Bradford District and Craven Health and Care Partnership

ACTasONE

Proud to be part of the West Yorkshire Health and Care Partnership

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

City of Bradford Metropolitan District Council

Bradford and District Person/Residential and Nursing Care Homes Provider List

Reference: BMDC/DN420609

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2. SERVICE SPECIFICATION

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GENERAL INFORMATION RELEVANT TO ALL SERVICES

1 Introduction

The City of Bradford Metropolitan District Council ('The Council') and Bradford District and Craven Health and Care Partnership part of the NHS to West Yorkshire Integrated Care Board ('the ICB') are seeking providers to deliver Residential and Nursing Care Homes services across the Bradford districts. This will be following their acceptance by the Council onto the Residential and Nursing Care Homes Provider List.

This document sets out the Service Specification relating to the provision of these services and contains the full Statements of Requirements for delivery.

The requirements for the delivery of these services and their relationship to CQC standards can be found in the Service Specification and should be considered the minimum that providers should deliver in a standard residential home.

There are further statement of requirements which describe the care and / or health requirements that should be delivered in addition, depending on the service type or Person/people who use the service groups. These are:

2.1 – Enhanced Statement of Requirements for Nursing

2.2 – Enhanced Statement of Requirements for People with Mental Health issues who may also have Autism

2.3 – Enhanced Statement of Requirements for People with Learning Disabilities who may also have Autism

2.4 – Enhanced Statement of Requirements for People with Physical Disabilities

Change Process over Lifetime

It is anticipated that the Provider List will operate for a period of ten years. During this time, it is acknowledged that there will be changes to the external environment, and regulations, guidance, practices and processes will need updating to reflect this. In order to keep the List relevant, the following change procedure is built in.
Where legislation, national policy and regulations change, Providers should immediately adopt the latest published version.
Where local practices, process or guidance change, this will be timetabled at the Service Improvement Board for notification and/ or discussion with Providers.

If, during the operation of the List the Council considers that any amendment or addition to the Provider List documents is reasonably required in order to maintain the safe and compliant

delivery of good quality services, an addendum in writing will be issued to all providers, and will constitute a formally executed variation to the Provider's contract with the Council.

2 Strategic Direction for Services

2.1 Happy Healthy at Home: A plan for the future of health and care in Bradford Districts and Craven.

This sets out how we will work as a system to deliver better outcomes, services and resources for people through joined up planning by the health and care system partners in Bradford District and Craven and working together. It can be found at
https://bradford.moderngov.co.uk/documents/s18401/Appendix%20to%20Document%20I.pdf

2.1 Bradford District Plan

The Bradford District Plan has been developed for 2021- 2025. It is a working document that has been subject to public consultation and has now been agreed by both the Council's Executive and Full Council.

The Council Plan 2021-2025 builds on some of the same priorities as the 2016 – 2020 plan but also looks to address some new major challenges our district will face in the coming years. These include responding to and recovering from the COVID-19 pandemic; and following the Council's declaration of a climate emergency, taking steps to deal with that and to continue to build on sustainable delivery.

These can be found on the Council's website at
https://www.bradford.gov.uk/media/3273/bradford-council-plan-2016-2020.pdf
https://www.bradford.gov.uk/media/6152/councilplan2021-25.pdf

2.2 Home First

The department of Health and Wellbeing adopted a new vision for adult social care in April 2017 'home first'. This sets out our ambition for health and wellbeing in Bradford and District. We have called the vision home first because we firmly believe that people who need help from social care in Bradford would want us to do as much as we can to make sure that they are supported to stay in their own homes. Being around family, friends and in your own home is the best place to feel happy, healthy and in control of your life.
https://www.bradford.gov.uk/adult-social-care/policies-and-reports/home-first-vision/

2.3 Personalised Commissioning

The National Framework for Continuing Healthcare 2018 is the process for determining whether an individual is eligible for NHS Continuing Healthcare or NHS-funded Nursing Care.

Where an individual is eligible for NHS Continuing Healthcare, the ICB is responsible for care planning, commissioning services, and for case management.

It is the responsibility of the ICB to plan strategically, specify outcomes, procure services, manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare. This role is fulfilled by the ICB's Personalised Commissioning Department and services commissioned must include ongoing case management relating to the care package for all those eligible for NHS Continuing Healthcare, including review and/or reassessment of the individual's needs.

Individuals eligible for Continuing Healthcare are entitled to receive funding in their own home, residential or nursing homes. Funded Nursing Care is only payable directly to a nursing home for the Registered Nursing element of an individual's care.

As the lead Commissioner, the Local Authority therefore leads on procurement, performance monitoring and processes the payments into residential and nursing homes for people eligible for CHC or FNC via a Section 75 arrangement.

https://www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf

2.4 Market Shaping

The Care Act (2014) introduced duties on local authorities to facilitate a vibrant, diverse and sustainable market for high quality care and support, for the benefit of their whole population, regardless of how the services are funded. This should include a variety of different providers and different types of services that offer a genuine choice of service type.

The Council will continue to engage with the market through forums whilst further developing the Market Position Statement (MPS). This details the Council's view of the current state of the social care and support market in Bradford, how it intends to work with the market in the future and the opportunities for business change providers may want to consider through providing population data. This enables us to work with providers of services to shape the market to enable this to be achieved. Over time, Specialist Market briefings and other associated documents, as well as real-time data may be produced to further inform the market as the Council implements its commissioning strategy for Adult and Community Services. As new opportunities are identified or the needs of the district changes, the introduction of the Provider List will create flexibility for Providers to meet this.

Alongside this we are also working with other departments to better facilitate joined-up working e.g. our links with planning department will enable to engage with prospective planning applicants at the pre-planning stage and to be signposted to the MPS to reinforce our market shaping role.

The current MPS and other commissioning information can be found on the link to the Council's pages below.

https://www.bradford.gov.uk/business/commissioning-adult-health-and-social-care-services/commissioning-adult-health-and-social-care-services/

2.5 Respite

The Council's Department of Health and Wellbeing are currently reviewing respite opportunities across the district, focussing on ensuring the district has a range of services that can meet diverse needs. At this time Providers of Residential and Nursing services offer respite on a rotational or ad hoc basis. Should this requirement change, the Council and ICB will engage with Providers regarding the requirements.

2.6 Personal Budgets and ISFs

At present there are no immediate plans to introduce personal budgets within Older Person's residential and nursing services. The Commissioners' are awaiting publication of a Department of Health report on this. Should the decision be made to introduce personal budgets or ISF's during the lifetime of the Portal, the Provider will be expected to work with the Commissioners to implement these.

2.7 Mental Wellbeing in Bradford district and Craven

The Mental wellbeing strategy places great emphasis on wellbeing and the wider determinants of mental health. Our aim for Bradford and Craven is to create environments and communities that will keep people well across their lifetime; where they are open to speak about emotions without fear of stigma and discrimination. We want to make it acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills and understanding to support their needs through evidence based interventions.

The strategy can be found on the council's website here: https://www.bradford.gov.uk/media/3578/mental-wellbeing-strategy-in-bradford-district-craven.pdf

3 Legislation, Guidance and Policy

The service will adopt the legislation and recommendations from statutory and mandatory publications by appropriate professional and regulatory bodies as well as support and implement any local standards. These are detailed in the Statement of Requirements (section 9 of this document) and Enhanced Requirements (Schedules 1 to 4).

By signing up to the Provider List the Provider will commit to working at all times in accordance with the requirements as stipulated in CQC's regulations/ fundamental standards, this Specification and the Quality Charter.

4 Partnership Working

The development of the Provider List as an approach to contracting has been made possible through the strong relationships and cooperation of all partner organisations that has been established. The continuation of these relationships will be central to its operation going forward.

4.1 Provider Forums

As part of the Partnership working approach described above, the Council and NHS require Providers to engage in a range of opportunities including via regular Provider-led forums which will facilitate a joined up approach to development throughout the lifetime of the Framework.

The function of these forums will be to discuss and share information and developments regarding the strategic and operational issues that impact upon Bradford Adult and Community Services, ICB and other partner agencies and Residential and Nursing Care Service Providers and Person/people who use the service(s). This will help to foster a collaborative culture of continuous improvement in the development of clear communication channels to achieve good working relationships between all organisations and identify and build upon good practice. Provider Forums can be used to share experience, expertise and successes in relation to quality and performance activities, as well as reviewing monitoring mechanisms and support needed from the Council.

4.2 Service Improvement Board

A Service Improvement Board (SIB) is established for Residential and Nursing Care and is a partnership approach focused on improving joint working arrangements, developing process and improving pathways at an operational level.

The Board currently meets a minimum of six times per year and is made up of self-nominated providers including owners, quality and operational staff, the BCA, Healthwatch and commissioners and quality leads across the ICB and Council. Other professionals also attend on an ad hoc basis as determined by the agenda.

Under the new contracting arrangements, we will be extending the Terms of Reference to include an annual review of performance data and to agree key areas of focus for the forthcoming year. This is covered in more detail in the Quality Charter.

4.3 Risk Management and Serious Concerns Meetings

Monthly multi-agency meetings (currently called Serious Concerns Meetings) are held to share market information/intelligence across all service areas. This forms part of the risk management quality and safety arrangements and affords a multi-agency approach in supporting providers to improve, maintain and sustain the quality of service delivery. Updates are provided by the adult social care contract and quality assurance team on the status of on-going work with providers and feedback any progress evidenced through enhanced monitoring arrangements. The meeting comprises the adult social care contract and quality assurance team, adults

safeguarding, CQC, health care professionals, and the Council's operational 'front line' social work representatives. The focus of these meetings is to agree actions to support Providers to make improvements and stabilise delivery.

The above procedure is scheduled for review following the introduction of the new Joint Multi-Agency Safeguarding Adults Policy in 2020. This will be tabled for discussion at SIB.

4.4 Community Partnerships

Community Partnerships (CPs) are Bradford, districts and Craven's way of delivering integrated community, health care and wellbeing services through 13 locally led partnerships covering communities of 30-60,000 people. CPs were created to give community based staff and local people the opportunity to say what is important to them based on their local knowledge and information to ensure that future health, care and wellbeing services meet their needs.

Each CP has equal voice/representation of all system partners and is driven by the needs of local providers and communities working together. They are responsible for developing and designing local services to support delivery of the system vision of supporting people to be happy healthy at home.

4.5 Primary Care Networks

Primary Care Networks (PCNs) consist of groups of GP practices who are working together with a range of local providers, across primary care, community services, social care to their local populations. These are not dissimilar to the CP model and there is overlap and the role and functions of CPs and PCNs will increasingly overlap as time progresses.

In Bradford district and Craven there are 12 local PCNs led by groups of GP practices with a designated Clinical Director working with a range of local providers. PCNs are driven by an NHS England contract and are responsible for the delivery of new PCN service specifications to populations. One of these service specifications relates directly to people living in care homes. Each PCN is required to support an aligned group of Care Homes and identify a named clinical lead. It is hoped that the PCN aligned to the Care Homes will work in collaboration to build mutual respect and an understanding of each other's role and provide opportunities to introduce standardised approaches to care and practice to improve outcomes for people living in Care Homes.

4.6 Mental Health Provider Forum

The Mental Health Provider Forum consists of all providers, statutory and community from across the district who are delivering to the key outcomes of the strategy. This is a space for information sharing, co-design, innovation and problem solving to ensure services are meeting the needs of people in our district.

5 Operation of the Provider List (PDPS)

The Provider List is established through the use of a Pseudo Dynamic Purchasing System. This approach will enable the Council (as the lead commissioner, acting for itself and on behalf of the ICB) to purchase packages of care on behalf of individuals. It is an on-going process, so will be opened and closed during its lifetime. This will allow Providers to enter, leave or reapply to deliver services as needed. It is envisioned that this will support the development of new services as need is identified by allowing new entrants into the marketplace or as part of a provider's business strategy. The PDPS will be in place for 10 years.

The application process is designed to enable access for all. The process validates a Providers legal ability to provide those services within the district. We will consider Providers who do not sign up as to constitute a risk and will therefore recommend no placements.

It is proposed that any necessary revisions to documentation throughout the lifetime of the Provider List will be brought to the Service Improvement Board (see also 4.2).

5.1 Call-offs (Placements for Individual packages of care)

When the Provider List becomes operational, new, individual contracts for Residential and Nursing Care will only be commissioned from organisations that have been accepted on to the Provider List.
The primary use of the PDPS will be for individual placements. Any opportunities the Council intends to call-off under this List for larger scale Managed Services will be communicated to Providers through the YORtender system.

5.2 Existing Business

Existing packages of care and corresponding Individual Service Agreements will be automatically transferred to the new Contract, under a 'Continuity Call Off' mechanism. Details will be confirmed in writing to the Provider following appointment to the Provider List.

For further information on the operation of the Provider List through the PDPS, please refer to Document 1, Invitation To Apply

6 Contract and Quality Assurance

Commissioners have developed a unified approach to quality which is outlined in the Quality Charter. Commissioners will undertake contractual compliance and administer quality assurance functions as defined in the Quality Charter. Providers must engage in specific measures, as outlined in the Quality Charter, which include data submissions, engaging in contract monitoring visits, adopting best practice and attending training and strategic events. There will be an annual review of quality across the sector and recommendations will be provided to commissioners to consider amendments to the Quality Charter each year. Providers must remain engaged with the current requirements of the Quality Charter and ensure compliance with changes to legislation, the requirements of the regulator and best practice. Providers will receive feedback

about performance and quality through Service Improvement Boards, provider forums and newsletters to understand market trends and quality across the sector.

7 Services in Scope

Linked to CQC descriptors, the following Service Types and the Person/people who use the service Bands are in scope for this Provider List.

Service Types
Residential Care - Care home services without nursing (CHS)
Nursing Care - Care home services with nursing (CHN)

Person/People Who Use the Service - Bands
Adults aged 18-65
Adults aged 65+
Mental health
Sensory impairment
Physical disability
Dementia
Learning difficulties or autistic disorder
Diagnostic and or screening service (DSS)
Care home service without nursing (CHS)
Care home service with nursing (CHN)
.
Geography/ Location
Throughout Bradford districts.

8 Delivery requirements

8.1 CQC Registration

The specification and schedules below are intended to work alongside the legislative and quality requirements which are placed upon Providers by the regulating body. This is currently CQC's Fundamental Standards Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or the Care Quality Commission (Registration) Regulations 2009. Providers are required to be registered with the Care Quality Commission for each service type and Person/people who use the service band they wish to provide under this agreement at the point of entry, registration must then be maintained at each delivery site and throughout the duration of this Contract. Any changes to registration must be notified to the commissioner when notified by home or CQC. Please see Services in Scope at section 7 above below for services commissioned under this list.

CBMDC and ICB require that standards in each of the homes never fall below their Fundamental

Standard Regulations- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Council and NHS ICB expect all Service Providers to operate at a 'good' quality rating as a minimum from CQC and strive for 'outstanding'. A rating of 'requires improvement' or 'inadequate' will trigger the requirement for Contract review and an agreed action plan for improvement. See Appendix 5 for further detail.

CQC retain the overall responsibility for the registration and monitoring of care providers' compliance with the registration regulations and fundamental standards below which care must never fall. Service Providers are required to comply with all relevant legislation that currently relates to the operation of their business or is amended or implemented at a future date.

It is a given that Residential and Nursing Care are regulated by CQC and the providers will have had to go through a rigorous registration process to legally operate as a care home.

Therefore the majority of requirements for the delivery of services are detailed in CQC's Fundamental Standards and can be found at www.cqc.org.uk.

8.2 Bradford Statement of Requirement and Schedules

In addition to the CQC standards, Providers are also expected to work to the requirements detailed within this Service Specification, including the Statement of Requirements and relevant schedules which describe our expectations for delivery.

The Statement of Requirements can be required as the 'core' specification which applies to all Service Types and Person/people who use the service bands. Schedules 1 to 4 are further specifications which describe the care and/ or health to be delivered in other settings and for specific Person/people who use the service bands.

8.2.1 Statement of Requirements for all Homes

This covers all homes which offer accommodation and personal care on site, 24 hours a day, to people who are not able to live independently (with support) in the community. Providers will supply safe, high quality care that meets the individual social care needs of the Person/people who use the service. The Provider will work collaboratively with health and social care professionals as well as the wider community to ensure that all outcomes detailed in the care plan are met and appropriate onward referrals are made to specialist services that the Person/people who use the service may require.

Residential care can vary depending on the needs of the individual(s) but can include:

- Meals, accommodation, housekeeping and laundry service.
- Assistance with daily activities such as personal hygiene, dressing, eating, and walking.
- Social activities and promotion of wellbeing.
- Self-care
- Assistive technology and equipment.
- Care and support for adults with, for example, mental health issues, learning disabilities, severe physical disabilities or needs arising from (former/) substance misuse.
- Supporting people at the end of life (EOL).

- Respite and short breaks.

The full description of requirements are detailed in section 9 and are considered the Core Requirements.

Age

The services are open to all Adults over the age of 18, however the majority of people are expected to be 65 and older.

Client Group and Person/people who use the service Bands.

The large majority of the people who will access these services are expected to be Older People with dementia.

Nationally 2 in 3 people who live in care homes are living with dementia. [1] Expert opinion and clinical guidelines support the view that early diagnosis is beneficial to patients, carers and society and should therefore be promoted. Ensuring that everyone with dementia receives a timely diagnosis and sensitive support and guidance means that people can plan for the future and receive therapeutic support. Diagnosis is therefore a strategic priority for Bradford.

People living with dementia who are over 55 have on average four comorbidities. [2] Studies suggest that 41% of people with dementia have high blood pressure and 32% have depression. [3] It is therefore essential that providers of residential and nursing care offer access to skilled and appropriate care for all the health and wellbeing needs of people with dementia.

Reducing avoidable transitions of care including transition to hospital inpatient care and transition between residential and / or nursing homes, is another strategic priority.

Whilst these services should also be accessible to people with Mental Health issues, Learning Disabilities and Physical Disabilities, these are not expected to be their primary presenting need. When supporting the needs of these client groups there may be different or additional requirements, and these are detailed in Schedules 2 to 4.

Access and Referral

Access and referral in to services will be through Adult Service's Independent Advice Hub (formerly 'Access') as detailed on the Council's website.

Eligibility

This service is open to all adults who are citizens of Bradford and are ordinarily Person/people who use the service(s) within the Bradford district.

To be eligible for the service the person will have had an assessment by the Council and meet the national minimum threshold for funded support; therefore, some or all of the care is being

[1] 'Home from home', Alzheimer's Society (2007)

[2] https://www.dementiastatistics.org/statistics/comorbidities/

[3] 'Dementia rarely travels alone', APPG on dementia (2016)

paid for by the Council. Services will then be commissioned on an individual basis (spot purchase) through a contract for a named individual, with the service which best meets the needs of the individual. If and when a managed service is required, this will be through the Call-Off Process detailed at 5.1.

8.2.2 Document 2.1 Enhanced Statement of Requirements for Nursing (Nursing Care - Care Home Services with Nursing (CHN)

This schedule clarifies the additional requirements for Personal care with Nursing**.** The standards in here are **in addition** to the requirements described in the main body of the Service Specification, including the core Statement of Requirements.

Where there is reference in the Core Statement of Requirements referring to District Nursing Teams, it is expected that this will be managed within Person/people who use the service(s)ial Homes.

8.2.4. Document 2.2: Enhanced Statement of Requirements for People with needs relating to Mental Health problems who may also have Autism

This schedule clarifies the requirements for people whose primary presenting needs relates to their Mental Health.

8.2.5 Document 2.3: Enhanced Statement of Requirements for People with a Learning Disability who may also have Autism

This schedule clarifies the requirements for people whose primary presenting needs relates to their Learning Disability.

8.2.6 Document 2.4: Enhanced Statement of Requirements for People with a Physical Disability

This schedule clarifies the requirements for people whose primary presenting needs relates to their Physical Disability.

8.3 Skills for Care

The provider shall, in meeting the obligations of this contract, meet the requirements of Skills for care 'Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England'.

The provider must submit the required data in the ASC-WDS Adult Social Care – Workforce Data Set, this enables Providers to apply for additional support toward ensuring a high quality staff.

9 Statement of Requirements

To be read in conjunction with CQC fundamental standards as described at **8 Delivery Requirements.**

1.0 Person Centred Care The Person/people who use the service(s) must have care or treatment that is tailored to them and meets their needs and preferences.
This standard has been expanded to include reference to Bradford specific procedures and includes specific reference to • Access to the Care Home • Person Centred Reviews • Choice, Control and Engagement • End of Life Care • Respite and Short Breaks • Moving On •

Access to the Care Home.

No	Standard
1	For Local Authority funded Person/people who use the service(s)s, using the Strengths Based Approach, the Social Worker, Person/people who use the service and their support network will together draw up and agree a Care and Support Plan / Self Directed Support Plan (SDS), which will be sent to the Provider prior to admission. This Support Plan will identify the Person/people who use the service outcomes to be achieved by the Provider.
2	For Continuing Health Care (CHC) funded Person/people who use the service(s)s the CHC Nurse assessor, Person/people who use the service and their support network will together draw up a CHC Care and Support Plan, which will be forwarded to the Provider prior to admission.
3	The Provider will ensure that long-term Person/people who use the service(s) are registered with all appropriate primary and secondary health provision that supports their Care Plan This includes being registered with an appropriate General Practitioner. This may be their previous GP if in area or, if the care home is aligned to a single GP practice, the Person/people who use the service(s) and their support network should be made aware of this and the benefits of this arrangement, prior to admission, thus encouraged to register with that GP practice.). This should be within 7 days of admission; in the event that this is not possible, the Provider will evidence that attempt has been made within this timescale and detail the reasons for any delay occurring (which may as a result of a delay by the Provider, the Person/people who use the service, and their Support Network or by the GP Surgery).

4	The Provider will ensure that staff are fully aware of the Person/people who use the service's Care Plan and will ensure these plans are adhered to. • The Provider will draw up an initial Care and Support Plan within the first 48 hours of admission. • A full person centred Care Plan will be drawn up by the Provider in most instances by the fourth week but no later than six weeks after admission. This will evolve and develop during the Person/people who use the service's stay. • The plan will be developed in line with the Provider's own policies and procedures but will include the outcome from any advanced wishes/ care planning and Providers are encouraged to have these discussions as early as possible.
5	Where the Person/people who use the service is living with a cognitive impairment, every effort will be made to engage with them in the best way possible to discover their views and preferences in accordance with the Mental Capacity Act Code of Practice.
6	The Provider as the person closest to the individual will support, where appropriate, the individual with their day to day finances where they lack the ability to do it for themselves. The Provider will have a clear policy for handling and safeguarding Person/people who use the service finances and benefits. The Individual Service Agreement sets out the basis for this. Power of Attorney should be checked to verify that it is valid for the relevant decision and is registered, or if there is a court appointed deputy for that decision making.
Person Centred Reviews	
	Commissioners' Review
7	The Commissioners will lead and co-ordinate an initial review as agreed with the Care Home Provider. Following that the Commissioners will lead reviews as appropriate for each funded Person/people who use the service, depending on outcomes, risk and need. Where reviews are not annual, the Commissioners may require the Provider to forward a copy of the annual review of the Person/people who use the service's Care and Person Centred Support plan, or respond to other information requests.
8	A review by the Commissioners to ascertain whether a Person/people who use the service's placement in a home remains appropriate may be requested by the Person/people who use the service, their support network including any Advocate, the Commissioners, or by the Provider or any other interested party. All parties will work together to ensure that a review of the Person/people who use the service's needs takes place within an agreed timescale which should be on the basis of risk.
9	The review will address the extent to which the outcomes required of the placement are being met. The Person/people who use the service's Support Plan / CHC Care and Support Plan will be amended as appropriate following the review. Any such amendments will also lead to similar adjustments by the Provider to the Person/people who use the service(s)' Care plan.

	Provider Review
10	The Provider will draw up a plan on admission as outlined above. Review of Care and Support Plans will involve such other people that appear necessary to contribute to this process; this may include health professionals or other people involved in delivering their care, and anyone who the Person/people who use the service wishes to invite from their support network.
11	The Commissioner, at any time, may request a copy of the Care and Support Plan. The Provider will make this available within 2 working days of the request.
12	Where a Person/people who use the service(s) is thought to have dementia but no diagnosis has yet been obtained, the care home should use the DeAR-GP (Dementia Assessment Referral to GP) screening tool and refer the Person/people who use the service(s) for memory assessment if screening is positive. Care Homes can refer directly into BDCFT OPMH Care Home Liaison for advice, guidance and assessment if required for mental health and behavioural issues in dementia.
13	Where a Provider is supporting a person with dementia they should use a comprehensive assessment to understand the person's behaviour. This will include an holistic review of the person that looks at their relationships, cognition, activities and environment and ensure personalised plans to support the person. Care homes are encouraged to adopt, in conjunction with the BDCFT OPMH Care Home Liaison Service, the CLEAR model of assessment and intervention to support people with dementia where this is being rolled out.
14	Both Person/people who use the service(s)ial and nursing homes must ensure that Person/people who use the service(s)s receive assessment and care in primary and / or secondary care for physical and mental health conditions comorbid with dementia.
15	Early development of an Advance Care Plan (ACP) is particularly important where someone is living with dementia as it is foreseeable that mental capacity will be lost. On admission the responsible manager at the care home should liaise with the person, their carer(s) and / or their GP to determine whether an ACP exists. Person/people who use the service(s)s should be given the opportunity to update an existing ACP or, if none exists, develop one.
Choice, Control and Engagement	
16	Where appropriate Person/people who use the service(s) should be supported to be as independent as possible and make choices about their life and where appropriate refer for assessment
17	Where available, Providers should access Telemeds and other health related professional referrals and pathways. The Provider should facilitate cooperative ways of working with other specialist services, including psychology, occupational therapists, physiotherapy, speech and language therapists, psychiatry and behavioural support to assist enablement and develop supportive move on plans.
18	Providers must respect lesbian, gay, bisexual and transgender (LGBT) lifestyles and choices. The recruitment and training of staff must ensure that they are sensitive and respectful of all Person/people who use the service(s)s and partners, friends or relatives, regardless of sexuality. Visitors must be able to express their ongoing love and maintain their relationship with privacy and without threat. The rights of

	same sex partners as next of kin must be recognised, with involvement in all discussions relating to care and treatment.
End of Life care	
19	Staff are appropriately trained and supported to cope with death, dying and bereavement; and to manage the processes and procedures sensitively to ensure the Person/people who use the service receives the appropriate care and symptom relief. This includes where the Person/people who use the service may not be able to recognise pain as a result of cognitive impairment or is unable to communicate their pain or symptoms to staff.
20	Staff have access to and are trained in the use of equipment associated with the provision of palliative care and are competent and confident in its use, such as syringe drivers monitoring and pressure-relieving equipment etc
21	Staff are familiar and make appropriate referrals to Telemedicine, Telehealth and Gold Line where available, thus allowing people to die in their preferred place of death and preventing inappropriate admissions to hospital.
22	An advanced care plan should be offered and discussed to meet the Person/people who use the service's wishes when or if they no longer have capacity to make the decision, as well as next of kin were appropriate. Person/people who use the service(s) are supported to die in their preferred place of care and are supported to remain there during the final stage of life, where unnecessary acute hospital admissions are avoided.
23	Care delivery must be managed in accordance with NICE Guidance and the Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020. This will be managed in line with the ReSPECT process and agreed with the GP and clearly documented within the individual's Care and Support plan. If required, the Provider will use the local Advance Decision to Refuse Treatment (ADRT) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policies ensuring Person/people who use the service(s) are able to express their treatment / resuscitation wishes and that treatment / resuscitation decisions are documented and shared with those who need to know, and that relevant signed, original documents are available immediately to clinicians in a time of crisis.
24	Spiritual and emotional needs are identified and appropriate support is provided, including developing relationships with religious and voluntary organisations/ support networks.
25	The Person/people who use the service's support networks are able to spend as much time with the person as they wish in line with the individual's preferences.
26	Where Person/people who use the service(s) are admitted from hospital or on any other shorter-term basis, the Provider will ensure that the relationship between short and long-term Person/people who use the service(s) is well managed and the environment of the home is conducive to this
27	The Provider will have an established End of Life process that reflects National and local guidance and policies, procedures guidelines and support materials that

	support the provision of excellent end of life care e.g. 'Gold Standard Framework', anticipatory prescribing, and involvement of specialist services where appropriate
Respite and Short Breaks	
28	Person/people who use the service's right to privacy and dignity is maintained during their respite break. Person/people who use the service(s) preferences and choices are documented in their records and are taken account of by all staff.
29	The Provider will draw up an initial Care and Support plan prior to admission based on the Adult Social Care Assessment. Following admission, this should be reviewed proportionate to the length of stay and needs of the individual.
Moving On/ Transitions in Care	
30	Where identified as relevant the Provider will ensure staff support the Person/people who use the service in planning for their future from the time they start using the service. This will form part of the Provider Care plan / CHC Care and Support Plan. In doing so, the Provider will ensure the Person/people who use the service is involved in all meetings to discuss their future move, including being involved in assessing the possible risk for them or others if they move. The Person/people who use the service is encouraged by the staff to use all the experience and daily living skills they have gained while using the service in deciding on their next move. Where the Person/people who use the service has cognitive impairment, their family and/ or support network must be involved.
31	Person/people who use the service(s) should visit the place they are moving before making a decision about moving. The Provider will facilitate this process to ensure it happens smoothly.
32	Person/people who use the service(s) who move on must have the opportunity to keep up friendships made during their time at the home. The Provider will facilitate this process, where practicable to ensure it happens smoothly.
33	The Provider will ensure Person/people who use the service(s) have a representative and someone from their support network to help the Person/people who use the service make the transition to their new home, providing social and emotional support during this period. This may include an Independent Advocate, and for those without capacity, an Independent Mental Health act Advocate (IMCA) should be appointed
34	The Provider will liaise and communicate with the Person/people who use the service, their support network, the social worker and other agencies involved, at least 7 days before the planned move date, to ensure that all arrangements are in place.

	For those individuals funded by CHC, discharge from hospital will be coordinated by the hospital discharge teams. For individuals moving from home to nursing home or between nursing homes, the person or their representative will choose the home and the ICB informed, unless the case is already allocated to a social worker in which case the process will be the same as the above paragraph.
Unplanned Move Ons	
35	The Provider will ensure that unplanned move-ons are avoided as far as possible, especially for those with cognitive impairment. In the event that this is not possible, e.g. in the event of an emergency or home closure, the move will be with the minimum of risk to the Person/people who use the service or others. The reasons will be consistent with the Providers clear written policy on moving on and be available to Person/people who use the service(s)s. The policy will clearly outline the circumstances in which a Person/people who use the service may be asked to leave and the circumstances in which they may be eligible to re-apply for admission.
36	The Provider will ensure that key professional staff, including the social worker, GP and Commissioners will be notified within 24 hours of any emergency or unplanned move-on. The Provider will ensure professionals are provided with the reason for the notice given, any potential risks identified, medication records and the progress of the Person/people who use the service during their stay.
37	Any unplanned move on must comply with the notice periods outlined in the Terms and Conditions
Hospital Stays	
38	Person/people who use the service(s) that require inpatient admission to hospital are supported to ensure a safe transition from the care home to hospital. The Care home provide a detailed handover of care needs and send all of the necessary documentation (appropriate to their health needs) and personal belongings as per the Hospital Transfer pathway (Red Bag).
Health and Wellbeing	
Skin Integrity	
39	Person/people who use the service(s) have their skin integrity assessed as part of their initial assessment when moving into the Care Home – this can be done by both qualified and unqualified staff, however support should be sought from the District Nursing Team and / or community based specialist services as necessary and accessed as required. The Provider ensures that all recommendations are incorporated into the Care and actioned in a timely manner.

40	The Provider will ensure that ongoing reviews of pressure areas are undertaken and that any wounds that are non-healing or non-progressing are reported to a tissue viability nurse for urgent assessment
Falls	
41	The Provider is responsible for ensuring that quality standards and guidelines relating to falls prevention are adopted to include, a multifactorial risk assessment and personalised care plan and correct use of equipment to support reduction of risk. The Provider should be aware of local specialist Falls service and access as required.
42	The Provider ensures that all Person/people who use the service(s) have an initial falls risk assessment within 24 hours of admission and the outcome recorded in their Care Plan. A recognised tool such as Cryer is recommended. Person/people who use the service(s) who are vulnerable to falls are actively supported by their key worker or equivalent member of care / nursing staff to reduce / prevent the risk of a fall, reduce further occurrence and thereby supporting a reduction in unnecessary emergency admissions related to falls. The Provider should focus on prevention for both the environment and also the Person/people who use the service e.g improving their strength and balance. This should be revisited monthly or as needs change.
43	Where the Person/people who use the service has had a fall in a Home, or is deemed to be at high risk following the initial assessment, a multifactorial falls assessment should be completed and developed in collaboration with the Person/people who use the service and other members of the MDT. The provider should have a Post fall pathway for managing a Person/people who use the service(s) who has fallen or been found on the floor. This should include immediate actions such as completing an accident/ post-falls report to determine causes/ circumstances of the fall and follow up monitoring or review of care plan of further actions/ interventions required to mitigate against further falls. A further multifactorial risk assessment should also be completed as per local protocol. If this fall has taken place in a Person/people who use the service(s)ial Home the Provider should also refer to the District Nursing Team or GP as per local protocol.
44	Ensure that staff have access to and follow a post fall action plan that includes undertaking checks for signs or symptoms of fracture and potential for spinal injury before the patient is moved
45	Ensure that Post fall baseline observations are completed (and followed up as required) to include neurological observations for all Person/people who use the service(s) where head injury has occurred or cannot be excluded (for example unwitnessed falls)
46	The Provider will collaborate with other members of the health and social care team to ensure that appropriate escalation are made should observations deteriorate (i.e. via 111, GP, District Nurse 999, Telemedicine, Gold Line)
47	The Provider ensures effective accident and incident governance arrangements are in place which includes such information as the number of incidents , themes and trends, causes of incidents place, times and date of incident, follow up and level of harm,

	documentation and checks and is regularly audited to ensure that necessary actions are taken to reduce the likelihood of reoccurrence within the home, for example using Root Cause Analysis and contributory factors The Provider has clear policies and procedures for accidents and incidents to include immediate post incident actions and subsequent follow up which may include monitoring (SAO2, BP resps etc), referral to telemedicine etc • Implementation of a post incident action plan; which includes completion/review of risk assessment and evidence of follow up checks to include consideration of the need to report to external agencies i.e. safeguarding, CQC RIDDOR and ICB. • The Provider has robust governance arrangements through a Managers investigation process post incident to ensure there is adequate oversight of incidents with clear actions to mitigate risks of reoccurrence
48	The Provider proactively seeks 6-monthly medicines reviews for all Person/people who use the service(s) by the GP to assess medicines administered
49	The Provider holds a Homely Remedies policy that outlines the safe administration of medicines without a prescription (e.g. paracetamol, simple linctus). The Provider will further develop this in line with medicines optimisation and emerging best practice e.g. proxy prescribing
50	The Provider, in partnership with GPs and other health professionals, will have a strategy for reducing the inappropriate use of anti-psychotic medication.
	Continence
51	The provider must manage effectively Person/people who use the service's continence, independence and wellbeing by providing effective bladder and bowel management for all Person/people who use the service(s), male and female with support from the District Nursing Team or other community based services such as specialist continence services
52	Where appropriate, Person/people who use the service(s) are supported to manage continence independently through provision of information and/ or self care
53	The Provider will ensure that there is appropriate onward referral to the GP and specialist nursing services for education and advice where required.
	Serious Incident Reporting and Management (STEIS) (This is applicable for all NHS funded placements)
54	Learning from incidents and what goes wrong in health and social care is crucial to preventing future harm. The current NHS Serious Incident Framework (2015) outlines that any acts or omissions in care which lead to patient harm or has the potential to cause patient harm should be reported on to the Strategic Executive Information System (**STEIS**) and investigated by the Provider using root cause analysis and human factors methodology. Providing lessons learnt and actions to reduce the likelihood of reoccurrence. The provider will notify BMDC via the online notification form of any incidents that meet the threshold for a serious incident and where a Person/people who use the service

	has CHC /FNC /Joint funding in place. The notification will then be shared with Bradford and Craven ICB for inclusion on the STEIS. The exception to this is where a category 3 or 4 pressure ulcer occurs, the care home must complete a root cause analysis (RCA) and email the template to seriousincidents.bradford@nhs.net. This is outside of the Council's Notification Form process as is considered a Serious Incident that also requires sharing of personal data which cannot be processed through the Council's Notification process. See also section 10.11 of the Nursing Schedule. For more information please refer to the full framework: Serious Incident framework 2015

2.0 Dignity and Respect Person/people who use the service(s)s must be treated with dignity and respect at all times while they're receiving care and treatment. This includes making sure: They have privacy when they need and want it. Everyone is treated as equals They are given any support they need to help them remain independent and involved in their community.	
This standard has been expanded to include reference to Working with the local community and the Person/people who use the service's support network	
1	The Provider will support Person/people who use the service(s) to maintain links to and access the local Community. Person/people who use the service(s) should have a wide choice in how their needs are met and are supported to access universal services such as transport, leisure and education, housing, health and opportunities for employment regardless of age or disability.
2	There are and will be opportunities for care home providers to get involved and work in collaboration with the Community Partnerships and Primary Care Networks, especially in relation to Enhanced Health and Wellbeing in care homes. This will enable people working in the care home sector to have a voice within the health and care system. They will have the ability to influence and shape future service provision and achieve better outcomes for people living in care homes. Providers are encouraged to engage in this as part of their approach to partnership working.
3	Providers will work creatively to increase people's independence relating to travel arrangements.

Legislation

- Mental Capacity Act (2005) and Mental Capacity Amendment Act (2019)
- Care Act 2014
- Equality Act 2010

Good Practice, Guidance and Local Initiatives

- NICE Dementia: Support in Health and Social Quality Standard (QS1)
- Gold Standard Framework – Care of dying adults in the last days of life: NICE Guidance (NG31)
- DoH Fundamental Standards for Health and Social Care: https://www.gov.uk/government/consultations/fundamental-standards-for-health-and-social-care-providers
- Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020. www.palliativecare.bradford.nhs.uk
- Accessible Information Standard
- Community Led Support
- Link in with Advocacy Services (Statutory and Non-Statutory) https://www.bradford.gov.uk/adult-social-care/living-independently/advocacy/

3.0 Consent

The Person/people who use the service(s) (or anybody legally acting on their behalf) must give consent before any care or treatment is given to them.

The Person/people who use the service must give consent before any intervention, treatment or decision is made. Only the Person/people who use the service or someone with the legal authority to do so can give consent e.g. Appropriate Lasting or enduring Power of Attorney or Court appointed Deputy. Providers can check the validity of such by completing online an OPG100 form.

This standard has been expanded to include reference to:

Deprivation of Liberty and Human Rights

1.	The Provider will ensure that assessment of capacity relating to making specific decisions is based on the legal test of capacity, using MCA principles and appropriate use of advocacy both professional and family or friends if and when required.
2.	The Provider will ensure that decisions taken by staff on behalf of a Person/people who use the service are demonstrably in the Person/people who use the service's best interests and have taken into account the checklist as provided in 5.49 of the Mental Capacity Act Code of Practice
3.	The Provider will ensure that an Urgent Deprivation of Liberty authorisation is made (if necessary), and at the same time an application for Standard

	authorisation, is made to the Supervisory body (the Local Authority) when the care home (Managing Authority) believes that it is in the Person/people who use the service(s) best interest to deprive them of their liberty.
4.	The provider will ensure that where there is a change in circumstance eg an increase in the restrictions necessary to provide care that the supervisory body is informed in line with DoLS code of practice. Where the authorisation is within 4 weeks of the end of the authorisation period the managing authority will submit a new application for further authorisation. If authorisation is no longer required or if Deprivation of liberty is no longer occurring the managing authority will alert the supervisory body.
5.	The Provider will ensure that all staff have been trained in and are able to demonstrate knowledge and practice of the Mental Capacity Act and deprivation of liberty
6.	The Provider will ensure there is a clear procedure which is followed setting out the actions required of staff in relation to Person/people who use the service(s) who do not have capacity to make decisions
7.	The Provider should review consent to receiving care and treatment and any best interests decisions to ensure the arrangements are as least restrictive as possible on a regular basis or as required.
8.	Ensure Person/people who use the service(s) are given information about the availability of independent advocacy and how to access it.
9.	For applications to authorise a DoLS renewal and general information please contact dolsadmin@bradford.gov.uk for advice support and guidance regarding mental capacity contact mca-service@bradford.gov.uk for information support and guidance on the Liberty Protection Safeguards contact lpsteam@bradford.gov.uk

Other Legislation and Guidance (not exhaustive)

The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. They are planned to come into force in April 2022and will have a new corresponding Code of Practice. Providers will ensure that they are aware of these changes and that the service is able to implement the new requirements once published.

4.0 Safety

Person/people who use the service(s)s must not be given unsafe care or treatment or be put at risk of harm that could be avoided.
Providers must assess the risks to their health and safety during any care or treatment and make sure their staff have the qualification, competence, skills and experience to Person/people who use the service(s)s safe.

This is covered by CQC and there are no additional Bradford specific procedures.

5.0 Safeguarding From Abuse

Person/people who use the service(s)s must not suffer any form of abuse or improper treatment while receiving care. This includes

- Neglect
- Degrading Treatment
- Unnecessarily or disproportionate restraint
- Organisational abuse

This standard has been expanded to include reference to Bradford specific procedures and

- People are safe and care is always delivered in their best interests

No	Standard
1	The Provider has a clear and workable whistle-blowing policy that is promoted with all staff, Person/people who use the service(s) and their support network and regularly reviewed. The Provider will ensure staff are aware of the duties and work in line with Safeguarding under the Care Act 2014, the Joint Multi-Agency Safeguarding Adults Policy and Procedures West Yorkshire, North Yorkshire and York and the Multi-Agency Organisational Safeguarding Enquiry Policy and Procedure.
2	The Providers, although not providing direct services to children and young people may, however, come into contact with them during the course of their business and as such, will adhere to requirement of Working Together to Safeguard Children , 2019 and the West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures
3	The Provider shall have and implement robust and up-to-date procedures, (including, disciplinary procedures, whistle-blowing policy and recruitment checks), for avoiding and responding to actual or suspected physical, sexual, psychological, financial or material and discriminatory abuse and acts of neglect or omission. Such procedures shall be reviewed by the Provider and will report to the Council that such procedures have been reviewed at least once every year.
4	The Provider has a designated Lead within their organisation who will follow Safeguarding processes and complete the associated documentation for recording and responding to instances of abuse and/ or neglect. This will also acknowledge the need to take steps necessary to safeguard adults at risk and to alert the relevant agencies (Police, safeguarding professionals etc.).
5	The Provider is subject to the safeguarding duties in accordance with the Care Act

	2014, including reporting procedures, by: - Ensuring that safeguarding concerns are reported within 24 hours to the Council. - Ensuring that concerns contain all relevant information with regard to any incident made to ensure that any enquiry can be conducted comprehensively - Ensuring that concerns are made to the relevant agencies - Ensuring that the Care Quality Commission is informed, that the CQC reference number is recorded - Ensuring that consent to report a concern on the Person/people who use the service's behalf is sought. Where it is decided that it is necessary and lawful to override consent then this must be explained to the Person/people who use the service, along with the rationale. - Where the Person/people who use the service is assessed in lacking capacity to consent to any specific decision, the Provider should work in accordance with the Mental Capacity Act 2005 and follow the best interest decision making process to decide on necessary action. This will include clarification of any Lasting Power of attorney/ court appointed deputy require consultation with those who know the Person/people who use the service best including any representative, family members and/ or Care Team. - Ensuring that staff are working in accordance with Making Safeguarding Personal and that the adult at risk is asked their desired outcomes as a result of any concerns. - Ensuring engagement with the safeguarding process, which may include participation in Safeguarding, Planning and Outcome meetings and producing written reports to contribute to safeguarding enquiries. - Notifying Commissioners as described in the Quality Charter
6	The Provider will ensure that policies and procedures are covered in induction and fully understood by staff. All staff will have an initial understanding of Safeguarding duties under the Care Act 2014 and of their own responsibilities to recognise and report abuse within the framework of the Joint Multi Agency Safeguarding Adults policy and Procedures within their first week of employment, such as the Safeguarding training available through Bradford's Safeguarding Adult's Board (or equivalent) and Working Together to Safeguard Children , 2019 and the West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures.
7	Comprehensive training on recognising and responding to abuse and neglect must be given to all staff as part of their core induction within 3 months and updated at least every 2 years. In addition, update training will be provided in light of new policies and procedures introduced either locally or nationally.
8	The Provider agrees to be bound by any decision made by the lead Commissioners with regard to restrictions on, or the cessation of, placements at the home in line with Serious Concerns in Appendix 5: Quality Approach. The decision will be time limited and taken as a consequence of a risk assessment using information which indicates that all Person/people who use the service(s) at the home are at risk of significant harm.

9	The Provider will ensure that due regard and promotion of Person/people who use the service choice and control is given to Person/people who use the service(s)s at all times to avoid abusive and disrespectful practice. This includes supporting choice and control with those who have a cognitive impairment.
10	The Provider will ensure staff are familiar with and implement the Herbert protocol in advance of the event of a person going missing.

Other Legislation and Guidance

- Joint Multi-Agency Safeguarding Adults Policy and Procedures West Yorkshire, North Yorkshire and York. Add link.
- Multi-Agency Organisational Safeguarding Enquiry Policy and Procedure
- Making Safeguarding Personal (LGA/ ADASS)
- Care and Support Statutory Guidance (Gov.uk)
- West Yorkshire Herbert Protocol: http://www.westyorkshire.police.uk/dementia/herbert-protocol
- Serious Concerns Policy
- Care Act 2014
- Mental Capacity Act 2005
- Human Rights Act 1998
- Equality Act 2010
- 'Freedom to Speak up' policy
- Working Together to Safeguard Children, 2019 and the West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures

6.0 Food and Drink

People must have their nutritional needs assessed and food must be provided to meet those needs. This includes where people are prescribed nutritional supplements and/or parenteral nutrition. People's preferences, religious and cultural backgrounds must be taken into account when providing food and drink.

This section has been expanded to include:

Health and Wellbeing: Nutrition and Hydration

	Nutrition and Hydration
1	The Provider will educate all staff, voluntary workers, Person/people who use the service(s) and carers on the importance of good nutrition and hydration in maintaining better health and wellbeing, improving recovery from illness or injury and prevent malnutrition and dehydration from occurring
2	Person/people who use the service(s) are weighed and screened for risk of malnutrition on admission using a validated tool such as MUST (Malnutrition Universal Screening Tool) via the District Nursing Team. Where screening identifies that a Person/people who use the service is at risk the appropriate nutrition and

	hydration Care Plan should be introduced, including Food First approach/ provision of high protein/high energy snacks/drinks, food fortification and appropriate meals
3	The Provider will ensure that food and drink intake is monitored and recorded for those identified as malnourished or at risk of malnutrition and actioned appropriately and promptly, and weighed and screened for risk of malnutrition on a monthly basis or where there is cause for concern.
4	The Provider will ensure that staff have access to training on the identification of dehydration, malnutrition, and obesity, using MUST and taking appropriate actions in terms of appropriate food and drink provision which may include modified texture diets.
5	Providers are required to ensure that staff are trained and competent to support people living with dysphagia (swallowing difficulties) and ensure the implementation of the International dysphagia diet standardisation initiative which sets out recommendations/guidelines for texture modified food and/or thickened fluid. https://iddsi.org/ Staff are able to demonstrate understanding of the signs and symptoms of swallowing difficulties, how to support people with dysphagia and when / how to refer to a speech and language therapist
6	Providers are expected to have systems in place to ensure that they are aware of and implement recommendations and good practice as published by NICE. Training in relation to these areas will be shared through SIB.
	Legislation and Guidance (not exhaustive) • CQC regulation 14 Meeting nutritional and hydration needs https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-14-meeting-nutritional-hydration-needs • www.nice.org.uk/guidance/settings/care-homes

7.0 Premises and Equipment Premises and equipment must be clean, suitable and looked after properly. Equipment must also be secure and looked after properly.	
This standard has been expanded to include reference to Bradford specific procedures and • Equipment, Assistive Technology, Telemedicine and Digital Monitoring • The Environment of the Care Home	
	Equipment, Assistive Technology, Telemedicine and Digital Monitoring
1	The Provider must ensure that the Equipment and Premises comply with the Fundamental Standards of Care .
2	The Provider will carry out pre-admission assessments in order to identify potential Person/people who use the service(s)' current and likely future need for equipment, including the needs of those with cognitive impairment and sensory needs. These will be met by the Provider and may include equipment not normally provided by the home, including the use of digital monitoring where appropriate. The Provider will

	not accept potential Person/people who use the service(s) whose assessed needs they are unable to meet.
3	The Provider should ensure that the environment is Dementia Friendly using tools from either The King's Fund Enhancing the Healing Environment (EHE) programme or the Alzheimer's Society.
4	The Provider will ensure that staff receive training in the use of all equipment including moving and handling and assistive technology. Training must be adequate to ensure staff are able to provide appropriate and safe care with the individuals consent and support them to use equipment and assistive technology correctly to maintain independence.
5	The Provider will make sure that adaptations and equipment are suitable, available and properly maintained. They will ensure that appropriate care is given safely, according to the individually assessed needs of each Person/people who use the service in order to maintain and promote Person/people who use the service(s)' independence.
6	The Provider should ensure that appropriate referrals are made to the District Nursing Team so that the appropriate equipment may be prescribed.
7	The Provider will ensure that they comply with the provisions and referral route set out in the Bradford and Airedale Community Equipment Service (BACES) Community and Equipment Protocol for Person/people who use the service(s)ial Homes, Nursing Homes and Hospices (BACES Board approved 26.11.2019). This policy explains the circumstances under which equipment may be loaned to a Provider. This can be found at https://www.bradford.gov.uk/adult-social-care/living-independently/bradford-and-airedale-clommunity-equipment-service/
The Environment of the Care Home	
8	All Person/people who use the service(s) bedrooms and public rooms must have windows. Person/people who use the service(s) can expect to be able to sit somewhere and have a view out of a window.
9	- Where possible encourage Person/people who use the service(s) to engage in a variety of outside activities or support them to spend time in gardens (where applicable) to increase their feeling of .wellbeing.
10	Providers must ensure that a documented list of personal belongings is agreed at the start of the placement and maintained throughout. Systems must be in place to identify personal belongings. eg dentures, glasses, clothing, equipment.
Legislation and Guidance (not exhaustive) https://www.bradford.gov.uk/bmdc/health_well-being_and_care/adult_care/living_independently/community_equipment_baces	

8.0 Complaints.

Person/people who use the service(s)s must be able to complain about their care and treatment. Providers must have a system in place so they can handle and respond to complaints. They must investigate it thoroughly and take action of problems are identified.

This standard has been expanded to include reference to Bradford specific procedures and

- Compliments
- Concerns
- Pre-complaints

No	Standard
1	The complaints log will be monitored regularly for any themes and trends, and root cause analysis (RCA) undertaken as appropriate. Further action should be taken address the issue as needed and fed back to Commissioners, including ensuring that all complaints are investigated, using appropriate investigation tools e.g. RCA.
2	Providers must ensure information is include in the organisation's complaints policy which include contact details for CBMDC Complaints Department, ICB complaints team, the CQC, and the ombudsman.
3	Providers will co-operate fully in any investigation conducted by Commissioners under its complaints procedure
4	Compliments must be recorded by the provider and learning shared within the organisation. Providers must analyse themes of compliments to identify good practices.
5	Concerns raised about a service, where the individual raising the concerns is explicit in not wishing to make a formal complaint or where the matter is resolved in 24-hour period, providers may record the matter as a concern. Information must still be recorded in the complaints log including any investigations and outcomes.

Other Legislation and Guidance (not exhaustive)

- Equality Act 2010
- Contact Adult Services: https://www.bradford.gov.uk/compliments-and-complaints/adult-social-care/make-a-compliment-or-complaint-about-adult-social-care/
- NHS Ombudsman
- CQC Complaints procedure: http://www.cqc.org.uk/content/complain-about-service-or-provider

9.0 Good Governance

Providers must have plans that ensure they can meet these standards.
They must have effective governance and systems to check on the quality and safety of care.
These must help the service improve and reduce and risks to your health, safety and welfare.

This standard has been expanded to include reference to Bradford specific procedures and

- Quality Assurance

1	The Provider will facilitate visits from the Commissioners, these may be

	announced quality assurance visits or unannounced under if Risk Based Validation (RBV)... The Commissioners will issue a draft report to the Provider. The Provider is given 10 working days to respond to the report, providing additional evidence as required where there are challenges to information within the report.
2	The quality assurance staff from the Commissioners will feedback to the home manager on the day of visit where practicable and will ensure Providers have the opportunity to feedback on any quality assurance.
3	The Commissioners will deal with any outstanding compliance actions as per the terms and conditions of the Residential and Nursing Care Home Portal 2019
4	The Provider will utilise forums such as the Provider Forum and working groups to develop their quality assurance process and service delivery through sharing of best practice with peers.

10.0 Staffing

Providers must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards.

Staff must be given the support, training and supervision they need to help them to do their job.

This standard has been expanded to include reference to Bradford specific procedures and

- Staffing Levels and Interaction
- Staff Induction, Supervision and Appraisal
- Staff Training

1.	The Provider will ensure the home's staffing establishment in terms of staff: to Person/people who use the service(s) ratio and skill mix reflect dependency levels of Person/people who use the service(s) in the home, not simply occupancy levels. Staffing should also reflect the diversity of the people in the Home, including languages spoken and show appropriate cultural awareness. Staffing rotas will provide appropriate cover at all times to ensure that Person/people who use the service needs are met in a timely and person centred way. Where available, Assistive technology, TeleHealth/ Telemedicine and digital monitoring are deployed appropriately. The Provider ensures that staff within the home have training around person centred planning and support Person/people who use the service(s) to identify and prioritise their personal goals, aspirations and support them to recognise existing strengths and resources to inspire and validate their goals and aspirations.
2.	The Provider will ensure that the use of agency staff is minimised by ensuring permanent staffing levels are appropriate and regularly reviewed. Where agency staff are utilised, the Provider ensures that agency staff are subject to robust screening ensuring they are qualified to work in the care home and that

	their training is in date. Where agency staff are required longer term, then arrangements to secure consistent staff should be in place.
3.	The Provider will ensure that staff vacancies across the home including managerial, nursing staff, care staff and auxiliary staff are kept to a minimum through firm recruitment and selection processes, opportunities for professional / career progression and consistent management and development practices.
4.	The Provider will ensure that staff groups work coherently and supportively as a team to ensure that Person/people who use the service needs are met in a timely and person centred way.
5.	The Provider will ensure that staff handovers between day and night shifts include discussion on changes to Person/people who use the service needs between care and nursing staff and recorded appropriately to ensure a strong focus on continuity of care.
6.	The Provider will ensure that staff are encouraged to build in positive interaction with Person/people who use the service(s) during the running of the home and routines, i.e. discussions and conversation during personal care routines enhancing the quality of life for Person/people who use the service(s)s and they have access to meaningful activity to maintain and improve their health and wellbeing.
7.	The Provider will appoint a lead Dementia Champion within the Care Home to provide leadership, encourage and embed service delivery and support local accountability. The provider and staff within the home recognise the connection between mental health and physical health and supports Person/people who use the service(s)s to make healthier lifestyle choices to improve their quality of life.
8.	Staff involved in patient care in all Person/people who use the service(s)ial and nursing homes must receive training that will enable them to identify signs of delirium and make an appropriate response.
9.	Staff not directly involved in patient care in all homes must receive training in dementia awareness.
10.	The Provider will involve Person/people who use the service(s) in recruitment processes as far as practicable. For example, providing easy read material so that Person/people who use the service(s) can be actively involved in the recruitment process where possible and helping to set interview questions or involvement in selection / decision making on potential candidates.
Staff Induction, Supervision and Appraisal	
11.	The Provider will ensure that regular appraisal is an essential part of staff development and quality improvement. The Provider will seek to include feedback from Person/people who use the service(s) and their support network in reviewing staff performance.
12.	The Provider will ensure that all staff receive one to one supervision

	sessions on a regular basis, the frequency of which will depend on the complexity of their work
13.	Supervision notes should be documented, signed by both parties and any actions followed up at a subsequent meeting. Supervision should be used as a forum to identify staff development needs, manage performance and act as a supportive environment where staff are able to express any concerns they may have and feel confident that they are acted upon. For nursing homes, this must include clinical supervision.
Staff Training	
14	The Provider has an appropriate and deliverable training matrix in place that clearly identifies and timetables the training and development needs of nursing, care and ancillary staff within the home. Where appropriate, the Provider will engage Person/people who use the service(s) in developing training plans for staff.
15	The Provider will ensure that all staff are trained and developed to the specific set of standards set out in the Care Certificate (introduced in April 2015) and has been assessed for competency to ensure that they provide compassionate and high quality care and support. Supervisors of care staff will be responsible for assessment against the standards of the Care Certificate. The Care Certificate is NOT a replacement for role and workplace specific induction training.
16	Where staff members' English and/or Maths levels are below Level 2 the Provider will support staff members to progress to this level where possible through available training in the community.
17	The Provider ensures that individual training records for staff are in place and kept up-to-date.
18	The Provider ensures that training needs are discussed, identified and timetabled in induction and subsequent supervision sessions with essential focus on:
	- All policies and procedures relevant to the staff group
	- Safeguarding, using 'the Care Act 2014 safeguarding duties
	- Whistle blowing
	- Person Centred Care and Support
	- Self Care/Health promotion/Behaviour change
	- Relevant, targeted training for the Person/people who use the service(s) the home supports
	-Common health needs such as tissue viability, pressure ulcers, continence and falls
	- Care Planning
	- Health and Safety

	- Moving and Handling
	- Mental Capacity Act and Deprivation of Liberty
	- Equalities.
	- Prevention/ care of minor ailments e.g. respiratory infections and urinary tract infections.
	- Supporting people with dementia and at End of Life.
19	The Provider will ensure that staff competency is checked regularly through supervision and observation, including discussion at staff meetings, ensuring knowledge is embedded so that staff are confident to apply learning in their areas of work. Opportunities should be offered for staff suggestions and feedback on running of the home and changing Person/people who use the service needs.
20	The Provider shall pro-actively seek external training where necessary to ensure all training needs can be satisfactorily met to meet all Person/people who use the service's needs through various methods available including e-learning. The Commissioners will support to offer information and advice to support this, including signposting to training platforms such as Altura. This may be in the case where in-house training provision does not provide the specialist courses available through external Providers
21	Where appropriate the Provider will prioritise applications for employment from young/ people leaving care with a view to providing a suitable pathway into the care sector.

Legislation and Guidance

- Preceptorship framework – For newly Registered Nurses, Midwifes and Allied Health Professionals.
- CQC regulation 18 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing#guidance
- CQC KLOE- E2
- Dementia Strategy 2009
- NICE Guidance
- Skills for Care Workforce Development Strategy

11.0 Fit and Proper Staff

The provider of your care must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.
This is all covered by CQC and there are no additional Bradford specific procedures.

12.0 Duty of Candour The provider of your care must be open and transparent with you about your care and treatment. Should something go wrong, they must tell you what has happened, provide support and apologise.
This is all covered by CQC and there are no additional Bradford specific procedures. Please also refer to the full terms and Conditions.

13.0 Display of Ratings The provider of your care must display their CQC rating in a place where you can see it. They must also include this information on their website and make the latest CQC report on their service available to you.
This is all covered by CQC and there are no additional Bradford specific procedures.

2.1 Enhanced Requirements for Nursing.

This section clarifies the requirements for Personal care with Nursing**.** The standards in here are **in addition** to the requirements described in the main body of the Service Specification, including the core Statement of Requirements.

Where there is reference in the Core Statement of Requirements referring to District Nursing Teams, it is expected that this will be managed within Person/people who use the service(s)ial Homes.

Outline

The Registered Nurse input is defined in the following terms:

'Services provided by a Registered Nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse'. (CQC)

Responsibilities for the Registered Nurse will include direct care delivery and where appropriate oversight and supervision to trained carers for delegated tasks which may fall into the list below.

- Management of continence including bowel management, stoma care, catheterisation (male and female) etc.
- Management of the deterioration in physical condition due to disease process
- Management of individual conditions e.g. Diabetes, Parkinson's, epilepsy etc.
- Management of complex mental health conditions as required
- Medication management that requires a Registered Nurse to administrate
- Pain assessment and management
- Palliative care including use of syringe drivers
- Respiratory management
- Recognition, prevention and assessment of falls and delirium
- Recognition and management of the signs and symptoms of deterioration
- Recognition and management of depression, delirium and dementia
- Swallowing/aspiration
- Technical feeding
- Tissue viability/pressure area care and prevention.
- Tracheotomy care and management
- Use of equipment (general & specialist- ensuring appropriate education and training)
- Wound care management

2 Legal Framework including national and local standards

In addition to those laid out in the Core Statement of Requirements and T&Cs, the following should be adopted by the provider:

2.1 National Framework for CHC and FNC, (Department of Health, 2018),

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf

2.2 Nursing and Midwifery Council The Code (updated 2018)

https://www.nmc.org.uk/standards/code/

2.3 Providers are expected to adhere to relevant NICE guidance to include but not limited to:

- NICE: CG161 - Falls: assessment and prevention of falls in older people
- NICE QS89 – Pressure ulcer management and prevention
- NICE: SC1 - Managing medicines in care homes
- NICE: CG176 – Head Injury Guidance
- NICE: NG48 – Oral Health for Adults in Care Homes

2.4 Providers are expected to adhere to relevant National screening tools to include but not limited to:

- Definitions of Pressure Ulcers grades in line with the guidance issued by the NPUAP-Pressure Injury Stages (2016).

  http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

- Nutritional screening and management using the 'Malnutrition Universal Screening Tool' ('MUST') or equivalent.

7 Access, Referral and Eligibility

Access and Referral

Access and referral in to services will be through Adult Services Access Team as detailed on the Council's website.

Eligibility

This service is open to all adults who are citizens of Bradford and are ordinarily Person/people who use the service(s) within the Bradford district.

To be eligible for the service the person will have had an assessment by the Council and / or Health and meet the threshold for CHC/ FNC funded support; therefore, some or all of the care is being paid for by the Council and/ or Health and receive a Funded Nursing Care contribution from the NHS at the weekly rate as determined by the Department of Health. Services will then be commissioned on an individual basis (spot purchase) through a contract for a named individual, with the service which best meets the needs of the individual.

NHS funded care is provided over an extended period of time; 'NHS-funded Nursing Care', is the funding provided by the NHS to care homes providing Nursing, to support the provision of nursing care by a Registered Nurse for those assessed as eligible.

If the individual has such a need and it is determined that the individual's overall needs would be most appropriately met in a care home providing nursing care, then this would consequently lead to eligibility for NHS-funded nursing care.

This support detailed in this specification relates to those Person/people who use the service(s) who are eligible for:

- NHS funding to include Funded Nursing Care (FNC)
- Joint funding between health and social care and whose care plan identifies the appropriate place of care as being a care home with Registered Nursing provision
- Continuing Health Care (CHC) funding based on assessed need.

- Joint funding between health and social care and whose care plan identifies the appropriate place of care as being a care home with Registered Nursing provision

- Continuing Healthcare (CHC) funding based on assessed need within a Person/people who use the service(s)ial or Nursing care setting.

- People who are eligible for Funded Nursing care can only receive this in a registered nursing home. Individuals eligible for Continuing healthcare or jointly funded packages of care can receive their funding in any setting. Individuals in nursing home would not normally receive District Nurse input as this would be provided by the Nursing home registered nurse but individuals in receipt of CHC funding would be eligible to receive DN input in a Person/people who use the service(s)ial setting.

Age

The services are open to all Adults over the age of 18, however the majority of people are expected to be 65 and older.

Client Group.

The large majority of the people who will access these services are expected to be Older People with dementia, the needs of whom are covered within the Statement of Requirements. However these services should also be accessible to people with Mental Health issues, Learning Disabilities and/ or Physical Disabilities. When supporting the needs of these client

groups there may be different or additional requirements, and these are detailed in Schedules 2, 3 and 4 respectively.

9 Outcomes

NHS Outcomes Framework Domains & Indicators

High level outcomes, supporting the health economy with:

- People will receive active and proactive health management and nursing care at home, leading to
    - Reduction in unnecessary A & E attendances
    - Reduction in unnecessary unplanned hospital admissions
    - Reduction in unnecessary ambulance call-outs and conveyances
    - Reduction in unnecessary delayed transfers of care
    - Improvement in people's experience of health management and nursing care

Local Outcomes: as reported and measured through the Quality Charter including, but not limited to;

- Improved experience through high quality essential care and effective governance systems and processes to reduce risk
- Minimization of predictable acute events such as urinary infections and pneumonia
- Avoidance of unnecessary progression of long-term conditions, coupled with a reduction in adverse drug events and the unnecessary burdens of irrelevant treatments
- Reduced risks of falls, fractures and other injuries
- Preventative care and exacerbations in illness are managed wherever possible within the home
- Care homes take part in local Community Partnerships (CP) and Primary Care Networks (PCN) to support community engagement and system working across Bradford District.

Service Requirements

Where relevant, the sections correspond directly with the Service Specification / Fundamental Standards.

1.0 Person Centred Care

The Person/people who use the service(s) must have care or treatment that is tailored to them and meets their needs and preferences.	
End of Life care	
1	Care Homes with Nursing will deliver high quality, safe and effective palliative care and symptom management at the end of life, including administration of medication via a syringe driver where appropriate to achieve the following outcomes • Person/people who use the service(s) with palliative care needs will receive high quality medical, nursing and therapeutic support. • Person/people who use the service(s) are supported by the home and other professional to ensure optimal symptom management • Person/people who use the service(s) experience excellent end of life care by Staff that have the knowledge and skills to deliver effective palliative care and symptom management at the end of life. This includes maintaining up to date training on the use of syringe drivers.
Management of health and wellbeing needs	
Nutrition and Hydration	
2	Where applicable the Care Home with Nursing will ensure that Person/people who use the service(s) with a PEG or Naso gastric feeding tube in situ are managed safely and appropriately and receive adequate nutrition by staff that are trained and competent to do so.
Skin Integrity	
For resources relating to skin integrity, please refer to the full NICE guidance/ NPUAP-Pressure Injury Stages (2016).	
3	Providers are required to ensure suitable screening and risk assessment is completed on admission, at least monthly and/or as needs change. People that have been identified as at risk of pressure ulcer development (including any with pre-existing pressure ulcers), have an appropriate up to date care/prevention plan to minimise the risk of pressure ulcer development which contains clearly identified goals, actions and on-going evaluation. Support & advice is available to nursing home staff via the Tissue Viability team. When required, Care Homes will make referrals to the Tissue Viability service using their referral process and criteria. Where a category 3 or 4 pressure ulcer occurs, the care home must complete a root cause analysis (RCA) and email the template to seriousincidents.bradford@nhs.net. This is outside of the Council's Notification Form process as is considered a Serious Incident that also requires sharing of personal data which cannot be processed through the Council's Notification process.
Continence	

4	The Provider must manage effectively Person/people who use the service's continence, independence and wellbeing by providing effective bladder and bowel management for all Person/people who use the service(s), male and female.
5	The Provider must have nurses who are competent and equipped to support Person/people who use the service(s) where needed with education and advice.
6	The provider must have nurses will be clinically competent to support Person/people who use the service(s) with catheter and stoma care and management of incontinence and constipation.
7	The Provider must ensure that there is appropriate onward referral to the GP and specialist nursing services for advice where required.
8	The Provider is responsible for the provision of other equipment, with the exception of those provided through prescription (i.e. sheath, catheter and stoma supplies).
Mobility	
9	Care Homes with Nursing are responsible for the assessment, ongoing monitoring and management of Person/people who use the service(s) with contractures or movement restrictions. Onward referral is made to the GP or relevant community services where additional support is required.
10	Staff endeavours to maintain a Person/people who use the service(s)'s mobility in order to promote independence and the health benefits associated with independent movement.
11	Staff should be trained and competent in the use of mobility relevant equipment and use it in the appropriate way.

10.0 Staffing

Providers must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards.
Staff must be given the support, training and supervision they need to help them to do their job.

Staff Training	
1	The Provider must ensure that the service has competent nursing staff that proactively meets Person/people who use the service(s)' health needs. Registered Nurses have a duty of care and a legal liability with regard to the patient. If they have delegated an activity they must ensure that it has been appropriately delegated. The Nursing and Midwifery Council (NMC) Code (2015) states in the section entitled 'Practise effectively' that registrants must: • Be accountable for your decisions to delegate tasks and duties to other people. • Only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions.

	• Make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and • Confirm that the outcome of any task you have delegated to someone else meets the required standard.
2	Registered nurses must maintain their registration by upholding the professional standards of practice and behaviour for nurses and midwives as set out by the NMC (The Code 2015) Providers should support their nurses through revalidation which aims to: • To raise awareness of the Code and the professional standards expected of nurses. • To provide nurse with the opportunity to reflect on the role of the Code in practice. • To encourage nurses' to stay up to date in their professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals • Encourage engagement in professional networks and discussions about their practice • To encourage a culture of sharing, reflection and improvement. • Encourage engagement and challenge isolation • Support individuals to make well-informed decisions about their self-care and support them to access to appropriate information and understand the range of options available to them. • Person-centred practice that engages, supports, encourages and facilitates involvement and helps individuals to make decisions that are right for them. • Effective communication to enable individuals to identify their strengths, assesses their needs, and develop and gain the confidence to self-care.
3	Providers: • Should act as a confirmer within the revalidation process. • Must ensure that appropriate checks are undertaken to ensure that the applicant is registered with the Nursing and Midwifery Council (NMC) and undertake annual checks throughout their employment to ensure their registration is maintained. http://revalidation.nmc.org.uk/
Management and leadership of the care home	
4	The Provider management will ensure that where Registered Nurses are employed there is support in place to allow them to meet revalidation requirements and are competent to practice.

2.2 Enhanced Service Requirements for People with needs relating to Mental Health problem who may also have Autism.

This section clarifies the requirements for people with mental health needs or mental health needs and Autism. For the purposes of this document, it will refer to people with mental health issues as shorthand but may encapsulate any combination of the above. It contains supplementary information **in addition** to the requirements described in the main body of the Service Specification, including the Statement of Requirements.

Where relevant, the sections and numbering correspond directly with the Service Specification.

Outline of Services

The Council is seeking providers who support our aspirations for people with mental health needs and autism to live as independently as possible within the recovery model of mental health provision. Person/people who use the service(s) will be supported to achieve the highest level of independence and recovery that is appropriate for them. Providers will be expected to work in flexible and imaginative ways in line with the legislation (currently the Care Act 2014) linked to the formal assessment and review process.

The strategic direction for people with mental health issues is to enable people who require Person/people who use the service(s)ial or nursing provision to progress into, or retain where possible, more independent accommodation such as Supported Living or their own tenancy with support. It is acknowledged that people with mental health needs will have periods in their lives where they require more intensive or therapeutic support but can often then move back into their own tenancies or reduce the level of professional support required. People who require longer term provision must also be enabled to retain their skills and be as independent as possible, regardless if this is within a residential or nursing care setting.

We require providers to work in a person centred way and in an individual's best interests to support them to achieve greater independence, choice and control over their lives. Providers will be pro-active in supporting and enabling move on plans for people in partnership with the Council, Health, housing and support providers, social care professionals, family members and advocates to provide this support. In order to achieve this, Person/people who use the residential and nursing care providers should have the facility to learn or recover independent living skills related to self-care, food production etc.

Legal Framework including national and local standards or strategies

At the time of writing, the current priorities are:

Under the Mental Health Act 1983 Section 117(2) there is a joint duty to be exercised by health and social services authorities to provide “after-care” services to various categories of people who have previously been detained in hospital under a Section.

Person/people who use the service(s) who come within the terms of this section, and are in receipt of Person/people who use the service(s)ial/nursing services, should have the same level of involvement from their care co-ordinator and the same access to health and social work support as those who are living in other circumstances. This must be reflected within the Person/people who use the service(s)/ health/social care support package and the functions/supports identified as part of the Care/Support Plan

There is a local joint policy in relation to s117 Aftercare that should be read alongside this service specification.

The ‘Government response to No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions’, Department of Health, 2015, aims to strengthen the case for significant change in the experience of care and outcomes for people with learning disabilities and/or autism, and mental health conditions between now and 2020.

This service specification will be developed alongside the local joint commissioning strategy and linked to the Five year forward view and mental health taskforce.

Eligibility and Access routes

Eligibility

The specification sets out the standards for the provision of Person/people who use the service(s)ial and nursing services for people experiencing problems in relation to daily living due to serious and enduring mental ill health.

Mental Health services can be accessed by people from the age of 18 to 65. Post age 65 people whose main area of need is with Mental Health services will remain within this service. Other Person/people who use the service(s) may transition to Older people services.

Services may be accessed by Person/people who use the service(s) with a diverse range of needs, including high support needs, complex needs, physical health problems, challenging behaviour, mobility problems and physical disabilities.

Non-eligible Person/people who use the service(s)

Person/people who use the service(s) are not eligible if they have:

- Acquired brain injury post 18 years old, e.g. following a head injury (unless there is a comorbid MH issue which is the primary requirement for provision of a service).
- A specific learning disability (IQ <70)
- Specific learning difficulties i.e dyslexia, dyspraxia attention deficit-hyperactivity disorder, dyscalculia and dysgraphia
- Offending behaviour which is not clearly related to a diagnosed mental health condition and is not likely to benefit from the intervention available within this service
- Problems arising from social exclusion issues which require social care rather than Person/people who use the service(s)ial care
- Physical needs which are more appropriately met within Primary Care, Acute Trust, Person/people who use the service(s)ial Care Home or a non-mental health type of Person/people who use the service(s)ial home.
- Issues related to drug and alcohol problems that are not likely to benefit from interventions available in this service.

Access

As mental health services are fully integrated across health and social care, access to this service is via a social care assessment under the Care Act 2014. This can be undertaken by any care co-ordinator within the multi-disciplinary team.

10. Service Requirements

Where relevant, the sections and numbering correspond directly with the Service Specification.

1.0 Person Centred Care

The Person/people who use the service(s) must have care or treatment that is tailored to them and meets their needs and preferences.	
1	Services are focused on positive and pro-active care within the recovery model. Person/people who use the service(s) should be at the heart of their care planning, decision making. Positive behavioural support models form an integral part of service provision.
2	The Provider should facilitate cooperative ways of working with other specialist services both with mental health and autism, including psychology, occupational therapists, speech and language therapists, psychiatry, physiotherapists and behavioural support to assist enablement and develop supportive move on plans. As Bradford Council and Bradford District Care NHS Foundation Trust operate mental health services together these will be the main operational services that providers will work with.
3	The Provider should ensure flexible service delivery, so that the service is tailored to individual requirements, rather than the person having to fit into the service on offer.
4	Packages will be reviewed under S.27 of the Care Act: which requires the local authority to ensure the care and support plan (or support plan) remains an accurate, up-to-date reflection of the person's needs and the outcomes they wish to achieve
Moving on	
5	The Provider will ensure that Person/people who use the service(s) are aware of the range of housing and support options available to them, using person centred tools to understand what housing options people want or would like to have when they move on from the service.
6	Person/people who use the service(s) will be enabled to experience other living situations and have peer connections to support them with this. Person/people who use the service(s) and their family/ carers will receive advice and support to choose the most appropriate living arrangements for them.
7	Person/people who use the service(s) will be enabled to change their current living environment to create a personalised home which reflects their lifestyle choices.
8	The Provider will create flexibility in the management of the service to enable a personalised delivery of support plans – this includes flexible rosters, flexible meal choices and times, looking at changing the environment to give people the opportunity to learn skills such as cooking, managing own laundry to staying out late

	and inviting friends back for social events ensuring that their spiritual and cultural needs are met
9	Wherever possible the Provider will be required to support Person/people who use the service(s) in improving their condition and integrating into society. The expectation is that Person/people who use the service(s) will be supported to live independently when appropriate. This requirement is of particular importance for Mental Health Person/people who use the service(s), where there will be an expectation of improvements and recovery in health and social functioning in most cases.
10	The provider will ensure that outcomes in the care plan are met in a timely manner
Managing Transitions	
It is recognised that moving into and moving on from a care home can be a distressing time for individuals and their families. Providers are required to work in partnership with other providers, health and social care service to make any transition as positive and seamless as possible.	
11	Carry out pre-admission visits to the individual, including their families and circles of support.
12	Supporting individuals to come for visits to the care home, for lunch or an overnight stay to see if they like it.
13	Identify and involving staff who will support the individual in the transition process.
14	Complete a detailed assessment of needs, linked to the formal health and social care assessment process.
15	Assess an individual's compatibility with other Person/people who use the service(s)s and any risks to the individual or other Person/people who use the service(s)s due to challenging behaviour.
Management of health and wellbeing needs	
16	The Provider should work with health professionals to ensure Person/people who use the service(s) have an up to date health assessment and health action plan, which identifies on-going health needs.
17	Person/people who use the service(s) should be supported to access their Annual Physical Health Check and act on advice provided.
18	The provider should work to prevent

	• unnecessary or inappropriate hospital and specialist in-patient admissions • unnecessary prolonged in-patient stays, including assessment and treatment units, and facilitate timely discharge
19	The Provider should work to increase the number of people accessing appropriate assessment, treatment and support services to meet their health needs, including long-term conditions and dementia.

10.0 Staffing

Providers must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards.

Staff must be given the support, training and supervision they need to help them to do their job.

Staff Training	
1	The Provider should ensure that staff receive specialised training to meet the health and support needs of the individuals they are supporting and seek advice and training from relevant health professionals to enable them to support individuals effectively. This includes understanding the theoretical basis that supports an individual's diagnosis.
2	The Provider should ensure that staff receive appropriate specialised training including (but not limited to) • MCA and Human Rights • Understanding and managing behaviour • Safeguarding • Care Planning that incorporates a strengths based approach • The assessment of Risk and Positive Risk Management • De-escalation and breakaway techniques • Person centred support and positive behaviour support for people who display or are at risk of displaying, behaviour which challenges services, this includes trauma informed care. • Expertise in communicating and supporting people who hear voices or who experience thoughts and experienced due to mental health issues

	• Epilepsy and the administration of appropriate medication • Use of nasal gastric feeding/care and 'peg' feeding/care • The use of oxygen, oral suction and nebulisers • Models of mental illness
Trauma Informed Care	
In some circumstances, people with complex presentations have also experienced trauma in their lives such as abuse. It is becoming so prevalent that service providers should naturally assume that many of the people to whom they provide services have, in some way or another, been affected by trauma. Although trauma is often the root cause behind many of the public health and social issues that challenge society, service providers all too often fail to make the link between trauma and the challenges and problems presented by the people they are supporting.	
3	It is essential that the provider has a skilled staff team to support people with complex presentations including those affected by trauma. The provider must work positively with clinical teams to provide services that are welcoming and appropriate to people with complex presentations and special needs affected by trauma.
Mental Health social inclusion issues	
Providers will encourage recovery and social inclusion, in which Person/people who use the service(s) has access to education, activities and employment and can learn new skills	
4	The provider will support Person/people who use the service(s) to access education, volunteering and employment
5	Person/people who use the service(s) should play a role in the running of the Person/people who use the service(s)ial or nursing home
6	Person/people who use the service(s) may have drug or alcohol issues and should be supported to overcome these issues as much as possible
7	The Provider will encourage the use of advocacy and advanced statements as appropriate

2.3 Enhanced Requirements for People with Learning Disabilities who may also have Autism

This section clarifies the requirements for people with Learning Disabilities or learning disabilities and/or autism and/ or mental health issues. For the purposes of this document it will refer to 'people with Learning Disabilities' as a shorthand but may encapsulate any combination of the above. It contains supplementary information in addition to the requirements described in the main body of the Service Specification, including the Statement of Requirements.

Where relevant, the sections and numbering correspond directly with the Service Specification.

Outline

Person/people who use the service(s)ial Care
The Council is seeking providers who support our aspirations for people with learning disabilities to live as independently as possible. Providers will be expected to work in flexible and imaginative ways in line with legislation (currently the Care Act 2014) linked to the formal assessment and review process.

The strategic direction for people with learning disabilities and/or autism is to enable people who require Person/people who use the service(s)ial, nursing or intermediate provision to progress or return, where possible, into more independent accommodation such as their own home or Supported Living. It is acknowledged that people with learning disabilities will have periods in their lives where they require more intensive or therapeutic support but can often then move back into their own home. People who require longer term provision must also be enabled to retain their skills and be as independent as possible.

We require providers to work in a person centred way and in an individual's best interests if it is deemed they lack capacity to support them to achieve greater independence, choice and control over their lives. Providers will be pro-active in supporting and enabling move on plans for people in partnership with the Council, Health, housing and support providers, social care professionals, family members and advocates to provide this support.

Short Term (Respite, Unplanned and Crisis)
The Council is seeking providers who can support our vision to provide and promote a range of opportunities for short terms stays that meet the needs and aspirations of people with a learning disability and their carers in responsive, flexible and person centred ways.

The Council is currently in the process of reconfiguring existing Person/people who use the service(s)ial short break (respite) services and working towards developing a range of services that offer greater choice and control to existing and potential Person/people who use the service(s), and family carers. This includes Person/people who use the service(s)ial short breaks (respite), emergency Person/people who use the service(s)ial respite provision, home based breaks, community, social and leisure breaks, and emergency home based back up breaks. Wherever possible new Person/people who use the service(s)ial short break (respite) services for people with learning disabilities will not be commissioned within the same premises as permanent care.

Staying local

Bradford Learning Disabilities intentions is for an all age approach focusing on improving services for people with learning disabilities who may have autism, who display behaviour that challenges, including those with a mental health condition. This approach will drive system-wide change and enable more people with a learning disability who have complex behaviour presentations, to have a home within their community, be able to develop and maintain relationships and get the support they need to live healthy, safe and rewarding lives.

Commissioning and procurement of services that support the transformation of learning disability and/or autism services, including frameworks for Person/people who use the residential and nursing care, intermediate step up step down provision, supported living. Develop access to respite care and alternative short term accommodation to avoid unnecessary hospital admissions

2 Legal Framework including national and local standards or strategies

The provider will ensure that the practices, procedures and management of the services comply with all legislation and codes of practice relevant to Person/people who use the service(s)ial care and short break (respite) services now and for the duration of the agreement.

The partnership will be delivering an enablement approach to supporting people including a less risk adverse approach by, increasing the use of telecare, telemedicine and assistive technology to promote independence, leading to less dependency on paid support.

In addition, the partnership is committed to providing community based clinical resources that operate on an enablement model to prevent the need for admission to inpatient services, ensuring that people with learning disabilities and/or autism have access to mainstream primary and secondary health care and intermediate health care provision

The Transforming Care Programme for Learning Disabilities and/or Autism - ‘National Plan: Building the right support’ is a key driver to ensure Local Authorities and ICBs work to reduce the dependence on in-patient services and develop alternative options of support for people.

The new National Service Model, including nine overarching principles define what good health and social care services should deliver for people with learning disabilities and/or autism from the perspective of people who use services.

The 'Government response to No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions', Department of Health, 2015, aims to strengthen the case for significant change in the experience of care and outcomes for people with learning disabilities and/or autism, and mental health conditions between now and 2020.

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. NICE guidance, 2015.

Transition from children's to adults' services for young people using health or social care services. NICE guidance 2016.

7 Eligibility and Access Routes

Eligibility for services will be determined by the appropriate social care assessment under the Care Act 2014 conducted by the Council in consultation with health professionals. Access to services for those eligible will be co-ordinated across health and social care, including where there is discharge from inpatient care..

10 Service Requirements

Where relevant, the sections and numbering correspond directly with the Service Specification/ Fundamental Standards

1.0 Person Centred Care The Person/people who use the service(s) must have care or treatment that is tailored to them and meets their needs and preferences.	
1	Services are focused on positive and pro-active care. Positive behavioural support models form an integral part of service provision. Service providers should promote supported decision making for individuals in all aspects of their life wherever there is opportunity.
2	The Provider should facilitate cooperative ways of working with other specialist services both within learning disabilities and mental health, including but not restricted to psychology, occupational therapists, speech and language therapists, psychiatry, physiotherapists and behavioural support to assist enablement and develop supportive move on plans.

3	The Provider should ensure flexible service delivery, so that the service is tailored to individual requirements, rather than the person having to fit into the service on offer.
Moving on	
4	The Provider will ensure the Person/people who use the service(s) is involved in future planning and are aware of the range of housing and support options available to them at an early stage. This should include using person centred tools to understand what housing options people want or would like to have when they move on from the service.
5	The Provider should provide opportunities for Person/people who use the service(s) to experience more independent living either within the home or by working with other professionals to consider a move-on plan including supporting the development of skills for independent living
6	Person/people who use the service(s) will be enabled to change their current living environment to create a personalised home which reflects their lifestyle choices.
7	The Provider will create flexibility in the management of the service to enable a personalised delivery of support plans – this includes flexible rosters, flexible meal choices and times, looking at changing the environment to give people the opportunity to learn skills such as cooking, managing own laundry to staying out late and inviting friends back for social events.
8	Wherever possible the Provider will be required to support Person/people who use the service(s) in improving their condition and integrating into society. The expectation is that Person/people who use the service(s) will be supported to live independently when appropriate.
Respite and Short Breaks	
9	The provider will work in co-operation with other learning disability services (e.g. Person/people who use the service(s)ial, Health and day services) to ensure that peoples support is stable, coherent and co-ordinated
10	The provider will ensure the mix of people accessing Person/people who use the service(s)ial short-breaks (respite) or group activities are considered fully, carrying out compatibility assessments where required, to enable all people to have positive experiences
11	The provider will work in consultation with carers to support them in their caring role, to understand their needs and enable them to have reliable and responsive breaks from caring
12	The provider will work with the Council to ensure that people with learning disabilities and their carers are allocated short break (respite) services in a fair and transparent way in line with the current established allocation tool for short breaks (respite)

13	The provider is required to plan, deliver and facilitate enjoyable and fulfilling experiences that meet the needs and preferences of people who use short break (respite) services, and involve people in planning, arranging and promoting activities
14	Opportunities are provided within short break (respite) services to assist the development of social, interpersonal and daily living skills, including accessing mainstream services, supporting friendship and shared interests
15	The provider is required to support people to maintain their existing interests, as well as participate in training, education and work like opportunities that enhance their lives, increase skills, interests and employment opportunities
16	To ensure the delivery of high quality and cost effective short break (respite) services to enable positive outcomes for people with a learning disability and offer a real break for carers.
Unplanned and Emergency	
17	Where possible the Provider will facilitate unplanned respite for existing Person/people who use the service(s) and Carers should the need arise.
18	Where possible the Provider will facilitate emergency respite for a new Person/people who use the service where the individuals' profile meets the Providers current delivery model.
19	The provider has effective procedures in place to ensure emergency respite provision can be provided to support the care and welfare needs of Person/people who use the service(s) and carers. Emergency and unplanned respite is provided in a way that minimises the impact on the planned respite of others
Crisis	
20	The provider will work with the Council/ ICB to facilitate a crisis placement where the individual is not a regular user of the service and has (complex) needs that may sit outside the provider's current delivery model. This will involve working together to identify a plan to put sufficient support in place with the aim of ensuring continued local placement for the individual whilst longer term plans are developed.
Managing Transitions and Preparing for Adulthood	
`The transition to adulthood can be a time of high anxiety, confusion and disruption for young people with learning disabilities and their families, as they move from children's to adult services, as can moving into and moving on from a care home. Providers are required to work in partnership with other providers, health and social care service to make any transition as positive and seamless as possible.	
21	The provider will work as part of a multi-agency team where young people are preparing for adulthood and may be exploring options for Person/people who use the service(s)ial care, including identifying and involving staff who will actively support the individual throughout the transition process.

22	As part of this the Provider will assess an individual's compatibility with other Person/people who use the service(s)s and any risks to the individual or other Person/people who use the service(s)s due to challenging behaviour.
23	The providers will work to ensure inclusion of existing circles of support when planning a move and that their role would have organic assessments that they are developing and making adjustments to inform the transition plan and changes during preparation for adulthood. This should also include responsibility for alerting the LA when client is ready to make changes to plan.
24	Utilise person centred support planning to develop goals to move to more independent living environment.
25	Supporting young people to develop the necessary skills to move to more independent living environment of their choosing wherever possible.

Management of health and wellbeing needs

26	The provider should have an awareness and understanding of the health inequalities that people with learning disabilities are likely to face and be able to identify reasonable adjustments that their service can make to overcome these.
27	The provider should have an awareness of the national mortality review programme for people with learning disabilities (LeDeR programme) and ensure that their staff teams have an understanding of the key causes of death for people with learning disabilities.
28	The provider should ensure Person/people who use the service(s) are supported to access their Annual Health Check and act on advice provided within this, monitor the Health Action Plan and make appropriate referrals for further interventions, supporting Person/people who use the service(s) to engage with these processes.
29	The Provider should have up to date health assessments and health action plans for all people they support which clearly identify any health issues and how to support these. Where appropriate this will include the provider working with primary, secondary & specialist services.
30	The provider should ensure they support all Person/people who use the service(s) to attend routine health appointments such as dental checks and visual checks in line with expectations of the rest of the population - for example 6 monthly dental check ups.
31	The provider should ensure Person/people who use the service(s) are supported to access national screening programmes as appropriate, ie cancer or Triple A screening.
32	The provider should ensure that Person/people who use the service(s) are encouraged and supported to attend for annual flu vaccinations.

33	Services should ensure staff they employ are encouraged to attend for flu vaccinations in order to reduce the risk of flu to their Person/people who use the service(s)
34	The Provider should ensure that all Person/people who use the service(s) have an up to date VIP hospital passport and communication passport
35	As people with learning disabilities have an increased risk of developing dementia, the Provider will work with memory clinics and health professionals to ensure people are supported to receive the right assessment, treatment and support to meet their needs
36	The provider should work to prevent unnecessary or inappropriate hospital and specialist in-patient admissions unnecessary prolonged in-patient stays, including assessment and treatment units, and facilitate timely discharge This will include ensuring that relevant information about health such as eating and drinking, toileting, weight, behaviour etc are monitored and recorded effectively to support health professionals to make informed decisions about health investigations, treatment and support.
37	The Provider should have an awareness of the processes and agencies involved if they are supporting people who are end of life, in order to ensure this is managed effectively.
38	The Provider should identify any needs and facilitate access and support for mental health care needs.

10.0 Staffing

Providers must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards.
Staff must be given the support, training and supervision they need to help them to do their job.

Staff Training	
1	The Provider should ensure that staff induction and training goes above and beyond the expectations of the care certificate. They should engage in specialised training to meet the health needs of the individuals they are supporting and seek advice and training from relevant health professionals to enable them to support individuals effectively. This includes understanding the theoretical basis that supports an individual's diagnosis.
2	The Provider should ensure that staff receive appropriate specialised training including (but not limited to) • Understanding and managing behaviour (including monitoring and recording of such) • Understanding Learning Disabilities and Autism to a higher standard than the care certificate

	• Skills in communication, including non-verbal communication methods • Person centred care • Positive behaviour support • Active support and how to ensure people are involved in their day to day lives • Understanding the impact of Trauma on a person and how to support trauma informed care. • Specialist Epilepsy Training and the administration of appropriate medication • Use of nasal gastric feeding/care and 'peg' feeding/care as appropriate • The use of oxygen, oral suction and nebulisers as appropriate • De-escalation techniques, Physical interventions, restraint and breakaway, including MAPPA if appropriate • Mental Capacity Act • Recognising a deteriorating patient including an awareness of Sepsis
3	To increase the individual's independence and reduce levels of paid care, support and clinical interventions linked to the formal assessment and review process
In some circumstances, people with complex presentations may have also experienced trauma in their lives. Although trauma is often the root cause behind many of the public health and social issues that challenge society, service providers all too often fail to make the link between trauma and the challenges and problems presented by the people they are supporting.	
4	It is essential that the provider has a skilled staff team to support people with complex presentations including those affected by trauma. The provider must work positively with clinical teams to provide services that are welcoming and appropriate to people with complex presentations and special needs affected by trauma.
5	Providers are committed to work to specialist team instruction, for example supporting people with a plan from psychology and having regular consultations to update and monitor the plan.
Legislation	
Good Practice, Guidance and Local Initiatives • Positive Behavioural Support (including Active and Productive Lives, Positive Behavioural Support Planning and Positive Risk Taking) • STOMP (Stopping over-prescribing medication for people with LD, Autism or both with psychotropic medicines) • Real Tenancy Test	

2.4 Enhanced Requirements for People with Physical Disabilities

This section clarifies the requirements for people with Physical Disabilities and contains supplementary information **in addition** to the requirements described in the main body of the Service Specification, including the Core Service Requirements.

Where relevant, the sections and numbering correspond directly with the Service Specification.

Outline
The Council is seeking providers who support our aspirations for working age adults who have physical disabilities/long term health conditions to live as independently as possible. Providers will be expected to work in flexible and imaginative ways to reduce the levels of paid support people receive linked to the formal assessment and review process.

The strategic direction for people with physical disabilities is to enable people who require Person/people who use the service(s)ial, nursing or intermediate provision to progress or retain, where possible, into their own tenancies. It is acknowledged that people with physical disabilities will have periods in their lives where they require more intensive or therapeutic support but can often then move back into their own tenancies. People who require longer term provision must also be enabled to retain their skills and be as independent as possible.

The care provided can be a long, medium or short term plan based on an individual's needs. We require providers to work in a person centred way and in an individual's best interests to support them to achieve greater independence, choice and control over their lives. Providers will be pro-active in supporting and enabling move on plans for people in partnership with the Council, Health, housing and support providers, social care professionals, family members and advocates to provide this support.

2 Legal Framework including national and local standards or strategies

7 Eligibility and Access Routes

This should be the same as main referral routes and eligibility will be determined on Social Work Assessment

9 Outcomes

- To reduce levels of paid care, support and clinical interventions linked to the formal assessment and review process

- To increase and retain independent living skills for people with physical disabilities
- To increase move on to greater independence
- To prevent unnecessary or inappropriate hospital admissions
- To prevent unnecessary prolonged in-patient stays.

Service Requirements

1.0 Person Centred Care The Person/people who use the service(s) must have care or treatment that is tailored to them and meets their needs and preferences.	
1	Services are focused on positive and pro-active care. Person centred support models will form an integral part of service provision. Service providers should promote decision making for individuals in all aspects of their life wherever there is opportunity.
2	The Provider should facilitate cooperative ways of working with other specialist services, including psychology, occupational therapists, physiotherapy, speech and language therapists, psychiatry and behavioural support to assist enablement and develop supportive move on plans.
3	The Provider should ensure flexible service delivery, so that the service is tailored to individual requirements, rather than the person having to fit into the service on offer.
Moving on	
4	The Provider will ensure that Person/people who use the service(s) are aware of the range of housing and support options available to them, using person centred tools to understand what housing options people want or would like to have when they move on from the service.
5	Person/people who use the service(s) will be enabled to experience other living situations and have peer connections to support them with this. Person/people who use the service(s) and their family/ carers will receive advice and support to choose the most appropriate living arrangements for them.
6	Person/people who use the service(s) will be enabled to change their current living environment to create a personalised home which reflects their lifestyle choices.
7	The Provider will create flexibility in the management of the service to enable a personalised delivery of support plans – this includes flexible rosters, flexible meal choices and times, looking at changing the environment to give people the opportunity to learn skills such as cooking, managing own laundry to staying out late and inviting friends back for social events.
8	Wherever possible the Provider will be required to support Person/people who use the service(s) in improving their condition and integrating into society. The

	expectation is that Person/people who use the service(s) will be supported to live independently when appropriate.
Managing Transitions and Preparing for Adulthood	
The transition to adulthood can be a time of high anxiety, confusion and disruption for young people with learning disabilities and their families, as they move from children's to adult services, as can moving into and moving on from a care home. Providers are required to work in partnership with other providers, health and social care service to make any transition as positive and seamless as possible.	
9	The provider will work as part of a multi-agency team where young people are preparing for adulthood and may be exploring options for Person/people who use the service(s)ial care, including identifying and involving staff who will actively support the individual throughout the transition process.
10	As part of this the Provider will assess an individual's compatibility with other Person/people who use the service(s)s and any risks to the individual or other Person/people who use the service(s)s due to challenging behaviour.
11	The providers will work to ensure inclusion of existing circles of support when planning a move and that their role would have organic assessments that they are developing and making adjustments to inform the transition plan and changes during preparation for adulthood. This should also include responsibility for alerting the LA when client is ready to make changes to plan.
12	Utilise person centred support planning to develop goals to move to more independent living environment.
13	Supporting young people to develop the necessary skills to move to more independent living environment of their choosing wherever possible.
Management of health and wellbeing needs	
1	The Provider should work with health professionals to ensure Person/people who use the service(s) have an up to date health assessment and health action plan, which identifies on-going health needs.
2	Person/people who use the service(s) should be supported to access their Annual Health Check and act on advice provided.
3	Person/people who use the service(s) should be supported to access national cancer screening programmes as appropriate and preventive services, such as flu clinics.

10.0 Staffing

Providers must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards.
Staff must be given the support, training and supervision they need to help them to do their job.

Staff Training

1	The Provider should ensure that staff receive specialised training to meet the health needs of the individuals they are supporting and seek advice and training from relevant health professionals to enable them to support individuals effectively. This includes understanding the impact of disability/long term conditions on an individual.
2	The Provider should ensure that staff receive appropriate specialised training including (but not limited to) • Safe moving and handling techniques • Skills in communication, • Person centred support and care planning. • Epilepsy and the administration of appropriate medication • Use of nasal gastric feeding/care and 'peg' feeding/care • The use of oxygen, oral suction and nebulisers

i Technical Security Requirements

The below is the minimum technical security requirements to be entered in to a specification where the supplier will process data for the Council, the specification must also cover the GDPR requirements set out in this guidance in relation to the scope and nature of the data to be processed.

The following criteria in section 1.1 applies ONLY to small providers with an on site IT provision, with no usage of cloud storage, and where the following criteria applies:

- No more than 10 laptops/PC/Servers (in total)
- No dedicated IT provider (local provision)

All other Providers MUST meets the criteria set out above in section 1.2

1.1. Small Providers Technical Requirements

1.1.1. The Provider shall ensure that any Council Data which resides on a mobile, removable or physically uncontrolled device is stored encrypted using a supported product.

1.1.2. The Provider shall ensure that any Council data which it causes to be transmitted over any public network (including the Internet, mobile networks or un-protected enterprise network) or to a mobile device shall be encrypted using a supported product.

1.1.3. The Provider must operate an appropriate access control regime to ensure people and administrators are uniquely identified.

1.1.4. The Provider shall ensure that all IT equipment where data is stored is kept in a secure location.

1.1.5. The Provider shall ensure it undertakes the Cyber Essentials Certification annually at a minimum. . https://www.cyberessentials.ncsc.gov.uk/

1.1.6. The Provider must perform a technical information risk assessment on the service supplied and be able to demonstrate what controls are in place to address those risks.

1.1.7. The Provider shall collect audit records which relate to security events in delivery of the service or that would support the analysis of potential and actual compromises. The retention period for audit records and event logs shall be a minimum of 6 months.

1.1.8. The Provider must be able to demonstrate they can supply a copy of all data on request or at termination, and must be able to securely erase or destroy all data to a reasonable standard.

1.1.9. The Provider shall not, and shall procure that none of its sub-contractors, process the Councils data outside the European Economic Area (EEA).

1.1.10. The Provider shall ensure that any cloud hosted services related to the Council Data reside within the UK or EU. (The hosting provider must ISO27001:2013 accredited)

1.1.11. The Provider shall implement security patches to vulnerabilities within 48 hours of a breach.

1.1.12. The Provider shall ensure that all Commercial off the Shelf (COTS) software and third party COTS Software is kept up to date and is in support.

1.1.13. The Provider shall work with the Council during implementation to agree any necessary security controls.

1.1.14. The Provider shall implement such additional measures as agreed with the Council from time to time in order to ensure that such information is safeguarded in accordance with the applicable legislative and regulatory obligations.

1.2. Technical Requirements

1.1.1 The Provider shall ensure that any Council Data which resides on a mobile, removable or physically uncontrolled device is stored encrypted using a product which has been formally assured through a recognised certification process.

1.1.2 The Provider shall ensure that any Council data which it causes to be transmitted over any public network (including the Internet, mobile networks or un-protected enterprise network) or to a mobile device shall be encrypted when transmitted.

1.1.3 The Provider must operate an appropriate access control regime to ensure people and administrators are uniquely identified.

1.1.4 The Provider shall ensure that any device which is used to process Council data meets all of the security requirements set out in the National Cyber Security Centre (NCSC) End User Devices Platform Security Guidance.

1.1.5 The Provider shall at their own cost and expense, procure a CHECK or CREST Certified Supplier to perform an ITHC or Penetration Test prior to any live data being transferred into their systems.

1.1.6 The Provider must perform a technical information risk assessment on the service supplied and be able to demonstrate what controls are in place to address those risks.

1.1.7 The Provider shall collect audit records which relate to security events in delivery of the service or that would support the analysis of potential and actual compromises. The retention period for audit records and event logs shall be a minimum of 6 months.

1.1.8 The Provider must be able to demonstrate they can supply a copy of all data on request or at termination, and must be able to securely erase or destroy all data and media that the Council data has been stored and processed on.

1.1.9 The Provider shall not, and shall procure that none of its sub-contractors, process the Councils data outside the European Economic Area (EEA).

1.1.10 The Provider shall implement security patches to vulnerabilities in accordance with the timescales specified in the NCSC Cloud Security Principle 5.

1.1.11 The Provider shall ensure that all Commercial Off the Shelf (COTS) software and third party COTS Software is kept up to date such that all Supplier COTS Software and third party COTS Software are always in mainstream support.

1.1.12 The Provider shall ensure that the service is designed in accordance with NCSC principles, security design principles for digital services, bulk data and cloud security principle.

1.1.13 The Provider shall implement such additional measures as agreed with the Council from time to time in order to ensure that such information is safeguarded in accordance with the applicable legislative and regulatory obligations.

1.1.14 The Provider shall hold Cyber Essentials Plus certification and ISO 27001:2013 certification