**Exempt Providers of Supported Housing:**

**Quality Framework: Criteria and Guidance**

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**Introduction:**

* The Quality Framework (QF) is intended to be a self-assessment tool, to provide guidance, so that service provision is of high quality.
* The QF is not an exhaustive list of criteria; the expectation is that Providers continually strive to improve and innovate re: the quality of service provision, which may result in Providers adding additional quality criteria of their own.
* It is also a tool for Lewisham Council to assess the quality of Providers’ service provision.
* Providers will be required to complete the QF annually & submit the completed QF to Lewisham Council.

**Completion of the Quality Framework Self - Assessment:**

* Providers are being asked to:
* Self-assess the 8 QF criteria categories in the tables below;
* against 3 levels of quality: red, amber, green (RAG):
* **Green:** means excellence and is associated with providers striving to be leaders in their field.
* **Amber:** means the service can evidence good practice; and is striving for green.
* **Red**: the required minimum standard is not met and urgent improvements are needed.
* Your **QF self-assessment** needs to be completed on a different document, ie. **using the Lewisham Quality Framework – Self Assessment template**.
* The QF criteria below are to be considered when completing your self-assessment.
* However, Providers **are no longer being asked to individually RAG each of the individual QF criteria below**.
  + Instead, we are asking Providers to **give one overall QF self –assessment RAG for each of the 8 QF categories**. Therefore, once you have completed your QF self-assessment, you should have a total of 8 RAG ratings.

**Quality Framework Criteria:**

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| **1.0 Assessment; Needs Assessments; Support Planning; Risk Management and Keyworking**  **Key Criteria**  **Needs Assessments**   * Following the Service Users (SU) moving into the scheme/service start date, an initial assessment of the SU’s support needs is required within the first 3 days; this would need to accurately reflect the SU’s needs, including reflecting key documentation, eg. the SARF. * Once the initial assessment of need has taken place, there needs to be a system in place for monitoring & reviewing needs periodically, which is appropriate to the service. A specific needs assessment form can be used, or needs can be reviewed as part of ongoing support planning and risk assessment processes.   **Support Planning**   * A support plan to be completed within 7 days of the service start date; this is an initial support plan and does not need to be a full plan. * A full support plan to be completed within 28 days of the service start date. * Support plans to be reviewed at an appropriate frequency; at least once every 3 months. * Support plans to be completed with the SU; needs to clearly show the SU’s voice / involvement; the SU to be offered a copy. * Support plans to be person centred and include goals that are: SMART; reviewed at an appropriate frequency; holistic; reflect key support needs (eg. substance misuse; budgeting; ETE); reflect other key documents, eg. the risk assessment, needs assessment, CPA notes. * Key areas to be included in support planning include (this is not an exhaustive list): * Move on to be a key focus of support plans and needs to be one of the goals from the first full support plan until the SU moves on. * Self care and daily living skills: eg money management; cooking; medication management; coping mechanisms. * Managing tenancy and accommodation, e.g. paying rent/service charges; adhering to behaviour requirements. * Substance misuse. * Social networks and relationships, including cultural needs. * Emotional and mental health, e.g. support to access talking therapies. * Physical health, including healthy eating and physical exercise. * Meaningful use of time (eg.Education, Training, Employment [ETE]). * A period of up to 3 months resettlement support is provided to SUs moving to independent living. * SUs and staff will need ready access to details of local resources, eg. mental health resources (eg MIND); substance misuse treatment agencies; educational resources. * Staff are aware of relevant individuals in key agencies and can give examples of regular information sharing. * Staff are knowledgeable about and can facilitate access to support and services provided by other organisations that may meet the needs of clients. * SUs confirm how they have been supported to access a range of services to meet their diverse needs – both those provided by the organisation and those available through other providers. * Support delivery to include the integration of appropriate approaches, eg psychologically informed environments; trauma informed approach.   **Risk Management**   * An initial risk assessment to be completed before the service start date; as this is an initial risk assessment, it does not need to be a full assessment, but will need to include key factors. * A full risk assessment to be completed within 3 days of the service start date. * Risk assessments to be monitored and reviewed at an appropriate frequency; reviews to take place at least once every 3 months. * SUs need to be involved in the process of drawing up the risk assessment (there can be instances where this is not appropriate re: aspects of the risk assessment); the SU to be offered a copy. * Risk assessments need to identify: risks & level of risks, triggers/signs and a management plan; the management plan to be implemented. * Risk assessments to promote positive risk taking; actions to be in place to ensure that the risks are as small as possible. * The risk assessment to reflect other key documents, eg. the support plan, needs assessment, CPA notes. * All staff need to have regular training on administering Naloxone and SU should be encouraged to attend training and carry Naloxone in case of overdose.   **Key Working**   * Key work meetings to take place at a frequency appropriate to the service & SU. For many services, this will be at least once per week. * Key points need to be documented; topics discussed to reflect support planning and risk management processes.   **Cross Cutting**   * Needs and risk assessments, support plans and reviews seek to involve other professionals, carers, family and/or friends, as appropriate. * There is evidence of SU’s views being incorporated, eg. SUs confirm that their views have been listened to and taken into account. * Needs and risk assessment and support planning procedures balance respect for clients’ views, preferences and aspirations with effective risk management. * Staff are able to describe the assessment and support planning processes and the rationale behind the key elements. * All SUs will need to sign a consent form which is in line with GDPR requirements; which allows Lewisham Council to inspect appropriate SU personal information. |
| **2.0 Security, Health and Safety**  **Key Criteria**   * There needs to be in place a Health & Safety policy which is reviewed at an appropriate frequency and at least once per year.   **Maintenance / Physical Environment Related**   * H&S practices and policies need to be in line with the relevant H&S legislation. * Providers will need to have a system in place which: * Lists all of the H&S activities required (i.e. carried out by internal staff and by external contractors) * ensures that all H&S activities required are monitored & reviewed. * Identifies: * how often the H&S activity needs to take place; * when it was last completed; * details of any follow up work needed; * details of progress re: the follow up work needed; * when the H&S activity is next due. * H&S activities undertaken need to be clearly documented. * Even if the Provider is responsible for a support only service (eg. in situations where the landlord is responsible for housing management activities); the support provider still has a role to ensure that all required H&S activities are carried out as required, to ensure the safety of SUs and staff. * Examples of H&S activities include (please note: this list is not exhaustive): * SUs having clear information regarding emergency out of hours arrangements with regards to: * emergency repairs & maintenance; * contacting the emergency services (police; ambulance; London Fire Brigade) * other emergency situations, eg. support related issues. * In line with The Regulatory Reform (Fire Safety) Order 2005 a current fire risk assessment is required. * Fire alarm & detection systems, regular servicing and testing, including: * Weekly testing of fire alarm & detection systems must be carried out. The alarm must be activated via a different fire call point each week. Call points should be numbered or colour coded. A schedule must be put in place thus ensuring all call points are tested over a said period of time. * All testing must be logged in the relevant fire log book. Any remedial actions required to be actioned and noted in log book. * Fire equipment, regular servicing and testing, e.g. fire doors; fire retardant furniture, including: * Firefighting equipment must be regularly serviced and tested in line with manufacturer’s instructions. All findings must be noted and remedial actions if required taken. * Final exit fire doors should be tested weekly to ensure they are fully operational and no hazards are present that could hinder their safe use. This must be documented. * All furniture and furnishing must meet the legislation as laid out in the Furniture and Furnishing (Fire Safety) Regulations 1988 (as amended in 1989,1993 and 2010) * Fire Drills: all establishments should have a minimum of two full planned evacuations each year. These must be logged in fire log book and any actions/concerns raised must be acted upon and rectified. * Fire evacuation policy and practices, including personal emergency evacuation plans (PEEP) and fire exit signage, including: * All persons should be made aware of the Fire evacuation procedures/policy and practices. These may need reviewing following evacuations and changes in legislation. * Personal Emergency Evacuation Plan (Peep). This is an individual plan for any persons using the premises who has an impairment or disability that could hinder their safe evacuation from the building, such as: mobility impairment, sight or hearing loss; that may mean that these persons require extra assistance to evacuate the premises. * Legionella Risk Assessment & testing: It is a legal duty to identify and assess whether there is a risk posed by exposure to legionella from hot or cold water systems. * Regular H&S checks of communal areas and SUs’ rooms to be completed & appropriate follow up work monitored and carried out eg. risk assessments for people who hoard; risky behaviour including smoking; drug taking and the paraphernalia (eg. sharps); knives/weapons that are associated with such behaviours. * Regular assessments of risk regarding SUs & staff regarding the physical environment of the scheme. * Risk Assessments must be relevant/current/monitored & reviewed in line with changes in legislation or, following an incident/accident. * There needs to be a business continuity plan in place for dealing with significant disruptions to the service. This should be reviewed as a minimum yearly or sooner if circumstances/procedures change. The plan should ensure that personnel and assets are protected and able to function quickly in the event of a disaster. * SUs are given the opportunity to be involved in H&S activities, which record their participation.   **H&S Compliance Schedule**  The H&S compliance schedule details the key health and safety and related activities that Providers are required to undertake, i.e. in accordance with the relevant legislation, contractual requirements & your own H&S policy requirements.  Providers are required to complete this schedule, i.e. the version that is in the Quality Framework Self-Assessment document. Providers will need to be able to evidence to Lewisham that these activities have been completed; also, that any follow up work required has been completed or is in hand.  H&S Compliance Schedule:   |  | | --- | | **H&S activities** | | **Inspection & Testing** | | Walkabout Inspection (Communal area) | | Periodic Compliance Check | | Room Inspections | | Fire Drills | | Breakpoint Testing | | Magnetic Lock Testing | | Fire Curtain / Smoke Vent Testing | | Fire Extinguisher Inspection | | Emergency Light Testing | | H&S First Aid Supplies | | Communal Fire Doors | | Secured Emergency Exit Fire Doors | | All Fire Doors | | Inspections for building defects / physical defects / structural issues (including external to the main building, e.g. boundary walls / fences.) This may be a landlords, or equivalent, health & safety / building survey or you may have alternative arrangements in place re: this. | | **Risk Assessments** | | General Risk Assessment | | Fire Risk Assessment | | Business Continuity Plan | | Personal Safety / Lone Working Risk Assessment | | COSHH Risk Assessment | | Asbestos Survey | | Legionnaires Risk Assessment | | Event & Activity Risk Assessment | | **Servicing** | | Fire Alarm Servicing | | Emergency Light Service | | Extinguisher Servicing | | Gas Safety Servicing | | Air Conditioning Servicing | | Hard Wire Testing | | Water Hygiene Testing | | PAT Testing | | **Other** | | **Annually** provide proof of the following insurances: public liability insurance; employer's liability insurance;professional indemnity insurance | | **Annually** provide a copy of the housing management agreement between the support provider and landlord. |   **Non Maintenance / Non Physical Environment Related Issues**  Examples of H&S activities include the following (please note: this list is not exhaustive):   * Welfare checks on SUs. * Missing person policy and practices. * Serious incident policy and practices * Policies and practices for addressing SUs behaviour which is not in keeping with tenancy and support agreements, e.g. behavioural contracts; temporary exclusion policy. * Lone working policy & practices that minimises the risks to people working alone and to SUs. * Visitors policy & practices. * It’s important that SUs feel safe where they live; this is a key priority for Providers, e.g. provision of CCTV.   **Additional Criteria**  Examples of H&S activities include (this list is not exhaustive):   * Staff are able to describe the health and safety procedures and the impact on their work. * SUs confirm they are aware of the health and safety procedures. * There is a range of information provided to clients about health and safety within the service. |
| **3.0 Safeguarding Vulnerable Adults and Young People**  **Key Criteria**   * Managers carry out reviews to monitor quality of safeguarding concerns raised to identify trends and themes to improve practice. * Services have a self-assessment tool which is used periodically to review local safeguarding practices. * The service has a nominated designated safeguarding lead who leads on the safeguarding agenda. * The service has a live database which reflects local safeguarding data. * The service can evidence strong person centred methods to communicate safeguarding to clients. * Staff and volunteers are provided with the most recent and up to date safeguarding training which is refreshed within three years. * Staff have regular meetings where they can share their views and wishes relating to challenging cases and safeguarding concerns such as reflective practice. * Risk assessments are well balanced between safety and wellbeing. * All staff including volunteers have an in-date DBS check. * There is evidence that the service is using a multi-agency approach to address complex cases and safeguarding concerns. * The service has in place robust policies and procedures for safeguarding and protecting vulnerable adults, young people and children in line with current legislation. * Services should have a proactive and embedded safeguarding system able to respond at all levels within the local safeguarding system, with particular importance shown to preventing abuse occurring, through the use of early intervention. * Staff / services to demonstrate a clear understanding of: * what safeguarding is. * how to identify the signs of abuse. * how to escalate safeguarding concerns (including local whistleblowing procedures), LBL Lewisham MASH; SLaM’s safeguarding team). * how to support a SU who is at risk; including ensuring appropriate safeguards are in place. This includes partnership working with other relevant professionals, eg. SLaM; LBL Serious Violence Team; VAWG services; MARAC; MAPPA; substance misuse treatment services. * Staff are made aware of and understand their professional boundaries and their practice reflects this; staff are able to explain how their practice maintains effective boundaries. * Service users need to have clear information about: * what safeguarding is. * what to do if they think they or other SUs are being abused. * The service to promote the safeguarding agenda with SUs on a regular basis through creative methods such as: newsletters, workshops, SU training, welcome packs and resident meetings. |
| **4.0 Fair Access, Diversity and Inclusion**  **Key Criteria**   * Policies and practices cover:   + equal opportunity, diversity, anti-discriminatory practice and harassment.   + discrimination on any grounds that cause a person to be treated with injustice. All persons to be treated equally or similarly and not disadvantaged by prejudices or bias.   + SUs and staff.   + access to services and employment.   + and promote community cohesion and social inclusion.   + hate crimes and hate incidents (HCAHIs). * The policies and procedures have been reviewed in the last three years and are in accordance with current equalities legislation and codes of practice. * There is an effective and proactive, co-ordinated multi-agency approach to preventing and challenging bullying, harassment, discrimination and HCAHIs. * The service to raise staff and SUs’ awareness by promoting a zero tolerance approach to HCAHIs (i.e. where all HCAHIs are challenged and appropriate follow up action/s are taken). * Staff to have a good knowledge of the resources available (both internal and external to the service) which may be able to offer advice and / or support to victims of HCAHIs, eg. Stop Hate UK’s Lewisham page: [https://www.stophateuk.org/london-borough-of-lewisham/](https://urldefense.com/v3/__https:/www.stophateuk.org/london-borough-of-lewisham/__;!!CVb4j_0G!EpVxjqWs098rusmPGfS2IgRztOt6wwF9OB2hWvlqD9WPp9YhIqp1ZHN3ZnKpAWIDIzqVPTzBnXA$) * All HCAHIs to be reported to Stop Hate UK, i.e. in line with GDPR requirements (eg. consent). * Fair access, fair exit, diversity and inclusion are embedded within the culture of the service and there is demonstrable promotion and implementation of the policies. * Staff are able to describe the policies and procedures, the principles behind them and the implications for their work. * Staff understand and are sensitive to the diverse needs of clients. * SUs confirm that they are supported to meet their cultural needs and are able to observe their religious and cultural customs. * The eligibility criteria, means of prioritising applications and the application process are written in plain English and other formats appropriate to the client group. * The communication needs of clients are catered for in helping them to understand the information, eg. this may include the use of interpreters. |
| **5.0 SU Involvement and Empowerment**  **Key Criteria**   * Providers to have a SU Involvement Policy and action plan, which are reviewed at an appropriate frequency and as a minimum yearly - SUs to feed into both of these documents. * Providers to have an allocated budget for SU involvement activities. * Staff and SUs to work in partnership to decide on how the SU involvement budget is spent. * SUs have opportunities to play an active role in shaping current and future service delivery; decision-making mechanisms facilitate SUI. * Formal and/or informal consultation takes place and proposals are developed or amended where possible in the light of SU feedback. * SUs are offered a range of opportunities to give their views, make comments, and offer ideas - both individually and in groups - about the services provided. * Appropriate support is available to enable SUs with different needs to be consulted & involved (eg. travel expenses, signing). * Times, dates, agendas/minutes and venues of meetings (eg residents meetings) / training to be given in advance with sufficient notice. * Services to encourage a culture that encourages SUs to ask questions and make appropriate challenges, eg.during residents’ meetings. * Services to undertake regular SU feedback / satisfaction surveys - as a minimum annually regarding the effectiveness of key aspects of service provision, eg. support planning; risk assessment processes; H&S; safeguarding; equalities; SU empowerment. * Providers to analyse the results of the SU feedback / satisfaction surveys; to identify & complete follow up actions, eg. this could feed into an annual service workplan. * Policy and procedure review of key policies and procedures to show the impact of SU involvement. * SUs are involved appropriately and effectively in such activities as:   + staff recruitment.   + business planning.   + review of the service description and its aims and objectives.   + management structures eg. board of management, sub-committees, AGMs; regional management meetings. * SUs to receive an induction / welcome pack which includes key information regarding the services and local resources, eg. complaints procedure; safeguarding; SU involvement opportunities. * SU involvement to be included in inductions to new service users. * Independence and self confidence is promoted through access to appropriate activities & resources (both internal & external to the service) & the service provider provides appropriate support to enable this; eg. cookery classes; other creative & leisure activities (eg art; music; drama; physical exercise); training, education and employment, counselling, advocacy, equipment and services relevant to individual needs, such as computer/ internet access provided to SUs at schemes. * SUs can provide examples of specific initiatives that have expanded their skills, confidence and self-esteem. * SUs are encouraged to play an active part in their local community and democratic structures, eg voting in local Councillor elections. * Providers to support and encourage service users to regularly meet to discuss service related matters, i.e without staff present and also with staff present. * Staff to attend SU only meetings on invite. * A room / appropriate meeting space to be provided for SU activities/ meetings. * Providers to support the SU’s group to elect a SU representative. There’s no requirement for SUs to elect a SU representative, i.e if this is SUs choice, however the opportunity / option to be available for SUs. * Providers to work in partnership with SUs to produce guidelines regarding what the role of SU representative involves. To include core main principles; plus the role to be adapted/tailored as appropriate to the service. * Providers & SUs to work in partnership to develop a SU representative training package, i.e which adequately prepares SU representatives for the role. * SU Group / representative/s to have the opportunity meet regularly (eg. monthly) with service manager. * SU representative/s to regularly (eg monthly) have the opportunity to attend part of staff team meetings. * SUs are offered opportunities to play a part in producing / sharing information, eg. newsletters; SU owned notice boards. * Providers to identify a SU lead staff member. Providers to have clear guidelines of what this role entails. * All relevant staff to receive training (ie not just the SU lead) to understand the value of service user involvement, at all levels. |
| **6.0 Complaints Policy and Procedure**  **Key Criteria**   * There is a written complaints policy and procedure that is reviewed yearly and following changes, at least every 3 years; this policy and procedure is used as a tool for service development. * The complaints procedure is as straightforward as possible. * A log records outcomes to complaints and shows that appropriate action is taken within required response times. * There is an escalation and appeals process. * The procedure is publicised in ways appropriate to the needs of the SU group eg. in SU induction or welcome packs, handbooks, notice boards, etc. * Staff, SUs and third parties know how to use the procedure and are empowered to do so. * SUs confirm that they feel able to complain and are confident that their complaint will be dealt with in a positive manner. * Independent advocacy is sought to help SUs, carers and family members to use the complaints system, where appropriate. * The organisation and its staff see complaints as a positive tool. * There is a periodic review (at least annual) of complaints received. * The service can demonstrate that reviews of policy, procedure and complaints received have been used to improve service delivery. |
| **7.0 Staff**  **Key Criteria**   * New staff to have a robust induction, which adequately prepares the staff for the role, eg. training to include relevant policies and procedures; shadowing established staff. This can typically involve a checklist of induction activities which need to be completed. * The staff induction should cover such areas as Evacuation Procedures, PEEPs, Personal Protective Equipment, Reporting of Accidents and Incidents, including verbal abuse from SUs or staff members. * Staff to attend mandatory training on key topics, eg. needs assessments; risk assessments; support planning; H&S; safeguarding; equalities; service user involvement and empowerment. * Staff to attend refresher training in line with your organisation’s policies procedures, eg. safeguarding; medication management. * Details of the training that staff have attended to be available to the Council for audit purposes. * Staff to have ongoing opportunities to attend non mandatory training, to enhance their skills, knowledge and professional development. * Staff to receive specialist training appropriate to the needs of the client group. * Staff to receive regular supervisions; these are to be documented. * Use of staff reflective practice sessions to be considered/take place, as appropriate. * Staff to demonstrate a high standard of knowledge regarding relevant/key policies, procedures & practices, eg. needs assessments; risk assessments; support planning; H&S; safeguarding; equalities; service user involvement and empowerment. |
| **8.0 Cross Cutting**  **Key Criteria**   * The service to continually strive to improve and innovate re: the quality of service provision; to deliver a high quality service; to be able to demonstrate improvements and innovations. * The vision for the service to be detailed in an annual service plan, which is SMART. * The service to undertake regular internal audits regarding service provision. * The service to comply with data protection / GDPR requirements. * Reviews of all key policies to take place at required frequencies, eg. H&S; safeguarding; equalities; SU involvement and empowerment. * Stakeholders and SU to be involved in reviews of service provision, policies, procedures and practices, as appropriate. * The service to provide social value to Lewisham. |

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