Somerset Council

Service Specification: Supported Living

April 2024

Document ownership:

Document Owner:	George Bray
Document Author:	Ami Bestall

Version Control:

Version	*Date*	*Description*	*Author*
0.1	21.06.2023	First Draft	Ami Bestall
0.2	10.01.2024	Second Draft	George Bray

Contents

1 Introduction

1.1 This document sets out the service specification, outcomes and standards which apply to the provision of **Supported Living** services to individuals in receipt of services (**Individuals**) purchased by Somerset Council (**SC** or the **Council)** which are delivered to Individuals by the **Provider**.

1.2 This document will be read in conjunction with:
- The contract and its appendices and schedules
- The Generic Specification

1.3 It is a statutory requirement that all Providers of regulated care services for adults are registered with the Care Quality Commission (CQC). Therefore, the regulations required for registration (and their associated standards), and the monitoring of the achievement of those regulations and standards (including any training requirements), are not duplicated in this specification.

1.4 This Service Specification reflects national policy advice and guidance and sets out the philosophy and standards to be adhered to by Providers in the provision of Supported Living and Domiciliary Care services.

2 Scope

2.1 The Care Act 2014 defines supported living as;

"supported living accommodation" means—

(a)accommodation in premises which are specifically designed or adapted for occupation by adults with needs for care and support to enable them to live as independently as possible; and

(b)accommodation which is provided—

(i)in premises which are intended for occupation by adults with needs for care and support (whether or not the premises are specifically designed or adapted for that purpose); and

(ii)in circumstances in which personal care is available if required.

2.2 The CQC definitions of Supported Living and Domiciliary Care are as follows[1]:
Supported Living: (As per CQC Definition.)
By supported living we mean schemes that provide personal care to people as part of the support that they need to live in their own homes. The personal care is provided under separate contractual arrangements to those for the person's housing. The accommodation is often shared but can be single household. Supported living providers that do not provide the regulated activity 'Personal care' are not required by law to register with CQC.

2.3 CQC additional supported living summary;
"These services involve a person living in their own home and receiving care and/or support in order to promote their independence. The care they receive is

regulated by the Care Quality Commission, but the accommodation is not. The support that people receive is continuous but is tailored to their individual needs. It aims to enable the person to be as autonomous and independent as possible, and usually involves social support rather than medical care."

2.4 Under certain configurations, where the ultimate owner of the accommodation is also the owner of the organisation providing Personal Care to the Individual, there is a risk of a service being found to be operating as an unregistered Residential Care home by CQC. It is therefore essential that, where there is any doubt whatsoever, the Provider obtains and retains **written** advice from CQC, and that this is made available to the Council on request.

2.5 This Specification does NOT encompass the Individual's relationship with their landlord, where they are a tenant. Where the Individual has a tenancy and an assessed eligible need that meets the National Minimum Eligibility Threshold for support to manage it (including arranging and/or carrying out day to day domestic tasks), this will be included in the Care and Support Plan provided by the Council and/or an organisation authorised to act on its behalf when referring the Individual to the service.

2.6 The Provider will provide care and/or support to Individuals in their homes, including buildings with communal areas in which Individuals have tenancies as part of a Supported Living service (the **Supported Living property**). Where included in an Individual's care and support plan this may include supporting Individuals to carry out and/or arrange for domestic tasks to be undertaken. However, Staff will not undertake domestic tasks on behalf of Individuals unless the task:

a. Has been identified as an assessed eligible need that meets the National Minimum Eligibility Threshold and has been included on the Purchase Order and/or within the Individual's Care and Support Plan by the Council and/or an organisation authorised to act on its behalf; or
b. Directly relates to a care task; for example, cleaning a bathroom after use where an Individual is not able to do so themselves; or
c. Directly relates Health and Safely and/or infection control; for example, assisting an Individual with laundry tasks where they are incontinent or vomiting, or in a kitchen area where an Individual is not able to do so themselves to an appropriate level of hygiene and/or safely handle hot and/or sharp utensils.

2.7 Where Individuals have shared use of communal areas, they will be responsible, as a group, for either carrying out these tasks themselves or making arrangements for them to be carried out on their behalf. Where identified as an assessed, eligible, need and included in an Individual's Care and Support Plan the Provider may support them to either carry out these tasks themselves or make arrangements for them to be carried out on their behalf.

2.8 **Shared / Background Hours**

Somerset Council considers Shared / Background / Core / Pooled hours (as they may be referred to by different providers) to be the minimum staffing support provided to continuously meet the needs of the individual(s) accommodated within the specified accommodation. This is a care and support provision in situ, which is to actively support people who may not have any designated 1:1 support; e.g. 4 persons sharing accommodation, none of which require 1:1 support as an individual, therefore shared hours are 15 hours per day. This shared support is active support for individuals and shared across the total number of people living within the accommodation. *The volume of shared hours will vary depending on the size of the supported living service and the types of need that it supports, and details must be provided to the Referrer in advance of the placement being made and at the time of every review*

Where the Individual 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 where for whatever reason the Individual 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.

2.9 **1:1 Support**

Somerset Council considers 1:1 support to be targeted, outcome focused and individualised support as identified within the individual's Care Act (2014) assessment and support plan. This support is identified to achieve a specific outcome or goal that the referrer has identified cannot be achieved through shared support and will be stated within the individual's Care and Support Plan. Care providers will not seek to enforce minimum levels of 1:1 hours or any other arbitrary figure as it must be based on the care and support plan. 1:1 support requires evidence to identify why targeted support is required; e.g. SALT, risk reduction plans, risk assessment, moving and handling (OT assessment), PBS plans.

3 Service Standards

3.1 The Service Standards that SC wishes all Supported Living services to achieve, are that:

- Services are outward looking and engaged in their local communities, enabling people to be included how, where and when they want to be.
- Individuals have personal privacy within their home and are supported to exercise that privacy in a way that is safe but right for them.
- Individual's personal possessions are respected, and they are able to exercise choice and control over how their space is decorated/furnished.
- Individuals in shared provisions are supported to work together to ensure that communal spaces are used and decorated to meet all Individuals needs/wishes.
- With Individual consent, the Provider works in partnership with the Referrer and health services to ensure Individuals' needs are met.

- All staff will recognise that this is a person's home, NOT a workplace and will always be respectful towards Individuals' homes and living environments, treating them in the same way as any other person's private space.
- The Provider will work across the wider provider community to learn from others around good practice and share any barriers, resolutions to enable a peer support approach across providers.
- The Provider is able to show Individuals that they are responsive to comments and prepared to learn from both compliments and complaints to improve everybody's experiences.
- Individuals are supported to exercise their right to choose who supports them and are actively engaged in recruiting their own staff team.

4 Service Outcomes

4.1 The Outcomes that SC wishes all Supported Living services to achieve, are that Individuals are enabled to:

a. Be fully and truly involved in their local communities. Advocating that Individuals access opportunities that are not attached to a diagnosis and supporting community resources to enable reasonable adjustments to support people to be able to attend.
b. Choose who they live with and who they invite into their home, in the same way as any other person.
c. Access transport which meets their needs. Through public transport, mobility vehicles etc.
d. Choose to move on from shared supported living provisions to independent living in the community if they so wish. Understanding what options are available, such as Homefinder or Affordable Housing options.
e. Maintain their skills, and develop new ones, in the areas that they want to.
f. Try new things, pursue leisure interests, participate in physical and mental activity and access community resources if they want to
g. Choose how to dress, what to eat and when, where to go shopping, what to do and when to do it.
h. Supported to have real friendships and relationships, that are not based on having a similar diagnosis or live in the same house. Individuals will be supported to seek and maintain friendships based on shared values and interests and be supported to maintain these how the Individual wishes to.
i. Any additional outcomes contained in the Individuals Care and Support Plan.

4.2 The Services will be provided in and from the Individual's home to support them with aspects of their life as described in their Care and Support Plan.

4.3 The types of support that the Council wishes to Commission are:

a. Personal care and support to meet an Individual's assessed eligible needs that meet the National Minimum Eligibility Threshold
b. Practical daily support to maintain and/or promote the Individual's independence.
c. Practical daily support to help Individuals to remain safe and secure in their homes.
d. Support to help Individuals to engage in their local communities and to participate fully in activities.

e. Support to maintain a tenancy, including reporting problems to the landlord.
f. Engage in assistive technology initiatives that will support to maintain or increase Individuals independence.
g. Any other types of care and/or support identified for provision by the Provider in the Individual's Care and Support Plan.

5 Accessing Services

5.1 Somerset Council, or an organisation authorised to act on its behalf (the Referrer) will make the initial referral to the Provider.

5.2 Services will be accessed through The Sourcing Care service. The Sourcing Care Service will ensure that opportunities of Individuals seeking supported living services are shared with all providers signed up to the framework.

5.3 Somerset Council will be utilising the iESE Care Cubed function (or any such system as replaces it) to benchmark costs based on national and regional data. Package costs will be put through this function to ensure that there is a fairness and transparency of cost across the market.

5.4 The Provider will arrange an introductory visit for each prospective Individual and, with their consent, their Carer and/or their representative(s) and/or Referrer in order to support planning and decision making. A Person-Centred Transition Plan will be agreed to support the Individual to move in the best possible way and to assist the Provider with arranging the appropriate services to meet the Individual's needs.

Times of the Service

5.5 The service must be available seven days a week between the hours of 7am and 10pm, and where night-time needs have been identified, between 10pm and 7am. The times of delivery should be agreed between the Provider and the Individual as part of the daily care planning.

5.6 Somerset Council will consider if a task is needed at a specific time, such as the need to be ready for a hospital appointment or the need to take medication at an exact time. Such tasks will be deemed to be 'time critical'.

5.7 If an Individual is assessed by Somerset Council as being 'time critical' this will clearly be identified in the Care and Support Plan and the service will be delivered within 10 minutes either side of the specified time.

5.8 Where care is not 'time critical' there is an acceptable tolerance for Providers to arrive to a scheduled visit either 30 minutes early or late, of the specified time, unless separately agreed between the Individual and Provider.

Out of Hours

5.9 The Provider must ensure that outside of normal office opening hours, that there is a dedicated responsible person(s) with sufficient knowledge and training to be a point of contact for enquiries and emergencies. The Provider will ensure the out of hours contact service has telephone and email capabilities as a minimum. The out of hours contact details must be clearly communicated to those who may need to use them.

6 Service Provision

6.1 The service will be deliverable 24 hours a day, 365/6 days per year, including Bank and Public Holidays. Care and/or support will be available to Individuals continuously but tailored to meet their individual needs. The service is individually planned and managed so that the parts of individual Individuals Care and Support plan the Provider is responsible for are met.

6.2 The Provider will ensure that a copy of the Individual's Person-Centred Plan is held by the Individual. The Provider will ensure that the Individual is aware of where their Plan is stored and that it is available to them at any time. Where an Individual requests a change to their support this is discussed and accommodated as appropriate.

6.3 The Provider will provide sufficient staffing to provide a safe, quality service to meet the assessed eligible needs of Individuals as required over a 24-hour period, to include either sleep-in or waking night staff if identified as an eligible need in the Individual's Care and Support Plan.

6.4 Staff working in Individual's homes will always acknowledge that the home belongs to the Individual(s) living there and follow all the usual courtesies when visiting a home belonging to someone else; for example, knocking and not entering the house/room before being invited in, waiting to be asked if they would like a drink, asking if they need to use the toilet etc.

6.5 Individuals and their representatives will be addressed by the name they prefer.

6.6 The Provider will ensure that staff take due care with all Individual's possessions.

6.7 The Provider must make good any loss or damage to an Individual's possessions that is caused by the negligence of the Provider's staff.

6.8 The Provider will ensure the provision of a management on-call service during evenings, weekends, and Bank Holidays to support their staff teams with the provision of out of hours advice to ensure a safe and responsive service. This

will include ensuring that there are contingency plans in place should any staff shortages arise, and cover need to be sought.

6.9 The Provider will work flexibly and collaboratively with other providers and/or volunteers, where Individuals receive support from more than one organisation, or type of service, in order to meet their needs and outcomes. The Provider will ensure that any information that is shared is done following GDPR guidelines and the Individuals permission.

6.10 The Provider will ensure that, where it is providing a service to meet the needs of people with complex health and/or physical needs, following discussion with the Individual and the provision of information, advice and assessment as required[2], all necessary equipment is available. The Provider will ensure that all required training is undertaken and done in conjunction with the relevant health professionals. Where any doubt lies, The Provider will ensure that they seek out appropriate advice and guidance.

6.11 The Provider will consult with Individuals about any changes in the delivery of their care and/or support that affects them, for example, a staffing change or change in time arranged to provide support and give reasonable notice where changes are unavoidable.

6.12 The Provider will ensure that staff teams and changes are communicated with the Individual in a way that meets their communication needs.

6.13 The Provider will provide care and/or support that meets the individual needs of each Individual detailed in their Care and Support Plan through their Person-Centred Plan. Each Individual's needs will be different, but the types of care and/or support provided may include, where appropriate, enabling and supporting Individuals to:

a. Participate in all aspects of daily life, including meal preparation, personal care and meeting their day-to-day needs
b. Make use of technology to enhance their lives.
c. Access up to date information on, and participate in, activities and opportunities in the community of their choice, that are not diagnosis led.
d. Try new things including education, volunteering, sports, leisure and work. This may include supporting Individuals to make contact with services and organisations to request that reasonable adjustments are made to accommodate their needs.
e. Participate in opportunities for peer support and social opportunities outside of their homes to increase their social networks in which ever capacity the Individual chooses. This may include platonic or romantic relationships or supporting Individuals to explore their sexuality, including accessing sexual health services.
f. Access advice and assessment in relation to equipment, home adaptations and telecare.

6.14 Where an Individual and/or their representative agrees, and it is recorded in their Person-Centred Plan, the Provider may be given a key or entry code to an Individual's home. Providers must ensure that:

a. Appropriate measures are taken to prevent loss, misuse, or theft of the code.
b. Staff access to Individuals' homes is at a minimum and only when an Individual requires care and/or support, or by their invitation.

6.15 The Provider will not:

a. Install, or operate from, offices within the Supported Living property or its grounds without the permission of **all** the Individuals living there.
b. Install any office equipment within a Supported living property without the permission of **all** Individuals living there.

Where an Individual is not assessed as having capacity to make this decision or does not have a representative that is independent of the Provider, then discussions with Individuals on the above will be supported by an Independent Advocate, which the Provider will be responsible for paying **all** charges in relation to.

6.15 Where Individuals agree to offices being sited in the properties they rent, the Provider will pay the rental for the room and all associated costs of running the office, including all equipment and a contribution to utility costs. However, the use of Information Communication Technology to manage and store written documentation relating to Individuals, and the running of the service on their behalf (where required), must always be the default option before an on-site office is considered.

6.16 Where installation of equipment affects the fabric of the building or furnishings, the Provider will seek permission from the landlord and will be responsible for returning the building to its original condition on removal of the equipment and/or if the service is transferred to another provider, unless a written agreement is made between all parties for the responsibility to pass to the new provider.

6.17 The Provider must ensure that staff do not display, within the Supported Living property and its boundaries (with the exception of any dedicated office space), any notices or documentation that relates to the operational management and function of the service or for the collective or personal use of staff.

6.19 In Supported Living properties, where some or all facilities are shared between a number of Individuals, the Provider will, jointly and in consultation with the landlord, ensure that each Individual is given the opportunity to choose their room from those that are available.

7 Personalised Care and Support and Promoting Independence

7.1 The Provider will ensure that all planning of care and support follows the ethos of person-centred statements lead by the Individual, these could be but are not limited to:

a. 'I am trusted to write and/or contribute to my own care and support plan.'
b. 'My care and support plan is based on my whole life, ambitions and wishes; not just my assessed care needs.'
c. 'I am encouraged to be creative and innovative about how I achieve the things I wish to in my life.'
d. 'I can choose who is involved in my care and support, such as family and friends: along with how they are involved.'
e. 'I am supported to have relationships of my choice, this may include looking for a romantic partner, accessing sexual advice or health care or explore my sexuality.'
f. 'I am supported to take risks, change my mind and know that it is ok if I make mistakes.'
g. 'I have all the right information to plan my own support and know where to get additional support if I need it.'
h. 'People do what they say they are going to, and ensure transparency if things need to change.'
i. 'I will have an appointed Key worker that will be my main point of contact if have questions or queries about my support.'
j. 'I will be supported to maintain contact with my friends and family in the most effective way for me. This may mean using communication books or technology such as facetime to help me.'
k. 'Where I receive personal care from my support team, this will be done with respect and dignity at all times. Intimate personal care must always be with staff that I am most comfortable with, takin into account cultural requirements and gender sensitivities.'

7.2 The Provider will ensure that all staff working with the Individual engages in principles around Personalised Care and Support, including but not limited to:

a. Capacity should be assumed at all times until it is confirmed that the Individual does not. Mental Capacity Act (2015) will be followed at all times to ensure that the Individual is empowered to make their own decisions where they are able to. Where an Individual does not have capacity, the Provider will ensure permissions are sought around any specific decisions.
b. Everyone involved in the planning process for the Individual must know their role, understand the process and what to expect from personalised support planning.
c. Plans should be driven by early interventions and solutions focussed approaches. Plans should be shared and owned by all sectors of the system: social care, health, the Provider, the Individual and their informal support networks.
d. No plan should be set in motion until the Individual has had input into the plan and the outcomes that they wish to achieve implemented.

e. All plans should be shared across the whole system, ideally removing, but at best significantly reducing the need for the Individual to have to retell their story to a multitude of professionals. Information sharing should be with the Individuals consent & following GDPR guidelines.
f. Care and support planning is continuous and evolving and plans should not be a static document.
g. All support planning should be proportionate to the needs of the Individual. Every Individual will have individual needs that vary in level of support required, including throughout their own lifetime.
h. An Individual's Care and Support plan should be a lifetime document that is future focussed and supports (as much as possible) a seamless transition into changing phases of the Individuals life. For example, long term conditions, preparing for age related support needs or recovery models of support.
i. Documents are owned by the Individual. They have access to any and all documents and these will be in a communication format appropriate to their need.
j. The Individual should see the minimum amount of professionals as possible and understand the role each person plays in their care and support.
k. Where the Individual has a personal budget, they have autonomy of how this is spent and used to meet their outcomes.
l. The Provider will ensure proactive and responsive communication between themselves and the Individual and their family. Where Individuals have complex communication needs and are unable to speak for themselves the use of additional ways of providing communication to families should be considered, for example, communication books, emails and use of tablet computers.
m. The Provider will support Individuals to seek the support of the Council, and/or an organisation authorised to act on its behalf and/or NHS services, to provide specialist advice and assessment when required, for example, support from a speech and language therapist or from clinicians who deal with specific health conditions, including epilepsy.

7.3 The Provider will ensure:

a. Consistency of staffing will be maintained, and the introduction of ad hoc staff will be minimised. Where staff outside of the regular team is required, the Provider will communicate this to the Individual in a manner that is appropriate to them.
b. That the Individual is actively involved in recruiting their own staff team and where permanent changes are made the Individual will be consulted.
c. That introduction of new staff is conducted in a person-centred way that meets the need of the Individual. This may include transition planning before any initial introduction.
d. Where an Individual's choice of staff cannot be followed, an explanation will be given to the Individual in a way that meets their communication needs.

7.4 The Provider will enable Individuals to undertake tasks with the aim of maximising independence and/or maintaining skills. These could include, but not be limited to:

a. Personal care and dressing
b. Preparing food and drink preparation
c. Shopping
d. Laundry
e. Social, educational, and recreational activities in the community
f. Managing relationships with other people
g. Managing personal correspondence and finances
h. Planning for the future.
i. Any other activities that support the Individual to increase or maintain their independence.

7.5 Choice and control: Individuals will be supported to ensure maximum choice and control over all elements of their lives, including but not limited to:

a. Timetable of the individual's day to day life, such as when they go to bed, what they wear, what they eat, how they see friends or family.
b. Individuals being able to participate in activities at all times, including evenings and weekends.
c. Health appointments are conducted as the Individual wishes, privacy of these appointments being dictated by the Individual.
d. The Individual will, where they have capacity, have autonomy over their finances including how they spend their money and recognising that Individuals may make, what others deem, unwise decisions around their finances. The Provider should support and signpost to appropriate services where additional financial support is required.
e. Where there is a share care/core hours element of the provision, the amount will be the minimum necessary to meet the needs of the Individuals but that there is as much control over their care and support as possible.

8 Moving Home

8.1 Where an Individual chooses to initiate a move to a different property, the Provider will, if required, support the Individual to inform the Referrer so that a review can be arranged and/or continuity of service can be maintained.

8.2 Where support to manage a tenancy has been identified in the Individual's Care and Support Plan and included on the Purchase Order, the Provider will support the Individual to perform the necessary tasks to end their current tenancy and, if required, take on a new tenancy.

8.3 The Provider **will not** initiate or arrange for an Individual to move to an alternative service, for example Residential Care, or to a different tenancy within the same Supported Living Property, without the express consent of the Individual and (if moving to a different tenancy within the same Supported Living Property) the landlord, and where appropriate their Carer and/or representative, supported by an Independent Advocate where required **and** the Council and/or an organisation authorised to act on its behalf, which will

be reasonable for any Best Interest Assessment that may be required **before** the move takes place.

8.4 If the move has been initiated by the Provider, for example due to service closing, then the Provider will be expected to meet some or **all** of the costs associated with the move for that individual; however, in all other circumstances the Individual will be responsible for meeting the costs.

8.5 The Real Tenancy Test - NDTi

9 Meeting Health Needs

9.1 The Provider will, wherever possible, encourage and support Individuals to manage their own health conditions.

9.2 Where applicable, the Provider will provide care and/or support that enables Individuals to meet their health needs, as detailed in their Care and Support Plan, thorough their Person-Centred Plan. This may include:

a. Enabling Individuals to register with a General Practitioner (GP) and dentist of their choice, subject to the practitioners accepting the Individual.
b. Enabling access to all relevant health screening opportunities.
c. Enabling access to regular check-ups with dentists, opticians, chiropodists etc.
d. Enabling Individuals to have an Annual Health Check with their GP, should they wish to, that results in a Health Action Plan detailing health improvement actions for the next 12 months.
e. Identifying any barriers that make it difficult for an Individual to access NHS services and agreeing any actions/reasonable adjustments required with the Individual and, with their permission, their representative or advocate, and documenting them in their Person-Centred Plan and Hospital Passport.
f. Accompanying the Individual to appointments if required and only where the Individual consents for them to do so.
g. Enabling access to Independent Advocacy services, including Independent Mental Capacity Advocates, as required under the Mental Capacity Act 2005.
h. Enabling and/or facilitating access to accessible health related information.

9.2 Where Individuals have additional health needs and are in receipt of a specialist health assessment and advice the Provider must ensure that, where applicable, all staff providing care and/or support are aware of, and actively implement, any specialist health recommendations into the Individual's Person-Centred Plan

9.3 Where an Individual is admitted to Hospital, the Provider will ensure that the referrer is informed as well as their family and/or anyone who is important to them as soon as possible and within a maximum of 24 hours.

9.4 If an Individual is admitted to hospital, at the request of the Individual, the Provider may support the Individual for the commissioned amount of hours per day. Should the hospital request additional support, this should be discussed directly with the hospital and costings negotiated between the Provider and Hospital setting directly. Reference should be made in Somerset to the Musgrove Park Hospital Learning Disability Policy 2013 and the Yeovil District Hospital Learning Disability Protocol 2014.

9.5 Where applicable, the Provider will ensure that staff maintain good practice at all times in the control of infection (e.g. washing of hands when dealing with bodily functions, wearing of gloves etc.).

9.7 Where applicable, the Provider will ensure that staff are provided with adequate protective clothing and equipment, including (where necessary) disposable aprons, gloves, and appropriate polythene bags for the disposal of soiled clothes, dressings, linen, drugs, instruments, and other waste matter.

10 Individual Finances

10.1 Where applicable, the Provider will provide appropriate support to enable Individuals to manage their finances, as detailed in their Care and Support Plan, through their Person-Centred Plan. The Provider staff's role in supporting an individual to manage their personal finances should be detailed in their Person-Centred Plan. This may include:

a. Enabling Individuals who can, to manage their own finances to the maximum extent possible
b. Where required, supporting Individuals to pay their daily living expenses, for example, food, utilities, etc. through a budget agreed with the Individual and, with their agreement, their representative or independent advocate.
c. Supporting Individuals to make informed choices about what they spend their disposable income on and saving for larger purchases, holidays etc.
d. Where required and applicable, supporting the Individual to access Motability services.

11 Training

11.1 The Provider will ensure that they keep records of all staff training in line with CQC requirements and that they produce an Annual Training Plan detailing new and on-going training requirements in order to promote service quality and development.

11.2 The Generic Specification outlines the minimum staff training and induction standards expected.

11.3 In addition to any processes and procedures stated elsewhere in this document the Provider will ensure there are appropriate processes in place that are understood by staff and regularly reviewed for example:

a. The loss, misuse, or theft of any keys/keycode held by the Provider
b. If staff are unable to gain an answer from the Individual on attempting to provide care and/or support
c. Discovery of an accident to the Individual