitoring

12.1 Outcomes will be monitored on a quarterly basis.

12.2 The Outcomes star will be used to monitor outcomes for service users. This will be
provided by The Authority and will be submit on a quarterly basis.

12.3  Outcome targets:
To be defined after the initial baseline assessment; but must show continuous improvement in outcomes for People.

13. Quality Assurance Monitoring

13.1 Monitoring the quality of provider policies, procedures and the application of these; including service user and family awareness of these and their involvement in continually developing them.

13.2 Quality will be assessed in a number of ways:

- The Provider is expected to submit a self-assessment at least annually
- Visits to service; these may take the form of - shadowing at the service, pre-arranged appraisal visits, and unannounced visits.
- We may consult with staff, service users and other stakeholders.
Moving On Up project Specification

Section 1 – Introduction

1. Nature of the Service

1.1 The purpose of this Service Specification is to describe the key features of the Moving on Up Project - MOUP.

1.2 The Service Specification should be read in conjunction with the terms and conditions that form the body of the Contract.

2. National, Regional and Local Context and Drivers

2.1 National Context:
- Our Health, Our care, Our Say (2005)
- Just Enough Support Principles
- Mental Capacity Act (2005)
- Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care (2007)
- Autism Act (2009)
- All Together Now (2010)
- A Vision for Adult Social Care: Capable Communities and Active Citizens (2010)
- Think Local Act Personal (2011)
- Care Act (2014)
- The Department of Education Paper (2015) ‘Care Leavers’ Transition to Adulthood’

2.2 Regional Context:
The Greater Manchester Commissioning for Reform Strategy sets out the key role commissioning will play in delivering our ambition for place-based, whole-system reform. In order to do this we need to embed a new approach, one which ensures that our reform principles are drivers of our commissioning activity.

The principles that underpin our approach to reform are:
- Use of an Asset Based approach that recognises and builds on the strengths of people, families and our communities rather than focusing on the deficits.
- Flexible approach / response to support and prevent escalation.
- Behaviour change in our communities that builds independence and supports residents to be in control
- Integrated services that place people, families, communities at the heart
- A stronger prioritisation of wellbeing, prevention and early intervention
- An evidence based understanding of risk and impact to ensure the right intervention at the right time.
- As well as building on people’s personal and social assets, the service will also build relationships and work in partnership with a wide range of local community assets to assist in achieving positive outcomes for people.
2.3 **Local Context:**

- Salford services are now delivered as part of an Integrated Care Organisation (ICO). The ICO delivers contracts from a joint health & social care budget with the aim of meeting people’s needs more efficiently and effectively.
- Under this contract Support should be provided in the home and community.
- There is an expectation that Providers will ensure that they have extensive knowledge of their local area, activities, groups and other opportunities so that this information can be disseminated to People and also use this to provide a good service and meet people’s desired outcomes.
- Whilst maximising independence/ability to make informed choices is important this shouldn’t be at the detriment of the individuals’ health & wellbeing.
- People’s mental capacity to make choices will be supported and where appropriate People will be enabled to make informed and proportionate choices.
- Positive risk taking policies and processes should be used to support People to achieve their aspirations and build natural support/friendships.
- Effective, regular, positive communication is essential to achieving the outcomes required for individuals’ and Providers are expected to ensure that good relationships exist with family carers, the Complex Needs Team, community services and all agencies involved in a Person’s life.

3. **Partnerships**

3.1 The Authority wishes to work in partnership with the Provider in delivering a high quality of service to its Service Users.

3.2 The Service must be developed flexibly and creatively to meet the needs and wishes of Service Users, Carers and stakeholders, in partnership with them.

3.3 It requires a co-ordinated and collaborative approach with other Providers, and community provision to ensure that a comprehensive range of services is available at the most appropriate times. An expectation is placed on the Provider to actively liaise with other agencies involved in the care and support of Service Users to support this approach. It may also involve Service Users receiving support and encouragement to enable them to take advantage of a broad range of opportunities, as citizens of their community.

3.4 Communication of People’s needs to other agencies; including any relevant reasonable adjustments that are required.

3.5 The Provider will cooperate with the landlord(s) and any other appropriate agencies, especially around safeguarding issues.

3.6 Other expected partnerships are listed below (not exhaustive):
- Salford ICO
- Salford Complex Needs Team
- Irwell Valley Housing Association
- Greater Manchester Mental Health
- Greater Manchester Police
- Salford Community Leisure
- Drug & Alcohol Services
- Domestic Abuse Services
- Neighbourhood Management
- Local Primary care service: GPs, Pharmacies, Dentists, Opticians
- Local Police / fire / ambulance
- Children’s services – Next Steps
- Connexions
- Training, Education and Employment services and opportunities including job centre plus
- Salford Housing Options Point
- Other Registered Social Landlords(RSL)
- Citizens Advice Bureau/Welfare Rights
- Voluntary sector agencies that offer opportunities such as Empower
- Advocacy Services

4. Overview of the Service

4.1 The Moving On Up Project (MOUP) is a 24hour Service, aimed at supporting People with Complex Needs to: Self Manage their own condition, develop independence/daily living skills, integrate into the community, develop meaningful relationships, navigate services, and manage (where appropriate) a tenancy.

4.2 The Service will work to the principles of the I-Thrive Model, which offers a graduated response to need, and support and will be based on an Enablement Model, but should work together to support people to achieve their personal outcomes, and meet their needs as set out in their Person Centred Support Plan. People can be in receipt of different elements of the service, at different times.

4.3 There are 5 components to this Enablement Model of Service Delivery, which should work together to achieve personal outcomes and needs:

**The Supported Living Service**
24 hour supported accommodation for Young People, to develop independence, learn how to manage a tenancy and self-management skills. This will be the core service and will feature background support and individual hours.

**In -reach Support**
Accessible support on an unplanned/ad hoc basis; including access to low level 24/7 support, advice and guidance, emergency on call and short term crisis management

**Outreach Support (Community)**
Support for people living in the community, in their own homes; alone or with others. This service will be outcomes focused and aimed at developing skills /independence

**The Self-Management / Personal development Project**
This is the provision of low level support to prevent People the need for traditionally commissioned/paid support. It will offer goal focused, low level group support sessions, focused on self – management, social, and supporting people to access
other services. This is a preventative and maintenance service and should be available for all to access; subject to assessment.

**Crisis Management**
High intensity support, to manage risk, chaos and crisis. This service will include: individual work with People to develop protection, risk and crisis plans; Responding to individual crisis as they occur, and implementing action plans, where necessary.

4.4 The Service will provide support as detailed in individual’s support plans, and deliver on the duty under the Care Act 2014, and Mental Capacity Act.

4.5 All elements of the service will work together to ensure a comprehensive, holistic wrap around specialist service for people with Complex Needs. Staff will need to be skilled in Facilitation, Mentoring and Coaching.

4.6 People accessing this Service, will have a Key worker, who will ensure consistency and continuity, clear communication with all partner agencies, and clear record regards keeping with regard to support and measurement of personal outcomes.

4.7 A key element of this Service is the use of Assistive Technology, home automation, and the use of technology to provide support, and keep up to date accurate records. This includes, ensuring Staff have the equipment to provide support and keep records.

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**Section 2 - The Service**

5. The Service(s)

5.1 This Service will support People with Complex Needs. This will include People with one or more of the following disabilities, conditions and impairments:
- People with Autistic Spectrum Conditions (ASC) and/or
- Attention Deficit Hyperactivity Disorder (ADHD)
- Moderate Learning difficulties
- Attachment difficulties
- Low level Mental Health Problems. (i.e., depression, low mood, anxiety, self harming, drug and alcohol misuse, emerging personality disorders.)
- Other Co-morbid conditions, such as Tourette’s, dyslexia, physical and learning disabilities, health conditions such as epilepsy, diabetes etc,

5.2 Many of the People using the Service, will also have previously been Looked after Children.

5.3 As a result, People supported by this service are at greater risk of a number of social issues, including Criminal activity, Drug and Alcohol misuse, gang related issues, increased difficulties in developing skills around budgeting, decision making, understanding rights and responsibilities and executing tasks. Young people may also have difficulties accessing mainstream services, and social situations because of their social skills and behaviour difficulties.
5.4 This Service will support a number of People who have chaotic lifestyles, displaying risky and challenging behaviours. Many have issues with impulsivity and anger management and will struggle to adhere to rules, engage and self-motivate.

5.5 This Service is aimed at Young People aged 16-25. However it is not expected that at 25 the person would have to move out of this service, if they still required it, they would continue to use this service for a reasonable period (deemed as less than 2yrs, and still assessed as requiring support).

5.6 This service will provide access to 24 hour support, 7 days a week, 360 days of the year.

5.7 The Provider will also have access to an office/ training space during the daytime. This should be located centrally and accessibly.

5.8 Outreach is a mobile service, and it is expected that staff are enabled to perform and record their duties and Individuals notes through the use of technological devices (SMART phones, Tablets, IPads, laptops etc).

5.9 Outreach Workers should have access to a vehicle.

5.10 This Service will work across the geographic boundary of Salford.

6. Aims of the Service

6.1 The Service aims to:
   - Understanding the people supported, recognising their issues and developing strategies and interventions with the Person
   - Developing the Wellbeing of People who use the Service
   - Prompting Independence and Self care

6.2 This service is primarily for young people with Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD). A high percentage have co-morbid conditions and have been in care settings. These factors can cause significant difficulties in social and practical functioning, and make individuals extremely vulnerable in the wider community. The service will be well informed and skilled in working with these issues.

Personal and social issues for this group must be understood in order for strategies to be developed that are effective and successful.

It is important that the staff at this Service is knowledgeable in these conditions and associated issues to assist in delivering good self-management skills and effective development leading to greater independence.
6.3 The service will aim to work in person centred and holistic ways, focussing on the individual's conditions, and the impact on self and others. But also taking into account external factors that the Person may have difficulty with or a vulnerability to.

6.4 The service will support people to manage their own behaviour effectively. Staff will be trained in Positive Behaviour Support in order to help People start to manage their behaviour and take positive risks in an informed, measured and appropriate way.

6.5 The service will to actively promote wellbeing, including physical, emotional and mental health.

6.6 The Service will develop relationships with organisations that can assist with this aim; such as 42nd Street, Health Improvement Team, Achieve, Shine and any others that are applicable.

6.7 The service will work with People to increase their level of independence; including their social skills, daily living skills, personal care and overall health & wellbeing.

6.8 The principles of Just Enough Support will be adhered to and person centred approaches used.

6.9 It is an aim of the service to reduce reliance on paid support and increase use of less intrusive solutions. Assistive Technology will be utilised to achieve this.

6.10 It is expected that the Provider will be able to evidence and execute a plan to develop the use of Technology Enabled Care in the delivery of this Service. Uses of Technology Enabled Care may include (but are not limited to):

- Managing the support network around the Person
- Improving access to advice and support
- Supporting People to access primary and secondary care
- Support in managing medication where appropriate
- Maintaining and/or improving Person’s independence
- Maintaining and/or improving Person’s social participation

6.11 It is expected that the Service will take an active role in supporting People to get ready to manage a tenancy and then provide support to gain and manage their own tenancy. This will include but not be exhaustive off

- Pre tenancy work
- Developing capacity regards housing
- Housing related support
- Money and rent
- Looking after home
- Health and wellbeing
- Positive use of time
- Community and contributions
7. Delivery of Support

7.1 Culture and Quality staffing:

✓ Organisational culture is the base from which ‘good’ or ‘excellent’ starts. We want services which have a strong person-centred culture, both in terms of the people who receive support and with the staff which deliver it. We need providers who develop their staff to be strong leaders who can ensure high standards are maintained and promoted.

✓ This is a challenging Service that requires a real change in skill set, from all levels of workers. It is expected that there is an investment in Staff that reflects their level of responsibility and accountability. It is expected that they will be able to identify and develop training packages for workers that reflect the changing skill set required.

✓ The Provider should have tiers of staff, which will be comprised of a small, but highly skilled, highly qualified Team, who are able to demonstrate strong understanding not only of the conditions people may have, but also social issues that affect people.

✓ This is Service that is dependent on Quality of Staff, rather than Quantity and it is expected that the Team work to Outcomes, whilst not forgetting the importance of developing strong relationships with People.

✓ Although there is an expectation that all staff meet the National minimum date set for social care (NMDS-SC). The Provider is expected to be able to demonstrate a much specialised training program, which includes comprehensive induction, refresher training, mentoring and coaching. The training Program will be specific to people with Complex Needs, and ensure that promotion of prevention, intervention, wellbeing and independence are delivered using the skills of Facilitation, Coaching and Mentoring.

✓ The Service will follow safe recruitment practices, and robustly examines the identity, right to work, competence, experience, references, full employment history, qualifications and attitudes of all potential staff.

✓ The role of the Key worker is essential to the development of strong relationships with the People they support, and the People using the Service will have choice in who provides this Key role to them.

✓ Each person using the Service will have a Key worker, depending, on the level of need, aspiration or outcome development, will depend on how often the Person meets with the Keys Worker. These procedures will ensure there is an adequate performance and outcome management framework in place.

7.2 Asset Based Approach:

✓ An asset based approach recognises and builds on a combination of the human, social and physical capital that exists within local communities.

✓ We want a service which uses asset-based practice as a collaborative process between the person and the service, which allows them to work together to achieve positive outcomes by drawing on the person’s strengths and assets.

✓ To successfully do this, staff need to develop quality relationships which respect the elements that the person receiving support brings to the process. This way of working promotes opportunities for people to have a say, and shape their own services and support.

✓ The service will also act as a facilitator in linking up with the social assets each person has, including support from family, friends, health professionals, community groups and voluntary organisations.
We want providers developing a strong working knowledge of what is available in the area and developing partnership with other local providers' for putting in the asset based approaches section.

7.3 Health and Care

- Support will be provided to register with the local GP and access local community health services. This will include support to access annual health/medical appointments, including, but not limited to Doctors, dentist, opticians, podiatry, auditory.
- To deliver the Health Charter social care providers: https://www.vodg.org.uk/publications/health-charter-for-social-care-providers/
- Support will begin with the assumption that the person is best-placed to judge their own well-being, but family and independent advocates will be involved where appropriate.
- To ensure that services and staff support the Positive Behaviour Support Competence Framework. See: http://www.skillsforcare.org.uk/Documents/Topics/PBS/Positive-behavioural-support-competence-framework.pdf
- Support will ask for and respect the person’s views, wishes, feelings and beliefs.
- Support will help people to monitor (and record, if appropriate) their own health and well-being, through regular health checks, making referrals and seeking advice and support as necessary.
- Support will encourage and promote access to healthy lifestyle choices, including diet, sleep patterns, activities and exercise.
- The Service will promote and support access to health services, including other community providers ensuring that adjustments are made to take account of person anxieties, fears or phobia.
- Staff will have a thorough understanding of people’ conditions or illnesses, and the knowledge and expertise required to identify changes in mood, behaviour and well-being. This will all be documented at the service to ensure consistent information is available to all staff supporting. Additional training requirements should be highlighted to the CLDT.
- The Service will work closely with any health professionals involved to support delivery of treatments and/or therapeutic programmes.
- The Service will continue to develop and maintain and deliver Health Action Plans; or Education, Health and Care Plans with support as required from the CLDT.

7.4 Communication:

- Providers will use a wide variety of communication methods to support People in expressing their needs and preferences, to ensure that they can contribute fully to all planning and decision-making that concerns them. Staff will receive adequate training and support for using these methods.
- Promote a culture which maximises customer’s choice and control, through training, supervision, role modelling, and monitoring.
- Implement person-centred planning systems that:
  - support customers to develop and express their needs and preferences
  - support the continuity of relationships with family and friends
  - record and communicate those needs and preferences
  - monitor and review person-centred plans
Use and support the use of TEC (Technology Enabled Care)
Support with the appropriate use of regular technology, such as tablets and applications that can support independence

7.5 Independence:
- The Service will deliver support within a culture of promoting independence, ensuring that their workforce has the appropriate values and attitudes, knowledge and skills, training and supervision.
- Staff will ensure that people have choice and control over their own lives through consultation, supported decision making and access to advocacy where necessary.
- Staff will promote people’s positive sense of identity and self-esteem
- Staff will build understanding of the person, including their history and future ambitions as well as understanding their day to day needs for support.
- Staff will support people to build and maintain friendships and relationships, supporting them to access this natural support, as appropriate, and as part of their independent leisure time.
- The Service will devise weekly programmes and activity plans that facilitate development and independence, building time in for an enabling approach to be implemented whilst avoiding providing support when it is not needed. This is likely to involve careful assessment of risk and testing out, for example, identifying times and/or circumstances where no support is required.
- Encourage people to consider the choices available to them and the implications of their choices, taking account in particular of potential risks.
- Operate robust personalised risk management systems which update and refine person support plans on a continuing basis, including risk assessments that support positive risk taking.
- Staff and people are encouraged to take positive risks in order to achieve outcomes.
- The Service will implement systems for continually reviewing support arrangements to ensure that they remain the most effective in promoting or maintaining independence for the person.
- The Service ensures that people have access to assistive equipment and Technology Enabled Care which can help maximise their independence.
- Where appropriate, staff will support people to move on to more independent living options.

7.6 Safeguarding and Behaviour Management:
- Adhere to local safeguarding policies and procedures for children and vulnerable adults;
- All levels of management will attend training in “Safeguarding Vulnerable Adults in Salford”, as provided by the CLDT.
- Use proactive behaviour management strategies which minimise the use of physical intervention and restriction.
- Support people to comply with any requirements on them under the Mental Health Act in line with associated regulations and guidance.
- Support people to manage their own safety and security both inside and outside the home.
- The Service and Staff will ensure that any restraint or physical intervention complies with the GM Positive Behaviour Support Strategy and is only used in line
with person plans, developed by the multi-disciplinary team and signed by the Authority’s care manager or team leader.

☑️ The Service will work closely with the members of the multi-disciplinary team to assess, monitor progress and revise plans accordingly.

☑️ Demonstrate expertise in the operation of the Mental Capacity Act, Deprivation of Liberty Safeguards and Best Interests practices.

☑️ Access to an independent advocate should be arranged and supported where appropriate.

☑️ Any suspected misconduct, dishonesty or behaviour, which is detrimental to the welfare or well-being of People, is thoroughly investigated having regard to the Authority’s Safeguarding of Adults at Risk Policy, which can be found online.

☑️ The Provider is required to notify the Authority and CQC as appropriate as soon as it becomes aware of any improper conduct by Support Workers or other staff in connection to the Services.

☑️ The Provider must ensure it has and implements policies to safeguard People, their Carers and its Staff in respect of photographs, recordings and use of the internet, and other electronic media.

### 7.7 Social Inclusion:

☑️ Support people to maintain and develop (or rekindle) their social networks with natural relationships beyond professional and paid support, by promoting and facilitating where necessary positive contact with family and friends.

☑️ Ensure that staff role-model interaction that enhances people’s confidence and self-esteem, through positive relationships both inside and outside their home;

☑️ Facilitate contact with neighbours, local shops, leisure services and community groups, so that people can participate in the local community in a way that suits their needs and preferences.

☑️ Ensure that staff support appropriate online behaviours and online safety for those wishing to access social media and other technology to maintain and enhance relationships.

☑️ An intention that People become more independent of support in this area in the future.

### 7.8 Technology:

☑️ The Provider will, in partnership with the Complex Needs Team, use technology to maintain records, for communication and diary planning. These are key factors of the Service.

☑️ It is expected that many of the People using this Service will be supported by various mainstream and specialist technologies, which Staff will need to support remotely through smart devices via Apps and emails.

☑️ All Staff will need to be provided with the appropriate technology to do the Job, and the Provider Organisation needs the IT infrastructure to support this.

☑️ Where appropriate the Provider will be able to evidence and execute a plan to develop the use of Technology Enabled Care in the delivery of this Service. Uses of Technology Enabled Care may include (but are not limited to):

- Managing the support network around the person
- Improving access to advice and support
- Supporting people to access primary and secondary care
- Support in managing medication where appropriate
- Maintaining and/or improving person’s independence
- Maintaining and/or improving person’s social participation
• Reducing/removing night support where appropriate and safe to do so

✓ The Authority will support the Service in accessing any GMCA wide or borough-wide licences to Technology Enabled Care and offer support and advice in the development of new Technology Enabled Care options where appropriate. The Provider will be required to show a tangible/evidence based willingness to use Technology Enabled Care to improve outcomes for person’s who receive Supported Living services.

7.9 Staffing, Management, Training & Supervision:
✓ Services will operate 24/7; this will entail a combination of staffing presence, on call and technology, as appropriate and agreed for each service and individual.

✓ The model of staffing will ensure that optimum hours are used to make sure that services are effective and avoids staff burnout, minimise use of agency staff usage and ensure flexibility in services.

✓ Staffing will be person centred and designed to avoid People becoming over reliant on staff/particular staff.

✓ Staff will be trained to the minimum standards and attend training offered by CLDT as required.

✓ Sufficient management will be in place to offer a robust structure; including maintaining a regular scheme presence to retain operational oversight, as well as quality checking service and making decisions where required. On call arrangements will be a robust and effective part of this structure.

✓ Use of Community team staff, as a level of Provider management must be avoided. As important partners, the CLDT will be responsive and flexible with appropriate requests (i.e. facilitating a hospital discharge). Contact with community team staff must constitute part of the Provider’s escalation processes that includes all lines of their own Management team.

7.10 Referral route
✓ There is a robust referral process attached to this service (please see Appendix 2: Referral Process)

7.11 Exclusion Criteria
✓ Exclusions are made for People who can access other Supported Living options.
✓ No qualifying Person shall be excluded or discouraged from accessing the Service as a consequence of their age, disability, gender, race, religion or belief.
✓ Anyone living outside Salford who is not registered with a Salford GP

8. Service Flexibility

8.1 Flexible and innovative approaches to service delivery are necessary to allow for reaction to the changing needs and demand of People.

8.2 The portability of support will enable People to be supported in the best place; allowing people to achieve more by extending services into the community and to move on, if
required, to meet their aspirations.

Being creative and flexible with support hours will help People to achieve their ambitions; using an asset based approach to make this sustainable without paid support in the longer term.

9. Staff training

9.1 The Authority requires that, when delivering the Service to Service User, the Provider ensures that:

(i) The highest standards of protection are afforded to vulnerable people and are adhered to throughout the term of the Contract.

(ii) There is an appropriate match between individual Worker and staff skills, knowledge and competency and the individual needs of the Service User.

(iii) It minimises the need for change and provides a consistency in the number of Workers providing support to an individual.

9.2 The Provider will maintain a detailed record; containing relevant information concerning the individual’s care and support and actions taken in its delivery and the time of service delivery and be updated on a regular basis.

9.3 Mandatory training will be covered by the Provider’s induction training and annual training.

10. Purpose and Method of Contract Monitoring

10.1 The purpose of Contract Monitoring is to ensure that the specified services:

- are delivered in accordance with this Contract.
- are effective in delivering outcomes that enable People to live good lives, as independently as possible.
- demonstrate continuous improvement.
- provide value for money.

10.2 Contract Monitoring will take place through a combination of provider self-monitoring, regular contract meetings, appraisal visits and consultation in order to demonstrate service delivery meets the strategic requirements and are delivering to the contract specification.

   The ICO will:
   - Monitor the number of key-worker sessions per month
   - Expect quarterly updates on People’s progression
   - Do qualitative interviews with people using the Service
   - Have sight, with the Person Permission of the key-worker records

11. Service Performance Monitoring

11.1 The Provider will be required to submit a Performance Workbook on a quarterly basis. This will be submit one week following the end of each quarter, and an audit trail will be maintained so that the information can be verified.
11.2 The following indicators will be measured:

- Rates of staff recruitment and retention
- Agency staff usage
- DBS at recruitment and expiry/renewal
- Management of staff (supervisions, observations and appraisals)
- Use of hours – activities and opportunities offered
- Staff training and qualifications
- Satisfaction of People in Supported Lives and their families
- Quality of service (Quality Framework to be developed)
- Outcomes for Individuals (Outcomes measurement tool to be implemented) – submission quarterly.
- Complaints / Safeguarding
- Attendance at Provider Forum

11.3 Other key performance indicators may be agreed between the Provider and the Authority.

12. Outcomes Monitoring

12.1 Outcomes will be monitored on a quarterly basis.

12.2 The Outcomes star will be used to monitor outcomes for service users. This will be provided by the Authority and will be submitted on a quarterly basis.

12.3 Outcome targets:
To be defined after the initial baseline assessment; but must show continuous improvement in outcomes for People.

13. Quality Assurance Monitoring

13.1 Monitoring the quality of provider policies, procedures and the application of these; including service user and family awareness of these and their involvement in continually developing them.

13.2 Quality will be assessed in a number of ways:

- The Provider is expected to submit a self-assessment at least annually
- Visits to service; these may take the form of - shadowing at the service, pre-arranged appraisal visits, and unannounced visits.
- We may consult with staff, service users and other stakeholders.
Appendix 1:

Detailed supporting information overleaf.