Specification

Empowering Independence Service – Complex and/or Mental Health Needs

1 October 2019 – 30 September 2022

Version 0.7

Adult Social Care

Adult Transformation and Commissioning

Contents

Definitions

‘‘Adult Social Care’’

means: the Adult Social Care directorate within Cornwall Council.

‘‘Commissioners’’

means: all employees procuring and contracting services to be delivered on behalf of the Council. For this contract the key Commissioners will be officers within Cornwall Council’s Adult Transformation and Commissioning service.

“Contract”

means: the Contract for the provision of the Service, which will be awarded to a successful Supplier.

“Council”

means: Cornwall Council, County Hall, Treyew Road, Truro, Cornwall TR1 3AY.

‘‘Housing’’

means: the Council’s Housing service and Cornwall Housing Ltd.

“Provider”

means: any person or persons, firm or firms or company or companies applying to tender for the Service, or, where there is more than one organisation applying, the lead organisation.

‘‘Rough Sleepers/Sleeping’’

means: 1) people who are sleeping in the open air including but not limited to the street, in tents, doorways, parks, bus shelters or encampments; 2) people in buildings not designed for habitation including but not limited to stairwells, barns, sheds, car parks, vehicles or stations.

“Service”

means: the provision of the Empowering Independence Service that forms part of the Adult Social Care Prevention Offer as described in this Specification.

“Service User”

means: an individual who accesses the Service as defined in this Specification.

''Specification''

means: this document providing a detailed description of the key features of the Service and the outcomes required which should be read in conjunction with the Terms and Conditions of the Contract.

''Staff''

means: all persons employed by the Service Provider to perform its obligations under this Contract; as well as sub-contractors and volunteers used in the performance of its obligations under this Contract.

"SWEP"

means: the Severe Weather Emergency Protocol (SWEP). The purpose of SWEP is to prevent deaths on the street during adverse weather. It is usually triggered if the temperature is forecast to be zero degrees or below for three consecutive nights or if a heatwave warning is raised. During cold weather SWEP, rough sleepers, regardless of eligibility under statutory duties, should be offered a warm space 'sit-up' chair with warm drinks overnight. During a heatwave, rough sleepers regardless of eligibility should be able to access a cool indoor space, with cold drinks between 12pm and 3pm.

1. Introduction

1.1 ***Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible***[1].

1.2 Cornwall Council's vision for all commissioned services is that they should be of high quality, effective, and led by demand, need and the desired outcomes for people in Cornwall. This Specification describes the key features of the Social Inclusion Service and the outcomes required, and should be read in conjunction with the Terms and Conditions of the Contract.

1.3 The Service forms part of the Adult Social Care (ASC) Prevention Offer aimed at preventing, reducing and delaying individual's needs for care and support. The Service is for residents of Cornwall aged 18 years and over who have complex and/or mental health needs and have been identified as potentially benefiting from access to the Service.

1.4 This Contract is one of five locality based contracts delivering the Empowering Independence Service across Cornwall. Service Providers will be expected to work in partnership to ensure that people with high risk behaviours and complex needs are supported appropriately. This Contract is for the area(s) set out in the table below.

[PLEASE DELETE ROWS AS APPROPRIATE FOR FINAL CONTRACT]

AREA 1	WEST
AREA 2	WEST TO MID
AREA 3	MID
AREA 4	MID TO EAST
AREA 5	EAST AND NORTH

1.5 **The key aims** of the Service are to:

- Enhance quality of life for people with health and wellbeing needs
- Reduce or delay the need for formal care and support
- Prevent and reduce Rough Sleeping and homelessness in Cornwall
- Reduce unplanned use of emergency services

1.6 **The key objective** of the Service is to improve the pathway of accommodation and support for adults with complex and/or mental health needs in Cornwall.

1.7 **The key outcomes** of the Service are:

[1] Department of Health and Social Care (2018) *Prevention is better than cure: Our vision to help you live well for longer.*

- Improved self-management of health and wellbeing
- Increased independent living skills

1.8 This will be achieved through delivery of the following three Service components.

A. Community Outreach: The Service Provider will offer short term support to people living in the community regardless of tenure. This component of the Service will provide all levels of support for people with complex and/or mental health needs living in independent accommodation.

B. Supported Accommodation – high/medium tolerance: The Service Provider will offer short term accommodation with support to people with complex and/or mental health needs. This component of the Service will provide high to medium levels of tolerance to drugs and alcohol and high to medium levels of support.

C. Supported Accommodation – limited tolerance: The Service Provider will offer short term accommodation with support to people with complex and/or mental health needs. This component of the Service will provide limited tolerance to drugs and alcohol and high to medium levels of support. It will also make provision for up to five 'sit-up' spaces for rough sleepers during Severe Weather Emergency Protocol (SWEP) activations.

1.9 This Contract relates to the revenue funding for the support service only and does not cover rental and capital build costs for the accommodation.

1.10 The Service Provider will be expected to work in collaboration with other providers in Cornwall delivering preventative support, health and social care services, as well as Service Users, local communities, the Council, NHS Kernow Clinical Commissioning Group (NHS Kernow), Cornwall Partnership NHS Foundation Trust (CPFT) and all other relevant stakeholders in the design and delivery of the Service. This includes working in partnership to develop a housing and support pathway for people with complex and/or mental health needs in Cornwall and agreement of a common referral process to ensure consistency for people accessing services.

2. Scope

2.1 The Empowering Independence Service will offer short term support to people living in Cornwall aged 18 years and over who have complex and/or mental health needs and have been identified as potentially benefiting from support to self-manage their health and wellbeing and increase independent living skills.

2.2 Service Users will have complex and/or mental health needs related to one or more of the following **primary needs**:

- mental health
- emotional wellbeing
- alcohol and/or drugs

- acquired brain injury
- high risk behaviours, including but not limited to hoarding and self-neglect

2.3 People accessing the Service may also be experiencing other multiple disadvantages related to physical health needs, dementia, learning disabilities, autism, rough sleeping, homelessness, contact with the criminal justice system, social isolation, poverty and/or abuse. The Service Provider will support people to make links in to other support services and health and social care agencies as appropriate.

2.4 The Cornwall and the Isles of Scilly Safeguarding Adults Board has established a dedicated High Risk Behaviour Panel for complex cases, which draws on the views of other partner organisations as appropriate. People with one or more of the above complex and/or mental health needs who have been referred through the High Risk Behaviour Panel will be prioritised by the Service Provider to offer access to the Service, and a key worker approach to the coordination of any specialist support required by the individual in collaboration with other agencies as appropriate.

2.5 People with one or more of the above complex and/or mental health needs who are rough sleeping, homeless or at risk of homelessness will be prioritised by the Service Provider to tackle the root causes of their circumstances and/or to prevent homelessness. This will include but is not limited to people identified as homeless by Housing services, as well as people ready for discharge from hospital, detoxification, rehabilitation or mental health wards.

2.6 It is anticipated that on an annual basis at least two hundred and eighty (280) people will be supported through Community Outreach and two hundred and twenty people (220) people will be supported through Supported Accommodation in total across the five locality based Contracts.

2.7 Referrals will be accepted from all sources and Service Users do not need to be assessed as eligible for support following a Care Act Assessment or assessed as eligible for NHS care. However, where appropriate ASC, CPFT or NHS Kernow may refer an individual for support from the Service Provider if felt that an intervention offered through the Service could reduce the need for formal care and support.

3. Background

3.1 **The Care Act 2014 and the NHS Five Year Forward View** have a clear focus on prevention and wellbeing. The Care Act stipulates that local authorities have a duty to promote wellbeing and provide or arrange for services, facilities or resources which would prevent, reduce or delay individuals' needs for care and support. The Forward View describes intentions to develop evidenced-based action plans to prevent health conditions from developing, and emphasises the importance of investing in the voluntary and community sector. Local authorities and the NHS are required to put prevention at the heart of everything they do: tackling the root causes of poor health, not just treating the symptoms, and providing targeted services for those most at risk. The Service will be expected to

support the Council in meeting its statutory duties in relation to preventing, reducing or delaying individuals' needs for care and support.

3.2 **The Housing Act 1996 (Part VII), as amended by the Homelessness Act 2002**, sets out clear duties and powers for local authorities in relation to households who are homeless or threatened with homelessness. The original rehousing duty states the local authority must find an offer of suitable settled accommodation for a homeless applicant when the person is found to be in priority need and unintentionally homeless. **The Homelessness Reduction Act 2017** increased the statutory duties for local authorities by stating that reasonable steps must be taken to: a) prevent a person from becoming homeless; and b) relieve homelessness by helping a person to secure suitable accommodation. This has included new duties on local authorities to develop and agree with applicants a personalised plan of the steps that will be taken to prevent or relieve homelessness. The Service will be expected to support the Council in meeting its statutory duties in relation to homelessness.

3.3 **The Five Year Forward View for Mental Health**[2] includes the requirement to create 'mentally healthy communities'. Housing, including specialist supported housing, is considered critical to the prevention of mental health problems and the promotion of recovery. NHS Kernow, Cornwall Council and the Council of the Isles of Scilly are committed to the co-production of a joint strategy for mental health, which will set out a clear direction of travel for future years.

3.4 **The recent Drug Strategy**[3] continues to highlight that stable and appropriate housing is crucial to enabling sustained recovery from drug misuse and sustained recovery is essential to an individual's ability to maintain stable accommodation. The Drug Strategy also states that heroin-related deaths can be prevented by the provision of naloxone and that local areas should have appropriate provision in place. The inquiry into drug related deaths has attributed these to a range of complexities and highlighted the need for a coordinated, whole system, partnership approach to meet the complex needs of those who use drugs.

3.5 **Shaping Our Future**[4] is the Cornwall and the Isles of Scilly Health and Social Care Partnership. The Shaping Our Future programme is founded on collaboration and integration. All system partners are committed to the following vision.

- We will work together to ensure the people of Cornwall and the Isles of Scilly stay as healthy as possible for as long as possible.
- We will support people to help themselves and each other so they stay independent and well in their community.
- We will provide services that everyone can be proud of and that reduce the cost overall.

[2] The Mental Health Taskforce (2016) *Five Year Forward View for Mental Health.*
[3] HM Government (2017) *2017 Drug Strategy.*
[4] www.shapingourfuture.info

One of the priority areas for the programme is 'prevention and improving population health.' This includes focusing resources on preventing ill health and doing more to keep people healthy, happy and well in their local communities. The Service Provider will be expected to support the health and social care sector in the development and delivery of Shaping Our Future.

3.6 **The ASC Prevention Offer Strategic Commissioning Intentions 2018-2022**[5] describes the local adult social care approach to commissioning preventative interventions over the next four years. The commissioning intentions consider how the Council will work with the NHS, partners and local communities to improve the quality of life and opportunities available for people with support needs in Cornwall by promoting wellbeing, early intervention and preventative care.

3.7 **The Cornwall Homelessness Strategy 2015-2020**[6] sets out plans to tackle the causes of homelessness and wherever possible prevent its occurrence, to support homeless households, and to ensure that there is sufficient accommodation available for those who do become homeless. **The Rough Sleeping Reduction Strategy 2017-2020**[7] is a subsidiary plan to the Homelessness Strategy and includes the aim to prevent rough sleeping by minimising the flow of new homeless people onto the streets and preventing a return to sleeping rough after a period of settled accommodation. Supported Accommodation is vital to the delivery of the homelessness and rough sleeping strategies for people with high levels of needs/risk unable to acquire and manage an independent tenancy, as well as providing support in the community to people with mental health and complex needs to tackle the root causes and prevent homelessness.

3.8 **The Digital Inclusion Strategy for Cornwall and the Isles of Scilly 2019-2023**[8] outlines why digital inclusion is an issue and how all sectors across Cornwall and the Isles of Scilly can work together to help address some of the barriers that residents and organisations face and need to overcome in order to access and embrace the digital world. It is essential that residents are supported to understand and improve basic digital essential skills. The Service Provider will be expected to promote digital inclusion in Cornwall.

3.9 **Engagement and consultation** took place over a two year period regarding the review and recommissioning of the ASC Prevention Offer. Increasing social capital, making local connections, developing community opportunities and sharing resources were considered vital to preventing the need for health and social care. People would like to feel they belong to their local community and would like to be able to easily access activities and support groups in their local area.

[5] Cornwall Council (2018) *Adult Social Care Prevention Offer Strategic Commissioning Intentions 2018-2022*
[6] Cornwall Council (2015) *Our Homelessness Strategy for Cornwall.*
[7] Cornwall Council and Cornwall Housing (2017) *Rough Sleeping Reduction Strategy 2017-2020.*
[8] Cornwall and the Isles of Scilly Leadership Board (2019) *The Digital Inclusion Strategy for Cornwall and the Isles of Scilly 2019-2023*

3.10 **Research and best practice** has been reviewed to inform the ASC Prevention Offer. The Provider will be required to give consideration to the following in their approach to Service delivery.

- Poor health can lead to homelessness and homelessness can lead to poor health[9]. People at greater risk of homelessness include people with needs related to mental health, domestic abuse, substance misuse and people with multiple and complex needs. Homelessness, and the fear of becoming homeless, can also result in ill health or exacerbate existing health conditions. As well as mental health and complex support needs, Service Users may have also experienced homelessness and have chaotic lifestyles. The Empowering Independence Service will help to prevent homelessness and offer support and accommodation to homeless adults with complex needs.
- According to Public Health England[10], there are healthy lifestyle choices that reduce our chances of becoming unwell. These include not smoking, eating a good diet, being physically active, reducing our alcohol intake, not taking illegal drugs, and taking care of our mental health. The Service Provider will be expected to take promotion of a healthy lifestyle into consideration as part of the Service delivery model.
- Evidence suggests that a small improvement in wellbeing can help to decrease some mental health problems and also help people to flourish. The New Economics Foundation[11] (NEF) *Five Ways to Mental Wellbeing* report sets out five actions to improve personal wellbeing that will need to be taken into consideration by the Service Provider in their approach to delivering the Service: connect, be active, keep learning, take notice and give.
- In accordance with the strategic direction of care and support services in Cornwall, the Service Provider will be required to take a strengths-based approach. A strengths-based approach values the capacity, skills, knowledge, connections and potential in individuals and communities. Staff members will need to work in collaboration with people accessing the Service, helping people to do things for themselves and to develop their own independent living skills. In this way, people can become co-producers of support, rather than passive consumers of support.
- The aim is to commission services that deliver better outcomes for individuals, and recognise that services need to be flexible and adaptable in order to meet this effectively. The Service Provider will be required to work with people accessing the Service to identify the outcomes that are important to the, and to develop outcome focused support plans.

4. Service Conditions

4.1 **Service access:** The Service Provider will consider referrals for the Service from:

[9] Local Government Association (2017) *The Impact of Homelessness on Health: A guide for local authorities*.
[10] Public Health England (2018) Health Profile for England: 2018 – Chapter 3.
[11] New Economics Foundation (2008) *Five Ways to Mental Wellbeing.*

- People who approach health and social care agencies requesting care and support, including people that are not eligible for social care and people going through the social care assessment and support planning process
- People who approach health professionals or people who are receiving treatment for health conditions, including but not limited to people accessing General Practitioners; or leaving hospital, drug and alcohol community treatment, detoxification, rehabilitation, or mental health services
- People who have been supported by rough sleeper/homelessness services, including but not limited to Cornwall Housing services, the Rough Sleeper Outreach and Resettlement service or the Homeless Crisis Accommodation service
- People who approach other Council and public sector services identified as having complex and/or mental health needs, including but not limited to people identified by Housing, Police, Probation, Fire and Rescue, Trading Standards or Revenue and Benefits services
- Any other referral sources where a person is identified as having mental health and/or complex need and may benefit from the Empowering Independence Service.

4.2 The Service Provider will be expected to develop a fair and transparent process for prioritisation of referrals in collaboration with Commissioners. Priority will be given to:

- People referred through the multidisciplinary High Risk Behaviour Panel
- People who are homeless or at risk of homelessness
- People who are accessing inpatient services including hospital, detoxification, rehabilitation, or mental health services and are ready for discharge
- People at risk of re-admittance to inpatient services including hospital, detoxification, rehabilitation, or mental health services without support from the Service.

4.3 There will be a demonstrable commitment to fair access, diversity and inclusion. Staff members will receive training on equality and diversity and ensure people are treated with dignity and respect. The Service Provider will proactively promote the Service, and ensure information about the service is accessible and available in forms reflecting the diversity of the local population. The Provider will ensure people with communication and/or cognitive impairments have equal access to the Service.

4.4 No blanket exclusions will apply and referrals will be assessed on a case by case basis. Providers will be expected to consider those who may have a schedule one offence or a history of arson. Where demand for the Service exceeds the Service capacity, the Service Provider will ensure that the referrer is informed of capacity issues and aware of alternative services.

4.5 Where appropriate, the Service Provider will assist the person to reconnect with and return to an area outside of Cornwall where the person has proven social and support networks.

4.6 **Service exits:** The Service Provider will ensure that there is continuous flow through the Service and that people are exited as appropriate to allow new Service Users to gain access to provision. The Service will provide appropriate support for Service Users during periods of crisis and will only refuse access to support or withdraw support prematurely in exceptional circumstances after all other options have been exhausted. Where the Service User presents needs or behaviour that the Service is not able to support, the Service Provider will proactively engage with other agencies / services to ensure that the Service User continues to be supported and have access to accommodation as appropriate.

4.7 **Strengths-based approach:** The Service will be provided in a manner that is flexible, person-centred and responsive to the individual needs and agreed outcomes of the Service User. The Service User will be supported to identify their strengths and to develop the skills and knowledge needed to achieve their goals. Service Users will be supported to develop increased self-esteem, self-worth and to integrate into their community.

4.8 All Service Users will have an up-to-date, outcome-focused support and risk management plan that is reviewed with appropriate frequency and includes input from other agencies as appropriate. Support plans will reflect any cultural, religious and lifestyle needs.

4.9 Staff members will initially offer information and advice and support to help people self-advocate; non-statutory advocacy will be offered when required. This includes but is not limited to helping people to complete forms and utilise online self-help tools related to independent living and self-management of health and wellbeing.

4.10 The Service Provider will ensure that, where possible and practicable, people accessing the Service have opportunities to be involved in all aspects of the Service. This will include but is not limited to decision making, planning and reviewing the service, staff recruitment, induction and training, and service delivery.

4.11 **Making community links:** The Service Provider will establish close working relationships with a range of statutory, voluntary and independent sector agencies and support Service Users to engage with these agencies. This includes but is not limited to NHS, social care and wellbeing, learning, work related, benefits, housing, and leisure services/ activities.

4.12 The Service Provider will support Service Users to develop their own social networks, encouraging links with family, friends, peer support/volunteers and the wider community. This will include but is not limited to utilising innovative approaches to facilitating volunteering opportunities such as time-banking. The Service User will be supported to resolve any issues with neighbours and to understand their rights and responsibilities as a member of their local community.

4.13 The Service Provider will be expected to work closely with local communities to help towards building better community resilience and encouraging community participation. This will include opportunities to enhance the Service through the provision of unpaid staff members and supporting people to ensure their volunteering experience is positive.

4.14 The Service Provider will help people to identify transport solutions when required to enable people to participate in community activities, develop social networks, access required services, or to return home from an inpatient service.

4.15 **Independent living skills:** The Service Provider will deliver support to help people to develop and increase independent living skills. This will include but is not limited to supporting people with securing and maintaining accommodation, managing domestic tasks, managing finances and budgeting, and accessing employment, education and training.

4.16 The Service Provider will support the Service User to determine whether their accommodation is fit for purpose and to identify opportunities for home adaptations, improvements or repairs when required; or to identify and secure appropriate alternative accommodation and make a planned move when required. This includes but is not limited to registering and bidding for social housing, as well as identifying and applying for private rented accommodation. The Service Provider will ensure that best use is made of existing resources, including but not limited to establishing links with Cornwall Housing's Housing Options service and Cornwall Council's Home Solutions service. The Service Provider will ensure that Service Users living in Supported Accommodation have access to tenancy accreditation training that provides them with evidence of tenancy readiness for housing providers at the point of move on.

4.17 The Service Provider will support Service Users to develop and increase daily living skills required to maintain accommodation and manage domestic tasks, including but not limited to paying for utilities, shopping, cooking, cleaning and laundry.

4.18 The Service Provider will be expected to support Service Users to understand the money that they receive, the bills they need to pay and to access benefits as required. People accessing the Service will also be supported to manage debt and to plan for the future.

4.19 The Service Provider will support people to prepare for and access education, employment and training opportunities as appropriate. This will include but is not limited to helping people to identity employment options and making links to programmes and projects set up specifically to support people with health and wellbeing needs to access education, employment and training opportunities.

4.20 **Digital inclusion:** The Service Provider will be expected to support Service Users to make links to programmes and initiatives set up to increase digital inclusion in Cornwall, in accordance with the Digital Inclusion Strategy described above. The national essential digital skills framework[12] defines the digital skills adults need to safely benefit from, participate in and contribute to the digital world.

4.21 The Service Provider will support Service Users where appropriate to make best use of technological solutions to empower independence. This will include but is not limited to consideration of access to apps and online platforms that support independent living and

[12] Department of Education (2018) *Essential digital skills framework.*

self-management of health and wellbeing. The Service Provider will ensure that people living in supported accommodation have access to a digital device and Wi-Fi.

4.22 **Self-managing health and wellbeing:** Staff members will receive training on offering practical support to Service Users to attain a healthier lifestyle and to self-manage their mental health and wellbeing, including during a crisis. This will include but is not limited to training on Making Every Contact Count, Connect 5, Mental Health First Aid and Suicide First Aid (including Applied Suicide Intervention Skills Training) delivered by Healthy Cornwall. Staff members will have received training on harm reduction and supporting people with complex needs related to alcohol and/or drugs and mental health. Providers will be expected to participate in local naloxone and other harm reduction programmes.

4.23 Where applicable:

- The Service Provider will take a key worker approach to coordinating support for the Service User from specialist services.
- The Service Provider will support Service Users to appropriately manage and reduce their use of alcohol and/or drugs in a safe and measured manner, in partnership with specialist treatment agencies as appropriate. Staff members will take a harm reduction approach and support individuals: 1) who use alcohol and/or drugs to reduce immediate and ongoing harm to their health; 2) who self-harm to undertake practices which minimise risk of greater harm; 3) to undertake practices that reduce harm and promote recovery in other areas of physical and mental health and wellbeing.
- The Service Provider will support Service Users to appropriately manage their mental health and will offer flexible support during any periods of fluctuation of their mental health needs. This will include but is not limited to working in partnership with specialist mental health services to agree and deliver the person's care and support plan. The Service Provider will prompt people to dispense and administer their own medication as appropriate.

4.24 The Service Provider will support the Service User to access appropriate general healthcare provision, including but not limited to registration with a General Practitioner and Dentist.

4.25 The Service Provider will support people to identify changes to their lifestyle that could impact on their health and wellbeing, utilising the Five Ways to Wellbeing principles, and to learn how to self-manage, including self-managing physical health, mental health, emotional wellbeing and alcohol/drug use. The Service Provider will deliver low level practical support with necessities including ensuring that nutritional and hydration needs can be met, and heating and other utilities are functioning as appropriate.

4.26 **Protection, health and safety:** There will be a commitment to safeguarding the welfare of adults and children and to working in partnership to protect vulnerable groups from abuse. There will be policies and procedures for safeguarding and protecting adults and children that are in accordance with current legislation and are reviewed annually. Staff members will have received appropriate training in relation to safeguarding children and adults,

confidentiality and professional boundaries. All relevant Staff delivering the service must have an enhanced Disclosure and Barring Service check that is renewed every three years. The Service Provider will participate in multi-agency case reviews as appropriate and utilise developing safeguarding processes.

4.27 Where applicable, the Service Provider will work with people accessing the Service to support them to appropriately reduce their response to financially harmful activities, including but not limited to mass mailing scams or romance scams. This will include but is not limited to establishing links with Trading Standards and the Police as appropriate.

4.28 The security, health and safety of people accessing the Service, Staff and the wider community will be protected. Risk assessments of the Service will be conducted at the start of service delivery and reviewed following an incident or otherwise at least annually. There will be health and safety, lone working and information governance policies and procedures that are in accordance with current legislation and that are reviewed annually. Staff members will have received appropriate health and safety, first aid and information governance training. The Service Provider will be expected to hold and maintain a valid health and safety accreditation for the duration of the Contract. People accessing the Service and Staff will know how to access help in a crisis or emergency.

4.29 The Service Provider will engage in health, social care, drug and alcohol and criminal justice governance processes by reporting deaths and other serious incidents, including but not limited to near deaths, to the relevant Commissioners. This includes but is not limited to reporting of naloxone training, supply and usage to the Council's Drug and Alcohol Action Team, engaging in case reviews following incidents, and contributing to and implementing the learning as appropriate.

4.30 The Service Provider will support Service Users to complete a health and safety checklist when visiting a Service User in their home environment. This will include but is not limited to consideration of fire safety, staying warm and well and identifying health and safety hazards in the home. Staff will be aware of how to make referrals for support where health and safety concerns have been identified.

4.31 There will be up-to-date policies and procedures for complaints and compliments that are reviewed annually. Complaints and compliments that are received by the service will be reviewed quarterly to enable key themes to be discussed at Contract Review Meetings and will be used to inform service development.

4.32 **High Risk Behaviour Policy:** This multi-agency policy and procedure has been written to provide guidance and a framework for professionals around safeguarding adults who are displaying high risk behaviours and at high risk of self-neglect. This policy is designed to be used once all other individual agency risk assessment and risk management approaches have been considered and tried. This policy introduces a formalised process of escalating cases for Council-led multi-agency collaboration and actions for people who present with high risk behaviours. Strategic responsibility for managing high risk behaviour in Cornwall and the Isles of Scilly (CIoS) rests with the CIoS Safeguarding Adults Board (SAB). The CIoS

SAB has established a dedicated High Risk Behaviour Panel for complex cases, which draws on the views of other partner organisations as appropriate. The Service Provider will be expected to prioritise referrals from the High Risk Behaviour Panel to offer access to the Service and a key worker approach to coordinate the care and support offered through specialist services.

4.33 The Service Provider may also make referrals to the High Risk Behaviour Panel in accordance with the policy where all appropriate steps to support an individual with high risk behaviour have been exhausted.

4.34 **Accommodation:** The Service Provider will ensure that Service Users are supported in an appropriate accommodation environment. The accommodation will be fit for purpose and appropriate to meet people's needs. However, it should be noted that this contract covers revenue funding for the support service only and not rental or capital funding for the accommodation or for housing management functions. It will be the responsibility of the housing provider to ensure compliance with all current statutory enactments, regulations and policies related to residential buildings, including fire protection. The housing provider will be expected to make best use of separate funding to offer help with additional housing management functions, including but not limited to enhanced Housing Benefit for Intensive Housing Management. Service Level Agreements will be in place where required to ensure that the responsibilities of the Service Provider and the housing provider are clear.

4.35 Each unit of Supported Accommodation will offer private bedroom space and meet appropriate national and local standards. Shared laundry, toilet, washing and kitchen facilities are required. Communal areas are required that offer opportunities for people accessing the Service to undertake group activities, including recreational activities and training. Sufficient office space should be provided to accommodate the required Staff for the service. There should be the provision for private meeting space for Staff to meet as a team, undertake one-to-one meetings, as well as space that can be utilised by other agencies. Sufficient outdoor space should be available that includes access to plants, trees and the natural environment. The Service Provider will also be expected to give consideration to how to accommodate people with pets.

4.36 Service Users will be offered self-contained accommodation when necessary to meet their needs, including but not limited to vulnerable females, people with high risk behaviours and people with mental health needs.

4.37 SWEP activation accommodation is not subject to the requirements above. It is expected that a chair would be provided in a safe communal area and that hot drinks would be made available. SWEP access is subject to risk-assessment to be completed by the Service Provider.

4.38 **Partnership working:** The Service Provider will work with other providers delivering support services for people with complex and/or mental health needs in Cornwall and

Commissioners to develop and agree a Service Level Agreement (SLA) regarding partnership working. The purpose of the SLA will include but is not limited to ensuring:

- Information sharing protocols are in place across organisations;
- There are no blanket exclusions and people with chaotic lifestyles and high risk behaviours are able to access support;
- A coordinated approach is developed to monitoring access to and exits from support services for people with complex and/or mental health needs in collaboration with Commissioners. This will include but is not limited to the Rough Sleeper Outreach and Resettlement service, Crisis Accommodation service, and the Empowering Independence services.

4.39 The Service Provider will work in partnership with other providers delivering support, health and social care services in Cornwall. This includes but is not limited to Social Inclusion and Empowering Independence services commissioned through the ASC Prevention Offer, and the Homeless Families and Homeless Young People services commissioned by Children's Schools and Families.

4.40 The Service Provider will engage in other pieces of multiagency complex needs work as directed by Commissioners, including but not limited to Safer Towns, Making Every Adult Matter, Blue Light, Time Credits and Making Every Contact Count.

4.41 The Service Provider will engage in other programmes and projects aimed at developing preventative approaches in Cornwall, including but not limited to the development of the prevention theme under Shaping Our Future.

5. Statement of Requirements

5.1 **The key aims** of the Service are to:

- Enhance quality of life for people with health and wellbeing needs
- Reduce or delay the need for formal care and support
- Prevent and reduce Rough Sleeping and homelessness in Cornwall
- Reduce unplanned use of emergency services

5.2 **The key objective** of the Service is to improve the pathway of support for adults with complex and/or mental health needs in Cornwall.

5.3 **The key outcomes** of the Service are:

- Improved self-management of health and wellbeing
    - Increased social inclusion
    - Improved emotional wellbeing
    - Managing physical health
    - Managing mental health

  - Managing behaviour/lifestyle

- Increased independent living skills
  - Secured and maintaining accommodation
  - Managing money
  - Accessing education, employment and/or training
  - Developing healthy lifestyle skills
  - Managing risk of harm from self/others

5.4 **Service components:** This will be achieved through delivery of the following three Service components as described below.

A. Community Outreach: The Service Provider will offer support on a one-to-one or group basis, face-to-face, online or by telephone to people living in the community regardless of tenure. This component of the Service will provide all levels of support for people with complex and/or mental health needs living in independent accommodation.

B. Supported Accommodation – high/medium tolerance: The Service Provider will offer accommodation with support to people who are unable to access accommodation in the community due to high levels of risk/need related to complex needs and/or mental health. In addition, up to five 'sit-up' spaces should be available under SWEP activation. This component of the Service will provide high to medium levels of tolerance to drugs and alcohol and high to medium levels of support. The aim of these services although not to condone or approve of the possession, use or supply of illicit drugs, is to work with those who currently use a range of legal and illegal drugs. Service Providers will seek to work with Service Users to promote their wellbeing and reduce harm. In order to do this, it will seek to offer a Service that is accessible to drug users, and will seek to avoid excluding drug-using Service Users where possible. The Service will also have naloxone accessible to minimise the risk of death from opiate overdose. While providing an accessible and inclusive Service to people who use drugs, the Service Provider will also recognise that it has other duties and obligations including but not limited to:

- An obligation to work within the law (Specifically Section 8 Misuse of Drugs Act (1971) and the Psychoactive Substances Act (2016)
- A duty to provide a safe Service for all workers and volunteers
- A duty to provide a safe Service for all Service Users, including non-users
- A duty to work with and be sensitive to the local community.

A detailed drug/alcohol policy will be required that is in accordance with the legal framework, and the Service Provider will be expected to operate in line with the local Substance Misuse on the Premises protocol agreed with Devon and Cornwall Police.

C. **Supported Accommodation – limited tolerance:** The Service Provider will offer accommodation with support to people who are unable to access accommodation in the community due to high levels of risk/need related to complex needs and/or mental health. This component of the Service will provide limited levels of tolerance to drugs and alcohol and high to medium levels of support. It is for people who have changed their behaviour in relation to drug/alcohol use but still need some flexibility to maintain this change, as well as people that have not had drug/alcohol problems, including but not limited to people with mental health needs only. Service Users will not be using drugs/alcohol in the main but may still have occasional relapses. The Service will include flexibility for those who relapse and will give people the opportunity to re-focus on not using. However, ultimately if people relapse they will be supported to find alternative accommodation. A detailed drug/alcohol policy and clear relapse policy will be required. The Service will focus on supporting recovery and building the resilience of people with mental health needs, not just on treating or managing their symptoms.

5.5 **Length of service delivery:** The maximum duration for a person to access Community Outreach would typically be no more than six months. The maximum duration for a person to access Supported Accommodation would typically be no more than two years. Where the Service Provider determines that the Service User still requires ongoing support from the Service to achieve their desired outcomes, and/or there is a delay in moving on from Supported Accommodation, the Service User may continue to access the Service for a longer period. The Service Provider will be expected to report any extended service delivery and the reasons to Commissioners for discussion. The Service Provider will also be expected to determine in collaboration with Commissioners whether the Service User would be better supported through alternative service provision, including making a referral for an ASC assessment to determine if the person is eligible for social care if appropriate. The duration of SWEP access is weather-dependent and can range from one night only to multiple nights.

5.6 It has been identified that there is currently an insufficient level of independent accommodation available for people with complex and/or mental health needs ready to move on from Supported Accommodation. The Service Provider will work in partnership with other support and housing providers, the Council and Cornwall Housing to ensure access to independent accommodation which is accessible and affordable for Service Users ready to move on from Supported Accommodation.

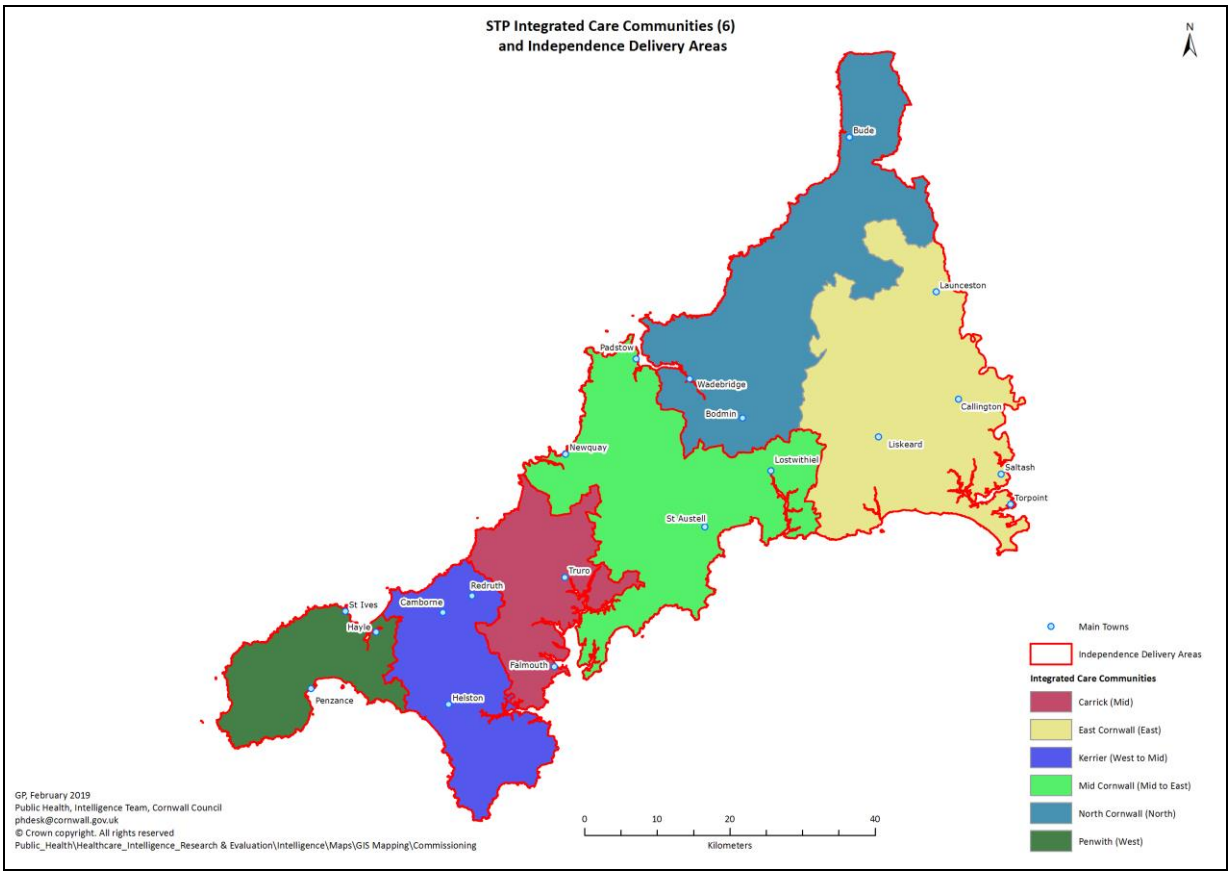
5.7 **Locality based commissioning and provision:** This Contract is one of five locality based contracts for the Empowering Independence Service across Cornwall. The Provider will ensure that the Service is delivered flexibly to meet needs within a local area and will work in partnership with other Empowering Independence providers to ensure a clear pathway of provision across Cornwall. This Contract is for the area(s) set out in the table below.

[PLEASE DELETE ROWS AS APPROPRIATE FOR FINAL CONTRACT]

AREA 1	WEST

AREA 2	WEST TO MID
AREA 3	MID
AREA 4	MID TO EAST
AREA 5	EAST AND NORTH

The map and table below show the total breakdown of provision across Cornwall and the anticipated approximate number of Supported Accommodation units and people supported through Community Outreach within each area. The final breakdown of Supported Accommodation units and numbers of people to be supported through Community Outreach within each area will be determined during the tender process. The Service Provider will ensure that the Supported Accommodation units are dispersed across the Contract area to meet the needs of people accessing the Service. A locality based approach will allow services to vary to meet needs within a particular area of Cornwall.



Contract	Service component	Units/People
1. West	Supported Accommodation – High/medium tolerance	30
	Supported Accommodation - Limited tolerance	10
	SWEP – sit up spaces	5
	Community Outreach	50
	Total Contract 1	**90**

2. West to Mid	Supported Accommodation - High/medium tolerance	40
	Supported Accommodation - Limited tolerance	10
	SWEP – sit up spaces	5
	Community Outreach	60
	Total Contract 2	**110**
3. Mid	Supported Accommodation - High/medium tolerance	40
	Supported Accommodation - Limited tolerance	10
	SWEP – sit up spaces	5
	Community Outreach	60
	Total Contract 3	**110**
4. Mid to East	Supported Accommodation - High/medium tolerance	40
	Supported Accommodation - Limited tolerance	10
	SWEP – sit up spaces	5
	Community Outreach	60
	Total Contract 4	**110**
5. East and North	Supported Accommodation East - High/medium tolerance	10
	Supported Accommodation East - Limited tolerance	5
	SWEP – sit up spaces	2
	Community Outreach East	25
	Supported Accommodation North - High/medium tolerance	10
	Supported Accommodation North - High/medium tolerance	5
	SWEP – sit up spaces	2
	Community Outreach North	25
	Total Contract 5	**80**

5.8 **A lead provider approach** to the Contract will be encouraged, which could include a consortium of providers, or a lead provider with subcontracted providers. This would allow one Contract to offer an Empowering Independence Service to people with complex and/or mental health needs, with specialist providers forming part of the agreement to meet specific needs. The Service Provider will be expected to demonstrate the arrangements in place to ensure the needs of different people can be met as set out in Section 2.

5.9 **Flexible budget:** 5% of the Contract value is to be used flexibly to meet the individual needs of Service Users based on the strengths and goals identified in the personalised support plan. This budget may be utilised for, but is not limited to purchasing equipment/ technological solutions, and/or paying for access to facilities/services/resources and/or purchasing basic necessities, for daily living or self-management of health and wellbeing. However, it is to be used flexibly to meet personalised needs.

5.10 **Call-off component:** In addition to the service detailed above, this contract contains a call-off component, which will allow additional hours to be purchased from the Service Provider in accordance with this Service Specification where determined that a higher number of hours are required for the individual. This includes additional one-to-one hours for individuals as determined through the High Risk Behaviour Panel, or the assessment and support planning process completed by health and social care agencies and purchased on an individual basis. Additional one-to-one hours will only be purchased when it is determined that the core support Service will not be enough to meet the person's needs. The Service Provider will be expected to work with Commissioners to complete and monitor the assessment of needs, the outcomes to be achieved and the timescales. The Service Provider will take a key worker approach and coordinate support from specialist services as required. Additional hours may also be purchased for SWEP activations, where maximum capacity and/or the complexity of the individuals accessing SWEP would impact on standard staffing resources. The Service Provider would be expected to work with Commissioners to identify and agree such additional hours.

6. Contract Management and KPIs

6.1 The Empowering Independence Service will be formally reviewed by the Council during the contract period. This includes the components as described below.

6.2 **Performance monitoring:** The Service Provider will ensure that appropriate tools are in place to record and review outcomes and outputs.

- Strategic outcomes - The Service Provider will be expected to work with Commissioners and partners to develop an approach to evidencing the following key aims of the Service during the Contract period.
    - Enhance quality of life for people with health and wellbeing needs
    - Reduce or delay the need for formal care and support
    - Prevent and reduce Rough Sleeping and homelessness in Cornwall
    - Reduce unplanned use of emergency services

  This will include but is not limited to development of an evidence based approach to reporting on the Social Return on Investment (SROI) of commissioning the Service. SROI captures social value by translating outcomes into financial value.

- Individual outcomes - Quarterly outcomes monitoring information will be submitted by the Service Provider using an Excel workbook provided by the Council. The Service Provider will be expected to demonstrate how the Service supports Service Users to progress towards achieving their desired outcomes. This will include monitoring the number of Service Users progressing towards achievement of individual outcomes as well as case study examples, including but not limited to written stories and/or vlogs. The Service Provider will develop tools to record and monitor progress towards achieving individual outcomes at point of access, at regular intervals during service

delivery, at point of exit and three/six/ twelve months following planned exist from the Service. Outcomes are expected to be person centred based on the needs of the individual and therefore the outcomes below may not apply to everyone.

INDIVIDUAL OUTCOMES	
Outcome Domain	**Individual Outcome**
Improved self-management of health and wellbeing	Increased social inclusion
	Improved emotional wellbeing
	Managing physical health
	Managing mental health
	Managing behaviour/lifestyle
Increased independent living skills	Secured and maintaining accommodation
	Managing money
	Accessing education, employment and/or training
	Developing healthy lifestyle skills
	Managing risk of harm from self/others

- Outputs - Quarterly output monitoring information will be submitted by the Service Provider using an Excel workbook provided by the Council. The Service Provider will be expected to demonstrate the delivery of the following output measures. Deadlines for submission of performance data will be provided by the Council on an annual basis.

OUTPUTS	
Output Domain	**Output**
Numbers of referrals and people supported	Number of accepted referrals and referral source
	Number of rejected referrals and reasons for refusals
	Number of people supported by each Service component
	Number of people with primary, secondary and tertiary needs related to 1) mental health, 2) alcohol/drugs, 3) other complex needs
	Number of people that were homeless / at risk of homelessness at point of access

Number of support hours	Number of paid support hours delivered
	Number of unpaid support hours delivered
Types of support provided	Number of services, facilities, resources accessed in community and type
	Number of people who made progress towards personal goals
	Number of people with a flexible budget in place, value and categories of spend
	Number of safeguarding concerns raised
	Number of referrals to the High Risk Behaviour Panel
Length of Service delivery	Number of people supported for up to 6 months
	Number of people supported between 6 and 12 months
	Number of people supported between 12 and 24 months
	Number of people supported for over 24 months
Exists from the Service	Planned exits and move-on type
	Unplanned exits, reasons and move-on type

6.3 The Service Provider will also provide the Council with any agreed additional performance information requested during the contract. The content, structure, frequency and tools used for the monitoring and assessment of this contract may be changed at any time by the Council in consultation with the Service Provider. However, any such change will not constitute a variation to the Contract and therefore the service provider will implement any such change of procedure at its own risk and cost.

6.4 **Satisfaction feedback:** Annual feedback will be required on request from people accessing the Service, carers, staff members and key stakeholders to provide satisfaction and experience of Service. The feedback will be shared with Commissioners and used by the service provider to improve the service.

6.5 **Quality assurance:** Quality concerns will be reported through the ASC Quality Assurance process and followed up as appropriate. A quality assessment will be undertaken on an annual basis in accordance with the standards set out in this Specification. This may include a self-assessment and/or a Service visit.

6.6 **Contract Compliance Meetings:** An annual Contract Compliance Meeting will take place between Commissioners and the Service Provider to check all Contract compliance requirements in accordance with this Service Specification.

6.7 **Contract Review Meetings:** Quarterly Contract Review Meetings will take place between the Council, the Service Provider and other strategic partners where appropriate. This will present opportunities to discuss any issues and evidence of good working practice in relation to:

- Performance outcomes and outputs data
- Policies and procedures
- Staff recruitment and training
- Fair access and exit
- Complaints and compliments
- Safeguarding
- Partnership working
- Service improvement plans
- What is working well/less well to inform future commissioning

6.8 **Operational Management Meetings**: These meetings offer a formal opportunity for both parties to discuss important aspects of the Contract, ensuring that issues are recorded and actions being taken are documented and agreed. These meetings will take place at intervals throughout the Contract period as agreed with Commissioners.

6.9 **Accommodation:** The Council also retains the right to inspect the appropriateness of the accommodation offer in accordance with this service specification at any time.

6.10 The following **Key Performance Indicators** will be used to monitor the performance of the locality based Contracts.

Key Performance Indicators (KPI's)					
Outputs	**Annual Target**				
	Area 1. West	**Area 2. West to Mid**	**Area 3. Mid**	**Area 4. Mid to East**	**Area 5. East and North**
Total number of people accessed/accessing the Service	90	110	110	110	80

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