SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

Service Specification No.	
Service	LSC – People with a Learning Disability and/or Autism and Mental Health Difficulties
Commissioner Lead	
Provider Lead	Sally Nightingale, Programme Lead – Learning Disabilities and Autism
Period	
Date of Review	

1. Population Needs

Our vision is for People to be able to live as independently as possible in their own homes, in the place where they want to be, with their families and networks around them. We want to ensure People live in the right type of home for their needs, in the right place and with the right support. Although this may not be possible for everyone, we believe that People with even the most intensive and complex health and social care needs still should have a range of choices open to them and be supported into service models which continue to maximise their independence and support their continued involvement in existing social networks.

This Service will provide flexible and person centred support for people with a Learning Disability / and or Autism (aged 18 and over) and with co-morbid mental health difficulties which may be of a chronic or fluctuating nature. This may include diagnoses such as schizophrenia, bipolar affective disorder, recurrent depression and personality disorders.

The People to be supported may have spent time in hospital settings, sometimes for many years, or as "revolving door" patients who do not "fit neatly" into a pre-existing service designed for those with singular diagnoses. They may lack or have fluctuating capacity and require a compassionate and assertive approach. The People to be supported will require systems which adapt to and communicate effectively with them and a service able to support recovery and wellbeing. They will require specialist communication and behavioural support.

The Service will provide support as detailed in each Person's support plan and deliver on the duty under the Care Act 2014, Mental Health Act and Mental Capacity Act.

The support offered may take several forms, from supporting People in their own homes to accommodation based and should be able to adapt with changing need.

The use of assistive technology should be maximised where possible to promote least restriction whilst ably contributing to overall risk management in line with need. Assistive technology should not be used as an alternative to human interaction.

Where applicable, the Service will cooperate with the landlord(s) and any other appropriate agencies, especially around safeguarding issues.

Providers delivering this Service should be able to:

- demonstrate an in depth understanding of the aims and objectives set out in Building the Right Support (including the legal frameworks that surround discharges from secure settings: Mental Health Act, Care Act and related frameworks and guidance).
- evidence their commitment to adopting an inclusive and supportive approach to recruitment and staff support; and
- evidence their ability to provide good quality evidence based care. They will have experience of achieving safe discharges from inpatient settings with the aim of keeping People living safely in communities and out of hospital / prison settings.

Providers should also be able to demonstrate:

- that People have real control over their care and support, actively engaging individuals in the co-design and development of support packages;
- the difference that they are making to People's lives through an asset based approach celebrating and facilitating People's gifts, talents and aspirations;
- that they seek solutions that actively plan to avoid or overcome crisis and focus on People within their natural communities, rather than service and organisational boundaries;
- that they enable People to develop networks of support in their local communities and increase appropriate community connections;
- that they take time to listen to a Person's own voice, particularly those whose views are not easily heard;
- that they fully consider the needs of the family and carers when planning support and care;
- that they ensure that support is culturally sensitive and relevant to diverse communities; and
- that they take into account a Person's whole life, including their physical, mental, emotional, and spiritual wellbeing.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

The Provider will provide evidence of how the Service delivers the outcomes below:

- improved support for those at risk of poor health outcomes and emotional wellbeing, to develop the skills and mechanisms to improve their overall health, emotional wellbeing and build their resilience;

- increased participation in employment, education and training and positive activities;

- improved family and peer relationships;
- increased opportunities to learn new skills and try new activities;
- inclusive provision which breaks down barriers in accessing support;
- improved partnership working and joint delivery of services and outcomes;
- addressing barriers to accessing and maintaining independent accommodation in the community.

People will:-

- feel valued and valuable;
- feel more in control of their lives;
- have increased sense of health and emotional wellbeing;
- become more independent and socially confident;
- learn and make progress towards employment where possible;
- have increased levels of independence/confidence to help them with their transition into more independent accommodation;
- build social networks;
- have received support which is relevant, timely and accessible.

The community will:

- see a model of exemplar care and support that challenges the stigma associated with these diagnoses

3. Scope

3.1 Aims and objectives of service

The Service will achieve the following key aims:

- to meet the care and support needs of the identified cohort group;
- to support sustainable discharges from hospital that reduce the risk of readmission and in so doing contribute to the Learning Disability and Autism Programme and positive individual stories for the identified cohort group.
- to deliver a pro-active Service which helps the Person to minimise the risk of crisis occurring;
- to deliver support flexibly across LSC, in any form required, such as individual bespoke community models of care or an accommodation-based 24 hour 7 days a week scheme including a core staffing model alongside any additional support required. There will be well suited staff groups and the recruitment and purchase of support staff which, apart from any core hours, could be provided under direct payment or Personal Health Budget arrangements;
- for each package of care to be tailored to support each Person;
- to support People to live safely in communities and remain out of hospital / prison settings; having good, meaningful lives with choice, control, aspirations and friendships/relationships and the achievement of identified outcomes;

- to support People to gain the skills and confidence to live independently and participate in the community, including the development of emotional and social vocabulary;
- to support People to access other services including health, social care, education, training, access to work and leisure services and be confident in a range of methods linking People into their community and supporting socially inclusive activities that further their own goals;
- ensure that support is given to People to attend for annual health checks associate with a diagnosis of a serious mental illness (SMI) or learning disability;
- to support People to engage with the professionals involved in their care and to be active participants in their lives;
- to model good health behaviours and provide wider role modelling particularly for those within the cohort between the ages of 18 and 25;
- to support the development of emotional resilience;
- to support People to move on to more independent and longer-term living arrangements when appropriate and in line with the Care Programme Approach.

3.2 Eligibility

The Service is designed to be access for People with identified mental health need and a Learning Disability and / or Autism or other needs which entitle them to health/social care support and are compatible through assessment or natural relationships with other users of this Service.

Access to the Service will be via the Integrated Care System (ICS) commissioners specifically for People being discharged from secure inpatient settings either long or short term and to prevent a hospital admission where someone may be currently living within the community.

This is the intention in the initial stages of this development however this may change over time depending on circumstances and by mutual agreement between commissioners, the Provider and the People supported.

3.3 Service description/care pathway

To become an intrinsic element of the triumvirate of the right physical space in the right place in the community, along with the right supported housing staff with the right skill and mind set proactive specialist rehabilitative secondary mental health, autism and learning disability care input, that leads to successful community living and on-going rehabilitation to step down further into more independent settings for Peoples supported.

The Service will support People to develop the necessary skills on a pathway towards independence that is sensitive to their particular developmental needs and values the critical importance of effective therapeutic relationship building.

The Provider will give advice and assistance to People supported that enable them to establish and maintain independent living arrangements and to maintain good mental health and wellbeing.

The Provider will use every effort to ensure the People supported have full understanding and involvement in the Service. Families are a key partner and should be valued. If People want to involve their families in their decisions, small or large, they should be supported to do so.

The Provider is expected to adopt an open and transparent approach to sharing information and concerns with relevant stakeholders.

The Provider will ensure there is the right complement of housing and support is available in their locality and will facilitate a move through to the least restrictive, independent and socially inclusive setting, as close to home as possible at all times.

The Service will be delivered flexibly and efficiently for up to 24 hours a day, 7 days a week and 365 days a year. This may be via direct staffing (waking night or sleep in) or using technology and on call, as appropriate

and agreed for each Service and Person supported, as dictated by the needs of the Person and those residing in each address. The use of Assistive Technology should complement the staffing model to ensure the least restrictive environment and it should not be used in isolation.

The level of support can be reviewed at any point by the Authority as and when needs change. The relevant Commissioning Authority will review the needs of the People supported periodically to ensure that needs are correctly identified and are being met effectively. The Provider will ensure active, ongoing evaluation to ensure needs / presentation changes are tracked, identified and responded to, including reporting this to the adult social care team.

Enhanced knowledge, skill and experience of providing support in line with a variety of legal frameworks is an important feature. Legal frameworks include the Mental Health Act, Mental Capacity Act, and Court of Protection directions, as well as Criminal justice/probation.

The Provider must use a wide variety of communication methods, incorporating a Total Communication Approach where appropriate to individual need, to support People in expressing their needs and preferences and ensure they can contribute fully to all planning and decision-making that concerns them.

The Provider must ensure effective communication is maintained to local partners under national requirements for all involved in the Person's care. A co-ordinated and collaborative approach is required. An expectation is placed on the Provider to actively liaise with other agencies involved.

The workforce will need to operate in line formal Deprivation in Domestic settings (DiDS), least restrictive practice principles, reducing restrictions according to ADASS guidance, enhancing mental capacity, advocacy, best interest decision making, positive risk management, duty of care, strong local leadership, and legal competence.

Informal/natural support should be encouraged where safe and appropriate and staffing should be optimised to ensure the delivery of each Person's daily and weekly programmes effectively and efficiently.

The Provider will ensure that staff have the ability to build good relationships to make sure that they understand the People they support, what is important to them, their personal strengths and ambitions. Staff should support People to identify opportunities and take positive risks to enable them to try new things and build a better life.

The staff team will give advice and assistance to People supported that enable them to establish and maintain independent living arrangements and to maintain good mental health and wellbeing.

Resilient and robust management structures must be in place to ensure that appropriate decision making and support to staff and to the People supported is available at all times.

The Provider will use collaborative ways of working that support People to actively engage in the design, delivery and evaluation of their services.

The Provider will also demonstrate approaches which enable staff to work in creative, person-centred ways, underpinned by the organisational systems and effective management structures to support and sustain this.

The Provider will support People to move on to more independent accommodation if their assessed need determines this.

The Provider will ensure that there are appropriate and robust policies and procedures in place to ensure that all staff understand their responsibilities and adhere to the General Data Protection Regulations (GDPR).

The Provider will employ and provide high quality support to appropriately skilled and trained staff to provide the following support:

- a core staffing model reflecting changing need and dynamic and providing shared access to 24 hour support; either via physical proximity or an active and responsive on-call system;

- value and retain its staff by offering competitive rates of pay with a clear progression pathway and incentives;
- ensure that each Person supported has a co-produced outcomes-focused support plan that captures progress through an outcome framework that is underpinned by relevant professional disciplines such as occupational, speech and language therapy and supports continuation of relevant treatment plans such as psychology;
- contribute to positive therapeutic risk management by committing to quality supervision and multi-agency care planning;
- develop and maintain effective working relationships with the Community Learning Disability Team and the Commissioning Team within the locality the Service is based; and other relevant organisations outside of that locality area but within LSC, demonstrating transparency and reciprocity;
- make use of high quality direct and indirect training and supervision from professionals including psychological and behavioural approaches to promote recovery and support behavioural change, the development of independent and self-caring skills sensitively and incrementally;
- ensure that records are kept up to date and accurate and any administration task is managed on time and to a high quality;
- provide any monitoring evidence and reports as required;
- manage and monitor medication concordance as per own governance arrangements and in line with care plans;
- identify and manage any risks and safeguarding concerns using the appropriate local guidance;
- have knowledge of activities, groups, leisure and cultural services, so that People can be supported to access mainstream services. Support People to make best use of community assets and create connectivity that will help to replace statutory and professional with other services from the voluntary sector and promote organic and naturalistic support;
- have a focus on health promotion, reasonable adjustments and ensuring access to mainstream health services is not restricted.

Recruitment

The Provider must comply with all legal requirements and regulations relating to the employment of all workers and work of any volunteers, following ethical care and value-based recruitment practices.

The Provider will:

- have robust recruitment policies and procedures including appropriate DBS checks and the taking up of references, and ensure that there are appropriate arrangements in place to cover rota emergencies. Agency staff must only be used in exceptional circumstances;
- demonstrate professional leadership at a management level consistent with offering appropriate support to the workers working with People supported;
- ensure that they have appropriate policies and procedures in place for sickness management, disciplinary investigations, grievance procedures and other management functions;
- have a Staff Code of Conduct that staff follow at all times;
- have a lone working policy in place including risk management;
- recognise the importance of informal support and neighbourhood and community connections and actively encourage People supported to engage and participate;
- have robust procedures in place for ensuring that staff comply with the support identified in support plans, risk management plans etc;
- ensure staffing levels are adequate for the wellbeing of the People who use the Service; Any required changes in staffing levels or support need should be communicated to the commissioner with the rationale for consideration;
- ensure its workers work effectively with the other agencies and organisations needed by the People who use the Service;
- demonstrate approaches which enable staff to work in creative, person-centred ways;

Staffing, management, training and supervision

Services must be able to operate 24/7; this will entail a combination of staffing presence, on call and technology, as appropriate and agreed for each Service and Person supported. Staffing arrangements must include effective communication management.

The model of staffing must ensure that optimum hours are used to make sure that the Service is effective and avoids staff burnout, minimises the use of unfamiliar agency staff and ensures flexibility in support.

All staff must have the necessary ability, skills, knowledge, training and experience to properly provide appropriate support in accordance with this service specification. There should be adequate training, and supervision and opportunity for reflective practice provided for all staff as appropriate to their role.

The Provider should identify ongoing training needs and ensure that workers receive appropriate training (including refresher training) to develop the necessary skills. This should include as a minimum.

- Positive Behavioural Support – British Institute of Learning Disabilities (BILD) accredited or similar to ensure staff understand the origins and functions of behaviour that challenges and the range of ways to support People;
- Autism – staff should have training to a level identified in the Skills for Health that will help them understand and respond appropriately to needs arise from Autism Spectrum Disorders;
- Attachment and Trauma – staff should understand the role that attachment issues relationship history and trauma can play in the development of behaviour that challenges;
- Understanding and responding to psychological distress;
- BILD accredited application of behavioural intervention techniques including physical intervention as part of a hierarchical approach;
- Suicide intervention training;
- Knowledge of a range of psychological approaches that may be used for People experiencing distress e.g. Cognitive Behaviour Therapy (CBT) for psychosis and anxiety and the ability to support People to use CBT/Dialectical Behaviour Therapy/other therapeutic skills to manage periods of increased anxiety/distress;
- Communication strategies such as the Royal College of Speech and Language Therapists 5 Good Communication Standards (Reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings) https://www.rcslt.org/-/media/Project/RCSLT/good-comm-standards.pdf?la=en&hash=726CDB9A9E2B575BEB7A57A7128BFB5E59F894C8
- Recovery theory

Induction should include:

- Medication administration and recording, Staff should have a working knowledge of the 'stopping over medication of people with a learning disability, autism or both with psychotropic medicines' (STOMP) agenda.
- Adult Safeguarding
- Whistle blowing policy
- All aspects of the Care Certificate and the standards related to this http://www.skillsforcare.org.uk/Learning-development/Care-Certificate/Care-Certificate.aspx

As well as induction training, staff must have their continuous development supported by the Provider.The staff team and management in place for this Service should also have experience in:

- Understanding Learning Disabilities and supporting People with Learning Disabilities and / or Autism (flexibility will be needed when employing junior staff to allow for training);
- Friendships and relationships;
- Breakaway training (this training must be delivered and updated using a BILD accredited model)

- Physical Intervention training (this training must be delivered and updated using a BILD accredited model);
- Active Support;
- Awareness of mental illness and People with LD, Managing Acute Mental Distress including self harm
- Health needs of People with a Learning Disability;
- Supporting People with profound and multiple disabilities;
- Person centred planning and thinking;
- Epilepsy and safe administration of rescue medication;
- Mental Health Act and Mental Capacity Act, and understanding of relevant law and ethics;
- Facilitating meaningful occupation;
- Engaging with a range of different professionals and agencies;

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

It is important that appropriate staff supervision arrangements are in place and followed, providing a safe and confidential place for staff at regular intervals. This must form part of ongoing staff development and appraisal processes.

Supervision should be of a high quality, formulation driven and evidence reflection and learning in the context of working with people with mental health.

On call arrangements should be a robust and effective part of the structure.

Use of the Authority's community team staff as a level of Provider management must be avoided. As important partners, the adult social care team will be responsive and flexible with appropriate requests e.g., facilitating a hospital discharge. Contact with community team staff must constitute part of the Provider's escalation processes that includes all lines of their own management team.

Finances and property

The Provider will

- support People regarding managing their money and accessing appropriate benefits. where the Person has the potential to undertake this role and there is no need for an appointee;
- support People's control over their own money and resources. so that they are enabled to manage money, budgets, letters etc. as much as they are able to. Where support is needed this takes account of the Person's preferences and wishes in how their money is spent and their financial responsibilities.
- facilitate and explain decision-making regarding household financial management where resource and/or responsibilities are shared between People in the household;
- assist People to maximise their income. where necessary, offering guidance and support in respect of income (including access to benefits), expenditure and the safe keeping of money whilst minimising the risk of financial abuse. The Service will have robust financial policies and procedures;
- proactively support the Person to ensure their tenancy is maintained – support People in all aspects of their relationship with their landlord. in fulfilling their own obligations as tenants and supporting them to access the right support (for example regarding advice, repairs, etc.) from landlords;
- maintain a housing management/service level agreement with the landlord or their agent;
- act as appointee for People where this is judged by the Department for Work and Pensions (DWP) or the Authority.

The Provider should work in partnership with relevant agencies to consider where adaptations could help better meet People's needs or how to make best use of additional capital to create a bespoke living environment, that meets and effectively reduces risk utilising least restrictive practices.

Health and care

Support will be provided to register with the local GP and access local community health services. This will include support to access annual health checks, medication reviews (including those related to the STOMP agenda and other health/medical appointments, including, but not limited to doctors, dentists, opticians, podiatrists and auditory specialists. This will also include for example health checks related prescribed medications and access to universal services and screening.

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

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

- managing challenging behaviour and adopting the least restrictive approach;
- take an enabling approach to ensuring that a Person's Personal care needs are met;
- staff will ensure that all assistance and support with personal care is given in a discrete and dignified manner;
- staff will help people to monitor (and record, if appropriate) their own health and well-being, through regular health checks, making referrals and seeking advice and support as necessary;
- people should be supported to learn how to manage their own physical health as much as possible; learning what is good and bad for health and enabling People to make healthier choices;
- staff will encourage and promote healthy lifestyle choices, including diet, sleep patterns, activities and exercise;
- staff will encourage and promote positive mental health using the national guidance of the five ways to wellbeing;
- the Service will promote and support access to all health services;
- staff will follow a detailed, documented Provider Support Plan with clear information that will guide them the Service will have an understanding of People's conditions;
- induction and training will support the knowledge and expertise required. Additional training requirements should be highlighted to the adult social care team;
- the Service will work closely with any health professionals involved to support delivery of medicines, treatments and therapeutic programmes;
- the service will continue to develop, maintain and implement Health Action Plans; or Education, Health and Care Plans with support as required from the adult social care team;
- Providers will work collaboratively with adult social care team during the annual reviews process and provide information in an appropriate format that will help inform the review.

The annual review action plan will be delivered by the Provider and evidenced to the adult social care team when requested.

Social inclusion

The Provider will:

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

Ensure that staff role-model interaction that enhances People's confidence and self-esteem, through positive relationships both inside and outside their home.

Facilitate contact with neighbours, local shops, leisure services and community groups, so that People can participate in the local community in a wide range of experiences and in a way that suits their needs and preferences. whilst learning about risk and how to look after their own safety as much as possible.

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

Support People to become more independent and develop life skills as appropriate to their needs and circumstances.

Ensure that People are aware of their own behaviour and are supported to manage this for themselves and understand the consequences.

Ensure People are supported in the least restrictive way that is possible and safe.

Technology enabled care

The Provider will, in partnership with the adult social care team, be able to evidence and execute a plan to develop the use of Technology Enabled Care in the delivery of this Service.

Technology Enabled Care may include (but are not limited to):-

- managing the support network around the Person;
- improving access to advice and support;
- supporting People to access primary and secondary care;
- support in managing medication where appropriate;
- maintaining and/or improving a Person's independence;
- maintaining and/or improving a Person's social participation;
- reducing/removing support where appropriate and safe to do so.

The Provider will be required to show a tangible/evidence-based willingness to use Technology Enabled Care to improve outcomes for a Person who receives services.

Safeguarding and behaviour management

The Provider and Service will adhere to local safeguarding policies and procedures for children and vulnerable adults and all staff and management will complete training in this regard.

All safeguarding concerns must be reported to the local safeguarding service and the commissioner informed.

The Service will support People with any requirements under the Mental Health Act in line with associated regulations and guidance.

The Service and staff will ensure that any restraint or physical intervention complies with local Positive Behaviour Support and is only used in line with Person plans, developed by the multi-disciplinary team and signed by the assigned co-ordinator. The Service will communicate with and work closely with the members of the local multi-disciplinary teams to assess, monitor progress and revise plans accordingly.

The Provider will demonstrate expertise in the operation of the Mental Capacity Act, Deprivation of Liberty Safeguards and Best Interests practices.

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

Asset based approach

An asset based approach recognises and builds on a combination of the human, social and physical capital that exists within local communities. We want a service which uses asset-based practice as a collaborative process between the Person and the Service, which allows them to work together to achieve positive outcomes by drawing on the Person's strengths and assets.

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

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

Providers will develop a strong working knowledge of what is available in the area and develop partnerships with other local Providers to further the concept of an 'Asset Based Approach'.

Culture and quality

Organisational culture is the base from which 'good' or 'excellent' starts. We want services which have a strong person-centred culture, both in terms of the People who receive support and with the staff which deliver it. We need providers who develop their staff through training, mentoring and supervision to become strong leaders who can ensure high standards are maintained and promoted.

The Provider will have strong ethos that is rooted in organisational and individual integrity, continuous improvement, openness, and transparency.

As a minimum, the Provider will:

- have an approach to training staff which focuses on continuous improvement and quality;
- support People to manage their own safety and security both inside and outside of the home;
- communicate changes in need to the relevant professionals and adult social care; and
- have an awareness and knowledge of protected characteristics and how to support People in a community setting.

Staff should be:

- compassionate
- patient
- motivated
- interested
- emotionally intelligent
- person-centred
- committed
- able to identify changes in behaviour that may indicate a deterioration in a Person's wellbeing or mental health and respond appropriately

The Provider must also have quality assurance systems in place including a structured feedback process, quality checks and continuous improvement plans showing where quality issues are being improved and in turn helping services to develop.

Ethical care

The starting point for commissioning of support will be individual need as determined through an Assessment. Support will be planned to allow staff sufficient time with the Person supported and, where relevant, sufficient travel time will be allocated to enable staff to attend any outreach/community support services.

People supported will be allocated the same staff wherever possible.

Health and safety

The Provider will ensure that robust policies and procedures around transport, buildings and the safety of staff, visitors and users and all other aspects of health and safety are in place.

The Provider will maintain a good working relationship with the landlord where relevant and ensure that the property remains in a good state of repair through regular maintenance systems and early dialogue with the landlord when necessary.

The Provider is responsible for ensuring accommodation is of sufficient standard when a Person moves in. It is the responsibility of the Provider to ensure the safety of the Person supported, staff and visitors at all times. The Provider will also ensure that all statutory fire, health and safety, food hygiene and 'Control of Substances Hazardous to Health' (COSHH) regulations are complied with.

Equality and diversity

The Authority has a statutory obligation to ensure services are accessible to all and as such the Provider is expected to demonstrate a commitment to equality and diversity. This will include how the Provider has promoted equality and diversity in employment and service delivery. The Provider will also be required to provide evidence of the equality measures and targets their organisation has set and their progress in meeting these.

Monitoring and review

The Provider will be required to provide information as agreed for monitoring purposes. This will be based on but may not be limited to outcomes from individual plans and any other stipulated indicators and measurements detailed agreed with the commissioner on award of the contract. Regular monitoring meetings will take place and the Provider will provide evidence to demonstrate that the service is being delivered in accordance with the service specification.

The Provider will maintain, and make available on request, a true, correct and systematic set of records.

The Provider will comply with all reasonable requests relating to the monitoring of any aspects of its performance.

The Provider will allow any Person authorised by the Authority to enter accommodation subject to the agreement of the Person supported.

3.4 Population covered

Lancashire and South Cumbria Integrataged Care Board (ICB) is made up of GP practices covering Lancashire and South Cumbria. The service is to be provided for patients registered with a GP within the boundaries of the ICB.

3.5 Any acceptance and exclusion criteria and thresholds

The service will meet the needs of people aged 18 and over, either on discharge from hospital or to prevent a hospital admission who have learning disability and/or autism and mental health difficulties.

3.6 Interdependence with other services/providers

Partnership working will be required with the following agencies (not exhaustive): Lancashire and South Cumbria NHS Foundation Trust (LSCFT), Lancashire and South Cumbria Police, Probation, Leisure services,

and local Police/Fire/Ambulance, local Primary Care Services: such as GPs, Pharmacies, Dentists, Opticians, Employment services and the Community Forensic Learning Disability - Mersey Care NHS Foundation Trust (MCFT) and Autism (LSCFT) Community Teams.

4. Applicable Service Standards

4.1 Applicable standards

The Provider shall comply with all relevant legislation, national policy and national guidance including those detailed within the following non-exhaustive list as may exist or come into effect from time to time:

- National Service Model (2015)
- Building The Right Support (2015)
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline Published: 1 December 2015
- CQC (Care Quality Commission) New Standards (2014)
- Positive and Proactive Care, Department of Health (2014)
- The Care Act (2014)
- REACH: Support for living an ordinary life: Service review – Pavilion Publishing and Media Ltd and its licensors 2013
- Raising our Sights Mansell Report: services for adults with profound intellectual and multiple disabilities DoH (2010)
- Dignity in Care (2010)
- Equality Act (Oct 2010)
- The Autism Act 2009
- Care Quality Commission (Registration) Regulations (2009)
- The NHS Constitution – The NHS belongs to us all (2009)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 2012
- High Quality Care for All (2008)
- Our Health, Our Care, Our Say (2006)
- Mental Capacity Act (2005) and the associated Deprivation of Liberty Safeguards
- Mental Health Act -1983 and 2007
- Human Rights Act 1998
- NICE (National Institute for Health and Care Excellence) Guidance, Guidelines and Standards
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline Published: 1 December 2015
- Annual NHS Operating Framework.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

7. Individual Service User Placement

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate