SERVICE SPECIFICATION for Supported Living Services

North Wales Supported Living Agreement

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1. INTRODUCTION

1.1. This Service Specification describes the key features of Supported Living and outlines the expectations when a Supported Living service is commissioned and contracted. Commissioner(s) are moving towards an outcome based approach to commissioning and this Service Specification reflects the direction of travel adopting a progression model, positive risk taking, co-productive and strength based approach. The Service Specification will be read in conjunction with the main contract terms and conditions as part of the North Wales Supported Living Agreement.

The main principles of Supported Living are that people own or rent their home or have their own tenancy/licence and have control over the support they receive, who they live with (if anyone) and how they live their lives.

Supported Living can look different for people and is not a prescribed service model. The Service may include personal care, daily living activities and practical tasks and may comprise of a few hours of support or 24 hour support. People are supported to achieve their personal outcomes, increasing their independent living skills and maximising their overall independence in their own home and in the community. The service promotes equitable access to local community provision to meet assessed needs and outcomes.

The Commissioner(s) are committed to the delivery of high quality, person-centred, flexible Supported Living services designed to enable people to maintain, develop and enable their independence at home and in the community with a focus on what matters to them and their support networks.

Commissioner(s) and the Provider shall arrange and deliver supported living services in accordance with the best practice national guidance as developed by the National Commissioning Board "Commissioning Services for People with Learning Disability" which can be accessible on the following link: http://ipc.brookes.ac.uk/publications/Commissioning_for_People_with_Learning_Disability.pdf and the Best Practice Guidance issued in March 2019 by the Welsh Local Government Association, "Commissioning accommodation and support for a good life for people with a learning disability"

1.2. **NATIONAL CONTEXT**

The Social Services and Wellbeing (Wales) Act 2014 ("the Act") applies to people 'in need' of any age and their Carers. In writing this Service Specification, the Commissioner(s) has taken into account the Code of Practice in relation to measuring Social Services performance; more specifically that it must:

- Co-produce the wellbeing outcomes that the Person wants to achieve.
- Protect and promote the Person's physical, mental and emotional wellbeing.
- Take appropriate steps to protect and safeguard the Person from abuse, neglect and any significant or other harm.

- Actively encourage and support the Person to learn, develop and participate in community and society in general.
- Support the Person to safely develop and maintain healthy domestic, family and personal relationships.
- Work with the Person to achieve greater economic wellbeing.
- Support the Person to have a social life.
- Promote the Persons right to live in suitable accommodation.

2. DESCRIPTION OF SUPPORTED LIVING

2.1. For the purposes of this Service Specification, the term “Supported Living”, shall mean care and support provided to People living in their own homes in the community with/or without housing related support.

2.2. The Service shall assist People to live in a home that they own, rent via a tenancy or shared tenancy or occupy under licence, receiving personal care and/or housing related support which is delivered by a Domiciliary Care Provider registered with the Care Inspectorate for Wales.

2.3. The Service will be compliant with the Supporting People Programme Outcomes Framework Practice Guidance and Reach Standards/or its equivalent.

2.4. The Service will be person centred, designed around needs and personal outcomes and may comprise of a combination of direct or shared support, waking night and/or Sleep-In, including the use of telecare or technology to enable the Person living on his/her own or as a co-tenant in a shared setting.

2.5. The Service will be flexible, responsive and creative both in its delivery and in the partnerships developed with other sources of support, such as family and friends, community networks third sector organisations, colleges and other support providers e.g. day opportunities. The focus is to maximise the Person’s independence by providing support with daily living such as personal care and practical tasks/activities. People are encouraged to develop their confidence and skills to carry out these activities and tasks for themselves or with a level of support that is appropriate to their individual needs, maximising the use of community services.

2.6. The Service will be flexible and responsive in ways that encourages the Person to achieve their own aspirations rather than to fit into what is available, supporting access to and making use of community services in the area.

2.7. The Provider will be required to work in the spirit of good co-operation with the Commissioner(s) including Health professionals, such as psychologists, psychiatrists, physiotherapists, speech & language therapists, occupational therapists, G.P.’s, district nurses etc., delivering against a Care & Support Plan/Care Treatment Plan which reflects the assessed needs and outcomes of the Person.

2.8. At the heart of Supporting Living is choice and control with ongoing care and support provided to sustain that choice in accordance with the Social Services and Well Being (Wales) Act 2014 and as defined in the Reach Standards for Supported Living.

3. SERVICE REQUIREMENTS

3.1. The aims and objectives of the Supported Living service ("The Service") are to ensure that people are able to:

- Live as independently as possible
- Receive their support in the least restrictive way possible
- Live in their own home by maintaining a tenancy/licence agreement, rental or ownership
- Have choice and control over their Service, including how it is delivered and by whom
- Receive a flexible service which responds to their individual preferences and needs

3.2. The aims of the Provider's Service under this Service Specification**:**

- To provide outcome focussed, person centred and responsive support that helps achieve the Person's full potential;
- To support and enable each Person to build on and develop existing skills whilst learning new skills, maximising their potential to be independent;
- To support the achievement of personal outcomes by working with families, other partners and organisations;
- To work effectively with all other relevant agencies to ensure seamless service delivery is achieved;
- To develop and maintain systems to monitor and evaluate the effectiveness of the Service;
- To maximise the use of Assistive Technology in order to promote the Person's independence;
- To ensure the Person's views, wishes, aspirations and goals are taken into account;

3.3. The Provider is expected to engage with families, carers and local communities, and in so doing to recognise these groups are assets and part of the solution in supporting the Person in the community. Such engagement helps place a greater value on mutual support, and build on existing resources and assets within families, neighbourhoods and community networks, providing improved resilience in our communities.

4. SCOPE OF THE SERVICE

4.1. The Service will be provided in the Person's own home or in the community by a Provider suitably registered with the Care Inspectorate for Wales to deliver domiciliary care. The Service under this Service Specification may be commissioned for adults, children or young people with the following needs:

- Learning disabilities with / without additional health needs;
- Challenging behaviour including dementia;
- Physical disabilities with / without additional health needs including acquired brain injury and sensory loss;
- Autistic spectrum conditions;
- Mental health needs;

5. VALUES

5.1. The Provider shall ensure that the values and rights below underpin the way in which the Person is supported:

- **Independence**: to think, act and make decisions, even when this involves a level of risk.
- **Dignity:** recognition that everyone is unique, with intrinsic value as an individual.
- **Respect:** for a Person's needs wishes, preferences, language, race, religion and culture.
- **Equality:** the right of people to be treated no less favourably than others because of their age, gender, disability, sexual orientation, religion, class, culture, language, race, ethnic origin or other relevant distinctions.
- **Privacy:** the right of the Person to be left alone or undisturbed and free from intrusion or public attention in their affairs.
- **Choice:** the right to make choices, and to have the alternatives presented and information that enable choices to be made.

6. ETHOS, APPROACH AND MODEL OF SERVICE

The service will be provided utilising the following approaches and service models.

6.1. Person Centred

6.1.1. Person-centred planning is a recognised approach that puts the person at the centre and deliberately shifts power towards them and can help reclaim some of the freedom which most of us take for granted" (Parley 2001). The legal requirements and advice provided in the Social Services and Wellbeing Act (2014), and Codes of Practice make the use of person centred practises a requirement.

6.1.2. The core principles of person centred practices ensure that children, young people, adults and their families are:

- At the centre of all planning and decision making processes and feel their contributions are valued.
- Treated with respect at all times by practitioners sensitive to family, culture, ethnic and socio-economic diversity.
- Given timely, unbiased and complete information that can be understood and that supports their ability to make informed choices.
- Given flexible, responsive and individualised support, resources and services.

6.1.3. Person centred practice is a continual process of listening and learning about what is important to (the things that matter to them and bring quality of life) and for (the things that they need to be healthy, safe and to learn) the person, now and in the future with family, friends and professionals working together to make this happen. Person centred planning works best when used within organisations that have embedded a person centred culture. It's not just about creating visual plans.

6.1.4. Person centred approaches explore what is happening from the person and other people's perspective. It looks at what's working and not working, what's important to the person, explores what changes are needed to achieve personal outcomes and who can help.

6.1.5. There are many different tools that can be used i.e. the relationship circle, communication chart. These tools allow for person centred conversations to happen. It is the conversation that is important and those using the tools need to understand how to be person centred for them to be effective.

6.1.6. The move to the personalisation of service delivery involves an organisational culture shift. All those involved, service users, families, carers and providers will require differing levels of support to recognise and positively engage with the change process.

6.1.7. Person centred practices need to be embedded into daily, routine communication and not seen as a separate 'set of tools' or a way of working in discrete circumstance.

6.1.8. Adopting person centred practices and approaches will include;

- The co-production of meaningful and achievable goals with Individuals, their families and advocates.
- Clarifying responsibilities of all individuals who are contributing to the support of the Person to achieve identified goals and outcomes.
- Developing the Provider's Support Plan/Personal Plan with involvement of Person and in consultation with families/ Staff where appropriate

- Ensuring flexibility regarding when care and support is provided rather than fitting People into prearranged runs/ groups of calls or activities.
- Being involved in, and contributing to, person centred reviews, upon the request of the individual

6.2. **Strength based**

6.2.1. People will be encouraged to self-care by identifying and building on their strengths and their own capacity along with those of their family, friends and Staff to resolve problems themselves, delivering their own solutions. This will include:

- Valuing the capacity, skills, knowledge, connections and potential in individuals, their families and their communities;
- Working in collaboration, helping people to do things for themselves becoming co-producers of support and developing shared care partnerships;
- Promoting individuals becoming actively engaged in their support;
- Using a strengths-based approach to maintain and improve social networks and enhance well-being; and
- Encouraging and supporting self-care and exercise.

6.3. **Positive Risk Taking**

6.3.1. In order to achieve outcomes, positive risk-taking is a feature. People may wish to make choices which might give rise to risks to their own or others' health and safety. The risks must be properly assessed and managed according to the Individual's physical and emotional capabilities, mental capacity and with due regard to the health and safety of other Individuals, Staff and anyone else who might be affected by the activity of the Person and in accordance with the Provider's Health and Safety Policy. The Provider shall promote positive risk taking in the delivery of their service promoting the Person's choice and control. This will be supported by:

- Ensuring a consistent Staff team is in place to provide continuity and development of trusting relationships;
- Identifying and managing risks whilst understanding that risk is a normal everyday experience;
- Ensuring that people and Staff assess risk dynamically, understanding that decision making can be enhanced through positive collaborations;
- Understanding that risks can be minimised, but not eliminated;
- Taking responsibility in encouraging a no-blame culture whilst not condoning poor practice;
- Working with the Commissioner(s) to understand and meet the changing needs and expectations of the Person(s) support and their family and supporting them to have more control over their health and care;

- Conducted Risk Assessments where there is potential for significant harm, self-neglect, injury or death, in accordance with regulatory requirements;

6.3.2. Any significant risks which the Person wishes to take and which are not identified in the Care and Support Plan shall be identified by the Provider and brought to the attention of the Care Co-ordinator. The overarching intention is to ensure that the Person is able to live an ordinary life, which includes accepting that taking risks is part of an ordinary life.

6.4. **Progression**

6.4.1. The main use of the Progression Model is to help plan how a Person can acquire, re-learn, or maintain, independent living skills. Care and support planning should help the Person achieve the maximum level of independence to which he/she aspires. It is important to match the service response to current need but also to work to reduce them over time, helping the Person gain confidence and skills, potentially reducing long term needs.

6.4.2. Progression assumes that people prefer to be less, rather than more, dependent and that most people are able to learn at their own pace. The model also takes account of people potentially losing skills, for example through progressive conditions such as dementia.

People learn best when it is something that they have chosen to do, something that matters to them that they want to achieve. It is important that the true choices of people are heard and understood when supporting individuals to develop their independent living skills.

6.4.3. At the heart of implementing “Progression” is:

- A culture across the wider system of care and support that emphasises outcomes;
- Process that ensure pro-active work aimed at supporting progression does not get displaced;
- A structure that supports the potential to “Progress” to ensure this is properly understood and support plans are designed to deliver this potential;
- An acceptance of risk associated with supporting people to progress their skills.

6.4.4. Past service responses may have led to a degree of over delivery of support and, on occasion, has increased dependency rather than decreased it. Reversing this may require very skilled and sensitive work with individuals, their families and their Carers.

6.4.5. Use of the model also assumes that it is the aim of the social and health services to listen to and act on individual’s aspirations. The main areas are:

- Strengths-based assessment;
- Specific assessment of the Person's abilities and needs in respect of daily living activities;
- Differentiation of "maintenance" needs (what is required to safely support current functional abilities) and "development" needs, things that help the person acquire the ability to be more independent and thus have lower needs in the future;
- Outcome focused support planning;
- Co-production;
- Positive risk management;
- Outcome based reviews;
- Outcomes measures to provide clarity of what is to be delivered and clarity of expectations

6.5. **Positive Behavioural Support**

6.5.1. Where appropriate Positive Behavioural Support ("PBS") will be adopted to support people with more complex needs and behaviours that challenge to live in their own homes in their communities.

6.5.2. PBS is an ethical, values-led broad framework of evidence-based therapeutic support that is particularly relevant for people with more complex needs who sometimes have behaviours that challenge.

6.5.3. PBS is person-centred, proactive and focuses on improvements in wellbeing as well as early intervention and prevention of challenging behaviour. PBS is a key element in reducing restrictive practices including inappropriate medication.

6.5.4. PBS is in full accord with the Social Services and Wellbeing (Wales) Act 2014, in that it:

- promotes physical and emotional well-being,
- addresses physical and mental health issues,
- emphasises personal and skill development,
- supports and encourages family and personal relationships,
- provides opportunities for social well-being and inclusion,
- promotes human rights, dignity and respect,
- enhances living accommodation and the person-environment fit.

PBS is described in more detail in the National Commissioning Board's overarching guidance for commissioning services for people with a learning disability.

6.5.5. PBS defines a good quality of life as what most people would want on a day to day basis such as a comfortable home, contact with family and friends, engagement in a wide range of activities, running a home, work and leisure, as an accepted and equal member of the community, free from pain, distress and abuse. PBS helps people to do more things for themselves. It includes active support which helps carers to give people more opportunities to learn, practice their skills and abilities and participate more fully in daily life, helping to maintain or develop independence as far as possible, which increases dignity and self-esteem. Active support comprises a set of tools and guidance for carers that includes a technology of positive interaction that provides individualised assistance to maximise participation and skill development. Also included is a detailed, flexible system for planning the Person's activities together with the requisite support. PBS should be an integral part of the Person's individualised care planning.

6.5.6. PBS can improve the quality of the lives of people and those around them. It can also help prevent the breakdown of support arrangements that can result in inappropriate admission to hospital, secure or other institutional residential settings.

6.5.7. Where PBS is utilised, the Provider will:

- Ensure staff receive training appropriate to their role and can gain qualifications in providing high quality support.
- Develop practice leaders who are competent and experienced in providing good quality support, lead by example and regularly coach staff in practice to develop their support skills.
- Effective liaison with the multi-disciplinary team to ensure consistency of approach to support

6.6. **Active Support**

6.6.1. The Active Support model will be available to ensure people are able to engage in meaningful activities, helping them to lead full lives. Active Support will be used alongside other approaches including Person Centred Planning, Progression/Enablement or similar.

Active Support is helping people to be actively, consistently, and meaningfully engaged in their own lives regardless of their support needs.

- Being engaged - doing things, participating, spending time with others, making decisions, making choices.
- Actively engaged - each day, through-out the day whenever there is an opportunity.
- Consistently engaged - with approaches that provide enough structure and predictability that people experience comfort, continuity, and have a better ability to be engaged.
- Meaningfully engaged - in ways that increase competence and opportunity, in ways that help people be and stay connected to others (socially), in ways that

provide enhanced esteem, in ways that are focused on needs, preferences, and goals of the person

6.7. Where Active Support is utilised, the Provider shall promote:

- **Participation** to give the Person the right level of assistance so that he or she can do all the typical daily activities that arise in life.
- **Use of Activity Support Plans** to organise household tasks, personal self-care, hobbies, social arrangements and other activities which individuals need or want to do each day, and to work out the availability of support so that activities can be accomplished successfully.
- **Good record keeping** to a maintain simple record of the opportunities people have each day that enables the quality of what is being arranged to be monitored and improvements to be made on the basis of evidence.
- **Practice leadership** (through the development of Active Support Champions, or similar) to lead by example; coordinate record keeping; provide training and coaching in the principles and practice of Active Support; collate and analyse data to inform outcome deliveries.

7. OUTCOME FOCUSED SERVICE DELIVERY

7.1. The national well-being outcomes (set out in Schedule 6) that people should expect in order to lead fulfilled lives are contained within the well-being statement, which forms the first part of the National Outcomes Framework.

7.2. In line with the Social Services and Wellbeing Act (Wales) 2014 the following overarching well-being outcomes are to be achieved in the delivery of the Service which will be personalised for each Person:

i. Securing rights and entitlements
ii. Physical and mental health and emotional well being
iii. Protection from abuse and neglect
iv. Education, training and recreation
v. Domestic, family and personal relationships
vi. Contribution made to society
vii. Social and economic well being
viii. Suitability of living accommodation

7.3. The Service is underpinned by people having control, flexibility and choice in the way that they choose to live. Schedule 1 sets out expectations for service delivery in order to meet the above outcomes.

7.4. The Provider shall have clear information about the outcomes to be achieved and evidence the Service provided in the most effective way.

7.5. In delivering the Service, the Supporting People Outcomes below shall apply as may be reviewed from time to time. Examples of Supporting People Outcome Indicators and Outcome goals are further set out in Schedule 2 and further

guidance is detailed in the Supporting People Practice Guidance which can be accessible from the following link: Supporting People Practice Guidance 2018.

Promoting Personal and Community Safety

- Feeling safe
- Contributing to the safety and well-being of themselves and of others

Promoting Independence and Control

- Managing accommodation
- Managing relationships
- Feeling part of the community

Promoting Economic Progress and Financial Control

- Managing money
- Engaging in education/learning
- Engaged in employment/voluntary work

Promoting Health and Wellbeing

- Physically healthy
- Mentally healthy
- Leading a healthy and active lifestyle

7.6. People will be assisted to achieve their outcomes including being able to exercise choice and control over their lives. The assumption underlying service decisions shall be that People are capable of making their own choices about their own lifestyle (unless restricted by any of the provisions of the Mental Capacity Act 2005 or Mental Health Act 2007 and with due regard to relevant health and safety legislation and Adult Protection procedures).

7.7. People receiving the Service will be encouraged and supported to achieve own personal aspirations and goals and where possible achieve or work towards the Person's Care and Support Plan.

7.8. The Provider and the Commissioner(s) shall ensure that outcomes are realistic and measurable but shall take into account that People will have aspirations that might not be possible to achieve through the Service provided. However the Provider and the Commissioner(s) will ensure that further exploration identifies what matters to the individual in relation to their particular aspiration. These are often outcomes that can be delivered.

7.9. The Provider and Commissioner(s) shall make all reasonable effort to work together with the Person receiving the Service and, where applicable, their relative(s) and/or Advocate to agree the outcomes to be achieved.

7.10. The Provider's Support Plans shall record the outcomes that are agreed between Provider, the Person (his/her representative) and the Commissioner(s) and these

will be reviewed quarterly and evidenced in line with the provisions of this Service Specification and regulatory requirements.

7.11. The Commissioner(s) shall ensure that where outcomes are agreed with the Person during the assessment, that subsequent care and support planning/review processes are shared with the Provider.

7.12. Where a Person is eligible and is funded by Housing Related Support, under the Supporting People Programme Grant (SPPG), the Provider shall periodically report outcome related information in accordance with the Supporting People Outcomes Framework and as agreed with Commissioner(s) from time to time.

7.13. The Commissioner(s) is looking to build a relationship with the Provider that is based on trust and openness. This will devolve greater responsibility to Providers, enabling them to develop their Service to the benefit of the People they support. All Services will be undertaken in a personalised manner and will be arranged to meet the specific needs of each Person in a way which promotes their wellbeing.

7.14. The Commissioner(s) will work in partnership with the Provider to ensure good quality Service is provided with the aim of maximising the use of available resources. There will be an expectation that the Provider will participate in local meetings, including provider forums, and service-specific/practice development workshops as required.

The Commissioner(s) and Provider are making a commitment to:

- Share key objectives;
- Collaborate for mutual benefit;
- Communicate with each other clearly and regularly;
- Be open and honest with each other;
- Share relevant information, expertise and plans;
- Monitor performance;
- Seek continuous improvement by working together to maximise the use of the resources available and by finding better, more efficient ways of working;
- Understand the potential risks involved in Service development;
- Promote the approach at all levels in the organisations (e.g. through training initiatives);

Be flexible enough to reflect changing need, priorities and lessons learnt, and which encourages and promotes full participation of Individuals and, where appropriate, their family, Carers and parent carers in Service planning and delivery.

8. TASKS AND ACTIVITIES

8.1. The Service shall focus on improved overall outcomes for individuals supporting the Person to carry out activities for him/herself rather than on the tasks and activities associated with the Person’s needs.

8.2. The tasks and activities detailed below are an indication of the types of tasks that are typically required of Providers. The list does not preclude imaginative or alternative solutions which might better suit a Person in the pursuit of their desired outcomes. The Provider shall promote an enablement ethos and People shall be supported to meet their needs independently or as independently as possible. Undertaking a task for a Person is often the easier option, however where the Person has the ability to fully or partially undertake a task independently, this must be encouraged and nurtured.

The tasks and activities will vary dependent on individual circumstances and may include but not limited to:

- Assistance with meal preparation
- Personal care
- Assistance with laundry
- Cleaning
- Household management
- Activities in the community
- Development of community network and opportunities
- Accessing wider services when appropriate as any other citizen e.g hair dressers, opticians, podiatry, dentist, education, probation

8.3. The way the tasks and activities are to be carried out, will need to be co-produced between Provider, the Person or their representatives, relatives, Staff and Advocates in achieving the outcomes stated in the Care and Support Plan and/or Care/Treatment Plan. In instances where the Provider does not have a direct role to play in achieving identified outcomes, it is expected that they proactively signpost or refer to other Services including services in the community or third sector services.

9. ACCESS TO THE SERVICE

9.1. Access to the Service will be determined by the Commissioner(s) following an Assessment of Need in accordance with the Social Services and Wellbeing Act (Wales) 2014. The Commissioner(s) will provide for every Person entering the Service a full and comprehensive assessment of need which will include a person centred Care and Support Plan.

10. THE PERSON'S RIGHTS

10.1. The Person receiving the Service shall have the right to:

- be treated fairly and respectfully
- exercise personal independence and choice
- have their personal dignity respected
- have their cultural social religious and emotional needs respected

- have access to all personal information held by the Provider
- participate in formulating their own assessment and support planning
- participate in any reviews or re-assessment of needs
- receive a non-discriminatory service
- receive assistance to maintain and develop personal skills
- have access to a formal complaints procedure
- be involved in any decision-making process as it affects them including the right to refuse reasonably a part of the Service
- to comment on the Service by means of an independent representative if necessary without fear

11. HOUSING RELATED SUPPORT

11.1. Where a Person is assessed by the Commissioner(s) as having the capacity to live independently with housing related needs and eligible to be funded by the Supporting People Programme Grant, the Provider will deliver this support, which may be part of a wider Service. Housing Related Support does not include personal care, preparation of meals, medical care or assistance with medication. It cannot be used to fund domestic assistance services (e.g. laundry, cleaning, ironing).

12. SERVICE HOURS

12.1. Weekly support hours shall be agreed between the Person, the Provider and the Commissioner(s) that enables the Provider to deliver the Service effectively, responding to the changing needs of the Person and his/her progression towards independence where applicable.

12.2. In delivering the Service, the Provider will be able to demonstrate how available resources are utilised creatively in partnership with the Person or the Person's representatives to achieve agreed outcomes. The ongoing requirements of the hours of support will be subject to monitoring and review by the Provider and the Commissioner(s) in accordance with the Person's needs and achievement of outcomes.

12.3. A significant change in the Person's needs may necessitate a need to increase or decrease the hours of Service required by the Provider as agreed at the Review of Service meeting between the Provider and the Commissioner(s). The support hours should be sufficient to provide the Service to the Person when they need it and for as long as they need it.

12.4. The Provider will work flexibly with the Person to support him/her to live an ordinary life and achieve own personal outcomes, therefore the ability to adjust staffing rotas to accommodate to the fluctuating needs and circumstances of the Person and maximising his/her opportunities as far as possible is essential.

12.5. It is envisaged that Staff, recruited to provide the specified service hours will undertake support duties that enable the Person to access activities at home or in the community.

12.6. Where the Person is supported by another Provider e.g. Day Service/Opportunity or Workplace, the Provider must ensure that there is sufficient flexibility within the staffing arrangements to accommodate those situation where for whatever reason the Person is not able to access the service (e.g. external day service), including sickness attendance at appointments and planned or unplanned closures to day services or choice to stay at home.

12.7. In the event that Person attends day opportunities independently without staff support, the Provider shall agree with the Commissioner(s) whether or not there is an eligible need for additional support to take account of eventualities when day opportunities are not available e.g. bank holidays.

13. SERVICE CONDITIONS

13.1. Information given to the Provider

13.2. The Provider will be given such information as required to perform the Service. This information shall be given with the Person's consent, but where this is not possible, the Significant Carer/Representative shall give permission. The information must be regarded as strictly confidential.

13.3. Wherever possible, information shall be shared with the Person's consent. Where the Person lacks the capacity to consent in relation to the decision in question, a decision will be made by the Commissioner(s) involving the Person's representative (if any) and in accordance with the principles of the Mental Capacity Act 2005.

13.4. The Commissioner(s) shall provide all relevant information to the Provider that is necessary for the Provider to carry out the Service as identified in the care plan including:

i. List of all equipment required to carry out the Service i.e. hoist, stair- lift or other equipment as identified by the specialist Staff i.e. Occupational Therapist, Speech and Language Therapist, Physiotherapists;

- If the equipment is available at the Service location
- If the equipment is in a workable condition
- the name and contact number of the contractor responsible for servicing the equipment, including method for cleaning equipment

ii. Manual handling plans detailing level of staffing and equipment required for any moving & positioning – such as use of hoists, wheelchairs, stand-aids, toilet seat risers etc;

iii. Details of other services provided to the Person and names of Providers as applicable;

iv. Any risks to staff, related to family members and / or visitors to the home and / or animals pets at the Person's home;

v. Information about other family members that live at the property;

vi. Pets at the Person's home;

vii. Any hazards and other information relating to the Person's home environment, well-being and behaviour that have been addressed within the Care and Support Plan;

viii. any known factors which may result in disruptive or challenging behaviours or any other factors which may otherwise impact on the Provider's ability to provide the service;

ix. Details of telecare equipment provided;

14. Person centred planning and delivery

14.1. Each Person's personal outcomes will be unique to them dependent on their circumstances therefore the Person's Care and Support Plan may not include all of the National Wellbeing Outcomes detailed in this Service Specification (Schedule 6).

14.2. The delivery of personal outcomes will be defined within the Person's Care and Support Plan and may be short-term or long term, dependent on the Person's circumstances.

14.3. The Provider shall operate a person centred approach to support planning with the involvement of the Person receiving the Service and/or his/her representative(s). The Service will be flexible and designed in a way that meets the Peron's outcomes, needs and preferences.

14.4. The Provider shall ensure that:

i. All Staff have the knowledge and skills required for person centred thinking and approaches;
ii. An enablement and progression approach to service delivery is adopted within the Team;
iii. Each Person has a brief summary of what is important to / for them, what people like and admire about them and ideally containing a picture of them (for example a one page profile);
iv. The Provider Staff know how to help the Person to have choice and control;

v. Provider staff contribute to the Person Centred Planning reviews where requested to do so
vi. A person centred culture is created within a team
vii. Action planning tools and resources are utilised in team meetings and review meetings;
viii. Policies and procedures are in place that support person-centred processes and materials that focus on enablement, progression and social inclusion;

14.5. As part of the support planning process, the Person receiving the Service shall have access to the Provider's Statement of Purpose which will at least include (but not limited to) the following information:

i. The ethos of the Service and aims and objectives of the Provider;
ii. Contact details for the Provider including arrangements for out of hours service;
iii. Provider's complaints procedures;
iv. Routine access available to the Person, Carers, friends, family providing an opportunity to feedback in a variety of means and which is reportedby the Provider to Commissioner(s) at agreed intervals e.g. six monthly;
v. Statement of concerning the Person's confidentiality;
vi. Access to advocacy services;
vii. The Person's rights and responsibilities;

15. The Provider's Support Plan

15.1. The Commissioner(s) expect that the Provider's Support Plan will focus on enablement, prevention and delivery of outcome that matter the most to the Person.

15.2. The Provider shall consider voluntary services in the community that may enhance or support the achievement of personal outcomes. The Provider shall use suitable resources and contacts in order to provide the necessary advice, information and signpost to a range of services available within the local area.

15.3. In drawing up the Provider's Support Plan, the Provider shall ensure that the Person and his/ her preferences remain at the centre of all decisions relating to his/her Service.

15.4. The Provider's Support Plan co-produced with the Person, shall identify how the Service will be provided and in a format which is meaningful to the Person. The amount of support agreed will be appropriate for the Person to achieve his/her outcomes with regular progress reviews.

15.5. The Provider's Support Plan will refer to means of empowering, facilitating choice, regaining or acquiring skills and/or maintaining existing skills. It shall clearly define the Service to be provided, showing how the Service will be delivered to meet the assessed need, promote independence and support the Person to live a fulfilled life, making the most of his/her capacity and potential.

15.6. The Provider will ensure that the Service provided is compatible with the Person's Care and Support and/or Care and Treatment Plan produced by the Commissioner(s), utilising the service hours that have been agreed. The Provider's staff will be fully conversant with the contents of the Person's Support Plan and that essential information is highlighted.

15.7. The Provider will have in place a means of recording action taken to meet objectives and outcomes and Staff will record the acquisition of new skills and the achievement of goals by the Person.

15.8. The Provider's Support Plan will be available in a language and format chosen by the Person that the Person can understand.

15.9. The Provider's Support Plan will be stored in the Person's own home and copy will also be submitted to the Social Worker upon request. In accordance with the RISCA requirements, the Provider's Support Plan shall be kept up to date through three monthly reviews.

16. The Landlord

16.1. The Service provided under this Service Specification is separate from housing arrangements. Where the Person's home is a tenancy, the Landlord and the Provider shall not be the same entity.

16.2. The Person living in his/her own home with tenancy/licence will have the same basic tenancy rights as all tenants should, and these are that:-

- A tenancy or licence agreement is in place
- The Person has control over where they live
- The Person has control over who they live with
- The Person has control over who supports them and how they are supported
- The Person has control over what happens in their home

16.3. Staff must always be aware that they are working in the Person's home and are respectful of their rights, choices and control over their home.

16.4. The Person's home shall be referred to and known as their home, and not as 'the scheme' or 'the unit'. It is therefore essential that the language used in Staff training and induction should reflect that the Person's home is not the Service. The Service is the Care and Support and/or the Care and Treatment provided in the Person's home.

16.5. The Person's home, or even part of it, is not an office of the Provider and should not be appropriated for such purpose. Unnecessary paperwork and equipment

owned by the Provider must be placed in the Provider's premises and not in the Person's home.

16.6. The Provider must ensure that where a tenancy is shared the Person's private space is respected.

16.7. The Provider shall utilise tools e.g. the Real Tenancy Test that complement the Provider's existing quality assurance systems in place to enhance good practice and indicate how improvements can be made for the Person.

17. Staff scheduled visits

17.1. The provision of the Service, when and how the Service shall be provided to meet the Person's required outcomes shall be agreed prior to the commencement of the Service. It is anticipated that this will remain under review as the relationship between the Person, his/her Carers/ family/neighbours and the Provider develops and in response to ongoing review of what matters to the Person receiving the Service and as outcomes are achieved. The Provider should ensure that there is effective communication with the Person being supported and their Carers / family regarding planned visits.

17.2. Staff visits shall be planned as required to promote the Person's independence moving away from traditional ('time and task') forms of service delivery. The Provide shall have policy / information in place regarding how it remedies significantly late or missed calls/ visits.

17.3. The Service shall be delivered in an efficient and outcome focussed manner, ensuring that Staff arrive times within time bands agreed and provide continuity of care and support. In the event that a Staff member is significantly early / delayed, it is the responsibility of the Provider to notify the Person of the expected changes by a telephone call where possible and agree an alternative time of service delivery.

17.4. The ongoing requirements of the hours of support will be subject to monitoring and review by the Commissioner(s) in accordance with the Person's needs and the outcomes that are expected to be achieved. The frequency of calls/visits may vary from time to time dependent on the needs of the Person.

17.5. Occasionally the Person may cancel visits with the Provider. The Provider shall ensure that procedures are in place within their organisation for notifying and recording cancellation of such calls/visits.

17.6. The Commissioner(s) may promote the use of an electronic care monitoring system. It is good practice to implement and utilise electronic care monitoring and ensure service contingency plans are in place in the event emergencies particularly if Staff are unable to arrive on shift to carry out the service. The Provider may utilise the Electronic Care Monitoring System for verification of the accuracy of timings though electronic data entry at the time of starting and

finishing the Service by Staff. Where this is intended there will be full consultation and agreement with the Provider. Any Provider wishing to implement their own electronic call monitoring system should discuss their intention with the Commissioner(s) and provide assurance that such a system shall enable Staff to focus on quality of service delivery.

18. Keeping People Informed

18.1. The Provider will provide an information pack for the people they support that will as a minimum include basic information as the Service commences. The information pack will be in an accessible format e.g. large print, appropriate language, photographs, audio tape, Braille, Easy Read, video etc and will be made available to individuals and their Staff. It will include:

- Statement of purpose: aims of the Service, philosophy of care and support, who the Service is for, including the range and level of care and support Services provided, cultural and social needs catered for.
- Contact details for the Provider including telephone numbers of relevant managers (including out of hours and emergency contact numbers)
- the services provided by the Provider
- A statement regarding the consequences of unacceptable behaviour
- The procedures/contingency arrangements in place in the event of emergency
- Safeguarding information, including procedures followed
- The process of quality assurance
- Information regarding where a copy of the most recent CIW and/or other relevant inspection reports or information can be obtained
- Details of payment options where they pay all, or part, of their care direct to the Provider
- Complaints procedure
- Details of how to access advocacy services

19. Delivering Positive Behaviour Support

19.1. People receiving the service may have support needs that fluctuate or change over time. This may include periods where they engage in behaviours that are challenging for services to work with. Providers must be aware of and be able to utilise best practice in supporting people who have these complex needs, including specifically PBS.

19.2. Good understanding of appropriate tools and strategies are required to promote appropriate behaviour and prevent/ manage challenging behaviour. Schedule 5

sets out the principles of Positive Behaviour Support required to be utilised as part of the Service.

19.3. The North Wales 'Promoting Appropriate Behaviour Policy is a positive step to creating a safer working environment for employees where appropriate behaviour from people receiving services is promoted and raises awareness of what is inappropriate behaviour and how any incidents would need to be managed.

19.4. In the event that the Person receiving the Service presents behaviour which challenges, the Provider shall work as part of the Multi-Disciplinary Team (MDT) and guided by the Social Worker / health professional use appropriate models of support e.g. Positive Behavioral Support and/or Active Support. If the Provider is suitably accredited and has the necessary competencies to use appropriate models and strategies, the Provider shall deliver the Service accordingly working as part of an MDT.

19.5. Where the Person presents behaviour that challenges, it is essential that the Provider working with the MDT undertakes a Multi Disciplinary risk assessment. The risk assessment will evaluate any potential for harm to the Person, the public, the Staff and identify risk reduction measures. The risk assessment will be regularly reviewed and updated.

19.6. Devising behavior support plans is the role of the MDT which includes the Provider unless the Provider is suitably accredited and has the necessary competencies to deliver this part of the Service without a need for MDT. All incidences of challenging behaviour should be recorded in the given recording methods (e.g. ABC charts) to allow for periodic service review (potential triggers, description of the behaviour itself, who was involved and what happened in response to the behaviour) in addition, where appropriate, to standard accident & incident records where there is any injury, property damage etc Records should be shared with the Multidisciplinary Team

19.7. All Staff supporting people with complex and/or challenging behaviour (including people with mental health issues / dementia) should be appropriately trained and skilled for example understanding Positive Behaviour Support, and/or Active Support and using positive behaviour management techniques where required.. Debriefing will be available for the Person and any staff following incidents.

20. Assistive technology, equipment and materials

20.1. The Provider shall be proactive in working with the Commissioner(s) to identify opportunities to increase independence through the introduction of technology.

20.2. The Provider shall respond to personal alarms and sensors where installed as part of a specialist Assistive Technology package e.g. bed sensors, falls monitor etc.

20.3. The Provider shall ensure that Staff have awareness and comply with the requirements of Telecare Equipment Passport document (specimen copy set out in Schedule 4) and that this document is completed, stored at the Person's home and is regularly reviewed.

20.4. The Provider shall have a level of understanding and competency in the use technology and equipment including specialist equipment and technology e.g. hoists, slings, pressure relieving mattresses, iPad, mini pads etc and Staff will be expected to be competent in its use where this is required as part of their service delivery. The Provider's use technology will take account of compliance with data protection with basic antivirus / firewall protection.

20.5. Staff shall operate the equipment that is indicated for such use in the Person's Support Plan. Where the Person, or his/her representative, expressly refuses to use the equipment or the equipment is not available in the Person's premises, the Commissioner(s) shall be informed.

20.6. The Provider shall assist in maintaining in a safe, serviceable and clean condition and replacing as necessary all equipment as necessary used by the Person.

20.7. At the end of the Service or upon earlier termination a Contract as appropriate, the Provider shall leave the service setting and all materials and equipment belonging to the Commissioner(s) and the Person in a secure, safe, serviceable and clean condition.

20.8. Insofar as the services include the cleaning of equipment, it shall be the duty of the Provider to clean such equipment as may be necessary to a state which conforms to the required standards.

21. **Health and Safety**

21.1. Further to the terms and conditions of the Contract, the Provider shall:

21.2. Provide the Social Worker or any relevant appointed Officer of the Social Services Department with copies of any incident forms within two working days of the incident occurring.

21.3. Ensure that all employees are competent to carry out the tasks required of them, providing training and information to Staff where necessary in accordance with this Service Specification and in particular ensuring that:

i. Staff have undertaken as a minimum the All Wales Manual Handling Passport (2 day) training where they are required to provide manual handling as part of the Service and complete appropriate training modules in accordance with any specific / Personal manual handling plans.

ii. Prior to administering medication, Staff have undertaken the medication training provided by BCUHB, which follows the administration of medication policy agreed between the Commissioner(s) and BCUHB. Medication can be

self administered and prompted by Staff or fully administered by Staff with appropriate training to supporting self, prompted or administered medication.

iii. Staff are trained in responding effectively to incidences of inappropriate behaviour, violence and/or aggression.

iv. Staff are trained in supporting people who engage in behaviours that are challenging to support and complete appropriate recording to enable analysis of incidents.

v. A fire safety risk assessment is in place and Staff follow a fire plan which details checks and procedures to be carried out.

vi. The Provider will ensure that each Person has a Personal Evacuation Plan agreed with the Commissioner(s), including where required fire evacuation equipment e.g. evc chair and reviewed at regular intervals.

vii. Systems are in place to ensure the safety of the premises and equipment in it, through a regular programmed checks and maintenance.

21.4. Staff who are unwell, and/or have infectious illnesses such as influenza, should not work with the Person until symptoms have passed. It is the responsibility of the Provider to provide alternative cover. The Provider shall have in place a Business Continuity Plan which will be communicated to Staff. Staff will be facilitated to support personal infection control measures offered such as influenza vaccination.

22. Risk Assessment Management

22.1. The Provider shall in compliance with the Management of Health and Safety at Work Regulations, assess the risks to Staff and make arrangement for their health and safety by effective planning, organisation, monitoring and review arrangements.

22.2. The Provider shall operate a risk assessment system which ensures all risks presented within the Service are clearly documented, evaluated and managed. The Risk Assessments will be regularly updated and checked for accuracy and relevance. Copies of the Risk Assessments will be provided to the Commissioner(s).

22.3. The Provider will be responsible for the completion of the risk assessment supported by the Multidisciplinary Team.

22.4. The Provider will liaise with the Housing Association relating to health and safety and risk management issues, which are pertinent to the safe operation of the Scheme.

23. Deprivation of Liberty Safeguards

23.1. In accordance with the Mental Capacity Act 2005, the Commissioner(s) and the Provider will always assume that the Person has capacity to make day to day decisions unless there is a mental capacity assessment that records clear evidence to the contrary. The Provider and Commissioner(s) shall acknowledge that mental capacity is decision and time specific.

23.2. The Commissioner(s) and Provider shall act in accordance with the Mental Capacity Act 2005 including Deprivation of Liberty Safeguards.

23.3. The Provider must inform the Commissioner if there appears to be significant changes or ongoing concerns about a Person's mental capacity.

23.4. The Commissioner(s) shall ensure that there is a current authorisation from the Court of Protection in place in respect of a Person in circumstances where, without the authorisation, the Person would be suffering a deprivation of his/her liberty.

23.5. The Provider shall notify the Commissioner(s) immediately where there are any changes in the Person's circumstances and the delivery of the Service which may result in the Person being deprived of his/her liberty.

24. Medication

24.1. The Provider shall observe the Commissioner(s)' medication policy **"**BCUHB Pharmacy and Medicines Management Standard Operating Procedure (SOP) for medicines management in domiciliary settings in North Wales" http://www.wales.nhs.uk/sitesplus/861/page/93220.

24.2. The Provider shall work in partnership with the Commissioner(s) to implement the policy and procedures, ensuring that Staff are fully trained and competent in regards to any medicines management activities specified in the Care and Support Plan. The Provider's Support Plan must clearly record any issues in relation to medication such as allergies. Clear policies shall be in place for the record keeping of the administration of medication which shall be followed by Staff.

24.3. The Provider shall comply with the requirements of the contract terms and condition with regards to undertaking any health related activities as agreed between the Commissioner(s) and the Provider in accordance with the All Wales Guidelines for Delegation.

25. Manual Handling

25.1. All Staff where the Care and Support Plan identifies a moving and handling need, shall have completed the "All Wales Moving and Handling Passport" or equivalent standard training prior to delivering the Service. The Provider shall ensure that specific Passport modules are completed to ensure competence with safe use of equipment detailed within Person manual handling plan/s and that refresher

training is provided to relevant Staff on an annual basis after completion of the initial training.

25.2. If there are any specialist Manual Handling procedures (advised by specialist social services or NHS Staff – manual handling assessors etc.), these will comply with social services or BCUHB guidance in relation to Manual Handling (i.e. for specialist equipment, bed bound, challenging behaviour and restraint). This guidance should be provided by the Social Services Department or BCUHB when the Service is commissioned and additional training organised as required. Where the Service can be carried out with equipment, this will be considered as part of the care planning e.g. supporting mobilisation with the use of equipment and one Staff member rather than two members of Staff.

26. Monetary Affairs

26.1. The Provider shall have policies and procedures in place to safeguard Staff who have access to the Person's money to include written protocols for Staff dealing with the handling of the Person's money and the receipt of gifts from the Person. These policies, procedures and protocols must be communicated to all Staff members and the Person and will be available to the Commissioner(s) as part of the monitoring of the service.

26.2. The Provider shall request a Review of Service meeting if the Person appears to be or is becoming incapable of managing his/her financial affairs in order that an appropriate Mental Capacity Assessment can be completed and appropriate action taken to safeguard the individuals financial support on-going.

26.3. Staff shall not manage any money belonging to the Person unless this has been identified in the Care and Support Plan. In these circumstances the Staff shall make a separate financial record for each Person and provide a form of receipt for the Person. The record should be located in the Person's own home and receipts should be provided. Receipts and any remaining monies should be reconciled in writing and, where appropriate, be countersigned by the Person or the Significant Carer/Representative.

26.4. Staff shall not keep in their possession the Person's pension credit/debit cards, store cards, loyalty cards, savings accounts pass books or other benefit cards or any other means of accessing the Person's monies other than when the collection of the Person's pension/benefits/savings has been identified as an appropriate activity by the parties. Staff shall only have the pension card when actually engaged in collecting the pension. Staff must return the card to the Person or to the Person identified in the Care and Support Plan with responsibility for the Person's monetary affairs.

26.5. The Provider or its Staff shall not act as witnesses or appointee to the Person's Will and shall not become an executor of a Person's Will.

26.6. The Provider will ensure that records of the Person's funds and any shared funds in respect of utilities, food, etc. are maintained in full and have in place a robust quality assurance methodology to audit. The Provider will make these records

and the records of their processes available to Commissioner(s) upon request. The Provider will have policies and procedures in place for Staff on the safe handling of money and property belonging to the Person, which covers:

- Recording the amount and purpose of all financial transactions undertaken on behalf of the Person. Records must be signed and dated by the Care Worker and the Person or their family/ advocate.
- Collection of pensions or benefits
- Safeguarding the property of the person whilst undertaking care and support tasks.
- Reporting the loss of or damage to property whilst providing care and support.

26.7. The Provider's Safeguarding policies and procedures shall make it clear that Staff shall not:

- Use credit or debit cards belonging to the Person, or have knowledge of the Person's PIN number.
- Accept gifts or cash (beyond a very minimal value)
- Use loyalty cards except those belonging to the Person
- Undertake personal activities during time allocated to provide care and support to the Person
- Make personal use of the Person's property
- Involve the Person in gambling syndicates (e.g. national lottery)
- Borrow from or lend money to Persons
- Sell or dispose of goods belonging to the Person and their family
- Sell goods or Services to the Person and/or buy goods or Services from the Person
- Incur a liability on behalf of the Person
- Take responsibility for looking after any valuables on behalf of the Person
- Allow any unauthorised person (including children) or pets to accompany them when visiting the Person without their permission and the Care Co-ordinator's approval
- Make or receive telephone calls that are personal or are regarding other people. The time allocated to the must be used to care and support the Person.
- Staff personal mobiles, for purposes not related to the direct care and support of the Person being supported, and during time that is allocated to the care and support of the Person, must not be used.

The Provider must have policies and procedures in place for Staff concerning the investigation of allegations of financial irregularities and the involvement of Police, Social Care including the Safeguarding Team and other professional bodies.

26.8. Where there is a joint tenancy/licence and household costs are shared, cost calculations of expenditure shall be made available.

26.9. The Commissioner(s) will oversee initial claims for Housing Benefit Management Support, the calculation of customer contribution and any other entitlements or funding from Supporting People which any Person who is eligible may from time to time become entitled to.

26.10. The Provider shall work with the Commissioner(s) to maximise the Person's benefit entitlements.

26.11. Where the Provider considers that an appointee could be needed for a Service User, but no appointee is currently in place, the Provider will notify the Commissioner(s) so that the Commissioner(s) may make appropriate arrangements through an appointeeship service. Where the Provider is currently the appointee for the Person, the Provider must notify the Commissioner(s) of such arrangement, and the Commissioner(s) may review the appropriateness of the appointment.

26.12. When the Person goes on holiday he/she shall will be expected to pay own costs from his/her own funds. This applies to board and lodging costs as well as travel and activity costs. Unless explicitly agreed, the Commissioner(s) will not pay any additional costs for staff time or board and lodging costs for the holiday. Additional staff costs may be funded by the Person's additional contribution.

26.13. The Provider will not expect the Person to pay Staff expenses in carrying their duties including purchasing of meals, drinks and other expenses. The Person is expected to cover mileage costs using Staff vehicles and pay towards meals or drinks when the Person has made that decision.

27. End of Life

27.1. The Provider shall acknowledge and inform the Commissioner(s) if the Person's need change and engage in multidisciplinary discussions between health and social care professionals surrounding the end of life needs of a Person.

27.2. The Provider shall ensure there is a regularly updated policy and procedure for supporting people at the end of life, including End of Life Pathways and Do Not Attempt Resuscitation agreements.

27.3. The Provider should be mindful that any surviving partner or co-tenant may require additional support following the death of the Person. Any ongoing needs in such circumstances will be referred to the Commissioner(s) to ensure an appropriate assessment of need is carried out. The Provider will have awareness of support

services in the local area and signpost the Person to access services in the local community.

27.4. The Provider will have a supporting mechanism in place to provide counselling to their own Staff where required.

28. Transport

28.1. Where a Care and Support Plan requires transport to be provided, the Provider shall ensure that any transport provided is:

i) appropriate to the Person's needs and in line with their outcomes;
ii) operated by an Person holding a valid driving licence relating to the type of Service being provided;
iii) has in force and maintains appropriate current motor vehicle insurance which is adequate for the type of use being made;
iv) has personal seat belts or wheelchair restraints which conform to the relevant British Standard or European equivalent which are used by the drive and passenger/s at all times;
v) maintained in a roadworthy condition and complies with all current Road Traffic Act requirements;
vi) driven in a safe and considerate manner by a driver who is not under the influence of any drug, medication or alcohol which may affect his ability to drive;

29. Records

29.1. The Person's rights and best interests will be safeguarded by the Provider's record keeping policies and procedures in compliance with GDPR.

29.2. It is the Provider's responsibility to ensure that all records relating to the Person are up to date, recorded accurately, respectfully and stored safely. These are the property of the Person and shall not be removed from his/her home. The records will be available for inspection by the Social Worker/ Named Designated Officer.

29.3. The Provider shall maintain clearly legible, factual and accurate records of service delivery through electronic care monitoring or timesheets as a record of actual times of service delivery by Staff which will be recorded through electronic means or duly signed by the Person (or where agreed, the Person's representative). Any such timesheets shall provide a verification of the Service provided and will be made available to the Commissioner(s) upon request without any delay.

30. Communication systems, diaries and health records

30.1. Where applicable, a travelling communication system will be applicable where another Provider may be involved, i.e. day care and the Person's ability to communicate his/her wishes are compromised.

30.2. Assessments, care plans and health related records prepared by BCUHB or as part of an MDT Team shall be followed appropriately and stored securely within the Person'. Records must be made available to the allocated Community Nurse/Speech and Language Therapist or other professional on request and his/her advice followed. Where the Person requires assistance with medication in accordance with the Care and Support Plan requirements, the Provider shall follow the procedures for recording in accordance with the medication policy.

30.3. In the event that the Provider requires additional training to perform the service relating to any complex health needs of the Person, the Provider shall receive the relevant training from the Health Board or equivalent training from an accredited Provider and maintain a record of all training undertaken in respect of each Staff, including a date of refresher training to be undertaken and competency of Staff signed off by the BCUHB and/or alternative accredited Provider prior to the service being provided.

30.4. It is an essential requirement of this Contract that the Provider monitors and records the Person's specific health needs and / or, challenging behaviours in accordance with methods advised by the MDT. Failure to maintain such records will be a failure to achieve the required Contract standard.

30.5. A person centred appointment diary will be kept dependent on the Person's communication needs. This may be a paper diary, iPad, calendar, using pictures, photographs etc. The Person will be enabled to be an active participant in the recordings of this diary.

31. Notifiable Events

31.1. The Provider shall inform the Commissioner(s) immediately or the next working day if a notifiable event occurs. Notifiable events include:

i) A formal complaint made by the Person, Staff or other person;
ii) A safeguarding concern occurs or is alleged;
iii) A serious accident to the Person, for example a fall;
iv) A significant change in the Person's mental or physical condition;
v) Admission to hospital
vi) Person's absence from the Service Location
vii) Other incident as detailed in the Regulation 26 of the Domiciliary Care (Wales) Regulations 2004, the Regulation and Inspection Social Care (Wales) Bill as amended from time to time
viii) Death
ix) Regular or persistent refusal to accept the Service
x) Other changes in the Service resulting from a change in circumstances or emergency

The Provider shall also ensure that where consent is recorded that the Person's family or representative is informed of any significant event.

32. Review of Service Meeting

32.1. In accordance with the Contract terms, a change in the Person's needs may necessitate an increase or decrease of the Service required by the Provider.

32.2. The Provider shall ensure that staffing levels allow for some flexibility to accommodate minor changes and fluctuations in need. Longer term or more substantial changes in needs should be notified to the Commissioner(s) who will request a review is undertaken at the earliest opportunity.

32.3. The Provider will work flexibly with the Person to support him/her to live an ordinary life and achieve their outcomes, therefore the ability to adjust staffing rotas to accommodate to the fluctuating needs and circumstances of the Person and maximising his/her opportunities as far as possible is essential. From time to time the Provider may require adjusting the staffing rotas to accommodate to the Person's needs and circumstances, maximising their opportunities as far as possible.

32.4. It is envisaged that Staff recruited to provide the specified service hours will undertake as part of their working day hours, support duties that enable the Person to access activities as required.

32.5. Where the Person is supported by another Provider e.g. Day Service/Opportunity or Workplace, the Provider must ensure that there is sufficient flexibility within the staffing arrangements to accommodate those situation where for whatever reason the Person is not able to access the service (e.g. external day service), including sickness attendance at appointments and planned or unplanned closures to day services or choice to stay at home.

32.5.1. In the event that the Person attends day opportunities independently without Staff support, the Provider shall agree with the Commissioner(s) whether or not there is an eligible need for services when day opportunities are not available e.g. bank holidays.

33. Registration with the Financial Conduct Authority

33.1. The parties acknowledge that the Person shall utilise support services in their community as and when required, however in the event that an agreement is reached and the Provider is required to provide independent budgeting and debt counselling services as detailed in the Person's Care and Support Plan, the Provider must register with the Financial Conduct Authority in order to ensure that the Service is provided within the legal parameters for the provision of financial information and support.

33.2. In accordance with the terms of the Contract, the Provider shall indemnify the Commissioner(s) against any and all claims that may be made in relation to the provision of financial advice to the Person as part of their Care and Support Plan.

33.3. The Provider shall maintain adequate records regarding the provision of financial advice as the Commissioner(s) may reasonable require for reviewing and performance monitoring purposes (performance indicators and outcome monitoring data) to enable the Commissioner(s) to submit to the Welsh Government any information or data required. In specifying the information to be compiled and maintained for this purpose, the Commissioner(s) will have regard to any directions or guidance which the Welsh Assembly Government may issue relating to the form and extent of such information.

34. Workforce

34.1. A sufficient number of suitably trained, competent and experienced Staff will be in place to deliver the Service effectively.

34.2. In addition to the terms of the Contract, the Provider shall ensure the Staff receive training which reflects the needs of the People they support and which is to be reviewed and updated at least annually. The training requirements are detailed in Schedule 3 to this Service Specification which will be tailored to the Person's service as required.

34.3. Out of hours contact will be available for Staff to provide advice, information and support by a suitably qualified and experienced supervisor/ manager who is appropriately equipped to address any issues that may arise.

35. QUALITY ASSURANCE

35.1. The Provider shall have a Quality Assurance System in place to monitor and evaluate the standards and quality of services provided which will involve the Person and partner agencies as appropriate.

35.2. The Provider's quality assurance system will take account of (but not be limited to) CIW and Commissioners' Quality Monitoring requirements and:

- Feedback from the Person receiving the Service (audited annually) including evaluation of complaints and compliments received
- Views of family, friends and other stakeholders sought
- Reviews of the Person's Support Plan
- Measurement of outcomes achieved
- Care and Social Services Inspectorate reports / notices
- Contract Monitoring reports / action plans
- Periodic review of policies, procedures and practices
- Evaluation of the skills, competency and conduct of Staff
- Learning from any accidents / incidents or near misses

36. 1 The Provider shall have established monitoring mechanism applicable in respect of the monitoring of the Person's Support Plan which will be three monthly in

accordance with the RISCA requirements and as agreed with the Commissioner(s) from time to time.

37. MONITORING AND REVIEW

37.1. The Purchaser's monitoring arrangements regarding the quality of the Service under this Service Specification will be in accordance with the following methods:

- Bi/Annual Provider Review meetings as agreed between the Commissioner(s) and the Provider
- Planned or unplanned monitoring visits undertaken by the Commissioner's Monitoring Officers
- Quality management activities and continuous improvement in accordance with the Commissioner's Service Outcomes Measurement Framework agreed with the Provider during the term of the Contract and the Framework Agreement
- Annual statutory review meetings in respect of the Person undertaken by Social Workers/Health Professionals where applicable
- Feedback from stakeholders on the quality of the service for example through quality monitoring questionnaires, sampling etc.
- An examination of written records, reports, logs and other written materials by Staff on the standards of service(s) being supplied.
- Staff rotas, timesheets, training records, accident and incident logs and other relevant record and other documents held or compiled by the Provider in relation to the provision of the Service, except where it conflicts with any over-riding duty of confidentiality
- Examination of the Provider's policies and procedures.
- Monitoring to consider service delivery against the tender submission (in the event of a tender process being undertaken)
- Examination of compliment and complaints received by the Provider.
- Inspection reports undertaken by the Care and Social Services Inspectorate for Wales including details of compliance and enforcement notifications
- Observation of the service delivery
- Supporting People outcome monitoring
- Informal Carer assessment (where applicable)

SCHEDULE 1

SERVICE DELIVERY EXPECTATIONS

Below are examples of service delivery requirements expected from the Provider in providing the Service under the Service Specification which will be tailored to the Person's care and support requirements.

1. Promoting independence

1.1. Support Plans are co-produced with the people, focussed on what matters to them and what they want to achieve

1.2. The Person is supported to learn activities of daily living (for e.g. domestic housekeeping tasks, cleaning, shopping, meal preparation etc.) and encouraged to undertake these tasks independently of staff in so far as able to.

1.3. The Person will be consistently supported to maintain existing skills.

1.4. The Provider shall have systems in place to record learning progress and monitor the Person's progress towards his/her personal outcomes.

1.5. There are tools/ methods in place (for e.g. TSI - Training in Systematic Instruction, Active Support, provider's in-house tools etc) that enable staff to teach the Person to learn to carry out activities of daily living as independently as possible.

1.6. Innovative and creative ways are sought to develop the Person's skills as far as possible to ensure that independence is encouraged at all times and opportunities to exercise choice are maximised in all areas of the Person's life.

1.7. The Provider's service is underpinned by person-centred practices and tailored to individual needs, outcomes and aspirations.

1.8. Staff work in an enabling way that allows the Person to increase or maintain the level of their independence and progress towards reduction in care and support where appropriate. Procedures, systems and suitable training will be in place by the Provider to ensure a progression approach is adopted within the staff team and that the Provider does not operate a restrictive culture or regime that would compromise a person's independence.

1.9. Policy, procedures and practice demonstrate how the Provider supports the Person to be autonomous and independent with proper safeguards in place. Tasks are completed with the Person as far as possible.

1.10. Staff are reliable and dependable, have practical skills, respond flexibly to the needs and preferences of the Person and demonstrate an understanding of varying needs. Procedures are in place to enable staff to report to the Person any proposed changes in service delivery and also to inform them of other services available such as the independent advocacy service or community services in the area.

2. Exercising choice and control

2.1. The Service will be based on supporting people in such a way that focuses on what matters to them, where they want to be or what they want to achieve; how they're going to do that; what they need to do; what others can help them with; and what help they need from services.

2.2. The Person's views and wishes are taken into account, and where a Person lacks, or may lack, mental capacity, decisions taken regarding his or her daily living are fully and appropriately documented.

2.3. Services are co-produced with the Person to meet identified needs and provided consistently with other services e.g. day services. Activities are promoted with whatever assistance is required to meet the Person's goals, outcomes, aspirations and personal responsibilities.

2.4. Feedback is accessible and sought from the Person and family through a variety of means with regards to the quality of service provided and their views are actively recorded and acted upon.

2.5. People are listened to when complaining or complimenting the service or suggesting improvements to the way the Service is provided. Records will be maintained by the Provider to ensure the views of the Person have been taken into account.

2.6. The Provider will be expected to review the Person's Support Plan every 3 months and to involve all relevant individuals in the process.

2.7. The Provider will participate in the Annual Care & Support Statutory Reviews and work with the Social Worker/Care Co-ordinator to facilitate reviews in a person centred way. The Provider shall evidence progress towards the Person's outcomes have been achieved.

2.8. Whenever appropriate, the Person will be supported to access independent advocacy to ensure personal views are represented.

2.9. The Person is encouraged and involved in the service planning, delivery and review processes at all times.

2.10. Person centered records inclusive of the Person's views and choices will be maintained within the Provider's service planning and review processes.

2.11. The Person will be supported to make a will if required.

2.12. The Provider shall give consideration to the change of life circumstances of the People they support in their life journey. As appropriate and in liaison with the Commissioner(s) and family or representative the Person will be supported to make end of life wishes known as part of the end of life planning process.

3. Health and well being

3.1. The Provider will ensure that staff are able to support individuals to maintain or develop healthy lifestyles. Staff should be able to support the person to cook healthy meals and to follow a lifestyle that includes regular exercise.

3.2. In the case of a Person with learning disability, the Provider shall ensure that the Person is supported to make an appointment for their Annual Health Check with the GP, provide support for the Person to attend the meeting, familiarise themselves with the All Wales Learning Disabilities Annual Health Check list (accessible from a third sector organisation e.g. Conwy Connect) in order to support the Person to follow up on any further health appointments as a result of the Annual Health Check.

3.3. Positive emotional well-being and good physical and mental health will be maintained to ensure that the Person has the best quality of life possible. The Service will enable the Person to successfully address physical and/or mental health issues, ensuring that health conditions are managed successfully.

3.4. Staff will support the Person to access information, specialist advice, support groups or organisations that may help better manage and understand their health conditions. Procedures and training records will be in place demonstrating how Staff will support the Person to experience a healthy lifestyle and wellbeing.

3.5. Staff will assist the Person with health appointments to maintain regular health checks. These should include national health screening appointments, hearing and sight tests on a regular basis.

3.6. Staff shall support the Person to access health professionals as and when needed including access to wellbeing services in the local area.

3.7. The choice of food and meals are made in consultation and discussion with the Person. Staff shall encourage the Person to have a varied and nutritious diet, requesting specialist advice and guidance where required.

3.8. Staff will have the necessary skills to support the Person appropriately in the decision making processes e.g. taking a regular shower and shall recognise their duty of care as part of their support to ensure the Person’s health and well being is promoted at all times.

3.9. The Provider is able to demonstrate its capacity to meet the assessed needs (including specialist needs) of the Person. Staff individually and collectively have the knowledge, skills and experience to deliver the Service effectively and support the Person’s health and well being outcomes.

4. Managing living accommodation

4.1. Staff will encourage the Person to have pride in his/her living environment and support the Person to maintain own home environment in a clean and tidy manner.

4.2. The Person will be supported to personalise own and/or communal accommodation areas.

4.3. The Person will be supported with the purchase of furniture, which meets the fire regulations and health and safety requirements.

4.4. The Person will be supported to adhere to the tenancy/licence obligations. The Provider's Staff will be familiar with the terms and conditions of the Tenancy /Licence Agreement to be able to support the Person to meet own tenancy/licence obligations and develop own skills in order to manage and maintain the home environment.

4.5. Inventory of all of the Person's individual possessions will be made and kept up to date as items are added and/or disposed of. In the event of a Person leaving a shared Scheme, an inventory must be updated. It is recognised that there is a communal equipment and a communal inventory is maintained.

4.6. Equipment within the Person's home will be checked regularly and where appropriate, the relevant certificates updated. The Telecare Passport document will be completed and kept under review.

4.7. Staff will be aware of procedures to protect the welfare of the Person in the event of an emergency including evacuation in case of fire, gas, main services such as water sewerage and electricity.

4.8. The Person will be allowed free and unsupervised access to and from the property unless otherwise indicated in their Care and Support Plan.

4.9. Staff will ensure that the Person is familiar with the fire precaution measures and emergency procedures. The procedures will be in place within the Person's home and will include a personal emergency evacuation plan (PEEPS) for each Person. It is the Provider's responsibility to ensure that the plan is completed and available for each Person. The North Wales Fire & Rescue Service will provide further advice as required.

4.10. The Person will be supported to arrange utilities and payment mechanisms or manage household budgets and bills. The Provider shall have clear systems are in place in respect of payment arrangements. Payment arrangements for each Person will be clearly documented and evidenced including where one Person contributes to another in respect of utility bills in accordance with the Commissioner's procedures. The Provider shall ensure the utility costs are regularly reviewed.

4.11. The Person will be supported to recognise the boundaries between house and garden and those of neighbours, recognising the right of access to every area in the Person's own home except each other's bedrooms within a shared Supported Living Scheme.

4.12. The Person's diverse needs shall be met rather than subject to routines of the Provider. The Provider shall have a policy that sets out Staff's arrangement for snacks, meals etc which will comply with the protocols of Commissioner(s) as reviewed and made available from time to time. Staff will provide their own food at all times or make a contribution to the Person, where this has been agreed.

4.13. Ensure the Person's possessions are kept secure by being vigilant and security conscious.

4.14. The Provider will undertake the delegated tasks within the Housing Management Agreement between the Local Authority and the Landlord. This may include Supporting People management activities.

5 Dignity and respect, rights and entitlements

5.1. All staff, including managers receive induction and have undertaken training to preserve and maintain the dignity, respect and recognise the diversity of the people they support.

5.2. All staff will adhere to Social Care Code of Conduct for Social Care Workers promoting the dignity, rights, equality and diversity of the people they support at all times.

5.3. Staff will treat the Person's property, space within the home and possessions with respect. Staff's belongings e.g. bags will be neatly placed in a confined and dedicated area in the Person's home.

5.4. Staff shall not use social media or mobile phones unless or required for the Service. The use of mobile phones including messages, texts and social media shall not at any time interfere with the support requirements relating to this Service. The Provider must have a policy in place that is mandatory for their Staff for the use of phones, social media and taking photos and/or videos. The Provider shall ensure that such a policy is adhered to by all Staff to ensure that:

5.5. Mobile phones are used appropriately and efficiently to support effective working practices. Staff understand the legislative requirements concerning the use of mobile phones whilst driving and on duty.

5.6. Staff demonstrate and evidence an understanding of the importance of non-judgmental attitudes and observe and respect the attitudes of the Person

5.7. Clear statements of principles relating to appropriate attitudes, code of conduct and working behaviour which are based on equality, diversity and anti-discriminatory practices are in place. These principles are also evident in appropriate working practices and procedures in place by the Provider.

5.8. The Person has his/her personal beliefs and rights respected at all times and are provided with opportunities to establish new relationships. The Provider has methods and procedures for

systematically assessing behaviour and attitudes in the work place at both team and individual levels, including demonstrating behaviour commensurate with the Code of Professional Practice for Social Care. The Provider will provide guidance and support to Staff where there is an indication that positive behaviour or attitudes are not evident.

5.9. The way in which the service is provided is appropriate to the Person's age, disability, gender, language, race, ethnic origin, sexual orientation, social class, political beliefs or religion and cultural background.

5.10. The Provider shall have up to date policies and procedures that take account of latest legislation and good practice guidance with regards to regard to personal data and information sharing so that their rights and best interests are safeguarded at that is regularly updated and understood by all staff.

6 Protect from Abuse and Neglect

6.1. The Person supported has an equal chance to live free from harm, fear, discrimination and prejudice.

6.2. The Person supported is treated with equal care and respect regardless of age, gender, disability, culture, race, nationality, religion, language and sexual orientation.

6.3. All staff are appropriately trained in the identification and management of abuse, discrimination and harassment. Policies and procedures are embedded for identifying and dealing with the abuse and making safeguarding referrals.

6.4. The Provider's policies and procedures for identifying and dealing with the abuse of vulnerable adults are complimentary to the All Wales Protocols and Procedures for the Vulnerable Adults and Children.

6.5. Staff will be aware of and shall comply with the Code of Conduct for Social Care Workers as they go about their daily work.

6.6. Equipment used and service settings in which services are delivered are assessed as appropriate to meet need and appropriately monitored and their use regularly reviewed.

7 Making a positive contribution to the society

7.1. The Person supported is advised of his/her rights and responsibilities as citizen and supported to contribute and participate as appropriate e.g. voting in elections, joining community groups etc.

7.2. The Person is supported and enabled to participate in his/her community, society and the delivery of Service. The Provider may be required to support the Person in the social and leisure activities and enable the Person to consider to be involved in valued paid work, work experience and a range of community based educational and leisure activities.

7.3. Staff will support employment opportunities for the Person they support including if includes complex needs. Staff shall not assume that the Person cannot work because of the complexity of disability causing a restriction on what can be achieved.

7.4. The Person will be made aware of the financial implications or work such as a fair wage, tax credits, effects of earning on benefits. The Provider shall support the Person to access specialist support and advice from other agencies e.g. third sector as applicable.

7.5. Staff will support the Person to sustain existing support networks offered by carers, family and friends and will, wherever possible create further links within their local community.

8 Social and economic well being

9.1. The Provider shall ensure that the Person is financially stable and has as much control as possible over money and possessions. The Provider will support the Person to develop an appropriate financial management system and the Commissioner's procedures/protocols in place.

9.1. The Person's income, which will be used to run the contribution to the household expenditure, is from DWP Benefits. Relevant financial procedures will be maintained and may be accessed by County auditors. A Financial Risk Assessment will be completed and from this an individual financial procedure developed for the Person. Where there is staff involvement the activity will be monitored by the Commissioner(s) and may be subject to Audit.

9.1. The Provider shall fully co-operate with the requirements where the Person has an appointed Deputy by a Court of Protection who will act in the best interests of the Person, ensuring the Person's assets are safeguarded and needs are met.

9.1. The Provider is required to adhere to the relevant sections of the Commissioner's financial Procedural Guidelines/Protocols shared from time to time in order to ensure sound financial accounting is in place and where applicable, take into account of appointeeship, court of protection arrangements. Accounts, where applicable, will be audited by on a regular basis..

9.1. Where financial assistance is required, the Person will receive the support necessary to maximise control while minimising the risk of financial exploitation.

9. Education, training and recreation

9.1. Staff have good knowledge of the local area in order to support the Person to make full use of the local neighbourhood, access to community and leisure facilities, education social activities, local events and opportunities that are available in the area. Records of confirming that activities have taken place will be in place for monitoring purposes.

10 Domestic, family and personal relationships

10.1 Staff are able to support the Person to maintain existing relationships and support networks as well as develop new personal relationships in their local community.

SCHEDULE 2

Supporting People Outcomes Framework

Promoting Personal and Community Safety

	Outcome indicators	Example Support Plan Goals
Feeling Safe	• Supported to develop routines that improve safety • Completion of security improvements to the service users home • Support to relocate in order to feel safe • Enabled an Person to feel safer by providing support that builds their confidence and control	• I will develop my own personal safety plan • My home will be safe and secure • I will tell the council of unsafe areas and give them any supporting information I have
Contributing to the safety and well-being of themselves and others	• Enable engagement with probation services • Obtained legal advice and representation • Supported to ensure well-being of other family members • Assisted to identify schools and enrol children • Obtained travel passes • Supported to identify appropriate childcare, families centres, playgroups etc • Accessed parenting advice / support groups • Supported in relation to legal issues with children, child protection or child in need status • Supported to address the impact of domestic abuse on individuals and their children • Assisted in identifying problem drug and alcohol use and accessed information and advice • Assisted to identify and engage with substance misuse advice and treatment • Supported to act on advice provided by professionals regarding substance misuse • Assisted in following and maintain a programme of reductions or abstinence	• I am going to attend my Probation appointments • I will speak to my solicitor to get legal advice on …. • I will find a local school and enrol my children • I will find a play group in the local area and attend regularly • I will attend play sessions with the Early Years Team • I will attend parenting classes with …… • I am going to speak to my solicitor regarding my ex-partner having contact with our children • I will attend an appointment with Women's Aid to talk about the support they can offer • I will attend the Freedom Programme • I will attend counselling with …… • I will attend core group meetings and child protection conferences in relation to my children • I will meet with my social worker when required • X and Y will attend the play based assessment at NH • I will attend my appointments with CADT / CAU • I will reduce my drinking by x drinks a day / week • I will take my children to school regularly • I will collect my methadone daily / weekly • I will keep a diary and write down daily how much I drink and how I am feeling when I am drinking

Promoting Independence and Control

	Outcome indicators	Example Support Plan Goals
Managing accommodation	• Accessed local authority homelessness and prevention services • Support though homelessness application process and helped to ensure compliance with information and documentation requests • Supported to access specialist advice • Assisted to identify appropriate and sustainable accommodation and arrange / attend viewings • Ensured understanding of tenancy / occupancy agreements • Supported to meet tenancy obligations • Assisted to acquire suitable furniture and household goods • Supported to identify local services / facilities • Helped to arrange utilities and payment mechanisms or manage household budget and bills • Supported in developing their skills in order to manage and maintain their homes • Supported to gain suitable adaptations	• I will provide additional information to my case worker • I am going to check my areas of choice form and tell the council of any changes I want to make • I will contact the law centre to discuss my housing application • I will know about other housing options • My utilities will be set up • I will not run out of credit on my gas and electric meters when I move to my next house • I am able to pay my bills on time and in full • I will make a list of household items I need for moving into my own home • I will know where my local housing office is • I will keep my room / flat clean and tidy • I will know how to complete basic DIY tasks
Managing Relationships	• Supported to establish contact and build relationships with other people • Supported to build confidence in their interactions, access advice and communicate effectively • Established awareness of the need to change behaviour and accessing services that can assist in making a change to develop healthy relationships • Enable access to mediation and advocacy services to improve communication and address areas of dispute or conflict • Assisted in dealing with officials, correspondence and administration to ensure effective communication • Supported to establish contacts and build relationships with culturally appropriate networks of support	• I am going to contact with my mum and dad • I am going to make contact with my old school friends • I am going to see my mum and sister twice a week • I am going to take part in the cooking class at NH to meet new people • I am going to open my letters and ask my support worker for help if I do not understand • I am going to speak to my solicitor about mediation and contact with my children • I am going to find a local mother and toddler group • I am going to make weekly trips to the library
Feeling part of the community	• Supported to identify personal aspirations and areas of interest • Developed hobbies / interests and improved life skills in their chosen area • Supported to access social situations, support or specific interest groups	• I am going to attend pottery classes at NH • I will find out about gardening clubs in the local community • I will find out where my local church / temple is and visit • I will find out the bus times so I can easily get to my church / temple etc on a regular basis

	• Supported to improve self confidence in social settings or establish and sustain social and support networks • Helped to ensure they are able to access their community and the services they need • Identified transport options • Address mobility issues • Increased confidence in accessing community services and the use of public transport • Supported to access specialist communication support • Supported to report hate crime and supported to access specialist advocacy services • Supported in identifying culturally appropriate support networks	• I am going to attend the activities that are run by my local church / temple etc

Promoting Economic Progress and Financial Control

	Outcome indicators	**Example Support Plan Goals**
Managing Money	• Supported to claim appropriate benefits and understand entitlements • Supported to access benefits / debt or other advice and act on the advice • Supported to make regular bill payments or set up direct debits • Ensured effective communication with creditors and agreed payment plans • Established and managed a personal or household budget • Developed a person's ability to live within their budget or reduce their debts to manageable levels	• I am going to phone the job centre and make a claim for IS / JSA / IS • I will contact Riverside advice about my debts • I will complete a budgeting plan • I am going to contact the people I owe money to and arrange to repay them • I am going to make my money last until my next pay day • I will know how much money I will need to pay my bills when I move into my own house • I am going to phone Child Tax Credits to sort out my claim
Engaging in education / learning	• Supported to identify education or skills needs, aspirations and career plans • Helped to establish and access learning options • Supported to address financial costs relating to accessing learning • Supported to build a person's confidence in their ability to learn • Assisted to access learning opportunities	• I am going to meet with the learn direct tutor to talk about IT courses • I will go to the next open day at x college • I am going to enrol on x course • I will find out if going back to college will impact on my benefits
Engage in employment / voluntary work	• Assisted in identifying individuals skills, experience and interests • Supported to access specialist career and employment advice	• I will create an up to date CV • I will speak to Carers Wales / Job centre advisor about work experience placements • I will find out about voluntary work in animal care

	• Supported to access work experience, volunteering advice and services • Assisted in developing a CV • Identified work available and completed job applications • Helped prepare to enter work • Assisted to arrange childcare or obtain financial and benefit advice	• I am going to do an online job search • I am going to apply for jobs in the construction industry • I will practice my interview skills • I will find child care for my children so I can attend my college course

Promoting Health and Wellbeing

	Outcome indicators	**Example Support Plan Goals**
Physically healthy	• Assisted to engage with primary and specialist health services or social services • Supported to register with GP or dentist, make appointments and referrals • Supported to ensure effective communication with health professionals and access prescribed medication • Supported to act on the advice of health professionals • Enabled to manage their health conditions in line with specialist advice • Supported to access OT advice • Supported to access mobility equipment, aids and adaptations to their home and better manage their day to day needs • Helped to ensure continued engagement with health or related services • Supported to have specific dietary needs recognised • Supported to ensure an individual's home environment is appropriate to their needs • Supported to reduce their incidence or likelihood of hospital admission through better health management • Accessed support group / organisations that may help better manage and understand their health conditions	• I will register myself and my children with a GP / Dentist etc • My children will have their eyes tested • I am going to take my medication daily • I will have all the aids I need to live my life • I will tell the council and give them evidence of what adaptations I need in my home • I will find a local support group and visit them to find out more about them • I will attend my local support group on a weekly basis • I will arrange for my chemist to collect repeat prescriptions for me • I will not run out of medication
Mentally Healthy	• Supported to engage with primary and specialist mental health services • Supported to communicate with mental health professionals and access prescribed medication • Supported to act on the advice of health professionals	• I am going to attend my appointments with the Community Mental Health Team • I am going to speak to my GP about my depression • I am going to take my medication daily • I will find out where my nearest support group is and visit them

	• Enabled to access or manage their mental health conditions in line with specialist advice • Helped to ensure continued engagement with mental health and related services • Accessed support groups / organisations that may help better manage and understand their mental health conditions • Supported to reduce their incidence or likelihood of hospital admission through better mental health management • Supported to ensure an individual's environment is appropriate to their mental health needs	• I will attend the local support group weekly • I am going to meet with my CPN weekly • I am going to keep a mood diary
Leading a health and active lifestyle	• Supported to access facilities and equipment that aids mobility and increases independence • Established the importance of self-care and ensured that services are accessed to enable independent self-care • Received advice and support to maintain hygiene of their home and improved their ability to maintain their home • Supported to shop independently or plan and prepare meals independently • Assisted to access the services required to lead a healthy active lifestyle like leisure / fitness groups and services • Develop an interest in lifestyle activities and hobbies • Accessed health, social care and other services they require to lead a healthy and active lifestyle	• I am going to keep my home clean and tidy • I am going to learn how to cook simple and healthy meals for my family • I will have enough money to buy food • I will walk the children to school once a week • I will make sure my children have a healthy breakfast before going to school • I will take the children to the park once a week

SCHEDULE 3

STAFF TRAINING
(To be tailored to each Service)

- The basic principles and values of care particularly the Person's independence and dignity
- Induction and training
- Supporting people to retain, regain and develop skills to manage their lives and environment and to meet planned outcomes
- Contribute to outcome based Care/Support Planning and review
- Person centred care and support
- Understanding of the role of equipment and telecare
- Supporting people to access and use services & facilities
- Supporting people to develop & maintain social networks & relationships
- Supporting people with social, emotional & identity needs
- Supporting people to prepare for, adapt to & manage change
- Bereavement & Loss
- Prepare family & networks to support people requiring ongoing care
- Support and motivate people to continue therapies
- Health and safety
- Knowledge of risk assessment procedures
- Basic first aid
- Safeguarding
- Medication
- Moving and handling
- Falls
- Understanding of Personal safety and lone working
- Environmental risks for older people and people with disabilities
- Infection control procedures
- Basic food preparation, storage and hygiene
- Healthy eating/Special diets
- Recognising health needs and seeking help through primary health care Services
- The process of ageing and end of life care
- Understanding dementia
- Communication skills appropriate to People's needs
- Confidentiality and Data Protection including GDPR
- Record keeping
- Common disabilities and diseases
- Awareness and understanding of the risks of abuse of vulnerable Adults
- The Safeguarding and Adult Protection
- Understanding professional boundaries
- Public disclosure and whistle blowing policies and procedures
- Awareness and understanding of sensory impairment
- The care of people who are confused or mentally ill
- Dealing with challenging behaviour and tools e.g. Positive Behaviour Support
- Promoting and maintaining continence
- Working in partnership with District Nurses, other Care Workers and agencies
- Children and Families, including Child Protection and Prevention of Abuse
- Business continuity planning

TELECARE PASSPORT

(to be included)

Schedule 5

POSITIVE BEHAVIOUR SUPPORT

Positive Behavioural Support (PBS) is an ethical, comprehensive, evidence-based approach developed within the learning disability field. It is person-centred and proactive in that it focuses on improvements in individuals' quality of life and prevention of challenging behaviour. PBS is accepted internationally as current best practice and is specifically recommended by key national government and professional organisations in numerous recent guidance documents as part of the ambitious transformation agenda across all vulnerable client groups.[16 1718]

PBS is in full accord with the Social Services and Wellbeing (Wales) Act 2014, in that it:

- promotes physical and emotional well-being,
- addresses physical and mental health issues,
- emphasises personal and skill development,
- supports and encourages family and personal relationships,
- provides opportunities for social well-being and inclusion,
- promotes human rights, dignity and respect,
- enhances living accommodation and the person-environment fit.

It is worth emphasising that the comprehensive nature of PBS means that it embraces the social model of disability and the insights of social role valorisation (SRV). The social model emphasises the importance of the environment as a factor in enabling or disabling people to live a good life. SRV also highlights the potentially negative impact of service design features that stigmatise, segregate and congregate people at risk of societal prejudice. It is therefore a fundamental feature of PBS to promote small-scale, homely living environments other than in exceptional cases. It is also a core aim of PBS to prevent people from being placed in stigmatising, segregated and congregated environments, and to support their return to a homely place in the community. PBS is not just a therapeutic technique to be applied in any environment with no regard for the

"fitness" of that environment.

PBS uses the least restrictive interventions and totally rejects any use of punishment. As such, it is accepted as the most effective protection for vulnerable people at risk of abuse and neglect.

Gore et al (2013) Definition and Scope for Positive Behaviour Support. International Journal of Positive Behavioural Support 3(2), 14-23.

NICE (2015) Guidelines on prevention, assessment and intervention for Challenging Behaviour and Learning Disabilities

Royal College of Psychiatrists and the British Psychological Society (April 2016) Challenging behaviour: A unified approach – Update. Joint statement by the Faculties of Intellectual

Disability of the Royal College of Psychiatrists, and the Learning Disability Professional Senate of the British Psychological Society

Key aspects are detailed below:

PBS is values led

The key aim of PBS is to help vulnerable people to have the same human rights and opportunities as other people, and to be treated fairly, with compassion, kindness, dignity and respect. It focuses on what services, carers and professionals need to do to meet individual people's needs in the best ways possible.

PBS focuses on improving quality of life

PBS defines a good quality of life as what most people would want on a day to day basis, such as a comfortable home, contact with family and friends, engagement in a wide range of activities, such as running a home, work and leisure, as an accepted and equal member of the community, free from pain, distress and abuse. PBS helps people to do more things for themselves. It includes active support which helps carers to give people more opportunities to learn, practice their skills and abilities and participate more fully in daily life, helping to maintain or develop independence as far as possible, which increases dignity and self-esteem. Active support comprises a set of tools and guidance for carers that includes a technology of positive interaction that provides individualised assistance to maximise participation and skill development. Also included is a detailed, flexible system for planning service user activities together with the requisite support.

By enhancing these aspects, PBS improves quality of life not just for the individuals but also for their carers.

PBS is inclusive

PBS assessments and interventions are designed with the active involvement of key people in the person's life. These are the people who know the person best and actually put PBS into operation. They, therefore, need to understand and agree with all that has to be done.

PBS is person-centred

The starting point is to get a clear picture of the person, how the person copes with their environment and gets the things they require. This allows their unique needs, aspirations, experiences and strengths to be recognised and puts them at the centre of their care, and gives them a voice and control over the outcomes they want to achieve.

PBS is evidence-based

PBS is evidence-based in two ways. Firstly, there is growing research that shows it improves quality of life and reduces behaviours that challenge, and that this is maintained over time. Secondly, PBS is evidence-based at every stage, as it is based on information about the individual from initial assessment through to checking if the intervention plan is working in practice.

PBS is a framework for multi-component intervention

PBS is not a single intervention. In order to meet each person's unique needs, it may include a wide range of methods and therapies such as value-based behavioural approaches, physical and mental health treatments, communication systems, active support, skill

teaching, activity planning, goal setting, behaviour management procedures, staff and carer training and stress management.

Schedule 6

NATIONAL WELLBEING OUTCOMES

i) I know and understand what care, support and opportunities are available and use these to help me achieve my well-being
ii) I can access the right information, when I need it, in the way I want it and use this to manage and improve my well-being
iii) I am treated with dignity and respect and treat others the same
iv) My voice is heard and listened to
v) My individual circumstances are considered
vi) I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me
vii) I am healthy and active and do things to keep myself healthy
viii) I am happy and do the things that make me happy
ix) I get the right care and support, as early as possible
x) I am safe and protected from abuse and neglect
xi) I am supported to protect the people that matter to me from abuse and neglect
xii) I am informed about how to make my concerns known
xiii) I can learn and develop to my full potential
xiv) I do the things that matter to me
xv) I belong
xvi) I contribute to and enjoy safe and healthy relationships
xvii) I engage and make a contribution to my community
xviii) I feel valued in society
xix) I contribute towards my social life and can be with the people that
xx) I choose
xxi) I do not live in poverty
xxii) I am supported to work
xxiii) I get the help I need to grow up and be independent
xxiv) I get care and support through the Welsh language if I want it
xxv) I live in a home that best supports me to achieve my well-being