NHS Standard Contract 2017/18 Particulars

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Community Services
Commissioner Lead	To be agreed
Provider Lead	To be agreed
Period	1st April 2017 to 31st March 2024
Date of Review	1st April 2018

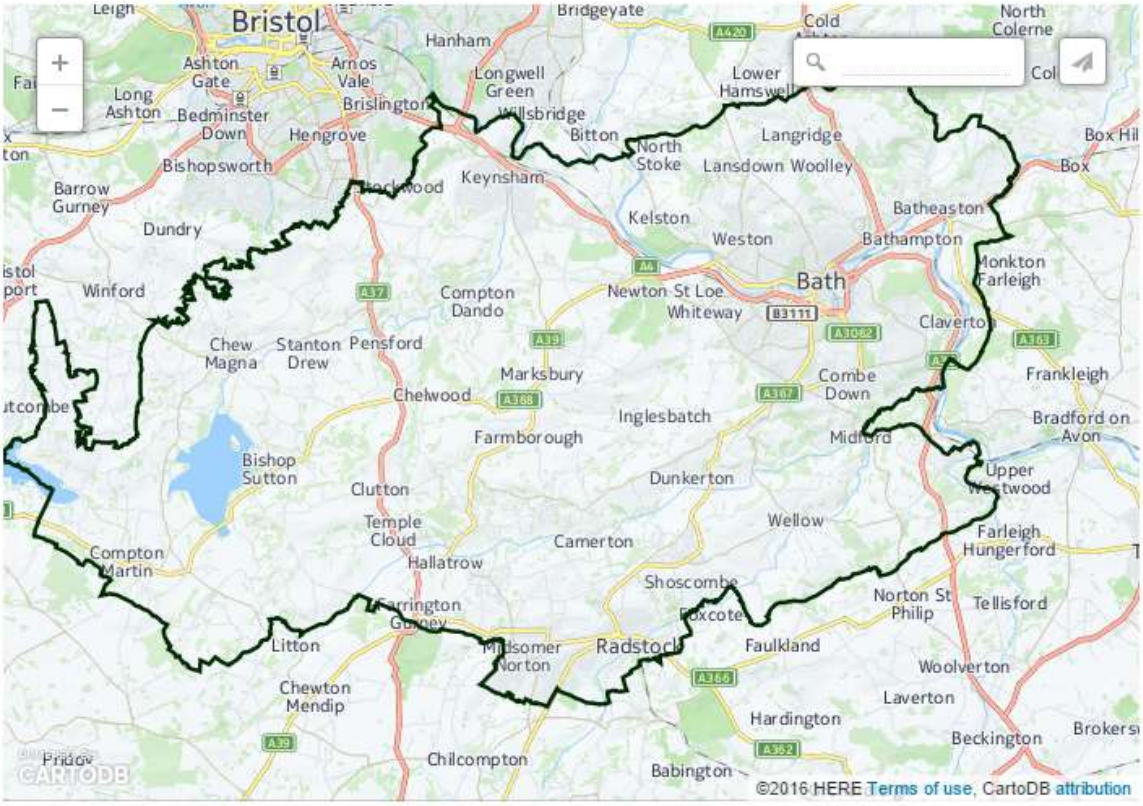
1. Population Needs

1.1 National/local context and evidence base

- NHS Bath and North East Somerset Clinical Commissioning Group (BaNES CCG) and Bath & North East Somerset Council (Local Authority) are the organisations responsible for making sure that the people of Bath and North East Somerset have the health and care services they need.

- The CCG covers the Bath and North East Somerset area, using the same boundaries as the Local Authority. The only difference in the boundaries is that the CCG's definition is for those people registered with GP surgeries who are within the Bath and North East Somerset boundary, rather than where their home is.

The GP registered population in Bath and North East Somerset as at March 2014 was 199,660

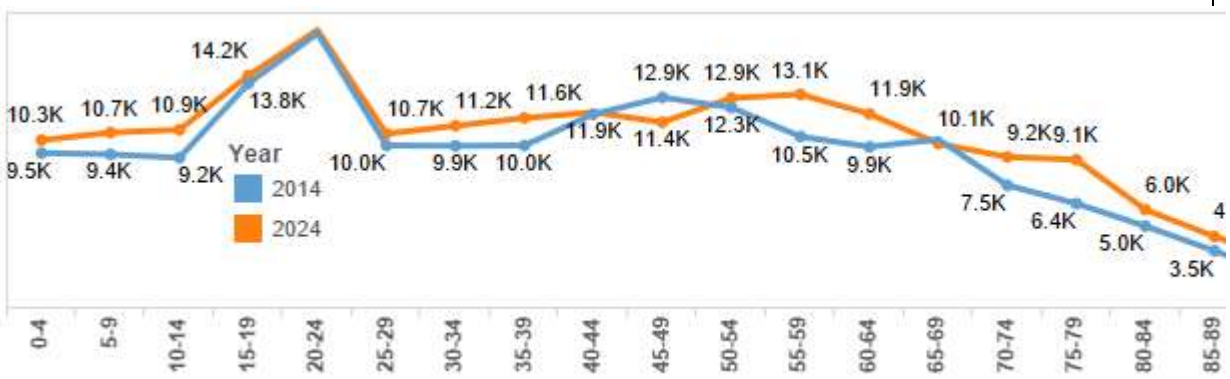


The Needs of Our Population

- Our population is growing and ageing – taking expected housing growth into account, the overall population is expected to increase to nearly 200,000 by 2024, an increase of 11% from 2014. The number of people aged over 75 is expected to increase by 33.4% by 2024
- A consequence of this change is that demand for health and social care is going to increase.
- There are increasing numbers of patients with co-morbidities, 30% of people with a long term physical health condition will also have a mental health condition and in comparison; 46% of people with a mental health condition will also have a long term physical health condition.
- Drug abuse and alcohol are already significant challenges
- There will also be a big increase in numbers of children and young people, with 5-14 year olds growing by 16.4% by 2024
- We know we have a substantial number of children with complex needs. As life expectancy for people with certain conditions and diagnoses increase in the early years setting, we expect these numbers to rise over time.
- There are 17,585 unpaid carers in Bath and North East Somerset and this figure is growing. Life expectancy is 80.9 for men and 84.5 for women, higher than national and regional levels. We experience a gap in life expectancy between our richest and poorest areas. For women this is 5.3 years and for men this is 8.2 years and has been increasing over time.

- Despite its relative affluence, Bath and North East Somerset is geographically diverse which means the area experiences challenges regarding access to services in remote rural areas as well as pockets of intergenerational poverty.

Comparative population change by age-range 2014-24



Further information sources that inform the local context and outcomes include;

- Bath and North East Somerset Joint Strategic Needs Assessment
- CCG Outcomes Indicator set which shows areas where we are performing well, and not so well.
- Dwelling-led population estimates accounting for expected housing growth defined in the core Council strategy and to a small geographical level.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	**Y**
Domain 2	Enhancing quality of life for people with long-term conditions	**Y**
Domain 3	Helping people to recover from episodes of ill-health or following injury	**Y**
Domain 4	Ensuring people have a positive experience of care	**Y**
Domain 5	Treating and caring for people in safe environments and protecting them from avoidable harm	**Y**

2.2 Local defined outcomes

- 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.

- Community services will 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.

2.3 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	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			●
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	●	●	●

2.4 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 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.

3. Scope

3.1 Aims and objectives of service

Vision:

- Bath and North East Somerset will be a connected area ready to create an extraordinary legacy for future generations - a place with a strong social purpose and a spirit of wellbeing, where everyone is invited to think big.
- We will have health and care services in the community that empower children, young people and adults to live happier and healthier lives.
- Our services will provide timely intervention and support to stem ill health, prevent social isolation and tackle inequalities. By placing people at the heart of services, they will receive the right support at the right time to meet their needs and conditions.
- Dedicated to supporting greater levels of prevention and to help people self-manage their conditions, community services will ensure that clear routes to good health and wellbeing are available.
- Supporting people to access services when they are needed in as seamless a way as possible; navigators will assist individuals to access pathways of care and support. Services will be easy to access and will connect and integrate across acute, primary care, mental health and community service boundaries.
- Services will 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.

Objectives:

To achieve this Vision 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.

3.2 Service description/care pathway

An integrated service will support and safeguard people to maximise their independence through timely interventions that support people to manage, stabilise or decrease any emerging risks, care and support needs. This will include: effective contact assessment; verification of self-assessments, assisted assessments, direct provision of information & advice; effective signposting to a range of other advice, information & advocacy services; facilitation of access to a range of voluntary, community & housing-related support services; access to assistive technology (telecare, telehealth and community equipment).

The nine functions required to deliver comprehensive person centred care and support are:

1. **First Response**
   To provide an initial response for any patient/service user and health or social care professional. Includes call handling; information gathering; using information to determine next steps and appropriate onward referral to universal, third sector or Community Services.

2. **Prevention and Self Care**
   Empowering people with the confidence and information to look after themselves when they can, and visit the GP when they need to, gives people greater control of their own health and encourages healthy behaviours that help prevent ill health in the long-term. In many cases people can take care of their minor ailments, reducing the number of GP consultations and enabling GPs to focus on caring for higher risk patients, such as those with comorbidities, the very young and elderly, managing long-term conditions and providing new services.

3. **Rapid Response**

Responding to an emerging care need - to prevent an admission into hospital or nursing/residential care wherever safe or to address safeguarding concerns. The response will include a rapid, multidisciplinary assessment and intervention focusing on care provision and treatment in the community. Responding to either an urgent health need or a breakdown of care.

4. Facilitated & Supported Discharge

Supporting people to return home as soon as possible following a stay in hospital and arranging the services to facilitate this. Community services will in-reach into hospitals to proactively manage discharges in a timely way and ensure that the necessary services are in place to safely be at home, including children's community health services

5. Maximising Independence

Focussing on maintaining someone in their own home as independently as possible. The care is person centred and goal orientated, focused on rehabilitation/reablement and delivered by a combination of professional groups working together to common aims.

6. Scheduled Ongoing Care and Support

This function provides for those who require ongoing home-based care and support but whose needs do not require multi-disciplinary case management. The care will be task orientated and will include regular review. Care of this type is predominantly provided by the community/district nurses in conjunction with the patient's regular GP and by individual social services staff.

7. Complex Case Management

People with complex needs will experience care and support that is planned collaboratively across primary, secondary, community health and social care, and delivered in the appropriate setting, be it the persons own home, nursing or care homes, or healthcare establishments. Care will be coordinated and seamless and be led by an appropriately qualified case manager.

8. Specialist Input

Delivering care where specialist clinical skills are essential – such as that provided by specialist diabetic nurses for example. This function will also ensure links to specialist teams across services, ensuring a seamless, coordinated pathway between community services and these specialist teams.

9. End of Life Care

This function will ensure that end of life care is properly planned and co-ordinated, delivered to a high quality and that people of all ages are treated with respect and dignity at the end of their life. End of life care will be person centred and people's choices and wishes will be taken into account.

3.3 Care and Support Pathways

Services will be organised around four care and support pathways, further information in relation to services expected to be delivered within each area of provision is referenced in Annex A and B of the specification:

- **Core functions of the Prime Provider including delivery of statutory functions**
  Connecting services and integrating person-centred care and support that is co-ordinated around an individual's needs, wishes and preferences

- **Prevention and Self – Management - Living Well and Staying Well**
  Prevention and self-management services that are open to all, that promote healthy and active lifestyles and help people stay well and independent, thereby reducing health inequalities

- **Early Intervention and Targeted Support - 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.

- **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.

Each of these is described in more detail below:

3.3.1 Core Functions of the Prime Provider;

The commissioned service(s) will deliver a sustainable, preventative, 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).

- 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.

Corporate Governance:

- There is a requirement that at an executive/decision making level there is professional, qualified social work, nursing and medical leadership.

Statutory Services:

- There are a number of mandatory statutory services where the Commissioner wishes to retain 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:

Adult Services:

- Provision of delegated social care functions for adults who have care and support needs or support needs as outlined in the Care Act 2014 including those with the financial means to contribute to the cost of meeting those needs. This includes but is not limited to: advice and information on social care issues, the undertaking of statutory assessments for both service users, carers and those in transition, risk assessments, undertaking eligibility determination for carers and service users, ensuring people who require advocacy support are identified and referred, support planning for both carers and service users, reviews for both service users and carers, undertaking social care hospital discharge responsibilities, assessments for Disabled Facilities Grants, manual handling assessments in both community and residential settings, minor works and the provision of equipment/aids that support

independence.

- Ensuring that the requirements of the Mental Capacity Act (MCA) are met: including undertaking best interest assessments, preparing paperwork for Deputyship and Community Deprivation of Liberty (DOLS) Court of Protection (CoP) applications. Also provide qualified staff to undertake Best Interest Assessments and Mental Health Assessments as part of the daily DOLS/Best Interest Assessor (BIA) and Approved Mental Health Practitioner (AMHP) rota managed by the Council.

- The Provider will also be responsible for supporting the Council in undertaking its safeguarding duties by: administering, coordinating and undertaking section 42 enquiries, supporting service users, friends and families throughout the safeguarding process, ensuring appropriate records are kept of the safeguarding process, working with other agencies to support the individual and achieve the outcomes identified, undertake risk assessments and lead non-statutory enquiries as required by the Council.

- Ensure that professionally qualified social care staff meet the requirements /expectations outlined by their registration body and by the Chief Social Worker for Adults, this will include programme for ASYEs (Assessed and Supported Year in Employment) and social workforce strategy.

- In undertaking these key functions the Provider will also undertake tasks in relation to: financial assessment, ordinary residence considerations, protection of property and arrangement of funerals, debt management, deputyship responsibilities, complaints and the collection of data to enable the Council to meet its requirements around statutory and national reporting.

- The Provider will ensure with the Council a smooth handover of cases takes place with the Emergency Duty Team.

- Provision of staff with Approved Mental Health Practitioner (AMHP) qualifications to support the daily AMHP rota coordinated by the Council.

- Note to the Prime Provider: the mental health social workers will remain employees of the Council however it is expected that they will work within integrated teams.

Continuing Health Care:

The Prime Provider will also undertake a range of functions in relation to Continuing Health Care (CHC) including:

- Identify people who are eligible for Continuing Health Care (CHC) funding and Funded Nursing Care (FNC); using extended and professional knowledge work together with people and their support network to ensure appropriate care and support plans are in place.

- Act as key workers to people eligible for CHC and FNC.

- Ensuring that all Continuing HealthCare assessments and reviews are completed within the NHS National Framework for Continuing Health Care & NHS Funded Nursing Care (November 2012) standard timeframes. This will include that social

care practitioners work jointly with NHS staff throughout the NHS continuing healthcare eligibility process, and should be involved as part of the Multidisciplinary Team (MDT) wherever practicable in accordance with the National Framework. The MDT should comprise health and social care staff presently or recently involved in assessing, reviewing, treating or supporting the individual. Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the Framework makes it clear that the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs.

- Presentation of the MDT recommendation on eligibility to the CCG so that a decision can be made based on the recommendation.

- Ensure good transitions happen in timely manner for CHC funded children moving into adulthood.

Children's Services:

- The Safeguarding Children Service (Designated Doctor, Named Nurses and Specialist Safeguarding Nurses - LAC) will work in partnership with other agencies and the B&NES Safeguarding Children's Board (LSCB) to promote the welfare and safeguarding of all children. The service will provide direct interventions to promote and ensure the safeguarding responsibilities of the organisation are fulfilled. The Designated Doctor will be responsible for child death arrangements.

- The service is based on and underpinned by the legislation contained in the Children Act 1989 & 2004 and will be provided by the Designated Doctor, Named Nurses and Specialist Nurses.

- This service must link with and meet requirements set out by the Executive lead for Safeguarding, the Director of Nursing and Quality NHS BaNES CCG and the Designated Nurse Safeguarding Children NHS BaNES CCG.

- The team will work closely with wider Health Services including Paediatricians, General Practitioners, Midwives, Health Visitors, School Nurses, Minor Injuries units and the adult workforce. In addition, the team will work closely with Local Authority children's services, the police and other statutory agencies, educational establishments and voluntary organisations.

- Note: the Designated Doctor will be employed by the Prime Provider but report to NHS BaNES CCG. The Designated Doctor function is one of the key aspects of the Community Paediatric Service.

- The Prime Provider will also provide arrangements for a Medical Advisor in relation to adoption and fostering.

Core Services:

- In addition to the statutory functions outlined 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:

- appropriate alternative providers of those services do not currently exist; or
- removing them would increase health inequalities; or
- 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.

- In addition the Commissioner, in partnership with the Prime Provider, will identify 'Mandatory Material Subcontractors' that the Prime Provider will not be able to stop using except with the express permission of the Commissioner.

3.3.2 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.

3.3.3 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.

3.3.4 Enhanced and Specialist Support – Helping people 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 are 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.

3.4 Person Centred Services

- Service provision will focus on the whole person, focusing on their strengths, interests, abilities and networks, not just their diagnoses, illnesses and deficits. Support will be built around individual preferences and choices and helping people to help themselves.

- The provider must ensure that there is engagement with local communities and partners, including people who use services and their carers, in the co-design, development, commissioning, delivery and review of local support and ensuring that leaders at every level of every organisation work towards a genuine shift in attitudes

and culture.

- The provider will implement a delivery model that offers people a single assessment and support plan that is coordinated and based around their individual needs, wishes and preferences. The planning and delivery of services will bring together everyone involved in supporting an individual to manage their care. Providers will deliver services through multi-disciplinary teams coordinated at local level that put people at the centre of their support and treatment plans.

- In particular, people with the most complex needs will benefit from many people coming together around a single support plan that is individually designed and can flex around the needs of the individual rather than the person having to 'fit in' with service requirements. There will be greater thought given to the social, psychological and economic impacts of managing complex needs both for the person and their family.

- The delivery model will use available and emerging technology to ensure that people have a single record that is transferrable and offer real-time access to staff so that a person does not have to keep repeating their story to different professionals.

3.5 Locality Based Provision

- The Prime Provider will be responsible for developing a locality-based model or 'Hub' that will harness the strengths and assets of local communities whilst ensuring that people can continue to access the specialist support they need when required. In response, and to support a new model of outcomes-based commissioning delivering improved person-centred and integrated care and support, the Prime Provider will 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. There will be recognition that positive health and social outcomes will not be achieved by maintaining a 'doing to' culture but that meaningful change will only occur when people and communities have the opportunities and infrastructure to control and manage their own futures. In community development terms, asset-based approaches value the capacity, skills, knowledge, connections and potential in a local community, and see people and communities as active co-producers of health and well-being, rather than passive recipients of care.

- Services will be configured around groups of GP practices serving a population of 30,000 to 50,000 people, and focused on delivering health and care outcomes.

- Each Hub will be supported by the commissioner to undertake community mapping to identify the health and care needs of the local population and harness the strengths of the community to identify the most effective local response, and will co-ordinate the services delivered by providers from different sectors e.g. social care, secondary care and voluntary, community and social enterprise (VCSE) organisations.

3.6 Interdependence with other services/providers

System wide Strategies and Protocols

- The service will engage with the development and implementation of multi-agency strategies for children, young people and adults where input from community health services is required.

Service Accessibility and Responsiveness

- Services may be offered through a variety of settings and may be through one-to-one or group sessions and using innovative methods to reach particular vulnerable groups.
- A wide range of effective prevention information will be available to include self-help and signposting.
- The Provider will use a strengths based approach.
- The Provider will provide proactive outreach to those communities that may face barriers in accessing services, including homeless families, traveller families and asylum seekers.
- Staff will be responsible for ensuring that families who do not have English as their first language have access to interpreting and translation services as required.
- Staff will responsible for ensuring that people who require information in different formats such as British Sign Language, braille, large font, easy read or Makaton are able to access these.
- The Provider will play an active part in providing integrated services to support troubled, struggling and vulnerable families; recognising that services may need to be configured differently to reach this small group of service users.
- There will be a clearly identified route for people who have previously used services to re-establish contact with the relevant service area.
- The Provider will attend meetings as required by the Commissioner.
- The Provider will ensure that it has one named representative on relevant strategy and planning groups relating to health and care promotion priorities and will attend the meetings. The Provider will implement agreed changes to service delivery in line with these strategies.

3.7 Navigation

- The Provider will create a system of care navigation 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.

- Care navigation will not replace a clinical role or act as a gatekeeper to services. It may be jointly delivered through a range of providers coming together to maximise particular areas of expertise, knowledge and resource to ensure the best outcomes for individual people using services. The Provider will explore the opportunity to harness and strengthen the role of volunteers in assisting people to access the support they need under the umbrella of navigation.

- The system will include access to a trained "care navigator" for people with the most entrenched multiple and complex needs, and for those people who don't engage in services, revolve in and out of services or are excluded from services.

- The care navigator will be the 'go to' person for people needing additional support to understand and work their way through what can be a very complex system. The care navigator will also act as a point of contact for professionals seeking to ensure that their services are effective and don't exclude 'seldom heard' groups.

- Care navigators will be co-located both within services and in the community and will develop a deep understanding of both. Co-location alongside professionals, as well as within community settings, will make it easier to link in with other relevant services such as housing, leisure and employment support too.

- Care navigators will be able to effectively link people and experts together whilst developing trust and good communication. Most importantly, care navigators will ensure that a person is supported to be in control of their care and support and can access services and support that help them to live the life they want and remain an active, contributing member of their community.

3.8 Information Management and Technology

3.8.1 Context

- The delivery of health and care services that are integrated around the individual requires a corresponding integration of IMT Systems and processes. The model of care outlined in Section 3.2 and 3.3 above will be one that must be supported by a Provider IMT strategy aligned with the ambitions set out in the NHS Five Year Forward View, underpinned by the National Information Board in 'Personalised Health and Care 2020', the Care Act 2014, Special Educational Needs and Disability (SEND) Reforms 2014; proposals must also support and be CP-IS compliant. The IMT strategy will recognise the need for relevant information to be available in real-time to professionals, patients and care-givers to support individual centric care in a paper-free environment.

- Clinical and administrative systems need to facilitate the sharing of appropriate data, not inhibit it, and make best use of modern technologies to provide an efficient and effective experience. Systems will facilitate the reuse of data captured for the purposes of giving care for analysis, at a macro and micro level, of activity undertaken and the outcomes achieved.

- All health and social care records will be kept digitally with the NHS number as the unique identifier and have the ability to communicate (only) relevant information automatically with other parts of the health and social care system, across organisational boundaries, whilst respecting individual consent. This includes information processed in all health and care settings, remotely, in the field and in the person's home.

- Technology and data will be a critical enabler for the successful delivery of community health and care in Bath and North East Somerset. As such the focus of IMT must be on supporting and enhancing care, including the intelligent use of data to proactively manage resources and demonstrate service delivery. Providers will provide appropriate solutions to underpin and support all the specified services that make best use of IMT, and are backed up by appropriate policies and procedures.

- All elements of the IMT specification should be delivered and managed within the designated financial envelope for the service. This specification defines the IMT that should be provided, but recognises that not all elements may be available or in place from day one. Where elements are to be provided later, this should be described in the service development and improvement plan and include:

    - Clear milestones for deliverables in the Providers IMT Strategy for this contract must be front loaded so that the benefits of integrated data are delivered early to support better care.

    - A detailed cost and expenditure schedule against a timeline contained within the envelope and resources for the delivery of each element should be specified so that the Commissioner can review contracted deliverables against the plan.

    - Payment milestones may be linked to some of these deliverables; tenderers must therefore ensure that plans and schedules are realistic as it may affect how they are paid.

    - A risk and impact assessment of the gaps in the IMT specification ahead of delivery

3.8.2 General Responsibilities for IM&T

- The Provider must have a Senior Responsible Owner for all IMT matters in it's and any associated Provider organisations that fall within the auspices of this contract. This person will need to be suitably senior and have the authority to manage and co-ordinate any IMT issues affecting delivery of 'the Services' the Provider is responsible for.

- The Provider is absolutely responsible for ensuring that in delivering any aspect of this contract whether directly or indirectly through a third party that:

    - All data is held and processed securely, is adequately protected / encrypted when at rest and in transmission, whether electronically or in paper format.

    - Cyber security measures such as meeting best practices to keep networks secure e.g. up to date AV, patching, PEN tests, 2FA remote access, monitoring/alerting are in place for the Prime Provider and any third party it subcontracts to where sensitive information is being processed or managed.

    - At least annual Penetration (PEN) Testing will be carried out by the Provider, their subcontractors and partners. PEN testing will be undertaken by a CESG approved organisation and a report on issues found, remedial actions and a remediation plan shared with the Commissioners to provide assurance. The report must be provided within six weeks of the PEN test taking place.

    - All electronic data is backed up at least daily and that back-ups are retained for 12 months in the event of a requirement to do a data restore.

    - Staff are appropriately security checked and trained in the secure processing, handling and management of data.

- There are appropriate access and leaver policy and controls in place.
- All data handling complies with all legislation, guidance and relevant standards relating to how this should be achieved.

- For access to Liquidlogic and any other Council application:
  - A Remote Access Agreement setting out responsibilities will need to be agreed between the Provider and the Council for access to Liquidlogic.
  - This agreement will need to form part of any subcontract or partnering arrangements where Liquidlogic access will be required or facilitated.
  - Access to the Liquidlogic application will only be from a Managed Device as defined by and in line with guidance on managed devices by The UK government's National Technical Authority for Information Assurance (CESG).
- Patient / client data will not be held in the Cloud unless explicit permission has been sought from the CCG and Council and assurances given on the security and integrity of any proposed solution.
- The Provider has a responsibility to put in place systems and processes that ensure data is clean, timely and accurate at the point of entry, that there is no duplicate entry of data and that there are no unreasonable barriers to safe, secure and clean data processing.
- Cyber security must be adequately taken account of and the provider is responsible for assuring and ensuring that CESG guidance such as 10 steps to cyber security is applied (or an alternative suitable standard).
- Where any breaches in in cyber security occur, the Commissioner must be notified at the earliest opportunity by phone and the incident followed up in writing.
- The Provider shall comply at all times with Data Protection Legislation and shall not perform its obligations under any Agreement in such a way as to cause the Commissioner to breach any of its applicable obligations under the Data Protection Legislation.
- The Provider acknowledges that, in the event that it breaches (or attempts or threatens to breach) its obligations relating to Personal Data that the Commissioner may be irreparably harmed (including harm to its reputation). In such circumstances, the Commissioner may proceed directly to court and seek injunctive or other equitable relief to remedy or prevent any further breach (or attempted or threatened breach).
- The Provider shall, at all times during and after the Agreement Period, indemnify the Commissioner and keep the Commissioner indemnified against all losses, damages, costs or expenses and other liabilities (including legal fees) incurred by, awarded against or agreed to be paid by the Commissioner arising from any breach of the Provider's obligations except and to the extent that such liabilities have resulted directly from the Commissioner's instructions.

- The Provider is responsible for treating all patient / service user data as the valuable and precious commodity that it is.

3.8.3 Electronic Care Records System for Health and Social Care (ECR)

- Social Care records will be maintained on the Local Authority electronic care record system, currently provided by Liquidlogic which is managed by the Council on it's own infrastructure. This is a new application designed to deliver an all age solutionc solution that supports effective case management of social care interactions and is Care Act compliant, supporting effective case management of all social care interactions and all the financial functionality required to underpin this.
- No other solutions for maintaining the social care record will be considered.
- The Commissioner is the Data Controller and the Provider is the Data Processor.
- The Provider shall comply at all times with the Data Protection Legislation and shall not perform its obligations under any Agreement in such a way as to cause the Commissioner to breach any of its applicable obligations under the Data Protection Legislation.
- The Provider acknowledges that, in the event that it breaches (or attempts or threatens to breach) its obligations relating to Personal Data that the Commissioner may be irreparably harmed (including harm to its reputation). In such circumstances, the Commissioner may proceed directly to court and seek injunctive or other equitable relief to remedy or prevent any further breach (or attempted or threatened breach).
- The Provider shall, at all times during and after the Agreement Period, indemnify the Commissioner and keep the Commissioner indemnified against all losses, damages, costs or expenses and other liabilities (including legal fees) incurred by, awarded against or agreed to be paid by the Commissioner arising from any breach of the Provider's obligations except and to the extent that such liabilities have resulted directly from the Commissioner's instructions.
- At the time of writing, the LA plans are to extend the use of the Liquidlogic case management system for both Children's and Adults to include the use of portal technology to improve efficiencies and end user service delivery and experience. As an example both Domiciliary care and Residential/Nursing care providers will be expected to use the "provider portal" to complete all transactions and financial processes with the Local Authority. This information would automatically then be processed through to the Councils FMS (Financial Management System). The use of Mobile Apps on both iOS and android will also be introduced allowing for remote inputting of Financial Assessments, and the ability to interact in real time with the Core Case Management system.
- The potential to develop and introduce other portals such as:
    - Information and Market Portal – Providing guidance for those looking for support, ability to submit assessments and review care services available.
    - Citizens Portal - Allowing citizens to review or feedback on aspect of the existing case such as personal budgets assessments and support plans.
    - MASH- Multi Agency Safeguarding Hub- which brings together a variety of agencies allowing information on children to be shared appropriately and

securely.

- The significant investment by the Council in the Liquidlogic application coupled with a redesign of operational processes and wider interaction with agencies, providers and third parties through the use of portals, and the integration of the LAS and LCS systems into working practice is expected to enable efficiencies for the Provider.

- Streamlined and designed system processes that both support and guide professionals and non-professionals alike, to ensure a consistent and efficient response to service delivery are possible, utilising the flexibility and configurability within the systems.

- Access to data for reporting and real time management information is also available to support operational management and provide statutory returns.

- Health records will be maintained on the Provider clinical information system(s).

- Due to the nature of the services specified it is likely a number of different electronic record systems will be required to deliver solutions that best meet the needs of the service and service users.

- It is the Provider responsibility to ensure the record system meets the need of the service and so detailed requirements of electronic health and social care record systems are not specified here.

- Attributes of effective health and social care records systems and their integration with other health and care record systems are below:

    - A system already established and in use in the English NHS/Social Services
    - Patient/Service User centric, allowing a professional a simple view of all relevant information about an individual.
    - Flexible and locally configurable.
    - Ability to enable patients/Service users and carers to manage their care and interactions with the health and social care system online including access to records.
    - Ability to enable patients/Services users and carers to monitor/manage their personal budgets online.
    - Provides an holistic view of an individual case record, allowing professionals to view all relevant information without the need to log-on to multiple systems.
    - Enables the extraction of case management, clinical and activity data for secondary use in an anonymised or pseudonymised way.
    - Allows the real time, contemporaneous collection of all notes, including appropriate clinical and non-clinical data at the point of contact with the patient/service user, including text, images and unstructured data.
    - Allows key information to be securely transferred electronically when patients/service users are referred to or discharged from services, in a clear consistent format. (This refers to messages that can be work-flowed by the receiver, ideally structured messages compliant with the NHS Interoperability Tool Kit (ITK). Use of email is not appropriate.)
    - Is mobile (including on and off-line working) to support taking of contemporaneous notes, and providing information to support care delivery at

the point of care.
- Is integrated with appropriate national systems including but not limited to the applications on NHS Spine e.g. CP-IS, SCR, E-referrals.
- Is able to interoperate with other local systems and supported by resource to make this a reality.
- Is able to exploit separate stand-alone innovative technologies.
- Removes the need for paper at the point of care.
- Reuses collected information to minimise duplication by professionals, individuals or carers.
- Meets all relevant HSCIC information standards.
- Doesn't require professionals, individuals and carers to access multiple systems with multiple log-ins to get a holistic view of an individual record.
- Includes Patient Administration System functionality.

Interoperability

- The Provider will be responsible for ensuring these and any other systems interoperate so that professionals have a joined up 'single' view of information that centres around an individual, and is available to the individual, in real-time.

- It is also the Provider responsibility to ensure that all safeguarding, technical security, information governance, data protection and assurance requirements are fully met, including gaining written permission on how information will be shared and with whom from both the CCG and the Council, such permissions will not unreasonably be withheld.

- The Provider is expected to contribute to CCG and Council aims to make relevant data that is essential to providing person centred care and support available to relevant individuals, suppliers and providers. This includes agencies the Provider may interoperate with but who may not be managed or commissioned by the Provider.

- The Provider therefore also has a responsibility to make information sharing (in this context) easy, with a low barrier to entry financially so that any suitable agency wanting or needing to share data with the Provider or any other commissioned health and social care services in the area can do so - where there is a clear case that this sharing will lead to improved health and care outcomes for patients / service users. Examples of this could be a MASH (multi-agency safeguarding hub) or sharing with YOT (Youth Offending Team) services.

3.8.4 Business Intelligence and Performance Reporting

Context

- Commissioners will work with an 'intelligent partner' in the delivery of performance management, reporting, business intelligence and evaluation.

- This means that the expectation will be placed on providers to be reactive and capable of dealing with changes in both local needs and national legislative circumstances and the consequence of these changes on the flow of management information to and from commissioners.

Quality and Performance Information

- The Provider shall be responsible for ensuring that {sub-contracted} services are delivering efficiently and effectively against national and local measures of performance.

- The Provider is wholly responsible to the Commissioners for the delivery of the services and for the performance of all of the obligations on its part under the contract.

- Good quality information is essential to enable the Provider and Commissioners to monitor performance under the contract. The following guiding principles will underpin the provision of information to support contract management:
    - the provision of information will be used for the overall aim of high quality service user care and support;
    - the parties recognise that some requests for information may require system improvements over a period of time;
    - requests for information will be proportionate and unless there are justifiable reasons for doing so, Commissioners will not request information directly from the Provider where this information is available through national systems

- The Provider will be responsible for the provision of performance reporting in accordance with the NHS Standard Contract schedule requirements listed below;

- SCHEDULE 4 – QUALITY REQUIREMENTS
    - Operational Standards
    - National Quality Requirements
    - Local Quality Requirements

- SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS
    - Reporting Requirements
    - National requirements reported centrally - the assessed collections and extractions published on the HSCIC website; Providers must submit data returns as appropriate for their organisation type
    - National requirements reported locally. The national requirements to be reported through local systems.
    - Local requirements reported locally. The local requirements including the timeframe, content and method of delivery for these reports
    - Audit - Quarterly statistical returns including raw data for local audit purposes

- Providers should note that where they sub-contract elements of the services, or contributions towards their delivery, to others. that the Provider retains overall responsibility for delivery of the services and for the performance of all of the obligations on its part under the contract:

Information to support Performance Management of Services

- Key local outcome and output measures will be agreed with Commissioners to include within the contract reporting requirements and recorded within individual

service specifications.

- Information and reporting will be provided to support the timing of the performance management processes where the contract reporting requirements do not already cover this. These processes will be determined through {consultation} with the Provider, but are likely to follow a quarterly basis with review of the following elements
    - Financial performance
    - Quality performance
    - Service Delivery and output measures
    - Client satisfaction and perception measures (including workforce perceptions to be determined as appropriate.
    - Strategic and developmental indicators including whole population outcome measures where relevant. This will include taking shared accountability for population level outcomes with other commissioning and service delivery organisations, through processes such as Health and Wellbeing Board reporting.

- The Provider will also be required to work with the Commissioner to develop an annual review including alignment with the strategic plans of commissioning organisations.

Surveying

- The Provider will be required to conduct regular surveying of local client base, This is to be aligned with national reporting requirements as relevant.

- The Provider will also be required to demonstrate that they conduct a good level of ongoing workforce engagement, including with sub-contracted services.

Evaluation

- The Provider will also be expected to work with the Commissioner to undertake system evaluations as appropriate. This will include a commitment to work openly and collaboratively with commissioning organisations, voluntary, community and academic organisations as appropriate.

Needs Assessment and Service Development

- In delivering business intelligence and performance reporting (including the details in this section).The Provider will work with the Commissioner to build an evidence base on the services and their future needs to inform ongoing service developments to improve integration and deliver the full service model.

- The Provider will work jointly with the Commissioner in order to understand how information collected by the Provider and sub-contracted services helps explain long term change in the needs of the local population.

- This approach may also require the sharing of pseudonymised data for research purposes and appropriate ethics and governance requirements will need to be developed. This requirement should be read alongside 3.8.8.

3.8.5 Information Sharing

- Since the publication of the Caldicott2 Review it has been an accepted principle that 'the duty to share information can be as important as the duty to protect patient confidentiality'.

- The use of interoperable systems and full Provider engagement with the BaNES community-wide interoperability and information sharing agenda will ensure that relevant information is available to support care to an individual wherever they present e.g. birth, end of life, social care, A&E, and Primary Care.

- The Provider will exploit technology in order to deliver an integrated electronic health and care record across its own services and with those in the local region. This view of information will be available to patients and carers as well as health and care staff.

- The Provider will provide a data sharing matrix describing where personal information will be shared and appropriately governed by Data Sharing Agreements. The Provider will manage consent to information sharing and respect an individual's right to dissent from sharing.

- Information sharing will not be limited to connecting of local systems and the provider will make use of, and contribute data to, national and regional solutions. These national, regional and local solutions will be integrated into the provider business processes to ensure that shared information is not just available but actively used to improve care.

Access to Provider systems and information

- Refer also to Annex 1 The Provider will:
    - provide the Commissioner with full cooperation and assistance in relation to any complaint or request made, including by:
        - providing the Commissioner with full details of the complaint or request;
        - complying with a data access request within the relevant timescales set out in the Data Protection Legislation and in accordance with the Commissioner's instructions;
        - providing the Commissioner with any Personal Data it holds in relation to a Data Subject (within the timescales required by the Commissioner); and
        - providing the Commissioner with any information requested by the Commissioner.

- Permit the Commissioner or the Commissioner Representative (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit, the Provider's data Processing activities (and/or those of its agents, subsidiaries and Sub-contractors) and comply with all reasonable requests or directions by the Commissioner to enable the Commissioner to verify and/or procure that the Provider is in full compliance with its obligations under this Lease Agreement;

- Provide a written description of the technical and organisational methods employed by the Provider for processing Personal Data (within the timescales required by the Commissioner) as required from time to time and in any event when the methods change the provider will notify the Commissioner before any procurement or changes come into effect.

3.8.6 Hardware, Software and Infrastructure including networks, telephony, video, CCTV, social media, software and licenses

- It is the Provider's responsibility to ensure that it uses the right business tools to meet the needs of all service operations it has responsibility for including 3rd parties it may commission. All products and their use must be legal, appropriately managed, supported, maintained and licensed. The requirements for data management, data handling and interoperability described in this document must all be taken account of in the Provider's decisions about what technology it will use.

- Any electronic tools used by the Provider (or any of its service providers) which they may wish the Council to utilise must work interoperably with the Council's technical environment which is:

-

Desktop Environment	Comments
Operating Systems	
Microsoft Windows 7 Professional SP1 (UAC enabled)	This is used on both physical PCs and Laptops and the Council's Virtual Desktops
For mobile and tablet devices IOS, Windows Mobile and Android devices are supported	must support all versions released in the last three years that are still under support
Microsoft Office	
Microsoft Office Professional 2010 (with SP2)	
Anti-Virus	
Trend Micro Office Scan	
Web Browser	
Microsoft Internet Explorer Version 11	Preferred version whilst in support
State other supported browsers e.g. Mozilla Firefox, Google Chrome	Externally facing options should support a wide range of browsers.
Citrix Virtual Desktop Environment	
All applications must work in both a traditional client/server environment and a Citrix XenDesktop 7.1 Virtual Desktop environment	
Applications should support delivery via application streaming using Microsoft App-V v5	Preferred delivery model
Applications should support delivery via Citrix XenApp 6.5 and later	
General Desktop Requirements	
Must provide MSI or similar installer package for silent client distribution	
Must not require local administrator or enhanced privileges on client PC's	

Applications must run in an environment supporting fixed size roaming profiles therefore they must not write or cache data to user profiles	
Provide a web enabled client.	
Java 7 Update 71 is available for client applications that require Java support however, the council is looking to move away from Java based applications.	Applications that do not require Java are preferred.

- The bandwidth over the network is generally good with even the most remote sites and home workers being up to 8Mb ADSL connections although some are on 2mb links. Nevertheless, where applicable, any solutions the Council is asked to utilise will be expected to operate across the Council network using the minimum amount of bandwidth;
- The Council has implemented a Citrix Access Gateway remote working solution enabling users to access Council ICT systems from any location and any device;
- The Council is PSN compliant and any data processed, held or managed by the Provider must be in a similarly secured technical environment - evidence of this will need to be provided
- The Council's entire desktop PC estate is in a virtual desktop environment.

3.8.7 Standards

- The Provider will use industry-standard best practice frameworks and methodologies, to ensure that the information technology services and systems are aligned to business needs, actively support them and add value. The Provider must therefore provide, or secure the provision of, robust and resilient data and voice infrastructure, and services that will enable timely and uninterrupted delivery and management of services to include, but not limited to:
    - Any technological solutions must meet the minimum accessibility requirements of prevailing legislation such as Equality Act 2010, BIP 0008 with respect to display / image resolution.

- In order to satisfy the requirements in this section, the Provider will be carrying out any IMT activities or responsibilities professionally and appropriately **which means** the activity has been carried out using recognized industry standards such as:
    - ITILv3+ for management of IT operations,
    - ISO27001 or equivalent such as PSN or N3 certification **(for the whole of the infrastructure including end user devices**) for security,
    - minimum of IGToolkit version 13 and any other IG requirements listed by HSCIC and the ICO;
    - BPSS in recruitment.

- IT staff will be suitably trained and certified in technologies in use and will be developed using a professional framework such as SFIA (Skills for Information Age).

- The Provider is expected to comply with other recognised industry standards (such as BS8766, BS7666, ISO 15489, e-GMS, FIPS 140-2) where the technological solutions in use require it.

- For the avoidance of doubt, as an example, if data is being transmitted, it must satisfy the minimum of FIPS140-2.

- End user computing will meet the minimum standards set by CESG and recognised industry standard Mobile Device management solutions will be employed.

- Meeting the requirements of Government Digital Services Good Practice Guides is a minimum requirement

- The Provider is expected to have protocols and measures in place to ensure High Availability and Resilience in its technological environment, as well as a hot DR solution, thus minimising the potential for any service downtime.

- The Provider is expected to carry out at an annual Penetration Test carried out by CESG approved PEN testers, with an objective to fix all Critical issues within 2 weeks and all other issues within 6 weeks.

- The Provider must work to a Quality Management system (ideally a recognised industry standard) in implementing new ways of working, new and improved technologies

Staff Recruitment & Training

- It is a requirement for the Commissioner that anyone accessing or processing health and social care data meets the Commissioners checks on Baseline Personal Security Standard (BPSS) and Safeguarding before they are allowed to process or gain access to any information which is:
  - An appropriate identity check
  - Confirmation of Nationality & Immigration Status
  - Verification of employment history (for the past 3 years)
  - Third-party verification of unspent convictions e.g. enhanced DBS

- All staff that are working on any of the commissioned services will have been appropriately trained. Including IG & DPA

3.8.8 Information Governance

- The Provider will have a suitably qualified Senior Information Risk Officer (SIRO) and Caldicott Guardian.

- The Provider shall comply with all relevant legislation. This will include:
  - The Data Protection Act 1998
  - Caldicott guidelines
  - Freedom of information Act 200
  - Health and Social Care Act 2012
  - Care Act 2014
  - Common law duty of Confidentiality

- The Provider will supply any Data Controller information requested for completion of their IG Toolkit. This shall be collated by the IG manager of either BaNES CCG or B&NES Council to avoid the Provider receiving a large number of requests.

- The Provider shall complete the IG toolkit and be compliant to level 2 on all requirements

- The Provider shall have a suite of policies, procedures and plans which will cover all of their processes. This will include:
    - Information Governance Framework
    - Information Governance policy
    - Information Security policy
    - Business Continuity plan
    - Records Management policy
    - Data Protection Policy
    - Freedom of Information Policy
    - Data Transfer policy

- Any Data Sharing will be documented and be agreed with the relevant Caldicott Guardians.

- The Provider will have agreed Incident Management and reporting procedures. Any IG breaches shall be report to the Data Controller as soon as possible and within the 24 hour limit started with the IG Toolkit SIRI process.

- The Provider's Caldicott Guardian or a suitably qualified deputy shall be available in case of a data breach.

- The Provider will assist the Data Controller with all actions regarding IG incidents.

- The Provider shall do a training needs analysis of all their staff and shall as a minimum require all their staff to do the on-line Information Governance training provided by the HSCIC or an approved equivalent

- All information Assets shall be protected by appropriate technical measures which shall be kept up to date.

- The Provider shall provide a list of Information Assets and owners for all of the assets used within this contract. The Provider will also supply a list of data flows in an agreed format.

- The Provider must be able to demonstrate that there are suitable controls on access to all information assets.

- The Provider will ensure that the Patients/Service Users are informed of any processing and changes to processing that occur. The Provider will ensure that the Patients/Service Users are able to opt out of sharing where appropriate.

- Audit trails will be available on all systems.

3.8.9 Innovation

- Innovative technologies, and service models supported by technology are expected to be an intrinsic part of the Providers IMT Strategy in terms of how the Provider will not only deliver its services but how it will ensure that it is doing so in a continually improved way.

- This will mean regular review and redesign of work practices and processes so that clinicians and practitioners are optimising the latest technologies for the benefit of patient and service user care and support. This will be implemented as part of the ongoing development of the services over the course of the contract and it is expected that these innovations and improvements will be front loaded in discharging this contract so that health and care benefits, improved person outcomes and financial efficiency are realisable at the earliest opportunity.

- These developments will align with national IMT strategy, the overall Provider strategy for the services and be closely linked to improvements in quality, outcomes, experience or efficiency.

- Patients/Service users will be offered evidence-based technological and analytical solutions to delivering care and support, for example enabling access to care beyond traditional face to face settings that provide efficiency, quality and excellent patient/service user experience. Where evidence is still immature, technology will be deployed as part of a robust pilot process to develop the evidence to support full implementation.

3.8.10 Efficiency and Adding Value

- The technologies already available to the Provider and which the Provider as a professional in the provision of community care services is expected to already have and be making use of should enable the services to be delivered for less than previous contract values, without any reduction in services.
- As well as efficiency and innovation, the Provider is expected to Add Value through its' use of IMT. This could be by providing technology to people in their homes which they can use to prevent or reduce feelings of social isolation, establishing something as simple as a friendship telephone calling circle or helping people of any age to participate in the digital world by providing access to a device with an internet connection to reduce digital inequalities.

- Alternatively, it could mean leveraging existing Provider and Commissioner technology to deliver enhanced or improved services for same or less cost.

- Added Value must be measurable in the context of Community Services provision.

- It is for the Provider to identify how they would Add Value through their use of IMT, examples of what has already been done will be required.

3.9 Clinical Engagement

- The Provider must ensure that there is good clinical leadership at corporate/organisational, local, and service delivery level and will provide a framework for Clinical Governance and support for those delivering the services.

- The Provider must continuously improve the quality of their services and safeguarding high standards of care and support by creating an environment in which (clinical) excellence will flourish, ensuring all professionals abide by the guidance of their professional self-regulatory body. Clinical Governance should be integrated into the Provider's whole governance arrangements. The Provider is

expected to outline clinical governance mechanisms to be applied when concerns about the quality of the service is raised and will be expected to comply with relevant clinical governance frameworks and to function under agreed operational and clinical policies.

- The Provider will be expected to undertake clinical audits to drive improvements in the quality, safety, consistency and value for money of the services.

- The Provider must ensure that clinical risk management is an integral part of the daily management. The Provider will use clinical risk management to improve decision-making and encourage the continued improvement of service delivery and the best use of resources.

3.10 Governance and Performance Management

- The Provider will be responsible for high-level system leadership of the overall delivery model, ensuring effective coordination and collaboration between providers and across localities, promoting the sharing of best practice.

- The Provider will be responsible for monitoring outcomes for the local community and for co-ordinating input and activity to deliver the contract whilst ensuring appropriate governance, quality assurance and engagement with patients or service users.

- The Provider is expected to bring together senior representation from providers, primary care, secondary care, public services, VCSE organisations and the local community (supported by subject matter experts).

- The Provider will be required to have appropriate measurement systems in place in order to measure their own performance and that of any subcontracted partners against performance measures agreed with the Commissioner.

- The Provider will report on performance measures to the Commissioner against an agreed schedule.

- The Provider will meet quarterly with the Commissioner to review performance. Measures may be revised over time to understand and meet changes in demand, and to reflect the development of local minimum data set requirements.

- The Provider will implement mechanisms for managing risk, including disaster recovery, contingency and business continuity plans. The Provider will keep the Commissioner informed about detail of the risk management structures and processes that exist, and how they are implemented.

- The Provider must have a system in place to analyse the type, frequency and severity of adverse incidents, in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements.

- The Provider must have a culture that encourages and supports staff to report adverse incidents.

- The Provider will be required to produce regular summary reports providing full details of all complaints and how they were resolved.

3.11 Prescribing

- The Provider shall prescribe evidence based medicines in accordance with the BaNES Formulary.

- Prescribing costs will remain with the Commissioner of the service and not transferred to another commissioner without explicit consent on a case by case a basis.

- Commissioners will recharge the Provider for any inappropriately charged drugs.

- The Provider shall record and monitor the amount, type and ranges of medication prescribed and provide quarterly reports to Commissioners. The Provider shall produce annual evidence of prescribing audits, outcomes and improvements made.

3.12 Equality and Diversity

The public sector equality duties 2011 outlines that a public authority must, in the exercise of its functions, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act.

- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Understanding the size and characteristics of the populations of Bath and North East Somerset will enable a better appreciation of the diversity of the needs represented across each of these locations, and would facilitate meeting these duties.

3.13 Workforce

- The Provider will take a lead on a new approach which is able to accommodate the growing demand for access and coordinated care and support around people, families, carers and communities. Workforce development and education and training strategies must be aligned to the emerging and future service delivery models.

- Approaches to workforce planning along with education and training strategies should be based on achieving population health outcomes. The exact nature and make-up of the workforce will be tailored according to localised population needs and circumstances; the health, care and support needs in Chew Valley, for example, are not the same as those in the centre of Bath.

- The Provider will be able to define the workforce requirements locally, aggregating them across the localities where appropriate and using this information to better

inform what and how providers train the health and care workforce.

- The Provider will develop a workforce strategy for B&NES which will be based upon an assessment of local need, taking into account emerging service models, defined population needs and outcomes, a focus on appropriate capabilities to enhance population outcomes, and the workforce skill-mix required to improve population outcomes and reduce inequalities.

- In order to deliver flexible, equitable and accessible services to people of all ages, the service will have sufficient workforce capacity and skill mix.

- There will be continuity of service and defined minimum service levels are met, irrespective of staff sickness, training, maternity leave and recruitment.

- In order to deliver the service vision and values as set out in this specification, and supporting service schedules for specific service areas, the Provider will have in place policies and procedures to recruit, retain, train and develop a suitably qualified workforce within its own services and with sub-contracted partners.

3.14 Innovation and Delivering Excellence

- The Provider will be expected to 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.

3.15 Efficiency and Adding Value

- The Provider is expected to develop a set of responses to support the financial and clinical sustainability of local services through the development of new care and support models.

- The Provider will be expected to develop approaches to sharing costs and risk sharing agreements across providers to set out how resources will flow between partners to deliver service objectives.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The standards and guidance listed below are applicable to all services:

- NICE Clinical Guidelines (CG)
- NICE Quality Standards (QS)
- NICE Technology Appraisal (TA)
- NICE Public Health Guidelines (PH)
- NICE TAs must be applied however NICE standards and guidance will be applied as detailed within the relevant individual service specifications or within the agreement of the Commissioners

4.2 Applicable standards set out in Guidance and/or issued by a competent body

- To be agreed

4.3 Applicable local standards

- To be agreed

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

- National quality requirements are as stated in the NHS Standard Contract Schedule 4 Parts [A-D]) Local Quality Requirements are to be agreed

5.2 Applicable CQUIN goals (See Schedule 4E)

- To be agreed

6. Location of Provider Premises

- The services will be locality and community focussed and should be delivered from a range of locations across Bath and North East Somerset.
- Equitable access across the locations is an important element in the estate solution.
- The Provider will fully consider all potential access needs in the planning and delivery of the service.
- Services will be co-located where possible with other services e.g. local authority services, schools, voluntary sector and community groups etc.
- Services currently co located in community hubs or with the local authority will continue to be delivered from these bases.
- Where formal leases are in place these will be assignable to a new provider.
- Accommodation will be provided in compliance with all statutory and mandatory regulations, guidance and good practice applicable to health and care accommodation for children, young people and adults.
- Accommodation will be maintained and serviced in accordance with statutory and health and care guidance which will be evidenced by due diligence testing.
- The Provider will ensure that total costs of all accommodation are separately identified and listed.
- Lease and recharge arrangements will be in place for all properties not owned by the Provider.
- Accommodation will meet privacy and dignity standards and to be compliant with segregation requirements for access to accommodation between children and adults.
- The Provider will provide clinical equipment, medical supplies including medicines, drugs, instruments, appliances and material necessary for care which shall be adequate, functional and effective for all the services.
- The Provider shall also provide non-clinical equipment to furnish the services including computers, telephones, desks, desk chairs, couches, trolleys, etc.

Annex A – Core Functions of the Prime Provider

The following schedules set out the services to be delivered within the Prime Provider;

A1.1 Adult Social Care

Service Description
Provision of delegated social care function for adults who have care and support needs or support needs as outlined in the Care Act 2014. To encompass those that will be funding their own care and those that require funding from the Local Authority. This includes but is not limited to: advice and information on social care issues, the undertaking of statutory assessments for both service users, carers and those in transition, risk assessments, undertaking eligibility determination for carers and service users, ensuring people who require advocacy support are identified and referred, support planning for both carers and service users, reviews for both service users and carers, undertaking social care hospital discharge responsibilities, assessments for Disabled Facilities Grants, manual handling assessments in both community and residential settings, minor works and the provision of equipment/aids that support independence. Ensuring that the requirements of the MCA are met: including undertaking best interest assessments, preparing paperwork for Deputyship and Community DoLS CoP applications. Provision of qualified staff to undertake Best Interest Assessments and Mental Health Assessments as part of a DOLS rota managed by the Council. Provision of staff with AMHP qualifications to support the AMHP rota coordinated by the Council. The Provider will also be responsible for supporting the Council in undertaking its safeguarding duties by: administering, coordination and undertaking section 42 enquiries, supporting service users, friends and families throughout the safeguarding process, ensuring appropriate records are kept of the safeguarding process, working with other agencies to support the individual and achieve the outcomes identified, undertake risk assessments and lead non statutory enquiries as required by the Council. The Provider will work closely with a wide range of other agencies including Children Social Care. The Provider will ensure that professionally qualified social care staff meet the requirements/expectations outlined by their registration body and by the Chief Social Worker for Adults, this will include programme for AYSEs and social workforce strategy. In undertaking these key functions the Provider will also undertake tasks in relation to: financial assessment, ordinary residency considerations, protection of property and arrangement of funerals, debt management, deputyship responsibilities, complaints and the collection of data to enable the Council to meet its requirements around statutory and national reporting. The Provider will ensure with the Council a smooth handover of cases takes place with the Emergency Duty Team. The mental health social workers will remain employees of the Council however it is expected that they will work within integrated health and social care teams.

Service Description Cont'd
Opportunities for future development • Strengthening of the advice and information provided to members of the public seeking social care support, this could be provided in more creative ways. • Development of self-assessment options and alternative ways of undertaking aspects of the delegated function. • Working with local communities and third sector organisations to support individuals to develop plans that maintain them in their local community - this could include the development of a brokerage type service. • Development of a positive risk taking approach. • Professional social work leadership within the senior management and executive arrangements

Referral Route	Indicative Staffing
• Public contact • Professional contact • Hospital discharges • Contact from third sector agencies All routes are via telephone, email, web based information or face to face contact.	• Registered Social Workers • Registered Occupational Therapists • Trained unregistered staff that support social workers and Occupational Therapists with their functions • Trained advisors to provide advice, information and signposting • Managers with experience of managing statutory social care services • Professional leadership role

Activity Data		Location(s)
Number of client contacts 15/16	1,848	• Royal United Hospitals Bath NHS Trust, BA1 3NG • Age UK, 18 Kingsmead Square, Bath BA1 2AE" • St Martins Hospital, Midford Rd, Bath BA2 5RP • The Hollies, High Street, BA3 2DP • Keynsham Health Centre, BS31 1AG"
Number of referrals 15/16	1,644	
Hours of provision 15/16	N/A	

Current Providers	Current Spend
Sirona care and health	£3,220,852

A1.2 Children's Safeguarding

Service Description
The Safeguarding Children Service (Designated Doctor, Named Nurses and Specialist Safeguarding Nurses - LAC) will work in partnership with other agencies and the B&NES Safeguarding Children's Board (LSCB) to promote the welfare and safeguarding of all children. The service will provide direct interventions to promote and ensure the safeguarding responsibilities of the organisation are fulfilled. The Designated Doctor will be responsible for child death arrangements. The service is based on and underpinned by the legislation contained in the Children Act 1989 & 2004 and will be provided by the Designated Doctor, Named Nurses and Specialist Nurses. This service must link with and meet requirements set out by the Designated Nurse Safeguarding Children NHS B&NES CCG. The team will work closely with wider Health Services including Paediatricians, General Practitioners, Midwives, Health Visitors, School Nurses, Minor Injuries units and the adult workforce. In addition, the team will work closely with Local Authority children's services, the police and other statutory agencies, educational establishments and voluntary organisations. Note: the Designated Doctor will be employed by the Prime Provider but report to NHS B&NES CCG. The Designated Doctor function is one of the key aspects of the Community Paediatric Service. The Prime Provider will also provide arrangements for a Medical Advisor in relation to adoption and fostering.

Referral Route	**Indicative Staffing**
Referral from any individual and agency.	Approx: • 0.3 FTE Consultant Paediatrician • Specialist Safeguarding Nurses • 0.5 FTE LAC Nurse

Activity Data		Location(s)
Number of client contacts 15/16	TBC	TBC
Number of referrals 15/16	TBC	
Hours of provision 15/16	TBC	
Current Providers		**Current Spend**
Sirona Care and Health		TBC

A1.3 Continuing Health Care Including Funded Nursing Care

Service Description
Brief Summary: • The key aim is to provide a quality service that identifies people who are eligible for Continuing Health Care (CHC) funding and Funded Nursing Care (FNC); using extended and professional knowledge work together with people and their support network to ensure appropriate care and support plans are in place. Act as key workers to people eligible for CHC and FNC. • To ensure all assessments and reviews are completed within the NHS National Framework for Continuing Health Care & NHS Funded Nursing Care (November 2012) standard timeframes. Liaison with Children's CC commissioning team to ensure good transitions happen in timely manner. **Opportunities for future development**: • review current arrangements and explore revisions to the pathway, include multidisciplinary assessment of people need, improving people experience, timeliness of assessment, documentation and reporting, greater involvement of social workers • Ensure people have access to information and advice about their care and support so they can make appropriate choices about how they want it to be delivered (including via PHB)

<table>
<tr><th colspan="2">Referral Route</th><th>Indicative Staffing</th></tr>
<tr><td colspan="2">The Provider will receive, acknowledge and administer referrals from relevant referrers in respect of CHC/ FNC.
Individuals or family members
Care managers
GPs
Hospitals
Providers of care with authorisation to act on behalf of an individual (such as a care home)
Community services, including community nurses and occupational therapists</td><td>The existing CHC team staffing establishment is 17.91wte which includes 12.82wte qualified nursing staff and 5.09wte administration support. The team recently recruited to 2 vacant posts and was fully established by October 2014. The team has qualified RN’s and RMN’s and it is expected that social workers will be part of the core team going forward</td></tr>
<tr><th colspan="2">Activity Data</th><th>Location(s)</th></tr>
<tr><td>Number of client contacts 15/16</td><td>681</td><td rowspan="3">Keynsham and patient/service users homes</td></tr>
<tr><td>Number of referrals 15/16</td><td>596 (CHC only)</td></tr>
<tr><td>Hours of provision 15/16</td><td>9-5 service 5 days week Mon-Fri</td></tr>
<tr><th colspan="2">Current Providers</th><th>Current Spend</th></tr>
<tr><td colspan="2">Sirona Care and Health</td><td>£569,679</td></tr>
</table>

Annex B – Service Schedules

It is expected that all other services will be organised around three service schedules as outlined below. The Prime Provider will be accountable for delivering the outcomes across all schedules but may sub-contract specific roles and services.

Schedule 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
- child and adolescent mental health services
- specialist equipment services
- adult social work
- independent living services
- homelessness and housing support
- occupational therapy
- targeted youth supported

- learning disabilities services
- community hospital and unplanned care
- employment support
- targeted family support
- community paediatrics
- 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