SCHEDULE 2c

SERVICE SPECIFICATION

FOR THE PURCHASE OF

Lot 6 - Specialist Support in the Community for People Living with Dementia in West Kent

Lot 7 – Specialist Support in the Community for People Living with Dementia in Thanet & South Kent Coast, and Ashford & Canterbury Coastal

Lot 8 - Specialist Support in the Community for People Living with Dementia in Dartford, Gravesham, Swanley, and Swale

Contents

INTRODUCTION

1. This Service Specification, in conjunction with the Contract Terms and Conditions and other documents which form this Contract, defines the Commissioners' minimum requirements for Service Providers who deliver Specialist Support in the Community for People with Dementia commissioned through this contract. It details the standards and outcomes that must be achieved and describes how these will be evidenced and monitored.

2. This Service Specification sets out the requirements for the provision of Specialist Dementia Services in the Community which are designed to support people living with dementia to improve and maintain their wellbeing, develop resilience and confidence and to help people live as independently as possible through a responsive range of quality service provision and interventions designed to promote wellbeing and support individuals, their Carers and communities to become more resilient and find solutions and support within their community.

3. The term Specialist is used within this Service Specification to express the importance of the service being focused on activity which is specific to Individuals living with dementia; and provided by highly skilled professionals.

4. Delivered in the community, these services will be accessible for individuals who have received a diagnosis of dementia or are showing early signs of a dementia.

5. The services will be outcome focused – the primary aims being to promote wellbeing, support independence and reduce loneliness and social isolation for Kent residents regardless of whether or not they are receiving other services from Adult Social Care.

6. This Specification supports the aim of developing a new outcome-focused care and support model throughout the Contract term to meet the Council's strategic objective that 'Older and vulnerable residents are safe and supported with choices to live independently'.

7. It is important to ensure that the services delivered through this Specification are accessible to all Individual living with dementia in Kent, reflecting their diversity and range of needs and aspirations.

8. The specification has been divided in to two parts. Part A (Community Based Wellbeing Support) is required to commence on 1st October 2021. Part B (Post Diagnostic Support Service) may be introduced via this contract at a later date.

9. This specification has been produced through engagement with older people and Carers, provider organisations, CCG Commissioners and local care leads, District and Borough Councils, key stakeholders in the community and

Kent County Council (KCC) Commissioners. KCC wishes to thank all those who have contributed to this Service Specification.

KENT STRATEGIC CONTEXT

10. Kent is home to 1.55 million people, the most populated county in England.

11. KCC's vision is to help people to improve or maintain their wellbeing and to live as independently as possible. 'Your life, your wellbeing' details the Council's vision for the future of Adult Social Care. As the demand for Adult Social Care is increasing and finances are under pressure, expectations of Adult Social Care are changing.

12. Adult Social Care in Kent needs to continue to respond to these challenges. 'Your Life, your wellbeing' sets our approach to Adult Social Care into three themes that cover the whole range of services provided for people with social care and support needs and their Carers:

    Level 1) promoting wellbeing – Finding out what matters to an individual in their life in order to enable them to live the life they want to live. Supporting and encouraging people to look after their health and well-being to avoid or delay them needing additional support including Adult Social Care.

    Level 2) promoting independence – providing short-term support so that people are then able to carry on with their lives as independently as possible. This will include promoting choice, control, dignity and respect whilst understanding whether an individual's need require urgent interventions.

    Level 3) supporting independence – for people who need ongoing social care support, helping them to live the life they want to live, in their own homes where possible, and do as much for themselves as they can.

13. The following service specification is a key element in achieving the themes above.

14. Preventative community based wellbeing services which help prevent or delay deterioration in people's health and wellbeing, and thereby enable them to live safely in their own homes for longer, are seen to be a key strand in the strategy to reduce demand on health and social care resources. The universal support services commissioned will therefore be available to those who require support, regardless of whether or not they are receiving any services from Adult Social Care.

15. The Council's 'Your life, your wellbeing' strategy is due to come to an end in 2021. Commissioners will work with Providers to ensure that services

commissioned under this contract align with the strategy that supersedes 'Your life, your wellbeing' when it is published. In response to the COVID-19 pandemic the Council is currently working to priorities outlined the Strategic Reset paper presented to the Cabinet in July 2020. The strategic reset sets out the key elements for how, by working in partnership with the Voluntary, Community and Social Enterprise (VCSE) sector in Kent, the county will move successfully towards recovery from COVID-19.

16. The VCSE sector has been increasingly recognised nationally for its contribution to shaping local communities, and its importance is also recognised in Kent. The council's Civil Society Strategy (currently in draft format following a public consultation period) is due to replace the Voluntary, Community Sector (VCS) policy adopted in 2015 and represents the Council's commitment to developing a strategic relationship with the VCSE sector. The Civil Society Strategy recognises the huge contribution made by volunteers to communities, made by both formal and informal volunteers.

17. The NHS, social care and public health in Kent and Medway are working together to plan how we will transform health and social care services to meet the changing needs of local people. The Kent and Medway Sustainability and Transformation Partnership (STP) are focussed on how best to encourage and support better health and wellbeing, and provide improved and sustainable health and care services, for the population of Kent and Medway.

18. The vision for the STP local care model is a:

> "…collective commitment of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well. We will help people to understand that hospitals aren't always the best place to receive care. Clinical evidence shows us that many people, particularly frail older people, are often better cared for closer to home. The model will build a vibrant social, voluntary and community sector to support people to look after their health and wellbeing, connect with others, manage their long-term conditions and stay independent."
> *(The Kent & Medway Sustainability and Transformation Partnership - 'Local Care' Investment Case)*

19. Improving the way the Council works with the NHS through integrated commissioning and provision to promote the wellbeing of adults with care and support needs, including Carers, is vital to delivering the ambition of effective and efficient co-commissioning and delivery. This service must co-operate with any activity to further enhance this and adhere to any developments and enhancements as this develops. Providers will be required to work collaboratively with the Integrated Care System and Local Care Partnerships.

20. It is expected that Providers will work in collaboration with their local Community Navigators and Primary Care Network Link Workers and use the electronic directory of services that is being developed in collaboration with

the STP when it becomes available for use. Providers may also be required to attend MDT meetings where this is considered necessary.

21. The service has been divided into geographical Lots across the county to give providers of all sizes the potential to provide these specialist dementia services. Providers are expected to work collaboratively with any other provider commissioned by KCC to provide specialist dementia services in other areas of the county to share best practice and provide a seamless service.

22. The services commissioned through this Contract is a key delivery and support mechanism for Kent residents being referred from Community Navigation and Social Prescribing Providers.

23. Dementia is predicted to effect just under 25,000 people in Kent in 2020 (Kent Public Health Observatory). An overview of older people profiles can be found in *Appendix 1: Person Profiles* and figures regarding the prevalence of dementia in Kent can be found on the Kent Public Health Observatory.

THE SERVICE

Part A – Community Based Wellbeing Support

24. The service should be person centred and holistic for Individuals living with dementia.

25. The approach will be strength based, focusing on people's personal assets, independence, and social inclusion with a no wrong door approach to ensure that access routes into and though the service are seamless, clear and simple. We want people living with dementia to be fully supported to maintain and improve their wellbeing, to become more resilient and to find solutions and support within their community. The service will need to promote wellbeing as a concept to individuals in order to build resilience and help keep people mentally, emotionally and physically well.

26. The delivery model should aspire to promote wellbeing and offer people ' A Life Not a Service', supporting them to continue participating in activities that they enjoy and to maintain or establish new networks and support systems, rather than a default option of meeting people needs through a formal service. However, a person centred approach must also recognise that how this is achieved will vary depending on the needs of the individual. People with more complex and/or multiple needs may require a more structured offer to help and support them. As such the support and interventions offered through this

service will need to understand and be able to meet the needs and aspirations of this diverse population.

27. The service should deliver interventions that have an evidence based approach demonstrating good practice. This should not stop innovation and creativity to meet the specified outcomes. It would be expected that robust evidence is collected so that evaluation forms part of this process therefore enabling the service to evolve over the lifetime of the contract as necessary to provide services that are evidenced as achieving the outcomes of the service.

28. Mechanisms used to identify the support people need and the appropriate response in each case will vary depending on the needs of the individual and be based on best practice standards. This could include sign posting or support people to take part in activities which promote wellbeing such as those identified through the 'Six Ways of Wellbeing' or via 'One You' national resources. This may include being active (e.g. health walks), learning (e.g. reading), or taking an active role in their community (e.g. volunteering).

29. Providers should have an awareness of the specialist services available in their area which support people (particularly those with physical disabilities, and sensory impairments) their Carers and their families, so that they can refer them on to services which are able to provide them with specialist information, advice and support to help them understand the condition and its impacts.

30. Providers should also work with specialist services to ensure that best practice is incorporated within their own organisation in relation to specialist knowledge and support (for example via staff training).

31. Commissioners want the service to support wellbeing across a range people identified in Paragraph 12 of this Specification, from individuals benefiting from the promotion of wellbeing (Level 1) to individuals requiring more structured support to maintain their independence (Level 3). The aspiration for the Service is by the end of the initial contract period (from year 3 onwards) there has been a shift towards providing more preventative services (that fit under the definitions set out in paragraph 12 – Level 1 and 2) than reactive services (paragraph 12, Level 3), providing that an evidence based evaluation process and demand / need supports this.

32. The service will work with younger people living with dementia and their Carers to develop improved understanding of the needs of this group, given that younger people under the age of 65 with dementia may experience a different set of challenges, they may be less affected by physical health problems and consequently more active and mobile, as such will require more creative and flexible interventions to support their wellbeing. The issues faced by younger people with dementia may also impacts on their families in different ways to families of people with dementia over the age of 65.

33. When the contract commences the services provided must include:

    - A Dementia Helpline (included only within the West Kent contract and will cover all 3 contract areas);

- Dementia cafes for Individuals living with dementia and their Carers
- Dementia peer support groups where Individuals in the early to middle stages of their condition can meet and share experiences and offer mutual support and advice;
- Social opportunities (including day services – excluding where directly funded by Adult Social Care); and
- Befriending services

34. As outlined in this specification KCC and Kent CCG's are working to align funding streams to ensure more appropriate and effective use of all budgets in this area. To this end the specification is also seeking providers to be able to deliver 'Post Diagnosis Support' for those living with Dementia and their families and or carer(s) through the provision of Dementia Co-ordinator roles. These co-ordinators will have specific functions to fulfil in supporting those living with Dementia and their families and or carer(s) to navigate the various statutory and non-statutory support that is available, and act as an advocate when necessary. It is expected that this area of the service could be expanded over the life of the contract as and when other funding is identified.

35. Providers will use an evidence-based approach to develop the services over the contract period as outlined in Paragraph 27 of this Service Specification.

Community Focus

36. Community Navigators have been commissioned under a separate contract to have oversight of the full range of social, health, economic and environmental support available locally and establish excellent knowledge of, and links with, local opportunities and sources of information/support. This includes supporting Individuals to access a range of community activities which allow them to connect with, and contribute to, their local community. Community Navigators are also Trusted Assessors supporting Individuals to access equipment and technology that helps them remain independent for longer

37. Providers should work with their local Community Navigator(s) as appropriate to support Individuals to access their local communities and to identify gaps and trends in services in order to help shape the services provided under this Contract over the contract period.

38. Place-based approaches aims to take a strategic approach to delivering services by brining organisations together around the population they serve. To support this, providers are expected to work with existing community based assets as described in Section 6 (Delivery Network Collaboration) of the Service Specification Schedules.

39. The Council has partnered with Breaking Barriers Innovations to develop a strategy for making complex health and social care systems work for the benefit of residents in an area with the ultimate aim of creating more resilient communities. The project is currently being piloted in Northfleet and Sheppey.

Providers are expected to engage with the project when it is rolled out in each contract area and implement learning from the project as it publishes findings from its activities.

40. Providers are expected to work with existing KCC community based assets as described in Section 6 (Delivery Network Collaboration) of the Service Specification Schedules.

Dementia Friendly Communities

41. People living with dementia have told us that they want to continue to be part of main stream activities and continue living as part of their community for as long as they can, accessing shops, leisure centres, cafes and restaurants as they have always done. We also know that when people receive a diagnosis of dementia (or any other condition) sometimes they retreat and isolate themselves.

42. A Dementia Friendly Community (DFC) is a city, town or village where people with dementia are understood, respected, supported and are confident that they can contribute to community life. A DFC supports all people affected by dementia (such as carers and family members), not just those with a diagnosis. It is important that the community understands, reflects and supports the needs of people with dementia throughout their dementia journey, as their needs develop and change, and not just at the final stages.

43. The aim of all the groups is to share best practice and ideas, promote the Working to Become Dementia Friendly Recognition Symbols, help maintain momentum, help steer in the right direction, helping to create those communities of interest and support the building of relationships and making local connections. Communities are constantly evolving which means our DFC's are too.

44. There are 19 DFC across Kent. Currently, KCC DFC officers support this initiative by:

    - Being the KCC first point of contact for supporting all DFC's/ DAA's;
    - provide different levels of support depending on the individual situation of each group;
    - Promoting and enabling DFC to be independent and run by the community;
    - Attending DFC Meetings either in person or more recently virtually;
    - Refreshing or re-invigorating existing groups;
    - Setting up DFC where they do not exist or supporting interested individuals to set up a group, including engagement with the local community, setting up, chairing and administering meetings;
    - Attending the West Kent Dementia Action Group and attending and facilitating the Kent Wide Dementia Action Alliance;
    - Promoting and facilitating events in Dementia Action Week;

- Supporting with the writing and development of Constitutions;
- Supporting succession planning and moving to community ownership; and
- Communication and engagement with All DFC's regarding wider issues relating to dementia

45. Appendix 3 contains the details of the 19 DFCs across Kent.

46. The Provider will support the administration, set up and running of Kent DFCs in their contract area.

47. The Provider is required to work in partnership with KCC DFC officers and the Kent DFCs to ensure a smooth transition process and the development of the new procedures.

48. Further details of the work of the DFCs can be found below.

Note for Providers on Dementia Friendly Communities: *This draft version of the specification is being published while engagement is ongoing with a range of stakeholders, including the DFCs themselves to gain their input, as to how the successful provider and the DFCs can best work together for the maximum benefit of the community over the contract period. Therefore, providers are asked to note that this section of the specification in particular is subject to modification and commissioners welcome any feedback accordingly.*

Administration of the Working to Become Dementia Friendly Recognition Symbol

49. Kent has its own Working to Become Dementia Friendly Recognition Symbol (WTBDF) which organisations, schools, care and health organisations and sole traders are encouraged to apply for. This symbol is to showcase that an organisation is working towards becoming more dementia friendly for their community. The Symbol was developed by members of the Kent Dementia Action Alliance and is in place alongside the Alzheimer's Society's work on recognising Businesses and Dementia Friendly Organisations.

50. Recognised providers can use their symbol on advertising and literature, have access to their local Dementia Friendly Community support network to share best practice and influence change.

51. WTBDF Providers are asked to meet a short criteria which supports becoming dementia friendly, they are asked to make some pledges and take small

actions and considerations to help make their organisation dementia friendly. Officers encourage joint working with an organisation or group from another sector to help build up support networks within the community and strengthen local connections.

52. Each year Providers are asked to complete a self-assessment in order to renew their status as a recognised provider. There are currently 67 Organisations across Kent that have Kent's Working to Become Dementia Friendly Recognition Status. Applications and reviews are processed by the Dementia Friendly Communities Team and Chairs of DFC's where possible. Specific tasks relating to this carried out by DFCs include:

    - Awareness raising of the symbol;
    - Processing applications Kent wide;
    - Working/ Communicating with the local areas regarding applications, linking DFC's up with organisations;
    - Working with organisations and DFC's to process annual reviews, keeping records and electronic copies;
    - Reviewing requirements of application to ensure they are in line with current guidance/ legislation; and
    - Direction for those organisations where there is not an active DFC in the area

** Of note, the Symbol is owned by the Kent Dementia Action Alliance, not KCC.**

Administration of the Dementia Friendly Kent Awards

53. The Annual Dementia Friendly Kent Awards aim to recognise and celebrate the hard work and dedication undertaken during the last year to improve the lives of people living with dementia in Kent. It is also an opportunity to share good practice and replicate across Kent. Last year this was attended by 200 people. The Awards are funded by external sponsors, many of which are part of our Dementia Friendly Communities across Kent. Nominations for the awards can be made by anyone and are judged by people who are living with or are affected by dementia.

54. Specific tasks relating to this carried out by DFCs include:

    - Working with Chairs of DFC's to plan the event, ensuring we are responding to local need;
    - Promotion of event to DFC's and communities;
    - Seeking and managing sponsorship;
    - Managing/ encouraging nominations;
    - Managing communication and records; and
    - All aspects of event management including planning, attending and facilitating on the day.

Administration of the Seed Fund

55. The Dementia Friendly Communities Seed Fund financially supports the initiation of projects that deliver outcomes which enable people with dementia to remain part of their communities through addressing loneliness and reducing social isolation and/ or which enable people to maintain pastimes, hobbies and activities.

56. Specific tasks relating to this carried out by DFCs include:

- Promotion to DFC's and communities;
- Managing and processing applications;
- Facilitating evaluations of applications and annual reviews; and
- Sharing of best practice

Aims and Objectives of the Service

57. The Provider will work with Individuals to identify their needs in order to deliver the following objectives, which support the Personal Outcomes identified in this specification:

- Individuals are empowered and supported to achieve their personal goals and address any immediate concerns; and
- Individuals' health, wellbeing and independence is improved, or maintained, as a result of the support received

58. The success of the service in meeting the aims and objectives will be assessed using the measurement tool that the Provider choses.

OUTCOMES

59. This specification responds to development in social policy regarding a shift in focus from service inputs to the outcomes they achieve and as such this specification primarily focuses on the outcomes of the services required. This model may appear different from previous specifications as it does not tightly prescribe what providers should do in order to achieve the outcomes required.

60. KCC is confident that provider organisations have the ability and skills to organise their resources in the best way possible to achieve the outcomes specified.

61. Providers are encouraged to operate flexibly, be innovative and 'try new ways of delivering services, outcomes and interventions', then learn and improve what they do. As such KCC welcomes innovative approaches that add value

and maintain and improve Individuals wellbeing whilst also meeting Individuals' needs.

62. Outcome focused services are fundamentally person-centred in approach, recognising that each Individual is unique and will have different requirements and levels of needs. Outcomes can be defined as "the intended impact or consequence of a service on the lives of individuals and communities". An outcomes focused service aim is to achieve the aspirations, goals and priorities as defined by the Individual accessing the service though interventions and activities.

63. KCC is specifying the outcomes which the providers are to achieve, these outcomes have been co-produced and are what people have told us is important to them.

64. This specification details the service outcomes in terms of minimum levels of delivery and requirements. The Contract is not designed to operate at as a full cost recovery model and it is expected that Providers will seek alternative and additional ways of working to ensure all outcomes are fully delivered within West Kent (Lot 6), Thanet and South Kent Coast, and Ashford and Canterbury Coast (Lot 7), or Dartford, Gravesham and Swanley, and Swale (Lot 8).

Personal Outcomes

65. These personal outcomes have been developed through a process of engagement including public consultation, and co-production. The summary report of the public consultation can be found attached to the Kent Business Portal.

66. Some of the personal outcome statements are 'we' and not 'I' statements within this Specification as specialist support services for those living with Dementia should support the individual as well as their family and or Carer(s). When measuring personal outcomes, it may be appropriate therefore to engage family and or Carers in the measurement of outcomes, I addition to the Individual living with Dementia.

67. The Provider is expected to support all Individuals that they work with (under all parts of the Specification) to achieve their personal outcomes by using an approach which best meets each Individual's needs. A range of different responses and approaches will be required, particularly in relation to the level of need and identified goals/outcomes of Individuals.

68. The personal outcomes set out below have been identified by the people of Kent as being important to them and then co-produced with key stakeholders to arrive at the final list:

Information and advice

1. We are supported to access or find the correct and relevant specialist information and advice about my condition and its impact on me, my family and or carer(s)

My Community

2. I am able to access social activities that I enjoy, in a safe space
3. We feel supported in, and by our local community

My Care and Support

4. We feel listened to, by someone with the knowledge and understanding of the condition

My Health

5. I feel less lonely
6. I am supported to live safely and independently and carry out everyday activities that I choose

System Outcomes

69. Commissioners will work with CCG Colleagues and the Provider to measure the system outcomes identified below and demonstrate how the service specified has contributed to the following:

- Reduction in the number of Individuals entering social care and health services unnecessarily;
- Reduction in the level of unmet need at the point of referral to social care or health; and
- An increase in community capacity so that communities are more able to support vulnerable residents to feel less lonely and isolated

Social Value

70. KCC services have a social purpose and therefore the Council will require that services become smarter at determining social value working within the commissioning process. This will be through improving the economic, social and environmental wellbeing of Kent.

71. The Public Services (**Social Value**) **Act 2012** requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area.

72. The Provider must demonstrate how they will contribute to and measure the following social value contributions in their delivery of the contract:

Theme	Description
Good Employer	Support for staff and volunteer development and welfare within the service providers' own organisations and within their supply chain.
Community Engagement & Development	Development of resilient local community and community support organisations, especially those in areas and communities with the greatest need.
Green and Sustainable	Protecting the environment within the providers' own organisation and within their supply chain.

Part B – Dementia Post Diagnostic Support Service

73. KCC and Kent CCGs are in discussions regarding the potential to commission a Post Diagnostic Support Service, funded by the CCGs, as part of this Contract.

74. The aim of a Dementia Post Diagnostic Support Service is to be the main point of contact for the Individual diagnosed and their carer during the entire dementia journey. The service will provide, through the role of a Dementia Coordinator, appropriate emotional support, practical facilitation, guidance and information to meet the needs of those entering the service, as well as facilitating access to well-being interventions which promote independence and quality of life.

75. KCC and CCG commissioners will work with the Provider to develop appropriate specifications and design the service should this requirement be taken forward during the contract period.