**Service Specification – Community Crisis and Discharge Support Service**

**Service Details – (high Level):**

**Start Date –** 1st April 2023, however if there is more than one EOI then this date will be influenced by the timescales for a full procurement exercise

**Location** – County of Norfolk and Waveney part of Suffolk

**Funding** –

|  |  |  |
| --- | --- | --- |
| **Source** | **Amount** | **Status** |
| Baseline | £456,970 | Recurrent annual funding |
| Committed Additional | £150,000 | Recurrent BCF funding |
| Other Funding Opportunities | Variable | Winter Slippage \ Support Opportunities\* |

\*During 2022/23 the SCHPT spent an additional £330,000 on discharge support services and whilst this isn’t recurrent funding, the future thinking is to utilise winter support money into this service to create greater capacity to free up beds across the whole system.

**Operating Hours** – The model is made up of two distinct elements the volunteer led community support element and the discharge support element, and we would expect the provider(s) to regularly monitor the optimum hours of service and deliver within those parameters, this may include weekends.

**Contract** – The initial term of this contract will be 12+12 months, to allow partners to develop the model, and then we will look to move to a long-term arrangement upon an successful evaluation of the service

**Numbers** – To support approximately 6,300 – 7,500 individuals per annum and enough volunteers to support those individuals. There would also be support for approximately 1800 – 2000 individuals per annum for more complex or discharge support where a volunteer isn’t the appropriate response

**Overall Delivery Model** – The preferred option is one where the risk is shared amongst more than one organisation, that operates a framework approach to supporting new providers as to ensure maximum coverage across the whole of the location area

**Section C – Service Delivery**

**Service Description** – The service will have 2 distinct areas of support, the first being a volunteer led community support offer which is open to anyone who needs low level community support for a short period (c. maximum 2 weeks) weeks to support them to overcome a situation. The second element is a more complex support offer for those individuals where volunteer support wouldn’t be appropriate, this could be to support a more supportive discharge process for individuals within a NHS or community bed, or for individuals in the community (in their own home or other community settings) whose circumstances are slightly more complex so require an individual with a different skill set to support them.

**Service delivery model** -The operating model is for the provider(s) to develop and describe how they will operate and deliver the service based off the rest of the summary, and will be outcomes focused, however there are areas of the model we would like to see, which are.

* Support the “single point of access” approach and move to a single operating system for managing the service, the preferred option would be NVH (Norfolk Volunteer Hub)
* As part of the “single point of access” operate a triage function to ensure the correct level of support is offered to all
* Develop and operate a framework approach so new providers can be appointed quickly to support the model at the lead providers’ risk
* Move to a single number, single access details, and promote those changes
* Deliver a two-tier system made up of volunteers for the low-level community support and more skilled individuals for the complex and discharge support element of the model
* To ensure the new model delivers a service that meets the outcomes requested (see KPIs later in summary)
* To work together with other providers to ensure that any risk is minimised and to create greater diversity and equality within the service delivery
* To innovate to ensure those harder to reach rural areas are supported equally as more urban areas
* To support a large number of volunteers and ensure they are trained and incentivised (see staff and supervision in summary)
* To work with commissioners once the contract has been awarded to design the final delivery model and service specification
* Delivery of the service would be based on the most appropriate interaction for that individual so could be telephone, face to face or a mixture of the two.
* For the discharge support there may be an element of entering an individual’s home prior to them leaving their current setting to ensure they can return home safely

**Interdependencies with other services**

The service will maintain and proactively develop relationships with a variety of partner agencies, and have an extensive knowledge of local activities, to ensure best outcomes for service users:

* Acute Care
* Primary Care
* Adult Social Care
* Norfolk County Council
* Suffolk County Council
* District Councils
* Norfolk and Waveney ICB
* VCSE providers of Norfolk and Waveney

**Section D – Staff and Supervision**

The organisations will be a mixture of paid individuals and volunteers, so will split them for the summary,

**Paid staff** – depending on the organisation there will be an element of paid individuals and some of the tasks they may provide are but not limited to.

* Management of the Volunteer Co-Coordinators
* Resolving any issues that have been escalated to the manager
* To attend local governance fora when requested
* Ensure all data requests are acted on in a timely fashion
* Management of volunteers and match them to tasks accordingly
* Ensure all safeguarding issues are reported and acted on, including escalating appropriate issues to the manager
* Embed themselves within the locality/district council i.e., look to co-locate with the appropriate team within the appropriate locality
* Take an active part in joining the appropriate forums and meetings for that locality
* Support the Health and Wellbeing Partnership Board with data and anything else it asks for
* Grow the numbers of volunteers within that locality
* Understand and engage with all the VCSE within the locality, i.e., what services are available and how to refer into them
* Market the services of the volunteer support model in all settings both health care, primary care, and community

**Volunteer Staff** – The provider(s) needs to have a track record in supporting and growing a volunteer network to support the expected delivery numbers of the service approx. 500 per week

The provider(s) will work together to develop a shared volunteer’s model to support volunteers and create opportunities jointly so that current registered volunteers can be fast tracked to support each other’s organisation where geographic gaps have been identified.

The provider(s) will regularly use their volunteer data jointly to map out what volunteer resources they have first in locality footprint, and with further development to show the same information at PCN level.

The provider(s) will use that information to prioritise volunteer recruitment campaigns in areas where service demand requirements require more volunteers.

All volunteers recruited for this service are supported to complete the volunteer passport training provided by adult learning if they want to.

That all partners look to recruit their volunteers where possible via the VN volunteer portal and volunteers undertaking home visits will be DBS checked prior to them doing those visits

**Section E - Mobilisation**

This is self-explanatory however the preferred start date is 1st April 2023, however if this is dependent on the response to the expression of interest and if a full procurement is required then the start date will change accordingly

**Section F - Premises**

The preferred operating model is aligned with either the 5 Place Board areas or the 8 Health and Wellbeing Partnership areas, and is a place based operating model so that means understanding and operating within smaller place-based areas. On top of this we have 20 PCN (Primary Care Networks) and 3 acute hospital systems there will also be an understanding that the provider(s) will have a knowledge of what is required within these areas.

So, in terms of premises across all the partners and the interdependencies for this service there are various opportunities in regard to premises so it would be good to hear how you would utilise those opportunities to deliver the service.

**Section G – IT Platforms**

To move towards a single point of access, using a single system preferably NVH. Gaining DPIA / Approvals to share data with NHS (all), Provider(s) of the service, any future provider on the network, and all interdependencies

**Section H – KPI (Outcomes)**

The service model and KPI will be outcome based and finalised as part of the joint production of the service specification and deliver model, however some of the outcomes are but not limited to:

* To follow up a referral within 24hrs of receiving it, sooner if possible. (This doesn’t currently include weekends)
* Triage request to appropriate service
* To offer 2 weeks’ initial low-level support for individuals
* To refer on to other agencies based on skills and level of need of the individual
* To ensure all individuals continue to receive appropriate support once their low-level intervention has finished if it is appropriate to continue with support
* To support the Health and Wellbeing partnership boards with relevant information and data
* To grow the locality capacity by making links with other VCSE within that locality
* To run volunteer recruitment programmes to grow the capacity within the localities
* Provider(s) to ensure there is enough volunteer capacity across Norfolk and Waveney to ensure a safe service
* To support the ongoing discharge of individuals from all NHS and community beds were requested to do so

**Section I – Waveney specific**

The service is equitable across the whole county and Waveney, so where provider(s) currently don’t operate within Waveney it is imperative that the service is offered on an equitable delivery level within that area within 3 months of the contract starting.

This includes providing data, liaising with existing providers, growing volunteer opportunities, linking in with local services and district council, and growing the area to ensure that there is the same level of knowledge and support within that area that there is across the rest of Norfolk.