Appendix 3d - Non-Regulated Support Core Service Specification

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1.0 Introduction

1.1 Non-Regulated Support is domestic and enabling support delivered to Individuals living in their own homes and does not include personal care. The Service Provider must deliver a support service that assists with identified needs in accordance with the Care Act Eligibility determinations:

a. Avoiding Individuals being admitted to hospital or a care home
b. Reducing the reliance on formal care and support
c. Practical support in the home or care home in order to reduce reliance on formal care and support
d. Outcome based support in the community to support with practical things such as time management, social activities, mood management, to prevent social isolation or would offer direct support to people e.g., signposting and wellbeing visits.

1.2 This schedule sets out the core specification for a new Non-Regulated support service for Individuals with identified support needs. It describes what the Authority requires from the Service Provider in delivering the Service and is considered alongside the Living Well at Home Agreement, Service Contract and ITP document.

1.3 The service should be delivered using a holistic approach that considers an individual's needs in the context of their skills, ambitions, and priorities as well and the other people in their life.

1.4 The service will support Individuals with a range of interventions.

2.0 Scope

2.1 The Service is commissioned as a targeted, non-clinical service and is predominantly aimed at people aged 18 or over who are deemed to be ordinarily resident within the administrative area of Lancashire County Council.

2.2 The Service aims to promote and or maintain the independence of Individuals we support by:

a. Developing effective working relationships with the various functions within the Authority.
b. Ensure that individuals experience seamless service provision, receive consistent advice regarding the support available to them and support individuals to understand complex information.
c. Work flexibly to develop and enhance the Service to meet changing levels of demand and priorities.

d. Contribute to delivering a health and care system that aims to promote, maintain or regain independence and build confidence.

2.3 The Service will not provide personal care to Individuals or those individuals who do not meet the identified criteria under 2.1.

2.4 The Service will use strengths-based approaches to meet the identified and/or highlighted needs of individuals relieving the pressure on regulated care services.

2.5 The Service shall be available to all eligible Individuals irrespective of gender, religion or belief, ethnicity or race, culture, sexuality, disability, age, class or socio-economic status.

2.6 The Service shall be delivered within Lancashire County Council's admirative boundaries subject to the Geographical Boundaries defined in the call off procedure. However, there may be occasions when the Service Provider is requested to provide the Service outside of these boundaries for example when an Individual is a Lancashire resident but temporarily residing outside of the defined boundaries.

2.7 As we move into an increasingly digital world, we want Individuals who have additional support needs to have every opportunity to feel connected and immersed with a digital offer. Providers will refer people to the TEC (Technology Enabled Care) service when appropriate and propose creative solutions to increase independence, connectivity with health providers, safety, privacy, choice and control for people utilising the very best in technology enabled support. Successful providers will keep up to date with the latest innovations and will proactively promote new technology as it comes available.

3.0 Service Requirements

3.1. **<u>Individual Groups</u>**

The primary Individual groups served by this specification are:

a. Older people
b. Individuals with dementia
c. Individuals with physical disabilities
d. Individuals with learning disabilities and/or autism
e. Individuals with mental health needs.

Other Individual groups which may receive this Service include Individuals who have:

a. Individuals with sensory impairment

b. Individuals with spinal injuries
c. Individuals with acquired brain injury
d. Individuals with alcohol / Substance dependency
e. Individuals with neurological conditions; or
f. Adults approaching the end of their life

The Authority may require from time to time for the Service to be delivered to other Individuals that fall outside of the scope of the primary and other Individuals detailed above and are to be determined at the sole discretion of the Authority.

3.2. Legal Context

The Service Specification is underpinned by The Care Act (2014) Wellbeing Principle. The Principle applies equally to individuals with eligible needs and those who do not have eligible needs and states the importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist. Care Act Wellbeing Principles underpinning this Service specification include but are not limited to:

a. Personal dignity (including treatment of the individual with respect)
b. Physical and mental health and emotional wellbeing
c. Control of the individual over day-to-day life
d. Participation in work, training, education, training or recreation
e. Social and economic wellbeing
f. Domestic, family and personal wellbeing
g. Suitability of living accommodation
h. The individual's contribution to society

3.2.1 The Service will work with Individuals to achieve their agreed outcomes in relation to managing areas of their life which have been impacted on or are at risk of being impacted on by their individual circumstances.

3.2.2 The Service will deliver support via a variety of appropriate delivery methods, e.g. face to face, online, via telephone etc.

3.2.3 The Service will work with Individuals to ensure that they continue to develop the skills, experience, confidence and personal resilience to achieve and maintain their independence.

3.2.4 The Service will provide relevant information, advice and guidance to Individuals and will engage with, and signpost to key local partners, services and organisations who will support the delivery of the Service outcomes.

3.2.5 The Service will make all reasonable adjustments to support the diverse needs of people in Lancashire who utilise the service. The Service Provider will identify and work alongside, other services and professionals to ensure all needs are met where reasonably possible to do so.

3.3. Key Principles

The Service Provider must value an Individual's right to:

a. Be independent
b. Be regarded and treated as individuals
c. Make choices for themselves
d. Be treated in an equal and fair way which may include making reasonable adjustments
e. Be treated with respect, dignity and confidentiality
f. Access specialist support to realise potential
g. Receive non-judgemental support

The Service model must be consistent with the five key principles of the Mental Capacity Act 2005 and the associated code of practice, which are:

a. Principle 1: A presumption of capacity
b. Principle 2: Individuals being supported to make their own decisions
c. Principle 3: An Individual is not to be treated as unable to make a decision merely because
d. they make an unwise decision
e. Principle 4: Best interests
f. Principle 5: Less restrictive option.

3.4. Service Outcomes

The provider will be expected to work with commissioners and Individuals who use the service, to develop an approach to monitoring outcomes for individuals. The chosen method will be designed to be completed in collaboration with the Individual with an emphasis on change and maintenance outcomes.

The focus of the Service must be firmly on promoting independence, choice, control, social inclusion and wellbeing. To achieve the Service outcomes the Service Provider will:

a. Promote the independence of the Individual through an enabling and strengths-based approach.
b. Support the Individual to achieve their desired outcomes and to maximise independence and recovery from mental ill health.
c. Support the Individual to engage with family/friends, their interests and

community services.

d. Support the Individual to improve their health and wellbeing.
e. Support the Individual and work with their families to promote their understanding of key hazards and control measures.
f. Work with the Authority and with the Individual and their families to encourage self-assessment and increase the number of self-assessments to determine the persons needs and potential support that will meet that need.

Providers must make use of the 'Think Local Act Personal' (TLAP) [1]statements when planning care and support.

3.5. Types of Support

The following list of types of support required is not intended to be exhaustive or needed in all cases and should not preclude creative solutions which may better suit an individual. Such requirements that the Service Provider must provide may include:

a. Enable Individuals to access social activities, reducing social isolation and improving an Individual's overall wellbeing
b. Maintaining a habitable home
c. Enabling the Individual to self-care
d. Other support that promotes safeguarding
e. Identification and mitigation of any immediate risk and reporting of possible safeguarding adults, safeguarding children, domestic abuse or hate crime concerns.
f. Other support that promotes effective risk management and keeping Individuals safe

3.6. Keeping Individuals informed and in Control

The Service Provider must ensure that they keep Individuals informed and in control all times.

3.7. Health and Safety

The Service Provider must ensure it is compliant with Health and Safety legislation and ensure that there is a comprehensive health and safety policy with clear written procedures for management of health and safety, which comply with all current and relevant Health and Safety legislation and define individual and organisational responsibilities.

3.8. Partnership Working

[1] Six themes of Making it Real - About - Making it Real - Think Local Act Personal

Partnership working is at the heart of successful delivery of the Service. This applies to the relationship between the Authority and the Service Provider, but also with other significant agencies supporting people.

The Service Provider must cooperate and work in partnership with other organisations to: promote the wellbeing of Individuals; signpost Individuals to other relevant services; contribute to the prevention, reduction or delay of the development of an Individual's needs; and improve the quality of person-centred and joined-up support, including the outcomes a person achieves.

This includes, but is not limited to, the following partners:

a. Community Health Services
b. Community Mental Health Teams/Services
c. NHS Trusts
d. North West Ambulance Services
e. Lancashire Fire & Rescue Service
f. District Councils
g. Other Registered Care Providers
h. Carers' Services
i. Voluntary, community and faith sector organisations
j. Family members/informal carers
k. Housing providers

The Service Provider must make appropriate use of local networks for information, advice and advocacy to ensure that an Individuals needs are met holistically, and resources are used effectively.

3.9. <u>Supporting the wider health and care system</u>

The Service Provider must contribute to prevention strategies which are aimed at:

a. Reducing the number of unplanned admissions to hospital
b. Supporting the safe and timely discharge of patients from hospital
c. Supporting Individuals to recover faster from illness
d. Supporting Individuals to remain in community settings rather than institutional care and support.
e. Developing integrated care pathways
f. Supporting carers to maintain their caring role
g. Identifying and meeting the needs of vulnerable Individuals at the earliest possible Stage

The Service Provider will work closely with local organisations, across the health and social care system to continually improve the support for Individuals, in accordance with identified needs and taking into account changes in national and local guidance and policy. This may involve working with a range of statutory, voluntary and community sector organisations to

deliver the required outcomes and developing information sharing protocols to enhance partnership working where needed.

3.10. System Escalation

There will be times when the health and care system is in a period of escalation, for example in emergency situations such as: floods; civil emergency; health outbreak or pandemic; periods of heatwave or cold weather; and periods of severe system pressure, including service closures/suspensions and potential closure or temporary cessation of hospital services.

In these circumstances, the Service Provider may be asked to:

a. Take urgent actions in partnership with other organisations
b. Reprioritise delivery of the Service
c. Flex their workforce and the Service
d. Increase welfare checks in neighbourhoods

3.11. Reporting

The Service will be required to submit reports to the Authority as specified within the individual service specifications at the point of any call off from this specification.

3.12. Compliments, Concerns and Complaints

The Service Provider will be required to have in place a procedure to deal with compliments, concerns and complaints and must provide reports pertaining to these as defined in individual service specifications

3.13. Digital Care Records

The Authority is working with stakeholders to increase the use of shared Digital Social Care records (DSCR) and during the course of this contract the Authority may require Service Providers to make use of DSCR in order to undertake electronic care planning.

4.0 Workforce Requirements

4.1. Planning and Management

The Service Provider must identify within their own organisation a suitable person or persons with full knowledge and understanding of workforce issues pertaining to the delivery to be responsible for workforce planning for the Service.

The Service Provider must develop workforce plans which need to be updated at least annually or more often as appropriate to ensure that arrangements are in place to maintain the workforce capacity and capabilities required to deliver the Service for the duration of the Service Contract.

Specific plans must be developed for the following:

a. Recruitment and retention of staff
b. Management of sickness and other absences
c. Learning and development

The Service Provider should develop separate documents for the following:

a. Succession plans for key management posts and/or posts requiring scarce skills
b. Specific plans for issues identified locally/organisationally

The Service Provider must have in place an effective sickness absence management and monitoring system and must inform the Authority at the earliest opportunity if such absences will impact upon their capacity to deliver the Service.

4.2. <u>Business Continuity Management</u>

The Service Provider must have a business continuity plan in place to ensure the delivery of the Service is continuous and consistent for the benefit of People using the service. The Service Provider must:

a. Develop and maintain a business continuity plan;
b. Review the business continuity plan on a regular basis, but not less that once every three years; and
c. Provide the Authority with a copy of this plan if requested to do so.

The business continuity plan must include:

a. Identification of service critical functions and the resources required to deliver them, including but not limited to:
    I. Premises
    II. People
    III. ICT Hardware & Software
    IV. Telecommunications equipment
    V. Suppliers/Contractors
    VI. Any other critical equipment/supplies.

b. Identification and assessment of risks that could limit the availability of the above resources and potentially lead to a disruption in the delivery of services

c. Appropriate continuity solutions should an impact be experienced

d. Supporting information such as key contact numbers, generic and hazard specific action plans, incident management procedures.

The Authority shall have the right to carry out an open audit of the business continuity plan with no less than 24 hours' notice.