**SCHEDULE 1 – Mental Health Intermediate Care**

**SERVICE SPECIFICATION**

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| * 1. **Introduction** |
| * 1. This schedule sets out the specification for intermediate care referred to as a new rehabilitation support Service for adults with mental health needs. This support can be provided to meet the identified needs of individuals within a Residential/Nursing Home, Supported Housing or within a Service User's own home. This Schedule describes the main features of the Service and the outcomes required, and must be considered alongside the contract, framework agreement and ITT document.   2. Definition - A whole systems approach to recovery from mental illness that maximises an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support (RCP, 2009)(Killaspy, 2005)   Rehabilitation is a personalised, interactive and collaborative process, reflecting the whole person. It enables an individual to maximise their potential to live a full and active life within their family, social networks, education/training and the workplace where appropriate.  *Point of clarification for respondents to the consultation (i.e. this note will not be part of the final specification): The framework services agreement, service contract and ITT document will be available during the procurement process.* |
| 1. **Scope** |
| * 1. The Service will be provided to Service Users with care and support needs who: * Meet the national eligibility threshold for care and support as set out in the Care and Support (Eligibility Criteria) Regulations 2014 for the Care Act 2014; * Have unmet eligible needs and outcomes that could be met through the provision of rehabilitation support; and * Are deemed to be ordinarily resident within the administrative area of the named partners within the contract.   1. The Service may also be provided in circumstances where the Authority exercises its powers, under Section 19(3) of the Care Act 2014, to meet a Service User's urgent care and support needs without having first conducted a needs assessment or eligibility determination.   2. The Service is predominantly aimed at people aged 18 or over but there are no explicit age restrictions, so there must be flexibility to provide this Service to young people with Mental Health needs and/or learning disabilities as they transition to adulthood. Providers Care Quality Commission (CQC) Statement of Purpose must reflect this requirement   3. The Service will be commissioned by the Authority or any organisation named within the contract.   4. Rehabilitation placements will be jointly funded by the Authority and the relevant Clinical Commissioning Group (CCG).   5. The Service shall be available to all eligible Service Users irrespective of gender, religion or belief, ethnicity or race, culture, sexuality, disability, age, class or socio-economic status and any other protected characteristic named in legislation.   6. The Service shall be delivered within the Authority and or named partners' organisational boundaries subject to the geographical areas appointed to. However, there may be occasions when the Service Provider can bid for Services outside of their appointed area.   7. Rehabilitation must be an intermediate short term service (up to 2 years) for the following cohort: * A person with severe and complex mental health needs who has become ‘stuck’ and non-progressive in their recovery. * When less intensive mental health services cannot meet the needs of the person. * Without rehabilitation, the person would be (or are) high users of inpatient and community services. * When there has been an erosion of therapeutic optimism within mainstream services towards a person with complex needs, which may be hindering their recovery. * When a person is facing a transition from a highly supported setting to a less supported placement; this includes people leaving forensic or secure services, people leaving out-of-area placements, or leaving residential care to live in the community. * When a person needs help in overcoming disabilities associated with severe and complex mental health needs that would benefit from a structured environment and intensive therapeutic programmes.   **2.9** The service can be delivered in the following settings :   * **Supported Housing** - schemes that provide personal care to people as part of the support that they need to live in their own homes. The personal care is provided under separate contractual arrangements to those for the person’s housing. The accommodation is often shared, but can be single household. Supported living providers that do not provide the regulated activity ‘Personal care’ are not required by law to register with CQC. * **Home Care** - delivered to people living in household accommodation that is owned or occupied by the person receiving care, and that occupation is entirely independent of the care arrangements (which remain at all times a visiting arrangement). * **Residential Care** - care home services with or without nursing provision. |
| 1. **Service requirements** |
| **3.1 Regulatory and legal**  The Service Provider must be registered with the Care Quality Commission (CQC) and will maintain registration throughout the duration of the contract under the following regulated activities :  **Residential Rehabilitation**   * Accommodation for persons who require nursing or personal care * Treatment of disease, disorder or injury.   **Supported Housing / Homecare Rehabilitation**   * Personal care * Treatment of disease, disorder or injury.   The CQC regulations required for registration (and their associated standards), and the monitoring of the achievement of those regulations and standards are not duplicated in this specification. The Service Provider must comply with all relevant legislation that relates to the operation of their business.  The Service provided under this contract must be provided in accordance with (but not limited to) the requirements of:   * The Care Act 2014 * Care Standards Act 2000 (including any amendments, modifications or re-enactments). * CQC * The National Minimum Standards for Domiciliary Care * The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 -The National Minimum Standards for Care Homes * The Domiciliary Care Agencies Regulations 2002 * Mental Capacity Act 2005 (Deprivation of Liberty Safeguards) * Equality Act 2010 * Human Rights Act 1998 * Autism Act 2009 * Deprivation of Liberty Safeguards * Service Users’ individual assessed needs and outcomes and any subsequent assessment, rehabilitation care and support plan or review documentation * Any future legislative changes or changes to National Minimum Standards that determine the standard of care to be delivered.   **3.2 Client Groups**  The primary client groups served by this specification are:  People with mental health needs   * Who may experience continuing difficulties and disability in relation to personal functioning, mental health symptoms and relating to others. * Who will continue to be highly symptomatic, often presenting with other co-morbid conditions, which may include a history of problematic substance misuse. * Who usually present with high levels of disability from complex co-morbid conditions, with limited potential for gaining skills required for community living. * Whose recovery has been slow and problematic requiring repeated admissions to mental health services and detainment under The Mental Health Act 1983 * Who may continue to present with risks to self and others * Who may have a forensic history   Other client groups which may receive this Service include:   * Adults with long term conditions which are impacting on their mental health * Adults with learning disabilities * Young people with needs requiring rehabilitation transitioning to adulthood from Children and Adolescent services.   **3.3 Key principles**  The Service Provider must value Service Users' rights to:   * Be independent * Be regarded and treated as individuals * Make choices for themselves * Be treated in an equal and fair way * Be treated with respect, dignity and confidentiality * Access specialist support to realise potential * Receive non-judgemental support   In addition, the Service Provider must:   * Treat Service Users as individuals and promote each Service User's dignity, privacy and independence * Tailor rehabilitation support to be a time limited intermediate care service – typically up to 2 years * Enable Service Users to maintain direct control over their recovery journey * Acknowledge and respect Service Users' gender, sexual orientation, age, ability, race, religion, culture and lifestyle * Maximise Service Users' self-care abilities, independence and wellbeing * Recognise Service Users' individuality and personal preferences * Provide support for carers, whether relatives or friends, and recognise the rights of other family members * Acknowledge that Service Users have the right to take risks in their lives and to enjoy a lifestyle of their choosing * Provide protection to Service Users who need it, including a safe and caring environment * Provide a consistent and high quality Service which is person-centred, flexible, reliable and responsive   The service model must be consistent with the key principles of the Mental Capacity Act 2005 and the associated code of practice, which includes:   * A presumption of capacity * Individuals being supported to make their own decisions - ensuring access to advocacy service for those who may require this * Least restrictive option. The Service Provider must adhere to any conditions of discharge imposed by a Mental Health Review Tribunal and seek authority from the Secretary of State if a condition of discharge is to be varied.   **3.4 Service outcomes**  The focus of the Service must be firmly on promoting rehabilitation and recovery, providing specialist time limited support to deliver effective rehabilitation and recovery which will lead to service users making choices, taking control, progressing to independent living, social inclusion and wellbeing.  To achieve the Service outcomes the Service Provider will:   * Provide a suitable and safe environment that meets the needs of the Service User * Provide a high quality recovery and support Service in a therapeutic environment where the Service User feels safe, respected and is treated with dignity * Ensure the Service is appropriate to meet the needs of Service Users presenting with severe and enduring mental health difficulties and associated clinical risks around their diagnosis * Ensure the Service will promote recovery and the wellbeing of the Service User by providing a rehabilitation support service which encompasses improving activities of daily living in a way which promotes the Service User’s health; choice; control; independence; self-reliance and improvement to the Service User’s quality of life * Cooperate with discharge planning for service users with the CCG and its agents * Ensure the Service to be delivered within shared supported accommodation or a residential/nursing setting is able to meet the assessed social, personal, and healthcare needs of an individual and such needs being detailed within an agreed rehabilitation care and support plan for each Individual Service User Placement. * Enable the Service User to meet all identified needs within the Service User’s individualised rehabilitation care and support plan * Deliver evidence and outcome based care * Support Service Users, many of whom will demonstrate high levels of need following multiple acute admissions, poor engagement with services, limited responses to treatment and increased vulnerability or risk due to symptoms or neglect * Assist with moving on to other more suitable accommodation where the need for support has reduced or no longer exists   **Promote the independence of Service Users through an enabling approach :**   * Support Service Users to regain skills and gain confidence to achieve greater independence in their day to day living * Work to support Service Users to remain in the community and prevent, reduce or delay the need for more intensive care and support, bybuilding resilience * Support programmes of rehabilitation, reablement and recovery*,* education, training and employment * Motivate and facilitate Service Users to develop or maintain skills related to activities of daily living, for example washing, dressing, feeding, toileting, bathing and mobility * Encourage Service Users to acquire or maintain skills relating to areas of non-personal care, for example shopping, cooking and cleaning * Support Service Users to access community resources and encourage best use of assistive technology, such as community equipment and telecare to support activities of daily living * The Service Provider will support flexible, innovative solutions for Service Users. This is especially important for those with dual diagnosis – this often is mental health and substance misuse either drugs or alcohol * Support Service Users to develop problem solving skills and coping strategies * Work with Service Users and their care coordinator/social worker to develop and respond to relapse prevention plans which aim to empower the Service User and their Service Provider to facilitate detection and treatment of relapse * Ensure Service Users with mental health needs access all screening and Annual Health Check appointments as applicable and identify all barriers that make access to health services difficult including the availability of staff/family who know the Service User well, specific phobias e.g. needles, waiting rooms etc. The Service Provider will set out the actions that need to be taken to overcome these barriers and record in the Service User's rehabilitation care and support plan * Use the Recovery Star as a framework (or other appropriate alternative) for a strengths approach to supporting positive change around Service User led outcomes and priorities * Work with the Community Health Teams, and other agencies to prevent inappropriate admissions to hospital at the point of crisis.   **Support Service Users to achieve the outcomes in their rehabilitation care and support plan and to maximise independence :**   * Support Service Users to achieve the outcomes identified within their rehabilitation care and support plan * Continuously review the achievement of, and progress towards, outcomes, enabling Service Users to gain greater independence and contribute to annual reviews * Work with families and other services so that they understand the approach to maximising independence * Support with parenting responsibilities/caring and help maintain independence and confidence within this outcome   **Support Service Users to engage with family/friends, their interest and community services :**   * Support Service Users to sustain significant relationships, including with family carers * Encourage and support Service Users to participate in their community and to use community resources and facilities * Support Service Users to develop confidence in their own ability to engage with hobbies/interests and to access their wider community, e.g. employment, volunteering * Support Service Users to communicate and engage positively with others in a way which is appropriate to their personal preference and lifestyle. * Support Service Users to identify and report hate crime and to develop approaches to minimise the impact of hate crime.   **Support Service Users to improve their mental health and wellbeing :**   * Recognise the specific mental health needs, including those associated with dual diagnosis and to develop approaches to respond to these * Monitor rehabilitation care and support plans and report progress against the plan * Development of move on plans for service users who require ongoing support when rehabilitation has been completed * Have an understanding of the chronology of the disorders, but maintaining a holistic focus in addressing the substance misuse, psychological, social and physical health problems * Use problem solving techniques to manage issues and build coping strategies to manage known risks * Provide a flexible, person centred, empathetic, non- confrontational and non- judgemental approach which is important for maintaining an appropriate intervention programme * Provide support that will promote optimism and build motivation to deal with substance problems and other associated difficulties * Provide advice and information about the impact of substance use and support access to specialist services to manage needs * Use a harm reduction approach to substance misuse in the first instance * Support Service Users to maintain their health and personal hygiene * Promote healthy eating and hydration with Service Users * Support Services Users to re-establish routines to access primary care, dentists, opticians, chiropodists and other healthcare services including sexual health advice * Support Service Users to comply with medication regimes, including supporting self-administration * Encourage Service Users to use self-care programmes for long term health conditions * Support Service Users to make informed decisions about the management of their care and treatment using appropriate information, including risks and benefits * Support Service Users to alleviate loneliness and isolation * Work with Service Users and their care coordinator/social worker to develop and respond to relapse prevention plans * Make reasonable adjustments as part of the Equality Duty and in relation to delivering health care via Health Action Plans, Communication Passports and assistive technology.   **Support Service Users to stay safe and take a positive approach to risk, rights and responsibilities:**   * Ensure any risks to the Service User or others are appropriately and effectively managed (e.g. self-harm, harm from others, intimidation) through regular review and updating of risk assessment * Support Service Users to maintain their accommodation * Enable Service Users to exercise their Voting Rights   **3.5 Types of care and support tasks**  The Service required will be set out as part of Service Users' agreed outcomes and person-centred rehabilitation care and support plans. Therefore, the following list of types of care and support tasks required is not intended to be exhaustive or needed in all cases, and should not preclude creative solutions which may better suit an individual where it is part of their agreed rehabilitation care and support plan. Such requirements that the Service Provider must provide may include:  **Care Tasks**  Personal care and support is defined by the CQC as meaning physical assistance given to a person and could be in connection to the following types of tasks:   * Direct assistance with or regular encouragement to perform tasks of daily living * Providing advice and support on self-care * Regular encouragement to dress, undress and supporting choice of what clothes to wear for the day * Providing support to manage the health care of the Service User under the direction of a health professional where this has been specifically agreed and the Care Worker has received the appropriate training. * Support with safe disposal of clinical waste * Assistance when and where required:   To get up or go to bed  Assistance with transfers from or to bed/chair/toilet  Washing and bathing using equipment if necessary, shaving and hair care, denture and mouth care, hand and fingernail care, foot care (excluding any aspect which requires a registered chiropodist or podiatrist)  Support with using the toilet, including necessary cleaning and safe disposal of waste/continence pads (including in relation to the process of menstruation)  Empty or change catheter or stoma bags and associated monitoring  Assistance with skin care such as moisturising very dry skin  **Other support that promotes wellbeing and self-care of the person :**   * Regular prompts to take or safe administration of prescribed medication in accordance with agreed protocols and CQC standards * Assistance with putting on appliances with appropriate training, for example leg calliper, artificial limbs and surgical stockings, and assistance with visual and hearing aids * Food or drink preparation - ensuring that Care Workers have an understanding of nutrition and hydration, and are able to support Service Users to plan, shop, prepare and cook nutritious food * Assistance with eating and drinking (including the administration of parenteral nutrition), including any associated kitchen cleaning and hygiene * Support access to activities including employment, education and voluntary work * Ensuring that any assistive technology, such as telecare is active i.e. a regular basic check to ensure the telecare base unit and/or phone line has not been disconnected.   **Other support that promotes safeguarding :**   * Identification, mitigation of any immediate risk and reporting of possible safeguarding adults concerns * Identification, mitigation of any immediate risk and reporting of possible safeguarding children concerns * Identification, mitigation of any immediate risk and reporting of possible domestic abuse or hate crime.   **Escorting and social activities :**  Supporting and facilitating access to social, vocational and recreational activities as stipulated in the rehabilitation care and support plan, including but not limited to:   * Effective use of protocols/risk plans to identify when formal support should be used to introduce /re-establish activities with regular review to identify when this can be reduced/ceased dependency * Support to develop structured daytime routines including accessing employment opportunities * Support to attend appointments which promotes the Service User's continued health and wellbeing * Assisting to access local community based services * Support Service Users to participate in appropriate physical activity * Helping Service Users to make their way to places and to assist in road safety and learning routes.   **Cleaning and domestic support around the home**  Where it is stipulated in the rehabilitation care and support plan that cleaning and domestic support is required around the care home, or within supported accommodation, the Service Provider will undertake this or support the Service User to do so. This may include vacuuming, sweeping, washing up, polishing, cleaning floors and windows, bathrooms, kitchens, toilets and general tidying, using appropriate domestic equipment. The Service Provider will also undertake or support the service user to:   * Make beds and change linen * Dispose of household and personal rubbish * Assist with laundry * Clear areas of any potential slip or trip hazards * Identify and mitigate as far as possible any hazards or risks around the household.   **3.6 Service availability and flexibility**  The Service Provider must be available to meet the full requirements of the specification 24 hours a day, 7 days a week, 365 days a year. The Service Provider will not operate on a reduced basis over periods of public holidays or festivities unless the Service User is able to receive informal support from family and friends to meet their needs during periods for public holidays, for example Christmas Day. The Service Provider will be required to provide the following:   * Up to 20 hours 1 to 1 support per week ( including non-clinical based therapy and approaches e.g. Mindfulness) * Core Support over a 24 hour period x 7 days per week ( this can be formal support and assistive technology)   **NHS funded therapeutic interventions**  Provide therapeutic support on a sessional basis, if specified in the assessment of need by the clinical team (this list is not exhaustive):   * Occupational therapy using evidence based model * Psychological input using evidence based interventions * Cognitive Behavioural Therapy * Dialectical Behaviour Therapy   The Service must be provided in a flexible manner to ensure the Service User's identified needs and outcomes are met within 2 years.  The Service Provider must:   * Be able to participate in mini competitions to respond to new requests and demand through effective management of referrals, workforce capacity and staff rostering/coordination * Make effective use of the Care Navigation Service Oracle Sourcing system to respond to requests for rehabilitation packages * Ensure that there is the necessary capacity to pick up and commence rehabilitation packages over weekends/Bank Holidays when necessary * Encourage reductions in care and support needs where safe to do so and/or where independence permits * Minimise the number of different Care Workers delivering care and support to the Service User to promote consistency and continuity * Ensure that there is a match between the Service User's needs and the skill sets, knowledge and competency of Care Workers. * Undertake Service User risk assessments prior to commencement of the Service and produce a plan to manage these * Ensure the Service is delivered in accordance with the Service User's Rehabilitation care and support plan and personalised outcomes. * Report to the Care Navigation Service on a regular basis to confirm the availability and capacity of the service including any unexpected vacancy or change in individual circumstances   The Service Provider will be flexible and responsive in:   * Its approach to Service provision; * Dealing with a Service User's fluctuating needs; and * Supporting the individual outcomes of the Service User   **3.7 Keeping Service Users informed and in control**  The Service Provider must supply Service Users with reliable and timely information via an information pack when their Service commences and update as required to ensure they are kept informed and involved. The information pack should be user friendly, clear and understandable, and include the following:   * Statement of purpose * Contact details for the Service including out of hours and emergency contacts * Service provision details * The contingency arrangements in the event of Service interruption * Safeguarding information * How to access the most recent CQC inspection reports * Complaints procedure.   The Service Provider must keep Service Users informed in advance and involved in decisions about any planned changes to their Service including unavoidable short term changes to their Service.  **3.8 Recording**  With the Service User's knowledge, the Service Provider must ensure that Care Workers record progress in relation to delivery of the rehabilitation care and support plan including details of any significant occurrence. Records should include (where appropriate):   * Assistance with medication, including time and dosage on a medication chart * Other requests for assistance with medication and action taken * Details of any change in the Service User's circumstances, mental health, health, physical condition or care and support needs * Any accident, however minor, involving the Service User and/or staff * Any other untoward or serious incidents (e.g. emergencies or safeguarding issues).   **3.9 Out of hours contact**  The Service Provider must ensure that at all times outside of normal office opening hours there is a dedicated responsible person(s) with sufficient knowledge and training to be a point of contact to respond to emergencies from Service Users, Care Workers and the Authority. The Service Provider will ensure the out of hours contact service has telephone and email capabilities as a minimum.  **3.10 Rehabilitation - care and support planning**  The Service Provider may, without reference to the Authority, mutually agree day to day changes with the Service User to their direct care and support provision and minor revisions to the direct care and support elements of the Service User's rehabilitation care and support plan. The changes made still need to meet an assessed need. In agreeing any such changes the Service Provider is required to:   * Ensure that such changes are in keeping with the objectives of the rehabilitation care and support plan and continue to meet the Service User's assessed needs and identified outcomes in a safe way * Inform the Authority if a Service User's support needs reduce or if the Service User's needs increase and cannot be met within the existing care package and rehabilitation care and support plan * Update the Service User's rehabilitation care and support plan so that it remains current and reflects the actual support that is being provided by the Service Provider * Consult with the Service User's carer/representative/advocate where they would have substantial difficulty in agreeing such changes, including those who lack mental capacity. * Ensure that the rehabilitation care and support plan is provided in a way that reflects the Service User's level of engagement, strengths, abilities and interests and enables them to meet their needs and maximise their independence. Rehabilitation care and support plans should:  |  |  |  |  | | --- | --- | --- | --- | | **Rehabilitation Milestones** | | | | | **Time** | **Service** | **Individual** | **Measures** | | **3 months** | Initially following agreed clinical plan  Design rehabilitation care and support plan  Plan agreed with Care coordinator Community Rehab worker  Maintaining/re-establishing links with family and friends | Initially following agreed clinical plan  Introduction of outcomes model | Managing challenges  Strategies followed  Taking prescribed medication | | **6 months** | Implement and engage  Monitoring against agreed outcomes  Introducing community assets/resources  sourcing information to support engagement with local community options to participate | Participating in 1-3 activities  Engaging with planning processes able to identify preferences  Knowledge of risks and issues  Monitoring against agreed outcomes | Managing challenges  Strategies followed  Taking prescribed medication  Engaging in routines  Established relationships  Service and individuals knowledge of risks and engaging in plan  Reintroduction of community services  Agreed with Care coordinator Community Rehab worker | | **Up to 9 months** | Active engagement with rehabilitation & engagement structured plan  Looking ahead Adjusting and engaging individual and circle of support in next phase of plan - Monitoring against agreed outcomes | Full participation in timetable  Agreed risk taking  Engaging with planning processes able to identify preferences  Sourcing information  Selecting 3 community options to participate  Re-engaging with family and friends | Able to spend time without direct support – staff present  Recognising own triggers  Building network of community assets – engaging with GP  Agreed with Care coordinator Community Rehab worker | | **Between 9 & 12months** | Move on plan | Development of coping strategies  Maintenance of current health and well-being | Introduction of daily living challenges  Problem solving  Relapse prevention plans designed and tested  Introduction of assistive technologies – Mobile Apps to support recovery  Move on Plan agreed with Care coordinator Community Rehab worker | | **12 – 18 Months** | Preparation for leaving | Supporting move to return to own home or to long term support | People progress from the service |  * Not be written in the third person * Include the mental health diagnosis;symptoms; how does the Service User understands their condition; what help do they need to stay well? * Identify what support they need from staff to help manage their mental health * Any restrictions on the Service User in relation to their mental health, e.g. CTO, section of MHA, (in legal restrictions) * When completing the Rehabilitation care and support plan, all goals should be **SMART**; (**S**pecific – the goal should specify what the Service User wants to achieve; **M**easurable – it should be possible to measure if the goal has been achieved or not; **A**chievable – ensure the goal is achievable; **R**ealistic – is the goal realistic and relevant for the person; **T**imed – establish when the goal will be achieved or reviewed) * All actions should clearly state a named individual responsible for each specific activity. * All rehabilitation care and support plans should be reviewed regularly, dependant on individual need but at least three monthly and should clearly indicate the review date. * Include if the Service User has insight. This includes cognitive aspects, stress vulnerability, psychological needs e.g. anxiety, coping strategies, cognition, protective factors, risk issues (in risk management plan and staying safe section, con-cordance with medication). * All Service Users will have a separate crisis and contingency plan, which includes relapse signatures, known triggers for mental health deterioration and relapse prevention, management plan and useful contacts * Other interventions – e.g. need for 1:1 support, monitoring mood, motivational interventions, any specialist mental health interventions would be recorded in this part of the plan. * Identify the rehabilitation milestones. * The expected outcome, it will be clear that the Rehabilitation care and support plan is working with progress measured against milestones with the abilities and feelings of the Service User being reflected.   The Service User will be informed of the purpose of their rehabilitation care and support plan, and the Service Provider will involve the Service User and/or family/next of kin where appropriate in the review of their rehabilitation care and support plan.    The Service Provider will have in place a mechanism that assists the Service User and the Care Worker to view and monitor progress against the outcomes, as set out in their rehabilitation care and support plan.  The Service Provider will monitor, with the Service User, that their individual outcomes are being achieved. Records should be maintained to evidence progress and provision over time.  The Service Provider will notify the Authority when the Service User has achieved or optimised their rehabilitation potential.  If a Service User will not cooperate or can no longer follow their rehabilitation care and support plan the Service Provider is required to notify the Authority for a review of the Service User's needs and move on plan.  The Service Provider will facilitate the timely move on from rehabilitation services to own home or less intensive support for Service Users who have progressed and optimised their rehabilitation.  **3.11 Business transition at the end of the contracting period**  The Service Provider must cooperate with the Authority, work with outgoing Service Providers and take a lead and proactive role to service transfer, including but not limited to:   * Ensuring Service continuity for current Service Users and the new arrangements are established in a safe, timely and sensitive manner * Managing any workforce transfers as required under TUPE legislation and ensuring the approaches to recruitment, retention and training are robust during the transition * Working with the Authority and Service Providers to develop and implement a clear and effective communication strategy * Ensuring information, finance, premises, management and other systems are in place. * Appointing a designated lead contract manager to provide a readily available contact point for the Authority throughout this phase.   **3.12 Referrals and commencement of the Service**  The Service Provider will be invited to bid for rehabilitation packages of care via the Authority's Care Navigation Service using the Oracle Sourcing system and must keep a record of any occasional referrals received outside of this process e.g. direct from the Authority's social work staff, Emergency Duty Team, care package restarts by NHS staff upon hospital discharge.  The Service Provider is expected to bid for rehabilitation package requests within the given timescales set out in the mini competition.  There will be some Service Users receiving rehabilitation services who will have their care package transferred to the Service Provider, as their existing Service Provider has not secured a place on the new framework.  **3.13 Transition pathway**  The Service Provider must work with education and health services to ensure a smooth transition to Adult Services.  The Service Provider will comply with the requirements of the Children and Families Act 2014. Part 3 of the Children and Families Act places a duty on the Authority to develop for children and young people with more complex needs, a coordinated assessment of needs and a new 0 - 25 Education, Health and Care plan (EHC plan).  There is scope to make use of EHC plans as a basis for arranging and agreeing support for young people with ongoing care and support needs in adulthood. In these situations, the plans must identify which aspects of the plan are being met by the Care Act 2014.  Therefore, the Service Provider will be required to vary their current CQC Statement of Purpose to enable them to provide support to young people. This is to remove the potential for any gap in provision of care and support as people move from children's to adult social care.  The Service Provider will be required to provide information on the availability of the Service to enable young people and their families to plan ahead.  **3.14 Partnership working**  Partnership working is at the heart of successful delivery of the Service. This applies to the relationship between the Authority and the Service Provider, but also with other significant agencies supporting Service Users.  The Service Provider must cooperate and work in partnership with other organisations or individuals to: promote the wellbeing of Service Users; signpost the Service User to other relevant services; contribute to the prevention, reduction or delay of the development of Service Users' needs; and improve the quality of person-centred and joined-up care and support, including the outcomes Service Users achieve. The Service Provider must work with the community health teams, and other partners to prevent inappropriate admissions to hospital at the point of crisis.  This includes, but is not limited to, the following partners:   * CQC * General Practitioner (GP) Practices * Community Mental Health Teams / Services * NHS Trusts * CCGs * Other Registered Care Providers * Carers' services * Voluntary, community and faith sector organisations * Family members/informal carers * Health practitioners to manage and minimise the risks for Service Users with swallowing assessments and identified needs in this area * CAMHS and Family Services to ensure a smooth transition to Adult Services.   The Service Provider must make appropriate use of local networks for information, advice and advocacy to ensure that a Service User's needs are met holistically and resources are used effectively.  **3.15 Risk assessment and management**  The Service Provider must have a Risk Management Policy, and must operate systems to ensure it can complete an assessment of risk and provide a risk management plan where necessary on all aspects of tasks carried out by its staff. A copy of the policy must be available to the Authority on request.  **For Staff**  The Service Provider must maintain clear policies, procedures and guidance for all staff on safety precautions that must be taken relating to risk, including lone working, and will ensure that staff are familiar with the guidelines and their application in the work situation. The policy must be comprehensive and include care tasks, community based activities, moving and handling, use of equipment and environmental hazards. The Service Provider must have clear monitoring procedures to ensure its staff work to these standards.  **For Service Users**  Responsible risk taking is a normal part of living. Service Users must not be discouraged from participating in activities solely on the grounds that there is an element of personal risk. Service Users must be encouraged to discuss and judge risk for themselves and make their own decisions where the safety of others is not unreasonably threatened and where the Service User has the mental capacity to do so. Where a Service User lacks mental capacity, a best interest decision must be made, recorded and retained. A risk assessment must be undertaken in all circumstances where a risk has been identified and maintained on the Service User’s file for staff reference, and for inspection by the Authority if required. Risk assessments must be reviewed as changes arise, and in line with good practice guidance. All Care Workers must have access to the risk assessment and have read and understood its content prior to undertaking any care provision.  In relation to Service Users who present challenging behaviour, the Service Provider is required to ensure that there is a written, individualised behaviour support plan for Service Users requiring them that includes:   * Relational support requirements * Proactive strategies * Reactive strategies * Monitoring and review arrangements   **3.16 Health and safety**  To ensure staff are informed and deal confidently with accidents, injuries and emergencies, the Service Provider is required to ensure that:   * There is a comprehensive health and safety policy with clear written procedures for the management of health and safety, which comply with all current and relevant Health and Safety legislation, and define individual and organisational responsibilities * There is a detailed policy covering the risks and support for lone workers * Infection control procedures are in place when a Care Worker or Service User has a known transmittable disease or infection * The provision and wearing of protective clothing where appropriate * Procedures and governance for managing violence and aggression to staff are in place * One or more competent persons, depending on the Service provided, are nominated to assist in complying with health and safety duties and responsibilities, including:   + - Identifying hazards and assessing risks     - Preparing health and safety policy statements     - Introducing risk control measures     - Providing adequate training and refresher training     - Ensuring all records relating to health and safety are accurate and kept up to date * Any accidents or injuries to a Service User that require hospital treatment or GP attendance are reported to the Service Provider's Service Manager and noted on the Service User’s care records * All staff know the Service Provider's procedures for dealing with emergencies * All staff have first aid training and manual handling training where appropriate * Identity cards are worn by all staff * They promote an understanding of the risk of fire and other hazards among their staff and the Service Users they support. This will particularly apply to those whose behaviour or environment may pose particular fire risks e.g. smoking or open fires. This will include taking account of advice from, and agreements reached with, the Lancashire Fire and Rescue Service to ensure risk assessments are completed and advice is followed.   **3.17 Health/medical care**  The Service Provider is required to ensure that Care Workers have access to the contact details of the GP with whom the Service User is registered. The GP, the NHS 111 service or 999 (depending on and appropriate to the circumstances) must be contacted without delay whenever a Service User requests assistance to obtain medical attention, or appears unwell and unable to make such a request. The Service User's next of kin must be informed as soon as possible.  The Service Provider will need to support the health care of the Service User under the direction of their GP, District Nurse, Community Matron, other health care professional or Community Health Team where this has been specifically agreed and the Care Workers have received the appropriate training and have been deemed competent by a health care professional. This will not ordinarily include any care requiring a medical or professional qualification, but will require appropriate training. A record of all applicable training shall be maintained by the Service Provider.  The Service Provider must ensure that Care Workers who are required to assist Service User to take prescribed medication receive appropriate instruction and written guidance in accordance with its policies and procedures and are supported by appropriate training and assessment of staff competency.  The Service Provider will ensure Service Users access all screening and Annual Health Check appointments as applicable and identify all barriers that make access to health services difficult, including the availability of staff/family who know the person well, specific phobias e.g. needles, waiting rooms etc. and set out actions that need to be taken to overcome these barriers, and record in the Service User's care records.  **3.18 Supporting the wider care system**  The Service Provider must contribute to prevention strategies which are aimed at:   * Reducing the number of unplanned admissions to hospital * Supporting the safe and timely discharge of service users from hospital * Keeping people in community settings rather than institutional care and support * Developing integrated care pathways * Identifying and meeting the needs of vulnerable Service Users at the earliest possible stage * Reporting any observed poor and/or unsafe care.   The Service Provider will work closely with local organisations, across the health and social care system to continually improve the Service to Service Users, in accordance with identified needs and taking into account changes in national and local guidance and policy. This may involve working with a range of statutory, voluntary and community sector organisations to deliver the required outcomes and developing information sharing protocols to enhance partnership working where needed.  The Service Provider will be required to assist when care and support is coordinated by a health professional. As such, the Service Provider will liaise with adult social care services, community nursing and therapy teams, voluntary agencies, acute trusts and other professionals and agencies to ensure seamless nursing and personal care provision to Service Users.  Where appropriate, the Service Provider will maintain the therapeutic rehabilitation care and support plan, including rehabilitation exercises and techniques or mobility and transfers under the instruction of a care professional.  **3.19 Social value**  The Service Provider must ensure that Service Users make effective use of public transport to encourage independence and this will also reduce the carbon footprint.  The Service Provider must give consideration to the employment needs within their local community when recruiting and selecting staff and as such must give consideration to how their recruitment processes support the local economy.  In accordance with the Authority's social value policy[[1]](#footnote-1), The Service Provider must work with the Authority to enhance the social value associated with this Service in terms of sustainable employment and investment in the workforce. |
| 1. **Workforce requirements** |
| **4.1 Data and intelligence**  The Service Provider shall register with the Skills for Care National Minimum Data Set for Social Care (NMDS-SC) and complete the following:   * The NMDS-SC organisational record and update this data at least once per financial year * Fully complete the NMDS-SC individual staff records for a minimum of 90% of the staff, including updating these records at least once per financial year * Apply for funds to support workforce development from Skills for Care.   The Service Provider shall retain records that ensure they can demonstrate their performance under this contract. Records will show resource inputs, organisational processes and outcomes related to the Service and Service Users.  The Service Provider must participate in any survey of Adult Social Care employees organised by the Authority or Skills for Care and actively encourage its staff based in Lancashire to respond.  The Service Provider will be required to provide to the Authority, as required and within reason, additional workforce related data not covered by the NMDS-SC and other established methods of data collection.  **4.2 Planning and management**  The Service Provider must identify a suitable person or persons with full knowledge and understanding of workforce issues pertaining to the delivery to be responsible for workforce planning for the Service.  The Service Provider must develop workforce plans to be updated at least annually or more often as appropriate to ensure that arrangements are in place to maintain the workforce capacity and capabilities required to deliver the Service for the duration of the contract.  Specific plans must be developed for the following:   * Recruitment and retention of staff * Management of sickness and other absences * Learning and development. * Risk management and positive risk taking   The Service Provider should develop separate documents for the following:   * Succession plans for key management posts and/or posts requiring scarce skills * Specific plans for issues identified locally/organisationally.   The Service Provider must have in place an effective sickness absence management and monitoring system, and must inform the Authority at the earliest opportunity if staff absences will impact upon their ability to deliver the Service.   * 1. **Social Care Commitment**   To demonstrate its commitment to delivering quality care and support, the Service Provider is expected to make and maintain the Social Care Commitment[[2]](#footnote-2) from contract award   * 1. **Staff supervision and annual appraisals**   The Service Provider must ensure that all staff have regular, planned and documented supervision sessions at a minimum every 3 months.  The Service Provider must ensure that all staff have a documented annual appraisal and a plan for learning and development.  The Service Provider must ensure that staff know when and how to raise an issue, comment, concern or complaint with their manager.   * 1. **Leadership and management**   The Service Provider must be able to evidence that it is developing effective leadership at all levels of the organisation by encouraging and supporting staff to develop leadership skills and competencies through training, supervision and reflective learning.  The Service Provider must be able to evidence that its managers, including registered managers, hold or are working towards the appropriate management level qualification, as recommended by Skills for Care, and continue to refresh their learning regularly.  The Service Provider must ensure that individual registered manager(s) complete the Manager Induction Standards within six months of taking up a management role.   * 1. **Enabling care and support**   The Service Provider must ensure that learning and development activities for staff focus on maintaining and promoting independence. Care Workers should be confident in enabling people to make their own choices and supporting them to achieve these. They should treat the Service Users and their family and carers as equals and partners in providing care.   * 1. **Core skills, induction and The Care Certificate**   The Service Provider must ensure that all staff possess the core skills their role requires.  The Service Provider must be able to evidence that at recruitment they have assessed the core skills of Care Workers and that they are supported in further developing their core skills. As such, a values based recruitment and retention process should be adopted to create and maintain a workforce which embraces workplace values in line with national guidance[[3]](#footnote-3).  The Service Provider must ensure that all Care Workers are supported to overcome any cultural communication barriers between themselves, services, carers and other professionals.  The Service Provider must ensure that all Care Workers receive a thorough induction to their new role, the organisation and the care sector.  The Service Provider must ensure that all new Care Workers achieve the Care Certificate within the time period defined by Skills for Care.  The Service Provider must be able to evidence how they are working to bring all Care Workers to a standard of knowledge and skills as required by the Care Certificate, whether individuals are new starters, or who have previously worked in care or existing members of staff.   * 1. **Qualifications and learning**   The Service Provider must ensure that its staff are supported to maintain their training, qualifications and continued professional development as appropriate and in accordance with the requirements of regulations and the role they are carrying out.  In accordance with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Service Provider must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of Services Users at all times. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities effectively. They should be supported to obtain further qualifications.  As a minimum, staff should be working towards, or have achieved, a relevant qualification as advised by Skills for Care:  **Registered Managers**   * Level 5 Diploma in Leadership for Health and Social Care and Children and Young People’s Services.   **Care Workers**   * Care Certificate (for new and existing staff) * Level 2 Diploma in Health and Social Care.   **Generic**  The Service Provider must ensure that all staff have access to learning and development opportunities which enable them to meet the needs of all those using the Service. The learning requirements of staff are therefore expected to go beyond the level of induction and the Care Certificate.  The Service Provider will be expected to work within the Skills for Care Common Core Principles for Dementia[[4]](#footnote-4):  The Service Provider must consider what specific skills and knowledge staff require to ensure that the diverse needs of Service Users are met and must put in place plans to enable this within the Service. The following non-exhaustive list of specific skills and knowledge is relevant to the delivery of the Service:   * Dementia care * Continence care * Challenging behaviour * Communication * Falls prevention * Combating loneliness and isolation * Skin care * Working with carers * Strokes * Dignity in care * Assistive technology * The Mental Capacity Act 2005 and consequent deprivation of liberty safeguards * Safeguarding adults * The requirements and responsibilities under the Equality Act 2010 and the Human Rights Act 1984.   **4.9 Specific skills and knowledge**  The Service Provider must consider what specific skills and knowledge are required for all staff groups which include mandatory and up to date training to ensure that the diverse needs of Service Users are met. They must ensure that such skills and knowledge are available within the Service. The following non-exhaustive list of specific skills and knowledge will be relevant to the delivery of the Service:   * Person Centred and Recovery Based Approaches/values based practice * The Mental Capacity Act 2005 and consequent deprivation of liberty safeguards * The Mental Health Act 1983 and 2007(Specifically including conditionally discharged service users and CTO’s) * Safeguarding adults * Carers’ awareness, assessment and support * Challenging behaviour * Positive behavioural support and standards of good practice * Epilepsy and behaviour, autism, borderline personality disorder, anxiety disorders and other mental health issues; self-injury * Speaking up, empowerment, advocacy and how people who use the Service are involved. * Dementia Care * Supporting people with learning disabilities * Combating loneliness and isolation * Working with carers * Mental Health * Autism * Assistive technology * A flexible, person centred, empathetic, non-confrontational and non-judgemental approach, which is important for maintaining an appropriate intervention programme * A recovery based approach * Trusting and supportive relationships with clinical or social work professionals * Support to give Service Users the motivation to deal with substance problems and other associated difficulties * An understanding of the chronology of the disorders and maintaining a holistic focus in addressing the substance misuse, psychological, social and physical health problems * A harm reduction approach to substance misuse in the first instance * Advice and information about the impact of substance use.   The Service Provider must use a positive behaviour support framework for developing an understanding of a Service User's challenging behaviour. It must include:   * Personalisation of both assessment and care and support arrangements * Systematic assessment of the Service User’s behaviour * Attention to the broader context to ensure that other factors influencing the individual’s behaviour are properly understood * Development of both proactive and reactive support arrangements * Preventing the Service User’s challenging behaviour as much as possible through the provision of a more helpful and less challenging environment * Avoiding support arrangements that punish the person in any way or create unnecessary restrictions on their freedom of movement and choice.   The Service Provider must ensure Care Workers receive specialist training in autism and the Care Worker will be able to:   * Use appropriate communication skills when supporting a Service User with autism i.e. make reasonable adjustments to develop the most effective ways of understanding and communicating the Service User's experience, help others to understand them and find ways of responding * Support families and friends, and make best use of their expert knowledge of the Service User * Recognise when a Service User with autism is experiencing stress and anxiety and support them with this * Recognise sensory needs and differences of a Service User with autism and support them with this * Support the development of social interaction skills * Provide support with transitions and significant life events * Understand the issues which arise from co-occurrence of mental ill health and autism.   **4.10 Business continuity**  The Service Provider must have a business continuity plan in place to ensure the delivery of the Service is continuous and consistent for the benefit of Service Users. The Service Provider must ensure that the business continuity plan is able to deal with the following non-exhaustive list of issues that could impact upon the delivery of the Service:   * Inadequate staffing levels/staff absences * Financial resource management * Administration and management * Core IT system failure * Adverse weather conditions e.g. snow, flooding * Pandemic * Complaints and regulatory intervention * Business transfer or sale. |
| **5.0 Quality and safeguarding** |
| **5.1 Quality standards and assurance**   * The Service must be provided by appropriately qualified/experienced staff, in line with the standards set by the CQC. * The Service Provider must ensure that they meet the registration requirements for delivery of the appropriate regulated activities and must include correct information within their Statement of Purpose submitted to CQC. * The Service Provider must not have a rating of 'Inadequate' or 'Major Concern' or as part of the inspection report is found to be in breach of Care Quality Commission (Registration) Regulations 2009 or Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. * Where a Service Provider has a rating of 'requires improvement' or equivalent they will be required to provide mitigating evidence, explaining the position and remedial actions implemented. * The Service Provider should understand and work towards NICE guidance[[5]](#footnote-5) and quality standards[[6]](#footnote-6) on Home Care and Transition between inpatient hospital settings and community or care home settings for adults with social care needs[[7]](#footnote-7) and operate the Service in line with evidence and recommendations contained within them. The Service Provider should also adhere to the Skills for Care Code of Conduct for Healthcare Care Workers and Adult Social Care Workers in England[[8]](#footnote-8).   As part of an approach to continuous quality improvement, including promoting better terms and conditions for Care Workers, the Service Provider must:   * Commit to and implement stages 1 and 2 of Unison's ethical care charter[[9]](#footnote-9) on commencement of the first year of the Framework with the exception of the requirement relating to zero hours contracts * Ensure that from the commencement of the second year of the Framework they do not use zero hours contracts in place of permanent contracts, unless a Support Worker specifically requests to be employed on such terms due to their personal wishes and circumstances; and * Cooperate to explore the feasibility of implementing stage 3 within future frameworks.   The Service Provider must be committed to achieving and maintaining high quality services. This will be a key factor in their own business success, for the Service Users they support and also in the achievement of the success of the wider care system.  The Service Providers must ensure that continuous quality improvement systems are in place to ensure the Service is run in the best interests of Service Users, demonstrates the quality and consistency of information, measures Service User outcomes and ensures that risks to Service Users are minimised. As part of the Service Provider's approach to continuous improvement, the Authority encourages the use of the Care Improvement Works guides, tools and resources produced by Skills for Care and the Social Care Institute for Excellence.  The Service Provider must use an outcome based framework for a strengths approach to supporting positive change around Service User led outcomes and priorities e.g. the Recovery Star for adults managing their mental health.  The Service Provider must have quality assurance and monitoring systems, which seek the views and experiences of Service Users, carers and health and social care professionals, to enable a realistic assessment of the Service provided.  The Service Provider will be expected to follow the Skills for Care 'Principles to Practice' [[10]](#footnote-10)which defines the principles and the key areas to support good mental health.  All staff should be actively involved in the quality assurance and monitoring processes. Quality services will be recognised as a motivating force and staff must strive for continuous improvement and best practice.   * The Service Provider's quality assurance system must demonstrate: * Measurable organisational improvement * The quality and standards of the Service provided * Training that provides staff with the skills and tools to promote quality improvement * Staff are empowered and supported to make positive changes * Positive attitudes and working relationships * Early warning systems * Learning from complaints, serious incidents and safeguarding alerts/investigations * Continuous building on good practice * Introduction of new procedures.   The Service Provider will be required to cooperate with the Authority in evaluating and improving quality, not only of the care to individual Service Users but also compliance with the Framework Agreement, and in improving the quality of the Service.  The Service Provider must have a clear set of policies and procedures to support good practice and meet the requirements of legislation and this specification. These policies and procedures should be dated and monitored as part of the Service Provider’s quality assurance system. They should be reviewed at a timescale that is appropriate to the content of the policy and at least annually.  The Service Provider must ensure that all policies and procedures in place have a person centred emphasis, which promote feedback of Service User experience, and which ensure safe and appropriate working practices.  **5.2 Complaints Concerns and Compliments**  The Service Provider must have a written complaints policy and procedure in place in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16, The Service Provider must take all reasonable steps to bring the arrangements to the attention of Service Users in an understandable way and keep a complete record of all complaints made by Service Users, or their representatives and subsequent investigations.  The Service Provider shall record sufficient detail of complaints and compliments, which will include the:   * Date and time it was received * Name of the person making the complaint/compliment * Nature of the complaint/compliment * Names of the staff involved * Timescales for remedial action to be taken * Action taken to remedy the complaint * Date and time when the remedy was completed.   The Service Provider will acknowledge the complaint on receipt and will provide a comprehensive reply within 30 working days of the complaint being received providing remedial actions if required. The response must include details of how the complaint may be escalated if they are not satisfied with the outcome.  The Service Provider will be required to evidence to the Authority the learning from complaints and actions taken as a result to improve the quality of the Service and experience for Service Users.  A record of compliments received should be retained by the Service Provider and shared with all staff to promote good practice and an understanding of what can make a difference to Service Users.  **5.3 Safeguarding**  The Service Provider must ensure that robust arrangements are in place to safeguard Service Users from any form of abuse or exploitation as detailed in Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including physical, financial, psychological or sexual abuse, neglect, discriminatory abuse, self-harm, inhuman or degrading treatment through deliberate intent, negligence or ignorance.  The Service Provider has a responsibility to safeguard Service Users in accordance with CQC Essential Standards Outcome 7 and the Care Act 2014, and comply with the government guidance: Working Together to Safeguard Children 2015.The Service Provider must have in place policies and procedures for identifying and dealing with the abuse of vulnerable people which are complementary to the Pan Lancashire Policies and Procedures for Safeguarding Adults[[11]](#footnote-11) and Children[[12]](#footnote-12). The Service Provider must have in place policies and procedures for identifying and dealing with the abuse of vulnerable adults which are complementary to the agreed Multi-Agency Safeguarding Adults Policy and Procedures.  The Service Provider must also comply with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 – Duty of Candour to ensure its safeguarding practice promotes openness, transparency and trust.  The Service Provider must ensure that policies and procedures are covered in induction and fully understood by staff. All staff must be given an initial understanding of their safeguarding duties within their first week of employment. Comprehensive training on awareness and prevention of abuse must be given to all staff as part of their core induction within 3 months and updated at least annually. In addition, update training will be provided in light of new policies and procedures introduced either locally or nationally.  The Service Provider will minimise the risk and likelihood of incidents occurring by:   * Ensuring that staff and Service Users understand the aspects of the safeguarding processes that are relevant to them * Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed * Ensuring that Service Users are aware of how to raise concerns of abuse * Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern. * Having effective means of receiving and acting upon feedback from Service Users and any other person * Having a whistleblowing policy and procedure in place * Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:   + having clear procedures followed in practice monitored and reviewed, and take account of relevant legislation and guidance for the management of alleged abuse   + separating the alleged abuser from Service Users and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the Service Provider   + reporting the alleged abuse to the appropriate authority   + reviewing the Service User's rehabilitation care and support plan to ensure that they are properly supported following the alleged abuse incident. * Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance * Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local Authority policies * Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding * Taking into account relevant guidance set out by the CQC * Ensuring that those working with Service Users wait for a full Disclosure and Barring Service disclosure before starting work * Training and supervising staff in safeguarding to ensure they can demonstrate the necessary competences.   The Service Provider must also have policies and procedures in place on the safe handling of money and property belonging to Service Users. |
| **6.0 Performance management** |
| The Authority is establishing a new Performance Framework for Mental Health Rehabilitation services. All Service Providers offered places on the Framework will have to comply with the requirement to provide performance information in the following key areas:  **Service Requirements**  KPI 1 Rehabilitation milestones  KPI 2 Service User outcome measures (Outcomes being achieved)  **Workforce Requirements**  KPI 3 Staff Training – General  KPI 4 Staff Training – Specific  **Quality and Safeguarding**  KPI 5 Quality check visits  KPI 6 Experience of people who use services: Complaints and Concerns  KPI 7 Experience of people who use services: Compliments  **Adult Social Care Outcomes**  KPI 8 Supporting people to obtain or retain employment  **Please note**: Residential and nursing care home providers will also be required to complete Quest for Care returns.  Detailed descriptions are provided in Annex 2 |

**Annex 1 – Glossary**

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| **Term** | **Definition** |
| Advocacy | Help to enable a person get the care and support they need that is independent of the local council.  An advocate can help a person to express their needs and wishes and weigh up and take decisions about the options available to them. They can help a person find services, make sure correct procedures are followed and challenge decisions made by councils or other organisations. |
| Assistive technology | Equipment that helps a person carry out daily activities and manage more easily and safely in their own home. Examples include electronic medicine dispensers, memory prompts and pendant alarms. |
| Business continuity plan | A set of documents, instructions and procedures which enable a business to respond to accidents, disasters, emergencies and or threats without any stoppage or hindrance in its key operations. |
| Care | Support provided to individuals to enable them to live as independently as possible, including helping a person to live with ill health, disability, physical frailty or a learning difficulty and to participate as fully as possible in social activities. This encompasses health and social care. |
| Care Navigation team | A team within the Council which is responsible for finding suitable home care services and residential care on behalf of individuals. |
| Carer | Carers look after family members, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is usually unpaid. |
| Clinical  Commissioning Groups (CCG) | Clinical Commissioning Groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. |
| Community equipment | Equipment which is supplied to a person to enable them to live safely in their own home and remain independent. The type of equipment offered includes walking aids, bathing aids, special beds and other items. |
| Education, Health and Care Plan | An education, health and care plan is for children and young people aged up to 25 who need more support than is available through special educational needs support.  Education, health and care plans identify educational, health and social needs and set out the additional support to meet those needs. |
| Eligible needs | The needs that a person has for care and support that the council is required to meet by law. |
| Emergency Duty Team | The emergency duty team can be contacted about any urgent social care need that occurs outside office hours, weekends and public holidays. |
| Intermediate Care  (includes reablement and rehabilitation) | "A seven day service incorporating a range of integrated health and social care services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long term residential care, support timely discharge from hospital and maximise independent living." Intermediate Care – Halfway Home DH 2009 |
| Long term condition | Conditions such as diabetes, asthma, arthritis or dementia that cannot be cured, but whose progress can be managed and influenced by medication and other therapies. |
| Needs assessment | The process of considering whether a person needs help or support because of their age, disability or illness. |
| NHS continuing healthcare | Ongoing care outside hospital for someone who is ill or disabled, arranged and funded by the NHS. |
| Ordinarily resident | The place where a person lives, or main home, which determines which council will assess their needs and potentially fund any care and support they need. |
| Outcomes | An aim or objective that a person would like to achieve or need to happen. For example, for a person to continue to live in their own home. |
| Person-centred | Person-centred care is about ensuring that the person is at the centre of everything done with and for them. This means that the Service Provider needs to take account of their individual wishes and needs; their life circumstances and health choices |
| Service Provider | For the purposes of this specification, Service Provider is defined as the entity with which the Council has entered into a contract with. It is recognised that this may be an individual Service Provider, the lead organisation in a consortium or the prime contractor in a sub-contracting arrangement. |
| Reablement | Reablement is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. |
| Recovery | Clinical recovery – ‘recovering’ from the illness itself and getting back to normal. For many people, including many mental health professionals, recovery means when the symptoms of an illness have gone  Personal recovery recovering a life worth living, without necessarily having a clinical recovery. This occurs when someone builds a life that is satisfying, fulfilling and enjoyable, when they make the most of their lives even if they continue to experience the symptoms of an illness  “[Recovery is] *a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness...”* (Anthony, 1993) |
| Rehabilitation | A whole systems approach to recovery from mental illness that maximizes an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support (RCP, 2009), use of (Killaspy, 2005)  Rehabilitation is a personalised, interactive and collaborative process, reflecting the whole person. It enables an individual to maximise their potential to live a full and active life within their family, social networks, education/training and the workplace where appropriate. |
| Rehabilitation Care and Support Plan | The plan detailing the needs of the person, how these will be met and what outcomes are to be acheived |
| SEN | Special educational needs. Children have special educational needs if they have learning difficulties that need special educational provision. |
| Service user | An individual with assessed support needs who is the intended recipient of homecare. |
| Social care commitment | The Social Care Commitment is an agreement between employers and employees where they both sign up to seven clear commitments to develop skills and knowledge within their workforce. |
| Telecare | Technology that enables people to remain independent and safe in their own home, by linking their home with a monitoring centre that can respond to problems. |
| Transition to adulthood | The process by which young people with health or social care needs move from children's services to adult services. |
| Travel | Travel associated with direct service contact/assessment or review. This does not include travel from the home care workers home to the service user but from office to service user or service user to service user. |

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| **ANNEX 2 - Key Performance Indicators - Detailed Descriptions** | |
| The Authority is establishing a new Performance Framework for Rehabilitation services. All Service Providers offered places on the Framework will have to comply with requirement to provide information in the following key areas:  **Service Requirements**  KPI 1 Rehabilitation milestones  KPI 2 Service User outcome measures (Outcomes being achieved)  **Workforce Requirements**  KPI 3 Staff Training – General  KPI 4 Staff Training – Specific  **Quality and Safeguarding**  KPI 5 Quality check visits  KPI 6 Experience of people who use services: Complaints and Concerns  KPI 7 Experience of people who use services: Compliments  **Adult Social Care Outcomes**  KPI 8 Supporting people to obtain or retain employment  **Please note**: In addition residential and nursing care home providers will be required to complete Quest for Care returns. | |
| **Service Requirements** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **KPI 1 Rehabilitation Milestones (as detailed within the specification)** | | | | | | | **Rationale** | The Authority requires Service Providers to evidence that they are committed to rehabilitation support. Monitoring the Service Provider’s performance in terms of achieving rehabilitation milestones with Service Users will ensure that Service Providers are working to improve in this area.  The Authority must assure itself that care and support delivered within its footprint is rehabilitation focussed, adaptable and best meets the supported adults' rehabilitation care and support needs.  The vision for this KPI is for absolute take-up of provider-led rehabilitation care and support plans that are outcome-focused and wholly focused on the Service User as an individual | | | | | | **Definition** | % Service Users that have achieved the rehabilitation milestones | | | | | | **Numerator** | A – Number of Service Users provided with a service that have achieved one or more milestones | | | | | | **Denominator** | B – Number of Service Users provided with a Service during the period. | | | | | | **Formula** | (A ÷ B) x 100 = %outturn | | | | | | **Worked Example** | tbc | | | | | | **Good**  **Performance** | tbc | | | | | | **Return Format** | Quarterly | | | | | | **Frequently Asked Questions** | | | | | | | **What this indicator does:** Measures the % of Service Users achieving milestones during the reporting period.  Rehabilitation milestones are intended to monitor the ability of the provider to create the conditions in which rehabilitation is more likely to occur. Rehabilitation care and support plans should be meaningful to the person and their benefits be realised in their immediate, or distant future.  **What to include:** All Service Users with support commissioned by The Authority and or partners  **What to exclude:** If the Service Provider delivers care and support services to people whose care is not commissioned by The Authority and or partners submissions must exclude this data  **How is this standardised:** All Service Providers will be required to collate and use the findings from to evidence continuous improvements in service.  **Definitions:**  Rehabilitation outcomes: It is not sufficient to only create a rehabilitation care and support plan. Service Providers must be able to plan to meet the milestones This way Service Providers, and The Authority, can be assured that everyone is receiving an equal opportunity to achieve their own rehabilitation milestones  **Example of auditable evidence:**  The Authority may ask for evidence for this KPI, this may be routine or as a result of intelligence that it receives. The Authority may ask for the following forms of evidence, or for other evidence not listed here:   * Person-centred plans * Rehabilitation care and support plan * Outcome monitoring * Participation in routines/activities * Care notes/diaries * Risk assessments * Staff rotas | | | | | | | **KPI 2 Service User outcome measures (Outcomes being achieved)** | | | | | | | **Rationale** | The Authority requires Service Providers to evidence that they are committed to improving the quality of the Service they provide. Monitoring the Service Provider’s performance in terms of achieving outcomes agreed with Service Users will ensure that Service Providers are working to improve in this area.  The Authority must assure itself that care and support delivered within its footprint is person-centred, outcome focused, adaptable and best meets the supported adults' personal care and support needs.  The vision for this KPI is for absolute take-up of provider-led rehabilitation care and support plans that are outcome-focused and wholly focused on the Service User as an individual | | | | | | **Definition** | % Service Users that have achieved one or more outcomes | | | | | | **Numerator** | A – Number of Service Users using Services that have achieved one or more outcomes when reviewed. | | | | | | **Denominator** | B – Number of Service Users provided with a Service during the period. | | | | | | **Formula** | (A ÷ B) x 100 = %outturn | | | | | | **Worked Example** | Suppose the number of Service Users that have agreed one or more outcomes are being achieved during the reporting period is 100 (A)  Suppose the number of Service Users is 300 (B)  The percentage of Service Users that have completed an outcome measures survey is:  (100 ÷ 300) x 100 = 33.33% | | | | | | **Good**  **Performance** | Good  performance is typified by a higher  percentage | **Collection**  **Interval** | Quarterly | **Data Source** | Rehabilitation care and support plan | | **Return Format** | Percentage | **Target** | To be confirmed | **Reporting**  **Organisation** | Service Provider | | **Frequently Asked Questions** | | | | | | | **What this indicator does:** Measures the % of Service Users achieving outcomes during the reporting period and, when reviewed, have agreed that their outcomes are being achieved.  Rehabilitation care and support plan outcomes should be meaningful to the person and their benefits be realised in their immediate, or distant future.  **What to include:** All Service Users with support commissioned by The Authority and or Partners  **What to exclude:** If the Service Provider delivers care services to people whose care is not commissioned by The Authority and or partners submissions must exclude this data  **How is this standardised:** All Service Providers must record outcomes achieved during routine reviews of Services with each Service User at least once per reporting period. All Service Providers will be required to collate the findings to evidence continuous improvements in service.  **Definitions:**  Outcomes: Outcomes are something that is personal to every individual, it is something they want to achieve but need support to achieve it. Outcomes should be ambitious and must inevitably increase independence, personal skills, confidence and/or health & wellbeing. Examples of good outcomes are being able to travel independently, or with friends, on public transport or to be responsible for an activity in the house, such as laundry, or get fit by joining a gym, health club or take up running or cycling.  Identified outcomes: It is not sufficient to merely identify outcomes in a person-centred plan. Service Providers must be able to plan to meet these outcomes and are expected to produce a clear plan, made with the Service User's involvement, and a timetable, which includes milestones. This way Service Providers, and The Authority, can be assured that everyone is receiving an equal opportunity to achieve their own rehabilitation care and support outcomes.  **Example of auditable evidence:**  The Authority may ask for evidence for this KPI, this may be routine or as a result of intelligence that it receives. The Authority may ask for the following forms of evidence, or for other evidence not listed here:   * Person-centred plans * Rehabilitation care and support plans * Outcome plans * Care notes/ diaries * Risk assessments * Staff rotas   **Correlation:**  This KPI also correlates with the Authority's vision for the future of care and support in Lancashire, where a strength-based and outcome-focused approach is always taken wherever care and support is offered and delivered in Lancashire. | | | | | | | |
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| **Workforce Requirements** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **KPI 3 Staff Training - General** | | | | | | | **Rationale** | The vision for this KPI is to create stable and effective care and support by promoting long-term staffing and professionalisation of the care sector in Lancashire. Service Providers will facilitate this by supporting staff to develop professionally in their careers. This will include offering training that will provide staff with the skills to provide high quality and effective care. It is desirous that the professionalisation of staff and stability and security of the sectors' labour market will foster a culture in companies and organisations of high-quality, effective and person-focused care and support in Lancashire, which is also flexible, reliable and responsive.  The Authority believes that a well-trained workforce will contribute towards strong safety measures for our Service Users and also improve the quality of services provided.  All staff must complete introductory training, which includes how to promote equality and people’s rights, as well as first aid, food hygiene, giving medication, and moving and handling people.  Staff are encouraged and given time to improve their skills through courses in health care and social care. | | | | | | **Definition** | % of Care Workers offered, currently undertaking or have achieved Level 2 Diploma in Health and Social Care  % of Care Workers currently undertaking or have achieved the Care Certificate. | | | | | | **Numerator** | A1– Number of Care Workers currently offered, undertaking or have achieved a Level 2 Diploma in Health and Social Care  A2 – Number of Care Workers currently undertaking or have achieved the Care Certificate. | | | | | | **Denominator** | B1 - Number of Support Worker posts within the organisation during the reporting period. | | | | | | **Formula** | (A1 ÷ B1) x 100 = %outturn  (A2 ÷ B1) x 100 = %outturn | | | | | | **Worked Example** | Suppose the number of Care Workers who are currently offered, undertaking or have achieved a Level 2 Diploma in Health and Social Care is 43 (A1).  Suppose the number of Support Worker posts within the organisation (B1) is 75  The percentage of Care Workers who have been offered, undertaken or achieved at least a Level 2 Diploma qualification in Health and Social Care is:  (43 ÷ 75) x 100 = 57.33% | | | | | | **Good**  **Performance** | Good performance is typified by a higher percentage | Collection  Interval | Six Monthly | **Data Source** | KPI submission  Template (TBC) | | **Return Format** | Numerator, Denominator and Percentage | **Target** | 90% | **Reporting**  **Organisation** | Service Provider | | **Frequently Asked Questions** | | | | | | | **What this indicator does:** Measures the number of Care Workers within the organisation who have been offered, are undertaking or have achieved at least a Level 2 Diploma in Health and Social Care.  **What to Include:**   * Front line workers and Managers who line manage front line workers working with Service Users in Lancashire.   **What to Exclude:**   * Staff within the organisation who do not provide Care and support services directly and/or do not line manage workers that do. * All staff working for the Service Provider whose work solely relates to locations outside of Lancashire. * All staff on maternity leave for the full duration of the period being measured.   **Definitions:**   * **Number of Care Workers** – Is the total number of Care Workers employed by the Organisation during the reporting period. For example if at the beginning of the period the Organisation employed 30 workers and at the end of the reporting period the Organisation employed 35 workers but 10 workers had left the organisation, the total number of Care Workers would be 45.   **Example of auditable evidence:**   * Training records * Employee files | | | | | | | |
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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **KPI 4 Staff Training – Specific** | | | | | | | **Rationale** | The vision for this KPI is to create a stable and effective care and support by promoting long-term staffing and professionalisation of the care sector in Lancashire. Service Providers will facilitate this by supporting staff to develop professionally in their careers. This will include offering training that will provide Care Workers with the skills to provide high quality and effective care. It is desirous that the professionalisation of Care Workers and stability and security of the sectors' labour market will foster a culture in organisations of high-quality, effective and person-focused care and support in Lancashire, which is also flexible, reliable and responsive.  The needs of Service Users have become increasingly complex. Care Workers with skills that meet the needs of Service Users they support will improve the quality of services provided. | | | | | | **Definition** | % of Care Workers that have specific training that meets the needs of those people for whom they provide support. | | | | | | **Numerator** | A – Number of Care Workers that have had training specific to the needs of those people for whom they provide support. | | | | | | **Denominator** | B – Number of posts within the organisation during the reporting period that require specific training. | | | | | | **Formula** | (A ÷ B) x 100 = %outturn | | | | | | **Worked Example** | Suppose the number of Care Workers that have specific training based on the needs of the people they support (A) is 20  Suppose the number of posts within the Service Provider that require specific training (B) is 75  The percentage of Care Workers who have training based on the needs of Service Users is:  (20 ÷ 75) x 100 = 26.67% | | | | | | **Good**  **Performance** | Good performance is typified by a higher percentage | **Collection**  **Interval** | Six Monthly | **Data source** | Provider records | | **Return Format** | Percentage | **Target** | To be confirmed | **Reporting**  **Organisation** | Service Provider | | **Frequently Asked Questions** | | | | | | | **What this indicator does:** Measures the level of Care Workers who have specific training to meet the needs of Service Users.  **What to Include:**   * Care Workers and managers who line manage front line workers working with Service Users in Lancashire.   **What to Exclude:**   * Staff within the organisation who do not provide care services directly and/or do not line manages workers that do. * All staff working for the Service Provider whose work solely relates to locations outside of Lancashire.   **Definitions:**   * **Specific training** – specific training is training based on the specific needs of the Service User that the Support Worker supports and can relate to a long term condition e.g. schizophrenia or the type of support required e.g. therapy * **Number of Care Workers** – Is the total number of Care Workers employed by the Service Provider during the reporting period. For example, if at the beginning of the period the organisation employed 30 workers and at the end of the reporting period the organisation employed 35 workers but 10 workers had left the organisation, the total number of workers would be 45.   **Example of auditable evidence:**   * Rehabilitation care and support plans for Service Users which identify specific needs * Evidence that Care Workers with appropriate training are allocated to Service Users with specific needs (e.g. staff rotas and Care and Support Plans) * Staff training records * Staff files | | | | | | | |
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| **Quality and Safeguarding** | |
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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **KPI 5 Quality check visits** | | | | | | | **Rationale** | The Authority requires Service Providers to evidence that they are committed to improving the quality of the Service they provide. Undertaking quality checks will ensure that the Rehabilitation Service provided by Care Workers is monitored. | | | | | | **Definition** | % Care Workers that have received a quality check during the provision of support | | | | | | **Numerator** | A – Number of Care Workers that have received a spot check during the provision of support during the reporting period | | | | | | **Denominator** | B – Total number of Care Workers | | | | | | **Formula** | (A ÷ B) x 100 = %outturn | | | | | | **Worked Example** | Suppose the number of Care Workers that have received a spot check during the provision of support during the reporting period (A) is 40  Suppose the total number of Care Workers (B) is 75  The percentage of Care Workers that have received check during the provision of support is:  (40 ÷ 75) x 100 = 53.33% | | | | | | **Good**  **Performance** | Good performance is typified by a higher percentage | **Collection**  **Interval** | Quarterly | **Data Source** | Provider records | | **Return Format** | Numerator Denominator and Percentage | **Target** | 60% | **Reporting**  **Organisation** | Service Provider | | **Frequently Asked Questions** | | | | | | | **What this indicator does:** Measures the % of workers that have received a spot check during the provision of support  **What to include:** All Care Workers providing support commissioned by The Authority and or Partners  **What to exclude:**   * If the Service Provider employs Care Workers that deliver care services only to people whose care is not commissioned by The Authority submissions must exclude this data * Support employed for fewer than x (3 or 6) months   **Definitions:**  • **Spot check** – is an unannounced visit from a Manager during the provision of support to evaluate the support delivered  **Example of auditable evidence:**   * Records of spot checks on staff file * Service user survey   **Correlation with**: KPI staff training issues may be identified during spot checks | | | | | | | |
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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **KPI 6 Experience of people who use services: Complaints and Concerns** | | | | | | | **Rationale** | The Authority requires Service Providers to evidence that they are committed to Service User involvement and empowerment, fair access, diversity and inclusion. Monitoring the Service Provider’s performance in dealing with complaints, concerns and compliments in a timely manner will evidence that a Service Provider ensures that Service Users' views are taken seriously. | | | | | | **Definition** | % of complaints and concerns that have been completed /resolved within 28 days | | | | | | **Numerator** | A– Number of complaints and concerns that have been completed/resolved within 28 days | | | | | | **Denominator** | B – Number of complaints and concerns that have been received in the reporting period | | | | | | **Formula** | (A ÷ B) x 100 = % outturn | | | | | | **Worked Example** | Suppose the number of complaints and concerns that were resolved/completed within 28 days during the reporting period was 4 (A).  Suppose the total number of complaints and concerns that were received during the reporting period was 8 (B).  The percentage of complaints and concerns that were resolved / completed within 28 days during the period (4 ÷ 8) x 100 = 50.00% | | | | | | **Good**  **Performance** | Good performance is typified by a higher percentage | **Collection**  **Interval** | Six Monthly | **Data Source** | KPI submission  Template (TBC) | | **Return Format** | Numerator, Denominator and Percentage | **Target** | 80% | **Reporting**  **Organisation** | Service Provider | | **Frequently Asked Questions** | | | | | | | **What this indicator does:** Measures the timeliness of dealing with complaints, by capturing all complaints that have been completed/resolved during the reporting period.  **What to include:** All formal written and verbal complaints and concerns and that have been received during the reporting period relating to Service Users whose support is commissioned by The Authority and or partners.  **What to exclude:** If the Service Provider delivers care and support services to people whose care is not commissioned by The Authority and or partners, submissions must exclude this data  **Example of auditable evidence:**  Complaints procedure  Evidence that Service Users and carers find it easy to feed back. Check the number of compliments received alongside this. If both the number of complaints and the number of compliments is low, check whether Service Users and carers know how to provide feedback and whether it is monitored effectively.  Also monitor whether learning from complaints is implemented effectively and evidenced.  **Correlation**  KPI 6 and 67 The number of complaints/concerns as a proportion of the number of Service Users receiving a service from the Service Provider in the period (taken from LCC's systems). | | | | | | | |
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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **KPI 7 Experience of people who use services: Compliments** | | | | | | | **Rationale** | The Authority requires Service Providers to evidence that they are committed to Service User involvement and empowerment, fair access, diversity and inclusion. Monitoring the Service Provider’s performance in dealing with complaints, concerns and compliments in a timely manner will evidence that a Service Provider ensures that Service Users' views are taken seriously. | | | | | | **Definition** | % of feedback that has been compliments within the reporting period | | | | | | **Numerator** | A– Number of compliments received in the reporting period | | | | | | **Denominator** | B – Number of compliments, complaints and concerns that have been received in the reporting period | | | | | | **Formula** | (A ÷ B) x 100 = % outturn | | | | | | **Worked Example** | Suppose the number of compliments received during the reporting period was 10 (A).  Suppose the total number of compliments, complaints and concerns that were received during the reporting period was 18 (B).  The percentage of feedback that was compliments during the period (10 ÷ 18) x 100 = 56% | | | | | | **Good**  **Performance** | Good  performance is  typified by a  higher percentage | **Collection**  **Interval** | Six Monthly | **Data Source** | KPI submission  Template (TBC) | | **Return Format** | Numerator, Denominator and Percentage | **Target** | 60% | **Reporting**  **Organisation** | Service Provider | | **Frequently Asked Questions** | | | | | | | **What this indicator does:** Measures the number of compliments compared with the total number of items of feedback during the reporting period.  **What it is measured against**: Each provider will be benchmarked against themselves from period to period and also against their peers and county.  **What to include:** All formal written and verbal compliments, complaints and concerns that have received during the reporting period relating to Service Users whose support is commissioned by The Authority.  **What to exclude:** If the Service Provider delivers care services to people whose care is not commissioned by The Authority submissions must exclude this data  **Example of auditable evidence:**  Compliments and Complaints procedure  Evidence that Service Users and carers find it easy to feed back.  If both the number of complaints and the number of compliments is low, check whether Service Users and carers know how to provide feedback and whether it is monitored effectively.  Also monitor whether learning from complaints is implemented effectively and evidenced. | | | | | | |
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This will provide for increased skills, independence, and community engagement and will ensure care and support is targeted at improving the lives of supported adults.  **What this indicator does:**  Why it is important  This KPI will ensure that The Authority, and care providers, are doing all they can to improve the lives of adults under their care. A key way of measuring this is by ensuring care outcomes are identified and met. Providers must identify adults who are willing and able to access paid or unpaid employment and want to achieve this as a support outcome. The skills gained from employment are invaluable for the supported adult to make connections with members of the community, family and friends, gain independence skills, such as managing money more effectively or identifying and performing routine tasks and to have more disposable income.  Why it is needed  The Authority and its partners must do more to ensure that effective, tailored and responsible care and support is provided for adults who need it, when they need it. It is not acceptable for adults to merely be supported by having their meals cooked or their clothes laundered. Supported adults should be supported to increase their skills and expand their experiences by accessing, and integrating into, their communities. Employment increases skills, such as social skills and working to own initiative, or using public transport and time management. The supported adult must be at the centre of identifying outcomes and planning how these should be achieved, employment must always be an option and supported adults must always have the opportunity to achieve employment on their own or with support.  **What to include:**  Care providers should include all adults whose care is funded by The Authority and services are provided under this contractual framework agreement.  Care providers can include data relating to service users who are returning to paid/unpaid roles they had before their period of rehab.  The care provider should include all adults whose care is funded, even in part, by The Authority and or Partners, except where a direct payment is used.  **What to exclude:**  Unpaid employment with the care provider's company/organisation cannot be recorded under this KPI, except in the circumstance where The Authority has permitted, in writing, this recording.  Employment, which would otherwise be paid to unsupported adults, is completed without pay, unless this is prior agreed, by the supported adult, as a fixed term internship.  **Definitions:**  Paid Employment: Any employment of any number of hours which provides an income to the supported adult in employment. Employment should be legitimate and pay the National Minimum Wage for the person's age group.  Unpaid employment: Any employment of any number of hours which does not provide any income to the supported adult in employment excluding circumstances where the supported adult completes unpaid work within the care provider's own company/ organisation (see "what to exclude"). These roles are likely to be voluntary roles.  **How to measure:**  The calculation above is sufficient for The Authority to measure the performance of care providers in Lancashire. Care providers should regularly self-regulate to assure themselves that they are meeting targets set by this KPI.  **Example of auditable evidence:**  The Authority may ask for evidence for this KPI, this may be routine or as a result of intelligence that it receives. The Authority may ask for the following forms of evidence, or for other evidence not listed here:   * Person-centred plans * Rehabilitation care & support plans * Outcome plans * Care notes/ diaries * Risk assessments | | | | | | | | |

1. <http://www.lancashire.gov.uk/media/898255/approved-social-value-policy-and-framework.pdf> [↑](#footnote-ref-1)
2. <https://www.thesocialcarecommitment.org.uk/> [↑](#footnote-ref-2)
3. <http://www.skillsforcare.org.uk/Recruitment-retention/Values-based-recruitment-and-retention/Values-based-recruitment-and-retention.aspx> [↑](#footnote-ref-3)
4. <http://www.skillsforcare.org.uk/Documents/Topics/Dementia/Common-core-principles-for-dementia.pdf> [↑](#footnote-ref-4)
5. <https://www.nice.org.uk/guidance/ng21> [↑](#footnote-ref-5)
6. <https://www.nice.org.uk/guidance/qs123/chapter/using-the-quality-standard> [↑](#footnote-ref-6)
7. <https://pathways.nice.org.uk/pathways/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs> [↑](#footnote-ref-7)
8. <http://www.skillsforcare.org.uk/Documents/Standards-legislation/Code-of-Conduct/Code-of-Conduct.pdf>. [↑](#footnote-ref-8)
9. <https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf> [↑](#footnote-ref-9)
10. <http://www.skillsforcare.org.uk/Documents/Topics/Mental-health/Principles-to-Practice-good-mental-health.pdf> [↑](#footnote-ref-10)
11. <http://plcsab.proceduresonline.com/chapters/contents.html> [↑](#footnote-ref-11)
12. <http://panlancashirescb.proceduresonline.com/> [↑](#footnote-ref-12)
13. [↑](#endnote-ref-1)