SHORT TERM CARE AT HOME SERVICE SPECIFICATION

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1.0. Introduction and Background

1.1. The Authority's vision is to enable people to live as independently and healthily as possible with the right level of care and support for themselves and their informal carers with prevention, early intervention and promoting independence at the heart of our approach.

Our approach will put the Individual at the centre of every decision and build on their existing strengths and circumstances to help keep them safe and living independently for as long as possible, whilst also being mindful of their wishes and choices.

- We will offer care and support to prevent as many avoidable hospital and care home admissions as possible.

- Where a hospital stay is unavoidable, we will ensure care and support (including equipment) is offered to enable the Individual to recover quickly and safely at home, and assessments for any ongoing care and support will take place in people's own homes.

2.0. The Service

2.1. The Service will be called Short Term Care at Home.

2.2. The Service aims to:

a. Support people to regain life skills that have been temporarily lost, or where there has been a gradual deterioration or a risk of loss of ability, and to help people to retain or regain their independence
b. Prevent people from requiring more intensive forms of care (for example, hospital or care home) and to help them return home after a stay in hospital or in a short-term care home setting
c. Support people in their own home who may not otherwise be able to stay safe and well at home
d. Help people avoid unnecessary admissions into residential homes, hospital or other formal care settings through working with the individual and their support networks
e. Support people at home with high quality interventions and be connected within their local communities where they feel safe and supported with personalised care that promotes choice and control in all aspects of daily life
f. Support people to achieve their goals through a strengths-based approach which allows people to learn new ways of undertaking personal and home-based activities, with the support of equipment and/or technology to help them remain independent

2.3. The Service will focus on the needs of the Individual at that point in time, providing support in the following situations:

a. Urgent support - Where a Individual requires urgent care and support at home where normal living arrangements (including unpaid/informal care) have broken down unexpectedly or another crisis situation has led to a need for urgent care and support without which could lead to hospital or care home admission. In exceptional circumstances, this could be used to support hospital discharge.
b. Planned support - The Service will support all planned discharges from acute and community hospitals and bed-based care settings currently working through a Discharge to Assess (D2A) or rehabilitation model. The Service will also receive referrals for Individuals living in the community which will focus on prevention, recuperation and rehabilitation.

2.4. This Service is for adults aged 18 and over who are ordinarily resident within the administrative area of the Authority and who have been assessed by heath and/or social care as appropriate for the Service.

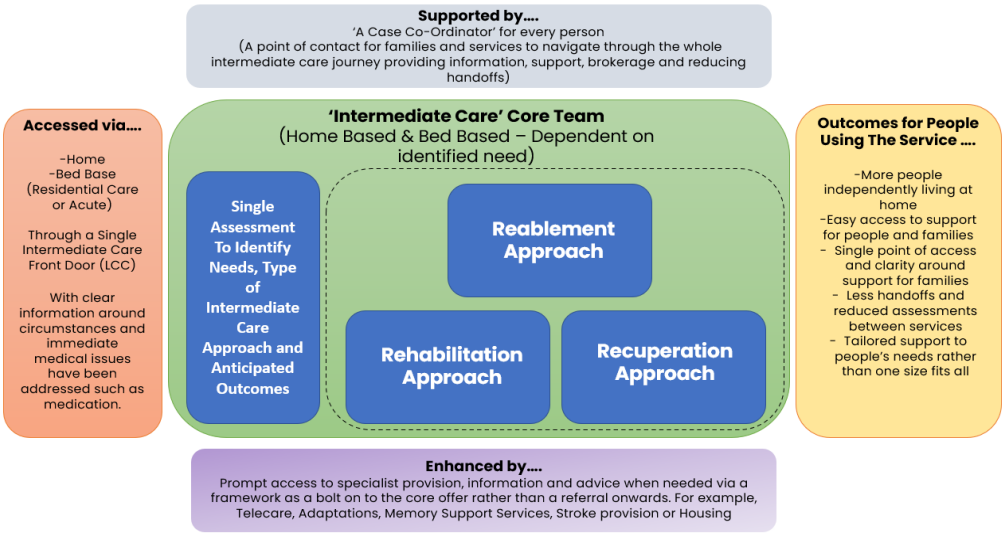
2.5. The Service will make all reasonable adjustments to support the diverse needs of adults in Lancashire who access the service. The Service is inclusive of people who may lack mental capacity as well as people who may have existing physical health and/or mental health conditions. The Service Provider will identify and work alongside, other services and professionals to ensure all needs are met where reasonably possible to do so.

2.6. The Service forms part of the Authority's statutory offer of Intermediate Care required under the Care Act 2014 as detailed in Section 3 of the Care and Support Regulations 2014. It may also be provided in circumstances where the Authority exercises its powers, under Section 19(3) of the Care Act 2014, to meet an Individual's urgent care and support needs without having first conducted a needs assessment or eligibility determination.

2.7. The Service will form part of an overall assessment that will identify any ongoing support needs, after having given full consideration to all low and no cost care options that are appropriate and proportionate to need whilst maximising independent living through the right equipment, technology and daily living aids.

3.0. Service Model

3.1. The Service vision is to provide an end-to-end Service. The diagram below is an illustrative high-level vision:



3.2. The Service model will be outcome focussed with an approach to stabilise, recuperate, reable and rehabilitate to reach an optimum level of independence, appropriate to the Individuals' circumstances and identified goals.

3.3. In most cases, an assessment will take place in an Individual's home and be undertaken by any professional such as therapist, nurse or social worker and social care worker to determine the issues and needs which will be required to be addressed to support the Individual's immediate social care needs alongside any equipment. On occasions, it may be the level of care required is determined prior to discharge from hospital or care setting.

3.4. The Service will support Individual's in their own homes where urgent support is required to be provided by the Service Provider to stabilise the situation and avoid a potential hospital or residential care admission. Furthermore, the Service will deliver planned and preventative support to assist in regaining or learning new daily living skills from both a functional and well-being perspective.

3.5. In all cases, and within 5 days of commencement on the Service, the Service Provider will have worked alongside the Individual and the Authority to determine whether the Individual's immediate needs have been met as well as identifying any short-term goals and identified needs for further progression towards independence. If short term goals are identified, the Service Provider will work alongside the Individual and the Authority to generate a Short-Term Care at Home plan that identifies any rehabilitation goals and/or care needs requiring to be met within a period

of no more than six weeks, in most cases. Throughout the Individual's time on the Service, the Service Provider will be able to cease and reduce care where determined appropriate (see section 6).

4.0. Service Capacity and Availability

4.1. Services for Short Term Care at Home ordinarily will be commissioned via a Block Contract(s) within 5 Geographical Boundaries of Lancashire which will be specified at each Call-Off. Services may also include commissioning on a spot purchase arrangement.

Block Contract Hours

Geographical Boundary	Block Contract Min Hours p/wk	Block Contract Starting Hours p/wk
Fylde and Wyre	2200	**2650**
Morecambe Bay (Lancaster District)	1400	**1800**
East Lancashire	2900	**3300**
Preston, Chorley & South Ribble	3500	**3925**
West Lancashire	1000	**1325**

The Authority may increase the Block Contract up to a maximum of 20% of the annual value of the Block Contract Starting Hours for the financial year (financial year will run from April to March). The value will be calculated using the Block Contract Starting Hours for each Geographical Boundary and then the hourly rate being paid within that financial year.

Eg, for illustrative purposes only

Geographical Boundary	Block Contract Min Hours p/wk	Block Contract Starting Hours p/wk	Example Hourly Rate for Financial Year	Max Annual Block Contract Value
Fylde and Wyre	2200	2650	£10.00	(2650x£10.00)*52= Starting Annual Block Contract Value £1,378,000 £1,378,000 +20%= Max Annual Block Contract Value £1,653,600

4.2. The Block Contract guarantees payment for minimum volume of hours with the successful Service Provider.

4.3. A map of the Geographical Boundaries is available in Section 14.

4.4. Service Providers will accept all packages across the Geographical Boundary area unless capacity of the block hours has been maximised.

4.5. All referrals requesting care will require a response from the Service Provider to accept the referral and provide a start date and time. This response for acceptance of the Care Package request will be required within 2 hours of receipt of the referral during operating hours.

4.6. It is estimated that approximately 75% of the referrals will require mobilisation of Service either same day or within 24 hours with referrals coming to support an Individual to remain at home or to facilitate hospital discharge. By exception there may be occasions where commencement of Service is required within 2 hours.

4.7. The remaining 25% referrals will be anticipated to be planned support and not require either same day start or within 24 hours.

4.8. The volumes stipulated in 4.6 and 4.7 are approximations that are subject to change as demand changes over the course of this Contract.

4.9. The Service Provider must work alongside the Authority around specific transformational work to improve jointly agreed ways of operating the Service over the lifetime of this Contract. The following are indicative:

a. Operational procedures
b. Management information
c. Introduction of technology enabled support

4.10. Care and support will be provided based on the needs of the Individual in any of the following formats:

a. One or more visits per day over the course of a single or multiple days
b. Block overnight care of a minimum duration of 8 hours over the course of a single or multiple days
c. Block care during the day of a minimum duration of 2 hours over the course of a single or multiple days
d. 24-hour care over the course of a single or multiple days

4.11. As the Service develops, overnight visits may include the option of short duration visits ranging from 30 to 60 minutes.

4.12. It is estimated that the proportion of people in receipt of overnight care is approximately 10% of the overall care hours per week.

4.13. An Individual can be in receipt of care from one day up to approximately six weeks based on the identified goals, although there may be cases in which the duration of care exceeds six weeks due to their progression towards independence being ongoing, but this is expected to be minimal.

4.14. Should an Individual on the Service be admitted to hospital, the following must apply unless determined and agreed otherwise:

4.15. For any Individual who is in receipt of the Service and are admitted to a hospital ward or it is highly unlikely they will be discharged within 3 days, the Service will cease immediately with the exception of long term home care packages. For any Individual who is in A&E, AMU or medical assessment that hasn't been formally admitted to a hospital ward, the Service will remain open for up to 3 days unless notified discharge is unlikely to occur within that time period. The Service Provider in conjunction with the Authority, will communicate with the hospital wards to ascertain the potential discharge plan.

4.16. It is anticipated, in line with any identified additional demand for the Service and as stipulated by the Contract, that additional funding, including NHS funding, may be attracted into the Service over the life of the Contract. The Service Provider must have the ability to be flexible in their ability to deliver service capacity required, work collaboratively with the Authority, stakeholders and other providers around mobilisation and exit plans for any temporary surges in activity and be proactive in helping to attract additional funding and evidence the benefits of the Service to the Authority and other stakeholders.

4.17. It will be mandatory for the Service Provider to deliver and be able to flex the scope of the contract within the agreed parameters at 4.1 to meet anticipated seasonal pressures via an increase or decrease in hours provided. The Authority will work alongside the Service Provider to agree the option to take on any increase in hours and notify the Service Provider a minimum of six weeks prior to the commencement of these hours. At any time where a decrease in the block contracted hours is required, the Service Provider will be notified a minimum of four weeks prior to any decrease in hours commissioned. The notice period for any change in hours commissioned will be determined based on the significance in the change of hours and in liaison with the Service Provider. Any increase and decreases will be introduced incrementally where required at the discretion of the Authority and in discussion with the Service Provider.

4.18. At the end of each 4 week period any unused hours (to a maximum of 20% of the block) will be carried forward to the following four week period

4.19. Carry over hours can only be used in the next 4 week period and will be allocated prior to the block allocation of hours.

4.20. Where 4.17 applies, the Service Provider and Authority will jointly review the care hours delivered on a quarterly basis to understand the reasons for the unused hours.

4.21. Where there are hours available within the block and carry over, any hours of care rejected, outside of 1A KPI 2 tolerance, the Authority reserves the right to offset this sum against future contract payments.

4.22. If the demand for hours is consistently underused, the Authority in discussion with the provider, may reduce the contract volume, with 4 weeks' notice as per Section 4.17

4.23. If the demand for care hours is greater than the block and any carry over hours, the provider *may,* with previous written permission from the Authority deliver additional hours to a maximum of 20% of the current block.

4.24. 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 and will not operate on a reduced basis over periods of public holidays or festivities. The Service must be made available to many people at the same time in different locations within the Geographical Boundary in which they are appointed.

4.25. The Service Provider must use its best endeavours to ensure there are sufficient support staff to cover the Geographical Boundary in which they are appointed to operate.

4.26. The Service Provider will meet the demands of the service as they arise.

4.27. The Service Provider must have the ability to flex the level of support available to the Individual where capacity allows so it reflects the Individuals actual need, specific goals and desired outcomes.

4.28. The level and frequency of care required to an Individual will be set out by the referrer. The Individual can choose to vary the times and durations of visits in consultation with either the Service Provider or the Authority dependent on capacity and needs.

4.29. Prior to any care starting the Service Provider must:

a. As far as is reasonably and safely possible, be proactive in accepting all referrals in the Geographical Boundary to which they are appointed through effective management of referrals, workforce capacity and staff rostering/coordination. On occasions where there are capacity issues in pockets of the geography, this is to be discussed with The Authority to discuss alternatives.

b. Commence the Individual's risk assessment and produce a plan to manage any known risks. On request, the Authority will ask to view risk assessments completed.

4.30. Due to the nature of the Service, it is likely that some requests for care will be commissioned and subsequently cancelled at short notice. The Authority will endeavour to provide as much notice as possible of such instances. The Service Provider will make any resulting capacity available immediately for use with the exception of any capacity already committed and where that staff member cannot be reassigned up to a maximum of one day.

4.31. Once an Individual has met their identified goals, the Individual's journey on the service will cease. Any further support needs identified (including non-regulated support) are required to be handed over successfully to the Authority prior to closure of an Individual's case.

4.32. Where it has been established by the Authority that the Individual has reached their optimum as specified in the Short Term Care at Home support plan, but have ongoing longer term regulated care needs, the Service Provider will continue to deliver until notified by the Authority of when the care can be ceased.

4.33. The Authority allows for up to 10 minutes of travel time within each visit made to an Individual in order to allow the Care Worker to travel between visits. E.g., a half an hour visit will include up to 10 minutes of travel time and a minimum of 20 minutes support time; an hour's visit will include up to 10 minutes of travel time and a minimum 50 minutes of support time.

4.34. It is expected the travel time included with each visit made is sufficient in allowing the Care Worker to get to the person's property in a timely manner.

5.0. Referrals and Service Pathway

5.1. Referrals to the Service Provider from the Authority will be through an electronic referral mechanism and/or a telephone call. This may be subject to change throughout the contract. The referral details to the Service Provider will include:

a. Name
b. Address
c. Telephone Number
d. Date of Birth
e. Reason for referral/ presenting needs
f. Current Medical Conditions
g. Any known Safeguarding issues
h. Any known Mental Capacity issues including capacity to agree to referral
i. Next of Kin

j. Current care arrangements (formal care, family carers, etc)
k. Any moving and handling equipment or techniques in place or to be used by the Service Provider
l. Any known risks and mitigations required
m. Time slot preference requests:
    i. Mornings: 7:00 - 9:00 9:00 – 11:00
    ii. Lunch: 11:00 – 13:00
    iii. Afternoon 13:00 – 15:00 15:00 – 17:00
    iv. Evening 17:00 – 19:00 , 19:00 – 21:00, 21:00 – 23:00
    v. 24 hour care
    vi. Overnight care

5.2. From the commencement of the Service, it is anticipated referrals will be received through the referral pathway from the following:

a. The Authority's teams responsible for hospital discharge and hospital avoidance
b. The Authority's Community Adult Social Care teams
c. The Authority's Emergency Duty team

5.3. Where agreed by the Authority, the Service Provider will be notified that the following may also refer through the agreed referral pathway, though this is not an exhaustive list:

a. NHS Hospital staff
b. Community health services (nurses, GP's Physios, Occupational Therapists)
c. Voluntary, Community and Faith sector
d. Carers Services (Peace of Mind for carers)

5.4. It is the responsibility of the referrer to ensure adequate information of the care needs are made clear which enables the Service Provider to deliver safe care, and referrals may not be accepted where the basic information is not provided. This includes any community equipment needs and specific moving and handling instructions.

5.5. Short Term Care at Home plans and urgent requests for care may contain more than one intervention and will focus on addressing an Individual's current abilities, needs, risk factors and goals such as:

a. Therapy to improve mobility, strength, balance, range of movement and confidence
b. Therapy to support engagement in relearning or developing new skills
c. Confidence building techniques to modify tasks including grading activities and compensatory techniques

d. Strategies to manage cognitive and behavioural issues impacting on activities of daily living
e. Moving and handling, including transfers
f. Identify and reduce hazards in the home through modifications, onward referrals and equipment to improve the Individual's safety
g. Building new or reconnections with community networks as appropriate to the Short Term Care at Home plan

5.6. The Service Provider will deliver support to stabilise and assess the needs of the Individual within the first five days. Feedback provided by the Service Provider will contribute to determining any ongoing care and support and the development of the Individual's Short Term Care at Home plan.

5.7. A Short Term Care at Home plan must be developed within 5 days of service commencement that will be undertaken by the Authority in conjunction with the Service Provider outlining the Individuals goals including how these are to be delivered to achieve the desired outcomes.

5.8. The assessment to develop the Short Term Care at Home plan in conjunction with the Service Provider will consider the following (list is not exhaustive):

a. Past and current physical and mental health needs
b. Social situation
c. Functional wellbeing (activities of daily living and instrumental activities of daily living
d. Sensory and motor skills
e. Cognition, behaviour, emotional wellbeing
f. Work/life roles
g. Home environment
h. Wishes and aspirations of the Individual and their carer(s)

5.9. The Short Term Care at Home Plan will also be conducted utilising feedback from the Service Provider, NHS and any other stakeholders.

5.10. Development and recording of the plan will be an iterative and incremental process with regular and scheduled proactive reviews to note progress.

5.11. The Authority will be responsible for oversight of progress of an Individual through the Service and will carry out regular formal reviews with the Service Provider.

5.12. The Service Provider will also have the autonomy to undertake cease and reductions as set out in section 6.

5.13. The Service Provider will be responsible for carrying out tasks as identified within the Individual's Support plan. The Service Provider will be responsible for reporting progress and high-risk concerns to the Authority.

5.14. There will be a minimum of one daily communication, such as phone call or electronic method, between the Service Provider and the Authority to discuss the Individuals on the Service, their progress and any other relevant factors.

5.15. In addition to 15.14, upon a Short Term Care at Home plan being developed, it is expected there will be a requirement for a minimum of weekly written feedback provided to The Authority by the Service Provider in the Individuals progress against those goals.

5.16. Throughout the Individual's journey on the Service, the intention is to have a named worker from the Authority as a point of contact for the Service Provider and Individual.

6.0. Reduction and ceasing of care packages

6.1. The Service Provider will have the ability to reduce the amount of care an Individual is in receipt of without seeking the permission of the Authority where the Service Provider has consulted with the Individual, and they are in agreement to reduce their care. The Service Provider needs to be satisfied that the following conditions have been considered (this list is not exhaustive):

a. No concerns regarding mental capacity
b. No concerns surrounding any background history (including physical, Social Circumstances, Mental Health or cognition, self-neglect and/or hoarding)
c. No complex health conditions, (co-morbidities, end of life care etc)
d. No concerns surrounding other Social Care matters (family dynamics, risk of Carer breakdown)

6.2. Where there are identified concerns, but remains opportunity to reduce care, it is expected that discussions may be required to be held between the Service Provider and the Authority before the Service is reduced.

6.3. Where the Service Provider identifies the Individual's care can be reduced with or without requiring discussion with the Authority, the Service should be reduced with immediate effect or as soon as is appropriate to do so and the Authority notified within 24 hours.

6.4. The Service Provider will document within their own recording system the reduction in Service, confirmation that the considerations listed above have been met and the rationale for the reduction.

6.5. The Service Provider will have the ability to cease an Individual's Service without seeking the permission of the Authority where the Service Provider has consulted with the Individual and they are in agreement to cease their Service, goals have been met and the Service Provider is satisfied that the following conditions have been considered (this list is not exhaustive):

a. No concerns regarding mental capacity
b. No concerns surrounding any background history (including physical, social circumstances, mental health or cognition, self-neglect and/or hoarding)
c. No complex health conditions, (co-morbidities, end of life care etc)
d. No concerns surrounding other social care matters (family dynamics, risk of Carer breakdown)
e. Noted active 'Safeguarding Adults Alert'
f. Significant input from other community health professionals
g. Noted family/next of kin concerns
h. The person is not waiting for an onward package of care to commence

6.6. Where there are identified concerns, but remains opportunity to cease the Care Package, it is expected that discussions may be required to be held between the Service Provider and the Authority before the Service is ceased.

6.7. Where the Service Provider identifies the Individual's care can be ceased with or without requiring discussion with the Authority, care should be ceased as soon as is appropriate to do so and Authority notified within 24 hours.

6.8. The Service Provider will document within their own recording system the cessation in Service, confirmation that the considerations listed above have been met and the rationale for the reduction and who they communicated with. This information is required to be provided to the Authority within 24 hours.

7.0. Service Outcomes

7.1. Whilst standard care and support will be delivered under this Service, the Service is very much focussed on assisting an Individual to maximise their independence and reduce their reliance on formal care. The Service will therefore be required to meet the following outcomes:

a. High quality intervention planning and delivery to support timely and safe discharge from hospital or bed based settings, community support and hospital avoidance
b. Partnership working across health and social care that delivers positive outcomes in improving an Individual's health and wellbeing as part of their local community
c. People and their informal carers, faced with entering acute or residential care from any setting, are given opportunity to remain or return home as a result of access to the service

7.2. Appropriate utilisation of health and social care services resulting in:

a. Fewer unnecessary conveyances to hospital and/or acute admissions and readmissions
b. Fewer unnecessary or premature admissions to long term residential or nursing care
c. Less reliance on long term care
d. Reduced length of stay in hospital following an acute phase of care
e. An increase in the number of people able to remain living in their own home
f. Increase the independence and confidence of the Individual following hospital or bed-based setting discharge, illness, or injury by developing coping strategies or adapted techniques
g. The Individual is able to lead a more active lifestyle, both from a mental well-being and physical perspective leading to an overall feeling of improved confidence and wellbeing
h. Improved quality of life and supporting to maintain relationships within the community and reduction in feelings of isolation
i. Improved health and social care outcomes for people attending urgent care settings or following a hospital stay or recent illness or injury
j. An Individual's functioning ability significantly improves through the Service period culminating in the Individual achieving the goals that matter to them, in order for the Individual to lead and maintain as independent a life as possible

8.0. Types of care and support tasks

8.1. Section 3.5.1 & 3.5.2 of the Core Specification applies in addition to:

8.2. The Service required will be set out in the Service User's Short Term Care at Home support plan or via an initial telephone call and/or electronically prior to a full assessment of need being undertaken. 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 Care and/or Short Term Care at Home Support plan. Such requirements that the Service Provider must provide may include:

8.3. Practical support with activities of daily living, but not limited to:

a. Support to access activities including employment, education and voluntary work
b. Cleaning the home for hygiene reasons, disposal of rubbish, general tidying and laundry where identified as part of the goals and they are clearly part of the Individual's Short Term Care at Home plan
c. Prompting to take medication or safe administration of medication which has been prescribed to the Individual, and in accordance with agreed medication protocols
d. Support with mobilising around the home or within a short distance of the home as defined by the Short Term Care at Home Support plan

8.4. In most cases, the Service will encourage and support as stipulated or indicated within the Short Term Care at Home plan. However, there will be a requirement to perform the task on behalf of the Individual at times which will be stipulated in the Short Term Care at Home plan.

8.5. In executing any support, the Service Provider should have regard to, and where appropriate, try to incorporate the following principles:

a. Extending goals in collaboration with the Individual and the Authority when they have been achieved in order to promote further independence and self-management
b. Signpost the Individual to other sources of information about services that may be useful to achieving their overall enablement objectives
c. Building confidence and self-esteem and motivating the Individual, reinforcing and explaining the ethos of the service and self-management
d. Recognising problems or obstacles that prevent the Individual attaining their goals and applying appropriate solutions
e. Seeking professional assistance to enable the Individual to overcome obstacles preventing their goals being achieved
f. Allowing more time and flexibility during initial visits to implement new practices

9.0. Recording and Reporting

9.1. Section 3.8 of the Core Specification applies and in addition.

9.2. The Service Provider must record the following for each referral which may require to be completed on the Authority's preferred system or other platforms yet to be determined. The Service Provider will work alongside

the Authority around any software updates or changes to recording and reporting systems over the lifetime of the contract. This list is not exhaustive:

a. Referrer
b. Referral Source (Hospital discharge, urgent community, planned support)
c. Time and day when referral received
d. Time and day of acceptance or rejection of referral
e. Start date of the Care Package
f. Type of care requested, block hours, single visits
g. Requested hours
h. End date of the Care Package
i. Rejection of referral and reasons why rejected
j. Total number of hours of care delivered at the end of the Service
k. Overnight care
l. Double Carer Packages (including total number of hours delivered at the end of service)
m. Outcome/ goals met
n. Name
o. Date of birth
p. Address
q. Contact number
r. Next of Kin
s. Local Authority Identifier and or/ NHS number

9.3. The Service Provider will be required to develop, in agreement with the Authority, effective and accurate communication systems to keep the Authority informed of service capacity and availability.

9.4. A daily update of service capacity must be provided to the Authority, through the agreed method, by the Service Provider by 10am each day including usage of the hours, number of people on the service and any other relevant information regarding capacity and pressures within the Service.

9.5. The Service Provider must monitor usage of the contract closely and notify the Authority at the point in which usage of the block hours reaches 80% as and when this occurs.

9.6. The Service Provider will twice weekly share a list with the Authority of all Individuals on the Service for 6 days or more where the Service Provider has yet to have received a Short Term Care at Home plan. This will enable the Authority to review and appropriately action where required the Individual's progress on the Service and to maintain flow.

9.7. The Authority may at times may require information on an ad-hoc basis, where it is expected the Service Provider and Authority work collaboratively to support any requests which are reasonable to do so.

10.0. KPI's

10.1. The key performance indicators within the Contract have been set at levels that the Authority believes will be achievable within the six months of Contract operation.

11.0. Partnership Working

11.1. Partnership working section 3.14 of the Core Specification applies and in addition:

11.2. The Service Provider will work alongside the Authority, NHS and any other stakeholders to identify goals and timescales with the Individual and the Service Provider.

11.3. The Service Provider must work in an integrated way with the Authority and other stakeholders to ensure the Individual receives a seamless personalised service. This will provide an opportunity for peer review to support consistency and continuous improvement of practice.

11.4. Over the lifetime of the Contract the Service Provider's responsibilities may evolve to undertake goal setting as part of the Short Term Care at Home plan. This is an aspiration, and the Service Providers will only be required to undertake these functions when the Service is fully established and the Service Providers, the Authority and relevant stakeholders have agreed this approach.

11.5. The Service Provider and the Authority must be respectful of each other's opinions, be positive in engagement and trusting and supportive of the decisions made to collectively achieve the very best outcomes.

11.6. In the spirit of partnership working, shared learning and opportunities in striving to continuously be improving the service delivery, it is an aspiration to work towards the possibility of co-location.

12.0. Social Value

12.1. The Service Provider shall deliver the Services at all times having regard to the approach to social value. The Service Provider shall maintain and keep up to date records in line with the Authority's Social Value Policy as required by the Authority. The Service Provider, at the request of the Authority, is required to provide an annual summary report detailing

progress and measurable benefits. The summary report shall include reference to the outcomes as per 12.2.

12.2. In accordance with the Authority's social value policy[1], the Service Provider must work towards achieving the following social value outcomes:

a. More local people in work with support around career progression and training
b. Responsible businesses that do their bit for the local community e.g., charitable work
c. A local workforce that is fairly paid and well supported
d. Reduction in costs by investing in prevention e.g., making use of other services and community assets.
e. Protecting our environment and reducing climate change

12.3. The Service must use a range of innovative delivery approaches that provide additional social value, this could include:

a. Apprenticeships
b. Developing Community Circles
c. Working with local networks, groups and organisations in order to establish opportunities for people to improve their social connections and wider health and wellbeing
d. Approaches that benefit the whole community not just an Individual supported by the Service
e. Identify people and/or informal carers who are willing to be involved in ongoing engagement
f. Proposing innovative support or additional value not identified in the areas above

12.4. The Authority reserves the right to update its Social Value Policy and may change the system used to monitor social value.

13.0. Changes to this Specification

13.1. This Service is being commissioned at a time of significant change within the health and social care system, and the Authority is committed to working together in developing these services further throughout the period of the PDPS.

13.2. We will be working towards the key principles within the good practice guidance 'A new community rehabilitation and reablement model'[2] and

[1] http://www.lancashire.gov.uk/media/898255/approved-social-value-policy-and-framework.pdf
[2] A new community rehabilitation and reablement model (england.nhs.uk)

'Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge[3]

13.3. The Authority therefore reserves the right to make changes to this specification over the course of the PDPS duration of up to 12 years in line with changing requirements and external factors such as new advances in technology e.g., telecare, telehealth.

13.4. The Authority could introduce more autonomy and flexibility for Service Providers, such as becoming trusted assessors/reviewers and in accordance with the Authority's duties under the Care Act 2014, the Authority may require the Service Provider to assist with assessments and reviews. With appropriate support and training this may include the prescribing of low level equipment.

13.5. The Authority may introduce changes to information systems e.g., Service Providers digital care records that are interoperable with the Authority's Individual record databases to enable improved recording, data in live time and improved tracking of an Individuals journey on the Service and Service capacity.

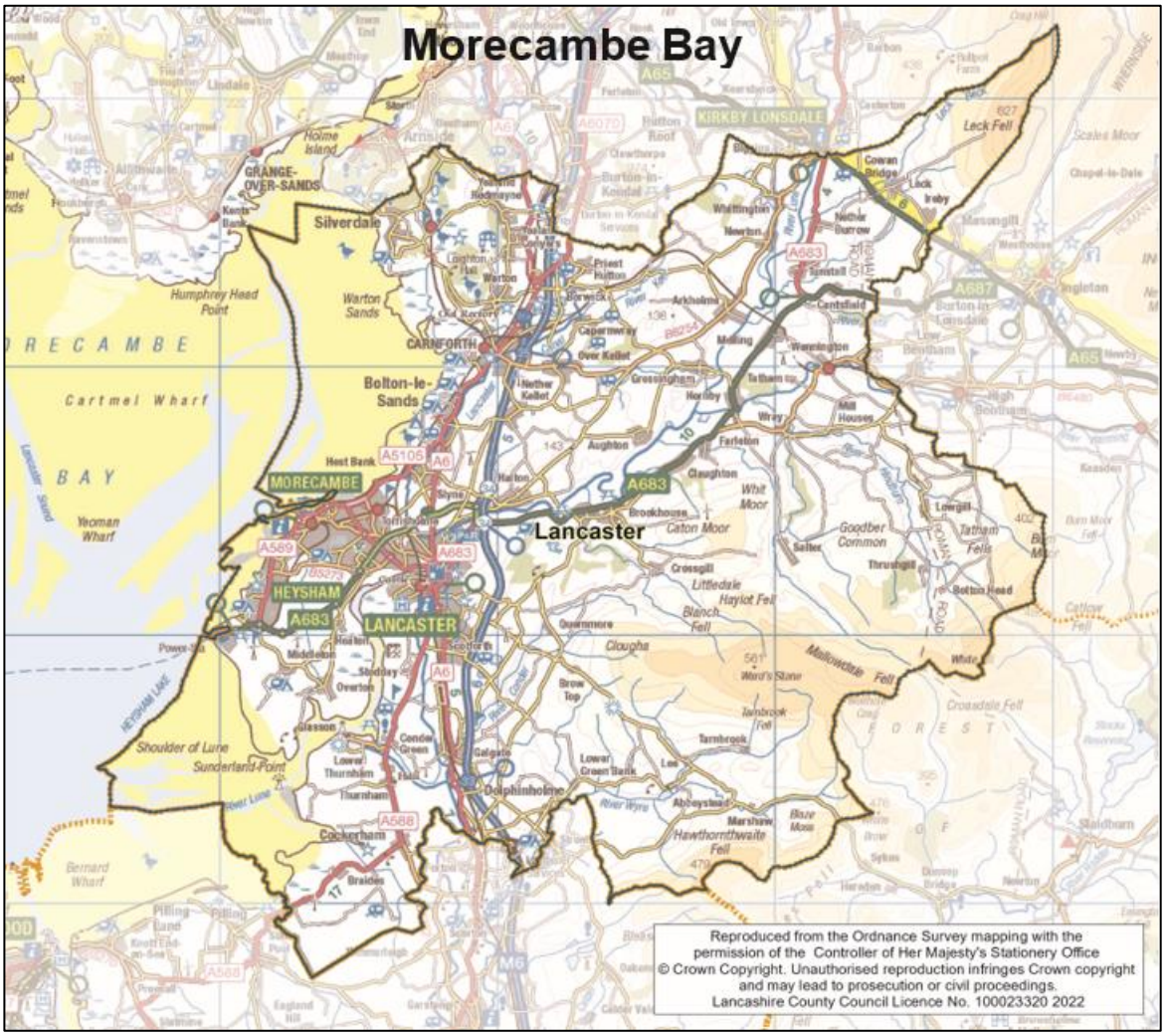
13.6. As the Services evolve, night time (overnight) pop in visits may be incorporated.

[3] https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761-intermediate-care-framework-rehabilitation-reablement-recovery-following-hospital-discharge.pdf

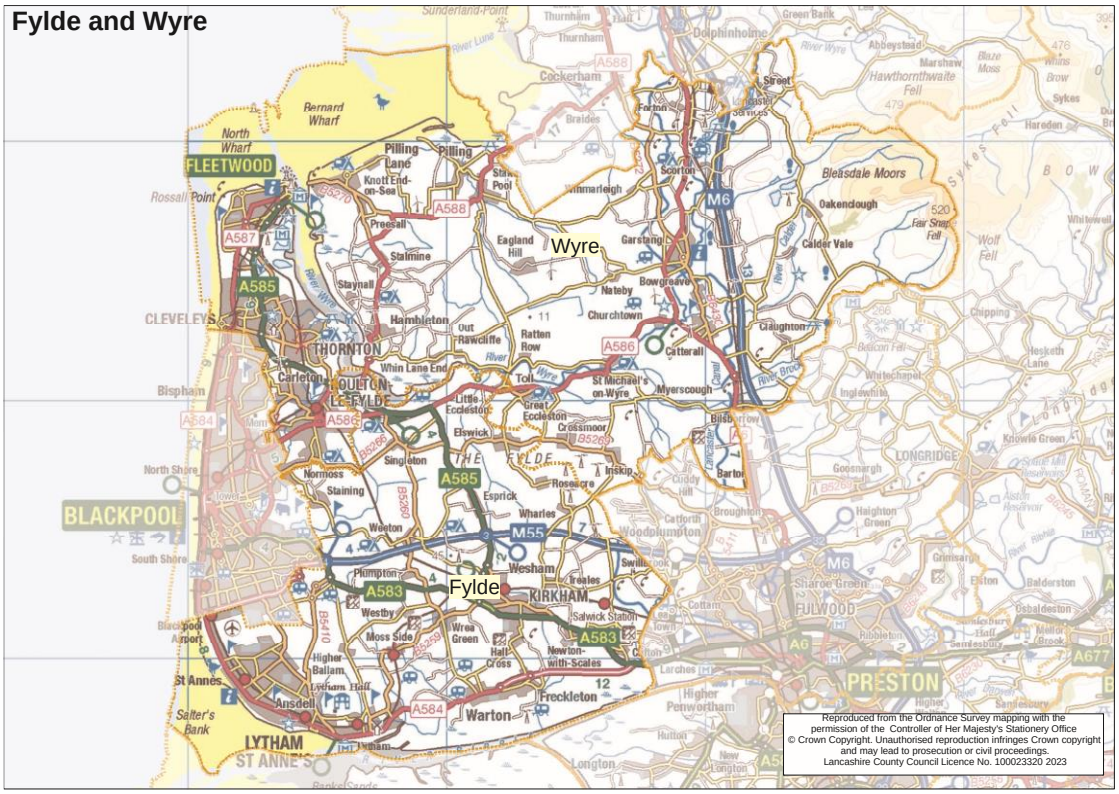
14.0. Boundary Maps

14.1. Lancashire 14

14.2. Morecambe Bay

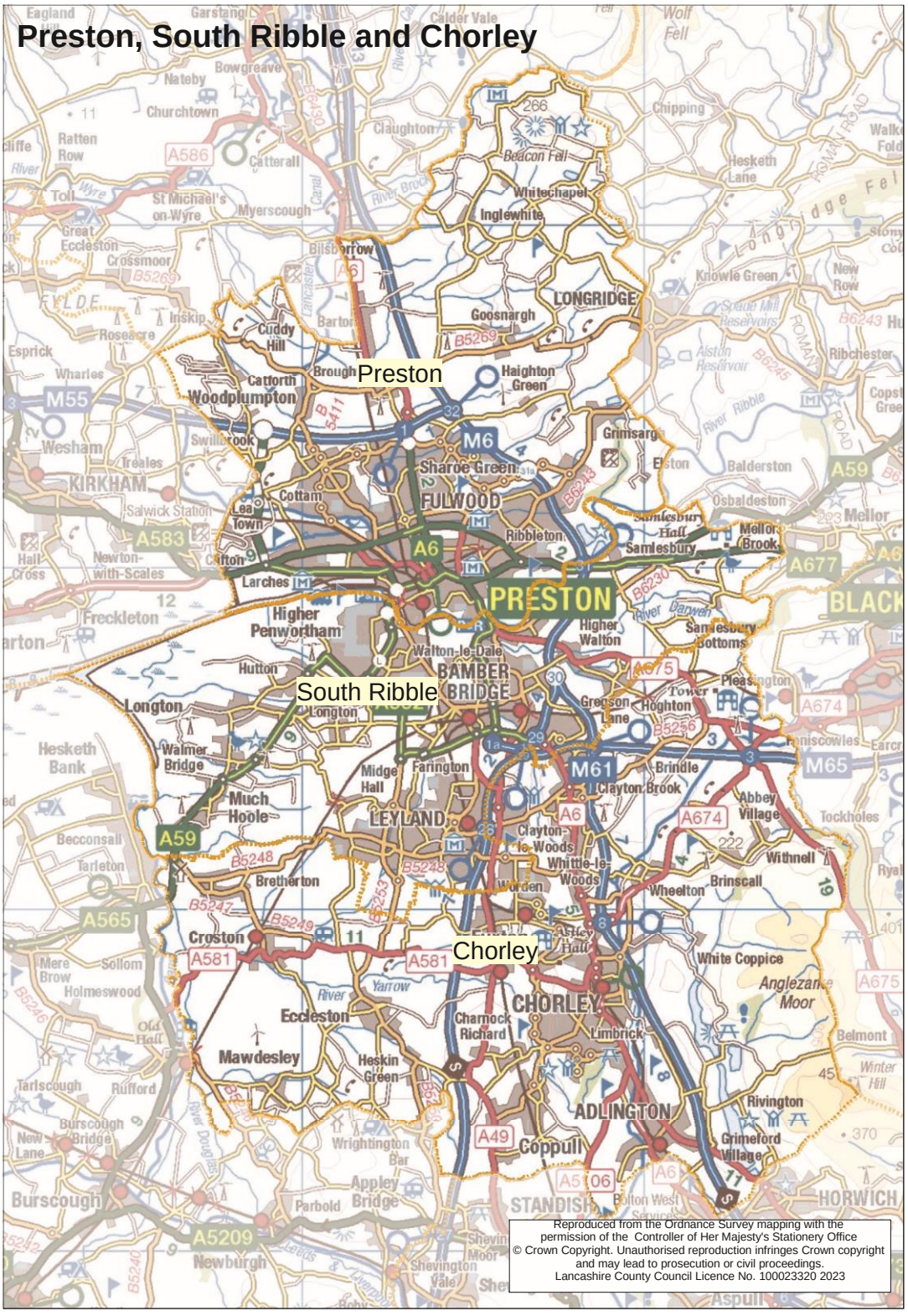


14.3. Fylde and Wyre



14.4. West Lancashire

14.5. Preston, Chorley & South Ribble



14.6. East Lancashire