

**SERVICE SPECIFICATION FOR  
SUPPORT FOR INDEPENDENT LIVING IN STAFFORDSHIRE (SILIS)  
SERVICE**

Version Control

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**Please note that this document is draft and any contents are subject to further discussions and feedback. At this stage the Council is looking for feedback on the contents. The requirements set out in this document are aspirational and will be subject to budget constraints before finally agreed.**

## 1. INTRODUCTION

- 1.1. From 1st April 2018 the new Support for Independent Living in Staffordshire (SILIS) Service will enable vulnerable older and disabled people to maintain their independence, health and well-being in their home and community.
- 1.2. In all instances the Provider of the SILIS Service may opt to directly provide services, or may wish to sub-contract or work with other agencies to deliver the services.
- 1.3. The Service will be designed with Individuals at the centre and will be delivered in a way that takes a holistic view of Individual's needs. Whilst not all relevant services will be included within the scope of the Service, the Service will develop links with specialist services and consider commissioning these on behalf of Individuals rather than signposting or referring to them.
- 1.4. It is accepted that development of the Service will be required across the lifespan of the Services Agreement however some services will be required to be delivered as soon as the Services Agreement is live from 1<sup>st</sup> April 2018.
- 1.5. The Provider will undertake widespread promotion and an inclusive approach to encourage Individuals, including the self-funder market to access the new Service directly.
- 1.6. A key aim of the Service is to help Individuals to make changes to their home environment that will prevent the need for more costly interventions, such as admission to hospital or residential care, following life crises.
- 1.7. However, it is envisaged that some Individuals will be referred to the Service by statutory health, social care and housing agencies as well as by advice services and Voluntary, Community and Social Enterprise (VCSE) agencies and the Provider will need to develop links to enable staff to work closely with these agencies to ensure that the Service is seamless.
- 1.8. The Service will deliver:
  - 1.8.1. a high quality information and advice service which is multi-channel
  - 1.8.2. a seamless, joined-up approach to service delivery between partner agencies;
  - 1.8.3. ability to control implementation of an Individuals' chosen option where possible;
  - 1.8.4. support to exercise choice for Individuals where required;
  - 1.8.5. timely delivery once the chosen option is decided by the Individual;
  - 1.8.6. a single point of contact and good feedback about progress.
- 1.9. The Service will include and improve upon the following existing services:
  - 1.9.1. Home Improvement Agencies (HIA's);

1.9.2. Assistive Technology (AT) including referral to telecare providers;

1.9.3. independent living centres

The Service will also include the following services:

1.9.4. the administration of financial support for disabled adaptations and repairs and moving to a more suitable home.

The Provider will work within the statutory requirements and established policies for this funding and provide all necessary information to the funding authorities to enable control of their budgets.

1.10. It is expected that the Provider of the Service will seek to maximise the potential of the self-funder market to support Service development. There is a requirement that a reasonable proportion of income generated from the self-funder market will be reinvested to support development of the Service.

1.11. The Service is being jointly commissioned by Staffordshire County Council (the Council) and six District and Borough Councils, namely:

1.11.1. Lichfield District Council

1.11.2. Newcastle-under-Lyme Borough Council

1.11.3. South Staffordshire Council

1.11.4. Stafford Borough Council

1.11.5. Staffordshire Moorlands District Council

1.11.6. Tamworth Borough Council

1.11.7. The partnership may expand in the future to cover the two other District Councils not included in the initial partnership; namely Cannock Chase District Council and East Staffordshire Borough Council; and also expand to include other providers of Health and Care Services in the Staffordshire area such as the six CCGs in the partnership area.

1.12. The Provider is expected to comply with all relevant legislation, regulations and statutory circulars in so far as they are applicable to the services provided. These will include (but are not limited to):

1.12.1. Care Act 2014

1.12.2. Social Value Act 2012

1.12.3. Local Authority Act 2000

1.12.4. NHS and Community Care Act 1990

1.12.5. Health Act 1999

1.12.6. Mental Health Act 1983

1.12.7. Mental Capacity Act 2007

1.12.8. Disability Discrimination Act 2005

1.12.9. Client Access to Personal Files Act 1987

1.12.10. Our Health, Our Care, Our Say 2006

1.12.11. Independence Wellbeing and Choice 2005

1.12.12. The Children Act 1989

1.12.13. Children Act 2004

- 1.12.14. Data Protection Act 1998
- 1.12.15. Equality Act 2010
- 1.12.16. Housing Grants Construction and Regeneration Act 1996;
- 1.12.17. and any relevant European Community Legislation.

(This list is not exhaustive)

- 1.13. Any reference in the Service Specification to legislation, regulations and statutory circulars includes any modification, re-enactment or replacement of it.
- 1.14. The Provider will develop positive working partnerships with local communities and a wide range of support agencies such as:
  - 1.14.1. Citizen's Advice Bureau
  - 1.14.2. Housing Advice Agencies
  - 1.14.3. Housing Associations
  - 1.14.4. Advocacy Services
  - 1.14.5. Health and Social Care Services for Adults
  - 1.14.6. Children's Services
  - 1.14.7. Local Advice agencies
  - 1.14.8. Local VCSE organisations
- 1.15. The citing of specific organisations does not limit the Provider to only working with those organisations.
- 1.16. The Provider will update the Steering Group with details of the agencies with whom it works at regular intervals.
- 1.17. The Provider will be required to accept all work-in-progress at the commencement of the Services Agreement and complete the works according to specification.

## **2. SERVICE VALUES AND PRINCIPLES**

- 2.1. For disabled customers the Service will be provided in the context of the social model of disability. The social model of disability says that disability is caused by the way society is organised, rather than by a person's impairment or difference. It looks at ways of removing barriers that restrict life choices for disabled people. When barriers are removed, disabled people can be independent and equal in society, with choice and control over their own lives.
- 2.2. The Service will also acknowledge that although the Service may be accessed by Individuals who may not be eligible for services under Care Act criteria they may still be vulnerable and should be supported accordingly to access services to address their health and well-being needs.
- 2.3. All staff working either directly or sub-contracted by the Provider must have a current valid DBS Check and must be fully trained in disability awareness and equality. The Provider must keep records of this and make it available to view on request by the Council.

2.4. The following values will underpin all activities undertaken by the Provider:

2.4.1. Individuals retain the greatest possible control over their lives.

2.4.2. Individuals are treated with courtesy, respect and dignity.

2.4.3. Individuals are personally involved in any decision making processes that impact on their lives. Decisions are made with local solutions and impacts in mind;

2.4.4. The following principles will be observed by the Provider in delivering the Service:

2.4.4.1. adoption of a person-centred asset-based approach.

promotion of the independence, choice, dignity, privacy, respect and participation of Individuals and their carers;

2.4.4.2. acknowledgement of and respect for an Individual's gender, sexual orientation, age, physical or mental health ability, race, religion, culture, social background and lifestyle;

2.4.4.3. promotion of choice for the Individual to have the optimum control over their own life;

2.4.4.4. recognition of the rights and responsibilities of Individuals, including the right to take risks;

2.4.4.5. the planning and provision of the Service in partnership with Individuals, their carers, families, friends or advocates, support workers, other independent and statutory agencies;

2.4.4.6. to act only on the authority of the Individual engaged with the Service or their nominated representative; including the delegation of work to third parties to ensure training for staff in disability awareness, disability equality and the influence of the social model upon the delivery of Service;

2.4.4.7. to ensure training for staff to develop an appropriate level of local knowledge within a reasonable timescale after the commencement of the Service;

2.4.4.8. where possible local solutions will be considered first for Service delivery and Service development.

2.4.5. Specifically for the Service this means:

2.4.5.1. tailoring the Service to the Individuals needs to enable them to live full, independent lives;

2.4.5.2. developing the Service to offer Individuals a choice in how and where they live, ensuring that homes and support are well designed, accessible and flexible to meeting their needs;

2.4.5.3. ensuring that Individuals have access to the information and advice they need to make decisions about their care and support;

2.4.5.4. finding new collaborative ways of working that support Individuals to actively engage in the design, delivery and evaluation of accessible homes services;

- 2.4.5.5. developing approaches to enable staff to work in creative, person centred ways, underpinned by the organisational systems to support and sustain this;
- 2.4.6. The Provider and the Strategic Partnership Board shall:
  - 2.4.6.1. Work in a spirit of collaboration and partnership to ensure that appropriate services are available to Individuals who require them;
  - 2.4.6.2. Share a commitment to ensuring continuous improvement in service delivery to enable good quality, effective and person-centred solutions.

### **3. OUTCOMES**

- 3.1. Positive outcomes for Individuals who engage with the Service will be achieved by the Provider providing expert advice and information, undertaking assessments, supplying AT and telecare advice and supporting Individuals throughout the repair, adaptation or improvement of their existing home or a move to more appropriate accommodation, so that they are able to remain living independently in a warm, safe and secure environment.
- 3.2. The required high level outcomes of the Service are as follows:
  - 3.2.1. Better managed independent living as a result of AT/ aids and adaptations/minor repairs;
  - 3.2.2. Enhancing quality of life for Individuals with care and support needs;
  - 3.2.3. Delaying and reducing the need for care and support;
  - 3.2.4. Reduced admissions to residential care;
  - 3.2.5. Reduced number of injuries due to falls;
  - 3.2.6. Reduced emergency admissions to hospital;
  - 3.2.7. Reduced re-admissions within 30 days of discharge from hospital;
  - 3.2.8. Reduced hip fractures in over 65s;
  - 3.2.9. Reduced visits to GP;
- 3.3. The quantifiable outcomes above will be measured across the whole population by the relevant statutory agency. The impact of the Service in achieving these outcomes and measurement of the more qualitative outcomes will be self-assessed by Individuals who use the service. The Provider will work pro-actively with the Strategic Partnership Board, health and social care agencies and Individuals to develop an agreed approach to measuring health and care interventions, independence and quality of life. This will be agreed prior to commencement of the Service and the Strategic Partnership Board reserve the right to amend these during the life of the Services Agreement.
- 3.4. The Provider will be required to submit quarterly performance reports to the Strategic Partnership Board showing how these outcomes are being achieved and escalate any delivery issues which impact on the achievement of outcomes.

- 3.5. The Provider should develop a cost-benefit analysis tool to demonstrate both the direct and indirect benefits realised to health, social care and the Individuals themselves by the Service.
- 3.6. The Strategic Partnership Board anticipate a shift in the balance of different solutions to meeting needs from major adaptations to earlier, more minor changes to Individuals' homes, use of AT or a move to more suitable accommodation.

## 4. SERVICE DESCRIPTION

- 4.1. The Service will provide a range of elements including:
  - 4.1.1. advice and information
  - 4.1.2. access and assessment
  - 4.1.3. support to consider and move to alternative accommodation
  - 4.1.4. AT including referrals to telecare providers
  - 4.1.5. access to minor repairs and adaptations (including support to move home from hospital or residential care), home safety, home security and energy efficiency improvements
  - 4.1.6. major adaptations
- 4.2. These service elements are described in more detail below. Although most Individuals will utilise information, advice and assessment services, the other service elements represent options that Individuals may choose to help them live more independently. The order in which they are listed is not intended to imply a specific order in which service elements should be considered. The Provider will present all options and help Individuals to consider the cost effectiveness and appropriateness of each.
- 4.3. Advice and Information
  - 4.3.1. The single most important aspect of the Service for many Individuals will be the provision of comprehensive information and advice about their housing and care options. The two main options for Individuals will be whether they stay put or move to a more suitable home. The majority of Individuals will wish to stay where they are so long as they can maintain a high level of independence and well-being in their home and neighbourhood. The Service will provide them with all of the advice they require to make informed choices about their future in their current home.
  - 4.3.2. The Service will also provide non-regulated financial advice including but not limited to benefit maximisation, money management, making informed financial decisions, accessing funding available to repair, adapt or move home as appropriate, facilitating access to independent financial advice.
  - 4.3.3. Some Individuals will simply require information about basic pieces of equipment that enable them to continue to function independently by accessing easily all parts of their home (inside and out), and carrying out daily living tasks such as cooking, cleaning and bathing.

- 4.3.4. Others will need to know more about the range of physical aids and adaptations and AT that may be available to enable them to stay independent at home and in the local community.
  - 4.3.5. Advice will be given about likely financial implications, explaining that some services may be free, others may require grant applications to statutory or charitable bodies, and others may need a financial contribution.
  - 4.3.6. If it becomes apparent that a move to an alternative home is the preferred option, then the Service will provide clear and comprehensive information and advice about the full range of housing options and the support services available.
  - 4.3.7. The advice service will be able to cover all of these areas of information and advice without having to refer on to other services. Where more specialist complex services that fall outside of the remit of the Service are required, then the Provider will liaise with the relevant services and co-ordinate contact with the Individual.
  - 4.3.8. The information and advice service should also use its position where possible and appropriate to signpost to other health and well-being initiatives and other locally based groups.
  - 4.3.9. All available channels of communication will be made available including by phone, e-mail, internet, leaflets, letter or face-to-face and in a suitable format.
  - 4.3.10. The Provider will ensure that advice is equally available to all Individuals regardless of location and whether they live in one of the major population centres or somewhere more rural.
  - 4.3.11. The Provider will provide information and advice to Individuals who are not eligible for funded services, but who may benefit from the Service. These requests may come directly from the Individual or via another route, such as family or carers, statutory health and social care providers or from a VCSE organisation
  - 4.3.12. The Provider will put in place an effective programme of promotion and publicity including identification of Individuals, ensuring that under-represented groups are aware of the service, including eligibility and means of access.
- 4.4. Access and Assessment
- 4.4.1. The Provider will ensure that the Service is easily accessible to everyone, particularly individuals with a protected characteristic as defined by the Equality Act 2010. The Service will also be readily available for referrals from other agencies.
  - 4.4.2. As part of the personalisation imperative and the initial filtering process, Individuals, their carers or advocates should be encouraged to undertake some form of self-assessment process to which the Provider will enable access.

- 4.4.3. Wherever a person makes their initial approach (if it is not directly into the Service), they will be directed into the Service single point of assessment. Assessments will focus on enabling Individuals to take control of decisions about maintaining their independence either in their existing home or following a move to more suitable accommodation. Following assessment, the individual will be provided with clear information and kept fully informed about the outcome of an assessment and progress of their case.
- 4.4.4. The assessment will include consideration of the variety of options available to maintain or improve independence, including equipment, AT, telecare, minor repairs and adaptations or a move to alternative accommodation if appropriate.
- 4.4.5. In line with the wider social care and health policy, AT will be the primary consideration as a means of preventing or forestalling more costly formal interventions.
- 4.4.6. Initial assessment / screening will be undertaken by suitably trained staff within the Service. This may happen over the telephone, at an accessible home centre or in the Individuals' home, taking into account their needs. In consultation with the Individual this will identify their needs and the options for resolving these. Where Individuals are referred into the Service following assessment by an Occupational Therapist (OT) or other professional this stage will be limited to exploring the options for resolving the assessed needs.
- 4.4.7. Those staff carrying out the assessment / screening process will need to have appropriate supervision and direct access to a suitably qualified OT.
- 4.4.8. The Service will develop a relationship with the Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP) OT locality teams and paediatric OT service for those cases in which more specialist knowledge and the support of a DCC/NHS OT is required.
- 4.4.9. Current experience demonstrates that some assessments clearly point to Care Act eligibility in some areas but not in all areas, and the expectation is that the Provider will cater for a market that includes self-funders and those who are eligible for funded support. Consideration needs to be given to how the caller receives a holistic service covering this kind of eventuality which would point to staff involved at this early stage having the additional skill set that includes an expert level of knowledge about statutory requirements for eligibility criteria. Close liaison with health and care partners and ongoing training will ensure that staff accurately assesses eligibility for statutory services and access to alternative funding sources if funding support is not available.
- 4.4.10. Assistance with financial assessments will be provided if, for example, the need for a means-tested grant is established.

4.5. The Service will consider the development at least one accessible home centre. The centre will act as a hub for assessment with outreach work such as mobile assessment units and pop-up assessment centres being deployed from the main centre to ensure that an equitable service is provided across the county.

4.5.1. The centre(s) will provide free, impartial face to face assessment with Individuals and accompanying carers and family members, across a very wide range of daily activities which Individuals are struggling with, for example, bathing, walking, driving, feeding, working at a computer, preparing meals, getting in and out of bed.

4.5.2. The accessible home centres will also provide:

4.5.2.1. information and support to staff or volunteers in related VCSE organisations, for example, about equipment available.

4.5.2.2. presentations and demonstration of products to community groups e.g. carers groups.

4.5.2.3. loan of equipment to enable professionals to carry out assessments and provide individuals with a short trial period.

4.5.2.4. product awareness training sessions for health and social care colleagues.

4.5.2.5. space for relevant statutory and third sector agencies to hold meetings and training sessions.

4.5.2.6. facility for statutory services to carry out assessments

4.6. The Provider must employ adequate staff resources to ensure that enquiries, assessments and support activity meet the performance requirements of this contract.

4.7. Alternative Accommodation

4.7.1. The Service will provide comprehensive advice and information about alternative accommodation options where that is identified as the preferred solution to address the Individuals' needs.

4.7.2. Options will include moving to a home that is more suitable to the customers' needs or specialist accommodation such as sheltered or extra care housing. Options for purchase or lease of alternative accommodation will be explained as well as rented housing options.

4.7.3. The Service will provide practical support to help Individuals identify alternative accommodation available and consider the appropriateness of this in meeting their needs. A full financial assessment of the cost of moving against the Individuals' available budget will be carried out before the decision is made. The Service will then help with planning the move and arranging removals and utility connections.

4.7.4. Where the Individual needs financial support to acquire a more suitable home or to pay for removal etc. The Service will assist them in applying for grant or charitable funding as appropriate.

- 4.7.5. The Service will also liaise with any agencies offering practical help in settling into the new home and make arrangements for any relevant handyman work needed by the individual.
- 4.7.6. The Service will also research and provide information about local services and facilities where the Individual is moving to a new location.
- 4.8. Assistive Technology (AT) including Telecare
- 4.8.1. AT will facilitate improved risk management in the homes of frail and vulnerable Individuals and assist in providing a more co-ordinated and personalised care and support service that should improve outcomes and choices. The Service will provide advice on AT drawing from a variety of sources to ensure equipment solutions are personalised and integrated with other services, and supports independent living in the community.
- 4.8.2. The Service will provide information on providers who can, install and maintain appropriate AT equipment, including both telecare and stand-alone equipment to meet the Individuals' assessed needs. The Provider will support the Individuals' induction to the use of the AT, review its' continued use and the Individuals' needs and remove AT equipment when no longer required.
- 4.8.3. The Service will work in partnership with other local authorities, social landlords and the VCSE sector to provide maximum choice of AT services for Individuals both in terms of the range of equipment and the charging arrangements to make sure all needs can be met.
- 4.8.4. The Provider will increase the take-up of AT and telecare services by communicating the benefits to Individuals, carers, family and friends by providing AT opportunities in a diverse range of settings across health, housing and social care.
- 4.8.5. The Provider will ensure that their assessors are confident in their assessments, advice on the use of equipment and appropriately skilled and up to date in their response to the information delivered by AT. The Provider will develop approaches to promote the adoption of assisted living technologies such as telecare, amongst Individuals, their families and professionals.
- 4.9. Minor repairs and adaptations
- 4.9.1. The Provider will provide access to 'handyman' services and services to carry out minor repairs, minor adaptations and home safety improvements in the homes of older or disabled people. The Service may be provided to self-funders subject to agreement of charging arrangements with the Strategic Partnership Board. Council.
- 4.9.2. This element of the Service will include responding to referrals and linking into other providers for minor adaptations where the cost is less than £1,000 and the Individual has been assessed as Care Act eligible. The Provider will also assist in undertaking minor adaptations facilitating speedier discharge from hospital or residential care.

- 4.9.3. Currently, Minor Works are requisitioned where the cost falls below £1,000 (excluding VAT) and the work would not otherwise be funded by a Disabled Facilities Grant (DFG), these falling outside the scope of this Service. However, the local commissioning landscape is subject to review and the interrelationship between Minor Works and DFG funded work may be subject to change during the Contract Period. The Provider will promote the importance of home safety, security and affordable warmth measures to vulnerable older or disabled people within the community. The Provider will be pro-active in offering information, advice and home safety checks and following these up with improvements to individual's homes.
- 4.9.4. Maintenance tasks that are the responsibility of social housing landlords are not available to tenants of such landlords through this Service although tenants may choose to use the Service for other works.
- 4.9.5. The cost of providing this Service will be clearly established within the pricing document.
- 4.9.6. Charges must be based on hourly rates for contact time only, not including travel time. The cost of materials will be charged separately and excluded from the hourly rates. The Provider will need to demonstrate fair charging arrangements for older or disabled people in different financial circumstances as well as arrangements for other people within the community.
- 4.10. Major adaptations
- 4.10.1. The Service will provide support to people requiring major adaptations to their homes from the initial design and exploring funding options through to completion and aftercare. The Provider will have specialist knowledge and experience in the delivery of major adaptations and specifically the legislative provisions and guidance associated with Disabled Facilities Grants (DFGs). They will work with Individuals and other partner agencies taking a lead role in administering DFGs and other assistance and as such will provide a service which supports the districts and boroughs to meet their statutory responsibility to deliver mandatory DFGs. This shall include the following:
- 4.10.1.1. receiving enquiries and administering financial assistance
  - 4.10.1.2. means testing of potentially eligible applicants
  - 4.10.1.3. specifying eligible works
  - 4.10.1.4. approving applications in eligible cases
  - 4.10.1.5. inspecting completed works and
  - 4.10.1.6. payment of contractors invoices.
- 4.10.2. The Provider will also compile all of the documents and information required to achieve complete funding application(s) on behalf of Individuals, including accessing other grants, charitable and others sources of funding as appropriate.

- 4.10.3. The Provider will be responsible for all the essential elements of work associated with the DFGs administration including:
- 4.10.3.1. Considering assessments of need referred to the Service by OTs from statutory health or social care services or from within the Service (for self-funding customers);
  - 4.10.3.2. Carrying out assessment of the Individuals personal circumstances and financial resources to determine eligibility for grants or other funding;
  - 4.10.3.3. Assessing whether the proposed works are 'necessary and appropriate' and 'reasonable and practicable' in accordance with the current legislative requirements or other provisions as prescribed by the Local Housing Authority;
  - 4.10.3.4. Designing and specifying the work. This may be carried out by external professionals such as architects, or by staff in-house but in either case, the Provider shall manage this process and ensure that the design matches the person's expectations at best value (all within the agreed fee structure for this Service);
  - 4.10.3.5. Obtaining Planning, Listed Building and / or Building Regulation consent and any other necessary building consents or permissions as appropriate
  - 4.10.3.6. Developing and maintaining a pool of reliable contractors (offering social value through local employment opportunities where possible) and ensuring they are adequately insured, financially sound, provide excellent customer service and pay due regard to health and safety provisions;
  - 4.10.3.7. Obtaining accurate and competitive costs for the works, a framework, using individual tenders or a schedule of rates agreed with the Strategic Partnership Board; any agreed system will ensure 'best value' to the Local Housing Authorities. The Provider shall have regard to any existing procurement frameworks used.
  - 4.10.3.8. Drawing up contracts to formalise the working relationships between the Individual and contractor and all other parties including a recognised defect liability period, ensuring that all relevant building, health and safety and Construction and Design and Management (CDM) regulations are adhered to during the course of the work;
  - 4.10.3.9. Assisting the applicant or their representative in completing all necessary funding documentation in accordance with procedures detailed and agreed by the Local Housing Authorities.
  - 4.10.3.10. Approving eligible applications for assistance in accordance with criteria provided by the Local Housing Authorities and where appropriate re-approving such assistance should additional 'unforeseen' items of work be identified.

- 4.10.4. Supervise eligible and other works as they progress on site and liaise with the Individual and contractor to ensure the successful completion of the works.
- 4.10.5. Inspecting and certifying the completion of eligible works in accordance with any agreed procedures.
- 4.10.6. Pay for the completion of eligible works (from a Local Housing Authorities client account) upon the receipt of a contractors invoice and completion of the works to the satisfaction of the Provider.
- 4.10.7. Upon the completion of the grant eligible works, in individual cases the Provider will supply each Local Housing Authority with sufficient information that enables them to insert local land charges in relevant cases.
- 4.10.8. Ensuring that the Individual is provided with details of all relevant guarantees and maintenance arrangements and that they are able to use the adaptations installed.
- 4.10.9. The Provider will be responsible for securely holding individual Local Housing Authority Disabled Facilities Grants (Better Care Fund) funds in separate 'client accounts' including any Local Housing Authority 'top up' to that fund once the works and associated costs have been agreed..
- 4.10.10. The Provider will have the power to 'draw down' from these individual accounts in eligible cases, using the nationally prescribed Disabled Facilities Grant system or other eligibility criteria provided by the Local Housing Authority. This will enable them to pay individual invoices from contractors for works in that particular local housing authority area, upon the completion of the eligible works.
- 4.10.11. The Provider will ensure the Service minimises and reduces the need for Local Housing Authorities to 'top up' their Disabled Facilities Grants (Better Care Fund) allocation.
- 4.10.12. Having regard to the Local Housing Authorities Disabled Facilities Grant (Better Care Fund) and any predetermined 'top up'; the Provider will be expected to manage demand for major adaptations within that total budget for each Local Housing Authority Area.
- 4.10.13. The Provider will ensure that IT and other systems provide each Local Housing Authority with access to real time, 'live' data on the number and type of grant referrals, likely predicted financial commitments for current and future financial years, cost of grants approved and paid.
- 4.10.14. The Provider will produce written procedures for agreement with the Steering Group prior to the commencement of the Service detailing how they will administer every aspect of the Better Care Fund (DFG).
- 4.10.15. The Provider will receive requests for major adaptations (DFGs) directly from registered providers. These requests may include specifications of work, and costings etc. and the Provider will need to introduce systems to progress such enquiries efficiently to completion.

The Provider will be required to maintain excellent working relationships with such registered providers including regular liaison, exchange of information regarding likely referral rates, monitoring adaptation works specified by the registered provider to ensure value for money for the Local Housing Authorities.

4.10.16. The Provider will have a proposed fee structure in place to be agreed by the Strategic Partnership Board, including those works that are wholly or part funded by statutory grants, those that are privately funded, those works that do not require technical input but do require grant administration and casework (i.e. tenant of a registered provider) etc.

4.10.17. There may be instances such as changing circumstances, when work carried out by the Provider has to be aborted prior to the grant being approved. The costs associated with such abortive work will be borne by the Provider.

## **5. ELIGIBILITY CRITERIA**

5.1. The broad scope of the Service means that the eligibility criteria are complex.

5.2. All residents of the Contract Area are eligible for the information, advice, assessment and support services provided by the Service.

5.3. Individuals needing minor adaptations costing under £1,000 and who are Care Act eligible will not be expected to pay for these works from their own resources. This will be funded by the Council or via the customer's personal budget allocated by the Council. These works are outside of this Services Agreement but will be incorporated into the Integrated Community Equipment Service (ICES) Service currently also being commissioned by the Council. The Provider will be expected to work with the ICES provider to provide a seamless service.

5.4. Minor repairs and minor adaptations for non-Care Act eligible Individuals can be supplied by the Provider and will form part of the self-funded offer expected under this Service. Similarly home safety, security and energy efficiency improvements can be provided and charged for except where products and materials have been made available by statutory or charitable agencies for use in the homes of specific groups of Individuals.

5.5. Co-ordination of major adaptations for Care Act eligible Individuals will be provided at no direct cost to the Individual, where they are also eligible for grant funding. This work will be paid for through the fee income included within the grant.

## **6. PERFORMANCE INDICATORS**

6.1. The Provider will be expected to propose details of performance indicators that they intend to monitor, which will demonstrate effective service delivery and value for money and at a minimum should be those detailed in section 3.

- 6.2. Performance indicators will be agreed prior to Service commencement date and the Strategic Partnership Board reserves the right to amend these.
- 6.3. As a guide, minimum outputs are provided for each of the current service elements, contained in section 3, it is anticipated that these numbers will increase during the length of the Services Agreement and that there will be a shift in which solutions are provided to meet Individual's needs. For example, the Strategic Partnership Board would expect an increase in the number of Individuals who receive AT to increase.

## **7. MANAGEMENT INFORMATION**

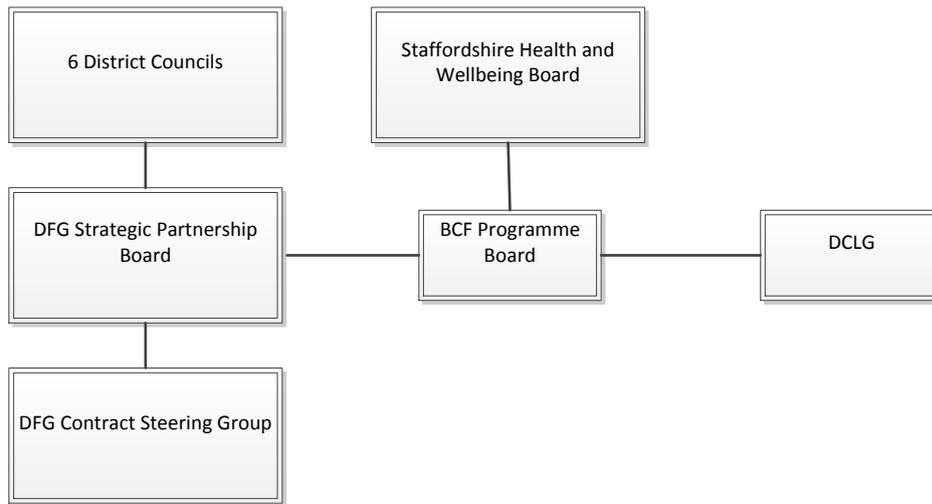
7.1. Management Information will be developed and agreed with the Strategic Partnership Board prior to the Service commencement date, however, baseline information to be collected, broken down by district and age range and submitted quarterly includes:

- 7.1.1. Number of enquiries received and outcomes (Including advice and information only, AT, major adaptation, repair, minor adaptation, referral to other agency)
- 7.1.2. Number of self-funders
- 7.1.3. Level and type of AT
- 7.1.4. Level of telecare provided
- 7.1.5. Level, type and value of minor adaptation
- 7.1.6. Level, type and value of work undertaken by the handypersons service
- 7.1.7. Level, type and value of fee paying work undertaken
- 7.1.8. Level, type and value of major adaptation
- 7.1.9. Level, type and value of fee paying adaptations work generated
- 7.1.10. Level of DFGs
- 7.1.11. Budget balance
- 7.1.12. Number of households assisted to move to alternative accommodation
- 7.1.13. Number of visits to accessible homes centre and mobile / pop up centres
- 7.1.14. Number of self-assessments completed on line
- 7.1.15. Number of complaints broken down by type
- 7.1.16. Equalities information

## **8. MONITORING AND GOVERNANCE**

8.1. The Governance arrangements for the partnership are shown below:-

**Figure 1 -- Governance arrangements**



8.2. The Provider will be expected to participate in and contribute to regular development and performance monitoring meetings.

8.3. The performance monitoring meetings will include:

8.3.1. Meeting bi-monthly to maintain an overview of the Service

8.3.2. The Provider working alongside the Steering Group and Strategic Partnership Board to identify any opportunities for service development and improvement,

8.3.3. Considering qualitative data and monitoring data supplied by the Provider

8.3.4. Considering any underperformance issues, the reasons why and to agree how these will be addressed

8.3.5. Deciding how any increased demands for the Service will be met

8.3.6. Considering any disputes not resolved at operational level

8.3.7. Considering any implications of contract performance and service activity

8.3.8. Ensuring equitable levels of Service provision across the Contract area.

## 9. LINKS WITH OTHER SERVICES

9.1. The Provider will work with partners to enable links between IT systems where appropriate and feasible. For example, links between the Providers IT system for assessment and casework will need to be made with SCC social care and children's services systems so that personal details and assessment records for people assessed by SSOTP OTs can be seamlessly utilised by relevant staff within the Service.

9.2. Given the clear synergies between SILIS Service and ICES Service it will be important for the two Providers to work collaboratively and exploit any potential opportunities for integration to avoid duplication of visits to Individual's homes.

## 10. GLOSSARY OF TERMS

### 10.1. Assistive technology (AT)

10.1.1. AT is often called personalised technology because it is less about the equipment in isolation and more about how Providers integrate with other services to deliver personalised support and empower people to live safely and independently. Solutions can include telecare and telehealth equipment, environmental controls, mobile technology and communication aids. It can range from simple devices to prevent sinks flooding, to GPS tracking and Smart-phone applications.

10.1.2. For the large number of people who need lower-level support services rather than care in the home, AT can make the following contributions:

10.1.2.1. Providing the confidence needed for people to remain living at home independently.

10.1.2.2. Giving service users a sense of security in the knowledge that if a problem occurs they are able to raise a call for assistance.

10.1.2.3. Giving peace of mind to carers and relatives in the knowledge that the AT equipment will trigger a response in the event the service user raises a call or their behaviour triggers an alert for assistance.

10.1.3. Acting as a powerful assessment and prevention tool which results in outcomes for improved quality of life.

### 10.2. Better Care Fund

10.2.1. From April 2015 the pot of Government money allocated to disabled facility grants is being transferred to the Better Care Fund, which is allocated by Staffordshire County Council in accordance with the Passporting Agreement.

## 12. APPENDICES

### 13. Appendix 1 - Baseline volumes

Some work has been done to identify current demand however it should be noted that this data is from the current service and mainly represents publicly funded individuals:-

Currently approximately 80 enquiries per month;

Fallout rate is around 35% (28 per month) this is predominantly due to:-

Client contribution too high;

Client's needs changed;

Client failed to engage;

These account for 70% of fallout cases;

Timescales vary but across the partnership time from enquiry to work commencing currently takes between 168 and 280 days;

There is limited data around enquiries but for works:-

66% of applications are for Level Access Showers or stairlifts;

The proportion rises to 76% in some areas;

Costs vary enormously across different areas and whilst some variation can be explained by multiple works, the spread is significant and does not appear to provide good value for money;

Very few self-funders opt to use the current provider to organise their works – this leaves them vulnerable;

There is some evidence of benefit to the wider Health and Care Economy but not as much as we would like.

## Appendix 2 - Supporting Information

### 1.1. Strategic context for change

The SILIS Service will be commissioned by Staffordshire County Council and six of the housing authorities, Lichfield, Newcastle, South Staffordshire, Stafford, Staffordshire Moorlands and Tamworth District Councils. It is envisaged that the Service will contribute to wider strategic aims as detailed below.

Build a Healthy Staffordshire With an environment that improves health and wellbeing for all.

Help people to help themselves by giving simple, clear information and advice to enable them to take responsibility for keeping themselves healthy, safe and prosperous.

Grow communities to support people and which help people to live independently in their own home, with care and support from family, friends and the whole community.

Offer extra help for those who need it to prevent and respond at times of crisis to get people back to independence.

Be honest about the options available so that people understand who is eligible for support and who will pay for it.

Maintain long term care services working with our partners and providers to ensure that when people do require support, we can offer quality and safe services that meet people's needs.

1.2. The Council plans to redesign the way it delivers Adult Social Care Services. The redesign programme will be a major change programme in Adult Social Care over the next three to five years. It will ensure that the Council can carry on offering high quality services, whilst meeting the requirements of the Care Act and other national legislation, and contribute to the Council's financial challenges.

1.3. The vision for the programme is "to support people to live independently for as long as possible, to reduce demand for health and adult social care and to promote health and wellbeing."

1.4. The programme will focus on the need to:

1.4.1.1. Provide information and advice to help people stay healthy, plan for their future needs, use services effectively and take responsibility for their own health and care, as well as details about local services.

1.4.1.2. Encourage and support people to look after themselves, their families and their communities

- 1.4.1.3. Maximise the benefits of new technologies
  - 1.4.1.4. Build on community assets, local resources and mobilise volunteers to contribute to healthy communities
  - 1.4.1.5. Maximise the impact of prevention and recovery services
  - 1.4.1.6. Reduce the need for adult social care
  - 1.4.1.7. Allow greater choice and control for service users
  - 1.4.1.8. Increase the use of personal budgets and direct payments
  - 1.4.1.9. Maximise the quality and productivity of services
  - 1.4.1.10. Transform the market for new care and support services
  - 1.4.1.11. Streamline pathways, integrate health and social care services and reduce transactional costs
  - 1.4.1.12. Integrate services where possible, particularly between the NHS and social care.
  - 1.4.1.13. Make sure that service users and carers can influence the service redesign and help the public understand the programme and create realistic expectations about the support and care that the Council is able to offer, through involvement and communication
  - 1.4.1.14. Achieve the required savings
  - 1.4.1.15. Make sure staff have the right skills
- 1.5. At certain points in their lives, as a result of ageing, accident or injury, sensory impairment or degenerative illness, many people will need an intervention that enables them to remain safe and independent in their home. Interventions may come from family or friends, the local community, voluntary groups, private providers or public services. Such interventions may include advice and information, enabling equipment, assistive technology or aids and adaptations. Very often people do not know where to turn to initially and may end up frustrated by the wide range of services available and the varying points of access to those services.
- 1.6. The Government's Care Act recognises this problem and places great emphasis on the need for the integration of health and care services. There is also a recognised need to ensure that housing and housing-related support services are also part of this integration.
- 1.7. Current Service Provision
- 1.7.1. In Staffordshire there are a number of services that contribute to this agenda including the following:
  - 1.7.2. Independent Living Centres
    - 1.7.2.1. There is one independent living centre in Staffordshire managed by the Council – Millbrook in South Staffordshire to support adults of all ages and disabilities, their carers and families, health and social care professionals, voluntary, community and business organisations.
  - 1.7.3. Staff at the centre offer free and impartial assessment and advice to anyone who is experiencing difficulty with maintaining their

independence, and will work with them to identify practical solutions to these difficulties.

- 1.8. A wide range of products are available for people to look at. They include:
  - 1.8.1. Bathing and showering products
  - 1.8.2. Riser-recliner and armchairs
2. In addition the Integrated Community Equipment Service (ICES) based in Stafford has a public display area which includes:-
  - 2.1.1. Wheelchairs, scooters, walking products
  - 2.1.2. Meal preparation, feeding and drinking products
  - 2.1.3. Beds and associated products
  - 2.1.4. Clothing and personal care products including toileting, washing, dressing aids
  - 2.1.5. Moving and handling equipment
3. Home Improvement Agencies (HIA's)
  - 3.1.1. The HIA is commissioned by the Council and seven District and Borough Councils. The service in Cannock District Council is currently provided in-house.
  - 3.1.2. The HIA comprises three complementary services:
    - 3.1.2.1. Home Adaptations
    - 3.1.2.2. A team of Caseworkers and Technical Officers work with people, Occupational Therapists and trusted local contractors, to help them remain in their own home, living independently, in safety and comfort. Staff advise on improvements and adaptations that people need in their homes and help them to apply for local authority grants, loans, or any other funding needed to carry out the required work. Work is undertaken by reputable local contractors, and the HIA administers the work to ensure that individuals are completely satisfied. Work carried out might include door widening, installing hand rails and bathroom adaptations. The HIA charges a range of fees between 8% and 11% for all works carried out based upon the cost of those works. If the works are grant funded, this fee is usually included within the grant.
    - 3.1.2.3. Housing Options service which helps people considering a move to check whether there are any services, benefits, aids and adaptations or grants which might help them remain in their existing property. If a move is the answer then advice on options including sheltered and extra care housing will be explored. If a person decides to move then a caseworker can help with finding out what is available, planning the move, getting trustworthy removal contractors and arranging transfer of utilities. The advice and support service is free although costs will be incurred for services such as removal companies, solicitors, etc. Caseworkers may be able to access funding or grants to help with these costs.
4. Integrated Community Equipment Services (ICES)

- 4.1. ICES is commissioned by the Council, in conjunction with (need to insert details of partners) in order to provide a range of equipment from simple to complex items for daily living, rehabilitation and specialist purposes. Staffordshire County Council is currently the lead commissioner for the pooled budget. The service is currently achieved through three distinct work streams and these are:
  - 4.1.1. Simple Aids for Daily Living (SADL's) without electrical or hydraulic parts - these are provided by a provider network through the Dorset Retail Model.
  - 4.1.2. Complex Aids for Daily Living (CADL's) which may have electrical or hydraulic parts and are provided by a national supplier, Pluss. This is the rental model.
  - 4.1.3. Bespoke Special Items of Equipment, which are on neither the SADL nor the CADL stock lists. These are provided via a local procurement structure.
- 4.2. ICES uses a bespoke IT system which is web based. SSOTP staff facilitate the ordering of equipment and management of activity.
- 4.3. The contract for this service is currently being re-tendered with the Council as the lead commissioner and the new service to go live on 1st June 2018. Although the ICES service is not within the scope of the SILIS Service it is anticipated that there will be clear links made between the services with potential for further integration in the future.
5. Assistive technology / Telecare
  - 5.1. The Council has agreements with three providers who supply telecare solutions. These are:
    - 5.1.1. Wellbeing
    - 5.1.2. Stafford and Rural Homes
    - 5.1.3. Trent and Dove Housing
  - 5.2. The system consists of one or more sensors, or detectors and a link to a nearby carer or monitoring centre who can respond to the alert. There are a wide range of sensors which detect events such as:
    - 5.2.1. Falling over
    - 5.2.2. Wandering at night
    - 5.2.3. Not preparing meals or using the bathroom
    - 5.2.4. Leaving the house unsecured etc.
  - 5.3. There are also sensors that monitor the environment and detect risks such as:
    - 5.3.1. Possible hypothermia
    - 5.3.2. Carbon monoxide build up
    - 5.3.3. Overflowing baths etc.
  - 5.4. In line with the vision of the Strategic Partnership Board, assistive technology including telecare is anticipated to become a key area for development.
6. Occupational Therapy Service

- 6.1. Occupational Therapy assessments are current accessed in the first instance through the SSOTP referral points, however this will be changing and first point of contact will be through a professionalised “front-door” where non-complex assessments will take place without a home visit.
- 6.2. For more complex cases, there are a number of integrated health and care teams based in local offices based across the county.
- 6.3. Contacts - TBC

Draft for Consultation Only