Specification

Empowering Independence Service – Physical Health Needs and/or Disabilities

1 October 2019 – 30 September 2022

Version 0.2

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.

“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.

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 physical health needs and/ or disabilities and have been identified as potentially benefiting from access to the Service.

1.4 This Contract will be delivered countywide.

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
- Reduce unplanned use of emergency services

1.6 **The key objective** of the Service is to improve the pathway of support for adults with physical health needs and disabilities in Cornwall.

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

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

1.8 This will be achieved through delivery of **Community Outreach.** The Service Provider will offer short term support to people living in the community regardless of tenure.

1.9 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.

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 physical health needs and/or disabilities and

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

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 physical health needs and/or disabilities related to one or more of the following **primary needs**:

- physical health needs, including but not limited to physical disabilities, mobility issues, HIV, visual and hearing impairments and other long term conditions
- cognitive impairment, including but not limited to dementia
- learning disabilities
- neurological development disorders, including but not limited to autistic disorder, Asperger's syndrome and pervasive development disorder

2.3 People accessing the Service may also be experiencing other multiple disadvantages related to mental health, emotional wellbeing, drugs and alcohol, acquired brain injury, high risk behaviours, 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 It is anticipated that on an annual basis at least two hundred and fifty (250) people will be supported through this Community Outreach Service.

2.5 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 health 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 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.

3.2 **Shaping Our Future**[2] 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.

[2] www.shapingourfuture.info

- 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.

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.

3.3 **The ASC Prevention Offer Strategic Commissioning Intentions 2018-2022**[3] 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.

3.4 **The Digital Inclusion Strategy for Cornwall and the Isles of Scilly 2019-2023**[4] 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.

3.5 **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.

3.6 **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:

- According to Public Health England[5], 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

[3] Cornwall Council (2018) *Adult Social Care Prevention Offer Strategic Commissioning Intentions 2018-2022*
[4] Cornwall and the Isles of Scilly Leadership Board (2019) *The Digital Inclusion Strategy for Cornwall and the Isles of Scilly 2019-2023*
[5] Public Health England (2018) Health Profile for England: 2018 – Chapter 3.

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[6] (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 them and to develop outcome focused support plans.

4. Service Conditions

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

- 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
- People who approach other Council and public sector services identified as having physical health needs and/or disabilities, 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 physical health needs and/or disabilities 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:

[6] New Economics Foundation (2008) *Five Ways to Mental Wellbeing.*

- People who are homeless or at risk of homelessness
- People who are in hospital and are ready for discharge
- People at risk of re-admittance to hospital

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 Service 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. 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 **Service exists:** 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 as appropriate.

4.6 **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 with 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.

4.7 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.

4.8 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.

4.9 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.

4.10 **Making community links:** The Service Provider will establish close working relationships with a range of statutory, voluntary and independent sector agencies and support Service

User's engagement with these agencies. This includes but is not limited to: health and wellbeing, learning, work related, benefits, housing and leisure services/ activities.

4.11 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.

4.12 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.

4.13 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.

4.14 **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.

4.15 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.

4.16 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.

4.17 The Service Provider will be expected to support people 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.

4.18 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.

4.19 **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[7] defines the digital skills adults need to safely benefit from, participate in and contribute to the digital world.

4.20 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 self-management of health and wellbeing.

4.21 **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 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.

4.22 Where applicable, the Service Provider will ensure that the Service User is encouraged to access specialist physical and mental health services and supported during any periods of fluctuation of their physical or mental health needs and will work with professionals to agree and deliver the person's support where appropriate.

4.23 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 but not limited to preventing a fall and/or staying physically active and/or mentally stimulated. 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.

4.24 **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 as appropriate including but not limited to the High Risk Behaviour policy.

4.25 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.

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

4.26 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 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 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.

4.27 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.

4.28 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.

4.29 **Partnership working:** The Service Provider will work in partnership with other providers delivering wellbeing, health and social care services in Cornwall to ensure that provision is developed appropriately and referral routes are clear. This includes but is not limited to Social Inclusion and Empowering Independence services commissioned through the ASC Prevention Offer.

4.30 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
- Reduce unplanned use of emergency services

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

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

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

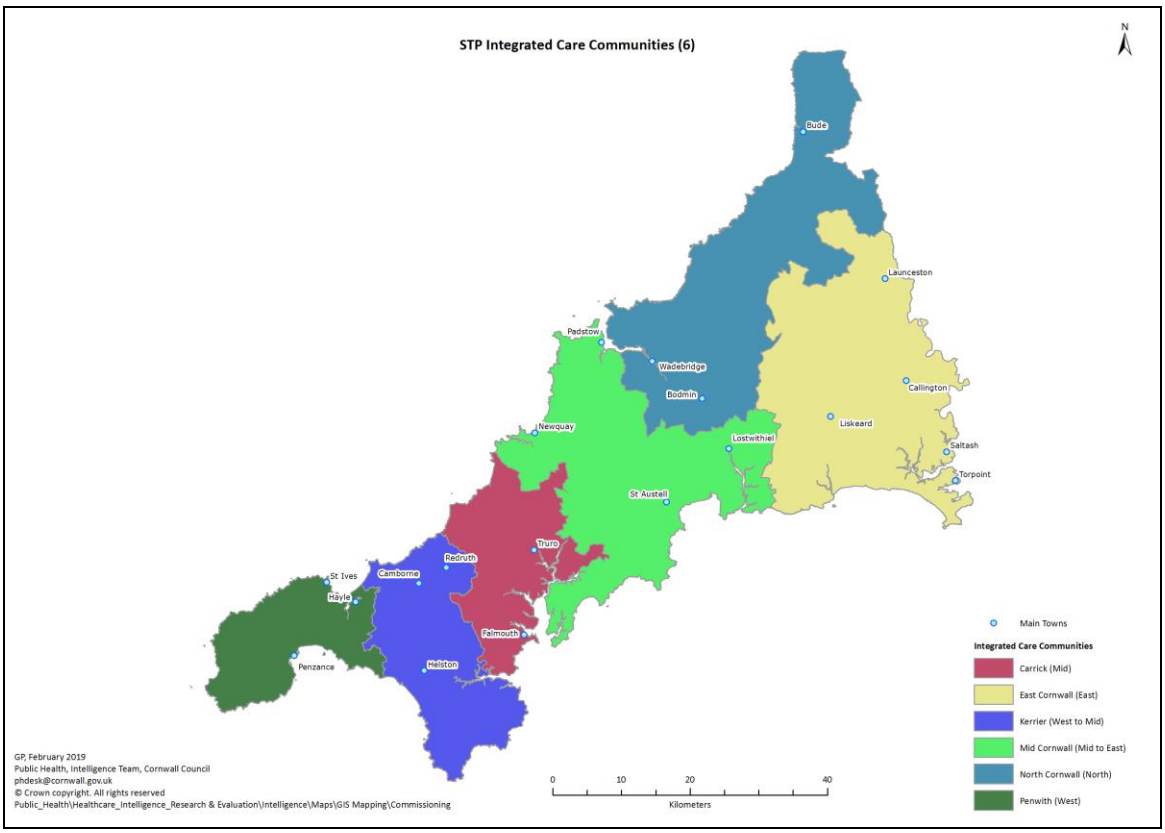
- Managing physical health
- Managing mental health
- Managing behaviour/lifestyle

- 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 This will be achieved through delivery of **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. The Service will provide different levels of support for people with physical health needs and/or disabilities depending on the needs of the individual.

5.5 **Length of service delivery:** The maximum duration for a person to access the Service would typically be no more than six months. Where the Service Provider determines that the Service User still requires ongoing support from the Service to achieve their desired outcomes, 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 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.

5.6 **Locality based commissioning and provision:** A locality based approach will allow the Service to vary to meet needs within a particular area of Cornwall. The Provider will ensure that the Service is delivered flexibly to meet needs within a local area and will give consideration to the approach to Service delivery within the six Integrated Care Communities in Cornwall during the tender process and ongoing Service delivery. As a result, the provision may vary from one area to another.



5.7 **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 physical health needs and/or disabilities, 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 3.

5.8 **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. The Service Provider will monitor the number of people with a flexible budget in place and categories of spend to inform performance returns.

5.9 **Call-off component:** In addition to 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 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.

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
  - 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 the Service
	Number of people/type of primary 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 and categories of spend
	Number of safeguarding concerns raised
	Number of referrals to the High Risk Behaviour Panel
Length of Service	Number of people supported for up to 6 months

delivery	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	Number of planned exits
	Number of unplanned exits and reasons

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 The following **Key Performance Indicators** will be used to monitor the performance of the Contract:

Key Performance Indicators (KPI's)		
	Outputs	**Annual Target**
1	Total number of people accessed/accessing Community Outreach	250

If you would like this information
in another format please contact:

Cornwall Council
County Hall
Treyew Road
Truro TR1 3AY

Telephone: **0300 1234 100**

Email: **enquiries@cornwall.gov.uk**

www.cornwall.gov.uk