Quality Monitoring Framework

Learning Disability Residential and Supported Living Services

Outcomes based monitoring tool
for the providers of residential care and supported living services in Northumberland

Northumberland Learning Disability Partnership Board

Northumberland County Council

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1.	**Standard 1: Getting my support right** **‘I get the best support possible, which helps me take control and fulfil my personal goals and dreams; I am listened to with respect and involved in my care and treatment.’**

No.	Outcomes	Minimum requirements	Suggested sources of evidence
1.1	**Finding help** ‘*I have a good experience when I first seek information, help or support.’* *‘There is continuity in the contact I have with professionals and I don’t have to keep explaining things over and over again.’*	**Minimum requirements are not restricted to but must include:** • Good information and access (including self-referral if possible) for all people who are eligible for the service, including under-represented groups. • Clarity for staff and service users about access criteria, staff roles, service limitations and the procedure for terminating the service. • Support that is flexible and convenient with regard to timing, location, choice and accessibility of service provision. • Effective verbal and written communication systems to share relevant information among team members.	• Feedback from referrers/people who use the service. • Service information, service user guide/welcome pack, publicity materials, which can be print, easy read, pictorial, electronic or media format. • Systems to record and monitor referrals and service usage by people from disadvantaged/ minority groups. • Statement of purpose, referral protocols, referral/pre-admission information, assessment documentation, staff training and knowledge of procedures.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
1.2	**Assessing my needs and supporting me well** *'My personal needs have been assessed to make sure I get care that is safe, well-organised and flexible, supports my rights and preferences and leads to the right outcomes for me, even if I live in a rural area and no matter how complex my needs and situation are.'* *'My cultural background and communication needs are taken into account. I can explain my needs properly, or a family member or advocate can explain them on my behalf.'* *'There is recognition that my needs are subject to change and the overall aim of assessment and support is to help me achieve maximum independence, for as long as possible'* *'The decisions about whether I am able to use a service have been open and fair, with no barriers to access and quality of the services I am offered.'*	• Person-centred assessment (self-assessment if possible) and family/ advocate involvement as necessary, to identify and meet health, social, personal and emotional needs, outcomes and preferences, including end of life support where appropriate. • Up-to-date support/risk management plans, linked clearly to accurate assessment, for all service users, including those with complex needs. • Promotion of independence balanced with effective risk management; move on/ resettlement needs addressed from the start; assessments, support plans/ risk management plans reviewed at least annually. • Compliance with the Equality Act 2010 and reasonable adjustments (e.g. for sensory, physical, mental health needs or autism spectrum disorder). • Openness and sensitivity to the needs of men, women, people from black and ethnic minorities, lesbian, gay, bisexual and trans-gendered people, and those with different beliefs/ religions. • Joint working, signposting and support to access treatment/ care not provided within the service.	• Evaluation, satisfaction surveys, audits, feedback reports. • Documented examples of outcomes e.g. move on plans; recording of signposting/ referring on e.g. to nursing. • Needs assessment, risk management and person centred plans owned by and developed with the individual, in a format that suits them, involving others as appropriate. • Staff induction/ training, policies and procedures; checks on quality/ storage/ review of paperwork. • Publicity material (print/easy read or other media) about assessment/ support planning; staff handbook; charter/ standards on display; statement of purpose. • Reasonable adjustments and consideration of equality issues; checks on communication aids.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
1.3	**Reviewing my support** *'I understand the process of reviews or meetings in which I am involved; they are as accessible and user friendly as is practical.* *'I understand the remit of my reviews and what decisions can be influenced by my views.'* *'I am given time and support before my review meeting to be clear about what I want to say should happen next for me at my review.'*	• Regular and systematic reviews • Help for people to prepare for reviews, adopting person-centred review principles. • Proactive involvement of service users and their family/ friend/ advocate in reviews. • Individual support/ risk management plans revised in response to reviews. • Review dates recorded in support plans, complementing the reviews provided by other agencies, and people informed of their right to request a review at any time.	• Confirmation from service users/ family/ friends/ advocates that they understand, are actively involved and satisfied with the review process and the verbal/ written information provided. • Information and support given to service users about reviews and meetings they attend. • Examples of how reviews have been made as accessible/ culturally appropriate as possible. • Service users' files showing that all needs have been reviewed with appropriate frequency and at least annually. • Policy and procedures for reviewing and updating information in support/ risk management plans.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
1.4	**Respecting and listening to me** *'I am treated as an individual with dignity and respect.'* *'I receive planned support to go where I want to go and do what I want to do, not what the person who supports me wants me to do.'* *'I find it easy to complain if things are not working well;* *I get clear feedback on the outcome of my complaint, and services improve as a result.'* *'I am asked for my views to help make services better.'*	• Clear evidence/examples of how people's privacy and dignity are maintained at all times, including at the end of their life. • Service design/delivery around individual needs, choices and person centred approaches, and not for the convenience of the organisation or staff. • A clear complaints procedure (including appeals process) in accessible formats that is openly displayed, reviewed regularly, and which staff, service users, family members and third parties understand and feel confident in. • Clear recording of complaints and feedback on actions taken. • Effective means of involvement in order to obtain views from service users and improve services. • Feedback mechanisms and opportunities for people who use the service to participate in service improvement/ development plans.	• Feedback, survey/consultation reports, action plans, committee/ board meetings. • Person centred plans/ reviews and examples of involvement (e.g. suggestions box, discussions, resident/ house meetings, questionnaires, staff recruitment, service aims). • Examples of recent improvements made as a result of service user/ relative/ friend/ advocate feedback or complaints. • Complaints procedure/record book; information on complaints in welcome packs, handbooks, notice boards. • Staff training and supervision; whistle blowing policy/ procedures. • Protocols, policy, guidance, publicity, charter/standards and evidence that they have been discussed with and understood by services users and their relative, friend or advocate.

2.	**Standard 2: Having the right people to work with me** **'I have a good and positive experience of people involved in my treatment and support.'**

No.	Outcomes	Minimum requirements	Suggested sources of evidence
2.1	**How staff help me** *'People I rely on and respect for their specialist knowledge, skills and expertise are there for me when I need them, and refer on to appropriate services as necessary. They are consistent and I trust them to make good decisions.'* *'Staff work together to help me make positive changes in my life, and I am given opportunities, encouragement, and support to promote my independence and social inclusion.'* *'There are people around who really want to help me fulfil my dreams and potential; if possible I choose who supports me so that I get good support.'*	• Staff promote people's independence and can describe outcomes that the service can help people achieve. • Staff fully understand person-centred approaches and engage and communicate effectively with people who need the service. • Staff understand the importance of relationships, goals and aspirations and are sensitive to diverse needs. • Staff are skilled and experienced in meeting needs in culturally appropriate ways. • Staff are competent in risk management and health and safety procedures. • Staff are knowledgeable about the range of services and support provided by their own organisation and other organisations.	• Feedback and surveys from service users and their relatives, friends or advocates on how they view staff. • Examples of outcomes in response to service users, relatives/friends/advocates' concerns raised about staff. • Quality checks on needs/ risk assessment and support plans, reviews, activity files and key worker systems. • Written evidence of how training links into policy and procedural guidance and directly impacts on support given to individuals.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
2.2	**How staff are supported to help me** ‘*My needs are met by staff who are well managed, properly qualified and who develop and improve their skills through training and supervision.’* *‘There are always enough members of staff available to keep me safe and meet my health and social needs.’*	• Staff training targeted to meet the needs of the people who use the service (See 3.1 ‘Safe services’); and other relevant training such as training in person centred approaches. • Additional training in autism awareness, mental health awareness and other specialist training, as appropriate. • Clear links between training, policy, procedural guidance and practice. • Supervision for all staff (at least 6 times per year) and yearly appraisal. • Involvement of service users and carers in recruitment and training of staff, and updated CRB/DBS checks for all staff. • Staffing levels sufficient to deliver safe person-centred support and to cover periods of sickness and annual leave, without affecting levels of support to each individual. • Minimum staff turnover and minimum use of agency staff. • Staff are committed to and supported in training, supervision, appraisal and continuing professional development.	• Feedback from staff, service users, relatives/ friends/ advocates; independent surveys and audits that influence staffing systems, team meetings and training. • Information about how staff are supported e.g. team meetings, supervisor’s open door policy, one-to-one sessions, as well as regular supervision and appraisal. • Examples of pathways, multi-agency working, communication and inter-organisational protocols. • Information on qualifications, skill mix, staff rotas, staffing, sickness levels, use of agency staff and turnover. • Tools and systems used to determine sufficient and appropriately qualified staffing levels, plus evidence of their use and ongoing review. • Staff Code of Conduct, staff induction, supervision, training and appraisal records.

3.	**Standard 3: Helping me to feel safe and take responsibility** **‘I feel safe and an equal citizen with the same rights and responsibilities as other people, and get the right support to enable me to take part in my community, as much as is possible.’**		
No.	**Outcomes**	**Minimum requirements**	**Suggested sources of evidence**
3.1	**Safe Services** *‘I am protected from harm (including abuse) or the risk of harm and staff respect my human rights.’* *‘Should any serious incidents occur, relevant authorities are notified and safeguarding procedures are in place, so the organisation that provides my support responds to and learns from them’.* *‘I get safe and coordinated care, even where more than one care provider is involved or if I move between services.’*	• Systematic arrangements and competent staff to ensure the psychological and physical safety of people who use the service (inc. valid CRB/DBS checks for all staff & appropriate liaison/reporting to NCC/reg.bodies). • Accessible information, processes and support for service users making complaints and raising safeguarding issues. • Clear, well-publicised policies, procedures and staff training. • Accurate risk assessment/ management plans and care/support plans, which are securely stored and accessible to relevant staff and service users, as appropriate. • Positive risk taking and safe promotion of choice, empowerment and independence.	• Feedback from service users/ relatives/ friends/ advocates; evidence of outcomes resulting from concerns raised. Feedback from staff about how they are supported to identify areas of risk and report concerns. • Training records and signed evidence of staff understanding policies/ procedures e.g incident reporting, information sharing, Whistle Blowing and Disclosure and Barring Service referrals. • Records, audits, reports on e.g. risk management, medication administration, CRB/DBS checks. • Accessible information on safety, dignity, privacy and rights, and guidance for raising safeguarding issues/making complaints. • Audit trails and examples of how people are enabled to take positive risks towards independence and social inclusion (e.g. in statement of purpose, support plans, ‘This is Me’, health passports, independent advocacy involvement).

No.	Outcomes	Minimum requirements	Suggested sources of evidence
3.2	**Safe Environment** *'I am cared for in a clean environment that protects me from the risk of infection.'* *'I live in a place that is clean, regularly decorated in a style I like and furnished and equipped with well maintained goods.'* *'I feel safe when getting out and about and when travelling in public and private transport.'*	• People living/ receiving support in an accessible, comfortable and well maintained environment, which is clean and free from unpleasant odours. • Resources and equipment that are kept in good working order. • Individuals having their own toiletries and personal items, and choice over the style of decoration and furnishings where possible. • Provision/ opportunity for private discussions with staff and others, such as family members or an advocate. • Procedures and support to ensure people's safety whilst away from the usual environment, for instance when travelling on public transport.	• Surveys and feedback from people who use the service and their relatives/friends/advocates. • Maintenance checks and reports. • Staff training records, procedures policies and publicity material on health and safety, best interest assessments and dealing with restrictions under the Mental Health Act 2007. • Person centred plans, risk assessment/management plans and recording of how people are helped to feel safe within the service, in external venues and when travelling alone in public or private transport.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
3.3	**Being part of my community** *'I have my own home: good quality housing which is safe and secure with security of tenure.'* *'I choose how to take part in my community and the place I live will be in the heart of, or support me to get to, a busy and active community'* *'I am supported and encouraged to prepare for employment, find work and stay employed.'* *'I can gain the qualifications, skills and training I need to improve my ability to work and help me progress in my career.'* *'I have the opportunity and support to develop my interests, learning and participation in cultural, creative, sports, leisure and community activity.'*	• Empowering and supporting people with their individual strengths, engagement in the wider community and development of social networks. • Independence promoted through confidence building, appropriate skills training, equipment, adaptations and services relevant to individual needs. • Goals for housing, employment, training, education, social, leisure, sports, arts and community activities included in assessment/ support plans. • Planning and support to achieve outcomes, including exit and move on from the service as appropriate.	• Examples from service users of specific initiatives that have expanded their skills, confidence and self-esteem; general feedback from service users/ relatives/friends/advocates. • Promotion of independence and positive risk taking in staff induction, training programmes, management practices, strategies, service information, person centred plans; organisational policies/ procedures and evidence of compliance. • Availability and accessibility of information on services, activities and opportunities for leisure, arts, sports, training, education and employment appropriate to individual needs. • Tenancy agreements. • Service user employment/ activity/move on outcome data.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
3.4	**My rights and responsibilities** *'I know my rights and how to find out more about what responsibilities I can take.'* *'I have the same rights and responsibilities as other citizens.'* *'I am treated equally and fairly, regardless of my age, race, gender, beliefs, sexual orientation or disability.'* *'I get help/signposting to access financial and legal advice as needed, support to manage my finances, and use the money allocated to me in new creative ways.'*	• A statement of rights and responsibilities within the service (e.g. rights to information, consultation, review and to complain). • Support to help people understand and exercise their rights and responsibilities in society e.g. to vote in local and national elections, and to access services and facilities they need. • Protection of human rights, including rights for safety and privacy, and to be free from discrimination, harassment and abuse, including that related to age, disability, race, gender, beliefs, sexual orientation, gender reassignment, pregnancy & maternity and marital/civil partnership status.	• Rights/responsibilities explained within the service description, handbook, customer charter etc. • Staff training, policies and procedures on equality, diversity and safeguarding. • Evidence from reviews/records of how service users have been supported with their rights and responsibilities within the service and the wider society. • Feedback and confirmation from people who use the service and their relatives/ friends/ advocates that their views have been listened to and taken into account, and that information and support is made available to meet their cultural, religious and/or lifestyle needs. • Examples of how equality issues have been considered when producing/ reviewing any major policy, procedure, function, service or strategy, as appropriate.

4. Standard 4: Helping me to keep healthy and feel good

‘I choose how to be healthy; I have the information and advice I need to feel empowered and make the right choices for me.’

No.	Outcomes	Minimum requirements	Suggested sources of evidence
4.1	**Meeting my health needs** *‘I am able to get my physical and dietary needs met appropriately. I get the medicines I need, in a safe way and when I need them.’* *‘I get the treatment, care and support that my health or social care professional and I agree will make a difference to my health and wellbeing.’* *‘I get support to effectively access health services as necessary; I expect my doctors, dentists and other health professionals to communicate well with me and can be supported to communicate with them as needed.’* *‘I, or someone on my behalf, can challenge decisions made by health professionals, multidisciplinary teams and senior management teams.’*	• Provision/access to food, drink and snacks with appropriate nutritional value, at times that meet individual needs, preferences and any cultural/ religious requirements. • Safe access to medication, treatment and appropriate monitoring services required. • Support for emotional/psychological needs and appropriate referral for those who have identified mental health needs. • Staff able to talk to people about health issues and clear about what they can and can’t do to help. • Appropriate referral and support for people to access and understand the range of health services available (e.g. GPs, emergency care, dentists, pharmacies, opticians, chiropody, and health screening); ensuring reasonable adjustments have been made where required, and people can make a complaint or give feedback about their experience of health services.	• Feedback from service users/ relatives/ friends/ advocates and evidence of physical/ emotional/ psychological needs being met within the service e.g. in support plans, records, menus, activity plans, medication audits. • Percentage of service users who have had an annual health check and a health action plan. • Evidence of referral to appropriate services for health problems; confirmation that reasonable adjustments are made as required. • Accessible self-help resources; information on health services, staff roles, choices and what to expect. • Systems, staff training, appraisal and supervision for ensuring service users’ health needs are met and that they attend regular appointments. • Focus group/forum discussions on health service experiences, and evidence this is fedback appropriately.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
4.2	**Maintaining a healthy lifestyle** *'I get the right information, education and support to help me make healthy choices and deal with the consequences of unhealthy choices.'* *'I get guidance on a healthy diet, and support to buy, prepare and cook food at a time that I choose.'* *'I get help to do exercise and to access local facilities such as sports centres; this includes help to use transport when needed, and being able to use disabled facilities when necessary.'* *'I have enough money to eat a healthy diet and to do physical exercise.'*	• Systematic promotion of healthy lifestyle choices for all people who use the service. • Information, discussion and access to help/ advice for the following: - smoking cessation - healthy eating, exercise and weight management - alcohol and substance misuse - long term health needs - mental health and emotional well-being - sexual and reproductive health - other health concerns e.g. sleep	• Feedback and evidence of health promotion initiatives e.g. in care plans, and support to maintain healthy lifestyles, e.g. through diet plans/ menus, shopping, budgeting for a healthy diet and exercise. • Publicity material and events on key health promotion messages; availability of accessible health information. • Percentage of service users who have had an annual health check and a health action plan. • Written evidence of regular appointments attended for GP, dentists, opticians, chiropody; and referral to specialist health promotion/ health services where appropriate.

5.	Standard 5: **Helping me to make choices** **'I get help to make my own decisions about how I live my life and how I am supported.** **If that is not possible, decisions are made with the help of my carer and/or an advocate.'**

No.	Outcomes	Minimum requirements	Suggested sources of evidence
5.1	**My views are important and I can get help to make decisions.** *'I get good advice and information to speak out for myself and make real choices about the decisions that impact upon my life. I can have an advocate if I need one.'* *'I am always involved in discussions about my care and treatment. I receive meaningful information so that I can choose to receive or reject any type of examination, treatment, care or support.'* *'If I am unable to make certain choices due to my illness or disability, my family member, friend, or advocate receives appropriate information in decisions about my care, treatment and support.'* *'Where necessary, decisions are made on my behalf within the legal framework provided by the Mental Capacity Act (2005) and Deprivation of Liberty safeguards.'*	• Routine discussion of choices about how people want to be supported, including at the end of their life. • Advice and help for people to know their rights and make safe informed choices about how they live their life, meet their needs and achieve their personal goals, hopes, dreams and aspirations; involvement of relevant people (e.g. family member, advocate, or specialist) in assessment, treatment and care decisions as appropriate. • Clear information and procedures on informed consent, assessed lack of mental capacity and independent advocacy. • Staff training and competency in Mental Capacity, Deprivation of Liberty safeguards, and the use of independent advocacy.	• Feedback and examples of how the service seeks views of service users and/ or their relatives/ friends/ advocates, and how these lead to improved outcomes; audits/ survey reports. • Choices, interests, aspirations and appropriate use of advocacy documented e.g. in pre-admission/ admission records, assessment, person-centred plans and reviews. • Service information and materials about support available to make decisions, informed consent, advocacy, and what happens when a person lacks capacity. • Policies, procedures, staff supervision, training and appraisal records; written evidence of how people give consent e.g. Mental Capacity Assessments, Best Interest assessments and advocacy involvement.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
5.2	**Choices that matter the most to me** *'I choose who I live with and where I live; I choose my friends and relationships.'* *'I can make positive choices about how I spend my time and money within the overall context of being healthy and safe; that includes working, and doing things that interest me.'* *'I understand that everyone can make mistakes and I can change my mind about the choices I've made.'* *'I make choices about the staff that support me. Where I share my support with other people, service managers listen to and act on any concerns I have about the staff who support me.'* *'I am able to choose which GP I see, and other health and social care professionals where possible.'* *'If my placement becomes untenable, systems are in place to resolve or help me move on.'*	• Discussions with people about what matters most to them, reflected in their assessments, support plans and daily choices. • Support for people to have their own home and, if the service is delivered in a shared setting, the opportunity to meet other residents prior to admission. • People being empowered to make informed and safe choices about friendships and intimate relationships. • Help and advice for individuals to choose how to use their money, within the context of keeping healthy and safe. • Accessible information and support to help people make choices about health and social care services they need. • Service user involvement in staff recruitment; systems to find out and act on how people feel about the staff that support them.	• Feedback from service users and their relatives/friends/advocates; surveys and reviews. • Evidence in person centred plans of the implementation of choice, and sound reasons where choice has not been possible in certain situations. • Evidence of changes in routine, and service response to changes in choice, needs and circumstances e.g. in service information, activity files and support plans. • Menu plans and file/records, which detail likes/dislikes and special dietary needs. • Accessible information on health and social care services and the range of activities and choices within the community. • Service user involvement in staff recruitment. • Staff supervision and appraisal; systems to capture and respond to information on choices/ concerns about staff.

6.	**Standard 6: Involving and caring about relatives and friends who support me** **'The role of any family member or friend providing unpaid care and support to me is promoted, valued and recognised.'**

No.	Outcomes	Minimum requirements	Suggested sources of evidence
6.1	**Involving my relative or friend in my care and planning future services** *'Staff understand the importance of my relationships with my family and friends; they support me when there are problems with my relationships, or when those close to me are ill or die'.* *'If I don't have close relatives or friends, general advocacy or Independent Mental Capacity Advocacy is explained and offered to me where appropriate'.* *'With my agreement, my relative, friend, or advocate receives clear and accurate information and is involved in decisions about my care, treatment and support, in a way that is respectful and helpful.* *'They are given the opportunity to be involved in the planning, development and evaluation of services and planning for my future when they may no longer be able to support me.'*	• Support and encouragement for people to maintain contact with relatives and friends. • Support for people who use the service to address relationship issues, bereavement, and planning for the future (referring to specialist help if needed). • Appropriate involvement of relevant family members/friends in the care and support of people who use the service. • Acceptance of service users' refusal of consent to family/friend involvement, unless there is serious risk to a service user's welfare; then supporting relatives or friends in other ways (e.g. signposting to carers' assessment/ support, general information and advice). • Routine consultation with relatives and friends in relation to current services, new developments and satisfaction surveys.	• Feedback from service users and their relatives/friends about how well they are involved. • Written evidence that service users' relatives/friends are appropriately involved in assessments, support plans and reviews throughout the duration of the service, and receive information about the service, how to complain and relevant policies/ procedures. • Mechanisms and evidence of capacity assessments, consent, best interest decisions and advocacy involvement. • Evidence of how relatives/friends have been involved in surveys, consultations, service development plans, recruitment and training.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
6.2	**Recognising and responding to the needs of my relative or friend who supports me.** *'My relative/friend is valued by all staff involved and this is reflected in my care plan, as well as their own support plan if they have one.'* *'My caring relative/friend is aware they may have a right to a Carer's Assessment under the Carers and Disabled Children Act 2000 and The Carers Equal Opportunities Act 2004.'* *'My relative or friend who supports me is protected from inappropriate caring, financial hardship, and pressure to take on caring roles so that they can stay well and have a life of their own.'*	• Demonstrating to relatives and friends of people who use the service that they are valued and their views are respected. • Responding to relative/friends' needs for information, advice, and involvement, as appropriate and with consent from the service user as necessary (e.g. when discussing information about the service users' support, rather than general information/advice or signposting). • Where necessary, signposting relatives or friends providing unpaid care to a relevant organisation for carer's assessment and support, as appropriate.	• Feedback from relatives or friends (and service users) that they feel respected and valued by staff; examples of support, advice, signposting as appropriate. • Where appropriate, written evidence e.g. in client records that relatives or friends providing unpaid care and support have been signposted to an organisation that can offer carer assessments and support plans.

7.	Standard 7: **Information about me and my support** **'I receive and understand information about my care and support. I know that it is kept confidential, and used to get my support right and to do the best for me.'**

No.	Outcomes	Minimum requirements	Suggested sources of evidence
7.1	**Understanding information about my care and support** *'I know what is in my paperwork and what it says about me, my expectations, goals and responsibilities.'* *'I am given accessible information about my care and support in a way that suits me (e.g. easy read/audio).'* *'My paperwork is understood and signed by both staff and me; I get support for this to happen.'*	• Information about the service and individual support that can be easily understood by people with learning disabilities, including those with physical disabilities and sensory impairment (in accordance with the Equality Act 2010). • Systems in place to ensure information about the service is accurate, reviewed regularly and updated. • Quality monitoring of needs/risk assessments and support plans/risk management plans to ensure they are accurate, accessible and reviewed regularly. • Service user and stakeholder feedback and involvement in producing and improving information provided by the service.	• Person centred plans, client records, feedback from people who use the service, relatives, friends, advocates and referrers. (e.g. compliments/complaints/ suggestions/surveys). • Information leaflets/publicity materials in different accessible media, appropriate content, style and availability. • Examples of service user involvement in the development of information and publicity materials. • Staff trained in Equality and Diversity, use of interpreting services, person centred approaches. • Quality checks on assessment, risk assessment/ management, and support planning documentation.

No.	Outcomes	Minimum requirements	Suggested sources of evidence
7.2	**Knowing how information about me is used and shared** *'My paperwork includes contact details of named staff who support me, information about medication and any extra help I need such as specialist people and equipment.'* *'I am given information about the outcomes of reviews or meetings in a manner that is meaningful to me.'* *'Information about me is kept confidential, and only shared with my consent and when there is a genuine need to do so.'*	• Signed person-centred plans, which include details of named staff, medication and specialist equipment. • Clarity for people who use the service as to who else has access to information about them. • Clear verbal and written information about the circumstances under which information may be disclosed or shared, including reference to safeguarding and child protection legislation. • Compliance with the Data Protection Act (1998) and policy, procedures, staff training and competence in data protection/ confidentiality, safeguarding and child protection. • Appropriate involvement of relatives, friends or advocates whilst respecting the confidentiality of the service user.	• Feedback from people who use the services and their relatives/ friends/ advocates; audits/reviews and reports. • Staff training records; written policies and information sharing protocols/guidelines (in line with Equalities Act, Data Protection, Safeguarding children and adults). • Information displayed and leaflets/ publicity materials (in different accessible media). • Examples where people who use services have contributed to the development of information and publicity materials. • Quality checks on assessment, risk assessment/management and support planning documentation.

8.	**Standard 8: Managing and paying for my support** **'I choose how I am supported, and all the things are in place that can help me manage my support, in a way that suits me; I am charged a reasonable cost and only for services that I need.'**

No.	Outcomes	Minimum requirements	Suggested sources of evidence
8.1	**Managing and paying for my support** *'A fair and open assessment of my financial circumstances, including my income, capital and savings has been undertaken prior to the service commencing; I am protected from the risk of very high care costs and losing assets.'* *'I have received advice to ensure that I am getting all the income, including pensions and benefits to which I am entitled, and which may help with my support charge.'* *'Providers have been clear with me, or others paying for my support, about how charges for my care are made up. The costs reflect the quality of the service I receive.'* *'There is a planned and balanced approach to crisis and risk that does not take away my sense of being in control of my life; I have opportunities and the resources for self-help, such as clear information about personal budgets and how to use them.'*	• Peoples' views and preferences incorporated into the way support is planned, organised and paid for, and balanced with effective risk management. • Systems in place to address any disagreements about the way support is organised or paid for, and to ensure people understand the process of Financial Assessment and their right to appeal. • Clear information and advice about entitlements, charges, how to make payments and a breakdown of service costs. • Support available for people to manage their own support and finances where possible (e.g. through direct payments, personal budgets, self-directed support or private arrangements). • Written and publicised emergency call-out and out-of-hours support arrangements, which are understood by staff, service users and relatives/ friends/ advocates.	• Evidence in person-centred plans and client records of how people have been helped with support planning, positive risk taking and money management; capacity assessments and signposting where required. • Information, policies and procedures for staff, service users and their relatives/ friends/ advocates about the way support is organised, including emergency and out of hours arrangements; evidence of referral to specialist support as required. • Accessible information about financial assessments, charges, and paying for care, including breakdown of costs – for service users and their relatives, or others paying for their care.