ROCHDALE
BOROUGH COUNCIL

STAR
PROCUREMENT

Document 2: Specification For:

INDEPENDENT LIVING SCHEME (ILS)

Rochdale Borough Council
Adult Social Care
Independent Living Scheme (ILS) Specification

1. Rochdale Vision for the Future ..... **Error! Bookmark not defined.**
2. Specification Purpose 2
3. Service Delivery and Eligibility 3
4. Service Model 5
5. Technology-Enabled Care 8
6. Outcomes and Continious Development 9
7. Supporting people to manage finances where required 10
8. Strengths Based Approach 10
9. Returning Home 11
10. Provider Workforce, Training, and Community Integration 11
11. Coproduction and Engagement 12
12. Social Value 12
13. Safeguarding 13
14. Governance and Compliance 13
15. Financial Arrangements 14
16. A Recovery of Sums Due 15

1. Rochdale Vision for the Future

1.1. The Council Plan 2028, available on the Council's website, outlines four main priorities for the next five years:

- Promote health, wellbeing, and success for all, especially children and young people.
- Develop a thriving, fair, and sustainable economy with better jobs, housing, and transport.
- Address climate change through awareness, energy efficiency, and responsible waste management.
- Transform council services via digital innovation, strong partnerships, and efficient funding.

1.2. The Council aims to empower resilient communities by removing barriers, preventing crises, and creating opportunities. In response to national changes and the 10-Year Health Plan, it remains committed to strong partnership working.

1.3. The Adult Social Care Strategy (2024) sets out a vision to promote independence, protect from harm, and deliver high-quality care by keeping people at the centre of all decisions. The mission is to ensure timely, appropriate support, value the workforce, and enable independent, healthy living for all residents.

1.4. Our Commitments:

- Working with people at the heart from the start.
- Continuing to join up support.
- Supporting people to be safe, independent and well.
- Making it easy to find information, advice and guidance.
- Promoting equality, diversity and inclusion.

2. ILS Flat Specification Purpose

2.1. At the heart of Rochdale's Adult Services is the 'Home First' principle, emphasising the importance of supporting individuals to return to their own homes whenever possible.

2.2. Nonetheless, it is acknowledged that immediate discharge home is not always feasible. Reasons may include situations that temporarily prevent a safe return, such as:

- Hoarding or hazardous property conditions
- The requirement for substantial adaptations (e.g., installation of ramps or accessible bathrooms)
- Significant disrepair or unsuitability of housing

2.3. To address these barriers efficiently, Rochdale Borough Council collaborate with housing teams, occupational therapists, and voluntary sector partners. This multidisciplinary approach ensures obstacles to a safe and timely return home are rapidly identified and resolved, supporting the overall aim of promoting independence and wellbeing.

2.4. The ILS Flats offer accommodation for up to six weeks in four fully furnished, self-contained properties, designed to facilitate prompt hospital discharge and prevent unnecessary extended hospital stays or short-term placements in 24-hour care environments when individuals are not immediately able to return home.

2.5. Delivering a focused reablement service that empowers individuals to rebuild confidence in daily living skills, fosters independence, minimises reliance on long-term care, and improves health and wellbeing

outcomes. The objective is to deliver a safe, person-centred, and adaptable service that prioritises wellbeing, continuity, and dignity throughout each stage of support.

2.6. Placements typically last between one and four weeks, though they may extend up to six weeks. Providers are expected to develop comprehensive support plans focused on reablement goals, ensuring personalised support that addresses each individual's unique needs, requirements, preferences, protected characteristics, and personal circumstances.

2.7. The provider will deliver the following forms of support:

- Assistance with securing appropriate housing
- Facilitating community engagement to minimise isolation
- Guidance on debt management and relevant referrals
- Advice on benefits and appropriate signposting
- Support in addressing alcohol and substance misuse
- Aid with accessing educational opportunities
- Coordinating with specialised cleaning firms, and other partners when necessary to assist in overcoming any obstacles that may prevent people from returning to their homes.

3. Service Delivery & Eligibility

Service Delivery

3.1. Providers are required to ensure a minimum of four fully furnished properties, all compliant with the Decent Homes Standard and accessible to those with frailty or mobility impairments.

3.2. This service is exclusively open to providers from the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector. Eligible organisations must be registered as a charity, CIC, faith group, or social enterprise, and demonstrate a track record of community-based service delivery. Applications from private, for-profit entities will not be considered.

3.3. Providers must establish and maintain a physical base within the borough of Rochdale. This requirement ensures prompt responsiveness to referrals and facilitates a deep understanding of local community needs and experiences.

3.4. Properties must feature safe and efficient heating, adequate insulation, modern plumbing, and secure doors and windows.

3.5. Furnishings must include a comfortable bed, suitable seating and essential appliances such as a refrigerator, oven, and washing machine.

3.6. Accessibility features should include step-free entry, widened doorways, grab rails in bathrooms, and non-slip flooring, ensuring safety and comfort for individuals with mobility challenges or other vulnerabilities.

3.7. Providers must maintain robust systems for accepting referrals at short notice, enabling prompt hospital discharges and effective reablement support.

3.8. Referrals should be acknowledged within two hours, and admission to an ILS flat should be arranged within 24 hours unless an alternative planned date is agreed and authorised. This responsiveness helps alleviate NHS pressures, reduces the risk of hospital readmission, and minimises the potential for deconditioning in those requiring temporary support.

3.9. Upon hospital discharge, the provider supports the individual's transition from hospital to the ILS property, meeting them at the property and providing a thorough orientation and basic supplies.

3.10. The provider is responsible for ensuring the flat is warm and welcoming, with basic provisions such as milk, bread, butter, tea, and coffee available upon arrival.

3.11. Focus is supporting people to return home, and when individuals are returning to their home, the provider must ensure that the environment is safe, comfortable, and conducive to recovery. This includes making certain that the home is adequately heated, the fridge is cleared of any expired food, and the property is clean and fit for habitation. These measures are essential to promote a smooth transition back to independent living.

Eligibility

3.12. The Service will be available to adults aged 50 + for those in Independent Living schemes and 18+ in the case of general needs accommodation.

3.13. Individuals eligible for this service have an existing home; however, their current residence is temporarily unsuitable for their needs. This may be due to mobility challenges, the necessity to await property adaptations, or a period of recovery during which returning home is not advisable. In circumstances where the home remains unsuitable in the longer term, some individuals may require additional housing support.

3.14. The service is not designed for individuals needing ongoing or indefinite accommodation beyond the short-term intervention of the ILS flats.

3.15. Individuals deemed as eligible for this service are those identified as:

- Medically stable
- At risk of long-term, bed-based care
- Require short-term intervention to support rehabilitation
- Individuals that may be suitable include (but are not limited to):
- Post-surgery, including early discharge Individuals from orthopaedic surgery
- Older people with co-morbidities
- Individuals identified as having the potential to return to their normal place of residence following a short-term period of support and enablement
- Physically disabled adults with co-morbidities, requiring a period of additional support
- Individuals that, following a crisis or period of illness, need to recover their daily living skills and/or improve mobility including people with a learning or physical disability
- Individuals that need enabling support and whose homes require adaptation including people with a learning or physical disability.

4. Service Model

4.1. The current provider offers four self-contained flats across Rochdale, Heywood, and Middleton, and providers may have an opportunity to utilise these units as the foundation of their service delivery approach subject to agreement with Rochdale Borough Housing. While these established flats are the

primary accommodation, the Commissioner welcomes proposals from providers able to offer alternative, suitable options, such as properties with disabled access and no age restrictions.

4.2. These alternatives should enhance service effectiveness, improve outcomes for individuals, or increase scheme capacity and be situated across the neighbourhoods of Rochdale.

4.3. The number of individuals requiring support will vary based on assessed need and demand. Providers will be kept informed of forthcoming changes, such as new referrals or hospital discharge plans. Providers are expected to manage the provision accordingly ensuring timely discharge from the ILS service to support capacity management.

4.4. Providers are expected to manage the provision accordingly ensuring timely discharge from the ILS service to support capacity management. Providers are to assist Commissioners in promoting the availability of the ILS properties to stakeholders, including wider ASC teams, brokerage, hospital discharge and community partners. This may involve:

4.5. Developing and sharing promotional materials
4.6. Responding promptly to enquiries and facilitating timely assessments and admissions
4.7. Collaborating with commissioners to identify and address barriers to occupancy
4.8. Improving the service offer utilising existing community services
4.9. Sharing a weekly capacity tracker

4.10. Where decisions are made to no longer offer an ILS property, providers are expected to proactively explore other options throughout the contract's duration to better serve residents or offer improved value for money.

4.11. All alternative accommodation must fully comply with supported living standards, be located within Heywood, Middleton, or Rochdale, and remain accessible to the intended individuals accessing the service.

4.12. The provider is required to ensure rapid and timely responses to all referrals. Prompt communication and swift action are crucial, particularly during admissions and discharges.

4.13. Providers must demonstrate clear processes for identifying, sourcing, managing, and maintaining alternative accommodation throughout the contract, ensuring ongoing suitability and compliance with all relevant standards.

Decent Homes Standard

4.14. All accommodation used for the service, whether existing or alternative, must meet the Decent Homes Standard. This includes:

4.15. Freedom from category 1 hazards under the Housing Health and Safety Rating System (HHSRS)A reasonable state of repair.

4.16. Reasonably modern facilities and service.

4.17. A reasonable degree of thermal comfort (effective heating and insulation).

4.18. Providers are responsible for ensuring that accommodation is safe, properly maintained, and suitable for the individual needs. Evidence of compliance with the Decent Homes Standard may be requested during the tender process and for ongoing contract monitoring.

Referrals and Assessments

4.19. Referrals shall be received from adult social care and hospital discharge teams. Providers must verify that all referrals meet the established eligibility criteria and can be appropriately supported within the service.

4.20. Providers are required to carry out a comprehensive needs assessment encompassing physical, emotional, and social factors either immediately prior to admission or within the first 24 hours of admission.

4.21. If a referral does not meet the eligibility criteria, this must be promptly raised and discussed within the designated working group. In the absence of an imminent working group meeting, a separate meeting must be convened at the earliest opportunity, involving the referrer, commissioning representatives, and the provider, to review and resolve the referral in question.

4.22. This ensures that all aspects of the persons wellbeing are considered from the outset and enables the tailoring of support to their specific requirements and outcome goals.

4.23. In addition, providers should proactively visit individuals in hospital where appropriate, working alongside them and clinical staff to facilitate effective discharge planning and ensure a smooth transition into the accommodation.

4.24. Effective and ongoing collaboration with hospital discharge teams and relevant professionals is essential. Providers must maintain open channels of communication, regularly sharing information and updates to promote coordinated support and continuity of care.

Individualised Support Plans

4.25. The provider is required to deliver one-to-one action planning sessions. These sessions must be used to assess individual needs and establish clear, personalised support objectives.

4.26. The provider should promote good health and wellbeing, while fostering confidence and independence.

4.27. Weekly coaching provides three hours dedicated to personal development and housing stability.

4.28. Training sessions (totalling two hours per week) support life skills and independent living where required.

4.29. The Provider must demonstrate a strong commitment to Equality, Diversity and Inclusion (EDI) by ensuring the service is accessible and responsive to people from all backgrounds. This includes adapting communication methods to accommodate diverse cultural, religious, and linguistic needs, as well as addressing potential barriers to services.

Ongoing Welfare and Service Monitoring

4.30. The provider is required to carry out daily welfare checks to monitor individuals' wellbeing and address any immediate concerns. The provider must actively maintain support planning to ensure services remain responsive to changing circumstances. In addition, comprehensive service reviews must be conducted every twelve weeks to assess progress, update goals, and confirm the continued suitability of support.

SMART Goal-Based Action Plans

4.31. Support plans must be developed using SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals, enabling measurable outcomes and sustained progress for each individual.

Collaborative Partnership Working

4.32. The provider is required to maintain effective partnerships with health, social care, and other relevant services. These partnerships must ensure a holistic approach to supporting individuals and addressing their broader needs.

4.33. A dedicated working group will hold weekly meetings to review referrals, track individual progress toward returning home, and address any challenges that could delay positive results. Led by commissioning, the group will include members from the provider, hospital discharge team, adult social care, Stars, and care at home services. This collaborative approach helps partners work effectively together to monitor progress and support successful outcomes.

Admissions, Discharges, and Void Management

4.34. The provider is required to implement clear procedures for managing admissions, departures, and voids. These procedures must ensure smooth transitions for individuals accessing the service and efficient use of housing resources.

4.35. The provider remains financially responsible for rent, utilities, routine cleaning and turnover costs during void periods.

4.36. Void turnaround targets apply from keys being returned to the point the property is ready for admission. Readiness includes safety checks completed, cleaning undertaken and utilities active.

4.37. Damage or deep cleaning beyond routine turnover may be recharged to the responsible party where lawful and proportionate, following the process in the Damage and Insurance section.

Rapid Relief Housing-Related Support

4.38. The provider is required to deliver tailored housing-related support, focusing on rapid relief and effective intervention to meet the immediate needs of individuals.

Additional Support Areas

4.39. The provider is required to deliver the following additional support services:

4.40. **Benefit Claims and Debt Management** - The provider must assist individuals accessing the service with benefit claims and debt management to promote financial stability.

4.41. **Anti-Social Behaviour** - The provider must provide support to address incidents of anti-social behaviour, ensuring safe and harmonious living environments.

4.42. **Complaints Handling** - The provider is required to manage complaints in line with Rochdale Borough Council policy, ensuring transparency and accountability.

4.43. **Move-On Guidance and Support -** The provider must deliver comprehensive guidance and support to facilitate individuals' transition from supported accommodation. This includes ensuring that their usual place of residence is safe and secure for their return, as well as providing access to suitable onward housing options. The aim is to enable a smooth and successful move towards independent living.

Experience, Skills & Knowledge

4.44. The provider delivering this service will have:

4.45. A commitment to inclusive and supportive recruitment and workforce development, ensuring staff are well-trained, compassionate, and equipped to deliver person-centred services that respects the dignity and preferences of people in the service, including those with cognitive impairments.

4.46. Staff receive comprehensive training designed to meet the diverse needs of residents including varying age groups, physical and cognitive abilities.

4.47. The service demonstrates a clear ambition to embed Technology Enabled Care (TEC) solutions that enhance quality of life and promote independence.

4.48. Demonstrated experience in housing-related support, including working with individuals who require assistance to maintain tenancies, navigate housing options, and access appropriate accommodation solutions.

4.49. A proven track record of charitable or community-based work, evidencing strong values, social responsibility, and engagement with local communities to enhance wellbeing and inclusion.

Data collection and Reporting

4.50. To ensure robust management of service delivery, demonstrate value for money, and provide clear evidence of outcomes, the provider is required to collect and submit comprehensive data on a regular basis. Data returns must be provided weekly and quarterly, and should include, at minimum:

4.51. **Referrals:** Number of new referrals received, including source date of referral, admission date and demographic information.

4.52. **Rejections:** Record of referrals not accepted, with detailed reasons for rejection to support service improvement and transparency.

4.53. **Start and End Dates:** Admission and discharge dates for each Individual enabling monitoring of service utilisation and turnover.

4.54. **Outcome Goals:** Clearly defined goals for each individual, established through initial assessments and individualised support planning.

4.55. **Outcomes:** Evidence of progress towards or achievement of outcome goals, including qualitative and quantitative measures.

4.56. **Good News Stories:** Case studies or testimonials that illustrate positive impact, personal development, or successful interventions, highlighting the value of the service.

4.57. **Voids:** Details of any unoccupied accommodation units, including duration and reasons for voids, to support occupancy management.

4.58. In addition to the above, providers should ensure that data collection processes are robust and enable meaningful analysis, including the identification of trends, challenges, and areas for improvement.

4.59. Data should be collated in a format that supports contractual monitoring, facilitates informed decision-making by commissioners, and promotes continuous improvement.

4.60. Providers are also encouraged to use collected data to inform service development, share learning with stakeholders, and contribute to wider sector best practice.

4.61. Regular reporting will underpin accountability, transparency, and the achievement of positive outcomes for individuals.

5. Technology-Enabled Care (TEC)

5.1. The Council are committed to expanding the influence of Technology Enabled Care (TEC), championing innovative solutions that enhance service delivery.

5.2. While the provider will not be delivering direct care, it is nonetheless expected that TEC is embedded as a fundamental element within the service specification. This means providers should integrate and promote TEC opportunities in the management and operation of ILS properties, supporting improved outcomes for people accessing the service and carers through increased efficiency, quality, and user experience.

5.3. Providers are encouraged to actively embrace, adopt, and continually develop TEC as part of high-quality practice. The expectation is that the provider facilitates access to TEC solutions—such as digital monitoring, assistive technology, or communication aids—within the accommodation environment.

5.4. This supports people's independence and wellbeing, without involving the direct delivery of personal care. Providers should work collaboratively with the Council to identify and embed TEC opportunities wherever possible, ensuring the service remains at the forefront of innovation and best practice.

6. Outcomes and Continuous Development

6.1. Rochdale Borough Council prioritise working with providers who actively support individuals in staying connected to their communities, maintaining and developing relationships, and participating in leisure and cultural activities.

6.2. Providers should promote good health and wellbeing, while fostering confidence and independence. It is vital that the service is culturally appropriate, recognising and respecting each person’s cultural identity, beliefs, language, and traditions

6.3. Effective discharge planning should begin immediately upon admission to the ILS flat and remains a core objective throughout the placement, ensuring individuals can return home as swiftly and safely as possible.

6.4. This process requires consistent, coordinated communication between all involved teams, including health, social care, housing, and voluntary sector partners, to facilitate a seamless transition back to independent living.

6.5. The service is committed to a holistic, multidisciplinary approach. This involves working with health and social care teams, developing assessments to support non health needs that includes regular evaluations, and ongoing feedback from the individual and their family.

6.6. Continuous reviews during the placement period are essential for tracking progress, identifying evolving needs, and swiftly addressing any barriers to independence. Such proactive support helps maintain wellbeing and minimizes the risk of unnecessary hospital readmission or transition into long-term care upon discharge.

6.7. Prolonged hospital stays for individuals who are medically fit for discharge but await appropriate housing pose significant risks, including physical deterioration, hospital-acquired infections, and

adverse mental health outcomes such as depression and delirium. These delays can diminish confidence and independence, hindering the individual's ability to regain previous levels of functioning.

6.8. Furthermore, delayed discharges place additional strain on families and care services, reduce hospital capacity for other patients, and increase financial pressures on health and social care systems. Addressing these delays is vital for achieving better outcomes for people and ensuring more efficient use of NHS resources.

6.9. ILS flats provide a reablement opportunity for people in recovery, being able to continue their recovery in an environment that encourages day to day activity just through daily living tasks cannot be underestimated in the positive impact this has on individuals allowing them to achieve their baseline timely and reduces the risk on deconditioning further that can result in increased health needs and reduced independence.

6.10. Facilitating stable exit pathways is essential to ensure individuals can transition to positive onward housing solutions that reflect their unique needs and circumstances. This requires a personalised approach, with housing options explored and tailored in collaboration with the individual and their support network to promote long-term stability and independence.

6.11. Collaboration with housing teams, occupational therapists, Stars, Care at Home providers and social care professionals plays a crucial role in overcoming housing-related barriers.

6.12. Issues such as hoarding, property disrepair, or the need for adaptations must be identified early and addressed proactively. By working together, these teams can ensure that the necessary changes and supports are in place to allow individuals to return home safely and confidently.

6.13. Delivering services that consistently meet regulatory standards is fundamental to upholding the dignity, safety, and wellbeing of every individual supported by the service. Continuous evaluation and adherence to best practice guidelines ensure that all aspects of care remain person-centred and responsive to changing needs.

6.14. Working in partnership with care providers enables a truly holistic and integrated approach to support. This collaborative model addresses the broad spectrum of individual needs and preferences, ensuring that each person receives tailored assistance throughout their journey, from hospital discharge to the successful reintegration into their own home.

7. Supporting people to manage finances where required

7.1. Where applicable, the provider will be expected to:

7.2. Report to Adult Social Care if an individual cannot manage their own finances; the council will act as appointee if no suitable friend or family members are available.

7.3. Encourage people to bank unused cash regularly to prevent large accumulations.

7.4. Support individuals to manage money, budgets, and correspondence as independently as possible, respecting their preferences and wishes.

7.5. Assist in maximising income, offering guidance on benefits, expenditure, and safe keeping of money, while minimising financial abuse through robust policies and procedures.

8. Strengths Based Approach

8.1. Every community holds valuable assets such as knowledge, social connections, and unique resources that contribute to collective health and wellbeing. Rochdale Borough, in particular, shines as a lively

and diverse area and with the right support can actively collaborate and generously support one another.

8.2. A strengths-based approach acknowledges and leverages the human, social, and physical capital present within local communities. We seek to implement a service that utilises asset-based practices through a collaborative process between individuals and the service, enabling them to work together towards positive outcomes by drawing on each individual's strengths and resources.

8.3. To achieve success in this approach, staff must build meaningful and respectful relationships that fully recognise and value the unique strengths, experiences, and perspectives each individual brings. By fostering such relationships, the service empowers people to actively participate in decisions and have genuine influence over the design and delivery of their own care and support.

8.4. Additionally, the service will play a proactive role as a connector, helping individuals tap into their social assets—such as family, friends, health professionals, community and faith groups, and voluntary organisations. By facilitating these links, we can ensure that people are supported holistically, drawing upon the rich network of resources available within their communities to enhance wellbeing and independence.

8.5. The provider will foster a thorough understanding of available community resources and actively establish partnerships with local organisations, other providers, and community-based groups. By fostering these collaborative relationships, they will further embed the principles of a strengths-based approach, ensuring that individuals living in residential settings are supported to make the most of local opportunities and live fulfilling, independent lives.

9. Returning Home

9.1. It is essential to prioritise the development and implementation of a targeted action plan that enables individuals to return safely and promptly to their usual place of residence.

9.2. This plan should be person-centred, taking into account each individual’s unique needs and circumstances, and should be delivered in close collaboration with the individual, their support network, and relevant professionals.

9.3. Ensuring a clear and structured pathway home will support the restoration of independence, confidence, and wellbeing, while contributing to efficient and effective use of health and social care resources.

9.4. Provide support for home adaptations across owner-occupied, housing association, and private rental properties.

9.5. Direct individuals to financial advice and grant opportunities.

9.6. Work with social care teams to arrange deep cleaning and assess hoarding risks through home visits and multi-agency reviews. Involve individuals in creating personalized decluttering plans, ensuring their consent and communication. Coordinate with clearance contractors, prioritising safeguarding and dignity.

9.7. Individuals returning home may have been absent for several weeks, possibly due to a hospital admission followed by a stay in the ILS flat. It is important to check that homes are safe and fully functional, ensuring that the basics are checked before returning home this includes verifying that essential utilities such as heating and lighting are in working order, and that any perishable food has been removed from the refrigerator.

10. Provider Workforce, Training, and Community Integration

Ethical Leadership, Culture and Values

10.1. Ethical providers are expected to lead effectively and foster a positive, person-centred culture within their organisations, as this underpins high-quality services. To maintain and raise standards, they should prioritise staff development through robust training, mentoring, and supervision.

10.2. Providers need to define clear organisational values and ensure that recruitment and management practices are consistent with these values. Recognising, rewarding, and nurturing their workforce should be a priority.

10.3. Recruitment must follow a values-based approach, meeting all legal requirements, including for volunteers. Leadership teams should be trained in values-based recruitment and retention, and agency staff should only be used in exceptional circumstances.

10.4. All staff must be equipped to have strengths-based conversations and empower individuals to manage their own lives across all services. Providers should actively coordinate services, making full use of community resources to effectively engage with residents.

10.5. Additionally, developing leadership that encourages positive risk-taking, innovation, and creative solutions is important. Integration should focus on personal needs, resilience, and social inclusion, with a commitment to integrity, continuous improvement, openness, and transparency at every level of the organisation.

10.6. Staff will be highly skilled and confident in delivering both proactive and responsive support to promote positive behaviour and emotional wellbeing.

10.7. Management must maintain regular presence and oversight, ensuring quality and staff support. All staff must undergo enhanced DBS checks, including checks against the adult's barred list.

10.8. The provider must demonstrate a strong commitment to Equality, Diversity and Inclusion (EDI) by ensuring support is accessible and responsive to people from all backgrounds.

10.9. This includes adapting communication methods, activities, and environments to accommodate diverse cultural, religious, and linguistic needs, as well as addressing potential barriers to participation.

10.10. Staff should receive regular EDI training and be equipped to challenge discrimination, foster understanding, and create an environment where people feel respected, safe, and valued.

10.11. Staff will not be required to deliver any personal care; where an individual has care needs, this will be commissioned separately. Personal care will be provided through a commissioned care package, which will be delivered by either Stars or a Care at Home provider.

11. Coproduction and Engagement

11.1. We are committed to ongoing engagement with people who receive support, as well as their families and friends, to shape services, understand lived experiences, and continuously improve the services of Rochdale.

11.2. Individuals must be at the heart of service design, delivery, and evaluation through a co-commissioning approach that values their voice and expertise.

11.3. The provider should demonstrate how they involve people in meaningful ways, ensuring that residents have choice and control over daily aspects of life.

11.4. Where individuals consent, families should be kept informed in ways that suit them, while maintaining the person at the centre of all communication and decision-making.

12. Social value

12.1. As we continue to build our communities and services in Rochdale, we are committed to embedding social value in everything we do.

12.2. This means using our resources, partnerships, and commissioning practices to reduce inequalities, promote fairness, and create lasting benefits for local people. Providers are expected to operate in a way that strengthens the local economy, supports community wellbeing, contributes positively and minimises harm to the environment.

12.3. In Rochdale, we align with the Greater Manchester Combined Authority (GMCA) Social Value Framework, which supports the implementation of the 2014 GM Social Value Policy.

12.4. This framework provides a practical checklist for organisations to plan and deliver services that maximise social value across six priority areas:

- Employment and Economic Growth
- Inclusive and Resilient Communities
- Environmental Sustainability
- Health and Wellbeing
- Strengthening the Voluntary, Community and Social Enterprise Sector
- Innovation and Collaboration

12.5. For more information and to support you in responding the question related to Social value please visit: Social Value can make Greater Manchester a better place - Greater Manchester Combined Authority (greatermanchester-ca.gov.uk)

13. Safeguarding

13.1. The Service Provider must have robust safeguarding policies and procedures that align with RBSAB guidance. Safeguarding must be embedded in all aspects of service delivery to protect people from harm, abuse, or neglect.

13.2. The service provider will have a clear understanding of the safeguarding policies found and will embed this within their organisation and training programmes.

13.3. The overarching principle is that individuals can live safely, free from harm, and abuse or the fear of abuse, in communities that:

13.4. Have a culture that does not tolerate abuse.
13.5. Work together to prevent harm and reduce the risk of abuse.
13.6. Know what to do when abuse happens.

13.7. To implement the principles of making safeguarding personal to safeguard adults in a way that supports them in making choices and having control about how they want to live.

13.8. Promote an approach that concentrates on improving life for the adults concerned.

Providers must accept individual and collective responsibility to ensure that they:

13.9. Follow Multi-Agency Safeguarding Adults Procedures.

13.10. Promote good practice and uphold the values of the Safeguarding Adults at Risk Policy.

13.11. Ensure staff attend relevant safeguarding training and have access to appropriate resources.

13.12. Raise awareness of safeguarding within the organisation and the wider community.

13.13. Take timely and appropriate action when abuse is suspected.

13.14. Must notify the Adult Social Care and any other relevant regulatory body of safeguarding concerns or incidents.

13.15. Work closely with multi-disciplinary teams to assess, monitor, and update safeguarding plans

14. Governance and Compliance

14.1. This section pertains to the contract monitoring of services, outlining the processes and expectations. The provider will be required to complete and submit a quarterly contract monitoring return, which enables the organisation to maintain oversight and ensure compliance with both quality standards and contractual obligations.

14.2. Each submission is thoroughly reviewed and rated, with subsequent actions determined based on the findings; these may include no further intervention, a remote meeting, or a face-to-face discussion to address any concerns.

14.3. The contract management process begins with the distribution of the monitoring template to the provider ahead of each reporting period. These templates typically require information on service delivery, referrals, outcomes, voids, staffing, incidents, safeguarding, and feedback from residents and families.

14.4. The provider is expected to submit returns by the specified deadlines, accompanied by supporting documentation as appropriate. Failure to submit returns on time or with sufficient detail may result in follow-up requests or escalation.

14.5. Once returns are received, they are assessed against key performance indicators (KPIs) and contractual requirements. The KPIs, as detailed in Appendix 1, serve as the primary metrics for measuring compliance with regulatory standards, service quality, resident safety, and financial management.

14.6. Any areas of concern highlighted during this review are discussed at the contract monitoring meeting, where the provider is notified of the need for remedial action, which may include the development of improvement plans, additional reporting, or increased monitoring.

14.7. Contract management also involves regular communication between commissioners, stakeholders and the provider. This includes scheduled regular service meetings either remote or in person to discuss performance, share best practice, and support continuous improvement.

14.8. Where significant issues or breaches of contract are identified, formal escalation procedures are initiated in line with organisational and regulatory protocols. In serious cases, this may involve notifying external bodies and implementing contractual sanctions if necessary.

14.9. Throughout the year, providers are encouraged to seek guidance and clarification regarding contract requirements, ensuring a collaborative approach to quality assurance and service delivery.

14.10. The contract management framework is designed to be transparent, fair, and supportive, with the aim of safeguarding people using the service and promoting high standard services.

15. Contract Term & Financial Arrangements, and Real Living Wage

15.1. The provider will be paid the contract rate in equal monthly instalments.

15.2. The contract rate paid by Rochdale Borough Council is fully inclusive and covers all costs required to operate the Independent Living Scheme properties. The provider is responsible for paying all rents, utility charges (including gas, electricity, water, and any other service-related utilities), and for ensuring that each property is adequately furnished, cleaned and maintained. No additional charges for these items will be paid by the Council, and the provider must ensure that all such costs are met in full as part of the agreed contract price.

15.3. If a person has a care act need the personal care will be commissioned separately from RBC's flexible purchasing system and funded separately through the adult social care budget.

15.4 This contract operates on a 1+1+1 model, with continuation dependent on annual funding allocations through the Better Care Fund (BCF). The Commissioner cannot guarantee annual funding or set funding levels but aims for consistent service delivery throughout. Service activity will be adjusted based on identified needs, with indicative forecasts, routine updates, and advance notice of major changes to support workforce and capacity planning. Funding is set at £142,000 for 2026/27 and £146,000 for 2027/28. Funding for 2028/29 is expected to be maintained at a similar level to 2027/28; but may be negotiable during the third year of the contract, dependent on available resources.

15.4. Payments will be made via Banking Automated Clearing System (BACS), directly to the Provider's bank account. This is the Council's preferred payment method, and Providers must supply accurate bank details for this purpose.

15.5. **Real Living Wage (RLW) Requirement:** The Provider must ensure that all staff involved in the delivery of this service—including permanent, temporary, sessional, bank, and subcontracted workers—are paid no less than the UK *Real Living Wage (RLW)* as independently calculated and published annually by the Living Wage Foundation. This requirement must be met from the commencement of the contract and maintained throughout its duration. The Provider is responsible for:

15.6. Applying annual RLW uplifts in a timely manner.

15.7. Ensuring that any subcontracted organisations used in service delivery also meet RLW requirements.

15.8. Providing evidence of compliance through payroll records as part of quarterly contract monitoring.

15.9. This requirement aligns with the Council's commitment to fair employment, social value, and high-quality service delivery.

16. Recovery of Sums Due

16.1. If the provider owes RBC under this or any other agreement, RBC may deduct the amount from future payments.

16.2. Any overpayment can be recovered by the paying Party.

16.3. The provider must pay RBC in full, without deductions unless required by court order.

16.4. Payments must be made promptly, in cleared funds, to an account designated by the recipient Party.

Performance Metrics (Appendix 1 – Key Performance Indicators)

Performance Metric	Target		Method of Recording	Responsible organisation	Method of reporting
Referrals					
Review and accept/reject referral within 24 hours	The number of referrals accepted/ rejected within 24 hours will not be more than one in every 20 referrals.		Data – Record date and time of referral and date and time of acceptance/rejection	The Provider	Weekly
Number of referrals from hospital	Total number of referrals accepted and rejected		Data – Record date and time of referral and date and time of acceptance/rejection	The Provider	Weekly
Number of referrals from the ASC	Total number of referrals accepted and rejected		Data – Record date and time of referral and date and time of acceptance/rejection	The Provider	Weekly
Number of referrals from the community	Total number of referrals accepted and rejected		Data – Record date and time of referral and date and time of acceptance/rejection	The Provider	Weekly
Number of customers being readmitted to hospital	Total number of readmissions to hospital within 30 / 60 days	This is to be explored with partners to how this data can be tracked			Quarterly
Admissions to take place within 24 hours of initial referral	90%		Tracker		
Exiting Scheme:					
Discharge to a suitable place of residence within 6 weeks unless an extension is agreed with RBC	90% of those placed		Data collection	The Provider	Quarterly
Customers entering education, employment, training and voluntary work	10%		Data collection	The Provider	Quarterly
Void turnaround from keys in	24 hours			The Provider	Quarterly Monitoring
Safeguarding					

A summary report of all safeguarding alerts, including outcomes, is to be reported to the Contract Manager on a quarterly basis. For high level safeguarding alerts, these will be reported to the Contract Manager as soon as possible after the event.	100%		The Provider	Quarterly Monitoring
Satisfaction				
Number of complaints received			The Provider	Quarterly Monitoring
Number of compliments received			The Provider	Quarterly Monitoring
Completed exit surveys	95%		The Provider	Quarterly Monitoring
Overall satisfaction with placement	90%		The Provider	Quarterly Monitoring