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Appendix B

Bath and North East Somerset Community Services

Outline Service Specification Framework

February 2016

1. A New Commissioning Framework

NHS Bath and North East Somerset CCG and Bath & North East Somerset Council are changing the way in which Community Services will be delivered to ensure we are well placed to contribute to the ongoing health and wellbeing of our local population.

Our vision for integrated care and support requires providers of services to be much more closely focused on the contribution of effective care planning and care delivery for individuals, particularly those most vulnerable people who require ongoing and dedicated support.

Evidence suggests that level of integration required is best provided when services come together at a locality level. This means there will be a key and fundamental relationship between the Community Services Provider(s), Primary Care and Secondary Care. The Commissioner working with its Prime Provider and as a strategic partner will work together at that level and will direct the inputs of commissioned services to ensure they are tailored to meet the needs of that community. Whilst we appreciate that community needs can be common, we also know that in other ways there are significant differences between different areas of Bath and North East Somerset and these will have to be understood and catered for.

The ability to effectively control and coordinate care contributions will be a key measure for all providers within the new model of care and support, as well as ensuring that people are enabled to develop support plans that are co-ordinated and based around their individual needs, wishes and preferences

We are developing this new way of working with our key stakeholders and expect commissioned suppliers to be able to integrate their services and solutions and add further innovation to our thinking via a whole team delivery model based around localities.

2. The Services

It is expected that services will be organised around four service specifications as outlined in Appendix 1. The Prime Provider will be accountable for delivering the outcomes across all four specifications but may sub-contract specific roles and services as outlined above.

Specification 1: **Prime Provider:**
Connecting, Collaborating, Creating Health and Wellbeing for All
Connecting services and integrating person-centred care and support that is co-ordinated around an individual's needs, wishes and preferences.

Specification 2a: **Living Well and Staying Well**
These are prevention and self-management services that are open to all. They promote healthy and active lifestyles and help people stay well and independent, thereby reducing health inequalities

Specification 2b: **Regaining Health and Independence**
Early intervention and targeted support services aimed at keeping people well, connected to their communities, families and friends, enabling people to regain their health and independence following a period of illness. This includes preventative, targeted activity to halt the development of a condition or a reduction in independence

Specification 2c: **Enhanced and Specialist Support**
These enhanced and specialist services will meet a person's needs where a specialism is required or where multiple agencies need to work together to meet a person's long term conditions or complex health and care needs.

Key attributes of these specifications are explained in more detail in Section 3.1 below.

2.1 Specifying Services

Specification 1: Overarching Commissioning Specification
Connecting, collaborating, creating health and wellbeing for all

The commissioned service(s) will deliver a sustainable, preventive, planned and urgent health and care system in the local community that has a clear focus on health and care improvement, parity of esteem between mental and physical health and reducing inequalities for children, young people and adults.

In order to achieve this, the delivery of community health and care services will be led by a 'Prime Provider' (which may be a single provider or a consortium) that has overall responsibility for the management and delivery of all services within the contract scope under a commissioning contract with the Commissioner.

The Prime Provider is expected to act as an integrator of services and service delivery and to incentivise and facilitate collaboration amongst providers to jointly deliver services.

The Prime Provider will remain accountable to the Commissioner for the delivery of the entire service and for the coordination of its 'supply chain' (i.e. its sub-contractors) in order to ensure that it can and does deliver the entire service.

The Prime Provider will lead a process of transformation by building provider capacity and the delivery model to meet the terms of the contract and to design care pathways that will most effectively meet the needs of our population.

The Prime Provider is likely to be a provider of services itself but it will be expected to sub-contract elements of the service excluding the coordination role. It is recognised that the size and nature of the sub-contracts may vary in line with the term of the contract.

The Commissioner will work with the Prime Provider to determine the proportion, within a range, of the overall contractual value that continues to be provided by third sector and small and medium-sized enterprises (SMEs).

Core functions of the Prime Provider

In order to fulfil the requirements of the role, the Prime Provider will need to have project management capability, technical competence, financial standing and supply chain arrangements and will be required to:

- Ensure that care and support is integrated and person-centred. People will have access to a single assessment and support plan that is coordinated and based around their individual needs, wishes and preferences. Services and people work together to agree goals, identify support needs and develop and implement action plans to ensure there is an engaged and empowered person at the centre.

- Design and deliver services as close to a person's home as possible. Community services will be locality-based and will be responsible for monitoring outcomes for the local population and for coordinating input and activity to meet the identified health and care needs of its community whilst ensuring appropriate governance, quality assurance and continuous engagement with patients and service users.

- Work collaboratively across health and care systems (i.e. primary care, secondary care) to deliver an integrated and sustainable urgent care system reducing demand on primary care and hospital services and reducing hospital admissions.

- Guide people through the system by creating a care navigation service, including access to Care Navigators for people with the most complex needs, which will act as a bridge between individuals with care and support needs and providers who have the skills and resources to meet those needs.

- Implement an integrated IT solution that enables individuals and the people involved in their care and support (be they professionals, friends or family) to work effectively together. Clinical and administrative systems need to facilitate sharing of appropriate data and make best use of modern technologies.

- To make progress, effective clinical engagement must be central to all areas. Commissioners, providers, practitioners and people with health and care needs will work together in local networks to organise the whole care pathway – from diagnosis to long term management of complex health and care needs.

- Operate a contractor governance arrangement with the other providers, including managing performance issues centrally. Clinical governance for the whole pathway will help to align the ambitions of different practitioners, commissioners and people with health and care needs as people have responsibility for a single goal. It provides a way to make continuous improvement.

- Monitor the overall level of spend under the contract. Reducing costs is not a direct driver of this transformation. However, the Prime Provider will be expected to manage and improve services within the available budget. Any efficiency savings derived from improved care pathways will be used to accommodate the anticipated increase in demand for local services. If appropriate, the Prime Provider will recover a management fee from the other providers for its management costs.

- Agree any variations centrally and flow down to the sub-contractors.

- Ensure that the combined workforce of all providers is sufficient, skilled, well-led and supported with the capability and capacity to focus on prevention, early intervention and empower individuals to self-manage where possible.

- Reward excellence and innovation, encouraging a culture of continuous quality improvement, whilst delivering better outcomes for people in ways which deliver best value for money.

Key Provider Objectives;

To achieve the aims set out above the Prime Provider must ensure that:

- Care and support will be delivered in people's homes or in nearby local settings that enable them to remain independent as possible, for as long as possible, and to remain connected with their communities.

- Care and support will be accessible, equitable, integrated, sustainable and flexible for people of all ages.

- Care and support will connect and integrate across acute, primary care, mental health and community service boundaries.

- Providers work in formal partnerships and with local communities to deliver services through a range of resources whilst maximising the potential of voluntary, community and social enterprise partners through an asset-based approach.

- Services are good value for money with as much resource as possible dedicated to front line services.

- Providers have shared objectives and responsibility to ensure the integrated and seamless provision of services.

- Avoidable admissions to hospital are prevented through alternative community based options and people are supported to be discharged from hospital with appropriate and sustainable support in community settings.

- Services harness the potential of new technology to lead innovation in service delivery and the sharing of information between providers.

- There is an organisational culture that supports all staff to learn, improve and feel empowered, and to focus on prevention, early intervention and self-management for individuals.

- All staff are focussed on prevention, early intervention and empowering individuals to be more independent and connected with their communities.

- Services reward excellence and innovation, encouraging a culture of continuous quality improvement.

Statutory Services;

There are a number of mandatory statutory services where the Commissioner wishes to retain a direct line of responsibility and accountability for the delivery of these services with a direct means of intervention with the provider. These services are statutory functions of the CCG and/or the Local Authority and have been delegated to the Prime Provider to fulfil on their behalf:

- Statutory duties under Section 9 of the Care Act 2014;
- Safeguarding functions
- Emergency Duty Team
- Children and Families Act 2014 including the Role of the Designated Medical/Clinical Officer (DM/CO) under Special Educational Needs and Disability (SEND) legislation;
- Assessment for Continuing Health Care Eligibility
- Mental Capacity Act 2005 (MCA) requirements including the role of the Approved Mental Health Professional (AMHP)

Core Services;

In addition to the Statutory services listed above, both the Council and the CCG have statutory duties to protect against provider failure and to ensure business continuity. Therefore certain services will be deemed as essential, or core, services because:

a) appropriate alternative providers of those services do not currently exist: or
b) removing them would increase health inequalities; or
c) removing them would make dependent or related services unviable.

The Commissioner reserves the right to oblige the Prime Provider to continue to directly provide and not to make material changes to the way in which these services are provided without the agreement of commissioners. Details of these services will be provided at within the Invitation to Negotiate.

Specification 2a: Prevention and Self-Management
Living well and staying well

Universal prevention comprises activities designed to help people to live healthy and fulfilled lives, maintain good physical and mental wellbeing and avoid illness or injury.

This includes building strong foundations for health via the provision of good housing, employment, education and training, providing healthy environments for people to live and work in and protecting people from harmful hazards and communicable diseases.

It also includes providing universal access to preventative services and good quality information and advice about healthy lifestyles and wellbeing opportunities. The community is seen as a bank of resources to support health and wellbeing.

Self-management is a part of prevention. It is the action we take to look after ourselves so we can live well and reduce our likelihood of being ill. Self-management includes daily actions such as brushing our teeth, eating healthily, exercising and nurturing our relationships with other people.

People can also take care of themselves when they have common symptoms such as sore throats, coughs and minor ailments by using over-the-counter medicines for example.

Schedule of services

Services included within this domain include but are not limited to:

- sexual health prevention
- health visiting
- school nursing
- community transport
- carers support and centres
- children's centres
- lifestyle education and campaigns
- information and advice services
- advocacy services
- discharge support
- day services

Specification 2b: Early Intervention and Targeted Support
Regaining health and independence

Early intervention aims to keep people well, connected to their communities, families and friends, and to enable people to regain their health and independence following a period of illness. It includes preventive, targeted activity which will halt the development of a condition or a reduction in independence.

The pathway will give people quick and easy access to information and advice, targeted interventions which will recognise and build on a person's strengths, and tailored support to regain or retain skills and independence where needed. People will be supported in this way when they first become unwell, display symptoms or their current level of independence is at risk. They will be helped to understand and address the situation or circumstance before it becomes entrenched, working alongside the person, family or support networks involved to build on their strengths and keep them in control.

The risk of becoming ill or injured is not the same for everyone and is strongly influenced by a person's social circumstances therefore targeted prevention includes activities aimed at identifying and intervening early with people at highest risk of becoming ill or injured.

Interventions will support people to assess their health risks and behaviours such as smoking, being overweight, drinking too much, being inactive or being socially isolated and motivate them to make changes to avoid conditions developing and to maintain positive wellbeing.

People with the poorest health outcomes and people who lack capacity will have additional support to make positive health choices. The overall aim is that individuals with early indications of needs or long-term conditions are enabled to understand and self-manage their health and care needs, maximise their independence and reduce the need for specialist or long term support in the future.

Schedule of services

Services included within this domain include but are not limited to:

- mental health early intervention
- mental health recovery teams
- community nursing
- specialist foot care
- speech and language therapy
- reablement / intermediate care services
- social prescribing and community based opportunities
- learning disabilities services
- community hospital and unplanned care
- employment support
- targeted family support
- community paediatrics
- child and adolescent mental health services
- specialist equipment services
- adult social work
- independent living services
- homelessness and housing support
- occupational therapy
- targeted youth supported
- domiciliary care
- lifestyle support services
- volunteer progression (training and support)

Specification 2c: Enhanced and Specialist Support

Helping you to live well with complex or long term conditions

Enhanced and specialist services are those areas of care and support where a specialism is required or where multiple professionals or services need to work together to meet a person's long term condition(s) or complex heath and care needs.

Services will enable people with the most complex and multiple needs, including those living with one or more long term conditions, to drive their own recovery journey, build on their strengths and pursue their hopes and aspirations. By maximising the choice and control people have over the ways they engage with the support and opportunities they want, they will make sustained positive changes in their lives.

People will be supported to co-develop personalised , holistic and integrated care and support plans that maximise their potential and enable them to self-manage their condition, with specialist support and advice appropriate to their level of need. They will likely be supported by a case coordinator who will be the point of contact for their integrated care and support plan. People will be supported to step down to targeted or community resources as appropriate to self-manage their conditions but will always have a plan to step up the level of support, as necessary and when required.

Schedule of services

Services included within this domain include but are not limited to:

- mental health specialist care and support
- mental health community services and activities
- substance misuse services
- end of life services
- continuing health care
- speech and language therapy services
- musculoskeletal services
- continence services
- specialist cardiac and respiratory services
- sexual health intervention
- specialist neurological services
- specialist diabetes services
- specialist child health services
- specialist childcare and educational needs
- hearing and vision services
- other specialist clinical and therapy services

4. Outcomes Framework

This section outlines the overarching high-level outcomes and indicators that will form the basis of all four service specifications covering;

- Specification 1: Prime Provider
- Specification 2a: Living Well and Staying Well
- Specification 2b: Regaining Health and Independence
- Specification 2c: Enhanced and Specialist Support

We expect to further develop outcomes during the procurement and align outcomes to specific areas of service delivery.

Summary

Recent legislation and policy guidance including the Care Act 2014, the Children and Families Act 2014 and the NHS Five Year Forward View all promote the concept of 'wellbeing' and the duty to focus on delaying and preventing care and support needs whilst supporting people to live as independently as possible for as long as possible

In order to ensure that the principle of promoting wellbeing is embedded within community health and care, and to meet the legislative requirements of the NHS and Local Authority, this commissioning framework is based on a new model of outcomes-based commissioning. This will deliver improved person-centred and integrated care and support that will adopt a locality-based approach with services 'wrapped around' users of community health and care. In addition, the model will aim to address the financial and demographic challenges facing the health and care economy.

As previously stated, we want to facilitate people and communities to come together to achieve positive change using their own knowledge, skills and lived experience of the issues they encounter in their own lives. We recognise that positive health and social outcomes will not be achieved by maintaining a 'doing to' culture and believe that meaningful change will only occur when people and communities have the opportunities and infrastructure to control and manage their own futures. We will value the capacity, skills, knowledge, connections and potential in a local community and see people and communities as active co-producers of health and wellbeing rather than passive recipients of care.

a. National Outcomes

There is a requirement that all services contribute to the delivery of the mandated national outcomes described in the Public Health, NHS and Adult Social Care outcomes frameworks. Providers must also be cognisant of the priorities set out by the B&NES Health and Wellbeing Board.

b. Local Population Outcomes

In this section, the term “people” includes adults of working age, older people, children and young people in Bath and North East Somerset as appropriate. For all outcomes, consideration of carers should be apparent.

Outcomes	Contributing to Health & Wellbeing Board Strategy		
	Health	Equality	Quality
People will experience no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion, belief or socio-economic status		●	
People are able to live free from social isolation and loneliness and feel welcomed and included in their local community and are able to make valuable contributions			●
People have a network of considerate and competent people who support them, including carers, family, friends, neighbours, volunteers as well as health and care staff.			●
People have clear motivation, confidence and knowledge to help themselves to stay physically and mentally healthy and remain as independent as possible.	●	●	●
People with care and support needs and/or those supporting them are aware and understand how technology can help them in their day to day lives. People are able to act on this knowledge and understanding to use technology to benefit their day to day lives.	●	●	●
People feel in control of the decisions they are asked to make, either for themselves or on behalf of their family or support network. This includes all age end of life care.			●
People are enabled to set achievable goals e.g. returning to work, being part of their community, regaining strength or skills that enhance their physical or mental health			●

	Contributing to Health & Wellbeing Board Strategy		
Outcomes	**Health**	**Equality**	**Quality**
All people, especially children, young people and vulnerable people are safe and secure		●	●
People are supported to become more resilient to manage risks to their health and wellbeing and know how to stay healthy and remain as independent as possible.	●	●	●
People have opportunities to train, study, work or engage in other community activities that match their interests, skills and abilities, and which support their needs, and they feel valued for the contribution that they make to the community.		●	●
People can access support that promotes and sustains recovery and rehabilitation.	●		
Parents and children form strong positive attachments and parents are confident and able to meet the needs of their children	●	●	●

c. System Outcomes

In this section, the term “people” includes adults of working age, older people, children and young people in Bath and North East Somerset as appropriate. For all outcomes, consideration of carers should be apparent.

Outcomes
People are supported to co-develop a single and personalised care and support plan that maximises their potential and enables them to self-manage their condition where possible.
People's only have to tell their story once and they know who to contact to get things changed.
People are supported by excellent case management and professionals that work effectively together across organisation and professional boundaries
People receive the right response at the right time from someone they trust and experience co-ordinated support that is based on a person centred approach that looks at all aspects of a person's physical and mental health and wellbeing
People continue to receive an appropriate and consistent level of support as their regain health and independence following a period of illness or change of circumstance, relevant to their level of need at the time, with no sudden or unplanned withdrawal of services
People are more aware of the services available to them and how to use them including services to support wider determinants such as housing, transport, education and training.
People have support systems in place to get help at times of crisis that they understand and have agreed to. People are able to recognise and plan for any future crises. When required people have a crisis plan in place and have access to crisis management, which responds flexibly to the individuals, needs as required.

Appendix A: Specification Architecture