NHS Standard Contract 2019/20

Particulars (Full Length)

Contract title / ref: NHS BNSSG CCG Adult Community Health Services

The CCG has issued these draft contract particulars to bidders for adult community services based on the 2019/20 version. This is a legal contract, not meant for wide distribution. It is provided online for transparency. The NHS Standard Contract in use at the time of signing will be used, and subsequently updated as mandated by NHS England. The schedules will be updated prior to Contract Award in line with CCG requirements, any policy changes and the final negotiated Proposal. These particulars should be read in conjunction with the service conditions and general conditions available at: https://www.england.nhs.uk/nhs-standard-contract/19-20/

NHS Standard Contract 2019/20

Particulars (Full Length)

Version number: 1

First published: March 2019

Prepared by: NHS Standard Contract Team
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Classification: OFFICIAL

Publication Approval Number: 000248

Contract Reference	**NHS BNSSG CCG Adult Community Health Services 2020/2021**

DATE OF CONTRACT	
SERVICE COMMENCEMENT DATE	**1 April 2020**
CONTRACT TERM	**10 years from Service Commencement date, with a period of mobilisation from Contract Award to 31 March 2020**
COMMISSIONERS	**NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (ODS 15C)**
CO-ORDINATING COMMISSIONER	**NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group**
PROVIDER	**[ ] (ODS [ ])** **Principal and/or registered office address:** **[ ]** **[Company number: [ ]**

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GENERAL CONDITIONS

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**;

2. the **Service Conditions (Full Length)**;

3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by	**…….** **Signature**
[insert] for **and on behalf of** **NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group**	**…….** **Title** **…….** **Date**
SIGNED by	**…….** **Signature**
[INSERT AUTHORISED SIGNATORY'S NAME] for **and on behalf of** **[INSERT PROVIDER NAME]**	**…….** **Title** **…….** **Date**

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	**(Subject to contract award date)**
Expected Service Commencement Date	**1 April 2020**
Longstop Date	**1 April 2020**
Service Commencement Date	**1 April 2020**
Contract Term	**10 years commencing on 1 April 2020, with a period of mobilisation from Contract Award to 31 March 2020**
Option to extend Contract Term	**No**
Commissioner Notice Period (for termination under GC17.2)	**12 months**
Commissioner Earliest Termination Date	**12 months after the Expected Service Commencement Date for the Contract as a whole** **6 months after the Service Commencement Date for specific individual services within the Contract**
Provider Notice Period (for termination under GC17.3)	**12 months**
Provider Earliest Termination Date	**12 months after the Service Commencement Date for the whole of the Contract**

SERVICES	
Service Categories	**Indicate <u>all</u> that apply**
Accident and Emergency (A+E)	
Acute Services (A)	
Ambulance Services (AM)	
Cancer Services (CR)	
Continuing Healthcare Services (CHC)	
Community Services (CS)	Yes
Diagnostic, Screening and/or Pathology Services (D)	Yes
End of Life Care Services (ELC)	Yes
Mental Health and Learning Disability Services (MH)	Yes
Mental Health and Learning Disability Secure Services (MHSS)	
NHS 111 Services (111)	
Patient Transport Services (PT)	
Radiotherapy Services (R)	
Urgent Care/Walk-in Centre Services/Minor Injuries Unit (U)	Yes
Services commissioned by NHS England	
Services comprise or include Specialised Services and/or other services directly commissioned by NHS England	**No**
Service Requirements	
Indicative Activity Plan	**Yes**
Activity Planning Assumptions	**Yes**
Essential Services (NHS Trusts only)	To be defined, depending on Preferred Bidder type
Services to which 18 Weeks applies	**Yes**
Prior Approval Response Time Standard	Within 5 Operational Days following the date of request
Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of this Contract?	**No**

Is the Provider providing CCG-commissioned Services which are to be listed in the UEC DoS?	**Yes**
PAYMENT	
Expected Annual Contract Value Agreed	**Yes**
Must data be submitted to SUS for any of the Services?	**Yes**
QUALITY	
Provider type	To be inserted depending on Preferred Bidder type as NHS Foundation Trust/NHS Trust or Other
Clostridium difficile Baseline Threshold (Acute Services only)	**Not applicable**
GOVERNANCE AND REGULATORY	
Nominated Mediation Body	**Mediation will be arranged jointly by the NHS TDA and NHS England where the provider is an NHS Trust, and will be by CEDR or another independent body in other cases**
Provider's Nominated Individual	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Information Governance Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Data Protection Officer (if required by Data Protection Legislation)	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Caldicott Guardian	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Senior Information Risk Owner	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Accountable Emergency Officer	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Safeguarding Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Child Sexual Abuse and Exploitation Lead	**[ ]** **Email: [ ]** **Tel: [ ]**

Provider's Mental Capacity and Deprivation of Liberty Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Prevent Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Freedom To Speak Up Guardian(s)	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's UEC DoS Contact	**[ ]** **Email: [ ]** **Tel: [ ]**
Commissioners' UEC DoS Leads	**Insert**
CONTRACT MANAGEMENT	
Addresses for service of Notices	**Insert** **Provider: [ ]** **Address: [ ]** **Email: [ ]**
Frequency of Review Meetings	**Monthly**
Commissioner Representative(s)	**Insert**
Provider Representative	**[ ]** **Address: [ ]** **Email: [ ]** **Tel: [ ]**

2. SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents:

1. Evidence of appropriate Indemnity Arrangements
2. Evidence of CQC registration in respect of Provider and Material Sub-Contractors (where required)
3. Evidence of Monitor's Licence in respect of Provider and Material Sub-Contractors (where required)
4. Copies of all Mandatory Material Sub-Contracts, signed and dated and in a form approved by the Commissioner
5. Copies of the following Permitted Material Sub-Contracts, signed and dated and in a form approved by the Commissioner [*LIST ONLY THOSE REQUIRED FOR SERVICE COMMENCEMENT*]
6. [A copy of the/each Direction Letter] Mandatory where the Provider is a Non NHS Organisation
7. Evidence of appropriate Premises arrangements being put in place to deliver the Services
8. Copies of signed and completed Transfer Agreements between the Incumbent Providers ("Bristol Community Health Community Interest Company"; "North Somerset Community Partnership Community Interest Company"; "Sirona care & health Community Interest Company") and the Provider
9. Evidence that an appropriate IM&T solution is in place prior to Service Commencement Date including but not limited to all of the hardware, software, networking, training, documentation, support and maintenance necessary to deliver the service
10. Evidence of appropriate Counter Fraud and Security Management measures:
    - Fraud Policy
    - Security Policy

The Provider must complete the following actions:

1. Implement in full the agreed Mobilisation Plan (as set out in the Proposal and any amendments agreed during the Preferred Bidder Appointment) with supporting evidence.

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
January 2019	**Request for Proposals**	**Request for Proposals and all accompanying documentation and clarifications issued during the procurement. This includes, but is not limited to, the service specifications, enabler specifications and financial model template**
April 2019	**Information for Shortlisted Bidders and clarifications during Round 2**	**Information for Shortlisted Bidders and all accompanying documentation and clarifications issued during Round 2 of the procurement. This includes but is not limited to Draft Contract, Updated financial model template, questions asked during meetings and written clarification questions**

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

NOT USED

3. SCHEDULE 2 – THE SERVICES

A. Service Specifications

1. This schedule sets out the Specifications to be delivered. It is in multiple parts comprising:

IACS000
IACS001
IACS002
IACS003
IACS004
IACS005
IACS006

2. For contractual purposes, the CCG and the Provider acknowledge that the Service Specifications are subject to continual review to ensure that they remain consistent with the achievement of the Local Quality Requirements and nationally mandated requirements. Any changes to a Service Specification required reflecting (i) progress against the Service Development and Improvement Plan, and (ii) the Provider's actual practice in delivering Community Services or (iii) to ensure consistency with the achievement of the Local Quality Requirements shall be discussed as part of the review meeting process. The review of Service Specifications shall be a standing item on the agenda for review meetings. The CCG and the Provider will consider how any changes that are identified by such Review Meeting shall be documented, taking account of (i) whether the scope of the change is appropriate to form part of a formal Service Variation, (ii) the impact upon the achievement of the Local Quality Requirements and (iii) the Commissioner's statutory duties in respect of public involvement and service user and stakeholder consent. Those changes to a Service Specification that are agreed by the Parties subject to the provisions of GC13.

3. The Parties shall work together to develop a Communication Plan, and, for any proposed change to the service model, consider what degree of public involvement is appropriate, including reference to the Communication Plan.

Service Specification No.	IACS000
Service	Community Services Background information
Commissioner Lead	NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Provider Lead	
Period	
Date of Review	

1.	**LOCAL CONTEXT**
1.1	The CCG has commissioned a Single Provider of adult community health services for Bristol, North Somerset and South Gloucestershire so Community Services work seamlessly with Primary Care, Secondary Care, mental health services, local authorities and Third Sector Organisations to enable people to stay healthy, well and independent in the community. The adult Community Services Provider will be a key system partner in transforming the out of hospital care setting, so that services provide proactive care to meet population needs.
1.2	**Local services landscape**
1.2.1	This section provides background about the vision underpinning the out of hospital care approach and summarises the Community Services. The context of local services is first described.
1.2.2	The CCG serves a population of nearly one million people. The population is spread across a mix of rural, suburban and inner city areas. The population is expected to grow by 43,000 by 2021 with an approximate 7% growth in those aged under 15 years, 16% growth in 74 to 84 year olds and 18% growth in those aged over 85 years of age. With this increase in the elderly comes a greater number of the population living with multiple long-term conditions which will require preventative, proactive and reactive management and support from Community Services to stay healthy, well and independent. Each locality has local population-specific needs which the CCG expects to be met by the adult Community Services provider as well as other system partners.
1.2.3	The CCG covers three local authority areas: Bristol City Council, North Somerset Council and South Gloucestershire Council.
1.2.4	Adult Community Services were previously provided primarily through block contracts with three separate community interest companies. Bristol Community Health provided adult Community Services for Bristol. North Somerset Community Partnership provided adult Community Services for North Somerset. Sirona care & health provided adult Community Services for South Gloucestershire. There are also contracts with University Hospitals Bristol NHS Foundation Trust for the provision of beds at South Bristol Community Hospital which will be transferred to the community provider in April 2021 and North Bristol NHS Trust for rehabilitation beds.
1.2.5	The population mainly access three Secondary Care providers: North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust (which also provides tertiary care) and Weston Area Health NHS Trust. Other key providers are South Western Ambulance Service, Avon and Wiltshire Mental Health Partnership and Severnside who will provide an Integrated Urgent Care Service from 1 April 2019.

1.2.6 There are currently 85 general practices across the CCG geography. General practices are currently arranged in six localities, Bristol includes three localities: Bristol North and West; Bristol South and Bristol Inner City and East. South Gloucestershire is one locality. North Somerset has two localities: Woodspring and Weston and Worle. Each locality has a GP Provider Board consisting of a mix of GPs, nurses and practice managers. Within these localities practices are working at scale through developing GP Networks[1] covering 30,000-50,000 patients. The maturity of working at scale varies across the geography and is continuously developing. It is expected that the provider aligns with Primary Care at all levels to enhance and support partnership and integrated working.

1.3 Vision for integrated care

1.3.1 Thirteen organisations sit on the Board of *Healthier Together*, the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership. These are:

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Bristol City Council
- Bristol Community Health
- NHS Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group
- North Bristol NHS Trust
- North Somerset Community Partnership
- North Somerset Council
- One Care
- Sirona care & health
- South Gloucestershire Council
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- Weston Area Health NHS Trust

1.3.2 The adult Community Services Provider is expected to be part of this Board. Further information about *Healthier Together* is available at https://bnssghealthiertogether.org.uk/.

1.3.3 *Healthier Together*'s vision is for the health and social care system to progress towards an integrated approach to care, with organisations working together regardless of individual budgets. The geography is an aspirant Integrated Care System. Priorities include redesigning models of care to meets the needs of the population and ensuring effective infrastructure to enable this (https://bnssghealthiertogether.org.uk/where-have-we-got-to/).

1.3.4 The vision is that organisations will work together to provide services closer to patients' homes. This is being progressed by bringing together existing services centred around GP Networks and Localities within communities to create integrated localities that deliver a range of health services including community, mental health, social care and Third Sector services. It is expected that these changes will help people remain independent longer in their own homes, only needing to access Secondary Care when absolutely necessary.

1.3.5 As part of integrated working with Primary Care, the adult Community Services Provider is expected to work alongside Primary Care's Locality Transformation Scheme and GP Network development. The Locality Transformation Scheme is developing strong local primary care clinical leadership in localities to build relationships with other providers as the first steps to considering priorities for joint working and, in future, more integrated community models of care. Phase 1 involved GPs coming together to work in locality provider boards. Phase 2, which is current, involves GP locality provider boards starting to work with other providers on selected priority areas. Phase 3, forthcoming, is for integrated community localities to work in a 'provider alliance'.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

1.3.6	The CCG plans to work with Primary Care to enable localities/Primary Care Networks to establish the needs of their population, shape an optimal delivery model and deliver the aims of the NHS Long Term Plan. There is a focus on innovation and collaboration and the adult Community Services Provider is expected to be a key partner.
2.	**COMMUNITY SERVICES MODEL**
2.1	**Underpinning principles**
2.1.1	In January 2018 the King's Fund published *'Reimagining community services – making the most of our assets*[2]*'* which set out 10 key design principles for future models of community health services, emphasising the importance of building a community-based approach to care. These principals underpin the vision for Community Services for Bristol, North Somerset and South Gloucestershire. They comprise:
2.1.1.1	**Organising and co-ordinating care around patients' needs** Evidence suggests that better care co-ordination can improve the experience and outcomes of care and increase efficiency to avoid duplication. Patients using community services often need support from multiple services. It is vital that adult community services are closely connected to all parts of the health and social care system. Effective information sharing is critical to achieve this through shared records and interoperability of systems.
2.1.1.2	**Responding holistically to physical and mental health and social needs** It is important for the adult Community Services Provider to understand the full range of a patient's needs and how those needs impact on health and wellbeing so they can help patients access appropriate support. The CCG wants this to be achieved through partnership working across different services including with Third Sector organisations.
2.1.1.3	**Making the best use of community assets to deliver care** There are capabilities within communities that can be used to promote health. To develop asset-based models, health and care services need to work with a range of partners.
2.1.1.4	**Enabling professionals to work together across boundaries** Through multidisciplinary working, services can draw on the skills and expertise of a range of professionals to improve care and offer co-ordinated care. This may involve fully integrated teams sharing caseloads or be part of a less formal structure that supports collaborative working.
2.1.1.5	**Building in access to specialist advice and support** Community-based care should have access to specialist support as a core part of day-to-day work, so it is readily available and supports community services to manage clinical complexity, acuity and risk.
2.1.1.6	**Focusing on improving population health and wellbeing** Community Services are well placed to have a greater role in population health and proactive care as they are based in communities, have an understanding of population need and network across sectors and services.
2.1.1.7	**Empowering people to take control of their own health and care** This relies on partnership working between professionals and patients. Seeing patients in their own homes and communities gives valuable insight into patients' capabilities to self-care and the types of support that are available to help them do so.
2.1.1.8	**Designing delivery models to support and strengthen relational aspects of care** Relational aspects are the elements of care most closely linked to good patient experience. The focus is on patients feeling that professionals treat them as a 'whole person' and that there is continuity in the relationship.

[2] https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf

2.1.1.9 **Involving families, carers and communities in planning and delivering care**
A significant amount of care and support in the community comes from informal support networks including friends and family. Community-based services could usefully involve carers and families in planning and delivering care as well as supporting carers with their own needs.

2.1.1.10 **Making community-based care the central focus of the system**
It is important that we see a shift the focus across health and social care systems as a whole, whereby systems are based around communities and community services in their broader sense.

2.1.2 These principles mirror feedback from clinicians, patients, carers and the public, providers, partner organisations, the Third Sector and other stakeholders that have contributed to developing the specifications for this Community Services contract. Stakeholders have emphasised the importance of having adult Community Services that will respond to the needs of patients and carers, help patients to keep themselves healthy and well in the community, be consistent across Bristol, North Somerset and South Gloucestershire, work seamlessly with Primary Care and other partners, develop a workforce with strong generalist skills and adapt to increasing integration in the future.

2.2 **Service specifications**

2.2.1 Figure 1 illustrates the model of out of hospital care for Bristol, North Somerset and South Gloucestershire. The adult Community Services Provider is expected to work closely with general practice at an individual, GP network and locality level to meet the needs of the population and to help people stay healthy, well and independent in their community.

2.2.2 The four Service Specifications are integrated locality teams; acute and reactive care; specialist advice and support and locality hubs:

2.2.2.1 **Integrated locality teams** focus on relationships with Primary Care to support people who have relatively stable needs to manage and reduce the risk of acute worsening of their condition. This incorporates multidisciplinary team meetings between Community Services, Primary Care, social care and mental health to identify patients who need proactive support to maintain their health and wellbeing. Access to adult Community Services will be through a single point of access located within the integrated locality teams that will respond in a timely manner to patient needs and develop a consistent care plan agreed with the patient.

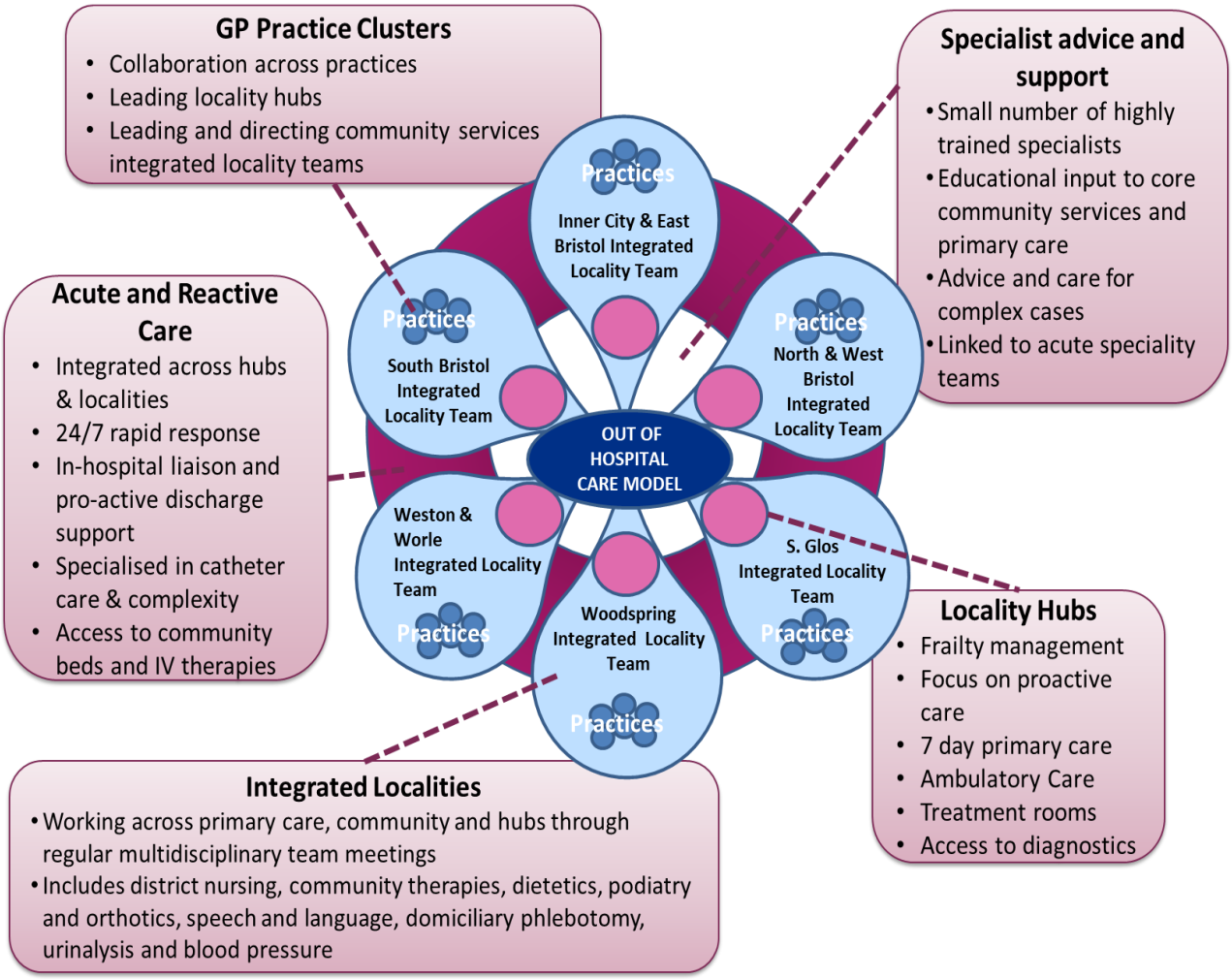
2.2.2.2 **Acute and reactive care teams** work across localities to manage patients who have acutely worsening conditions and are at risk of a hospital admission or attendance. These teams will provide a timely response to prevent admission, including rapid response. The teams will have links to Secondary Care and community beds to help patients remain in a community setting and enable prompter discharge from hospital. An integrated care bureau and a falls service sit within this specification.

2.2.2.3 **Specialist advice and support** has clinical staff knowledgeable about specific conditions such as diabetes and heart failure. There is an expectation that Community Services will strengthen links between Secondary Care specialist knowledge and Primary Care support and ensure patients, carers and professionals within the community are empowered and educated to better understand and manage the specialist clinical condition.

2.2.2.4 **Locality hubs** are settings that bring organisations together to meet population needs and focus on proactive care and a holistic approach to improve health and wellbeing. These hubs will also support patients to have the investigations and treatments they need closer to home. This specification includes frailty management and the development of future locality hubs to provide services at scale across providers, such as access to mental health services, social care support and Third Sector services. It is expected that Social Prescribing will be part of this service, using care navigation for patients and carers to access the support they need to keep them healthy and well and align with care navigators being developed in Primary Care Networks to ensure there is alignment and not duplication.

2.2.3 These four service specifications group together services according to the level of need and complexity of patients they support, all designed to help people to stay in the community.

Figure 1: Out of hospital model of care



2.2.4 Schedule 2a contains the detailed Service Specifications.

2.2.5 The adult Community Services Provider is expected to manage all the services it offers to the population in an integrated manner. Services will work together to enable seamless access and provision to the care and support people may need, reducing the number of transfers of care and gaps in care experienced. Concise and timely communication with people using the service and other organisations supporting them is required to enable continuity of care and a better understanding of a person's needs and expected goals. The population must have the same access to services no matter what their needs are or where they live. They will be able to rely upon staff to provide continuity of care through a co-ordinated and personalised service.

2.2.6 It is vital that issues around transport are identified by the Community Services Provider to help tackle social isolation and access to services. This will include developing innovative ways of accessing care and support.

2.2.7 The adult Community Services Provider is required to support self-care and proactive care, with all staff able to support an asset-based approach and work with patients, carers and other organisations in the system to promote independence and wellbeing. Social Prescribing will be a core part of all services, focusing on patients' and carers' ability to access information and services to support themselves.

2.2.8 Primary Care is increasingly working towards seven-day access to care. The Community Services Provider will need to provide seven-day access and work innovatively with Primary Care and other providers across the system to ensure patients and communities are able to access proactive and reactive care.

2.3 Implementation timeline

2.3.1 From the start of the Contract on 1 April 2020, patients and carers must experience, at minimum, the same level of service that they have been receiving with no gaps in provision to their support.

2.3.2 The CCG expects services to be available as per the agreed project plan timeline showing when and how different aspects of the Specifications will be delivered, and any staged transformation approach to ensure consistency and the development of services across the CCG geography. The CCG will performance monitor the Provider's achievement of the agreed implementation timeline as part of regular contract reviews.

2.3.3 The CCG expects to see transformation through new and innovative approaches to managing demand, a focus on population demographics and need over activity monitoring and using the workforce creatively in partnership with other organisations and services to support health, wellbeing and independence for the population.

2.4 Underpinning policies

2.4.1 The CCG requires the Provider to keep up to date with local and national policies and quality requirements. The list below provides examples of documents the CCG expects the Provider to follow when delivering Service Specifications IACS0001, IACS0002, IACS0003 and IACS0004. The Provider is required to incorporate the most up to date versions of these and similar policies and practice when delivering the model of care.

- Serious Incident Framework - https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
- Never Event Policy - https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf
- Mixed sex accommodation - https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/
- Complaints procedures - https://www.england.nhs.uk/wp-content/uploads/2016/07/nhse-complaints-policy-june-2017.pdf
- Patient Experience - https://improvement.nhs.uk/resources/patient-experience-improvement-framework/
- Relevant NICE Guidance – the Provider is expected to assess their position with regard to recommendations outlined within clinical guidelines issued by NICE to improve outcomes for people using the NHS and other public health and social care services. Specifically mentioned guidelines in the quality schedule are:
  - Sepsis - https://www.nice.org.uk/guidance/ng51
  - Falls in older people - https://www.nice.org.uk/guidance/qs86
  - Pressure Injuries - https://www.nice.org.uk/guidance/qs89
  - Antimicrobial stewardship - https://www.nice.org.uk/guidance/qs121
  - Healthcare associated infections - https://www.nice.org.uk/guidance/qs113
- Commissioning excellent care and nutrition - https://www.england.nhs.uk/wp-content/uploads/2015/10/nut-hyd-guid.pdf
- Safe staffing guidance - https://improvement.nhs.uk/resources/safe-staffing-risk-assessment-tool/
- Mental capacity act - https://www.legislation.gov.uk/ukpga/2005/9/contents
- Intercollegiate Safeguarding standards and procedures (separate documents for adults and children and young people)
- CQC standards and regulations - https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers
- End of Life care
  - https://www.nice.org.uk/guidance/qs13
  - https://www.nice.org.uk/guidance/qs144
- Make every contact count - https://www.makingeverycontactcount.co.uk/
- Learning from death reviews – https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- Learning disabilities mortality review - https://www.england.nhs.uk/wp-content/uploads/2017/04/LeDeR-prog-secondary-briefing.pdf
- Personal health budgets - https://www.england.nhs.uk/personal-health-budgets/

Service Specification No.	IACS001
Service	Integrated Locality Teams – Core Services
Commissioner Lead	NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

1.1.1 This specification sets out the Requirements of the Provider in relation to core adult community health services: Integrated Locality Teams. This covers a proportion of the overall Contract and should be delivered in conjunction with service specifications IACS002, IACS003 and IACS004 in the context of the overall model of care, strategic landscape and enabler specifications set out in set out in IACS000 and IACS006. Each specification is expected to work integrally together as one service to meet the needs of the population.

2. Outcomes

2.1 The CCG expects the Integrated Locality Team service to contribute to the achievement of the following domains. These are subject to change following the national annual review.

2.1.1 NHS Outcomes Framework Domains & Indicators

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

2.1.2 Adult social care domains

1. Enhancing quality of life for people with care and support needs
2. Delaying and reducing the need for care and support
3. Ensuring that people have a positive experience of care and support
4. Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

2.1.3 Public health outcome domains:

1. Improving the wider determinants of health
2. Health improvement
3. Health protection
4. Healthcare, public health and preventing premature mortality

2.1.4 Local defined outcomes

2.1.4.1 The CCG wants Community Services to be seamless, coordinated and holistic, based on the principles set out in Reimagining community services: Making the most of our assets[3] (The King's Fund paper). This requires a shift away from focusing on an individual condition to care designed in partnership with the patient and their carers. Care will need to transcend historical boundaries of care setting, organisation or budgetary responsibility. Community Services will include a single core assessment process, completed once by a trusted assessor that evaluates the full spectrum of an individual's needs and coordinates a service response across different agencies and professionals. Another key principle is the development of seamless professional links and redefining organisational boundaries to instil collaboration with Primary Care and change the role of hospital specialists to support the wider health and social care economy. Community Services should promote an ethos of continuity of care and community involvement through the creation of dedicated locality teams and building operational links with the Third Sector and wider community organisations. The underpinning model of care is focused on supporting patients to achieve the best possible outcomes, in line with their needs and agreed goals.

2.1.4.2 It is expected that the realisation of these strategic aims will translate into a number of tangible outcomes including:

- Patients, carers and families will have a positive experience of care.
- A patient or carer with multiple needs will have a single, integrated care plan developed with them.
- A greater proportion of care will be provided closer to home in community settings.
- There will be a reduction of admissions to hospital and length of stay in hospital for those who are admitted; particularly for people over the age of 65.
- There will be a reduction in the number of potentially avoidable admissions (admissions with 0 to 48 hour length of stay for which no clinical procedure was carried out).
- Wellbeing will be maximised and independence maintained for longer, reducing the overall need for long-term care.
- Professional skills and expertise, including those of the Third Sector, will be effectively shared across services and organisations, building a more effective and resilient workforce.

2.1.5 Community-based outcomes framework

2.1.5.1 The CCG aims to build on national work to form a locally-based community outcomes framework, developing this with the Provider and patients so that the framework is tailored to local needs. This outcomes framework will encompass two domain types:

2.1.5.2 **Overarching domains** which cross the entire care pathway:

- Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient.
- Treating for people in safe environment and protecting them from avoidable harm.
- Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information sharing that links seamlessly with other services provided within the community.

2.1.5.3 **Pathway domains** which align to key stages of the care pathway:

- Early intervention with a focus on prevention to promote health, well-being and independence.
- Treatment and / or support during an acute episode of ill health.
- Long-term recovery and sustainability of health.
- Care and support for people at the end of their lives.

3. Scope

[3] https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf

3.1 Aim

3.1.1 The ultimate aim of the Integrated Locality Teams is to provide and coordinate a high quality, holistic response to an individual's care needs in a domiciliary or other community care setting that transcends clinical conditions and treats the person according to the needs and goals they identify, whatever clinical condition(s) they may have. The aim is to ensure continuity of care and minimise the number of people needed to help support a person stay healthy, well and independent in the community. This will be achieved through a robust assessment and care planning process that puts the patient and their carers at the centre. The service will work as one, in close collaboration with Primary Care creating a joined-up experience of care for the people of Bristol, North Somerset and South Gloucestershire, focused on quality outcomes for patients and carers. It should function according to the 'home first' principle, enabling people to live as independently as possible and be supported when needed in the community. This requires a service that knows the people it engages with, is able to proactively support people with health needs to manage at home and responds reactively when their needs increase. Collaboration should not be limited to Primary Care and ensure that other services within the Community Service and other organisations e.g.: Secondary Care, mental health and the Third Sector are included in providing a holistic approach.

3.1.2 Objectives

The Integrated Locality Teams will work to achieve a number of specific objectives:

- Reduction of emergency admissions and attendances at A and E
- Improved access to 7 day services particularly those relating to urgent care and crisis response
- Ensure patients, their families and carers have a high quality experience of care while demonstrating measurable improved outcomes
- Work seamlessly with the Primary Care professionals and other organisations in the health and social care setting, to implement defined Integrated Locality Teams and jointly identifying and managing patients in conjunction with General Practice
- To minimise duplication, fragmentation and confusion by providing a single point of access for all referrals where inputs can be coordinated around the needs of an individual patient
- To work collaboratively with social care, mental health and Third Sector agencies to ensure individuals can access a comprehensive health and social care support package
- To provide a comprehensive response at all stages of the patient pathway from proactive care through to end of life care; supporting individuals to remain in their usual place of residence and to improve the proportion of people who die in their preferred place of death. The community service should be responsible for helping patients and carers to navigate the services they require relating to their needs and identified goals.
- To delay the need for long term care through effective preventative care and intervention
- To manage resources efficiently to deliver an excellent standard of service within the financial envelope available
- To work with commissioners to refine the model of care and service delivery, utilising evolving best practice

3.2 Service description

3.2.1 The CCG has commissioned a community health service that is available to the entire adult population, regardless of where they live. These services will be tailored to people's level of mobility, frailty and other characteristics on an individual basis, but limited to people who have particular characteristics or condition profiles. This includes the ability of patients and carers to access services across traditional geographical boundaries.

3.2.2 Integrated Locality Team overview

3.2.2.1 The CCG will have a fully integrated community service that meets the needs of our population both now and in the future through the following conceptual model of out of hospital care, where General Practice, the community service, mental health, social care and the third sector work together to improve outcomes for patients.

3.2.2.2 Fundamental to the delivery of a new model of community services is the establishment of comprehensive Integrated Locality Teams. The Integrated Locality Teams will be fully integrated with geographical clusters of GP practices and any corresponding Locality Hub, combining workforce across both the Hubs and the Integrated Locality Teams to build staff skills and optimise the efficient use of resources. The Integrated Locality Teams will work closely with Primary Care colleagues on the development and delivery of care plans; and will discuss and manage patients on a multi-disciplinary team basis, with social care, mental health and the Third Sector. The Integrated Locality Team will work seamlessly with other services within the community services also to enable seamless care as patient needs changes without the need for a further referral to the service.

3.2.2.3 It is expected that the Integrated Locality Team will function across a 'hub and spoke' model whereby expertise can be concentrated at the Locality Hub sites in each GP Locality with a focus on proactive support to enable people to stay health, well and independent in the community; but, equally important, is the active and visible deployment of Integrated Locality Team resources in the community, working directly alongside Primary Care and transcending the boundaries between GP practices and traditional community services.

3.2.2.4 The Integrated Locality Team should comprise key clinical and therapeutic disciplines vital to the holistic support of patients in Primary Care; including but not limited to:

- Community nurses
- Hyper trained health care assistants in line with Bristol, North Somerset and South Gloucestershire 'Healthier Together[4]' workforce strategy
- Physiotherapists
- Occupational therapists
- Dieticians
- Podiatry
- Speech and language therapists
- Pharmacists
- Health educators
- Exercise advisors
- Care coordinators (note: one of the above professionals can also act as the care coordinator should this be the delivery model proposed by the Provider)
- Care navigators – where people with lived experience provide mentoring support to patients to enable independence and wellbeing

3.2.2.5 The clinical and therapeutic interventions to be made available under this specification are defined in full detail in subsequent sections.

3.2.2.6 Locality teams will also have strong, formal links with other professionals and key services through partnership working and future integration, including:

- Social care teams
- Pharmacists including the CCG's medicines management team, Primary Care pharmacists, Locality Hub pharmacists and community pharmacy
- Mental health services- wherever possible community mental health nurses are to be directly linked to geographically relevant Integrated Locality Teams
- Hospital specialists

[4] https://bnssghealthiertogether.org.uk/documents/item-4-workforce-visions-and-priorities/

3.2.2.7 These formal links and system pathways may be enabled through the development of for example, an Alliance contract and joint working approach across Providers in Bristol, North Somerset and South Gloucestershire.

3.2.2.8 Mental health services and social care professionals should form part of the Integrated Locality Team multidisciplinary team.

3.2.2.9 In addition, the core Integrated Locality Team membership will be supported by specialist staff with particular enhanced skills (as described in specification IACS002). These specialist staff will work across locality teams taking a leadership role in educating team members and Primary Care professionals and providing direct advice and care in the most complex of cases. The specialist skills available should include, as a minimum but not limited to:

- Respiratory specialist staff
- Heart failure staff
- Continence staff
- Non-blue light falls response
- Strength and balance and mobility
- Management of neurological conditions including multiple sclerosis and Parkinson's
- Tissue viability staff including proactive pressure ulcer advice and guidance to prevent pressure ulcers
- Diabetes specialist staff
- End of life care

3.2.2.10 The Provider is expected to deliver only the specialist inputs above that form part of specification IACS002 and establish defined pathways and protocols for others that are not in the direct scope of this contract e.g. specialist hospice services or specialist neurological teams.

3.2.2.11 The Integrated Locality Team will not only coordinate service responses from within the community Provider contract but will work with social care, hospital specialists, mental health services and the Third Sector to design a comprehensive support package that meets the needs of the individual as documented and agreed in the person centred outcomes based care plan.

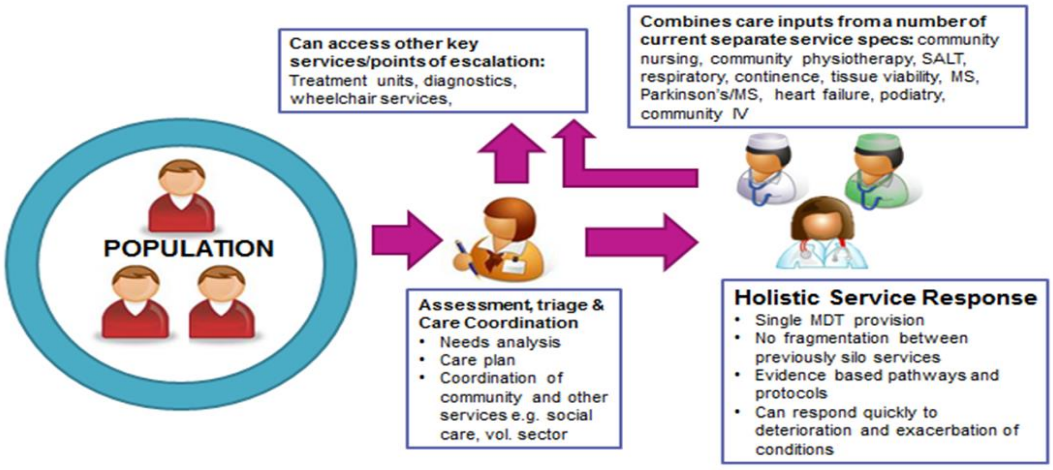
3.2.3 Care provision

3.2.3.1 The Integrated Locality Teams will coordinate and deliver a care response tailored to the needs and outcomes defined by each individual and their carer support network. This service will combine the key principles of a core common assessment process, development of an integrated care plan and provision of multi-disciplinary care that transcends previous notions of primary, community, secondary and social care. The number of Integrated Locality Teams will be determined through discussions with the Provider, the CCG and Primary Care Provider Locality Boards to ensure effective transformation that meets the needs of the local population

3.2.3.2 The Provider will deliver a person-centred outcomes based service response that will include assessment by a trusted assessor of any suitable professional background followed by coordination of clinical care inputs from across an entire multi-professional multi-disciplinary team

3.2.3.3 Multidisciplinary team professionals will have access to specialist support and will be able to swiftly navigate access to important additional services such as mental health, social care services, urgent ambulatory care and Bristol, North Somerset and South Gloucestershire-wide services such as diagnostics and wheelchair services. Patients and carers should experience care as a seamless journey with referrals not being treated as hand offs (see Figure 1)

Figure 1: Conceptual model



3.2.4 Referral

3.2.4.1 The Provider will accept referrals from patients and carers, GP practices and health and social care professionals directly involved in an individual's care and support. The Provider will ensure a single point of access for all of the clinical inputs and interventions detailed in this specification. This point of access will be provided in a way that maximises efficiency and integration with Primary Care ideally through interoperability with existing clinical systems. A single standard NHS.net email address and telephone number should also be provided.

3.2.4.2 The Provider will work to design a seamless and integrated approach for access to community services when patients present via the Integrated Urgent Care Service (IUCS) by calling 111. As identified in the Bristol, North Somerset and South Gloucestershire urgent care strategy[5] we have committed that we will develop a consistent assessment process where patients get to the right service for their needs irrespective of the chosen entry point or time of day. Where patients already have an agreed care plan with the Integrated Locality Team this will be shared with Integrated Urgent Care Service (expected through the Connecting Care hared record system) and will include key considerations on how to manage crisis most appropriately for that person. Where access to key community services are identified as needed by the patient through the agreed joint protocol the Provider will have an agreed process with the Integrated Urgent Care Service for connecting the patient with the service they need and ensure the patient is aware of the next steps and what to expect.

3.2.4.3 Upon receipt of referral the corresponding Integrated Locality Team will triage each case to determine the urgency and scale of service response required based on an evaluation of patient and carer need which will also be communicated to the patient and the referrer with a plan of review and detail of when this will occur. Where an individual may have multiple health and care needs a thorough core assessment should be undertaken by a trained care coordinator or by any other member of the Integrated Locality Team acting as a trusted assessor.

3.2.4.4 Non-urgent referrals will be processed within seven calendar days with confirmation of receipt and actions taken conveyed back to the referring clinician. Urgent referrals should be similarly processed within 48 hours and emergency referrals where an admission to hospital is otherwise imminent should be addressed with a corresponding action plan within two hours.

3.2.4.5 Where clinical advice is requested this should also be addressed within:

[5] https://bnssgccg.nhs.uk/library/delivering-urgent-emergency-care/

- 2 hours for cases prioritised as emergency after triage, where admission to hospital is otherwise imminent,
- 48 hours for cases prioritised as urgent after triage
- 7 days for problems prioritised as non-urgent after triage

3.2.4.6 In addition to receiving referrals from other parts of the health and care system the Provider, through their Integrated Locality Teams, will take an active role in working with General Practice in regular case-finding exercises to identify people who may benefit from proactive and holistic primary and community services. This case finding should take the form of a risk stratification algorithm. Predictive risk stratification modelling (e.g.: PRiSM) estimates the risk of individuals having an emergency admission to hospital within 12 months and selects patients for preventative community care to avoid admissions. The successful Provider would be expected to adopt partnership working with Primary Care colleagues to use an agreed Risk stratification algorithm within Patient records (triangulated by professional insight and experience) to proactively identify patients at risk of an Acute admission as a result of an exacerbation of their existing health challenges and via an multi-disciplinary team approach identify a suite of actions to work with the patient and as such as is reasonably possible relevant of delay the predicted acute episode of care.

3.2.4.7 The referral route and process will work seamlessly with existing GP systems e.g. EMIS Web. The Provider is required to co-design the referral process with CCG member practices as part of the mobilisation period. Further detail on the digital requirements is set out in IACS006. Any developments will ensure that communication with patients and carers is in their preferred format.

3.2.5 Assessment and care coordination

3.2.5.1 Assessment and care planning

3.2.5.1.1 During a patient's first contact with community services a proportionate core assessment will be completed evaluating the health and care needs and outcomes identified by the individual and carers. This core assessment can be completed by any member of the Integrated Locality Team as a trusted assessor ensuring that appropriately skilled staff are deployed to assess relative to the complexity of the patient's needs. This core assessment will be developed jointly with the Provider and Primary Care Provider Locality Boards and relevant system partners to produce one version of the core assessment across Bristol, North Somerset and South Gloucestershire during the mobilisation period and be signed off by the CCG. The principle of working is one professional, one visit and one form to inform cross professional working that meets patient identified needs and outcomes. For patients with a low level of clinical complexity, requiring a discreet intervention for a short period of time an abbreviated core assessment can be used focussing on aspects of preventative care, lifestyle intervention and education.

3.2.5.1.2 Results of the core assessment will be captured in a format that can be easily conveyed back to Primary Care, ideally through interoperability with the prevailing electronic clinical system. It will also allow for further clinical interaction i.e. that the format is read write not read only and is shared in the Bristol, North Somerset and South Gloucestershire shared care record, connecting care and with the patient.

3.2.5.1.3 Upon completion of the core assessment the relevant Integrated Locality Team, working in conjunction with an individual's GP will develop an outcomes driven, comprehensive care plan that appraises the health and care needs of the person and tailors a service response to enable the patient to achieve these outcomes. The format of this care plan will be agreed between the Integrated Locality Team and stakeholders but should evaluate the individual's:

- Physical environment, home adaptations and use of technology to promote safety and independence with a recognition of working with other partners to provide this e.g.: social care, third sector
- Medications management and compliance
- Management of long term conditions and symptom management
- Education, lifestyle and access to Third Sector services
- Mental health and emotional wellbeing
- Carer and family support
- Contingency planning and a response plan for periods of exacerbation or deterioration; if appropriate this should include Advance Care Planning for end of life care

3.2.5.1.4 The care plan will establish clear patient based outcomes and goals that will be agreed between the patient, carers, Integrated Locality Team and the individual's GP. The care plan will also include a symptom management or contingency plan that will support carers and professionals in acting appropriately during phases of deterioration or exacerbation; ensuring a suitable clinical response and minimising unnecessary ambulance and hospital activity.

3.2.5.1.3 A copy of this care plan should be held at the persons home, by the Integrated Locality Team and by the patient's GP. This care plan will be shared with the ambulance service, further supporting reductions in hospital conveyance. The format of this is to be determined with commissioners, Primary Care Provider Boards and the ambulance service during the mobilisation period. It is vital that processes are in place to ensure the plan is kept updated and any changes communicated to the patient and other organisations involved with patient care delivery. We expect this to be developed to have digital functionality over time.

3.2.5.1.4 The care plan will document whether the patient has any long term condition(s) and whether or not a formal diagnosis is recorded, where a formal diagnosis is not recorded this should be actioned for appropriate coding by the patient's GP.

3.2.5.2 Care coordination

3.2.5.2.1 Central to the delivery of a new model of integrated care is the way in which access to different services and professional inputs is planned and coordinated. The Provider will ensure that each person on the Integrated Locality Team caseload has a named care coordinator that will act as a consistent first point of contact facilitating access to services in line with the central care plan. This care coordinator may be a non-clinical or a clinical member of staff depending on the complexity of the patient and the Provider's judgement.

3.2.5.2.2 Care coordinators will work with individual GP practices acting as a focal point for navigating the health system, identifying available support services, processing referrals and monitoring the on-going delivery of care. The care coordinator will carry out these activities in support of the patient's primary GP and will therefore have a direct working relationship on a day to day basis.

3.2.5.2.3 It is the GP's primary role to make medical decisions, in collaboration with the patient and carers, as to the type and intensity of care and support an individual requires and the care coordinators role to manage the process by which services are accessed and delivered. The care coordinator will then act as a key point of liaison with the patient feeding back regularly to the GP and multi-disciplinary team on the progress of care delivery and any problems or issues arising.

3.2.5.2.4 The care coordinator will also act as a key conduit of communication between Primary Care and the rest of the out of hospital care environment ensuring that onward referrals and the coordination of other care services is managed with the knowledge and direction of the GP. It is therefore vital that the care coordinator has a highly developed day to day working relationship with staff in General Practice. It is also expected that the Provider will ensure staff are able to take maximal clinical responsibility for the management of patients when they are being seen by the service.

3.2.5.2.5 Care plans should be reviewed within the first three months and as needed to gauge adherence and make improvement and subsequently on at least an annual basis. This review will focus on the achievement of patient outcomes identified in the plan.

3.2.5.3 Primary Care engagement

3.2.5.3.1 The Integrated Locality Teams and wider community services staff will work in close collaboration with Primary Care professionals. In practice this must mean the alignment of key Integrated Locality Team staff such as care coordinators, district nurses and therapists directly with GP practices.

3.2.5.3.2 These staff must develop strong daily working practices and routine contact with GPs and Primary Care colleagues ensuring that care plans are produced and managed jointly where appropriate. A key principle is to ensure the correct skill of a member of staff is allocated to best meet and achieve patient needs and outcomes.

3.2.5.3.3 Key Integrated Locality Team staff, in particular care coordinators, social care, mental health, hospice nurses (where appropriate) and district nurses/community matrons should be represented at practice multi-disciplinary team meetings at a frequency agreed with the GP practice, in order to plan care delivery and the management of complex cases. Integrated Locality Team staff have an active obligation to update the patient's GP on the progress of community services delivery once planned and initiated, this should ideally be in a succinct written format, interoperable with the prevailing clinical record system/integrated record system, to be accessed as required.

3.2.5.3.4 The Provider will establish regular, formal mechanisms for collecting Primary Care feedback on the quality, responsiveness and coordination of community services and will ensure senior GP representation on senior management boards responsible for service planning, quality and delivery. The timing of this will be determined during the mobilisation period. It is also expected that the Provider develops a governance structure in partnership with Primary Care as Integrated Localities are developed (as described in IACS000).

3.2.6 Care delivery and review

3.2.6.1 Clinical care, in line with the holistic care plan, will be delivered by the most appropriately skilled professional in accordance with the supporting specifications. The Provider will ensure that continuity of care is prioritised and that staff know them and their carers needs. The number of separate visits from different professionals should be minimised and the Provider will cultivate a multi-skilled workforce, with staff providing a high level of generalist support rather than operating in silos of specialisation. The patient will have a single point of contact capable of dealing with queries relating to the individual's care plan, with the remit of contacting other professionals and organisations to answer questions and coordinate services.

3.2.6.2 The frequency and intensity of intervention will be dependent on the design of the initial care plan and the agreed goals and outcomes between the Integrated Locality Team and the individual.

3.2.6.3 The care plan will be reviewed at regular intervals agreed between the Integrated Locality Team, and the patient. A concise summary of feedback, changes made and any medical input required will then be fed back electronically to the patient's GP, ideally via direct interoperability with the clinical record system. The team will document progress against the agreed goals within the care plan and make adjustments to the level of support to reflect improvements or deterioration in wellbeing and independence.

3.2.6.4 Feedback on service delivery, changes to the care plan and progress against set goals will be communicated to the patient's GP and multi-disciplinary team as appropriate upon completion of a care plan review. This is to include concerns about a patient's short term health status and any recommendations relating to changes to Primary Care medical management e.g. medications changes.

3.2.7 Functions of the Integrated Locality Team

3.2.7.1 Integrated Locality Teams are a cornerstone of the model of care for Bristol, North Somerset and South Gloucestershire. These teams will provide the vast majority of community service contacts across a wide range of professional disciplines. The professional inputs and interventions provided by the Integrated Locality Team are described in detail within subsequent sections of this specification, however in broad terms, Integrated Locality Teams will deliver the following key operational functions:

- *Assessment, care planning and coordination* as described above
- *Proactive multidisciplinary care* encompassing the inputs and interventions below
- *Provision of clinical advice and support* - The Integrated Locality Team will have the capability to provide remote clinical advice and support to other professionals via telephone and email. Requests for advice via telephone should receive a response within the timescales detailed herein
- *Integration with Primary Care* - Integrated Locality Teams will develop genuine day to day working relationships with professionals in Primary Care, this will include regular representation of key Integrated Locality Team staff at practice multi-disciplinary team meetings and the alignment of named staff to practices or clusters of practices; but goes beyond this to actively blur the boundaries between Primary Care and community services with strong working relationships at an operational level.
- *Facilitating access to other professional inputs* - the effectiveness of the Integrated Locality Teams will not only be determined by how well they deliver direct care but also how well the interact with other professionals. Integrated Locality Team staff, under the auspices of a central care plan must be able to facilitate access to other professional interventions outside of the scope of these specifications. This particularly applies to medications reviews via the Locality Hub or CCG Primary Care pharmacists, mental health services, social care services and Third Sector services.
- *Leadership in advance care planning and end of life care* - Integrated Locality Team professionals will have a fundamental role in improving the quality and frequency of advance care planning. Professionals will proactively identify people approaching or potentially within the last year of life. The team will then work with patients, carers and other professionals to develop documented advance care plans for these residents. These advance care plans should utilise the CCG's recommended documentation (Recommended Summary Plan for Emergency Care and Treatment) as ratified by the CCG's End of Life Programme Board and Healthier Together – currently ReSPECT[6]

3.3 Interventions to be delivered

3.3.1 The following clinical and therapeutic interventions are to be provided in a single, integrated fashion under this specification, most commonly as part of the Integrated Locality Teams. These interventions are described in detail below.

3.3.1.1 Community nursing

[6] https://www.respectprocess.org.uk/healthprofessionals

3.3.1.1.1 Effective community nursing forms a central tenet of the Integrated Locality Team and will play a key role in the planning, coordination and delivery of care; working closely with Primary Care professionals. The Provider will primarily deliver such a comprehensive nursing service to patients in Bristol, North Somerset and South Gloucestershire who are in need of domiciliary care through a variety of skill mixes appropriate to the patients need.

3.3.1.1.2 The Provider will deliver a comprehensive community nursing response through the Integrated Locality Teams. This community nursing response should comprise an innovative skill mix of staff including (but not limited to) district nurses, nurse prescribers, advanced nurse practitioners, assistant practitioners and care assistants.

3.3.1.1.3 Regardless of the diversity of roles within the community nursing response it is expected that community nurses, as part of the Integrated Locality Team, have the required skills and competency to directly manage a full range of prominent long-term conditions prevalent across Bristol, North Somerset and South Gloucestershire (as defined in CCG Public Health Profiles). This direct management of multiple long-term conditions should be delivered by core community nursing professionals without an overreliance on a small number of specialist staff. A competency framework and training programme to support the management of multiple long-term conditions should be developed across all Integrated Locality Teams to ensure a consistent high standard of general nursing across Bristol, North Somerset and South Gloucestershire; such a framework should also include training in the associated mental health comorbidities and responsibilities under the Mental Capacity Act.

3.3.1.1.4 Community nurses will be equipped with the skills and confidence necessary to perform comprehensive needs assessments, develop care plans, coordinate services and deliver a range of health and care interventions.

3.3.1.1.5 Specifically community nurses will have the capability to deliver:

- *Comprehensive assessment and care planning* as described above.
- *Management of multiple long-term conditions* including (but not limited to) heart failure, COPD/Respiratory infection, dementia and cognitive impairment, diabetes (including monitoring, advice, support and administering injectable therapies)
- *Regular visiting, ongoing treatment and assessment* - regular provision of care in a patient's home or appropriate community setting (e.g. GP practices for ambulant patients) at a frequency appropriate to clinical need. This is to include on-going diagnostic monitoring and assessment and the provision of treatment in line with the established care plan.
- *End of life care* - community nurses form an important part of a network of end of life care professionals and organisations across Bristol, North Somerset and South Gloucestershire. Working in conjunction with the patient's GP, local hospices, the acute specialist palliative care team and key Third Sector Providers. Community nurses will, as key frontline professionals, work with the patient's GP to coordinate the inputs of these organisations in accordance with clinical need. Community nurses will provide on-going assessment as required, monitoring deterioration and prognostic indicators as well as providing pain management and symptom control for terminally ill patients.

3.3.1.1.6 The Integrated Locality Teams will adopt a common, consistent form of advanced care planning that has been agreed and ratified by the CCG's end of life programme board and Healthier Together and support the implementation and use of ReSPECT.

3.3.1.1.7 They will also use current and future developed methods of recording the wishes of patients and carers e.g.: EPAaCCS (Appendix 1) and the Bristol, North Somerset and South Gloucestershire anticipatory prescribing drug chart[7].

[7] https://www.bnssgformulary.nhs.uk/includes/documents/anticipatory-prescribing-form%20(1).pdf

3.3.1.1.8 The Provider will deliver end of life care in line with the effective principles of care for different stages of a patients care pathway as set out by the national framework in 'ambitions for palliative and end of life care'[8].

- *Post bereavement visit* - following the death of a patient on the Integrated Locality Team caseload a post bereavement visit will be undertaken assessing the needs of family and carers and sign-posting to relevant support and advice services e.g. bereavement counselling.
- *Wound management including leg ulcer management* - Integrated Locality Team nurses will provide evidence-based, high quality assessment, treatment and advice for patients with wounds, including provision of a local accessible community clinic based service for ambulant patients. The Provider will consider the scope of specialist tissue viability services and the current Locally Commissioned Service for wound care in General Practice (as referenced in IACS002) to mitigate any duplication of service and make the most efficient use of resources.
- *Medication and treatment administration*- Integrated Locality Team nurses will provide support and education to patients on the administering of their prescribed medications and in the ongoing delivery of treatments; such interventions may include:
    - Syringe pump medication
    - Rectal insertion
    - Transdermal medication
    - Intramuscular
    - Subcutaneous injection- including administering insulin where required
    - Care of central venous lines including site care and flushing of dormant lumens
    - PEG feeding including regular follow-up visits for monitoring
    - Manual evacuations and enemas
    - Stoma/ostomy care- linking with stoma care nurses in Secondary Care to ensure specialist care and support is provided where required
    - Opportunistic vaccinations- influenza, pneumonia, shingles
    - Administering of planned course of injectable treatments in line with the expected skill level of a community nurse e.g. (but not limited to) Zoladex and Prostat
    - Working with the relevant pharmacist to initiate medications review and clearance in a patients home if clinically beneficial
    - Bowel care

3.3.1.1.9 Appropriate nurse prescribing should be supported under the specification and is recognised as an important skill that should be promoted as much as possible across the workforce. It is expected that the Provider will develop its workforce according to the strategic principles of Healthier Together.

3.3.1.1.10 All staff will have the ability to signpost for further specialist care and access hospital teams for training and support in the on-going care for other invasive devices that may be used less frequently:

- *Continence care* - Integrated Locality Teams should provide a high standard of generalist continence care including the provision of advice and support, arranging the provision of continence supplies and accessing input from specialist professionals in the most complex of cases.

- *Catheter care* - Staff will provide highly responsive and effective catheter care eliminating unnecessary AandE attendances and avoidable emergency admissions.

[8] http://endoflifecareambitions.org.uk/

Such care is to include the flushing, replacement, insertion and on-going active management of urethral and supra-pubic catheters for both sexes. This provision also includes the bypassing of blocked catheters. Management of complex catheters e.g. chest drains or complex urinary catheters is to be supported under this specification with relevant training and clinical support from other professionals if necessary. Acute attendances as a result of blocked urinary catheters will be treated as a SUI to aid learning. Regular reviews and planned catheter changes should also be delivered in line with the agreed care plan, utilising other related services e.g. the Locality Hubs as appropriate. This care will be delivered in line with local guidelines and include the issuing of catheter passports.

- *Emotional wellbeing* – Community staff should have an appropriate level of mental health training and expertise to provide emotional wellbeing support for patients with common mental health conditions. Particularly those conditions that correlate with the presence of physical long-term conditions or disability e.g. anxiety and depression and those prevalent in older people such as dementia. Community nursing staff should be able to provide basic dementia screening and depression screening and coordinate a service response from other health service professionals, the Third Sector or specialist mental health services as required.

- *Continuing healthcare assessment* - Integrated Locality Team professionals will facilitate access to Continuing Healthcare through the completion of relevant assessment processes. The Provider should establish a clear formal process with the local Continuing Healthcare Team clearly articulating the means of accessing CHC packages of care and the responsibilities of key professionals within the assessment and care initiation pathway. This will include the provision of Personal Health Budgets in accordance with schedule 2M (Development plan for personalised care)

- *Provision of advice, education and support to maintain independence* - all Integrated Locality Team professionals have an overarching responsibility to provide advice, education and support to individuals to support overall wellbeing and independence. This includes lifestyle advice and signposting to supporting services beneficial to overall health and wellbeing.

3.3.1.2 Community rehabilitation (physiotherapy and occupational therapy)

3.3.1.2.1 Provision of key rehabilitative therapies is a core component of the Integrated Locality Teams. The Integrated Locality Teams should encompass an appropriate skill mix of physiotherapists, occupational therapists, therapy assistants and extended scope therapists. The competency and range of intervention of these key staff groups should be in line with those set out under the relevant skills for health competency and career frameworks; however the actual competency framework and mix of staff is at the determination of the Provider.

3.3.1.2.2 Rehab and therapy staff, as part of the overall Integrated Locality Team working shall aim to provide holistic rehabilitation with the ultimate goal of recovering and prolonging independence.

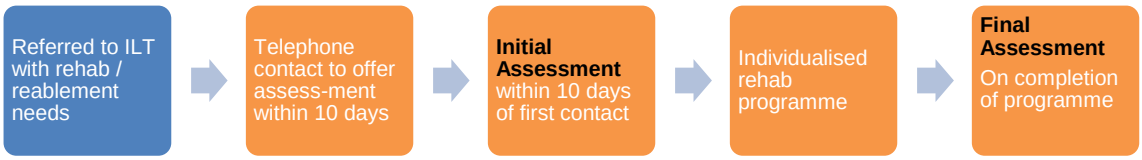
3.3.1.2.3 Therapy staff will work as part of the Integrated Locality Team to provide professional assessment, supporting the development of the core care plan and the setting of individual

goals and outcomes. Therapeutic programmes will then be designed and delivered that can demonstrate the following:

- An increase in both step-up care and home-based therapy, rehabilitation and reablement
- Programmes which systematically identify and actively engage people potentially eligible for rehabilitation services
- Effective coordination of care between Primary Care professionals and other members of the Integrated Locality Team minimising the need for unnecessary delays in the inception or continuation of rehabilitation and reablement
- Provision of personalised plans, as part of a single shared record, based on comprehensive individual assessment
- The use of technology to support the therapeutic and rehabilitation/reablement process
- Specialist input into the service as required
- Flexibility- enabling therapeutic programmes to be tailored to the needs of individuals; including the provision of evidence based exercise and education programmes in home and convenient community settings at a range of times to suit service users.
- A re-offer process – for patients who decline to take up rehabilitation; 3 attempts should be made at different times to invite them to take part in a programme

3.3.1.2.4 Upon identifying the need for rehabilitative therapy Integrated Locality Team professionals will undertake the necessary assessment process to construct a personalised programme of treatment; in line with Figure 2 below. The first therapy assessment should be made within 10 operational days of referral or of the Integrated Locality Team establishing clinical need. This initial assessment will encompass the programme design and the agreement of goals between the Integrated Locality Team professionals, patients and carers. A follow-up assessment will then take place at the end of the programme to gauge progress and measure outcomes. At all stages patients should be kept updated about their care.

Figure 2: Rehabilitation process



3.3.1.2.5 Integrated Locality Team professionals will develop programmes containing individually prescribed physical exercise or therapeutic functional activity training, self-management advice and multi-disciplinary education as part of the wider central care plan. The service should consider supportive tools such as training diaries in the delivery of rehabilitative programmes.

3.3.1.2.6 The individualised nature of these plans will consider that patients will progress and achieve their goals at different times and therefore allow flexibility in the length and intensity of the rehab programme.

3.3.1.2.7 Upon completion and discharge, effective written communication direct into electronic records will be fed back to other members of the Integrated Locality Team and to Primary Care professionals. The central care plan will also be updated to reflect on-going progress and changes in the patient's condition. Patients will finish their rehabilitation programme with an agreed personalised maintenance plan detailing how wellbeing and functional ability can be further improved and preserved on an ongoing basis. Integrated Locality Team professionals will also have the capability to facilitate access to a range of Third Sector organisations and activities that could support this maintenance.

3.3.1.2.8 All rehabilitation programmes will offer professional supervision consisting of the following elements:

- Initial assessment to determine risk factors, patient needs/goals and limitations
- Education and health behaviour change discussions
- Psycho-social health assessment and appropriate intervention
- Medical risk factor management
- Lifestyle risk factor management; physical activity/exercise, diet, smoking cessation
- Cardio-protective therapies
- Plans for long-term management including access to exercise groups and Third Sector services
- Audit and evaluation

3.3.1.2.9 Therapy and rehabilitation input as part of the Integrated Locality Team will be accessed based on clinical need and will be made available to key patient cohorts including (but not limited to) those with:

- Neurological conditions- multiple sclerosis, stroke, Parkinson's disease, brain injury and motor neuron disease
- Balance, mobility or functional problems following an episode of clinical deterioration or spell of acute care or falls risk identified
- Complex frail elderly patients
- Long term conditions requiring education and/or therapeutic intervention

3.3.1.2.10 Direct access physiotherapy solely for musculoskeletal problems **will be** included as part of this service specification and need to align with and adapt to a Bristol, North Somerset and South Gloucestershire approach across settings for this. Provision of post-operative orthopaedic rehabilitation is **not included** in this service.

3.3.1.2.11 The Provider will actively pursue and drive the transformation and integration of health and social care rehabilitation and reablement staff under a single model of management, sharing responsibilities and making the most efficient use of resources, as defined in IACS000.

3.3.1.3 Dietetics

3.3.1.3.1 Dietetic professionals will be part of the Integrated Locality Teams and will provide the multi-disciplinary team, Primary Care professionals, care homes and other community services with prompt access to specialist nutritional advice and intervention. Dieticians working within the Integrated Locality Team will be registered with the health care professions council and will adhere to current NICE guidance.

3.3.1.3.2 Practice will be based on evidence, utilising primary research, meta-analysis from the academic base of nutrition, dietetics, medicine and social and behavioural sciences and will provide appropriate therapy using audit, NICE guidance, national service frameworks, Cochrane reviews and professional consensus in line with national and local policies.

3.3.1.3.3 The dietetic expertise available will encompass clinical specialisms in complex nutritional support, enteral tube feeding, dietary support for chronic and metabolic conditions such as diabetes.

3.3.1.3.4 The Provider shall utilise an innovative skill mix of staff ranging from senior specialist dieticians to dietetic assistants.

3.3.1.3.5 Delivery of high quality dietetic support via the Integrated Locality Teams shall include:

- Collaborative working with the other professionals across the Integrated Locality Team to improve nutritional screening and ensure dietetic considerations are reflected in the care planning process
- As part of the Integrated Locality Team, support and improve the discharge pathway for malnourished patients, who are otherwise fit for discharge from in-patient and out-patient care
- Provide diet therapy for chronic and sub-acute conditions to individuals and groups as part of an multi-disciplinary team approach
- Provide ring-fenced dietetic time in primary and community care settings for patients with diabetes.
- Support the delivery of the Bristol, North Somerset and South Gloucestershire diabetes programme
- Provide development time to ensure dieticians have competencies as an educator for diabetes
- Provide dedicated, ring-fenced dietician input for housebound, nursing and residential home residents with a particular focus on the effective management of swallowing difficulties, nutritional screening and diabetes management
- Provide nutritional training and development to other health and social care staff, focused on malnutrition, enteral tube feeding and nutritional screening
- Deliver services to support lifestyle change and weight management
- In addition to the core dietetic services, dietetic professionals will provide advanced practitioner support to other professionals across the Integrated Locality Team and other agencies in the clinical areas of stroke, home enteral tube feeding, coronary heart disease and diabetes
- Enable patients to change their behaviours, achieve increased physical activity and improved nutritional intake
- Continually monitor, review and evaluate weight management and other clinical interventions
- Nutritional screening using the MUST tool, local ONS guidelines and supporting information as found in the Bristol, North Somerset and South Gloucestershire formulary nutrition section https://www.bnssgformulary.nhs.uk/

3.3.1.3.6 The Provider will deliver structured patient education courses to people with diabetes in Bristol, North Somerset and South Gloucestershire in line with Bristol, North Somerset and South Gloucestershire Healthier Together's diabetes programme and the National Diabetes Prevention programme as detailed in IACS002.

3.3.1.4 Podiatry and orthotics

3.3.1.4.1 A full range of podiatric and orthotic therapies should be accessible as part of the Integrated Locality Teams. This should encompass a full spectrum of complexity from basic foot health and nail care through to the treatment of ulceration and complex foot problems.

3.3.1.4.2 Podiatrists will be involved in the care planning and assessment process where foot health is a potential issue. Clinical interventions will be delivered across a diverse skill mix of effective professionals including assistant practitioners in podiatry, registered podiatrists and advanced specialist podiatrist for example diabetic podiatrists.

3.3.1.4.3 Foot care professionals will work as part of the Integrated Locality Teams but will also work seamlessly with other specialist teams, agencies or professionals including tissue viability services, community and acute specialist diabetes teams, vascular teams, orthopaedic and musculoskeletal teams. This joint working should occur across defined, formalised and agreed pathways and protocols between agencies and professionals.

3.3.1.4.4 Foot care professionals will provide treatment to all those individuals identified to the Integrated Locality Team from either Primary Care professionals, community services or any other professional directly involved in an individual's care and treatment. Individual treatment regimens will then be formulated against the agreed, central care plan.

3.3.1.4.5 These treatment regimens should include (but are not limited to):

- High risk foot management associated with long term pathologies e.g. diabetes, vascular rheumatology problems
- Wound and ulcer care
- Biomechanics and gait analysis
- Orthotic provision
- Nail surgery
- Therapy treatments e.g. laser therapy, electrotherapy, cryotherapy
- Nail and skin management for high risk patients
- Regular maintenance treatment and follow-up for those identified as at high risk of severe foot problems or amputation
- Foot health education (individual or group) to prevent deterioration in foot health

3.3.1.4.6 In addition the Provider is also required to form effective partnerships with community, Third Sector and faith sector Providers to facilitate easy access for patients to basic foot and nail care services e.g. nail clipping. The Provider is required to prioritise the treatment and regular follow-up of problems associated with the diabetic foot as well as rheumatology and vascular conditions that pose a high risk to foot health.

3.3.1.4.7 The Provider may choose to deliver basic foot and nail care, including nail cutting, where there is a genuine medical need that could result in more complex health issues e.g. for falls prevention or mobility issues. Verruca treatment is excluded from the direct scope of this service. The Provider should seek to ensure that partners across the local area, particularly the Third Sector, are engaged wherever possible in the provision of basic foot and nail care. The Provider will ensure foot care professionals have access to a wider specialist clinical network for urgent/emergency referrals and access to advice e.g. for advanced diabetic and vascular complications.

3.3.1.5 Speech and language therapy

3.3.1.5.1 Patients and Primary Care professionals will have defined access to speech and language therapy through the Integrated Locality Teams. The Provider is to work with speech and language therapy services across Bristol, North Somerset and South Gloucestershire to ensure local staff resources are used as efficiently as possible, so that complex skill levels are maintained and that sufficient speech and language therapy capacity is available to meet the needs of those suffering from a stroke and the varied other needs of the wider population.

3.3.1.5.2 The Integrated Locality Teams are expected to coordinate and manage speech and language therapy input based on individual need in accordance with the central care plan. This comprehensive, high quality speech and language therapy input will include assessment, impairment and functionally based therapy programmes, as well as advice and education for the individual, their carers and other healthcare professionals (including care home staff).

3.3.1.5.3 Specifically this speech and language therapy input through the Integrated Locality Team will provide:

- Assessment, differential diagnosis, rehabilitation and management of communication disorders as a result of brain injury and Progressive neurological conditions etc.
- Assessment, rehabilitation and management of swallowing disorders, including for those with advanced dementia or other neurological impairment
- Voice therapy for Parkinson's disease.
- Assessment for, and provision of, patient-tailored low tech communication aids.
- Differential diagnosis of swallowing difficulties in relation to adults presenting with a dual medical diagnosis of both an acquired neurological condition and dementia.
- Differential diagnosis of swallowing difficulties in adults presenting with either an undiagnosed neurological condition or other medical conditions e.g. oesophageal presentation
- Onward referral as appropriate to specialist centres for assessment of high tech communication aids.
- Internal training on a range of specialist topics e.g. to members of the Integrated Locality Team and wider Primary Care and health care professionals
- External training as required e.g. to nursing and residential homes on prevention for patients with swallowing disorders.
- Education of patients and carers to enable them to independently manage their on-going conditions

3.3.1.5.4 All patients referred to the Integrated Locality Teams will have access to speech and language therapy input based on clinical need. This extends equally to all patients in nursing and residential homes.

3.3.1.6 Home-based investigations service

3.3.1.6.1 The Provider will deliver an efficient and responsive home-based investigations service delivered by health care assistants or equivalent staff specifically trained in a number of basic care processes, specifically:

- Phlebotomy
- Blood pressure monitoring
- Collecting of urine samples for urinalysis
- Measurement of weight and basic monitoring
- In addition, the Provider is expected to support relevant public health campaigns through this service, including the delivery of opportunistic vaccinations and influenza vaccination

3.3.1.6.2 The Provider will also work with the commissioners to develop the capability to deliver basic near patient testing through this service over the course of the contract, for example, the provision of 24 hour blood pressure monitoring and electrocardiograms. It is anticipated that in the future as integration progresses this will develop alongside working more closely with acute Providers to meet the needs of the population closer to home.

3.3.1.6.3 The Provider will deliver domiciliary phlebotomy services to the required capacity and frequency to meet demand while ensuring timely service delivery to avoid delays in clinical analysis and results.

3.3.1.6.4 Domiciliary phlebotomy will be available to all individuals determined as in need of domiciliary care by the referring Primary Care professional. Phlebotomy services will be delivered in line with the following response times:

- Bloods referred as urgent: sampled within 24 hours
- Bloods referred as non-urgent: sampled within 7 days (including weekends)
- Bloods referred for on-going monitoring sampled within a specified timeframe or required regular intervals (e.g. monthly, bi-monthly, annually etc.)

3.3.1.6.5 The Provider will need to demonstrate that a planned regular programme of staff education, training and support is in place, including:

- All staff will be expected to have undergone appropriate training in phlebotomy, blood pressure monitoring, basic monitoring such as taking a person's weight, urine sampling, delivery of vaccinations and an awareness of adverse reactions.
- Staff to be aware and updated in the appropriate container selection and details of specific test protocols (e.g. glucose tolerance testing, drug level analysis) should be available.
- All staff must be aware of the Provider's protocol with regard to the disposal of sharps, contaminated materials and spillage and needle stick injuries.
- All staff must be immunised against Hepatitis B and their immunity status recorded every 5 years.
- The Provider to ensure that sufficient trained members of staff are available to meet the service demand at all times including periods of annual leave or sickness.

3.3.1.6.6 The Provider's approach to domiciliary care and home based investigations should be one that aims to maximise efficiency and adhere to the principles of *Making Every Contact Count*[9]. This means the Provider has a responsibility to maintain a multi-skilled workforce capable of delivering a range of interventions in a single visit and to use this capability to reduce waste and minimise the number of separate visits for patients. This may mean at times it is more resource efficient for community nursing staff or other professionals to carry out basic investigations like taking blood.

3.3.1.7 Support to nursing and residential homes

3.3.1.7.1 The Provider will ensure a fundamentally equitable standard of service provision and access to those residents in nursing and residential homes (care homes) via the Integrated Locality Teams. Through the geographically relevant Integrated Locality Team the Provider is to ensure all care homes have equivalent access to the full multi-disciplinary team of community services. The ultimate aim is to improve the quality and experience of care for nursing and residential home residents across Bristol, North Somerset and South Gloucestershire and to avoid unnecessary exacerbations and/or hospital attendance/admission. This encompasses a number of specific service objectives:

- To systematically develop a consistent, holistic care home support plan for individual nursing and residential homes across Bristol, North Somerset and South Gloucestershire for those people with multiple long terms conditions, those at risk of hospital admission, frail and/or considered to be in the last year of life
- To proactively identify care home residents at high risk of hospital admission, conduct a thorough assessment and put in place a care plan to improve outcomes and prevent such admissions. A copy of this care plan should be held by the patient and be transferred should they move care setting.
- To support care home staff to supplement their existing mandatory training programmes with direct access to enhanced clinical skills and competencies; particularly in continence care, dementia management, tissue viability, peg feeding and end of life care
- To provide a high standard of direct clinical care to care home residents (as defined in sections above) with complex needs and/or those who are at a high risk of admission
- To provide prompt and responsive clinical advice to care home staff, especially to support admission avoidance
- To drive improvements in care practice within nursing and residential homes and disseminating best practice across the sector
- Developing strong professional relationships with care home managers, staff and related Primary Care professionals
- Drive the adoption of a single, best practice approach towards advance care planning
- To integrate and align with an holistic model of care for the frail elderly in Bristol, North Somerset and South Gloucestershire and not create separate pathways

[9] https://bnssghealthiertogether.org.uk/mecc/

3.3.1.7.2 The Integrated Locality Teams, as part of their care homes support function, will have defined professional links with a number of other services across the health and social care system. In particular, the community mental health teams delivering direct care to nursing and residential homes should be represented at multi-disciplinary team meetings and processes should exist to share information and coordinate access to mental health professionals, promoting a collaborative approach to care planning and delivery.

3.3.1.7.3 The Integrated Locality Team will have strong professional links with other key services including:

- Primary Care
- Social services
- Integrated urgent care service – Severnside
- Other acute specialties and specialist services - for clinical advice and support
- Ambulance services
- Community beds
- Acute discharge and in-reach teams (links to urgent and reactive care)
- Integrated care bureau
- Local hospices – St. Peter's Hospice and Weston HospiceCare

3.3.1.7.4 The relevant Integrated Locality Team will agree a jointly owned support plan with the care home and GP practices related to that home, detailing the medical support to the home, agreeing joint working practices with the GP and setting out processes for effective information sharing between the care home and General Practice in line with the Care Quality Commissioner's framework for best practice and high quality care in a care home setting.

3.3.1.7.5 The Integrated Locality Team will, as a priority, initially target those homes where the greatest scope for quality improvement exists i.e. those with poor Care Quality Commissioners reports or quality assurance concerns or with the highest levels of acute sector activity.

3.3.1.7.5.1 *Development of care home support plans*
The Integrated Locality Team will work with care homes within their natural geography, at an organisational level, as part of a rolling programme and systematically work to develop and deliver a support plan to all homes in Bristol, North Somerset and South Gloucestershire.

3.3.1.7.5.1.1 The Integrated Locality Team will prioritise the development and delivery of a support plan to those homes with:

- Established safeguarding or quality concerns; inadequate Care Quality Commissioners reports
- A high number of hospital admissions or a high ratio of hospital admissions compared to the care home bed base

3.3.1.7.5.1.2 This holistic plan holistic plan is to be agreed between the Integrated Locality Team professionals, the care home and the supporting GP practice(s).Such a support plan is to capture, at a minimum:

- The case mix and clinical requirements of residents
- Identification of high risk residents for whom specific care plans should be developed detailing the inputs and frequency from the Integrated Locality Team (as described in the section below)
- The inputs, and their frequency, of GP practices with registered patients within the home
- An assessment of the care home staff skills and relevant training needs and facilitation of access to a matrix of training opportunities in collaboration with local partners
- An initial assessment of the homes operating processes e.g. staffing skill mix/establishment, record keeping, information sharing, care environment
- Agreement of a specific improvement plan relating to the above if required
- Identification of residents with end of life care needs for whom an advance care plan should be developed
- An assessment of what other service inputs are required by residents in the home and coordination of referrals to other services e.g. specialist end of life care services, falls prevention etc.
- RCA review of acute admissions and ambulance call outs

3.3.1.7.5.1.3 The support plan should focus on developing the skills and competencies of care home staff and delivering high quality, equitable access to the advanced skills of community service professionals. The support of the Integrated Locality Team should not be used as a substitute for core nursing and care activities which the care home itself should be responsible for providing.

3.3.1.7.5.2 *Comprehensive assessment and care planning for high risk patients*
The Integrated Locality Team will proactively identify patients within nursing and residential homes who would benefit from a period of more intensive clinical management across the multi-disciplinary team. This cohort of patients will be of particular complexity or will have care needs that cannot be quickly and easily met by other general health and social care services; these patients will be at high risk of admission to hospital.

3.3.1.7.5.2.1 Once an appropriate care home resident has been identified a core assessment will be carried out by an appropriate member of the Integrated Locality Team.

3.3.1.7.5.2.2 Based on the outputs of this assessment the Integrated Locality Team, in conjunction with the patient's GP, will develop a holistic care plan for the resident. This care plan will detail how the individual's care needs will be met and the responsibilities of the care home staff, members of the Integrated Locality Team and the resident's GP. The care plan will include a symptom management or contingency plan that will support care home staff in acting appropriately during phases of deterioration or exacerbation; ensuring a suitable clinical response and minimising unnecessary ambulance and hospital activity

3.3.1.7.5.2.3 A copy of this care plan should be held at the home, by the Integrated Locality Team and by the patient's GP. This care plan will be documented appropriately in agreement with the ambulance service to enable the sharing of information, further supporting reductions in hospital conveyance.

3.3.1.7.5.2.4 The care plan will document whether the patient has dementia and whether or not a formal diagnosis is recorded, where a formal diagnosis is not recorded this should be actioned for appropriate coding by the patient's GP.

3.3.1.7.5.2.5 The Integrated Locality Team will deliver clinical care and interventions to high risk individuals, in-line with the documented care plan; maintaining an active caseload of residents receiving intensive support. Once an individual's condition has been stabilised or processes have been developed by which care home staff feel confident to properly manage the needs of the patient, the input of the Integrated Locality Team can be reduced or the patient can be discharged from the caseload.

3.3.1.7.5.2.6 Care plans should be reviewed within the first three months to gauge adherence to patient goals and outcomes and make improvement and subsequently on at least an annual basis.

3.3.1.7.5.3 *Medications reviews*
The Integrated Locality Team will, as part of the initial assessment of care home residents, facilitate access to medications reviews working with Primary Care pharmacists ideally through joint reviews working directly with the resident's GP.

3.3.1.7.5.4 *Multidisciplinary team meetings*
The Integrated Locality Team will conduct regular multi-disciplinary team meetings within different care homes to discuss support provision as well as the specific clinical care to high risk patients on the service case load.

3.3.1.7.5.4.1 These multidisciplinary team meetings can be carried out within the relevant care homes themselves. The multi-disciplinary team should encompass all relevant professionals that form part of the Integrated Locality Team based on the needs of the particular care home or of individual residents. Invitations shall also be extended to care home staff, relevant GPs, mental health services, members of the relevant social care team and any other specialist clinicians that may provide valuable clinical input.

3.3.1.7.5.4.2 On a less frequent basis the Integrated Locality Team may wish to hold multi-disciplinary team meetings with a cluster of homes or GP practices to share common learning and disseminate good practice.

3.3.1.7.5.5 *Clinical advice and support*
The Integrated Locality Team will have the capability to provide remote clinical advice and support to care home staff and GPs via telephone and email in line with digital developments as described in IACS006.

3.3.1.7.5.5.1 As part of the care home support plan the process for accessing clinical advice will be agreed between the Integrated Locality Team and the home manager.

3.3.1.7.5.5.2 Requests for advice via telephone should receive a response within the timescales detailed herein.

3.3.1.7.5.6 *Urgent response and visiting*
The Integrated Locality Team will have the capability to coordinate and mobilise an urgent care response within two hours to home residents in the form of face to face visiting through the relevant Integrated Locality Team or the Acute and Reactive Care Function specified in IACS003. Such visits will be planned and agreed between the care home staff, the GP and the community services Provider. This response may be carried out by a member of the Integrated Locality Team working with the specific care home or a response may be coordinated through the Intermediate Care Function depending on appropriateness, availability of resource and considering continuity of care.

3.3.1.7.5.6.1 The Integrated Locality Team will also have the capability to coordinate and mobilise a response from other key services, including the relevant GP practice and mental health services.

3.3.1.7.5.7 *Leadership of advance care planning and end of life care*
Integrated Locality Team professionals will have a fundamental role in improving the quality and frequency of advance care planning. Professionals will proactively identify those residents approaching or potentially within the last year of life. The team will then work with care home staff to develop documented advance care plans for these residents. This should make use of current and future developments relating to end of life care e.g.: ReSPECT, the electronic end of life care record (EPAaCS) and the Bristol, North Somerset and South Gloucestershire community end of life anticipatory prescribing drug chart.

3.3.1.7.5.7.1 These advance care plans should utilise the standardised documentation as ratified by the Bristol, North Somerset and South Gloucestershire CCG's end of life care programme board and Healthier Together through the implementation of ReSPECT. The Provider is expected to work with the CCG to optimise the use and availability of information from ReSPECT across the system.

3.3.1.7.5.7.2 Depending on the skills and confidence of care home staff, it may be appropriate for members of the Integrated Locality Team to take a lead on initiating end of life care discussions with residents and families and in developing the first end of life care plans within a home. This should always be done jointly with care home staff to enable the transfer of skills and the building of confidence

3.3.1.7.5.8 *Analysis of training needs and workforce development*
Integrated Locality Team professionals, working directly with the social care quality assurance teams, will also have a prominent role in providing professional leadership to the care home sector. This will include an analysis of the skills and competencies of care home staff, establishing training needs and developing a strategy for improvement through the care home support plan.

3.3.1.7.5.8.1 The Integrated Locality Team will up-skill and develop care home staff through joint working 'on the ground' within the homes themselves as well as the delivery of more structured learning and education to individual or clusters of care homes.

3.3.1.7.5.8.2 The Provider will work with Bristol, North Somerset and South Gloucestershire Councils, Bristol, North Somerset and South Gloucestershire CCG and Healthier Together to develop and support a holistic training programme across the residential and nursing home sector.

3.4 Transitional care

3.4.1 This specification primarily details adult services to be provided to those over the age of 18, however, the Provider will also be required to provide professional input to those between the age of 16 and 18 years old as part of a transitional care plan coordinated by local paediatric services and Primary Care professionals..

3.4.2 This transitional provision may include (but is not limited to):

- Joint clinics with children's services professionals including SEND
- Advice and support to health care professionals within children's services
- Provision of information regarding adult services during the course of the transition period
- Contact with the patient and their family in advance of transition to adult services to provide information, reassurance and ensure a properly planned transition from children's services.
- Provision of key interventions and investigations such as wound care or domiciliary phlebotomy where it is clinically appropriate for a member of the adults service team to provide care

3.5 Telehealth and technology

3.5.1 The Provider is expected to engage fully with the development of new technology for the improvement of efficiency and patient outcomes. Across the services described and delivered under this specification the Provider should utilise new technology and telehealth to:

- Maximise efficiency, enabling health care professionals to care for a larger caseload remotely and reducing wasted time and resources
- Provide access to remote advice, monitoring and treatment providing the most timely care possible
- Facilitate access to remote advice from other health care professionals and specialists to support the provision of high quality care
- Maintain patient independence, improve health outcomes and prevent admission to hospital
- Empower individuals to manage their own health and wellbeing without delaying access to health and care services as the need arises

3.5.2 The Provider will meet the requirements of the digital specification in IACS006.

3.6 Discharge and outcomes capture

3.6.1 Following achievement of the established goals within a patient's care plan or the completion of the required clinical intervention from the Integrated Locality Team and supporting community services, the patient will be discharged back to the GP as the primary physician; this should be communicated and agreed between the Integrated Locality Team professionals and Primary Care staff.

3.6.2 This discharge process is to be completed in communication with the GP practice and will include a concise electronic summary of the clinical interventions delivered, the outcomes, progress against agreed goals and future care requirements. This summary is to be provided in a format that is interoperable with the prevailing GP clinical system and, for completeness of data, should be documented in a way that supports efficient clinical coding in General Practice. The Provider should have the capability to provide a similar discharge summary to other agencies e.g. social care or mental health. The Provider is expected to align with the processes described in contract schedule 2J (Transfer of and Discharge from Care Protocols) on the information provided at discharge.

3.6.3 Given the range of clinical inputs potentially delivered under the Integrated Locality Team care plan a concise summary of key changes, progress and further intervention required should be presented and easily accessible. The Provider will work with CCG member practices during the mobilisation period to agree the format and method for conveying discharge summaries.

3.6.4 Complex patients with multiple needs should only be discharged following multi-disciplinary team discussions involving the Integrated Locality Team, other health and care agencies and the individual's GP practice.

3.6.5 The Provider will ensure the real time collection of all relevant data to support the appraisal of the service and the monitoring of contractual key performance indicators – this is to include:

- Information on clinical outcomes and the control of long-term conditions
- Information on independence, wellbeing and social health
- Information on care goals, progress and achievement
- Information on care and family support; carer and patient satisfaction
- Information on how the patient or GP can re-access the Integrated Locality Team in the cases of relapse or persistent problems. This should not require a new referral for persistent problems within a 6-month timeframe.
- A granular break down of all clinical contacts with the individual during that care planning cycle, the frequency, intensity, length of time and attending professional to inform future service design and distribution of resources
- Activity and the involvement of other parts of the health and social care system- hospitals, mental health, social care, Third Sector

3.6.7 Details on data collection are included in the quality requirements and information requirements schedules of the Contract.

3.7 Multidisciplinary team meetings

3.7.1 Integrated Locality Teams should ensure they are represented at practice multi-disciplinary team meetings at a frequency conducive to the effective management of local patients. Care coordinators and/or community staff aligned to the practice area should ensure regular attendance and two way communication with GPs on the management of complex patients.

3.8 Hours of operation

3.8.1 The Provider is expected to deliver a comprehensive, integrated community service response to clinical need on a 24 hours a day, 7 days a week, 365 days a year basis. This response can be delivered through a combination of the Integrated Locality Team, locality hub services or the acute and reactive care function.

3.8.2 It is expected that the routine, planned care services of the Integrated Locality Teams are available and delivered during core daytime hours seven days a week (as below) from contract inception with the aspiration of moving to a 08:00 – 20:00, seven day a week service within a year.

- Monday – Friday 08:00 – 18:30
- Saturday 08:00 – 18:00
- Sunday 08:00 – 18:00

3.8.3 It is expected that the reactive and urgent care functions of the acute and reactive care function are available 24/7 to a suitable level of expertise and capacity to meet clinical need and levels of demand. This level of 24/7 functionality will be targeted to ensure the continuous functioning of all service elements relating to acute admission prevention and swift discharge from hospital e.g. urgent visiting, emergency care packages, clinical advice and reassurance, hospital in-reach.

3.8.4 This 24/7 coverage will be configured in a way that minimises unnecessary fragmentation in care pathways and unnecessary handovers of care, negatively impacting on continuity and quality.

3.9 Patient choice and personal health budgets

3.9.1 The Provider has a defined remit to actively offer patient choice and alternative forms of service provision, including the delivery of personal health budgets. This particularly applies should any instances occur where there are unacceptable delays in treatment or significant waiting times. Should waiting times become excessive for a particular provision the Provider should actively seek to offer patients a choice of alternatives or redirect to a Provider with available capacity.

3.9.2 This will include the provision of Personal Health Budgets in accordance with schedule 2M (Development plan for personalised care)

3.10 Working across other services and organisations

3.10.1 The locality teams will have a fundamental role in coordinating care across different clinical professionals within community services and other external agencies. The Provider will define specifically how the locality teams and other community interventions detailed in the supporting specifications will interact with:

3.10.1.1 Locality hubs

3.10.1.1.1 In Bristol, North Somerset and South Gloucestershire the Provider will deliver holistic and proactive care deploying Integrated Locality Team resources through the Locality Hubs to a defined cohort of patients in line with the development of locality transformation in Primary Care outlined in the supporting specification (IACS004). The Integrated Locality Teams, under the leadership of Primary Care, must establish seamless clinical and operational processes with the emerging locality hubs including standardised assessments and pathways, interoperable systems and data-sharing as well as the sharing and rotation of clinical staff to optimise efficiency. This ensures a highly educated and resilient workforce is developed with a broad knowledge of the local health and social care economy.

3.10.1.2 Primary Care

The Integrated Locality Teams are to work as one with Primary Care professionals across Bristol, North Somerset and South Gloucestershire. This will include joint decision making and care planning around the needs of an individual patient. Shared resource and workforce planning and joint processes covering information sharing, clinical governance, assessment and data recording. In addition each GP Locality will identify a named GP lead to provide strategic support to the community service Provider and the relevant Integrated Locality Team. These GP locality leads will provide expertise and support to service development, collecting Primary Care feedback, monitoring quality and managing demand. Operationally, locality lead GPs will also be available to their relevant Integrated Locality Team for general advice and support. The Provider will be responsible for ensuring appropriate representation at key Primary Care forums such as the locality provider board, commissioning locality meetings and practice manager's forums.

3.10.1.3 Mental health services

3.10.1.3.1 The Provider will work seamlessly with mental health services ensuring there is agreed, regular representation from mental health professionals to the locality team multi-disciplinary team meetings and that mental health professionals are fully involved in the care planning process for any individual requiring non-acute care in the community.

3.10.1.3.2 The Provider will agree a process with relevant mental health teams for ascertaining mental health professional input into the care planning process. Effective data sharing processes between mental health and community services should exist to facilitate:

- The capture of agreed health and care goals
- Tracking progress and achievement of goals
- Monitoring changes in a patient's condition and altering service response

3.10.1.3.3 The Provider should seek to align key link staff, particularly community mental health nurses, from the mental health provider to the Integrated Locality Team and put in place robust processes for communication with the mental health trust.

3.10.1.4 Social care services

3.10.1.4.1 The Provider will work seamlessly with social care services ensuring there is agreed, regular representation from social care professionals to the locality team multi-disciplinary team meetings and that these professionals are fully involved in the care planning process for any individual requiring non-acute care in the community.

3.10.1.4.2 The Provider will agree a process with relevant social care locality teams for ascertaining professional input into the care planning process. Effective data sharing processes between social care and community services should exist to facilitate:

- The capture of agreed health and care goals
- Tracking progress and achievement of goals
- Monitoring changes in a patient's condition and altering service response

3.10.1.4.3 Of particular importance is the ability to monitor on-going need and changes in an individual's condition or carer support network to ensure that a social services response can be mobilised proactively in the timeliest way possible. The Provider is expected to optimise the use of technologies to ensure that needs assessments are shared and where timely multi-disciplinary assessments are required that modern scheduling, capacity and demand systems are used.

3.10.1.5 End of life care services

3.10.1.5.1 Individuals with complex needs may deteriorate to the point where effective and high quality end of life care becomes the priority. The Provider will ensure end of life care skills are embedded as a fundamental tenet of the Integrated Locality Team and wider community staff capabilities.

3.10.1.5.2 The Provider will act as a champion of comprehensive advance care planning and will utilise a standard care planning approach transferrable across other end of life care services e.g. hospices, acute specialist palliative care teams, Third Sector organisations.

3.10.1.5.3 The Provider will work with acute trusts, hospices and other organisations as part of local and region-wide end of life care networks to agree standard operational processes, documentation and information sharing across the entire end of life care pathway. The Provider will also take a leading role in advocating effective end of life care and training the wider health and social care workforce in high quality palliative care; this is to include nursing and residential homes as a priority.

3.10.1.6 Third Sector services

3.10.1.6.1 The Provider will have an explicit responsibility for building a comprehensive awareness of Third Sector provision at a given locality level; and for coordinating those Third Sector services around the needs of an individual patient.

3.10.1.6.2 Each locality team will have direct access to one directory of services that is up to date and accurate. This should link to the IUCS directory of services and include 'Well Aware[10]' and the range of local authority directory of services. Specific staff should be trained in how to navigate and facilitate access to these services through a defined model of care coordination or social prescribing. The Provider will build networks and links with a range of localised Third Sector and faith organisations to facilitate access to on-going support.

[10] https://www.wellaware.org.uk/

3.10.1.6.3 Locality teams will have the autonomy to agree set processes and pathways for accessing local Third Sector organisations and the Provider will have the capability to source, manage and maintain any relevant sub-contractual arrangements that can demonstrate an evidence based benefit to the achievement of a patient's or carers health and wellbeing goals.

3.10.1.6.4 It is anticipated that particular opportunities for collaboration exist in the following areas:

- Maintaining independence, mobility and physical exercise; active involvement in community based activities and exercise
- Prevention, health coaching, education and lifestyle intervention
- Emotional wellbeing and combating social isolation
- End of life care
- Carer and family support
- The Third Sector – with the ability to evaluate the impact of engaging their services

3.10.1.7 Hospital specialists

3.10.1.7.1 To proactively manage the holistic needs of an individual effectively, community and Primary Care professionals should have access to support, advice and intervention from Secondary Care specialists. The Provider will work with local acute trusts, commissioners and Primary Care to agree defined access to support and advice from consultant teams most beneficial to meeting the needs of patient's in the community.

3.10.1.7.2 This specialist support and intervention should go beyond the relocation of outpatient clinics but should fully engage specialist teams in providing expertise and education to the wider workforce, building working relationships that can ultimately reduce the demands on acute medical services and provide prompt clinical input to complex cases across the community.

3.11 Information sharing and signposting

3.11.1.1 The Provider will ensure that the information management and technology capabilities of all services within this specification are fundamentally designed with the central priority of interoperability with other Providers and agencies across Bristol, North Somerset and South Gloucestershire. Of paramount importance is the direct interoperability with prevailing GP IT systems across Bristol, North Somerset and South Gloucestershire (EMIS). The Provider will be expected to act as a key partner in the Bristol, North Somerset and South Gloucestershire-wide digital strategy, including the usage and contributing to the future development of the shared care record and work towards full interoperability.

3.11.1.2 The Provider should ensure that system interoperability is optimised with the following key partners, as a minimum, including:

- GP practices
- South Western Ambulance Service ambulance trust
- Acute hospitals
- Social services
- IUCS - Severnside

3.11.1.3 The full information management and technology requirements are detailed within IACS006.

3.11.1.4 Providers are expected to design operational processes that ensure that the data required to evaluate services and understand the measurable benefits is collected as an integral component of delivering care.

3.11.1.5 Providers are expected to work in partnership with decision making principles set out in the terms of reference of the Bristol, North Somerset and South Gloucestershire digital delivery board.

3.11.1.6 Providers are expected to procure systems in line with national guidance around open APIs and the developing NHS digital strategy for both empowering the patient and delivery of services.

3.11.2 Signposting

3.11.2.1 The Provider will also ensure staff are trained in signposting to local services beneficial to overall health and wellbeing, including local community, Third Sector and faith sector organisations. Staff should have an awareness of supplementary services available in their local area of operation. The Provider should consider comprehensive and innovative ways to provide the most effective signposting and service coordination; potentially including the development of social prescribing.

3.11.2.2 The Provider will ensure the use of a comprehensive directory of services and will establish collaborative links with social care development coordinators within the local authority.

3.12 Community equipment

3.12.1 The community Provider will have a responsibility to ensure that clinically appropriate and cost effective use is made of community equipment to enable people to return to or stay in their homes or other community settings. The Provider should ensure that senior level clinical leadership is in place for this role along with an appropriate level of administrative support to maintain systems for ordering and tracking of prescribed equipment and management of peripheral stores. The Provider of community services is required to work seamlessly with local authority partners to ensure alignment of the contracts and to minimise duplication across the area. This could include the use of pooled equipment libraries / RFID tagging so that commissioners are aware of where equipment is located and can get it as seamlessly as possible to the people who need it.

3.12.2 The clinical lead will review and analyse the management information received from the Community Equipment contractor and contract managers to identify any concerns about non-compliance with prescribing policies and procedures or unexpected patterns of activity and to work with staff teams to address these concerns. Actions agreed as a result should be reported by exception to the commissioner.

3.12.3 The Provider should ensure that the following is in place:

- Staff should have appropriate access to be able to prescribe equipment after an assessment of need has taken place. Staff must be reminded that equipment should be prescribed by the individual who has undertaken the assessment, and in accordance with agreed policies.
- All staff who prescribe community equipment must have training as part of their induction and then at a frequency to be agreed. Compliance should be reported on the quality dashboard.
- A clear process to manage and approve prescribing decisions, particularly for high costs items and 'specials' to ensure that they are cost effective as well as clinically safe.
- Management of community (peripheral) stores in appropriate locations across Bristol, North Somerset and South Gloucestershire to enable staff to access frequently used items of equipment with minimum delay. The Provider will ensure that accurate records are kept of issue and return of equipment from peripheral stores.
- Lead on the development and implementation of clinical guidance relating to prescribing and use of equipment in liaison with the community equipment contract Provider, local authority contract managers and acute Trusts, and participate in Bristol, North Somerset and South Gloucestershire clinical and operational networks to advise on appropriate use of community equipment.
- Provide information to patients, their carer's and care homes on the terms and conditions for supply of equipment and advice on how to return equipment once it is no longer required or at the end of a short term load period.

3.12.4 The Provider will support and chair the Bristol, North Somerset and South Gloucestershire wide Equipment Review Group (ERG) which is responsible for oversight of the community equipment catalogue and making decisions on the range to be available to prescribers.

3.12.5 Where the Provider has concerns about the performance of the community equipment supplier, they should submit these concerns to the appropriate (local authority) contract manager with supporting evidence. The Provider will attend community equipment contract management meetings where performance concerns and proposals for service improvement can be addressed and agreed.

3.12.6 For clarity, this role does not include formal contract management. The lead responsibility for contract management with the community equipment Provider sits with the local authorities in the Bristol, North Somerset and South Gloucestershire area. The budget for the health contribution to the contract value is held by Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.

3.13.7 The Provider will not be required to submit performance reports as data will be taken from the Community Equipment Contract monthly report(s) for Bristol, North Somerset and South Gloucestershire. As noted above, data from these reports will be used by the Provider, with the commissioner if appropriate, to identify any budgetary or clinical quality issues which may relate to prescribing practice and agree remedial action if required.

3.14 Medicines management

3.14.1 Clinicians providing NHS-commissioned care within the Provider organisation should:

- Prescribe for adults in accordance with the Bristol, North Somerset and South Gloucestershire Joint Formulary[11] and other relevant local prescribing guidance.
- Prescribe for children in accordance with the paediatric updates in the Bristol, North Somerset and South Gloucestershire Joint Formulary, or the Bristol, North Somerset and South Gloucestershire Paediatric Joint Formulary[12]
- Practice antibiotic stewardship in line with national and local guidance
- All clinicians should follow the process outlined in the Bristol, North Somerset and South Gloucestershire Formulary for new drug requests and shared care protocols that can be found on the formulary website
- A prescribing budget for certain areas will be included in the provider contract (see individual service details) and the provider will manage spend within that budget
- Provider services are responsible for the production and updates of any necessary Patient Group Directions for their services, in line with the Bristol, North Somerset and South Gloucestershire Patient Group Directions Policy
- All dressings will be supplied or prescribed in line with the Pan Avon Dressings Formulary
- Provider services will work with commissioners to minimise the impact of medicines waste
- Specialist clinicians will engage with the commissioner and other providers in the development of pathways and guidelines involving medicines
- Medicine Incidents themes should be shared with the CCG Medicine Optimisation team via agreed route
- A Controlled Drug accountable officer should be nominated
- A senior pharmacist or healthcare professional is required to represent the organisation at system Medicine Optimisation groups such as Bristol, North Somerset and South Gloucestershire Drugs and therapeutics committee and STP Medicine optimisation board

[11] https://www.bnssgformulary.nhs.uk/
[12] https://www.bnssgpaediatricformulary.nhs.uk/

3.14.2 There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. The CCG and Provider will work collaboratively to ensure that patient care in relation to medication is safe, effective and sustainable; especially when patients transfer between care settings.

3.14.3 In the case of discharge from a Community Service it is normal for prescribing responsibility to transfer from a specialist to a general practitioner following discharge, but prescribing responsibility will remain with the specialist team when:

- Treatment is a medicine not reimbursed though national prices (excluded from the PbR tariff) and directly commissioned by NHS England, rather than a CCG
- Treatment is being provided as part of a clinical trial
- Medicines or medical devices cannot be prescribed on form FP10 by GPs
- Medicines are categorised as 'red' in the Bristol, North Somerset and South Gloucestershire Joint Formulary
- Medicines are categorised as 'amber' in the Bristol, North Somerset and South Gloucestershire Joint Formulary with a shared care protocol (SCP), but the conditions in SCP have not been met
- Treatment is being provided as part of a service that has been commissioned in such a way that arrangements are in place for ongoing supply to the patients under the direction of a secondary care clinician (e.g. homecare, home enteral tube feeds)
- Medicines are unlicensed or used outside the terms of their licence, unless these are listed in the Bristol, North Somerset and South Gloucestershire Joint Formulary for these indications

3.14.4 The prescriber is responsible for ensuring that appropriate clinical monitoring arrangements are in place for the medicines that they prescribe and that the patient and other healthcare professionals involved understand them.

3.15 CCG authorised access to FP10 prescription Pads for Providers and responsibilities

3.15.1 The Provider should have a nominated accountable office for controlled drugs or equivalent senior officer responsible for oversight of all prescription usage by the service including audit and raising appropriate concerns around controlled drug management.

3.15.2 The Provider is expected to ensure robust governance of all prescribing activity, including the use of policies and procedures relating to prescribing activity to support high quality, safe and appropriate prescribing and may periodically be asked to demonstrate this is the case.

3.15.3 The Provider is responsible for funding all prescribing activity undertaken on FP10 prescription pads. The provider will periodically be expected to provide data on the medication prescribed on FP10 prescription pads from the epact system.

3.15.4 The Provider should ensure it is fully compliant with the NHS Counter Fraud Authority guidance on Management and control of prescription forms, including prescription pad destruction as part of contract termination. For clarity Bristol, North Somerset and South Gloucestershire CCG will not be liable for any costs of inappropriately used prescriptions.

3.15.5 The following link[13] provides NHS provider organisations with the information needed to obtain and maintain prescribing codes for your organisation and prescribers, order prescription forms (FP10), reconcile invoices, access data about your prescribers and services. Providers should liaise with Bristol, North Somerset and South Gloucestershire CCG's Medicines Optimisation Team who contains the necessary CCG signatories to complete the process

13 https://www.nhsbsa.nhs.uk/sites/default/files/20172/Local_Authority_and_Provider_Welcome_Pack_v1.5.pdf

3.15.6 During contract termination the prescription services department of NHS Business Services Authority (NHS BSA) must be informed of the Provider's Organisational Data.

3.16 Safeguarding children and adults at risk

3.16.1 The Provider will ensure that Making Safeguarding Personal is integral to the service delivery to ensure that adults at risk are protected and that their views are heard within the safeguarding process.

3.16.2 The Provider will also ensure that all staff in contact with patients and the public have been appropriately trained in local safeguarding procedures and regularly maintain these competencies. The Provider will ensure that staff are appropriately supported to implement safeguarding procedures where concerns have been identified.

3.16.3 The Provider shall ensure:

- Up to date appropriate policies and procedures on safeguarding children and vulnerable adults are in place. These will adhere to all relevant legislation, Care Act 2014, codes of practice, statutory guidance and good practice guidance published by the Department of Health and the local safeguarding boards as appropriate, including Children Act 2014 and Working Together to Safeguard Children, 2018.
- Safeguarding policies are effectively communicated to its employees (including trustees, volunteers and beneficiaries).
- All staff are up to date with appropriate level of safeguarding training (for both children and adults) relevant to their role in the organisation safeguarding children and vulnerable adults at risk —as recommended in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Paediatrics and Child Health, 2014) and Adult Safeguarding: Roles and Competencies for Health Care Staff (Royal College of Nursing 2018)
- Compliance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards Accountability and assurance framework for adults at risk, also training and competency framework for Prevent.

3.16.4 The Provider shall fulfil its legal obligations concerning the gaining of Disclosure and Barring Service (DBS) checks and checking employees through the Independent Safeguarding Authority (ISA) and the relevant national or local safeguarding authority where applicable, evidenced by a Safer Recruitment policy; the provider will supply evidence of adherence to this to the commissioners, on request.

3.16.5 The Provider shall ensure that there are clear and appropriate policies and procedures in place to support:

- The immediate reporting of safeguarding concerns;
- The encouragement of Raising Concerns ('whistle blowing') where appropriate, including allegations against staff;
- Effective working practices to prevent abuse and neglect, and to protect individuals.

3.16.6 Policies shall highlight:

- the inappropriate nature of private arrangements of any sort between the carer and the patient, including the potential for gross misconduct, recognising the role is a position of trust; and
- actions necessary to participate in a multi-agency safeguarding environment, including attendance at the Safeguarding Boards or subgroups and the mandatory participation in strategy meetings, safeguarding adults reviews (SARs), serious case reviews (SCRs), domestic homicide reviews (DHRs) and other investigations pertaining to the safeguarding of adults or children at risk.

3.16.7 The Provider shall take responsibility for providing care only to the named service user, and this may not include care for any other adults or children (such as 'baby-sitting') even for short periods of time.

3.16.8 The Provider shall have a written policy of confidentiality that is compliant with the General Data Protection Regulation (GDPR) 2016 and Data Protection Act 2018 (Data Protection Legislation). Where appropriate, confidential information will only be disclosed with the consent of the patient concerned, though there are circumstances where consent should not be sought or is only sought under the common law duty of confidentiality. Examples include circumstances where disclosure is required by law or to safeguard children or adults at risk of harm. The Provider shall also ensure that all employees are trained and understand the importance of patient confidentiality.

3.16.9 *Children*

3.16.9.1 The Provider shall:

- Publish contact information for a named local lead for Safeguarding and Child Protection, who will undertake a local governance role, attend NHS safeguarding children advisory groups and liaise with local agencies to keep children safe.
- Ensure that processes are in place to support professionals making appropriate referrals to safeguard children at risk of harm.
- Establish a system for accessing information for children subject to a child protection plan with the local authorities in their area and ensure governance arrangements are in place and that this record system is kept up to date.

3.16.10 *Adults*

3.16.10.1 The Provider shall:

- Adhere to the Care Act 2014[14], which advises that the first priority in safeguarding should always be the safety and well-being of the adult – Making Safeguarding Personal, in line with the six statutory safeguarding principles.
- The Provider shall adhere to all guidance and legislation and have procedures in place to safeguard and promote the welfare and wellbeing of adults at risk.

3.16.10.2 The Provider shall evidence that it has:

- Published contact information for a named lead for adults at risk, who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named lead for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named Prevent lead who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- Up to date policies for Safeguarding Adults at Risk, MCA, DoLS and Prevent, which will be shared with the Commissioner on request;
- Systems in place to ensure that all staff have the appropriate level of safeguarding training, including MCA, DoLS and Prevent and evidence figures for training to meet required standards;
- Systems in place to record safeguarding supervision, with provision of data on request.
- Systems in place to record data relating to referrals, concerns raised and involvement in strategy meetings and Safeguarding Adult Reviews; and
- Met the requirement under Making Safeguarding Personal, providing evidence that the voice of the adult at risk has been heard, on request.

3.17 **Population covered**

[14] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

3.17.1	All services are to be accessible to the population over the age of 18 registered with a GP practice in Bristol, North Somerset and South Gloucestershire CCG with provision of transitional care for those aged 16-18 as detailed within this specification. There should be no barriers to accessing services to vulnerable patients e.g.: homeless patients, who may not be registered with a GP but should still be offered services according to their needs. There may also be cases where it is clinically appropriate for adult services to provide treatment to those under the age of 16 e.g. complex wound care and continence issues. This provision should be appraised on a case by case basis in conjunction with the referring GP and relevant paediatric services; the Provider should deliver care where it is safe and clinically appropriate for an adult service clinician to do so.
3.17.2	Unregistered patients living in the Bristol, North Somerset and South Gloucestershire area should also have equitable access to services and should be encouraged and facilitated to register with a GP. There will be equitable access for those patients considered homeless and/or vulnerably housed to ensure equity of access to services for those who are vulnerable. Referrals for patients registered with a GP practice in another CCG should be directed to the equivalent commissioned service in that local area.
3.18	**Any acceptance and exclusion criteria and thresholds**
3.18.1	All patients registered with a GP in Bristol, North Somerset and South Gloucestershire will have access to integrated community services on referral for assessment, care planning and coordination functions. Where, following assessment, it is thought a patient is clinically unsuitable to be managed by the Integrated Locality Team or other service described in this specification this is to be discussed with the referring clinician and the Provider is to support and coordinate access to the right alternative service provision.
3.18.2	All of the services set out in this specification should be available to all adults living in the BNSSG CCG area. Exclusion criteria are children under the age of 18.
3.18.3	To ensure equitable access to services the Provider is required to provide access to interpretation and translation services for individuals who are unable to communicate in English. Written information should also be available in other languages in accordance with local demographics
3.18.4	The adult community services provider is not expected to provide dietetic support to those patients under the Home Management Service[15] as they are managed by University Hospitals Bristol/Nutrica nurses. The provider is expected to be aware of those patient needs and ensure communication and link with the provider to holistically treat the patient. This is subject to change as part of the CCG's business as usual procurement of services.
3.19.5	**Managing demand**
3.15.5.1	There may be occasions where surges in demand for one or multiple community services outpaces available capacity or causes excessive delays and waiting lists. During these times the community service Provider, in agreement and partnership with the relevant Locality Lead GP(s) may initiate a mutually agreed triage and prioritisation process to ensure care is received where clinical need is greatest and that non-urgent or inappropriate referrals are suitably redirected.
3.19.5.2	In addition the GP Locality Lead(s) will have a role in challenging abnormally high referral rates, inappropriate referral behaviours and irregular patterns of demand at an individual GP practice or locality level.
3.20	**Interdependence with other services/providers**

[15] http://www.uhbristol.nhs.uk/patients-and-visitors/your-hospitals/central-health-clinic/home-management-service-(hms)/what-do-we-do/

3.20.1 The Provider will be required to work closely with a wide range of stakeholders, professionals and health and care agencies; including but not limited to:

- Primary care services
- General Practice
- Secondary Care services
- South Western Ambulance Service
- Care homes
- Any locally determined providers
- Local authority – social services and care agencies
- Mental health services
- Medicines management teams
- Third Sector
- Patients, carers, relatives

3.20.2 In addition there are a number of specific service aspects that are not commissioned within the scope of this contract but are referred to within the specifications. These related services will be commissioned separately by the CCG and the Provider is not expected to deliver these under the scope of this specification; such services include:

- GP cover to the locality hubs
- GP's within the locality hubs and GP locality leads who will act as key strategic partners for the community service Provider
- Pharmacists
- Delivery of continence products
- Wheelchair services
- Patient transport services, relating to the Locality Hub or otherwise

4. Applicable Service Standards

4.1 **Applicable national standards (e.g. NICE)**

There is a wide range of national and clinical guidance applicable to the delivery of the breadth of service functions described above; such guidance, for example, relates to management of long-term conditions, end of life care, wound care, catheter care, rehabilitation and physiotherapy, speech and language therapy, dietetic intervention and screening, effective provision of care to care home residents. Relevant guidance can be accessed via the NICE website: https://www.nice.org.uk/guidance

4.2 **Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

The Provider is required to consider all relevant evidence and guidance from appropriate Royal Colleges in the development and delivery of services.

4.3 **Applicable local standards**

Applicable local quality and reporting standards are detailed in the relevant quality requirements and information requirements schedules of the Contract.

The Contract also provides clauses about standards that apply to all Service Specifications.

5. Applicable quality requirements and CQUIN goals

5.1 **Applicable Quality Requirements**

Defined within the Schedule 4A-D

5.2 **Applicable CQUIN goals**

Defined within Schedule 4E
6. Location of Provider Premises
The Provider's Premises are located at: *To be inserted prior to Contract Award*
7. Individual Service User Placement

Service Specification No.	IACS002
Service	Integrated Adult Community Services – Specialist Advice and Support
Commissioner Lead	NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

1.1.1 This specification sets out the Requirements of the Provider in relation to core adult community health services: Specialist Advice and Support. This covers a proportion of the overall Contract and should be delivered in conjunction with service specifications IACS001, IACS003 and IACS004 in the context of the overall model of care, strategic landscape and specifications for enablers set out in set out in IACS000 and IACS006. Each specification is expected to work integrally together as one service to meet the needs of the population.

2. Outcomes

2.1 The CCG expects the Specialist Advice and Support service to contribute to the achievement of the following domains. These are subject to change following the national annual review.

2.1.1 NHS Outcomes Framework Domains & Indicators

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

2.1.2 Adult social care domains

5. Enhancing quality of life for people with care and support needs
6. Delaying and reducing the need for care and support
7. Ensuring that people have a positive experience of care and support
8. Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

2.1.3 Public health outcome domains:

5. Improving the wider determinants of health
6. Health improvement
7. Health protection
8. Healthcare, public health and preventing premature mortality

2.1.4 Local defined outcomes

2.1.4.1 The CCG wants Community Services to be seamless, coordinated and holistic, based on the principles set out in Reimagining community services: Making the most of our assets[16] (The King's Fund paper). This requires a shift away from focusing on an individual condition to care designed in partnership with the patient and their carers. Care will need to transcend historical boundaries of care setting, organisation or budgetary responsibility. Community Services will include a single core assessment process, completed once by a trusted assessor that evaluates the full spectrum of an individual's needs and coordinates a service response across different agencies and professionals. Another key principle is the development of seamless professional links and redefining organisational boundaries to instil collaboration with Primary Care and change the role of hospital specialists to support the wider health and social care economy. Community Services should promote an ethos of continuity of care and community involvement through the creation of dedicated locality teams and building operational links with the Third Sector and wider community organisations. The underpinning model of care is focused on supporting patients to achieve the best possible outcomes, in line with their needs and agreed goals.

2.1.4.2 It is expected that the realisation of these strategic aims will translate into a number of tangible outcomes including:

- Patients, carers and families will have a positive experience of care.
- A patient or carer with multiple needs will have a single, integrated care plan developed with them.
- A greater proportion of care will be provided closer to home in community settings.
- There will be a reduction of admissions to hospital and length of stay in hospital for those who are admitted; particularly for people over the age of 65.
- There will be a reduction in the number of potentially avoidable admissions (admissions with 0 to 48 hour length of stay for which no clinical procedure was carried out).
- Wellbeing will be maximised and independence maintained for longer, reducing the overall need for long-term care.
- Professional skills and expertise, including those of the Third Sector, will be effectively shared across services and organisations, building a more effective and resilient workforce.

2.1.5 Community-based outcomes framework

2.1.5.1 The CCG aims to build on national work to form a locally-based community outcomes framework, developing this with the Provider and patients so that the framework is tailored to local needs. This outcomes framework will encompass two domain types:

2.1.5.2 **Overarching domains** which cross the entire care pathway:

- Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient.
- Treating and caring for people in safe environment and protecting them from avoidable harm.
- Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information sharing that links seamlessly with other services provided within the community.

2.1.5.3 **Pathway domains** which align to key stages of the care pathway:

- Early intervention with a focus on prevention to promote health, well-being and independence.
- Treatment and / or support during an acute episode of ill health.
- Long-term recovery and sustainability of health.
- Care and support for people at the end of their lives.

3. Scope

[16] https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf

3.1 Aim

3.1.1 The aim of the Specialist Advice and Support dimension of the integrated community service is to provide responsive access to high quality specialist advice and intervention to support robust core generalist services in the community. This specialist support will be available to professionals both in the community and in General Practice and can take the form of remote clinical advice, education and training as well as the provision of direct care and intervention in clinically complex cases requiring specialist input. The services described in this specification will have defined, formal links with the clinical support, governance and infrastructure of secondary care specialist teams in order to ensure the maintenance and continuous development of specialist skills as well as giving primary and community professionals access to a diverse range of specialty staff.

3.2 Objectives

3.2.1 The specialist advice and support elements will work to provide seamless support to the Integrated Community Service and primary care and will achieve a number of specific objectives:

- Reduction of emergency admissions and attendances at A&E and urgent care services from prominent long term conditions where specialist community intervention and support can be provided e.g. respiratory disease, diabetes, heart failure, continence conditions and problems relating to effective wound care
- Improve access to a full range of specialist staff in a responsive fashion and in accordance with the clinical needs of patients
- Ensure patients, their families and carers have a high quality experience of care based upon the outcomes they want
- Work seamlessly with primary care professionals, the Locality Hubs and the Integrated Locality Teams to ensure specialist advice and support in line with commonly agreed care plans using a risk stratification approach
- To take a central leadership role in the upskilling of primary care professionals and community service staff in the specialist management of prominent long term conditions within the disciplines described in this
- To work in a genuinely integrated fashion with secondary care specialist services to deliver comprehensive support to the primary care and out of hospital settings
- To reduce the need for long term care through effective preventative care and promotion of self-management across all specialities
- To manage resources efficiently to deliver an excellent standard of service within the financial envelope available adopting a patient outcomes centred approach
- To work with commissioners and patients to refine the model of care and service delivery, utilising evolving best practice, considering developments in technology and data collection and distribution in a continuous improvement programme

3.3 Service description

The CCG has commissioned a community health service that is available to the entire adult population, regardless of where they live. These services will be tailored to people's level of mobility, frailty and other characteristics on an individual basis, but limited to people who have particular characteristics or condition profiles.

3.3.1 Overview

3.3.1.1 Fundamental to the delivery of a new model of community services is the establishment of comprehensive specialist teams, integrated with secondary care specialty functions but fully focused on providing support, education, advice and direct care outside of hospital. Direct professional integration must exist between those 'community facing' specialist staff and hospital teams; as well as with those core staff within the Integrated Locality Teams, Locality Hubs and primary care. All areas of the community service should work seamlessly together to ensure the patients journey is smooth with a reduction in gaps of provision of support and care to them with a reduction in the number of hand-offs..

3.3.1.2 Specialist teams within this specification shall have a leading responsibility for the continuous development and up-skilling of wider community nursing, health and social care professionals as well as providing direct education and support to GPs and nurses in General Practice. Specialist teams will also be a focal point for responsive, high quality clinical advice as well as providing direct assessment and treatment in cases of particular complexity.

3.3.1.3 The specialist disciplines that will provide this educational leadership, clinical advice and direct care will include and is not limited to:

- Specialist respiratory care – including pulmonary rehabilitation and home oxygen assessment and review
- Specialist heart failure care
- Community diabetes services
- Specialist continence assessment and treatment
- Tissue viability and specialist wound care
- Musculoskeletal – including assessment teams
- Learning disability
- Dermatology
- Tuberculosis services
- The Haven – refugee support service
- Health links
- Parkinson's
- Community equipment clinical leadership
- Lymphoedema

3.3.2 Interventions

The following clinical and therapeutic interventions are to be provided under this specification. These interventions should ensure access seven days a week to enable equitable access to services and flexibility for patients and their carers and families. These interventions are described in detail below.

3.3.2.1 Specialist community respiratory services

3.3.2.1.1 The community respiratory service supports people with chronic respiratory disease utilising the skills and support of specialist staff including specialist respiratory nurses, advanced respiratory physiotherapists and respiratory occupational therapists. The community respiratory service will operate in direct partnership with the secondary care respiratory team enabling access from community and primary care staff to a full range of specialist clinicians. Collaboration with the secondary care team should also extend to clinical supervision and governance, access to specialist medical opinion and the rotation of acute and community facing roles to build a well-rounded, highly skilled specialist workforce. This should follow the model of respiratory services set out by the local Sustainability and Transformation Programme.

3.3.2.1.2 The community respiratory service will provide input, assessment and treatment as part of a wider, holistic care plan delivered in collaboration with a patient's GP, and in conjunction

with the relevant Integrated Locality Team delivering core community services and Locality Hub where relevant. The functions delivered by the community respiratory service are described below:

3.3.2.1.2.1 *Provision of clinical advice and support*
One of the primary functions of the community respiratory service is to provide specialist clinical advice and support to health and care professionals in both primary care and the wider out of hospital setting. This advice can take the form of telephone or email contact with other professionals in line with the response times set out in paragraph 3.4.3.3 of this specification. Requests for advice should be easily accessible through a single email address and telephone number. Advising professionals should have access to the patient's care plan held by the GP and/or Integrated Locality Team and/or Locality Hub, ideally through direct interoperability of clinical systems.

3.3.2.1.2.1.1 Advice and recommended interventions should be captured as part of the care plan and communicated across the GP, Integrated Locality Team and Locality Hub as appropriate. It is anticipated that the majority of requests for advice will originate from primary care and other community service professionals, however advice may also be requested from other care settings e.g. care homes, hospices, mental health teams. All requests should be prioritised and addressed in accordance with clinical need, however where an individual is potentially unknown to the Integrated Locality Team the Community Respiratory Service should coordinate responses with the Integrated Locality Team and/or Locality Hub to ensure that specialist resources are only deployed in cases of the appropriate complexity.

3.3.2.1.2.1.2 The Community Respiratory Team should be properly integrated with the consultant-led specialist respiratory team in secondary care and should therefore have rapid access to the advice and opinion of consultant medical staff whenever this is clinically required.

3.3.2.1.2.2 *Education, training and workforce development*
The Community Respiratory Service has an explicit and fundamental leadership role in developing the skills, confidence and capabilities of the wider community health and care workforce with regards to the management of chronic respiratory conditions.

3.3.2.1.2.2.1 The Provider, in partnership with the commissioner, is expected to proactively evaluate available outcomes (through the two agreed PROM tools) and the 12 agreed Clinical and Social Outcome measures) and performance data from across the system and conduct training needs analyses to identify opportunities within the local workforce to improve staff capabilities, ultimately resulting in improved patient outcomes and a reduced variability in the quality of care

3.3.2.1.2.2.2 This proactive evaluation of outcomes and training needs analyses should apply to primary care, core community services including the Integrated Locality Teams, Locality Hubs, care homes, hospices, social care professionals and any other service where there is a clear opportunity to improve patient outcomes through training and staff development. Scoping of training opportunities should consider available outcomes data, including the locally agreed 12 Clinical and Social Outcome measures, the Quality and Outcomes Framework (QOF) in primary care, as well as available acute admissions data relating to secondary care.

3.3.2.1.2.2.3 The community respiratory service should develop a structured annual training programme primary care staff (both GPs and practice nurses) and for core community service staff, in particular members of the Integrated Locality Teams and Locality Hubs. This focused; proactive workforce development is integral to delivering a higher standard of generalist care across the out of hospital environment.

3.3.2.1.2.2.4 Training will be provided over a wide range of channels and methodologies to optimise access and this may include but is not limited to:

- Formal group training
- Real time support, apps and digital clinical decision support tools
- 'On the job' training including joint working and shadowing
- Mentoring and individual support
- Written information packs and guidance
- Online training including webinars and video conferences

3.3.2.1.2.2.5 The community respiratory service will use a range of approaches to maximise engagement with training and this may include delivery of education across clusters of organisations and professionals or the focussed training of specific staff/organisations within their regular clinical setting. Delivery of training to a specific organisation on-site at their place of practice may be particularly appropriate for sectors that find it difficult to release staff for training, particularly care homes and primary care. Training delivered in this way should be targeted to achieve the most significant improvement in outcomes.

3.3.2.1.2.2.6 All training and education will be evaluated and the service will be able to clearly demonstrate the additional skills developed across the workforce, the resulting outcomes and the level of engagement from different organisations and professionals across the area. The Community Respiratory Service will support the new Integrated Breathe Easy Groups by attending at least 6 of the 12 sessions per year at the current three local groups and support the British Lung Foundation with the establishment of two new groups, one in South Gloucestershire and one in Inner City and East for Black and minority ethnic communities.

3.3.2.1.2.2.7 The community respiratory service will implement the Bristol, North Somerset and South Gloucestershire Service users information standard operating procedure to ensure patients have sufficient information to help them manage their condition and stay well.

3.3.2.1.2.3 *Provision of direct assessment, treatment and intervention*
In the most complex of cases, that cannot be managed entirely within core generalist services, the Integrated Locality Team or the Locality Hub, the Community Respiratory Service will be expected to provide direct specialist assessment, a treatment plan that forms part of the individual's overall care plan and the direct delivery of appropriate clinical interventions.

3.3.2.1.2.3.1 This period of specialist assessment and management should be coordinated with the relevant GP and Integrated Locality Team/Hub and will involve a short term period of intensive specialist support linked to specific treatment goals and outcomes. Upon completion of this period of specialist support, or upon the achievement of defined treatment goals documented within the care plan, the individual should be discharged back to the care of the Integrated Locality Team/Hub and the GP. Even during the period of specialist management, follow-up activity and monitoring should be coordinated across the Integrated Locality Team/Hub and primary care to ensure the most efficient use of limited specialist resources is achieved.

3.3.2.1.2.3.2 Specialist assessment and intervention can be delivered within a person's usual place of residence, if housebound, or within community clinics operating within each GP Locality in Bristol, North Somerset and South Gloucestershire. The Provider will ensure equitable face to face access to this service for residents in care homes.

3.3.2.1.2.3.3 The community respiratory service should be able to deliver a wide range of interventions as part of specialist treatment plans and contingency plans, including (but not limited to):

- Management of breathlessness
- Breathing retraining for hyperventilation and breathing pattern disorders
- Assessment of daily functioning and strategies to improve functional status
- Medications review and management including wherever possible provisions for non-medical prescribing in line with local guidelines
- Integrated working with secondary care to manage the high impact users to prevent admissions and facilitate early supported discharge
- Provide 7 day admission avoidance (AA) services and early supported discharge services across Bristol, North Somerset and South Gloucestershire
- Specialist outpatient clinics
- Specialist assessment and symptom management
- Psychosocial interventions, including CBT based work for anxiety and depression related to chronic respiratory conditions
- Promotion of self-care and strategies for improving patient empowerment, carer knowledge and understanding, including the use of myCOPD application for both communication and telemedicine
- Palliative and end of life care, in conjunction with the Integrated Locality Team and local palliative care services
- Review and screening of appropriate oxygen needs (described below)
- Pulmonary rehabilitation (described below)

3.3.2.1.2.3.3 *Support of advance care planning and end of life care*
Specialist community respiratory service professionals will have a fundamental role in improving the quality and frequency of advance care planning. Professionals will proactively identify people approaching or potentially within the last year of life. The team will then work with patients, carers and other professionals to develop documented advance care plans for these patients. These advance care plans should utilise the CCG's recommended documentation (Recommended Summary Plan for Emergency Care and Treatment – ReSPECT[17]) as ratified by the CCG's End of Life Programme Board and Healthier Together.

3.3.2.1.2.4 *Pulmonary rehabilitation*
The community respiratory service will provide a high quality pulmonary rehabilitation service designed to improve quality of life, maintain independence and prevent deterioration of chronic respiratory problems. Pulmonary rehabilitation shall be offered to:

- All patients who consider themselves functionally disabled by breathlessness (usually people with an MRC score of three or more)
- Patients with an MRC score of two who are symptomatic and disabled by their condition, and who require a health care professional assessment and supervision of exercise training, rather than simple advice on lifestyle changes. (i.e. Not universally to everyone with an MRC score of two)
- Patients with a confirmed diagnosis of COPD and other chronic progressive lung conditions (e.g. Bronchiectasis, interstitial lung disease, chronic asthma and chest wall disease and also patients pre and post thoracic surgery including lung transplant)
- Patients who have either recently had an exacerbation of COPD requiring a hospital admission or whose functional baseline has significantly altered and is not following the expected recovery path

3.3.2.1.2.4.1 An accompanying carer should be encouraged to observe the exercise component and participate in the education sessions, where possible, unless a given session is specifically orientated for the patient only.

3.3.2.1.2.4.2 The Provider shall deliver pulmonary rehabilitation across four defined stages described below:

[17] https://www.respectprocess.org.uk/healthprofessionals

3.3.2.1.2.4.2.1 *Stage 1 – Manage referral and recruit patient*
The Provider will process the referral and offer eligible patients a place on a programme within 10 weeks of initial referral. Patients who are unable to attend through personal or medical reasons should be re-offered a place on two further occasion(s). If they cannot attend again, they are required to be re-referred, as their medical or motivational issues may need to be addressed. The Provider will send an acknowledgement confirming receipt of the referral to the patient and the referrer with confirmation of acceptance and an indication of waiting time.

3.3.2.1.2.4.2.2 The Provider shall send patients an offer in writing of an assessment date with a request to accept or decline. If no contact has been received from the patient regarding the assessment date, the Provider will attempt to contact the patient by phone on two further occasions. Patients will be advised that they can bring a carer to the assessment and the Provider shall encourage a carer to attend (with the patient's consent) to observe the exercise component and participate in the education sessions, unless the session is specifically orientated for the patient only. Patients should be provided with a clear explanation of what the assessment will involve.

3.3.2.1.2.4.2.3 The Provider shall offer a second assessment date to patients who are unable to accept the first offer. The Provider shall make a record of when the patient confirms that he/she is not willing to accept the second assessment date. If the patient is not willing to accept either the first or any subsequent offer (subject to a maximum of three), they will be referred back to the primary care professional and/or relevant Integrated Locality Team.

3.3.2.1.2.4.3 *Stage 2 – Assess patient for pulmonary rehabilitation*
Each patient attends a comprehensive assessment, by a specialist(s) in chronic respiratory care where they participate in a review of their general health, respiratory condition and its medical management; with the aim of optimising the participants condition prior to the rehabilitation programme.

3.3.2.1.2.4.3.1 The individual needs of the patient should be identified at the assessment, and a pulmonary rehabilitation programme should be tailored accordingly.

3.3.2.1.2.4.3.2 The Provider shall use the information provided by the referrer to form part of the risk assessment. This should include diagnosis, recent spirometry, relevant medical history including co-morbidities, MRC dyspnoea score, oxygen saturation if available, clinical tests if recent, relevant and available e.g. Blood culture or arterial blood gas results, drug management.

3.3.2.1.2.4.3.3 In addition the Provider shall consider the following elements, which may impact upon the time, location or booking process required to enable the patient to attend the appointment: special mobility needs, special access needs, any oxygen requirements identified, literacy needs, vision or hearing needs, e.g. large print communication and educational material.

3.3.2.1.2.4.3.4 The Provider shall undertake an individual comprehensive assessment based on all the information provided and the face-to-face assessment, including:

- Comprehensive medical review of patient to include respiratory history, exacerbations, hospital admissions, and all major co-morbidities
- Current drug management
- Social circumstances
- Smoking status and onward referral to smoking cessation services
- MRC dyspnoea score review
- Assessment of exercise capacity with correct number of repeat tests to achieve validity (6 minute walk tests or shuttle walk tests) with measures of oxygen saturation and breathlessness
- Assessment of peripheral muscle strength
- Assessment of quality of life, anxiety and depression using (a) validated measure(s)
- Assessment of functional status using a validated measure
- Base line observations – heart rate, blood pressure, height, weight
- Nutritional assessment (including BMI)
- Oxygen requirements– if further assessment identified, to be referred on to appropriate services
- Screen to identify those at potential risk of drop out – e.g. Where there are musculoskeletal, motivation and/or medication issues
- Literacy, language and cultural needs
- Education needs using a validated measure

3.3.2.1.2.4.3.5 The community respiratory team, in conjunction with the relevant GP, Integrated Locality Team and secondary care colleagues shall identify and manage medical issues that need addressing prior to starting the programme.

3.3.2.1.2.4.3.6 The community respiratory service shall retain the results of the baseline assessment as part of the individuals central care plan, accessible to both primary care and the relevant Integrated Locality Team. These baseline results should include metrics with regard to quality of life, function and mood measures, and exercise capacity tests and the results of these tests should be used as a benchmark to evaluate progress through repetition at the end of the programme.

3.3.2.1.2.4.3.7 Patients who demonstrate any musculoskeletal problems that impact on their ability to perform the exercise capacity tests will not be excluded from the programme, unless their problems actually prevent them from participating in any form of exercise. This may require consideration when evaluating their individual progress at the end of the programme.

3.3.2.1.2.4.4 *Stage 3 – Deliver a comprehensive pulmonary rehabilitation programme*
The community respiratory service shall be able to offer all eligible patients a place on a pulmonary rehabilitation programme within 10 weeks of receiving the initial referral, unless the patient cannot attend within that time frame for individual reasons. This will include the time taken to perform the assessment.

3.3.2.1.2.4.4.1 The community respiratory service shall ensure that the pulmonary rehabilitation programme contains individually prescribed physical exercise training, self -management advice and multidisciplinary education. The designed programme will ensure that goals are agreed with the patient and education needs are identified for all patients.

3.3.2.1.2.4.4.2 Every patient participating in pulmonary rehabilitation should have a training diary with written descriptions of endurance and strength exercise training at the highest tolerated intensity (and detailing the frequency during the week the patient is expected to do this) with a requirement for incremental progress.

3.3.2.1.2.4.4.3 The community respiratory service shall deliver the pulmonary rehabilitation programme with a minimum of two supervised classes a week for a minimum of six weeks using a range of appropriate professionals. Where appropriate, and in line with current best practice guidance, the training programme should include supervised exercise sessions with additional home training. Individual progress should be assessed by the use of appropriate assessment and outcome measures (including health status and functional exercise capacity) in line with those recorded as part of the baseline assessment.

3.3.2.1.2.4.4.4 The community respiratory service shall ensure that all patients have discussed and agreed a personalised maintenance plan prior to discharge from the pulmonary rehabilitation programme. All patients will be encouraged to use the myCOPD application during and after the pulmonary rehabilitation

3.3.2.1.2.4.4.5 The Provider shall demonstrate evidence of risk assessment, programme quality assurance and patient improvement.

3.3.2.1.2.4.4.6 The Provider shall develop and maintain a governance structure for the programme, with an individual identified as holding responsibility for the quality and delivery of the programme.

3.3.2.1.2.4.4.7 The Provider shall ensure that the programme is delivered by a multidisciplinary team of specialists experienced in chronic respiratory care and behaviour change.

3.3.2.1.2.4.4.8 The Provider shall ensure that the specialists in chronic respiratory care are supported by staff with qualities/competencies appropriate to the needs of the programme with experience of chronic lung conditions, exercise physiology and exercise assessment and the appropriate psychological inputs. This also includes administration duties to be performed by an appropriate level of staff (i.e. not necessarily clinical staff).

3.3.2.1.2.4.4.9 The Provider shall ensure that all sessions are supervised by a professional experienced in the management of chronic respiratory conditions and the delivery of aerobic and strength exercise training, with suitable support to adapt exercises for co-morbidities and breathlessness. They will endeavour to ensure continuity of care by ensuring that patients have the same trainer for the majority of their programme and this should be evaluated as part of the patient feedback survey. The Provider shall ensure that staffing/skill levels match the case mix of the patients taking part, the type of venue used and the rehabilitation programme ensuring safety to exercise.

3.3.2.1.2.4.4.10 The Provider shall adhere to staffing ratios recommended in the UK for pulmonary rehabilitation supervision of exercise classes (1:8) and (1:16) for education sessions, with a minimum of two supervisors in attendance one of whom must be a qualified respiratory specialist health care professional to supervise the exercise component. A greater staff to patient ratio is required if oxygen users are included.

3.3.2.1.2.4.4.11 The service shall provide suitable and safe equipment for use as part of the pulmonary rehabilitation programme and shall ensure that all equipment is maintained in a safe condition, according to the manufacturer's recommendations.

3.3.2.1.2.4.4.12 The following essential equipment is required:

- Oximeters, BP monitor, weight scales, height chart
- Stop watches (for assessments and exercise sessions, one for each patient)
- Weights and resistance equipment
- Music player, two bright cones, and 10 metre tape measure for shuttle walk tests.
- Chairs
- Telephone access
- Emergency equipment – oxygen, oxygen delivery devices, nebuliser and compressor, drugs for nebulisation
- Laptop / projector/ flip charts / white boards and supplementary written material for educational sessions

3.3.2.1.2.4.4.13 The Provider should ensure access to appropriate aerobic exercise equipment as required.

3.3.2.1.2.4.4.14 Exercise sessions: The Provider shall ensure that supervised exercise sessions including aerobics and strength training are performed at least twice a week for a minimum of six weeks with encouragement to undertake additional home training (with support from the myCOPD app if they have access to a computer, smart phone or tablet). The Provider shall ensure that every individual has a written prescription of endurance and strength exercise training at the highest tolerated intensity (above 60% peak performance/VO2) with evidence of increments and progress. The Provider shall adhere to the following exercise prescriptions:

- Aerobic exercise – walking is the most accessible form of exercise, but other forms of exercise can be considered. This can be completed either supervised or unsupervised at home.
- Intensity of aerobic exercise – wherever possible, prescribed at the highest possible level, progressed and monitored: a minimum of 60% and up to 85% of an individual's maximum exercise capacity.
- Frequency of aerobic exercise – twice weekly supervised exercise as a minimum, supported by a minimum of two additional home exercise sessions per week, to total a minimum of four sessions per week overall.
- Duration of aerobic exercise – initially aiming for 20-30 minutes of continuous exercise in each session, then increasing intensity once achieved; this may be comprised of two or more bouts of shorter time periods until the patient is able to achieve the desired 20-30 minutes continuous aerobic exercise. An essential minimum of six weeks, with no maximum upper duration.
- Strength training – both upper and lower limbs. Core exercises should be included.

3.3.2.1.2.4.4.15 Education sessions: The Provider shall ensure that baseline education needs are identified as part of developing the pulmonary rehabilitation patient plan. The Provider shall ensure that tutors are competent to deliver high quality and appropriate education sessions and are familiar with chronic respiratory disease patient's needs. The Provider shall carry out educational sessions/courses that cover a range of issues, including:

- Normal respiratory physiology and mechanics
- Understanding COPD/chronic respiratory diseases their pathophysiology, causes and treatment
- How to equip the individual to improve confidence, self-efficacy and self-management
- The roles of exercise and relaxation
- Medicines management and exacerbations
- Psychological impacts and minimising their effects
- How to manage breathlessness - smoking and smoking cessation services if appropriate
- The benefits of regular physical activity and exercise, and how to undertake physical activity and exercise safely and effectively
- Nutritional advice and eating strategies, including nutritional supplements where appropriate

3.3.2.1.2.4.4.16 The Provider shall ensure that written information is made available with consideration for literacy or language and vision issues and patients are offered the myCOPD app. The Provider shall ensure that the quality of education is assessed through patient satisfaction surveys or through validated questionnaires.

3.3.2.1.2.4.4.17 Safety: The Provider shall be aware of the importance of patient safety and ensure that appropriate safety facilities are available. The Provider shall ensure that resuscitation facilities and/or procedures are available and that staff have had recent training. In the case of emergency, suitable interventions administered that are appropriate to the location. For patients who desaturate on exercise and require ambulatory oxygen, the prescription of which has been determined by an ambulatory oxygen assessment, the Provider shall ensure that these patients attend pulmonary rehabilitation with their own ambulatory supply. If an increase, either temporary or permanent, in the prescription is required for the pulmonary rehabilitation programme and exertion, then the Community Respiratory Service will arrange this. Oxygen will be part of the emergency equipment provided.

3.3.2.1.2.4.5 *Stage 4 – final assessment and discharge*
Final assessment is important to establish effectiveness of the programme in achieving individual goals, physical performance, self-confidence and disease impact on quality of life. Intervention outcomes in the short term should include:

- Improvements in walking distance
- Improvements in health related quality of life as reflected in the validated QoL questionnaire
- Improvement in functional status using validated measure
- Reduction in anxiety and depression using (a) validated measure(s);
- Improvement in knowledge and understanding of condition using a validated
- Improvement in motivation as measured by the Patient Activation Measurement tool (PAM).measure / questionnaire.

3.3.2.1.2.4.5.1 In order to demonstrate the overall quality assurance and effectiveness of the pulmonary rehabilitation programme the Provider is required to demonstrate improvement on an aggregate basis to the short term intervention outcomes as set out above (using validated measures or questionnaires in each case), in at least 65% of patients who complete the programme.

3.3.2.1.2.4.5.2 Expected long-term outcomes include:

- Reductions in A&E attendance and hospitalisations for chronic respiratory conditions including COPD exacerbations over 12 months
- Improved exercise capacity although the effects of pulmonary rehabilitation diminish after a year;
- Improvement in patients' knowledge and awareness of their condition and their ability to self-manage.

3.3.2.1.2.4.5.3 The Provider shall re-assess the patient by repeating an individual comprehensive assessment at the end of the programme, reviewing the patient's attendance and completion of the programme and recording all goals attained. The Provider shall ensure that the same tools for assessment are used throughout the programme and appropriate assessment measures should be used to record final outcomes. Specific Quality of Life and other Questionnaires and exercise capacity tests should be used to benchmark the patient's progress. The Provider shall record the patient's achievement against the baseline assessment and patient set goals, and against the pulmonary rehabilitation programme goals.

3.3.2.1.2.4.5.4 The Provider shall ensure that an exit plan clearly outlining the maintenance options is agreed with the patient before he/she leaves the pulmonary rehabilitation programme, including the use of the myCOPD application. The Provider shall promote the importance of continuing exercise to the patient (e.g. walking in the park, joining a leisure centre or other independent exercise).

3.3.2.1.2.4.5.5 The Provider shall ensure that as part of the maintenance programme there is ongoing access to education and shall refer all patients to long-term management Providers, patient groups and support networks, shall identify Third sector and commercial lifestyle and exercise opportunities, and shall encourage the patient to take up such opportunities.

3.3.2.1.2.4.5.6 Completion of pulmonary rehabilitation, the attainment of goals and details of the agreed exit plan shall be documented and communicated as part of the patient's overall care plan, accessible to the GP and the relevant Integrated Locality Team.

3.3.2.1.2.4.5.7 The Provider shall send each patient an appropriate objective feedback survey that will request feedback about the patient's experience of the service. The Provider shall collate and analyse the results of the survey and produce a report as part of the wider annual evaluation of outcomes for the community respiratory service

3.3.2.1.2.5 *Home oxygen assessment and review (HOS-AR)*
The community respiratory service will be responsible for the assessment and on-going review of patients requiring home oxygen. The HOS-AR is designed to meet the needs of patients who might benefit from home oxygen. In most cases such people will show resting hypoxaemia with a SaO2 < 92%. The aims of this service are:

- To ensure that people prescribed oxygen and prescribing clinicians alike should be well informed about the nature, scope and capability of the home oxygen service
- To have quality at its core and be accessible, safe, effective and responsive to patients
- Be evidence-based, clinically led and continually strive to improve outcomes for patients
- Be affordable and represent good value for money
- To provide easy access to assessment and follow up procedures carried out by appropriately qualified and trained healthcare professionals using appropriate diagnostic equipment.
- Patient care will be improved through more effective management of the patient's oxygen requirements, leading to a higher standard of clinical treatment and improving outcomes
- By targeting the service on those who will benefit from home oxygen, affordability and value for money will be strengthened.
- Unnecessary or inappropriate prescription or provision of oxygen will be reduced

3.3.2.1.2.5.1 The service will work in an integrated manner with secondary care Providers to enable a seamless pathway for the patient and ensure the caseload is managed across the healthcare system in a timely manner.

3.3.2.1.2.5.2 The service will be responsible for the management and reconciliation of the home oxygen invoices and any associated reports from home oxygen suppliers for Bristol, North Somerset and South Gloucestershire. The service will be responsible for reviewing all prescriptions and raising any clinical concerns / inappropriate equipment orders with the originating clinician.

3.3.2.1.2.5.3 The service will provide clinical support to commissioners and other Providers around the management of patients where clinical concerns have been raised (clinical escalation).

3.3.2.1.2.5.4 The community community respiratory service will receive HOS-AR referrals from a broad range of sources that have made an assessment, which include but are not limited to, the following settings Primary Care, intermediate care, Secondary Care, tertiary care, occupational health, private health and so on.

3.3.2.1.2.5.5 The HOS-AR service will also assess and review patients with the clinical diagnosis of cluster headache who require home oxygen.

3.3.2.1.2.5.6 Appropriate identifications, work-up and referral of patients to HOS-AR should include:

- Patients should have a known clinical diagnosis and be medically optimized before referral. Following an initial assessment for home oxygen all patients need to be regularly reviewed to ensure that oxygen is provided only for patients who benefit clinically from it.
- Pulse oximetry should be routinely available in general practice and patients who are shown by oximetry to be hypoxaemic i.e. where SaO2 at or below 92%, and whose condition is stable, should be referred to the HOS-AR for full assessment
- Any patient who is hypoxaemic needs a diagnosis confirmed by a specialist clinician this can be a community specialist healthcare professional, GP with special interest or secondary care healthcare professional
- Where the patient's diagnosis is unclear or when significant co-morbidity might contribute to breathlessness or hypoxaemia e.g. heart failure they should be referred to an appropriate healthcare professional. Patients with potential hypercapnic respiratory failure should be also reviewed by an appropriate healthcare professional
- Patients who show intermittent or fluctuating hypoxaemia will need to be followed up and assessed more frequently

3.3.2.1.2.5.7 HOS-AR will be required to comply with British Thoracic Society Guidelines on the prescriptions and review of oxygen.

3.3.2.1.2.5.8 The fire service should conduct an on-site safety check/risk assessment when patients deemed to be at high risk are identified. Smoking households have a higher risk of domestic fire which could be potentially dangerous when home oxygen is provided. Fire services will be notified by the oxygen supplier of households with home oxygen. In order to minimise the risk of hypercapnic respiratory failure, the ambulance service should also be notified in the event of emergency transport to hospital. This could be through a range of mechanisms including issuing patients with oxygen alert cards, as recommended in the National COPD Strategy.

3.3.2.1.2.5.9 The community respiratory service will deliver a comprehensive HOS-AR function encompassing three principal stages:

- Home oxygen assessment
- Assessment for long-term oxygen therapy
- Assessment for ambulatory oxygen
- Follow-up ongoing assessment following initiation of home oxygen
- Withdrawal of oxygen therapy

3.3.2.1.2.5.9.1 *Home oxygen assessment*
The assessment should include quality assured diagnosis, assessment of resting and, when indicated, ambulatory finger or earlobe oximetry, or blood oxygen levels. In addition measurement of arterial / capillary blood gases will be required. The assessment should be conducted by a suitably qualified and trained healthcare professional with appropriate expertise in the management of chronic respiratory illness.

3.3.2.1.2.5.9.1.1 If oxygen therapy is indicated, the safety/the risk of having home oxygen, flow rate and duration of oxygen should be determined for each patient in accordance with national guidelines. In addition patients who make regular trips out of the home for work or leisure will need further assessment for ambulatory oxygen and consideration for pulmonary rehabilitation. If possible, pulmonary rehabilitation should be given before ambulatory oxygen. In some cases referral to social, psychological, dietary, occupational therapy or palliative care services will be required.

3.3.2.1.2.5.9.1.2 As part of the initial assessment a risk assessment (e.g. smoking, risk of falls etc.) needs to be undertaken. Prescribing of home oxygen to patients who smoke will be done in accordance with the South West policy on smoking and home oxygen.

3.3.2.1.2.5.9.1.3 Following consultation with the patient, the Provider shall identify the nature of the most cost effective equipment/delivery system most suited to the patient's lifestyle. Once identified, this equipment is made available to patients through oxygen supply companies.

3.3.2.1.2.5.9.1.4 The community respiratory service, in conjunction with members of the Integrated Locality Team, should ensure that patients and their carers understand how to use the oxygen equipment and manage their treatment. Training and written information (in appropriate languages for non-English speakers where required) should be offered to the patient/carer and repeated at reviews. The home oxygen supplier will provide the detailed information on the equipment supplied. The home oxygen order form (HOOF) should be completed and sent to the relevant oxygen supplier using the appropriate supplier portal and details of the plan for managing the patient's condition should be communicated to the relevant Integrated Locality Team and GP via the individuals centrally held care plan. Where appropriate, a consultant physician involved in the patient's care and/or relevant home care teams should also be notified. The assessment requires measurement of arterial or capillary blood gases as well as oximetry, and such equipment, properly maintained and calibrated according to manufacturing recommendations, must be available. In addition, a variety of oxygen equipment, both for long-term oxygen therapy and ambulatory use, must be available in order to assess the patient and ensure they are given the most appropriate equipment for their needs. This equipment should replicate that will be provided to the patient by the home oxygen supplier and these costs should be met by the Provider. Co-location with relevant diagnostic facilities such as chest x-ray would be advantageous.

3.3.2.1.2.5.9.2 *Assessment for long-term oxygen therapy*
The patient will be assessed and prescribed oxygen therapy in line with local and national guidance and best practice. The assessing clinician should explain the rationale for long-term oxygen therapy and its use. The most cost effective home oxygen equipment that best meets the patient's needs and preferences should be provided. Examples of the different types of equipment should therefore be available to demonstrate to the patient, in order to facilitate informed choice and help the patient to understand how to operate it. Once chosen, the clinician should complete a home oxygen order form (HOOF) using the home oxygen provider on the portal. Patients and carers should have the rationale for oxygen therapy explained and appropriate written supporting information. An appropriate risk assessment should also be undertaken.

3.3.2.1.2.5.9.3 *Assessment for ambulatory oxygen*
Certain patients may require ambulatory oxygen. This should primarily be to maximise quality of life and support normal activities of daily living, including undertaking exercise and trips out of the home and allows a longer daily use of long-term therapy. In these circumstances assessment should be carried out to simulate daily activities with the aim of avoiding significant desaturation and relieving breathlessness.

3.3.2.1.2.5.9.3.1 Some people who desaturate on exertion do not show resting hypoxaemia. Improved performance with ambulatory oxygen should be demonstrated before prescription. Higher flow rates and/or pulsed oxygen delivery systems may be indicated. Staff with additional experience of exercise assessment may be required in such cases.

3.3.2.1.2.5.9.3.2 The assessing clinician should demonstrate the types of ambulatory equipment available and agree with the patient the most cost effective equipment that would best meet his/her needs. The clinician should have confidence that the patient will make sufficient use of any ambulatory equipment provided, and ensure that he/she has the capacity – with adequate training – to operate it effectively (if necessary with the help of a carer). A HOOF should then be completed via the home oxygen supplier online portal.

3.3.2.1.2.5.9.3.3 Portable oxygen should also be made available for children using long-term oxygen therapy because they will need to be taken out of the home by parents/carers. The prescribing of oxygen is usually undertaken by specialist teams within the Acute Trusts or specialist c community teams (Lifetime).

3.3.2.1.2.5.9.3.4 Follow-up on-going assessment following initiation of home oxygen (clinic based or home visit): When home oxygen therapy has been started during acute illness a follow up visit that includes a review of the need to continue home oxygen should occur within 6 weeks. For patients starting home oxygen electively a review in 6-12 weeks will enable reassessment of the patient's clinical status, compliance with the oxygen therapy regime (including the appropriateness of the equipment) and whether further action is necessary (e.g. referral to specialist services or social care).

3.3.2.1.2.5.9.3.5 If any adjustment of the oxygen therapy is required, an amended HOOF will need to be completed and submitted to the oxygen supplier via their portal. Stable patients should be reviewed in accordance with national guidance and the patient's current requirements including monitoring of oxygen saturations, compliance with oxygen therapy and enquiry about smoking habit. All patients on oxygen therapy should be reviewed by the HOS-AR with repeat blood gases annually where appropriate. Where the review indicates that the patient is no longer deriving clinical benefit from the oxygen (either because the patient was/is not hypoxaemic or they gain no benefit from the therapy), discussion should take place about withdrawing it. Where the patient is not using the oxygen as prescribed, but still clinically needs it, further education may be required or a reduction in the prescribed use should be considered. Patients in receipt of home oxygen should be reviewed after any acute hospital admission or severe exacerbation treated at home in line with national guidance.

3.3.2.1.2.5.9.4 *Withdrawal of oxygen therapy*
When patients, at review, are found to no longer meet the criteria for home oxygen, this should be explained, the oxygen provision discontinued and other prescribed treatments reviewed. Where the patient continues to meet the criteria but is not compliant with the prescribed oxygen therapy, he or she should be counselled on the merits of the therapy and encouraged to increase usage to the recommended level.

3.3.2.1.2.5.9.4.1 In cases where oxygen was introduced before the adoption of the South West policy on Smoking and Home Oxygen and there is continued smoking, patient education and expert support to stop should be offered. In these cases a risk/benefit analysis should be undertaken with medical review. In some circumstances it may be appropriate to withhold or withdraw oxygen because of public safety and risk to others in line with the South West Policy on Smoking and Home Oxygen. Oxygen will be withdrawn when the smoking/fire related serious untoward incidence (SUI) is raised by the oxygen supplier.

3.3.2.1.2.5.9.4.2 All withdrawal decisions should be made in accordance with a suitable clinical protocol, designed by the Community Respiratory Service and agreed with the commissioners.

3.3.2.2 **Specialist heart failure care**
The heart failure service supports people with chronic heart failure utilising the skills and expertise of specialist staff including specialist heart failure nurses properly integrated with consultant led cardiovascular services in secondary care. Collaboration with the secondary care team will extend to clinical supervision and governance, access to specialist medical opinion and the rotation of acute and community facing roles to build a well-rounded, highly skilled specialist workforce.

3.3.2.2.1 The heart failure service will provide input, assessment and treatment as part of a wider, holistic care plan delivered in collaboration with a patient's GP, and in conjunction with the relevant Integrated Locality Team delivering core community services

3.3.2.2.2 The heart failure service is accessible to patients with all types of heart failure. The service should also accept clinically appropriate referrals where heart failure is suspected but a formal diagnosis has not yet been made.

3.3.2.2.3 The functions delivered by the heart failure service are described below:

3.3.2.2.3.1 *Provision of clinical advice and support*
One of the primary functions of the heart failure service is to provide specialist clinical advice and support to health and care professionals in both primary care and the wider out of hospital setting. This advice can take the form of telephone or email contact with other professionals in line with the response times set out paragraph 3.4.3.3 of this specification. Requests for advice will be easily accessible through a single email address and telephone number. Advising professionals will have access to the patient's care plan held by the GP and/or relevant Integrated Locality Team, ideally through direct interoperability of clinical system.

3.3.2.2.3.1.1 Advice and recommended interventions should be captured as part of the care plan and communicated across both the GP and Integrated Locality Team.

3.3.2.2.3.1.2 It is anticipated that the majority of requests for advice will originate from primary care and core community service professionals, however advice may also be requested from other care settings e.g. care homes, hospices, mental health teams. All requests should be prioritised and addressed in accordance with clinical need, however where an individual is potentially unknown to the Integrated Locality Team the heart failure service should coordinate responses with the Integrated Locality Team to ensure that specialist resources are only deployed in cases of the appropriate complexity.

3.3.2.2.3.1.3 The heart failure service should be properly integrated with the consultant-led specialist cardiovascular teams in secondary care and should therefore have rapid access to the advice and opinion of consultant medical staff whenever this is clinically required.

3.3.2.2.3.2 *Education, training and workforce development*
The heart failure service has an explicit and fundamental leadership role in developing the skills, confidence and capabilities of the wider health and care workforce with regards to the management of chronic heart failure.

3.3.2.2.3.2.1 The Provider, in partnership with the commissioner, is expected to proactively evaluate available outcomes and performance data from across the system and conduct training needs analyses to identify opportunities within the local workforce to improve staff capabilities, ultimately resulting in improved patient outcomes and a reduced variability in the quality of care.

3.3.2.2.3.2.2 This proactive evaluation of outcomes and training needs analyses should apply to primary care, core community services including the Integrated Locality Teams, care homes, hospices, social care professionals and any other service where there is a clear opportunity to improve patient outcomes through training and staff development. Scoping of training opportunities should consider available outcomes data, including the Quality and Outcomes Framework (QOF) in primary care, as well as available acute admissions data relating to secondary care.

3.3.2.2.3.2.3 The heart failure service will develop a structured annual training programme for primary care staff (both GPs and practice nurses) and for core community service staff, in particular members of the Integrated Locality Teams. This focused, proactive workforce development is integral to delivering a higher standard of generalist care across the out of hospital environment. Training should be provided over a wide range of channels and methodologies to optimise access and this may include:

- Formal group training
- 'On the job' training including joint working and shadowing
- Mentoring and individual support
- Written information packs and guidance
- Online training including webinars and video conferences

3.3.2.2.3.2.4 The heart failure service will use a range of approaches to maximise engagement with training and this may include delivery of education across clusters of organisations and professionals or the focussed training of specific staff/organisations within their regular clinical setting. Delivery of training to a specific organisation on-site at their place of practice may be particularly appropriate for sectors that find it difficult to release staff for training, particularly care homes and primary care. Training delivered in this way should be targeted to achieve the most significant improvement in outcomes.

3.3.2.2.3.2.5 All training and education will be evaluated and the service should be able to clearly demonstrate the additional skills developed across the workforce, the resulting outcomes and the level of engagement from different organisations and professionals across the area.

3.3.2.2.3.3 *Provision of direct assessment, treatment and intervention*
In the most complex of cases, that cannot be managed entirely within core generalist services and the Integrated Locality Team, the heart failure service will be expected to provide direct specialist assessment, a treatment plan that forms part of the individual's overall care plan and the direct delivery of appropriate clinical interventions.

3.3.2.2.3.3.1 This period of specialist assessment and management should be coordinated with the relevant GP and Integrated Locality Team and involve a short term period of intensive specialist support whilst titrating optimum therapy, linked to specific treatment goals and outcomes. Upon completion of this period of specialist support, or upon the achievement of defined treatment goals documented within the care plan, the individual will be discharged back to the care of the Integrated Locality Team and the GP. Even during the period of specialist management, follow-up activity and monitoring will be coordinated across the Integrated Locality Team and primary care to ensure the most efficient use of limited specialist resources is achieved.

3.3.2.2.3.3.2 Specialist assessment and intervention can be delivered within a person's usual place of residence, if housebound, or within community clinics operating within Bristol, North Somerset and South Gloucestershire's six localities. The Provider will ensure equitable face to face access to this service for residents in care homes. The heart failure service will be able to deliver a wide range of interventions as part of specialist treatment plans and contingency plans, including (but not limited to):

- Complex patients will be discharged from the heart failure service caseload once treatment goals have been achieved, titration of optimum treatment is reached, the condition is stabilised or the patient enters a palliative care phase.
- Patients with stable heart failure, under an optimised treatment regimen will be managed in primary care with the support of the Integrated Locality Team and not retained on the specialist service caseload for longer than is clinically necessary

3.3.2.2.3.3.3 *Support of advance care planning and end of life care*
Specialist community respiratory service professionals will have a fundamental role in improving the quality and frequency of advance care planning. Professionals will proactively identify people approaching or potentially within the last year of life. The team will then work with patients, carers and other professionals to develop documented advance care plans for these patients. These advance care plans should utilise the CCG's recommended documentation (Recommended Summary Plan for Emergency Care and Treatment – ReSPECT) as ratified by the CCG's End of Life Programme Board and Healthier Together.

3.3.2.3 Tissue viability and wound care
The tissue viability service will operate in a multi-professional way to provide specialist assessment and advice to promote the prevention, assessment, treatment and management of a wide variety of healing wounds including pressure ulcer prevention and management, management of leg ulceration, management of traumatic injuries and complex non-healing wounds.

3.3.2.3.1 The tissue viability service will provide input, assessment and treatment as part of a wider, holistic care plan delivered in collaboration with a patient's GP, and in conjunction with the relevant Integrated Locality Team (Integrated Locality Team) delivering core community services. The tissue viability service will also be appropriately integrated and supported by relevant specialist teams in secondary care, for example dermatology. The tissue viability service provides a broad range of interventions that aim to:

- Promote healing of complex non healing wounds
- Empower other professionals to manage
- Day to day at each stage of the treatment of complex wounds
- During an acute episode or unresolved chronic episode of care
- Support chronic disease management to maintain independence
- Facilitate patient choice during all stages of wound care
- Manage and reduce impact of delayed healing
- Avoid unnecessary hospital admission
- Facilitate and support timely hospital discharge
- Facilitate high quality end of life care provision
- Maintain optimum function
- Maintain and improve quality of life
- Optimise medicines management through non-medical prescribing and teaching and the provision and monitoring of a wound dressing formulary.
- Input into the management and upkeep of the wound dressing formulary
- Support individuals who have complex wounds and their families and carers.
- Provide both directly and by working in partnership with other services seamless care and case management working as part of a wider multi inter-disciplinary and multi-agency team and include the patient, carer and family within the decision making processes.

3.3.2.3.2 Specialist assessment and intervention can be delivered within a person's usual place of residence in accordance with the response times detailed in paragraph 3.4.3.3 of this specification. The Provider will ensure equitable face to face access to this service for residents in care homes. Referrals will be accepted from any health or care professional across the whole-system.

3.3.2.3.3 The tissue viability service will have robust, defined pathways in place to cover, at a minimum:

- Leg ulcer pathway
- Wound assessment and pressure ulcer prevention guidelines
- Wound formulary
- Anti-microbial pathway

3.3.2.3.4 The service will have the capability to perform important relevant diagnostics and investigations, for example ABPI Doppler.

3.3.2.3.5 In addition to the provision of direct clinical assessment and intervention the tissue viability service has a fundamental leadership role in the provision of advice, support, training and education to other professionals across the health and care system, as described below. Although primarily an adult service there may be occasions where a patient under the age of 18 will require wound care under the remit of these service professionals. Patients under the age of 18 should be able to access specialist wound care services where this is clinically appropriate and through the coordination of the relevant paediatric team or primary care professional.

3.3.2.3.6 *Provision of clinical advice and support*
One of the primary functions of the tissue viability service is to provide specialist clinical advice and support to health and care professionals in both primary care and the wider out of hospital setting. This advice can take the form of telephone or email contact with other professionals in line with the response times detailed in paragraph 3.4.3.3 of this specification. Requests for advice will be easily accessible through a single email address and telephone number. Advising professionals will have access to the patient's care plan held by the GP and/or relevant Integrated Locality Team, ideally through direct interoperability of clinical systems

3.3.2.3.6.1 Advice and recommended interventions should be captured as part of the care plan and communicated across both the GP and Integrated Locality Team.

3.3.2.3.6.2 It is anticipated that the majority of requests for advice will originate from primary care and core community service professionals, however advice may also be requested from other care settings e.g. care homes, hospices, mental health teams. All requests will be prioritised and addressed in accordance with clinical need, however where an individual is potentially unknown to the Integrated Locality Team the tissue viability service will coordinate responses with the Integrated Locality Team to ensure that specialist resources are only deployed in cases of the appropriate complexity.

3.3.2.3.6.3 The tissue viability service should be properly integrated with the consultant-led specialist dermatology teams in secondary care and should therefore have rapid access to the advice and opinion of consultant medical staff whenever this is clinically required.

3.3.2.3.7 *Locally commissioned service in Primary Care*
As part of improved/extended access in Primary Care there are wound clinics in existence that cover weekend provision for wound care. The Provider will align with these clinics to avoid duplication and also to ensure there is equitable access for all patients across seven days in Bristol, North Somerset and South Gloucestershire.

3.3.2.3.8 *Education, training and workforce development*
The tissue viability service has an explicit and fundamental leadership role in developing the skills, confidence and capabilities of the wider health and care workforce with regards to the management of complex wounds.

3.3.2.3.8.1 The Provider, in partnership with the commissioner, is expected to proactively evaluate available outcomes and performance data from across the system and conduct training needs analyses to identify opportunities within the local workforce to improve staff capabilities, ultimately resulting in improved patient outcomes and a reduced variability in the quality of care.

3.3.2.3.8.2 This proactive evaluation of outcomes and training needs analyses will apply to primary care, core community services including the Integrated Locality Teams, care homes, hospices, social care professionals and any other service where there is a clear opportunity to improve patient outcomes through training and staff development. Scoping of training opportunities will consider available outcomes data, including the Quality and Outcomes Framework (QOF) in primary care, as well as available acute admissions data relating to secondary care.

3.3.2.3.8.3 The tissue viability service will develop a structured annual training programme for primary care staff (both GPs and practice nurses), care home staff and for core community service staff, in particular members of the Integrated Locality Teams. This focused; proactive workforce development is integral to delivering a higher standard of generalist care across the out of hospital environment.

3.3.2.3.8.4 Training will be provided over a wide range of channels and methodologies to optimise access and this may include but is not limited to:

- Formal group training
- 'On the job' training including joint working and shadowing
- Mentoring and individual support
- Written information packs and guidance
- Online training including webinars and video conferences

3.3.2.3.8.5 The tissue viability service will use a range of approaches to maximise engagement with training and this may include delivery of education across clusters of organisations and professionals or the focussed training of specific staff/organisations within their regular clinical setting. Delivery of training to a specific organisation on-site at their place of practice may be particularly appropriate for sectors that find it difficult to release staff for training, particularly care homes and primary care. Training delivered in this way will be targeted to achieve the most significant improvement in outcomes.

3.3.2.3.8.6 All training and education will be evaluated and the service should be able to clearly demonstrate the additional skills developed across the workforce, the resulting outcomes and the level of engagement from different organisations and professionals across the area.

3.3.2.4 **Continence service**

The community continence/bladder and bowel service provision will include a nurse-led specialist continence service, including nurse prescriber capability, with oversight of bladder and bowel care provision including full assessment and review, pro-active treatment and management using appropriate products where required, aiming for a catheter-free community. The purpose of one specialist service taking overall responsibility for the entire continence pathway will place patients at the centre of their care and avoid the disconnect between GPs, community nurses and the continence service all having responsibility for parts of patients' continence care needs.

3.3.2.4.1 The specialist community continence service will need to engage with and educate community nursing, GPs, care home staff and social care to promote continence and prevent deskilling. The community continence/bladder and bowel service needs to work closely with primary care, the community urology service and secondary care to promote an integrated end to end pathway. Rotational or joint posts with secondary care and or the community urology service may support this aim.

3.3.2.4.2 The service will be responsible for implementing the continence formulary and regularly helping to review the formulary. The service will promote self-care, such as via patient held catheter passports, provide good quality patient information and encourage peer led support groups.

3.3.2.4.3 The Provider will deliver a comprehensive, evidence based continence promotion and treatment service based on individualised assessments to treat and manage bladder and bowel dysfunction. This includes the provision of advice and support to patients, carers and other healthcare professionals in developing management plans with the aim to:

- Prevent hospital admission
- Prevent falls
- Reduce infection rates e.g. in patients who are catheterised
- Facilitate timely hospital discharge
- Support self-care and maintain independence in order to manage and avoid crisis and reduce the need for long-term care
- Provide timely clinical care based on assessment and treatment options for patients
- Advise on the management options for patients and support carers and other healthcare professionals in developing management plans.
- Provide a resource for all healthcare professionals enhancing clinical care for patients through the provision of expert practice, education and training
- Provide diagnostics including bladder scanning (to establish if someone is emptying their bladder completely), urinalysis, observation of the perineum, digital vaginal examination to assess and teach pelvic muscle exercises, digital rectal examination to assess and treat male pelvic muscle exercises and to exclude faecal impaction if necessary,
- Provide bladder retraining, fluid advice, toileting regimes and advice on bowel care. develop and implement evidence based guidelines and protocols
- To support the prevention of an admission to long term care due to bladder and bowel dysfunction
- To assess and provide products for patients as required via the Home Delivery Service ensuring the best value for money

3.3.2.4.4 The Provider is **not** expected to provide the delivery service for continence products. This is accessible under another service contract. The Provider will however hold the budget for the prescription and issuing of continence products under the scope of this Contract.

3.3.2.4.5 The continence service will provide appropriate clinical assessment and therapeutic intervention as well as having a fundamental leadership role in the provision of advice, support, training and education to other professionals across the health and care system. These key functions are described below.

3.3.2.4.6 *Provision of clinical advice and support*
One of the primary functions of the continence service is to provide specialist clinical advice and support to health and care professionals in both primary care and the wider out of hospital setting. This advice can take the form of telephone or email contact with other professionals in line with the response times set out in section 3.4.4.3 of this specification. Requests for advice will be easily accessible through a single email address and telephone number. Advising professionals will have access to the patient's care plan held by the GP and/or relevant Integrated Locality Team, ideally through direct interoperability of clinical systems.

3.3.2.4.6.1 Advice and recommended interventions will be captured as part of the care plan and communicated across both the GP and Integrated Locality Team.

3.3.2.4.6.2 It is anticipated that the majority of requests for advice will originate from primary care, care homes and core community service professionals, however advice may also be requested from other care settings e.g. hospices, mental health teams. All requests will be prioritised and addressed in accordance with clinical need, however where an individual is potentially unknown to the Integrated Locality Team the continence service will coordinate responses with the Integrated Locality Team to ensure that specialist resources are only deployed in cases of the appropriate complexity.

3.3.2.4.6.3 The continence service will be properly integrated with the consultant-led specialist urology and gastroenterology teams in secondary care and therefore have rapid access to the advice and opinion of consultant medical staff whenever this is clinically required.

3.3.2.4.7 *Education, training and workforce development*
The continence service has an explicit and fundamental leadership role in developing the skills, confidence and capabilities of the wider health and care workforce with regards to the provision of high quality care and prevention of incontinence.

3.3.2.4.7.1 The Provider, in partnership with the commissioner, is expected to proactively evaluate available outcomes and performance data from across the system and conduct training needs analyses to identify opportunities within the local workforce to improve staff capabilities, ultimately resulting in improved patient outcomes and a reduced variability in the quality of care.

3.3.2.4.7.2 This proactive evaluation of outcomes and training needs analyses will apply to primary care, core community services including the Integrated Locality Teams, care homes, hospices, social care professionals and any other service where there is a clear opportunity to improve patient outcomes through training and staff development. Scoping of training opportunities will consider available outcomes data, including the Quality and Outcomes Framework (QOF) in primary care, as well as available acute admissions data relating to secondary care.

3.3.2.4.7.3 The continence service will develop a structured annual training programme for primary care staff (both GPs and practice nurses), care home staff and for core community service staff, in particular members of the Integrated Locality Teams. This focused; proactive workforce development is integral to delivering a higher standard of generalist care across the out of hospital environment.

3.3.2.4.7.3 Training will be provided over a wide range of channels and methodologies to optimise access and this may include and is not limited to:

- Formal group training
- 'On the job' training including joint working and shadowing
- Mentoring and individual support
- Written information packs and guidance
- Online training including webinars and video conferences

3.3.2.4.7.4 The continence service will use a range of approaches to maximise engagement with training and this may include delivery of education across clusters of organisations and professionals or the focussed training of specific staff/organisations within their regular clinical setting. Delivery of training to a specific organisation on-site at their place of practice may be particularly appropriate for sectors that find it difficult to release staff for training, particularly care homes and primary care. Training delivered in this way will be targeted to achieve the most significant improvement in outcomes. All training and education will be evaluated and the service should be able to clearly demonstrate the additional skills developed across the workforce, the resulting outcomes and the level of engagement from different organisations and professionals across the area.

3.3.2.4.8 *Provision of direct assessment, treatment and intervention*
The continence service will provide specialist clinical assessment and treatment in a range of settings, delivered by highly skilled and flexible teams. The service will have an emphasis on the treatment rather than containment of incontinence with the aim of promoting independence.

3.3.2.4.8.1 Patients can be assessed and treated within their usual place of residence or in a community clinic setting within the GP Locality geographies of Bristol, North Somerset and South Gloucestershire CCG. The Provider will ensure equitable face to face and remote access to specialist continence services for the residents of care homes.

3.3.2.4.8.2 Following assessment a defined treatment plan is agreed and incorporated with the central care plan shared across the relevant GP and Integrated Locality Team. It is envisaged that the continence service provides a period of short term intervention and support aimed at the treatment of continence conditions (often up to 12 weeks). This period will be linked to documented treatment goals and the patient will be discharged from the service caseload following achievement of these goals or where incontinence has proved intractable to treatment and the on-going follow-up and management does not require specialist care. In these instances the patient will be discharged to the on-going care of the GP and Integrated Locality Team.

3.3.2.4.8.3 Patients undergoing specialist treatment programmes are not provided with products during this period and are only transferred to the Home Delivery Service if their incontinence has not been treated successfully. The use of continence products prematurely can lead to a psychological dependence on them and reluctance to attempt curative treatment.

3.3.2.4.8.4 Patients can be referred for additional products such as handheld urinals and lifestyle aids and adaptations, such as commodes or raised toilet sears which may prevent the need for continence products and promote independence.

3.3.2.4.8.5 The continence service will off a wide range of treatment and management options including (but not limited to):

- Assessments on a one to one basis with the patient
- Education and support for the patient /carers regarding their condition
- Tests including bladder scanning and urinalysis
- Bladder retraining
- Digital vaginal and rectal examination to assess pelvic floor muscle function and to teach pelvic floor muscle training
- Management of complex urinary catheters
- Flushing and site care
- Bladder and bowel management
- Management of neurogenic bowel dysfunction and support to those with central nervous system disorders leading to faecal incontinence or constipation including:
- Assessment of patient needs and production of a bowel management plan in collaboration with the individual. The plan should promote autonomy and independence incorporating the goals and lifestyle aims of the patient.
- Provide a range of treatment functions including (but not limited to) optimising diet and fluids, rectal stimulation, oral laxatives, anal irrigation
- Evaluation of the bowel management plan using a range of clinical outcome measures
- Teaching patients intermittent self-catheterisation
- Trial without catheter (TWOCS)
- Catheterisation techniques
- Hydration advice
- Medication review

3.3.2.5 **Community diabetes service**

The CCG has undertaken a radical redesign and improvement in the delivery of diabetes care outside of hospital. This transformational change is being driven by the Diabetes Transformation Programme across Bristol, North Somerset and South Gloucestershire which focuses on education, technology, incentivising self-care and rapid access to a specialist when needed.

3.3.2.5.1 This community diabetes service will work entirely across primary care and the community but should be properly integrated with specialist diabetes teams in secondary care ideally through defined formal links, joint clinical leadership and rotation of clinical staff.

3.3.2.5.2 The community diabetes service will include a range of specialist skills including:

- Consultant diabetologist
- GP with special interest in diabetes
- Diabetes specialist nurses
- Specialist diabetes dietician
- Specialist podiatrist
- Psychological support specific to people with diabetes

3.3.2.5.3 It is acknowledged that the immediate availability of diabetes specialist nurse skills is limited and the Provider should develop programmes and initiatives to identify, attract and up-skill clinical staff across the health economy to take on these roles. The Provider should also pursue innovative uses of staff rotation and joint post with specialist diabetes service to ensure expertise is deployed proportionately outside of hospital.

3.3.2.5.4 The community diabetes service will have the ultimate strategic aim of improving health outcomes for people with diabetes whose care needs are more complex than routine management but do not require specialist treatment in an acute setting. The community diabetes service will also have a fundamental leadership role in supporting and developing the capabilities of General Practice, driving integration across organisations and enabling better navigation of the diabetes care system.

3.3.2.5.5 Specifically the community diabetes service will have the following objectives:

- To improve the clinical outcomes and quality of life for people with diabetes; particularly those outcomes relating to HbA1c control, blood pressure, lipids, BMI and supporting the diabetic foot care pathway with the aim of reducing amputation rates.
- To provide prompt access to specialist care in a community setting
- To facilitate greater access to appropriate professional advice and support in order to improve the management of diabetes patients in primary care
- As most people with diabetes receive their care in General Practice the CDT's role is to improve the competency, capability, confidence and knowledge of primary care professionals in managing diabetes patients, through the provision of training, education and virtual clinics
- Ensure patients receive the appropriate level of care, facilitating access to specialist and other support services where necessary
- Increase the proportion of patients receiving care closer to home
- To provide patient diabetes structured education in line with NICE guidance This structured education should be accessible when service users are ready to access it (i.e. not limited to one year post diagnosis)

3.3.2.5.6 The community diabetes service will utilise a range of interventions to deliver these outcomes as described below:

3.3.2.5.6.1 *Support to Primary Care*
The vast majority of diabetes care occurs in primary care. If an optimum level of diabetes care is to be reached for local patients then good standards of fundamental diabetes care need to be delivered consistently by all practices.

3.3.2.5.6.1.1 The community diabetes service will take a leading role in driving improvement in primary diabetes care and must position itself closely with all GP practices in order to foster collaborative relationships that share expertise and produce the synergy necessary to attain a higher standard of care provision. This will likely include virtual clinics, education, training and diabetes conferences.

3.3.2.5.6.1.2 The community diabetes service will promote the use of appropriate care planning in primary diabetes care in conjunction with the person's GP team and the relevant Integrated Locality Team where appropriate.

3.3.2.5.6.1.3 It is essential that the Provider works with Healthier Together's Diabetes workstream to implement and align work with the National Diabetes Prevention Programme across Bristol, North Somerset and South Gloucestershire.

3.3.2.5.6.2 *Provision of clinical advice*
The community diabetes service will offer specialist support to health and care professionals across the system via telephone and email. Such advice and support should be available to all health and care professionals with a relevant clinical concern but in particular this will include, primary care professionals, core community service professionals i.e. members of the Integrated Locality Team or Acute and Reactive Care Function and care home staff.

3.3.2.5.6.2.1 The community diabetes service will offer Virtual Clinics at practices where the team review individual cases but also review lists generated from EMIS with groups of patients to target for care improvement.

3.3.2.5.6.2.2 The community diabetes service will ensure a suitable clinician is available to provide an advice function for every GP practice within core service hours and will ensure that requests for advice via telephone and email are dealt with appropriately in accordance with the response times detailed in paragraph 3.4.3.3 of this specification.

3.3.2.5.6.2.3 *Support of advance care planning and end of life care*
Specialist community respiratory service professionals will have a fundamental role in improving the quality and frequency of advance care planning. Professionals will proactively identify people approaching or potentially within the last year of life. The team will then work with patients, carers and other professionals to develop documented advance care plans for these patients. These advance care plans should utilise the CCG's recommended documentation (Recommended Summary Plan for Emergency Care and Treatment – ReSPECT) as ratified by the CCG's End of Life Programme Board and Healthier Together.

3.3.2.5.6.3 *Locality hub clinics*
Initially patients can be reviewed remotely either in virtual clinic at the practice, or by request to the community diabetes team who view the practice EMIS record. The community diabetes team may return a plan of action for this patient, or in a small number of cases where the complexity or severity of a patient's diabetes exceeds the level of care, available in a primary care setting, a referral will be made to a community clinic providing multidisciplinary care comprising input from a Consultant Diabetologist and/or GP with Special Interest in Diabetes, Diabetes Specialist Nurse and other relevant disciplines as required e.g. specialist dietetic/podiatry input. These appointments will be offered in a fashion that suits patients and carers in terms of timeliness, location and accessibility. The service should aim to provide patients with access to such appointments within the response times included paragraph 3.4.3.5 of this specification.

3.3.2.5.6.3.1 Appointments will be offered in suitable community locations across Bristol, North Somerset and South Gloucestershire CCG within emerging Locality Hubs across Bristol, North Somerset and South Gloucestershire's 6 localities as ideal focal points for ensuring adequate geographical coverage of community based specialist care.

3.3.2.5.6.3.2 The community diabetes service, in conjunction with general practice and the relevant Integrated Locality Team, should ensure that all referrals made to community clinics are subject to adequate prior work-up, ensuring that the results of all relevant diagnostic tests are available in advance of the community clinic appointment. This includes, primarily, an up-to-date HbA1c reading and renal function test.

3.3.2.5.6.3.3 Patients will be given appointments that are of an adequate length for a thorough clinical consultation, be that an initial or follow-up appointment and meet national standards. The consultation will be provided by the most suitable clinician for the nature of the clinical presentation. A thorough and robust triage of each patient will be made to determine the most suitable clinician.

3.3.2.5.6.3.4 All patients referred to the community clinic for medical advice will be seen by all appropriate members of the multidisciplinary team as part of a 'one-stop-shop' approach. In rare instances the clinical need for this service will be on an emergency basis, where the patient needs to be seen at very short notice. The service should ensure that, where this is clinically appropriate, an appointment on an emergency basis can be undertaken by the most appropriate clinician within core service hours.

3.3.2.5.6.3.5 These specialist community clinics are not expected to include the same range of multi-specialist input as those specialist clinics currently delivered within local acute trusts such as renal disease, vascular surgery, antenatal care and young people's diabetic clinics.

3.3.2.5.6.4 *Professional education*
The community diabetes service has an explicit and fundamental leadership role in developing the skills, confidence and capabilities of the wider health and care workforce with regards to the management of complex wounds. The Provider, in partnership with the commissioner, is expected to proactively evaluate available outcomes and performance data from across the system and conduct training needs analyses to identify opportunities within the local workforce to improve staff capabilities, ultimately resulting in improved patient outcomes and a reduced variability in the quality of care.

3.3.2.5.6.4.1 This proactive evaluation of outcomes and training needs analyses should apply to primary care, core community services including the Integrated Locality Teams, care homes, hospices, social care professionals and any other service where there is a clear opportunity to improve patient outcomes through training and staff development. Scoping of training opportunities should consider available outcomes data, including the Quality and Outcomes Framework (QOF) in primary care, Practice level EMIS reports, as well as available acute admissions data relating to secondary care.

3.3.2.5.6.4.2 The community diabetes service should develop a structured annual training programme for primary care staff (GPs, practice nurses and clinicians), care home staff and for core community service staff, in particular members of the Integrated Locality Teams, linking with the National Diabetes Prevention Programme Provider across Bristol, North Somerset and South Gloucestershire. This focused; proactive workforce development is integral to delivering a higher standard of generalist care across the out of hospital environment.

3.3.2.5.6.4.3 The community diabetes service must design a programme that facilitates educational activity at different levels including:

- Foundation diabetes care
- Complex diabetes care
- Insulin/injectable therapy – initiation and on-going management
- Update training for Primary care clinicians who have previously completed the above

3.3.2.5.6.4.4 Training will be provided over a wide range of channels and methodologies to optimise access and this may include:

- Formal group training
- 'On the job' training including joint working and shadowing
- Mentoring and individual support
- Written information packs and guidance
- Online training including webinars and video conferences
- Secondment to the community diabetes team

3.3.2.5.6.4.5 The community diabetes service will use a range of approaches to maximise engagement with training and this may include delivery of education across clusters of organisations and professionals or the focussed training of specific staff/organisations within their regular clinical setting. Delivery of training to a specific organisation on-site at their place of practice may be particularly appropriate for sectors that find it difficult to release staff for training, particularly care homes and primary care. Training delivered in this way should be targeted to achieve the most significant improvement in outcomes.

3.3.2.5.6.4.6 All training and education will be evaluated and the service should be able to clearly demonstrate the additional skills developed across the workforce, the resulting outcomes and the level of engagement from different organisations and professionals across the area.

3.3.2.5.6.5 *Transfer of care*
Clinically appropriate referral and discharge criteria, which aligns with criteria outlined in contract schedule 2J – Transfer of and Discharge of Care Protocols, are to be agreed between the community diabetes service, local acute trusts and the commissioner in order to facilitate safe transfer of care from acute services to community specialists.

3.3.2.5.6.5.1 The community diabetes service will work with acute services to identify patients suitable for transfer to the community setting during the contract mobilisation period and ensure care is transferred to the most clinically appropriate setting as soon as possible.

3.3.2.5.6.6 *Home visits*
A proportion of people with diabetes are housebound or experience mobility issues that prevent them from attending a community or joint-clinic provided by the community diabetes service. In such circumstances, professionals should make arrangements to undertake an equivalent consultation within the patient's home or other mutually convenient venue. The Provider is to ensure equitable access to face to face and remote clinical intervention through the community diabetes service for people residing in a care home. The results of this assessment, on-going management plan and medical input required are to be communicated back to the patient's GP.

3.3.2.5.6.7 *Mental health input and psychological support*
The community diabetes service must work with commissioners and mental health/IAPT Providers to ensure that robust pathways and clinical protocols are in place that enable patients with diabetes to access psychological support appropriate to their clinical need and in a timely manner. Diabetes patients should have access to numerous forms of psychological support depending on the severity of their need. This access should broadly be in line with the pyramid model set out by NHS Diabetes and Diabetes UK (2010[18])

3.3.2.5.6.7.1 The pyramid model sets out five levels of mental health complications potentially impacting those suffering from diabetes, these levels are defined as:

- Level 1 – General difficulties coping with diabetes and the perceived consequences of this for the person's lifestyle etc. Problems at a level common to many or most people receiving the diagnosis
- Level 2 – More severe difficulties with coping, causing significant anxiety or lowered mood, with impaired ability to care for self as a result
- Level 3 – Psychological problems which are diagnosable/classifiable but can be treated solely through psychological interventions e.g. mild and some moderate cases of depression, anxiety states and obsessive/compulsive disorders
- Level 4 – More severe psychological problems that are diagnosable and require biological treatments, medication and specialist psychological interventions
- Level 5 – Severe and complex mental illness, requiring specialist psychiatric intervention(s)

3.3.2.5.6.7.2 The community diabetes service may choose not to provide mental health interventions directly but should work with commissioners and existing mental health Providers to ensure appropriate and timely access is available.

3.3.2.5.6.8 *Orthotic services*
The community diabetes service must have pathways in place to ensure clinically appropriate patients can access orthotic services.

3.3.2.6 Integrated community musculoskeletal services

[18] https://www.diabetes.org.uk/resources-s3/2017-10/Emotional_and_Psychological_Support_and_Care_in_Diabetes_2010%20%28DUK%29.pdf

3.3.2.6.1 The CCG is commissioning an integrated musculoskeletal service across Bristol, North Somerset and South Gloucestershire which will involve system partners working appropriately at all levels. This includes musculoskeletal specialists working within the community as well as in hospital. In order to deliver this model the provider will work in partnership with the CCG and all system partners to transform services to meet the needs of the population.

3.3.2.6.2 The community musculoskeletal service must act as an integrated system of care with other services provided elsewhere within the system such as secondary care, primary care and in community and voluntary sector settings. The aims of the service are to manage and co-ordinate consistent, timely, high quality integrated musculoskeletal care for the people of Bristol, North Somerset and South Gloucestershire. The services must be equitable and meet the needs of the local population. The overarching aims are as follows:

3.3.2.6.2.1 a. Improving population health

- To prevent ill health and maintain independence and wellbeing through developing links with public health and services offered in the community and voluntary sector, particularly in relation to prevention and self-management of musculoskeletal conditions.
- Diagnose musculoskeletal conditions accurately and quickly
- Maintain good health by slowing disease progression where possible
- Reducing the incidence of musculoskeletal conditions where lifestyle or health modifications have been identified.
- Improve the quality of life of people with musculoskeletal conditions
- To support and promote early self-management for both long term and transient conditions with confirmed routes for direct access from primary care and triage services
- To use appropriate tools to identify early people at risk of developing chronicity or unhelpful pain behaviours.
- Reduce the length of time to recover from surgical intervention and associated length of stay

3.3.2.6.2.2 b. Improving the experience and outcomes of people in Bristol, North Somerset and South Gloucestershire

- Involve patients, both individually and collectively, in their care, including agreeing realistic expectations of care.
- Using suitable tools (such as PAM described in the model for example) to inform the ability of people to engage with self-management appropriately
- Provide evidence-based pathways and service provision
- Promote and support research and evaluation that aims to measure and improve outcomes for people with musculoskeletal conditions
- Support the development of staff through integrated working and improved clinical network opportunities and training within the designated integrated musculoskeletal resources.

3.3.2.6.2.3 c. Lowering per capita costs- delivering better value through better care

- To ensure that only treatments that are evidence-based and offer clinical value will be used
- Focus on preventative measures and early management to reduce intervention later on
- Remove duplication and waste in the system
- To reduce variation across the system and learn from best practice and best use of limited resources
- Ensure that there is suitable investment in early intervention
- Plan for the predicted rise in demand for musculoskeletal services due to an ageing population

3.3.2.6.2.4 d. Enhancing the overall management of integrated system

- Improve the system of care delivery to ensure that information can be shared easily between Providers and specialities to improve continuity of care
- To standardise reporting mechanisms across the system to allow suitable monitoring of quality and performance indicators locally and benchmarking nationally.
- To ensure that there are agreed clinical outcomes and models of system delivery to make the services easier to navigate by patients, carers and other service Providers
- Ensure there is a suitable workforce in place to manage the current services and plan for service delivery in the future.
- To ensure that the model fits with the wider plan for locality working across Bristol, North Somerset and South Gloucestershire.

3.3.2.6.3 *The service model*
The service model will follow the model of musculoskeletal services set out by the local Sustainability and Transformation Programme. The model has been designed to ensure that there is true integration for the whole musculoskeletal pathway. Tier 2 is the community element of the musculoskeletal pathway in partnership with primary care. However, the model has a clear expectation of seamless movement between Tier 2 with Tiers 1, 3 and 4 (see Figure 1).

3.3.2.6.3.1 Tier 2 will be delivered in locations that are easily accessible for people. Ideally musculoskeletal specialities will share facilities and be co-located to ensure appropriate networking and maximising education and training for staff and improve communication regarding patient care.

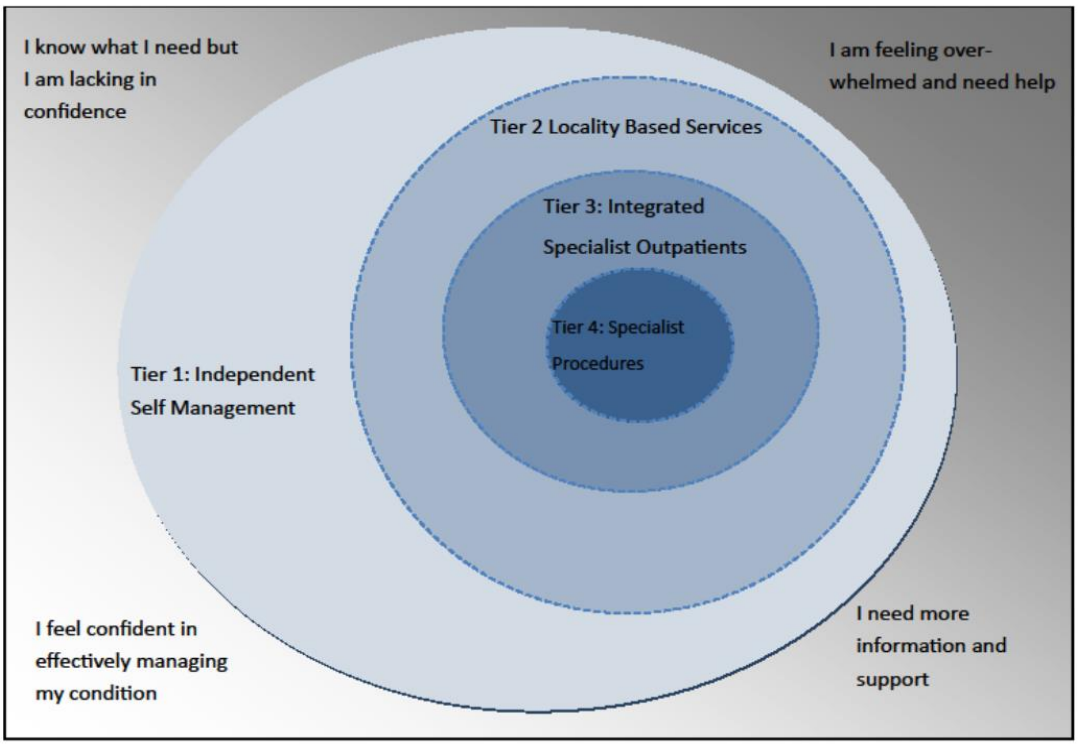
3.3.2.6.3.2 Premises will be in locations that meet the need of the local population and reduce health inequalities as well as improve the equity of access. All services must be provided in a variety of locations across Bristol, North Somerset and South Gloucestershire.

3.3.2.6.3.3 Musculoskeletal specialists should have the opportunity to work both in Tier 2 and Tier 3 either permanently or on a rotational basis to ensure that the knowledge is shared between primary and secondary care and clinical relationships are embedded within the model.

3.3.2.6.3.4 Tier 2 will provide treatment and be able to offer assessment clinics in high volumes and offer a range of services. The minimum requirements for this would be:

- Clinic rooms/ cubicles for assessment and treatment
- Ability to host a range of specialties
- Ability to run group sessions- education and exercise
- Access to some diagnostics (but expected to be more limited than Tier 3)

Figure 1: Integrated community musculoskeletal services care model



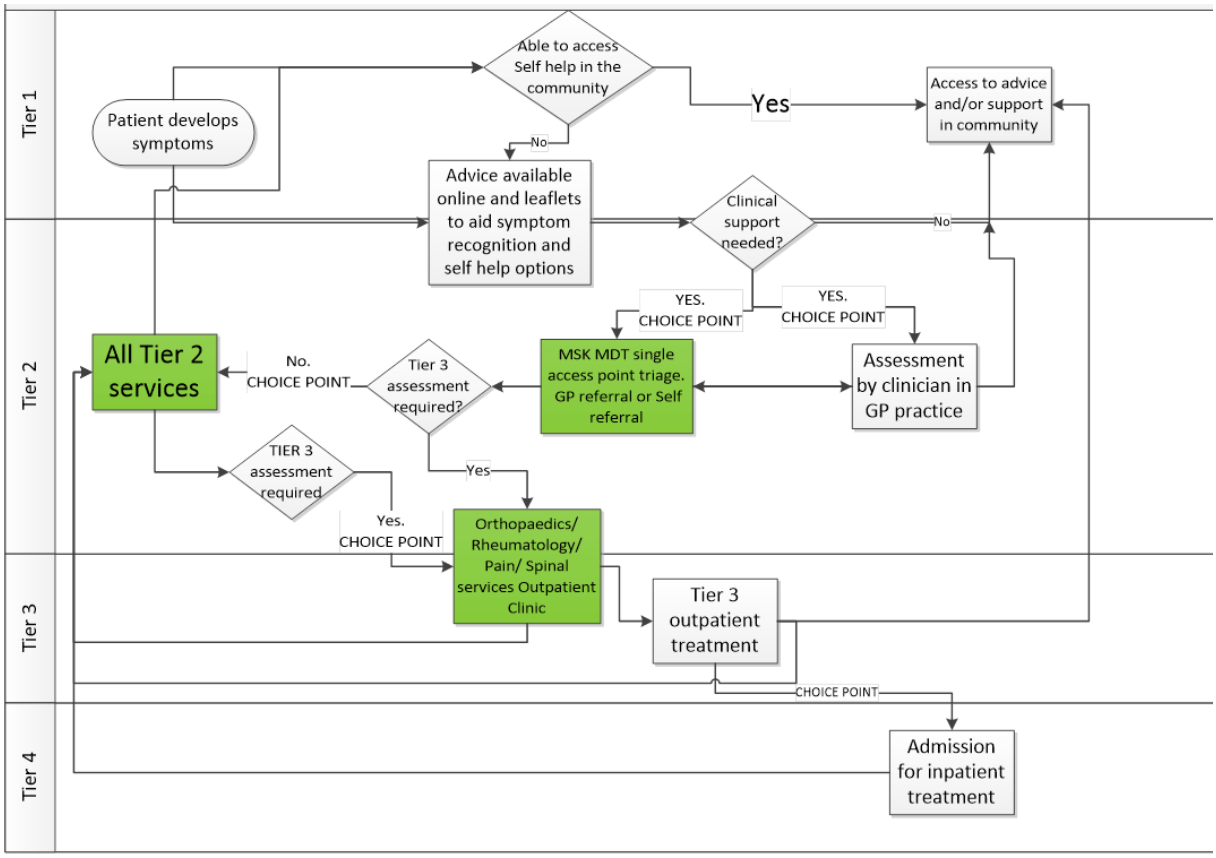
3.3.2.6.3.5 IT systems should be shared across the pathway to allow seamless care for patients and to reduce duplication and waste. All elective services and provision will be provided within the integrated service. Pain management services for all chronic pain conditions are included. The service model will embrace and emphasise interventions that promote self-management and cognitive behavioural techniques to promote self-management of musculoskeletal conditions.

3.3.2.6.3.6 The community integrated musculoskeletal service will deliver co-ordinated care with partners across the musculoskeletal pathway as a whole. The following services are within the scope of the services provided:

- Musculoskeletal triage
- Community pain services
- musculoskeletal physiotherapy including women's health
- Biomechanical podiatry
- Pain management programmes and self-management programmes

3.3.2.6.3.7 The pathway for patients to move across the model is described in Figure 2. The points in green are where multidisciplinary team assessment and/or triaged will be expected to be available.

Figure 2: Pathway to move across musculoskeletal care



3.3.2.6.3.8 Key principles underpinning the model include:

3.3.2.6.3.8.1 <u>Multidisciplinary and "cross-tier" working and case management</u>
It is anticipated that through integration and cross-speciality working at Tier 2, people will need to see fewer health professionals, less frequently, in order to access the services needed. It is recognised that it is the skill of the practitioner not their clinical background that is important. Therefore, the services may employ a number of varied allied health professionals to deliver the services required. Agreed competencies with coherent and equitable continuing professional development will be required for all Tier 2 staff. Clinical staff will be supported, where appropriate, by non-professional staff who can act as care navigators to support the patient to access the most appropriate services.

3.3.2.6.3.8.2 <u>Reduced variability across the pathway and improved access to services</u>
Tier 2 services must be easily accessible to patients – including options for self-referral to therapies. It must also be easy for patients to be transferred between services in Tier 2- or from tiers 3 and 4 seamlessly. Tier 2 services should be offered in locations across Bristol, North Somerset and South Gloucestershire, with a variety in GP practices and in community bases with suitable transport links. Tier 2 services could also be offered in local leisure centres or community centres and Providers are encouraged to forge links with the community and voluntary sector to enhance the self-management approach and provide innovative options for delivery of service.

3.3.2.6.3.8.2.1 Tier 3 services will be made available via a single access point within the community musculoskeletal services with clinical triage to ensure as much as possible that patients are seen by the most appropriate clinician first time. The method for referral must be clear and consistent for all practices across Bristol, North Somerset and South Gloucestershire and also for other Tier 2 services that may refer on behalf of the GP.

3.3.2.6.3.8.2.2 The GP must not be the main default for referral to specialist Tier 3 services, but key individual musculoskeletal specialist across the locality will be identified who can refer or transfer patient care. The services will need to improve access for various patient groups. The services will address the needs of the harder-to reach groups with consideration to the joint strategic needs assessment information to inform this. Services must be offered at times that are convenient to all and consider opening outside of normal hours if the demand is deemed to be sufficient and it is cost-effective to do so.

3.3.2.6.3.8.3 Self-care

Services will ensure that self-care is promoted at each step of the pathway and this will be supported with information that informs people how to access options to allow them to manage their condition. Self-care must be personalised to suit the needs of the person and the level of support offered will depend on how able the patient is to manage their own condition, this could be supported by tools such as the Patient Activation Measure or stratification tools such as StartBack. The commissioner will not specify which tools will be used nor when they will be utilised but there must be evidence that across the pathway this approach is being used to support evidence-based self-management which will be agreed with the Provider(s). A suite of information regarding what is available for self-care and prevention will need to be developed for Bristol, North Somerset and South Gloucestershire which all Providers of musculoskeletal services will have access to and be able to share with patients in a format that is preferable to them- electronic, paper, interactive apps etc. Links with the healthy lifestyle service in Bristol will be developed and other services that promote healthy living such as weight management and smoking cessation will all be actively promoted and supported by all clinicians in the pathway as part of "Make Every Contact Count[19]".

3.3.2.6.3.8.4 Biopsychosocial approach to care

The musculoskeletal services will promote where suitable a biopsychosocial approach to the management of conditions. All patients must have access to early and accurate diagnosis of their condition, use of stratification tools to access to early self-management and conservative therapies and treatments where appropriate. Regardless of diagnosis, assessment of the person's ability to manage their condition, or risk of chronicity will be assessed and used to inform the management plan as described. Early access to self-management programmes will be available and this must be in locations that are suitable to the population. Where diagnosis specific groups are considered to be of more use such as with Fibromyalgia, options will be available in the community to support a self-management approach to this condition in line with national guidance.

3.3.2.6.3.8.5 Tier 2

The services which are expected to be delivered in the community model are:

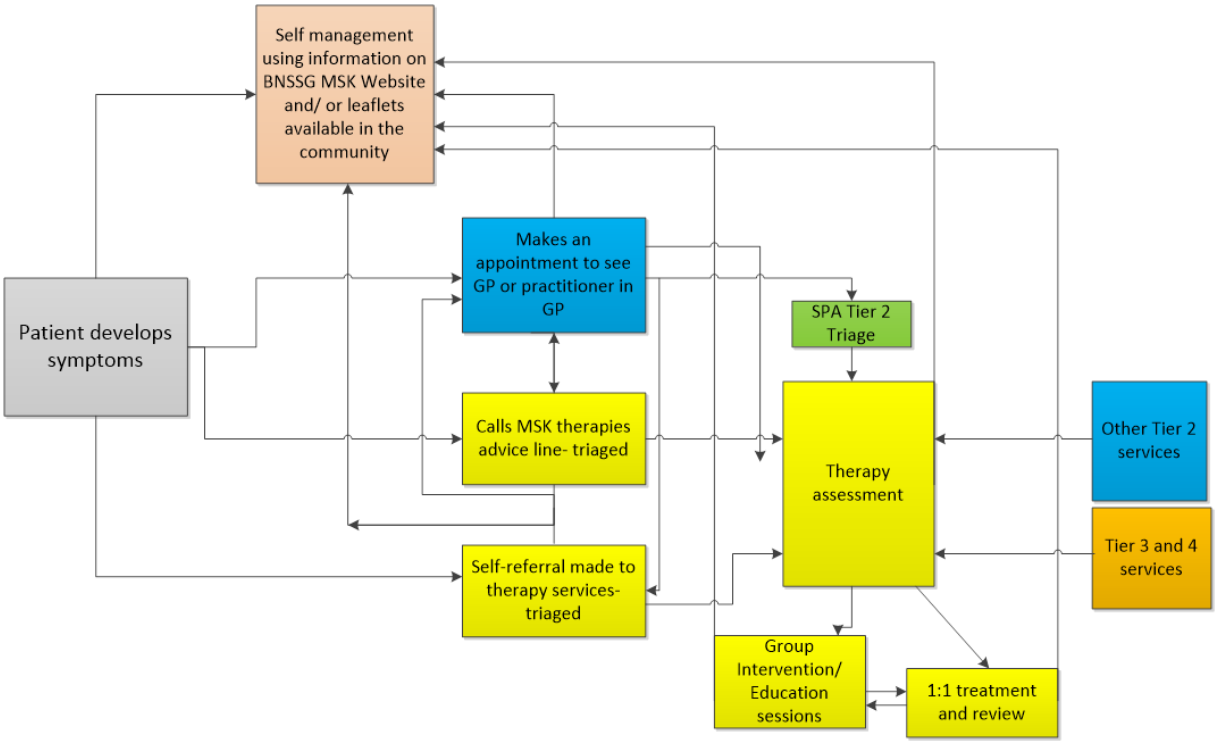
- Therapies- e.g.; physiotherapy, occupational therapy, osteopathy, chiropractic.
- Podiatry
- Specialist therapy services
- Self-management programmes
- Fibromyalgia self-management programmes
- Enhanced recovery services for post-op rehabilitation
- Specialist Pain management programmes
- Clinical Psychology
- Specialist nursing and clinical support
- Advanced musculoskeletal assessment/triage
- Appropriate alternative therapies

3.3.2.6.4 *Outpatient musculoskeletal therapies*

[19] https://bnssghealthiertogether.org.uk/mecc/

The musculoskeletal community service: Therapies will provide outpatient physiotherapy and/ or other therapy services such as osteopathy/ chiropractic services across Bristol, North Somerset and South Gloucestershire. Services are currently offered in community Provider settings and by secondary care Providers. The aim is to have one single musculoskeletal outpatient therapy service for Bristol, North Somerset and South Gloucestershire, moving services into the community from acute trusts. The service will be offered in a number of locations across Bristol, North Somerset and South Gloucestershire. Self- referral for therapies will be available and accessing a telephone advice line in a number of forms will also be introduced across the pathway Bristol, North Somerset and South Gloucestershire wide. The proposed access pathway for therapies is shown in Figure 3.

Figure 3: Access pathway for therapies



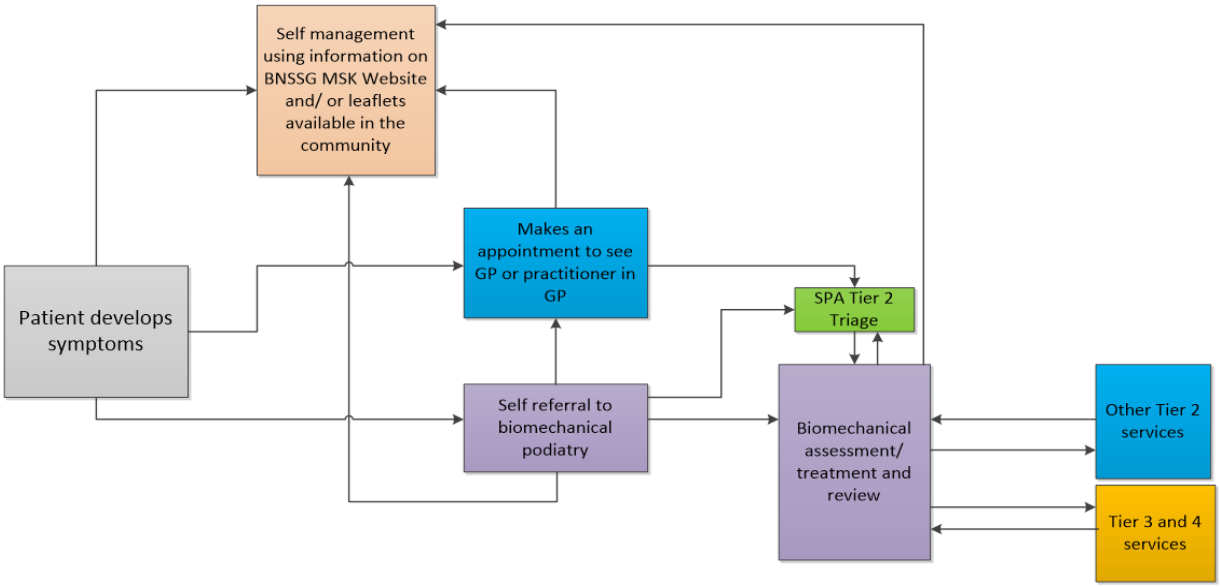
3.3.2.6.4.1 The service will offer the following:

- Access to therapy advice, assessment and management via self-referral, referral from other members of the musculoskeletal team across any Tier or via the single point of access for GPs.
- Option of telephone advice line and telephone assessment
- Assessment and treatment of adults with acute and chronic musculoskeletal pain conditions.
- It will also include the assessment of people with conditions that are likely to respond to physiotherapy in the community such as dizziness, bladder dysfunction and facial palsy.
- Simple advice either following face to face appointment or telephone assessment
- Rehabilitation groups for a number of conditions, which can be accessed by self-referral.
- Education sessions for certain groups such as lower back pain and antenatal.
- The service will also provide pre-operative and post-operative rehabilitation for orthopaedic procedures either individually or in a group setting as appropriate.
- All services will offer the same options of management and will be able to book in any of the designated sites if there are groups that are only available in the larger sites at a venue of choice for the patient.
- Therapy services will interface closely with advanced practitioner roles within primary care and with GPs and secondary care
- Therapy services will use an evidence-based approach to the management of conditions conservatively
- Therapy services will use shared records with GPs to ensure seamless care
- Outcome measures will be collected and reported in a consistent manner across all therapy services.

3.3.2.6.5 *Biomechanical podiatry*

The musculoskeletal service will provide biomechanical podiatry assessment and treatments, the services will be offered in a number of locations across Bristol, North Somerset and South Gloucestershire. The pathway for the provision of podiatry is shown below.

Figure 4: Pathway for podiatry



3.3.2.6.5.1 The service will offer the following;

- Access to biomechanical podiatry assessment and treatment by GP via the single point of access, self-referral or referral from other musculoskeletal specialist from any other tier.
- Biomechanical assessment and management of the lower limb for patients with musculoskeletal conditions
- Clinical gait analysis and fitting of simple orthotics
- Close liaison with the advanced practitioners and the surgical podiatry and orthopaedic service in Tier 3 will be essential
- Outcome measures will be collected and reported in a consistent manner across all biomechanical services.
- Biomechanical podiatry will interface closely with the general physiotherapy and therapy services and triage services

3.3.2.6.6 *Specialist therapies*

Therapies for more specialist conditions will be available in Tier 2, but due to the nature of the conditions and the smaller relative demand, this may be available in fewer locations. It may be partially provided in the community settings and also within the acute hospital to maintain specialist relationship and multidisciplinary team approach with Tier 3 specialists. The services that are included in this are:

- Specialist rheumatology physiotherapy and occupational therapy
- Specialist Hand Therapy
- Specialist chronic pain physiotherapy and occupational therapy
- Hydrotherapy (currently provided by secondary care services).

3.3.2.6.7 *Rheumatology physiotherapy and occupational therapy*

The service will offer the following;

- Assessment and management of people with inflammatory arthritis and other inflammatory conditions
- Education sessions for people with new diagnosis
- Assessment and management of patients with osteoporosis including education and exercise sessions
- Assessment and management of patients with Hypermobility
- Hydrotherapy

3.3.2.6.7.1 This service will need to be co-located with occupational therapy and for a proportion will also be co-located with Tier 3 clinics as it is recognised that a multidisciplinary team approach to these conditions is very important.

3.3.2.6.8 *Specialist hand therapy- physiotherapy and occupational therapy*

The service will offer the following;

- Multidisciplinary assessment and management of patients with complex hand conditions
- Splinting
- Pre-operative and Post-operative management of hand conditions

3.3.2.6.9 *Community pain services*

The service will offer:

- Assessment and management of patients with complex pain conditions that cannot be managed in other musculoskeletal community services effectively- these conditions may be musculoskeletal or non-musculoskeletal.
- Early assessment and intervention for complex post-surgical pain and complex regional pain syndrome
- Shared decision making with patient and the multidisciplinary team on referral to self-management or pain management programmes in Tier 2 or more targeted intervention from certain specialties.
- Assessment and management of patients who need specialist medication review that cannot be managed effectively in the community.
- To provide ongoing education and timely liaison with clinicians in Tier 2 and other specialities in Tier 3.
- To provide joint clinics and multidisciplinary working with other specialities in Tier 3 such as Spinal surgery

3.3.2.6.9.1 It is important that the pain services do not offer injections and interventions that are not in line with best practice and must work closely with the multidisciplinary team and clinicians in Tier 2 to support patients in a holistic way. Some services will need to be offered in a secondary care setting in partnership with hospital trusts.

3.3.2.6.10 *Pain therapies*

The service will offer the following;

- Specialist assessment and management of patients with chronic and complex pain presentations.
- Contribution to the pain management programme, including 1:1 sessions where necessary in preparation for entry to a pain management or self-management programme
- BackPack service in conjunction with psychology colleagues
- Multidisciplinary approach to management of complex patients with shared care plans

3.3.2.6.10.1 This service will need to be available in the community as well as in the acute hospitals to ensure accessibility for patients but to also maintain the link and care planning with Tier 3 specialists. The service will need to be co-located with clinical psychology for chronic pain to ensure multidisciplinary team approach is encouraged. Closer working with the general musculoskeletal therapy team will be established and maintained to ensure that patients are offered the appropriate level of support early on.

3.3.2.6.11 *Self-management programmes*

Self-management programmes will be available in a variety of community settings and will be accessed by referral from any other musculoskeletal practitioner in any Tier.

3.3.2.6.12 *Fibromyalgia self-management*

There is an aim with the new model to improve diagnosis and management of people with fibromyalgia in primary and community care. The new services will ensure that there is sufficient expertise in diagnosis and management of people with fibromyalgia. This will be supported by a specific self-management programme for people with a diagnosis of fibromyalgia made either in Tier 2 or Tier 3.

3.3.2.6.12.1 Access to this service will be via referral through the single point of access and an opt in mechanism for people to ensure that those who are ready to engage in self-management programmes are accessing the group and those in need of more support in terms of accessing further support will be offered alternative support in Tier 2. A proposed pathway for fibromyalgia is to be proposed by the Provider(s) and agreed with the CCG.

3.3.2.6.13 *Specialist pain management programme*

The pain management programme will be available to those with chronic pain most in need of specialist intervention. There will be equal provision of pain management programmes across the region, however, it will be available in fewer venues than the self-management programme due to the multidisciplinary and specialist nature of the programme. Referral to the pain management programme will always be via specialist assessment by a pain consultant in contrast to the self-management programme which can be accessed by any clinician in any Tier. The service will provide:

3.3.2.6.14 *Clinical psychology*

The clinical psychology team will be involved in the delivery of the self-management and pain management programmes across the system but will form part of an integrated Tier 2 therapy team to improve multidisciplinary working and education. The service will be accessed via referral from the pain clinic consultant/ multidisciplinary team. The service will offer:

- Assessment and management of patients with chronic pain in need of a CBT approach
- 1:1 treatment in cases where the person is not able or ready to engage in the pain management programme.
- Multidisciplinary support for patients with the therapy services to improve physical function.
- It is anticipated that there will be close links with IAPT and other mental health services

3.3.2.6.15 *Specialist pain professionals*

Specialist professionals will be available in Tier 2 but due to the nature of the conditions and the smaller relative demand, this may be available in fewer locations. It may be partially provided in the community settings and also within the acute hospital to maintain specialist relationship and multidisciplinary team approach with specialists.

3.3.2.6.16 *Advanced practitioners and GP with special interest/first contact practitioners*

Instead of a separate interface service, advanced practitioners will instead form part of the integrated musculoskeletal service and will also be part of primary care teams provided as a hub and spoke model to ensure most efficient use of the resource. It is anticipated that the advanced musculoskeletal practitioners will be responsible for clinical triage. It is also anticipated that integration with primary care with first contact practitioners will form an important development for the model. Advanced practitioners will be able to offer the following;

- Advanced assessment of musculoskeletal conditions either as first contact or by referral by another Tier 2 clinician
- Referral for a set of agreed diagnostic tests such as MRI, Ultrasound and X-Ray – to be agreed with the radiology teams and by evidence of competency
- Referral to agreed radiological interventions as agreed with the radiology team – evidence of competency to be demonstrated
- Advice and conservative management options for musculoskeletal – including transfer of care to Tier 2 therapies and groups as appropriate or to Tier 1 services
- Shared decision making tools to be used to aid informed decisions with regard to more invasive interventions such as surgery or injections.
- Other conservative management such as prescribing of analgesia and joint injections will also be provided.
- Advanced practitioners will be able to refer to Tier 3 on behalf of the patient's registered GP for further intervention and assessment as appropriate
- Close links with Tier 3 specialists will be essential and at least some of the working schedule should be spent in Tier 3 to develop relationships, trust and education across Tier 2 and 3.
- The advanced practitioner roles will be key links for integration between Tier 2 and 3 and should work closely with the musculoskeletal care navigators.
- Advanced practitioners and GPSIs will also provide surgical follow ups as agreed in local policy for certain orthopaedic conditions.

3.3.2.7 Learning disability

3.3.2.7.1 A community learning disability team will meet the requirements of Transforming Care Agenda[20] (NHSE 2015) and feed into the CCG service specification update process. The service will develop new pathways for people with a learning disability to support accessing mainstream services as well as direct care if this is applicable. The service will incorporate a multidisciplinary team service model focussed on the needs of the individual rather than the presence of a learning disability.

3.3.2.7.2 The service will have a workforce model which allows people with a learning disability to have the right care at the right time, reduce duplication and waiting times (including skill mixing / training/ competency and development plans). The service will develop a model which is financially sustainable and supports the future contracting negotiations. The service will implement a plan which supports staff through process of change in an effective manner to support well- being and reduce attrition.

3.3.2.7.3 The vision of learning disability care is divided into pathways defined by complexity:

3.3.2.7.3.1 High complexity – for those patients who are escalating or in crisis with the aim of preventing unnecessary admissions to hospital as well as those requiring admission to facilitate discharge. It would also include existing work undertaken as part of the CPA framework as well as out of area working. It is high demand and intensity from a clinician point of view requiring responsive and potentially high frequency input. Currently the service has a uni-disciplinary approach (nursing only with integration with mental health trust staff) to this cohort. Although referrals can be made to other professions this is separate to the main intervention and therefore the vision would be to move to a multidisciplinary team approach to managing high risk patients as per the NICE guidance. It would remain integrated with psychiatry and existing mental health workforce provided by the mental health trust.

3.3.2.7.3.2 Medium complexity – this would be a multidisciplinary team integrated approach to managing patients with clinical need that cannot be supported within mainstream services. It would move the focus of the service to front loading the assessment process with a single multidisciplinary team assessment at the point of referral and formulation of clinical need. It would move the service to focusing on rehabilitation and goal focused ways of working utilizing principles of “right care at the right time by the right person” as well as Making Every Contact Count reducing duplication in assessment. The service would remove internal professional waiting lists allowing the patients to have their needs met as part of a pathway approach rather than being dependent on waiting times. There will be a move to support the training and development of staff to develop assessment and formulation skills to support the move from profession specific to a more holistic approach. There will be a change in the emphasis of the service to managing someone with a learning disability who has a clearly defined clinical need rather than the presence of a learning disability being the reason for referral.

3.3.2.7.3.3 Lower complexity – this would be a multidisciplinary team approach to supporting service users to access mainstream services where this is possible as well as supporting primary care, health promotion work and those in hard to reach groups who require support to access healthcare. It will focus on a locality model supporting training and development of other health care professionals in the system to make reasonable adjustments. There will be a focus on developing volunteer programmes to support.

3.3.2.7.3.4 Wider – the role of the whole community learning disability team will be to support strategic work to ensure that reasonable adjustments are considered part of everyone’s business.

[20] https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf

This strategic work will sit in the team lead level to ensure that the voice of the patients with a learning disability is considered in wider organisational development and at a wider Bristol, North Somerset and South Gloucestershire level. This description of learning disability services is set within the context of a whole system approach of service redesign and reconfiguration to continue to improve life opportunities for all people with learning disabilities. This is In line with the national and our local commitment to focus on:

- More choice for people and their families, and more say in their care
- Providing more care in the community, with personalised support provided by multidisciplinary health and care teams
- More innovative services to give people a range of care options, with personal budgets, so care meets individual needs
- Providing early, more intensive support for those who need it, so people can stay in the community, close to home
- For those who do need in-patient care, ensuring it is only for as long as they need it

3.3.2.7.4 Our aim is to make sure more people are living in the community, with the right support and close to home, supported via a range of community services tailored to meet individual needs, via healthcare, social care and Third sector service Providers working in partnership.

3.3.2.7.5 The CCG commissions services from the Third Sector via a range of contractual methods and the majority of packages are commissioned on an individual spot purchase basis, which allows for bespoke, person centred support arrangements. People with learning disabilities and/or autism are not homogenous group and our future plans for the model of transforming care reflect a person centred, needs led approach to commissioning and service delivery. The CCG is committed to develop a broader community offer for complex individuals in order to ensure the care and support they receive is in line with the vision of inpatient care set out within Building the Right Support[21] (BRS) and the national service model[22] (NHSE 2015).

3.3.2.7.6 Bristol, North Somerset and South Gloucestershire and the Transforming Care Partnership (TCP) have agreed a set of commissioning intentions for people with a learning disability, autism or both, in order to ensure the care and support they receive is delivered by Providers that are committed to developing new models of care that is aligned to the vision and principles of BRS and the national service model (NHS England, 2015).

3.3.2.7.7 In line with the described principles there will be an expectation that Providers take all steps to build in rehabilitation capacity to ensure there is greater flexibility in regards to patient treatment options. In addition Providers must clearly demonstrate a commitment to ensuring:

- Care and treatment is integrated into the broader care and support pathway;
- Services will proactively encourage independence and recovery;
- There will be an emphasis on least restrictive practice;
- There will be a reduction in length of stay;
- And, that services will be co-located, not isolated.

3.3.2.8 **Dermatology**

The objectives of this service are to:

- Provide a community alternative to hospital Dermatology outpatient activity.

[21] https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf
[22] https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

- Improve patient experience and outcomes.
- Provide effective diagnosis and treatment for patients with dermatological conditions.
- Improve access to quality specialist services for the range of patients requiring assessment and treatment, regardless of their age, where they live, or what language they speak.
- Establish / continue an education programme for clinicians and patients and carers to improve their knowledge and understanding of their condition.
- To monitor, evaluate and audit the service at regular intervals to ensure both a high standard of care and effective use of the service as a whole.

3.3.2.8.1 Service requirements:

- Initial and ongoing assessment to identify health care needs in relation to dermatology.
- Joint consultations with a consultant dermatologist or GP with a Special Interest (GPSI) in dermatology.
- Specialist dermatology clinician care provision in a variety of settings by undertaking advanced and holistic assessment and management of dermatological conditions throughout the dermatology service and working in partnership with other professionals.
- The development, implementation and evaluation of initiatives to provide a high quality of individualised patient care.
- To request or carry out investigative procedures, monitoring and evaluating results and altering mode of treatment accordingly.
- Provision of evidence based advice regarding appropriate management plans for chronic skin conditions.
- To prescribe directly or request prescriptions for topical and systemic therapies.
- To provide intensive support for effective self-management in order that patients can be treated in their own home.
- To liaise with other health care professionals regarding advice for optimum treatment regimens for management of chronic skins conditions.
- To be an expert resource both locally and nationally on issues relating to the care of dermatology patients to all service users and associated agencies.
- To promote health issues such as eczema, psoriasis, sun awareness via advertising national awareness days e.g. National Eczema Week.
- Encourage supported self-care and patient support groups.
- Provide education sessions to GPs and other healthcare professionals.

3.3.2.8.2 The service will operate from Mon-Fri; 8am to 5pm. The service will operate a minimum of four GPSI sessions a week. Activity flows through these clinics will be monitored.

3.3.2.8.3 Further patient treatment not associated with the primary treatment will be handled within NHS/authorised by the referrer/referred on according to agreed pathway and protocol.

3.3.2.8.4 For newly diagnosed co-morbidity, the Provider will inform the patient's GP of the newly diagnosed condition in order that the appropriate referral can be made.

3.3.2.8.5 The Provider shall demonstrate a clinically effective and appropriate skill-mix of staff. Clinics will be specialist nurse led wherever possible, with access to medical input as appropriate. GPSI clinics should run independently and alongside to assure adequate diagnosis. Lines of managerial and clinical accountability shall be clearly outlined. A medical lead for the service is required with responsibility for overseeing the clinical governance framework and processes.

3.3.2.8.6 The community dermatology service will include administrative support to manage the coordination of the team, as well as relevant work related to the effective running of the service. In the future we would like the community Provider to consider a Bristol, North Somerset and South Gloucestershire approach to dermatology and transform services to best meet the population need.

3.3.2.9 Tuberculosis service

The aim of the specialist tuberculosis nurse service to be provided is to contribute to the control of the incidence of tuberculosis in Bristol, North Somerset and South Gloucestershire through the provision of case management, contact tracing, community treatment, education and awareness raising. This service is available to the population of South Gloucestershire and Bristol currently and there is an expectation of expansion and equity of service provision for the population of North Somerset also during the lifetime of the contract.

3.3.2.9.1 The following objectives will be discharged through the delivery of the specialist tuberculosis service to the designated populations:

- To reduce the time between emergence of symptoms, confirmation of diagnosis and commencement of treatment
- To ensure that each patient being treated for tuberculosis referred to the service has an allocated Key Worker who will be the single point of contact with the hospital-based tuberculosis services and other services
- To provide community-based treatment and support to people being treated for active tuberculosis
- To provide effective liaison between hospital-based clinicians so as to ensure continuity of care for people being treated for active tuberculosis
- To reduce the risk of recurrent disease and/or emergent drug resistance; by ensuring high treatment completion.
- To collaborate with hospital-based services in active case finding (contact tracing). The identification of contacts of active tuberculosis cases will be undertaken in line with NICE Guidance or criteria agreed by Incident/Outbreak Control Groups in Bristol, North Somerset and South Gloucestershire
- To work in collaboration with Public Health England to support outbreak management including attending outbreak meetings with all stakeholders, local coordination phlebotomy services, screening and follow up of DNA's
- To provide screening tests to contacts of a case, in line with training, clinical competence and shared care protocols
- To maintain accurate data of all patients using the HPA's ETS (Enhanced Tuberculosis Surveillance) database
- To increase the awareness of the signs and symptoms of tuberculosis amongst the public, healthcare professionals and communities so as to improve the timeliness of referrals to the tuberculosis services and reduce the stigma associated with tuberculosis in some of the local communities

3.3.2.9.2 This service is provided for anyone living within Bristol, North Somerset and South Gloucestershire or registered with a Bristol, North Somerset and South Gloucestershire GP. The service will be directed towards people who are being investigated for tuberculosis, or for adults who are being treated for active or latent tuberculosis. The tuberculosis service will receive all notifications of new cases of tuberculosis within Bristol, North Somerset and South Gloucestershire will enter these on the Health protection Agency's Enhanced Tuberculosis Surveillance (ETS) database.

3.3.2.9.3 People co-infected with HIV/tuberculosis will be cared for by the tuberculosis nurse team in collaboration with the HIV clinical team, until completion of their tuberculosis treatment. High risk groups include People from the Indian Subcontinent and Sub-Saharan Africa, including children born in the UK, homeless people and those with HIV infection. The service will adopt a flexible approach to meeting individual patients' needs, recognising that a proportion of patients may have difficulty engaging with services due to a range of social and personal factors tuberculosis patients who have complex medical problems will continue to be seen regularly by the hospital physicians, but will also be supported by the tuberculosis service professionals.

3.3.2.9.4 The tuberculosis service will receive all notifications of new cases of tuberculosis and will enter these on the Health protection Agency's Enhanced Tuberculosis Surveillance (ETS) database.

3.3.2.9.5 The tuberculosis service will be responsible for providing information, support and advice to local prison teams caring for inmates with tuberculosis, and will work collaboratively with HPA staff to provide contact tracing in these prisons. Paediatric patients are excluded from the clinical care element of this service; however, the service is responsible for providing contact tracing for these individuals. The service will cover Bristol, North Somerset and South Gloucestershire.

3.3.2.9.6 The tuberculosis service for Bristol, North Somerset and South Gloucestershire will be an active member of the West of England tuberculosis Partnership, and will both lead and contribute to ensuring that tuberculosis services are strongly located within a whole system approach.

3.3.2.9.7 The tuberculosis service will cooperate closely making sure that no patients are 'caught in the gap' between services. The service will work closely with acute hospitals, GPs, and the Health Protection Agency in achieving its objectives. The tuberculosis service will be responsible for providing information, support and advice to local prison teams caring for inmates with tuberculosis, and will work collaboratively with Health Protection Agency staff to provide contact tracing in these prisons. Where contact tracing is required in an institution such as an educational establishment the tuberculosis nurse team will work collaboratively with the Health Protection Agency to achieve this. The service will develop successful collaborative relationships with homeless services, drugs and prison services and refugee healthcare services.

3.3.2.9.10 The tuberculosis service will receive all notifications of new cases of tuberculosis within Bristol, North Somerset and South Gloucestershire and will enter these on the Health protection Agency's Enhanced Tuberculosis Surveillance (ETS) database. The tuberculosis service will be responsible for providing information, support and advice to local prison teams caring for inmates with tuberculosis, and will work collaboratively with HPA staff to provide contact tracing in these prisons. The service will be led by registered nurses who have been provided with appropriate specialist training in tuberculosis (pulmonary and non-pulmonary). These nurses will have access to regular clinical updates and be expected to attend and participate in meetings of secondary care's multidisciplinary tuberculosis teams. The clinical service will be supported by appropriate administration personnel.

3.3.2.9.11 The specialist tuberculosis service will be capable of accepting delegated activities (e.g. screening interventions) as agreed with the tuberculosis clinicians following appropriate training and assessment of competence; and accountable for the delivery of care delegated from tuberculosis and/or Infectious Diseases physicians working in the acute trusts.

3.3.2.9.12 The Provider may wish to consider skill mix for elements of the service delivery. Skill mix staff should have appropriate training and supervision for their role. Designated line management will be established, with clear relationships and lines of responsibility with the team, between the team and the Provider organisation and between the Provider organisation and the commissioner responsible for the tuberculosis service contract.

3.3.2.9.13 Staff will have access to appropriate clinical supervision, peer review opportunities and updating, audit support, and training (as agreed through annual performance appraisals) from the Health Protection Agency's Regional tuberculosis Consultant in Communicable Disease Control and clinical colleagues. The latter will be secured through active participation in regular multidisciplinary meetings;

3.3.2.9.14 Opportunities for enhancing the role of the tuberculosis service and improving the patient's experience will be explored through the Bristol, North Somerset and South Gloucestershire tuberculosis Prevention and Control Strategy Group. Interventions that may be undertaken by staff include the administration of screening tests (e.g. Mantoux, Interferon Gamma release Assay tests) so as to reduce the need for contacts to attend hospital facilities, thereby increasing uptake of screening.

3.3.2.9.15 This service will mainly be delivered in designated NHS facilities or in the patient's own home. In the event that patients or contacts are required to attend NHS facilities, these sites should be fully accessible. The commissioner reserves the right to visit premises and to gain assurance that the quality of the environment is suitable for the service.

3.3.2.9.16 Limited tuberculosis medicines are stored by the tuberculosis service and these should be held in compliance with the relevant medicines management policy.

3.3.9.9.17 The services will operate Monday to Friday 8.30 – 17.00.

3.3.9.9.18 The service will be directed towards people who are being investigated for tuberculosis, or for adults who are being treated for active or latent tuberculosis. Referral will come directly from tuberculosis physicians.

3.3.9.9.19 Referrals from tuberculosis physicians to the service will be accepted through the single point of access (SPA) and the Provider will ensure all current physicians are aware in advance of the inception of the contract. Whilst referrals will not be accepted directly from Primary Care; GPs and others working in Primary Care will be invited to seek advice on appropriate management / referral of suspected tuberculosis cases. Where appropriate, advice will be given in line with the tuberculosis Care Pathways. GPs will be made aware that tuberculosis referrals may be exempted from Choose and Book processes, as stated by the Department of Health.

3.3.9.9.20 The nurses will always inform the patient's GP that they are involved with the patient's tuberculosis care and follow-up. Where a patient moves out of the local area, the service will immediately transfer their care to the appropriate local tuberculosis nurse service, where this exists. If no such service exists the service will ensure that medical care has been appropriately transferred by the tuberculosis physician. The nurses will be responsible for ensuring contact tracing processes are carried out. Nurses will record treatment outcomes on the ETS system.

3.3.9.9.21 Patients will be discharged from the service when they have completed a prescribed course of tuberculosis treatment and have been discharged by the medical team, or when investigations for tuberculosis have shown the patient does not have tuberculosis. There will be no discharge follow-up, but patients will be provided with appropriate information and invited to contact the team in the future if they have any with queries or concerns.

3.3.9.9.22 The service will aim to contact patients newly referred to them within two working days, and have a face-to-face contact within one week.

3.3.10 Refugee services

3.3.10.1 As of October 2018 this service consists of The Haven, based in Inner City and East Bristol Locality. There is an expectation that the model will be developed over the first year of the contract with a detailed timeline and project plan agreed with commissioners to ensure there is an equitable offer to the population of Bristol, North Somerset and South Gloucestershire**.** The aims are:

- To promote equality and challenge discrimination by improving access to health care for asylum seekers and refugees.
- To provide high quality care that is responsive to the particular needs of asylum seekers and refugees.
- To relieve pressure from primary care teams and urgent care services by addressing the complex problems with which some asylum seekers and refugees initially present and facilitate registration with mainstream General Practice.
- To provide training for students, practitioners and front line staff so as to develop understanding and awareness of the needs and experience of asylum seekers and refugees and promote cultural competence.
- To identify in partnership with other agencies areas of unmet need within this population group, and signal to commissioners and Providers what service improvements are needed.
- To monitor, evaluate and audit the service at regular intervals to ensure both a high standard of care and effective use of the service as a whole.

3.3.10.2 Service requirements:

- Provide health assessments and initial health care for asylum seekers and new refugees arriving in Bristol, North Somerset and South Gloucestershire.
- Provide care for as long as necessary until each person can access health care through standard primary care.
- Provide patients with high quality healthcare delivered by health care professionals who have acquired specialist knowledge and support in this area.
- Facilitate patients' full registration into mainstream GP practices and forward to the GP the patient's health records and health care plan at each contact with the service, thus aiding the continuity of care.
- Offer support and advice to primary care Providers on issues related to health and welfare provision for this client group.
- Offer education and information sessions for the wider health community, including medical and nursing students.

3.3.10.3 The service will provide training for students, health professionals and other key staff on issues relating to the care of asylum seekers and refugees so as to promote understanding of their cultural, social and health needs.

3.3.10.4 The team will consist of clinical practitioners and have administrative support.

3.3.10.5 The Haven is provided in a primary care setting, which is accessible to the client group. This is close to Bristol city centre, near to public transport routes and in premises already known to the Bristol refugee population.

3.3.10.6 Referrals are initially accepted for patients living within the Bristol and South Gloucestershire areas. The CCG expects that this offer is expanded to cover the entire Bristol, North Somerset and South Gloucestershire population within a year of the contract start with the aim of all refugees in Bristol, North Somerset and South Gloucestershire being able access support that meets their needs. Patients can also be seen at home or at community locations during outreach visits by the Specialist Health Visitor. As the service sees children less than 5 years of age the provider is expected to access the eRedbook as described in IACS006.

3.3.10.7 Clinic sessions at The Haven are currently held on Monday, Thursday and Friday mornings; 08:30am to 13:30pm. The Haven uses two clinical rooms available for the hours of the clinical sessions only, and administrative room space for 2 additional people on a full time basis.

3.3.10.8 The Provider shall at all times ensure that the service environment:

- Is suitable for the delivery of the service;
- Is sterile (where appropriate) and conforms to the highest standards of Health and Safety;
- Is sufficient to enable the services to be provided at all times and in all respects, in accordance with this Specification.

3.3.10.9 The CCG reserves the right to visit premises and to gain assurance that the quality of the environment is suitable for patients.

3.3.10.10 The Provider will identify a lead clinician with responsibility for clinical governance and have a defined clinical incident reporting and management system. The service operates a culture of open communication and non-blame, and seeks assistance for issues which cannot be addressed from within the team. Regular team meetings review individual patient care; regular significant event meetings audit clinical incidents or system problems; six monthly team development meetings address personal and service development and training issues.

3.3.10.11 The Provider should have facilities appropriate to enable them to carry out surgical procedures appropriately, as per national standards. Adequate and appropriate equipment should be available for the chosen procedures, including appropriate equipment for resuscitation. All personnel providing this service through the contract must have appropriate indemnity cover to meet any claims against them in full.

3.3.10.12 For newly diagnosed co-morbidity, the Provider will inform the patient's GP of the newly diagnosed condition in order that the appropriate referral can be made. GPs are informed of all newly diagnosed conditions, treatments and referrals. The Haven GP will manage clinical care referrals until the patient is discharged from the Haven.

3.3.10.13 Vulnerable client groups who have historically poor access to health services including people from Black and minority ethnic populations, often with language barriers and a lack of knowledge of the UK health care systems. The Haven primarily works with newly arrived asylum seekers who have not previously registered with a GP, people recently granted refugee status and individuals and families from a refugee background arriving under the 'Family Reunion immigration scheme.

3.3.10.14 Patients will be discharged from the service according to each individual's needs. Interim and discharge letters will be sent by the Haven to the registered GP throughout the Haven service's period of care.

3.3.10.15 The service must not operate in isolation from other services required by the patient; local stakeholder and national patient consultation clearly indicate that services should be joined up to provide continuity of care. Arrangements will be in place for liaison and joint working with other statutory and Third Sector services working with this patient group.

3.3.11 Health Links

3.3.11.1 The Health Links service aims to improve access to health care for adults and children whose first language is not English. The service also offers advocacy to patients, assisting them with matters to improve their health and wellbeing. This is currently provided to primary care in PCHS buildings and it is anticipated that the service will be developed in the future by the Provider to provide an appropriate level of Bristol, North Somerset and South Gloucestershire service related to identified local population needs. The service seeks to:

- overcome cultural and language barriers within the healthcare setting and improve health and communications within Black and minority ethnic communities
- reduce inequalities in access to healthcare

3.3.11.2 The service will improve the standard of living and access to healthcare in deprived communities through the provision of interpretation and advocacy. It is expected that this service will be developed to ensure equitable access to Black and minority ethnic groups across Bristol, North Somerset and South Gloucestershire taking into account local population demographics over the life of the contract. At the inception of the contract the service will remain for Bristol only. However there needs to be a clear timeline for expansion of the service to allow equitable access across Bristol, North Somerset and South Gloucestershire. These developments will be expected to form part of the Service Development and Improvement Plan and will be reviewed in accordance with agreed timescales between the Provider and the CCG.

3.3.11.3 The team is comprised of translators who can speak a wide variety of foreign languages and dialects. Staff are to abide by the service's Code of Practice at all times and is accountable to their line manager. The service will include administrative support to manage the coordination of the team, as well as relevant work related to the effective running of the service. As this service is accessed by children less than 5 years of age, the provider will access the eRedbook as described in IACS006.

3.3.11.4 The service operates Monday-Friday: 9am-5pm. Interpreters can be accessed during these hours throughout health centres in the identified area. Alternatively the administrator can be contacted to make other suitable arrangements as required. The service does not operate out of hours. If urgent and out of hours work arises these are dealt with through alternative Providers or a telephone interpreting service. The service is provided from health centre premises.

3.3.11.5 Patients can access the service directly and health professionals can also contact the service when they identify or experience a potential communication break down due to language barriers.

3.3.11.6 There are no discharge criteria for Health Links as this service is required on an ad hoc and needs led basis and patients will use the service as required.

3.3.12 Parkinson's disease

3.3.12.1 This service should aim to develop and provide information, advice and support to people with Parkinson's disease and their families/carers to promote self-care and independence. There should be Parkinson's disease led clinics in the primary care and community setting. Visits should be enabled to people in a variety of settings to include very sheltered housing, residential homes, care homes with nursing as well as their own homes as well as clinical monitoring and medication adjustment. The Provider should be able to signpost and refer to other services, with the aim of integrating health and social care

3.3.12.2	It is anticipated that the Provider helps in the development of referral pathways and criteria for referral, develops others expertise through training, supervision and coaching and raises awareness throughout health and social care to both patients, carer's and professionals. The Provider should develop a Parkinson's disease patient held 'passport'/record to aid patient and carer's ability to share information.
3.3.12.3	It is expected that a Bristol, North Somerset and South Gloucestershire Parkinson's disease service should aim to best promote independence of patient's with Parkinson's disease and enable them to remain in the community and be best supported to manage
3.3.13	**Community equipment clinical leadership**
3.3.13.1	The Provider will have a responsibility to ensure that clinically appropriate and cost effective use is made of community equipment to enable people to return to or stay in their homes or other community settings. The Provider should ensure that senior level clinical leadership is in place for this role along with an appropriate level of administrative support to maintain systems for ordering and tracking of prescribed equipment and management of peripheral stores.
3.3.13.2	The clinical lead will review and analyse the management information received from the Community Equipment contractor and contract managers to identify any concerns about non-compliance with prescribing policies and procedures or unexpected patterns of activity and to work with staff teams to address these concerns. Actions agreed as a result should be reported by exception to the commissioner.
3.3.13.3	Staff should have appropriate access to be able to prescribe equipment after an assessment of need has taken place. Staff must be reminded that equipment should be prescribed by the individual who has undertaken the assessment, and in accordance with agreed policies. All staff who prescribe community equipment must have training as part of their induction and then at a frequency to be agreed. Compliance should be reported on the quality dashboard.
3.3.13.4	A clear process should be in place to manage and approve prescribing decisions, particularly for high cost items and 'specials' to ensure that they are cost effective as well as clinically safe.
3.3.13.5	Management of community (peripheral) stores in appropriate locations across Bristol, North Somerset and South Gloucestershire to enable staff to access frequently used items of equipment with minimum delay. The Provider will ensure that accurate records are kept of issue and return of equipment from peripheral stores.
3.3.13.6	The Provider will lead on the development and implementation of clinical guidance relating to prescribing and use of equipment in liaison with the community equipment contract Provider, local authority contract managers and acute Trusts, and participate in Bristol, North Somerset and South Gloucestershire clinical and operational networks to advise on appropriate use of community equipment.
3.3.13.7	The Provider will give information to patients, their carers and care homes on the terms and conditions for supply of equipment and advice on how to return equipment once it is no longer required or at the end of a short term load period.
3.3.13.8	The Provider will support and chair the Bristol, North Somerset and South Gloucestershire wide Equipment Review Group (ERG) which is responsible for oversight of the community equipment catalogue and making decisions on the range to be available to prescribers.
3.3.13.9	Where the Provider has concerns about the performance of the community equipment supplier, they should submit these concerns to the appropriate (local authority) contract manager with supporting evidence. The Provider will attend community equipment contract management meetings where performance concerns and proposals for service improvement can be addressed and agreed.

3.3.13.10 For clarity, this role does not include formal contract management. The lead responsibility for contract management with the community equipment Provider sits with the local authorities in the Bristol, North Somerset and South Gloucestershire area. The budget for the health contribution to the contract value is held by the CCG.

3.3.13.11 The Provider will not be required to submit performance reports as data will be taken from the Community Equipment Contract monthly report(s) for Bristol, North Somerset and South Gloucestershire. As noted above, data from these reports will be used by the Provider, with the commissioner if appropriate, to identify any budgetary or clinical quality issues which may relate to prescribing practice and agree remedial action if required.

3.3.14 Lymphoedema

3.3.14.1 Working closely with the tissue viability expertise delivered under this specification the Provider is required to deliver a specialist service providing care and support for patients with or at risk of developing lymphoedema. The lymphoedema service will encompass a range of treatment functions in line with the *Lymphoedema Framework: Best Practice for the Management of Lymphoedema*[23]. This includes, but is not limited to:

- Assessment, advice and education
- Risk reduction strategies
- Skin care
- Compression
- Simple and manual lymphatic drainage exercise
- Positioning
- Pain management
- Psychological support

3.3.14.2 The Provider shall ensure an appropriately skilled and resilient workforce is in place including:

- Senior lymphoedema specialist
- Medically qualified doctor, registered nurse or allied health professional
- Must hold the appropriate qualification to undertake manual lymphatic drainage and Complex Decongestive Therapy (CDT)
- Relevant experience at a senior managerial level, including experience of team management and evidence of CPD including the provision of patient education
- Lymphoedema therapist
- Must hold the appropriate qualification to undertake manual lymphatic drainage and CDT
- Relevant experience and evidence of CPD including the provision of patient education

3.3.14.3 Services should be offered in line with the Lymphoedema Framework Best Practice for the Management of Lymphoedema document. All services should include provision of the following:

3.3.14.3.1 *Prevention and managing risk*
All patients at risk of lymphoedema should be provided with appropriate information, and educated as to signs and symptoms, with self-management plans provided to reduce the occurrence of lymphoedema. Services should also emphasise the need for early reporting to health Providers, and referral to appropriate services if lymphoedema symptoms present. All patients at risk must be screened both pre and post-operatively, and post treatment following radiotherapy and chemotherapy, with limb volume measurements undertaken using a consistent measure. The lack of such baseline assessment impedes the effectiveness of early identification of lymphoedema.

3.3.14.3.2 *Timely referral and waiting times*

[23] https://www.lympho.org/wp-content/uploads/2016/03/Best_practice.pdf

Early identification of symptomatic lymphoedema and timely referral allows for earlier effective intervention based upon need. Patients requiring lymphoedema interventions may in the first instance be referred by any health professional either within the Bristol, North Somerset and South Gloucestershire area.

3.3.14.3.2.1 Once a patient has been in receipt of lymphoedema services and has moved into supported self-management, provision must be made by Providers to facilitate patient-led referral back into services for assessment and on-going management.

3.3.14.3.2.2 Referrals should be categorised as routine, urgent/palliative. Services should ensure that all patients are contacted within 5 working days of the receipt of the initial referral, and that from the point of referral, patients are seen as per the following guidelines:

- Routine – within 8-12 weeks
- Urgent/Palliative – within 2 weeks

3.3.14.3.2.3 Further onward referral may be necessary to oncology, vascular, dermatology, ulcer/wound care or other services as required. In these cases referral back to the GP or other services will take place within five working days.

3.3.14.3.3 *Management of lymphoedema*
Treatments should be offered in line with The Lymphoedema Framework: Best Practice for the Management of Lymphoedema. All patients with lymphoedema should receive a co-ordinated package of care, at a level of intervention appropriate to their needs. This should include onward timely referral to more specialist services should the initial Providers' scope of practice not cover complex presentations and intensive therapies.

3.3.14.3.3.1 The Provider should ensure that there is equity of provision and ease of access to more complex therapies within their localities, to ensure provision of appropriate care as close to home as possible.

3.3.14.3.3.2 Services must include:

- Comprehensive assessment
- Treatment plan
- Active treatment: Intensive treatment , followed by maintenance therapy for complex presentations and simple interventions for mild to moderate lymphoedema
- Regular follow-up at intervals dependant on patient needs
- Discharge plan
- Supported self-management programmes
- Re-access to services as required, based upon need.

3.3.14.3.3.3 All patients should receive information, education and support to move towards self-management of their condition.

3.4.1 Telehealth and technology

3.4.1.1 The Provider is expected to engage fully with the development of new technology for the improvement of efficiency and patient outcomes. Across the services described and delivered under this specification the Provider should utilise new technology and telehealth to:

- Maximise efficiency, enabling health care professionals to care for a larger caseload remotely and reducing wasted time and resources
- Provide access to remote advice, monitoring and treatment providing the most timely care possible
- Facilitate access to remote advice from other health care professionals and specialists to support the provision of high quality care
- Maintain patient independence, improve health outcomes and prevent admission to hospital
- Empower individuals to manage their own health and wellbeing without delaying access to health and care services as the need arises

3.4.1.2 The Provider will be expected to meet the requirements of the digital specification in IACS006.

3.4.2 Discharge and outcomes capture

3.4.2.1 All of the specialist services described above are intended to provide a short-term period of intensive specialist support for highly complex cases or during periods of exacerbation. This care and support is to be planned and delivered against defined and measurable treatment goals which will be documented in a common care plan across the specialist team, GP practice and Integrated Locality Team.

3.4.2.2 Following achievement of the established goals within a patient's care plan or the completion of the required clinical intervention the patient will be discharged back to the GP as the primary physician and/or the Integrated Locality Team; this should be communicated and agreed between the specialist services, Integrated Locality Team professionals and primary care staff. This discharge process is to be completed in communication with the GP practice and Integrated Locality Team, and will include a concise electronic summary of the clinical interventions delivered, the outcomes, progress against agreed goals and future care requirements. This summary is to be provided in a format that is interoperable with the prevailing GP clinical system and, for completeness of data, should be documented in a way that supports efficient clinical coding in General Practice.

3.4.2.3 Complex patients with multiple needs should only be discharged following multidisciplinary team discussions involving the Integrated Locality Team, other health and care agencies and the individual's GP practice.

3.4.2.4 Upon discharge the Provider will ensure the collection of all relevant data to support the appraisal of the service and the monitoring of contractual key performance indicators. This is to include:

- Information on clinical outcomes and the control of long-term conditions
- Information on independence, wellbeing and social health
- Information on care goals, progress and achievement
- Information on care and family support; carer and patient satisfaction
- A granular break down of all clinical contacts with the individual during that care planning cycle, the frequency, intensity, length of time and attending professional to inform future service design and distribution of resources
- Activity and the involvement of other parts of the health and social care system- hospitals, mental health, social care, Third sector

3.4.2.5 Following discharge from any of the services detailed above the Provider will retain the patient's details and clinical information, in the event of relapse or persistent problems the service can be re-accessed by the patient or GP for support, advice and clinical intervention within a 12 month timeframe without the need for a new referral.

3.4.3 Referral process and operating hours

3.4.3.1 The Provider will accept referrals and requests for clinical advice from GP practices and health and social care professionals directly involved in an individual's care and support. Referrals will be made through the same Single Point of Access for the Integrated Locality Teams and this point of access will be provided in a way that maximises efficiency and integration with primary care ideally through interoperability with existing clinical systems. A single standard NHS.net email address and telephone number should also be provided for each specialist discipline.

3.4.3.2 Upon receipt of referral or request for advice the corresponding specialist team or professional will triage each case to determine the urgency and scale of service response required based on an evaluation of clinical need. Specialist teams should have access to the individual's care plan developed by the Integrated Locality Team or Locality Hub where relevant, and specialists should have the capability to discuss the case with the relevant key worker, GP or nurse in primary care.

3.4.3.3 Where clinical advice is requested from a specialist team this should be addressed within (except as stated for the lymphoedema service):

- 2 hours for cases prioritised as emergency after triage, where admission to hospital is otherwise imminent,
- 48 hours for cases prioritised as urgent after triage
- 7 days for problems prioritised as non-urgent after triage

3.4.3.4 Where a direct clinical assessment, visit, clinic appointment or intervention is required from a specialist team these will occur:

- On the same operational day for problems prioritised as emergency after triage- where an admission to hospital is otherwise imminent
- Within 2 operational days for problems prioritised as urgent after triage
- Within 2 operational weeks for problems prioritised as non-urgent after triage

3.4.3.5 The specialist services outlined in this specification are expected to be available to deliver direct clinical care, advice, assessment and intervention within the core hours of 8am – 6.30pm Monday to Friday, with the exception of the Dermatology service, Tuberculosis service, The Haven and Healthlinks, whose operating hours are outlined above.

3.4.3.6 Specialist continence, respiratory and heart failure advice is also to be available to healthcare professionals throughout the out of hours period and at weekends, effectively making advice available 24/7. Such advice functions can be delivered in collaboration with relevant secondary care teams.

3.4.4 Working with other services

3.4.4.1 Specialist assessment
Where a patient is referred with particular complexity requiring the direct clinical care and intervention of a specialist team a direct assessment will be carried out determining the intensity and likely duration of specialist support as well as agreeing specific treatment goals with the patient. This first contact will be in line with the response times outlined above and determined by the clinical urgency of the referral after triage.

3.4.4.1.1 The input of specialist professionals and the resulting treatment goals will be captured as part of the central care plan held by the Integrated Locality Team, Locality Hub and the individual's GP; changes in treatment or the patient's management plan should also be duly communicated to these professionals via interoperability of clinical systems.

3.4.4.1.2 Specialist teams may deliver clinical activity in a person's usual place of residence or in community clinics situated in key locations across Bristol, North Somerset and South Gloucestershire. It is expected that a substantial number of these clinics will take place within the Locality Hubs in the future across the six GP Localities within Bristol, North Somerset and South Gloucestershire CCG. The Provider will need to liaise closely with localities as they implement the Locality Transformation Scheme to ensure services match the need of patients and the timing of transformation.

3.4.5 Multidisciplinary team meetings

3.4.5.1 Specialist service staff will be expected to attend relevant multidisciplinary team meetings in each practice or cluster of practices where there is a sufficient demand for specialist input. These meetings should occur with sufficient time and frequency to discuss the management of complex patients and make meaningful decisions around patient care for subsequent action.

3.4.6 Interdependencies

3.4.6.1 The Provider will be required to work closely with a wide range of stakeholders, professionals and health and care agencies; this is detailed in full above but is including but not limited to:

- Primary care services
- General Practice
- Secondary Care services
- SWAST Ambulance Service
- Care Homes
- Any locally determined Providers
- Local Authorities – social services and care agencies
- Mental Health Services
- Medicines management teams
- Third sector
- Patients, Carers, Relatives.
- Dementia crisis or care package breakdown

3.4.6.2 In addition there are a number of specific service aspects that are not commissioned within the scope of this procurement but are referred to within the specifications. These related services will be commissioned separately by the CCG and the Provider is not expected to deliver these under the scope of this specification; such services include:

- GP cover to the Locality Hubs
- GP Medical Director role within the Locality Hubs and GP Locality Leads who will act as key strategic partners for the community service Provider
- Locality Hub pharmacists and primary care pharmacists
- Delivery of continence products
- Wheelchair services
- Patient transport services, relating to the Locality Hub or otherwise

3.4.6.3 Locality Hubs

In Bristol, North Somerset and South Gloucestershire it is expected that holistic management is provided by the Locality Hubs to a defined cohort of frail and elderly patients. It is expected that the Provider will work closely with Primary Care Provider Groups, practices, the CCG and other organisations to establish these centres in the community and support patients to remain closer to home. The specialist teams, with the leadership of primary care professionals in the hub, must establish seamless clinical and operational processes with the Locality Hubs including standardised assessments and pathways, interoperable systems and data-sharing as well as the sharing and rotation of clinical staff to optimise efficiency. This ensures a highly educated and resilient workforce is developed with a broad knowledge of the local health and social care economy.

3.4.6.3.1 Locality Hubs are the ideal sites for community specialist clinics delivered on a GP Locality basis and it is expected that input of the specialist teams detailed within this specification will be made available as part of the overall Locality Hub model.

3.4.6.4 **Primary Care**
The specialist teams have a vital role in providing support, education and advice to primary care professionals. This will include joint decision making and care planning around the needs of an individual patient, Shared resources, workforce planning and joint processes covering information sharing, clinical governance, assessment and data recording. Specialist teams will have regular interactions with colleagues in Primary Care in accordance with the service requirements set out above.

3.4.6.5 **Mental health services**
The Provider will agree a process with relevant mental health teams for ascertaining mental health professional input into the management of complex patients. This input will be primarily coordinated through the Integrated Locality Teams but may require specialist support where mental health problems relate to a particular clinical condition. Effective data sharing processes between mental health and community services should exist to facilitate the capture of agreed health and care goals, tracking progress and achievement of goals and monitoring changes in a patient's condition and altering service response.

3.4.6.6 **Social care services**
Specialist services will work seamlessly with social care services ensuring that the same standard of advice and clinical support is provided to requesting social care staff. Specialist teams should also have defined routes, potentially through the Integrated Locality Teams, to put in place social care interventions that may aid the effective treatment of a complex condition. The Provider will agree a process with relevant social care locality teams for ascertaining professional input into the care planning process. Effective data sharing processes between social care and community services will exist to facilitate the capture of agreed health and care goals, tracking progress and achievement of goals and monitoring changes in a patient's condition and altering service response.

3.4.6.7 **End of life care services**
Individuals with complex needs may deteriorate to the point where effective and high quality end of life care becomes the priority. Specialist services will provide a clear and comprehensive clinical handover to end of life care professionals at this stage of a patient's treatment. Specialist clinical teams will provide ongoing advice and support to end of life care staff across primary, community and hospice settings and provide interventions to support effective symptom management if clinically appropriate.

3.4.6.8 **Third Sector services**
The Provider will have an explicit responsibility for building a comprehensive awareness of Third Sector provision at a given locality level; and for coordinating those Third sector services around the needs of an individual patient. Specialist teams will have access to a localised directory of service detailing the available Third sector services and will be able to coordinate access to such service either directly or through the Integrated Locality Teams.

3.4.6.9 **Hospital specialists**
To provide a comprehensive specialist service it is of vital importance that community facing professionals are properly integrated with relevant specialty teams within secondary care. This integration will include the development of formal agreements, joint clinical pathways and protocols, joint clinical governance and management structures, professional supervision and advice as well as the use of direct staff rotation between acute and community settings.

3.4.7 Information sharing and signposting

3.4.7.1 The Provider will ensure that the digital capabilities of all services within this specification are fundamentally designed with the central priority of interoperability with other Providers and agencies across Bristol, North Somerset and South Gloucestershire. Of paramount importance is the direct interoperability with prevailing GP IT systems across Bristol, North Somerset and South Gloucestershire. The Provider will agree a joint interoperability strategy with the Commissioners IMandT delivery team as part of the mobilisation period. The Provider should ensure that system interoperability is optimised with the following key partners, as a minimum, including:

- GP Practices
- SWAST Ambulance Trust
- Acute Hospitals
- Social Services
- GP Out of Hours Service and NHS 111 – Severnside from April 2019

3.4.7.2 *Signposting*
The Provider will also ensure staff are trained in signposting to local services beneficial to overall health and wellbeing, including local community, Third sector and faith sector organisations. Staff will have an awareness of supplementary services available in their local area of operation. The Provider will consider comprehensive and innovative ways to provide the most effective signposting and service coordinate; potentially including the development of social prescribing.

3.4.7.2.1 The Provider will ensure the use of a comprehensive directory of services and will establish collaborative links with Social Care Development Coordinators within the Local Authorities.

3.4.8 Transitional care

3.4.8.1 This specification primarily details adult services to be provided to those over the age of 18, however, the Provider will also be required to provide professional input to those between the age of 16 and 18 years old as part of a transitional care plan coordinated by local paediatric services and primary care professionals. This transitional provision may include (but is not limited to):

- Joint clinics with children's services professionals
- Advice and support to health care professionals within Children's Services
- Provision of information regarding adult services during the course of the transition period
- Contact with the patient and their family in advance of transition to adult services to provide information, reassurance and ensure a properly planned transition from children's services.
- Provision of key interventions and investigations where clinically appropriate

3.5 Medicines management

3.5.1 Clinicians providing NHS-commissioned care within the Provider organisation should:

- Prescribe for adults in accordance with the Bristol, North Somerset and South Gloucestershire Joint Formulary[24] and other relevant local prescribing guidance.
- Prescribe for children in accordance with the paediatric updates in the Bristol, North Somerset and South Gloucestershire Joint Formulary, or the Bristol, North Somerset and South Gloucestershire Paediatric Joint Formulary[25]
- Practice antibiotic stewardship in line with national and local guidance
- All clinicians should follow the process outlined in the Bristol, North Somerset and South Gloucestershire Formulary for new drug requests and shared care protocols that can be found on the formulary website
- A prescribing budget for certain areas will be included in the provider contract (see individual service details) and the provider will manage spend within that budget
- Provider services are responsible for the production and updates of any necessary Patient Group Directions for their services, in line with the Bristol, North Somerset and South Gloucestershire Patient Group Directions Policy
- All dressings will be supplied or prescribed in line with the Pan Avon Dressings Formulary
- Provider services will work with commissioners to minimise the impact of medicines waste
- Specialist clinicians will engage with the commissioner and other providers in the development of pathways and guidelines involving medicines
- Medicine Incidents themes should be shared with the CCG Medicine Optimisation team via agreed route
- A Controlled Drug accountable officer should be nominated
- A senior pharmacist or healthcare professional is required to represent the organisation at groups such as Bristol, North Somerset and South Gloucestershire drugs and therapeutics committee and STP Medicine optimisation board

3.5.2 There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. The CCG and Provider will work collaboratively to ensure that patient care in relation to medication is safe, effective and sustainable; especially when patients transfer between care settings.

3.5.3 In the case of discharge from a Community Service it is normal for prescribing responsibility to transfer from a specialist to a general practitioner following discharge, but prescribing responsibility will remain with the specialist team when:

- Treatment is a medicine not reimbursed though national prices (excluded from the PbR tariff) and directly commissioned by NHS England, rather than a CCG
- Treatment is being provided as part of a clinical trial
- Medicines or medical devices cannot be prescribed on form FP10 by GPs
- Medicines are categorised as ‘red’ in the Bristol, North Somerset and South Gloucestershire Joint Formulary
- Medicines are categorised as ‘amber’ in the Bristol, North Somerset and South Gloucestershire Joint Formulary with a shared care protocol (SCP), but the conditions in SCP have not been met
- Treatment is being provided as part of a service that has been commissioned in such a way that arrangements are in place for ongoing supply to the patients under the direction of a secondary care clinician (e.g. homecare, home enteral tube feeds)
- Medicines are unlicensed or used outside the terms of their licence, unless these are listed in the Bristol, North Somerset and South Gloucestershire Joint Formulary for these indications

[24] https://www.bnssgformulary.nhs.uk/
[25] https://www.bnssgpaediatricformulary.nhs.uk/

3.5.4 The prescriber is responsible for ensuring that appropriate clinical monitoring arrangements are in place for the medicines that they prescribe and that the patient and other healthcare professionals involved understand them.

3.6 CCG authorised access to FP10 prescription Pads for Providers and responsibilities

3.6.1 The Provider should have a nominated accountable office for controlled drugs or equivalent senior officer responsible for oversight of all prescription usage by the service including audit and raising appropriate concerns around controlled drug management.

3.6.2 The Provider is expected to ensure robust governance of all prescribing activity, including the use of policies and procedures relating to prescribing activity to support high quality, safe and appropriate prescribing and may periodically be asked to demonstrate this is the case.

3.6.3 The Provider is responsible for funding all prescribing activity undertaken on FP10 prescription pads. The provider will periodically be expected to provide data on the medication prescribed on FP10 prescription pads from the epact system.

3.6.4 The Provider should ensure it is fully compliant with the NHS Counter Fraud Authority guidance on Management and control of prescription forms, including prescription pad destruction as part of contract termination. For clarity Bristol, North Somerset and South Gloucestershire CCG will not be liable for any costs of inappropriately used prescriptions.

3.6.5 This link[26] provides NHS provider organisations with the information needed to obtain and maintain prescribing codes for your organisation and prescribers, order prescription forms (FP10), reconcile invoices, access data about your prescribers and services. Providers should liaise with Bristol, North Somerset and South Gloucestershire CCG's Medicines Optimisation Team who contains the necessary CCG signatories to complete the process

3.6.6 During contract termination the prescription services department of NHS Business Services Authority (NHS BSA) must be informed of the Provider's Organisational Data.

3.7 Safeguarding children and adults at risk

3.7.1 The Provider will ensure that Making Safeguarding Personal is integral to the service delivery to ensure that adults at risk are protected and that their views are heard within the safeguarding process.

3.7.2 The Provider will also ensure that all staff in contact with patients and the public have been appropriately trained in local safeguarding procedures and regularly maintain these competencies. The Provider will ensure that staff are appropriately supported to implement safeguarding procedures where concerns have been identified.

3.7.3 The Provider shall ensure:

26 https://www.nhsbsa.nhs.uk/sites/default/files/20172/Local_Authority_and_Provider_Welcome_Pack_v1.5.pdf

- Up to date appropriate policies and procedures on safeguarding children and vulnerable adults are in place. These will adhere to all relevant legislation, Care Act 2014, codes of practice, statutory guidance and good practice guidance published by the Department of Health and the local safeguarding boards as appropriate, including Children Act 2014 and Working Together to Safeguard Children, 2018.
- Safeguarding policies are effectively communicated to its employees (including trustees, volunteers and beneficiaries).
- All staff are up to date with appropriate level of safeguarding training (for both children and adults) relevant to their role in the organisation safeguarding children and vulnerable adults at risk —as recommended in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Paediatrics and Child Health, 2014) and Adult Safeguarding: Roles and Competencies for Health Care Staff (Royal College of Nursing 2018)
- Compliance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards Accountability and assurance framework for adults at risk, also training and competency framework for Prevent.

3.7.4 The Provider shall fulfil its legal obligations concerning the gaining of Disclosure and Barring Service (DBS) checks and checking employees through the Independent Safeguarding Authority (ISA) and the relevant national or local safeguarding authority where applicable, evidenced by a Safer Recruitment policy; the provider will supply evidence of adherence to this to the commissioners, on request.

3.7.5 The Provider shall ensure that there are clear and appropriate policies and procedures in place to support:

- The immediate reporting of safeguarding concerns;
- The encouragement of Raising Concerns ('whistle blowing') where appropriate, including allegations against staff;
- Effective working practices to prevent abuse and neglect, and to protect individuals.

3.7.6 Policies shall highlight:

- the inappropriate nature of private arrangements of any sort between the carer and the patient, including the potential for gross misconduct, recognising the role is a position of trust; and
- actions necessary to participate in a multi-agency safeguarding environment, including attendance at the Safeguarding Boards or subgroups and the mandatory participation in strategy meetings, safeguarding adults reviews (SARs), serious case reviews (SCRs), domestic homicide reviews (DHRs) and other investigations pertaining to the safeguarding of adults or children at risk.

3.7.7 The Provider shall take responsibility for providing care only to the named service user, and this may not include care for any other adults or children (such as 'baby-sitting') even for short periods of time.

3.7.8 The Provider shall have a written policy of confidentiality that is compliant with the General Data Protection Regulation (GDPR) 2016 and Data Protection Act 2018 (Data Protection Legislation). Where appropriate, confidential information will only be disclosed with the consent of the patient concerned, though there are circumstances where consent should not be sought or is only sought under the common law duty of confidentiality. Examples include circumstances where disclosure is required by law or to safeguard children or adults at risk of harm. The Provider shall also ensure that all employees are trained and understand the importance of patient confidentiality.

3.7.9 *Children*

3.7.9.1 The Provider shall:

- Publish contact information for a named local lead for Safeguarding and Child Protection, who will undertake a local governance role, attend NHS safeguarding children advisory groups and liaise with local agencies to keep children safe.
- Ensure that processes are in place to support professionals making appropriate referrals to safeguard children at risk of harm.
- Establish a system for accessing information for children subject to a child protection plan with the local authorities in their area and ensure governance arrangements are in place and that this record system is kept up to date.

3.7.10 *Adults*

3.7.10.1 The Provider shall:

- Adhere to the Care Act 2014[27], which advises that the first priority in safeguarding should always be the safety and well-being of the adult – Making Safeguarding Personal, in line with the six statutory safeguarding principles.
- The Provider shall adhere to all guidance and legislation and have procedures in place to safeguard and promote the welfare and wellbeing of adults at risk.

3.7.10.2 The Provider shall evidence that it has:

- Published contact information for a named lead for adults at risk, who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named lead for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named Prevent lead who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- Up to date policies for Safeguarding Adults at Risk, MCA, DoLS and Prevent, which will be shared with the Commissioner on request;
- Systems in place to ensure that all staff have the appropriate level of safeguarding training, including MCA, DoLS and Prevent and evidence figures for training to meet required standards;
- Systems in place to record safeguarding supervision, with provision of data on request.
- Systems in place to record data relating to referrals, concerns raised and involvement in strategy meetings and Safeguarding Adult Reviews; and
- Met the requirement under Making Safeguarding Personal, providing evidence that the voice of the adult at risk has been heard, on request.

3.8 Population covered

3.8.1 All services are to be accessible to the population over the age of 18 registered with a GP practice in Bristol, North Somerset and South Gloucestershire CCG with provision of transitional care for those aged 16-18 as detailed within this specification. There may also be cases where it is clinically appropriate for adult services to provide treatment to those under the age of 16 e.g. complex wound care and continence issues. This provision should be appraised on a case by case basis in conjunction with the referring GP and relevant paediatric services; the Provider should deliver care where it is safe and clinically appropriate for an adult service clinician to do so.

3.8.2 Unregistered patients living in the Bristol, North Somerset and South Gloucestershire area should also have equitable access to services and should be encouraged and facilitated to register with a GP. Referrals for patients registered with a GP practice in another CCG should be directed to the equivalent commissioned service in that local area.

3.9 Acceptance and exclusion criteria

[27] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

3.9.1 Acceptance criteria

3.9.1.1 All of the services set out in this specification should be available to all adults living in the CCG area. Exclusion criteria are children under the age of 18, except for dermatology services that also see children under 18 in the community, and The Haven element of the Refugee services as described below:
Eligible patients include:

- Anyone who is either seeking asylum or who has recently gained refugee status in the UK and has never registered with a GP here.
- Anyone who has come to join a refugee family member as part of the 'family reunion' immigration scheme and has not yet registered with a GP.
- Asylum seekers who have transferred to Bristol, North Somerset and South Gloucestershire from elsewhere in the country and who have complex health problems and require referral or signposting to the relevant services in Bristol, North Somerset and South Gloucestershire.
- Victims of human trafficking who do not have a previous GP.
- Failed asylum seekers who have not already registered with a GP.

3.9.1.2 To ensure equitable access to services the Provider is required to provide access to interpretation and translation services for individuals who are unable to communicate in English. Written information will also be available in other languages in accordance with local demographics.

3.9.2 Exclusion criteria for pulmonary rehabilitation

- Significant unstable cardiac or other disease that would make pulmonary rehabilitation exercise unsafe or prevent programme participation.
- People who are unable to walk or whose ability to walk safely and independently is significantly impaired due to non-respiratory related conditions. This should not exclude patients who have general musculoskeletal problems where exercise is recommended.
- People unable to participate in a group environment or for whom group sessions are not suitable, e.g. extreme frailty, sight or balance impairment, or for whom mental health, cognitive, personality or other communication barriers, that make group work inappropriate. These patients may require a modified approach.

3.9.3 Exclusion criteria for refugee services
Refugee Services:

- Illegal or unregulated migrants
- Migrant workers
- EEA migrants
- Overseas students

3.10 Managing demand

3.10.1 There may be occasions where surges in demand for one or multiple community services outpaces available capacity or causes excessive delays and waiting lists. During these times the community service Provider, in agreement and partnership with the relevant Locality Lead GP(s) may initiate a mutually agreed triage and prioritisation process to ensure care is received where clinical need is greatest and that non-urgent or inappropriate referrals are suitably redirected.

3.10.2 In addition the GP Locality Lead(s) will have a role in challenging abnormally high referral rates, inappropriate referral behaviours and irregular patterns of demand at an individual GP practice or locality level.

4. Applicable Service Standards

4.1 **Applicable national standards (e.g. NICE)**

There is a wide range of national and clinical guidance applicable to the delivery of the breadth of service functions described above; such guidance, for example, relates to management of long-term conditions, end of life care, wound care, catheter care, rehabilitation and physiotherapy, speech and language therapy, dietetic intervention and screening, effective provision of care to care home residents. Relevant guidance can be accessed via the NICE website: https://www.nice.org.uk/guidance

4.2 **Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

The Provider is required to consider all relevant evidence and guidance from appropriate Royal Colleges in the development and delivery of services.

4.3 Applicable local standards

Applicable local quality and reporting standards are detailed in the relevant quality requirements and information requirements schedules of the Contract.

The Contract also provides clauses about standards that apply to all Service Specifications.

5. Applicable quality requirements and CQUIN goals

5.3 **Applicable Quality Requirements**
Defined within the Schedule 4A-D

5.4 **Applicable CQUIN goals**

Defined within Schedule 4E

6. Location of Provider Premises

The Provider's Premises are located at:

To be inserted prior to Contract Award

7. Individual Service User Placement

Service Specification No.	IACS003
Service	Integrated Adult Community Services – Acute and Reactive Care
Commissioner Lead	NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

1.1.1 This specification sets out the Requirements of the Provider in relation to core adult community health services: Acute and Reactive Care. This covers a proportion of the overall Contract and should be delivered in conjunction with service specifications IACS001, IACS002 and IACS004 in the context of the overall model of care, strategic landscape and specifications for enablers set out in set out in IACS000 and IACS006. Each specification is expected to work integrally together as one service to meet the needs of the population.

2. Outcomes

2.1 The CCG expects the Acute and Reactive Care service to contribute to the achievement of the following domains. These are subject to change following the national annual review.

2.1.1 NHS Outcomes Framework Domains & Indicators

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

2.1.2 Adult social care domains

9. Enhancing quality of life for people with care and support needs
10. Delaying and reducing the need for care and support
11. Ensuring that people have a positive experience of care and support
12. Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

2.1.3 Public health outcome domains:

9. Improving the wider determinants of health
10. Health improvement
11. Health protection
12. Healthcare, public health and preventing premature mortality

2.1.4 Local defined outcomes

2.1.4.1 The CCG wants Community Services to be seamless, coordinated and holistic, based on the principles set out in Reimagining community services: Making the most of our assets[28] (The King's Fund paper). This requires a shift away from focusing on an individual condition to care designed in partnership with the patient and their carers. Care will need to transcend historical boundaries of care setting, organisation or budgetary responsibility. Community Services will include a single core assessment process, completed once by a trusted assessor that evaluates the full spectrum of an individual's needs and coordinates a service response across different agencies and professionals. Another key principle is the development of seamless professional links and redefining organisational boundaries to instil collaboration with Primary Care and change the role of hospital specialists to support the wider health and social care economy. Community Services should promote an ethos of continuity of care and community involvement through the creation of dedicated locality teams and building operational links with the Third Sector and wider community organisations. The underpinning model of care is focused on supporting patients to achieve the best possible outcomes, in line with their needs and agreed goals.

2.1.4.2 It is expected that the realisation of these strategic aims will translate into a number of tangible outcomes including:

- Patients, carers and families will have a positive experience of care.
- A patient or carer with multiple needs will have a single, integrated care plan developed with them.
- A greater proportion of care will be provided closer to home in community settings.
- There will be a reduction of admissions to hospital and length of stay in hospital for those who are admitted; particularly for people over the age of 65.
- There will be a reduction in the number of potentially avoidable admissions (admissions with 0 to 48 hour length of stay for which no clinical procedure was carried out).
- Wellbeing will be maximised and independence maintained for longer, reducing the overall need for long-term care.
- Professional skills and expertise, including those of the Third Sector, will be effectively shared across services and organisations, building a more effective and resilient workforce.

2.1.5 Community-based outcomes framework

2.1.5.1 The CCG aims to build on national work to form a locally-based community outcomes framework, developing this with the Provider and patients so that the framework is tailored to local needs. This outcomes framework will encompass two domain types:

2.1.5.2 **Overarching domains** which cross the entire care pathway:

- Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient.
- Treating and caring for people in safe environment and protecting them from avoidable harm.
- Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information sharing that links seamlessly with other services provided within the community.

2.1.5.3 **Pathway domains** which align to key stages of the care pathway:

- Early intervention with a focus on prevention to promote health, well-being and independence.
- Treatment and / or support during an acute episode of ill health.
- Long-term recovery and sustainability of health.
- Care and support for people at the end of their lives.

3. Scope

[28] https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf

3.1 Aim

The ultimate aim of an Integrated Community Service is to provide and coordinate a high quality, holistic response to an individual's care needs in a person's home or other community care setting. This will be achieved through a robust assessment and care planning process that puts the patient and their carers at the centre. The service will work in close collaboration with Primary Care, Secondary Care, Local Authorities and the third sector and other specialist services to create a joined-up experience of care for the people of Bristol, North Somerset and South Gloucestershire, focused on quality outcomes for patients and carers. It should function according to the 'home first' principle, enabling people to live as independently as possible and be supported when needed at home or in the community. This requires a service that knows and understands the people it engages with, is able to proactively support people with health needs to manage at home and responds reactively when their needs increase using a risk stratification approach. Predictive risk stratification modelling (e.g.: PRiSM) estimates the risk of individuals having an emergency admission to hospital within 12 months and selects patients for preventative community care to avoid admissions. The successful Provider would be expected to adopt partnership working with Primary Care colleagues to use an agreed Risk stratification algorithm within Patient records (triangulated by professional insight and experience) to proactively identify patients at risk of an Acute admission as a result of an exacerbation of their existing health challenges and via an multidisciplinary team approach identify a suite of actions to work with the patient and as such as is reasonably possible relevant of delay the predicted acute episode of care.

3.2 Objectives

3.2.1 The Acute and Reactive Care service will work to achieve a number of specific objectives:

- Reduction of emergency admissions and attendances at A&E
- Seven day services particularly those relating to urgent care and crisis response
- Ensure patients, their families and carers have a high quality experience of care while demonstrating measurable improved outcomes
- Work seamlessly with the primary care professionals
- To minimise duplication, fragmentation and confusion by providing a single point of access for all referrals where inputs can be coordinated around the needs of an individual patient
- To work collaboratively with Primary Care, social care, mental health and Third sector agencies to ensure individuals can access a comprehensive health and social care support package that allows proactive care
- To provide a comprehensive response at all stages of the patient pathway from proactive care through to end of life care; supporting individuals to remain in their usual place of residence and to improve the proportion of people who die in their preferred place of death through care navigation and effective use of ReSPECT[29] and Continuing Health Care local processes
- To delay the need for long term care through effective preventative care and intervention
- To manage resources efficiently to deliver an excellent standard of service within the financial envelope available
- To work with commissioners over the life of the contract to refine the model of care and service delivery, utilising evolving best practice

3.3 Service description

[29] https://www.respectprocess.org.uk/healthprofessionals

The CCG has commissioned a community health service that is available to the entire adult population, regardless of where they live. These services should be tailored to people's level of mobility, frailty and other characteristics on an individual basis, but limited to people who have particular characteristics or condition profiles.

3.3.1 Care Provision

3.3.1.1 The Acute and Reactive Care service needs to provide a rapid health and care intervention designed to prevent an admission to hospital 24 hours a day, seven days a week. This should incorporate the key principles of a core common assessment process, development of an integrated care plan and provision of multi-disciplinary care that transcends previous notions of primary, community, secondary and social care to deliver patient devised goals and outcomes.

3.3.1.2 The Provider will deliver a person-centred service response that will meet the needs of patients who are considered by the referrer to be at imminent risk of a hospital admission. The service will have access to specialist support and will be able to swiftly navigate access to important additional services such as mental health, social care services, and Bristol, North Somerset and South Gloucestershire wide services such as diagnostics and wheelchair services. The service will be designed to engage and communicate with patients and carers as core partners in care. This may include sharing records / plans and communications so that complex arrangements are fully understood by all parties.

3.3.2 Functions

3.3.2.1 This service will provide the majority of community service contacts relating to an urgent care need, specifically those people who are at risk of a hospital admission/attendance and in line with timeframes described in IACS001. This service will be vital in enabling a home first approach and the ability to achieve this.

3.3.2.2 The clinical inputs and interventions provided by the Acute and Reactive Care service are described in detail within subsequent sections of this Specification, however in broad terms, the Acute and Reactive Care service will deliver the following key operational functions:

- Rapid response and reactive care
- Urgent care services – including Integrated Care Bureau, Minor Injury Units, Walk-in Centre, Urgent Care Treatment Centres and Community Hospital beds
- Assessment, care planning and coordination
- Reactive multi-disciplinary care
- Provision of clinical advice and support – The Acute and Reactive Care service will have the capability to provide remote clinical advice and support to other professionals via telephone and email.
- Integration with other Providers – The Acute and Reactive Care service will be required to integrate with other Providers, including but not limited to General Practice, Secondary Care specialists and social care to ensure the patient receives the appropriate level of care in the reactive phase
- Facilitating access to other professional inputs – the effectiveness of the Acute and Reactive Care Service will not only be determined by how well they deliver direct care but also how well the interact with other professionals. They must be able to facilitate access to other professional interventions outside of the scope of these specifications. This particularly applies to mental health services, social care services and Third sector services.

- Support of advance care planning and end of life care – Acute and Reactive Care service professionals will need to be able to have a fundamental role in improving the

quality and frequency of advance care planning. Professionals will proactively identify people approaching or potentially within the last year of life. The team will then work with patients, carers and other professionals to develop documented advance care plans for these patients. These advance care plans should utilise the CCG's recommended documentation (Recommended Summary Plan for Emergency Care and Treatment – ReSPECT) as ratified by the CCG's End of Life Programme Board and Healthier Together.

3.3.3 Interventions

3.3.3.1 Rapid response and reactive care

3.3.3.1.1 *Rapid domiciliary prevention*

3.3.3.1.1.1 The Provider is expected to deliver a comprehensive Acute and Reactive Care service that is able to provide a rapid health and care intervention designed to prevent an admission to hospital 24 hours a day, seven days a week. For the purposes of admission prevention in the community a rapid intervention or definitive clinical assessment should be confirmed and provided within two hours of receipt of referral.

3.3.3.1.1.2 The Provider should ensure that the Acute and Reactive Care service has sufficient scale and capacity to provide an urgent, rapid response to clinical deterioration or a sub-acute[30] episode in a person's usual place of residence (including care homes). This may be achieved by combining resource across locality teams, social care teams and geographies, as well as the continued sharing of personnel with the Locality Hubs and Integrated Locality Teams during the out of hours period or periods of low demand.

3.3.3.1.1.3 This reactive response should be delivered in accordance with the contingency and symptom management plans detailed in a patient's central care plan (where the patient is already known to the service) as developed by the patient's GP and relevant Integrated Locality Team. Where the patient is not yet known to the corresponding Integrated Locality Team or a care plan does not exist, the Acute and Reactive Care service will manage the reactive episode promptly in accordance with clinical need, subsequently involving the Integrated Locality Team and patient's GP as required.

3.3.3.1.1.4 The Acute and Reactive Care service working with primary care and the reactive services available through Locality Hubs in the future will have the capability to provide a full range of community nursing, therapy, care and diagnostic interventions with the objective of keeping an individual in their usual place of residence rather than needing a hospital admission. The Acute and Reactive Care service should also have defined pathways and escalation protocols in place with acute, mental health, ambulance and social care services to ensure a holistic service response can be coordinated and mobilised quickly.

3.3.3.1.1.5 A rapid service response may be triggered by an urgent referral or contact from the patient's GP, a professional within the Integrated Locality Team, ambulance avoidance pathways, Integrated Urgent Care Service (IUCS) or another health or social care professional involved in the patient's care. This contact should be handled, triaged and coordinated via the same single point of access as all other Integrated Locality Team interventions.

3.3.3.1.1.6 The Acute and Reactive Care service will provide comprehensive packages of support following an acute episode.

[30] Sub-acute care is defined as care for someone requiring a coordinated, multi-disciplinary response to an acute illness, injury or exacerbation of an underlying condition. It is a goal oriented treatment rendered immediately as an alternative to acute hospitalisation, with the capability of administering technically complex treatments in the context of a person's underlying condition and circumstances. Generally, the individual's condition is such that it does not rely heavily on high technology monitoring or complex diagnostic procedures

3.3.3.1.1.7 The individual patient may also access an urgent service response by contacting their named care coordinator directly. This should be encouraged as standard practice as a first point of contact for exacerbations of chronic conditions and other sub-acute* episodes. The service response provided should be in accordance with the contingencies detailed within a patient's single care plan for those known to local services.

3.3.3.1.1.8 The scale of reactive intervention available should be tailored to projected activity levels at different times to ensure the most efficient use of resources. This will however, as a minimum, always include a responsive community service whose staff are trained to a high standard in the management of sub-acute presentation, catheter care (both male and female) and end of life care. Key clinical staff with specialist training in these areas should be available as part of the Acute and Reactive Care service 24/7. The service will work seamlessly with other teams specified in IACS001, IACS002 and IACS004 to ensure the patient receives care appropriate to their needs without the need for a referral to do so.

3.3.3.1.1.9 The Acute and Reactive Care service will be accessible to healthcare professionals across the health and social care economy through one single point of access telephone number and email address as detailed in IACS001 and further detailed IACS006. It is anticipated in the future that the service will consider how they will deliver a single point of access e.g.: using 111 infrastructures.

3.3.3.1.2 *Interventions provided*

The Acute and Reactive Care service will have the ability to rapidly mobilise a clinical/non-clinical staff response in accordance with the timeframes detailed in IACS001 following the decision to send a primary professional to complete a single trusted assessment including:

- Senior clinician assessment and treatment
- Therapist review, intervention and treatment plan
- Establish clear treatment and therapeutic goals
- On-going monitoring and support
- Undertake medication reviews
- Regular visiting 1-3 times per day from Therapy Assistants in order to support the achievement of therapeutic goals and provide basic care and support to enable the patient to remain at home
- Prescribing of equipment to prevent admission, facilitate discharge and support rehabilitation in accordance with agreed policies
- Falls prevention as detailed below

3.3.3.1.3 *Falls prevention and non-emergency falls*

The Provider will deliver a specialist falls prevention service through the Acute and Reactive Care service that is rapidly accessible once somebody has been identified as at risk of

falling; either following a stay in hospital or as identified in the community. This also includes the ability to respond and link with pathways across Bristol, North Somerset and South Gloucestershire that respond to non-emergency falls to prevent avoidable admissions and attendances to acute trusts. The falls prevention function will have the capability to deliver a full, multifactorial assessment including evaluation of:

- Poly-pharmacy in conjunction with input from primary care pharmacists either via the CCG's medicines management team or local pharmacists
- Cognition
- Osteoporotic risk
- Functional ability
- Footwear
- Continence
- Vision
- Hearing
- Assessment of home and environmental hazards
- A full physiotherapy assessment should also be available and include as a minimum:
- Falls history- mechanical, medical, environmental and other/unexplained
- Past medical and medication history
- Balance assessment through validated outcome measures e.g. TUG, Berg Balance, Short FES-I, Elderly Mobility Scale (EMS)
- Muscle strength assessment- range of motion (ROM), gait analysis, gait aids, pain, activities of daily living assessment

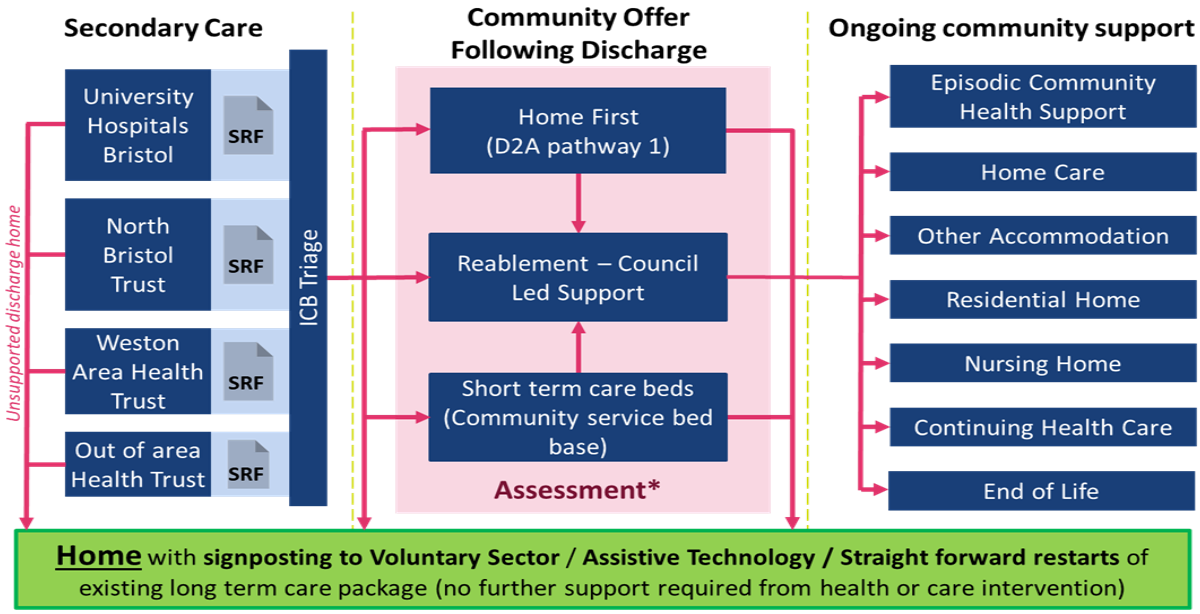
3.3.3.1.3.1 Patients, families or carers should be asked to complete a validated environmental assessment questionnaire prior to their first review and this, along with the full assessment, may inform a decision to involve social services, occupational therapy or other home adaptation services. Following full assessment an exercise and rehabilitation programme will be set out based on clinical need, in line with the approach described above. This programme should include a set of specific goals agreed with the patient as well as exercises to complete regularly at home. The Provider will also run group sessions at accessible community locations for those able to attend. Following completion of the agreed programme the patient should be followed up to monitor progress and evaluate the effectiveness of the therapeutic intervention. This evaluation should include a repeat of the validated outcome measures used to derive a baseline assessment in order to provide a quantitative measure of patient outcomes.

3.3.3.1.3.2 Patients should have the ability to contact the therapist or appropriate member of the Acute and Reactive Care service prior to this review should they experience any further problems or falls.

3.3.3.2 Integrated care bureau

3.3.3.2.1 The Provider is expected to ensure the capacity and processes are in place within the Acute and Reactive Care service, working with hospital and social care teams, to identify patients within the acute hospital who can be discharged to safe care in the community, through the integrated care bureau. This is a model where there is a culture of ownership across organisations towards admitted patients that aims to get people out of hospital more quickly to prevent deconditioning and support rehabilitation. This service is being developed across Bristol, North Somerset and South Gloucestershire and the Provider is expected to work as a key partner to ensure the Bureau develops and grows to provide a more integrated approach to discharge and admission avoidance in the future. Figure 1 shows the model for the integrated care bureau.

Figure 1: Integrated care bureau model



3.3.3.2.2 In this model the Community Services Provider will particularly support the function of short term care beds using the community bed base detailed below. This bed base will help support discharge for patients who no longer need to be in hospital care but require a period of support out of their home for rehabilitation and assessment. The service will then enable patients to return to an appropriate level of support in the community as per the right hand column. Reablement covers the council offer of support and it is essential that the Provider works with social care and other organisations across Bristol, North Somerset and South Gloucestershire to implement and develop the integrated care bureau approach. The CCG is planning a review of the Integrated Care Bureau prior to the adult Community Services Contract Award. Any updates will be included in the final Contract to be signed. It is not envisioned that any changes will have financial impacts

3.3.3.2.3 The Provider will ensure strong professional relationships exist between the hospital liaison staff, Primary Care, Integrated Locality Teams, Locality Hubs, social care teams, hospital discharge coordinators, patient transport and Third Sector agencies in order to deliver the most timely and effective journey through the acute environment.

3.3.3.3 Minor injury units

3.3.3.3.1 The Commissioner in partnership with the Provider will work together to support the implementation of the urgent care strategy[31] across the Bristol, North Somerset and South Gloucestershire system. This will mean adaptation of the current services defined below to meet the requirements of the CCG's urgent care strategy and national guidelines around urgent care. The Provider will need to flex the services accordingly so services are aligned and to these and meet the needs of the population. The urgent care treatment centre element and seamless working between primary care and the integrated urgent care service are a key tenant of the Urgent care strategy.

3.3.3.3.1.1 *Minor injury units service overview*

[31] https://bnssgccg.nhs.uk/library/delivering-urgent-emergency-care/

Minor injury units provide a first point of contact for advice and treatments for unplanned care. The service is delivered by emergency nurse. There are diagnostic facilities available at each site. Bristol, North Somerset and South Gloucestershire currently has:

- South Bristol urgent care centre situated at South Bristol Community Hospital open 08.00am-20.00pm seven days a week
- Yate minor injury unit open 08.00am-20.00pm seven days a week (from 15 April 2019). X-ray facilities, provided by NBT are available 08.00am-20.00pm seven days a week (from 15 April 2019).
- Clevedon minor injury unit open Seven days a week including bank holidays, 8am to 9pm and offers services to those over three years of age. X-ray facilities are available Monday-Friday 09.00-12.00 and 14.00-16.00

3.3.3.3.1.2 We expect the Provider to ensure harmonisation of opening hours of minor injury unit's across Bristol, North Somerset and South Gloucestershire to 08.00am-20.00pm including access to x-ray facilities from the commencement of the contract.

3.3.3.3.1.3 The service is accessed by a diverse population, both registered and unregistered. Where patients are not registered they are supported in registration with a GP practice. All service users will be registered on an IT system with reporting capabilities to identify GP Practice, out of area Practice, Repeat attendees and Child Protection monitoring. This system should have the capability to capture and record clinical information as part of a patient's shared care plan with other clinical services. As the service sees children 5 years and under there is a requirement to have access to the eRedbook as described in IACS006.

3.3.3.3.1.4 Patients may self-refer or be referred from any other Provider, including 111, ambulance service and ambulance referrals for category C (minor injury or illness). Where the patient's condition may have the risk of rapid deterioration immediate transfer is arranged with any necessary interventions being instigated. All consultations are undertaken in partnership with patients and an agreed action plan is implemented. Where treatments involve medicines patients are informed of all the necessary information in order that they are aware of how and when to take them and what side effects may be experienced. All service users are discharged with follow up advice for self-care and recognition of any need to seek further medical advice. The treatments used are based on the best available evidence and clinical guidelines and where treatments involve children or pregnant females there are additional safeguards.

3.3.3.3.1.5 Minor injury units will offer treatment for a range of common illness and injury including, but not limited to:

- Minor head injuries (without loss of consciousness)
- Coughs, colds and flu-like symptoms
- Skin conditions or skin infections
- Stomach upset or pain
- Breathing problems (such as asthma)
- Back pain
- Urinary tract infections
- Ear, eye and throat infections
- Cuts, strains and sprains
- Insect and animal bites
- Uncomplicated fractures e.g. fingers, toes and minor sports injuries

3.3.3.3.1.6 In addition the minor injury unit provision will work seamlessly across other co-located care services such as the Reactive Care Services described below and need to adapt to the development of Locality Hubs. The Provider will ensure pathways and protocols exist between these services to facilitate rapid transfer of patients e.g. for ambulatory treatment of a more complex, sub-acute episode. Staff, infrastructure, resources and expertise should be shared across co-located service models on these sites.

3.3.3.3.1.7 *Face to face clinical assessment*

The core activity of the minor injury unit's is to provide face to face assessment to presenting patients; an effective face to face assessment will encompass the following:

3.3.3.3.1.8 *Identification of immediate life threatening conditions*
The service has a robust system for identifying all immediate life threatening conditions and once identified and assessed will arrange emergency transfer using the most appropriate acute response. Emergency interventions are actioned according to existing evidence based pathways for managing life threatening conditions.

3.3.3.3.1.9 *Definitive clinical assessment*
The service can demonstrate that there is a clinically safe and effective system for prioritising patients, which meets the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre
- Paediatric Assessments will meet NICE guidelines in pain relief and definitive assessment
- Start definitive clinical assessment for 85% of all other patients within 60 minutes of the patient arriving in the centre.
- Access to diagnostics

3.3.3.3.1.10 At the end of the assessment, the patient is clear of the outcome, including the timescale within which further action will be taken and the location of any face-to-face consultation. The service ensures that patients are treated by the clinician best equipped to meet their needs Patients unable to communicate effectively e.g.: in English or people who are deaf, will be provided with an interpretation service.

3.3.3.3.1.11 *Service outcomes*
Minor injury units will achieve the following outcomes:

- 95% of patients will be seen and treated within 4 hours of attendance
- 85% of patients will be treated in a single episode of care
- Patients will be clear of the services available and how to access the service
- The service has systems in place to support and encourage the regular exchange of up-to-date comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).
- The service operates a complaints procedure that is consistent with the principles of the NHS complaints procedure.
- The Service demonstrates the ability to match capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. There are robust, contingency plans in place for those circumstances in which the service or wider health economy may meet unexpected demand.

3.3.3.3.1.12 Minor injury units have an important responsibility to work collaboratively as part of the overall urgent and emergency care system in Bristol, North Somerset and South Gloucestershire, providing high quality and equitable access to non-acute urgent care 365 days a year.

3.3.3.3.1.13 *Referral and prioritisation*
Minor injury units are an open access service and patients can be referred by the full range of health and social care Providers as well as self-presenting. Any person arriving at minor injury units in Bristol, North Somerset and South Gloucestershire should be registered, assessed and treated. Patients should be triaged and managed according to the four prioritisation groups outlined below:

3.3.3.3.1.13.1 Priority 1: immediate (potentially life threatening)

- Asthma
- Acute respiratory distress
- Acute allergy/anaphylaxis
- Chest pain
- Possible stroke of cerebrovascular accident
- Haemorrhage
- Major head injury
- Sepsis
- Unresponsiveness

3.3.3.3.1.13.2 Priority 2: urgent - 15 minutes (acute distress e.g. due to acute pain)

- Children in pain
- Adults in pain
- Confusion
- Digit dislocations and uncomplicated fractures
- Overdose
- Children under one year
- Acute psychiatric illness

3.3.3.3.1.13.3 Priority 3: 30 minutes

- Pregnant females
- Vulnerable groups where not in priority 1 or 2 e.g. people with learning difficulties or conditions on the autistic spectrum
- Frail and elderly patients

3.3.3.3.1.13.4 Priority 4: 1 hour

- All other service users

3.3.3.3.1.14 *Eligibility and exclusions*

3.3.3.3.1.14.1 The Provider will deliver services to all presenting patients with the exception of those:

- Who, following assessment, are deemed unsuitable based on safe, evidence based clinical good practice. The Provider will ensure people who meet this category are appropriately signposted to receive advice and support.
- Who are temporarily unsuitable for treatment according to good clinical practice, for as long as the unsuitability remains
- Who have not validly consented and were able to do so, or consent had not been given on their behalf where it could have been, taking into consideration the Mental Capacity Act (2005).
- Who exhibit behaviour which is unreasonable and which is unacceptable to the Provider, having regard to the coordinating Commissioner's zero tolerance policy on violence. Judgments about excluding a patient from the service on these grounds must take account of the mental health of the patient. These judgments will be taken by senior personnel within the service.

3.3.3.3.1.14.2 Patients should be appropriately stabilised prior to transfer.

3.3.3.3.1.14.3 Other exclusions include:

- Patients requiring major diagnostic investigations such as CT or MRI
- Major trauma
- Unconsciousness
- Cardiovascular compromised patients

3.3.3.4 Walk-in centre

3.3.3.4.1 Broadmead walk-in centre is based in the Bristol City Centre alongside Broadmead Medical Practice GP Surgery. The Walk-in service is run by nurses and offers the following services:

- Blood pressure checks
- Give contraceptive advice and emergency contraception
- Treat coughs, colds and flu-like symptoms
- Provide information on staying healthy and health promotion
- Treat minor cuts and wounds – dressings and care
- Treat muscle and joint injuries – strains and sprains
- Treat skin complaints, such as rashes, sunburn and head lice
- Treat stomach ache, indigestion, constipation, vomiting and diarrhoea
- Provide treatment of minor infections
- Advise on women's health problems, thrush and menstrual advice

3.3.3.3.4.2 There are no X-ray facilities at Broadmead walk-in centre.

3.3.3.3.4.3 Opening hours are Monday to Friday, sit and wait with no appointment necessary from 8am to 6.30pm, service closes at 8pm. Saturday 8am to 6pm, service closes at 8pm. Sunday and bank holidays (except Christmas Day and Easter Sunday) 11am to 3.30pm, service closes at 5pm.

3.3.3.4.4 It is anticipated that the service includes the nurse run component of the service and the current GP support provided to the service which is currently sub-contracted to Brisdoc. It is for the Provider to determine how the GP support component continues from the start of the Contract.

3.3.3.4.5 The service will need to consider Bristol, North Somerset and South Gloucestershire's Urgent Care Strategy and the development of urgent care treatment centres and adapt to whatever service is needed.

3.3.3.5 Urgent treatment centres

3.3.3.5.1 Nationally NHS England is requiring commissioners to implement Urgent Treatment Centres by December 2019. The aim of these are to provide fast and efficient care closer to home, improve patient care and reduce unnecessary A&E attendances. More detailed guidance on principles and standards have been released[32]

3.3.3.3.5.2 The Provider will be expected to work with system partners across Bristol, North Somerset and South Gloucestershire in any ongoing development of Urgent Treatment Centres and their role alongside/integrated with Locality Hubs and Integrated Urgent Care Service as appropriate. Vital principles will be to ensure there is no duplication of services and that patients and clinicians can navigate services easily to access the right care at the right time. Currently the Urgent Treatment Centre for North Somerset is likely to be placed at Weston Area Health Trust subject to public consultation in line with 'Healthy Weston' plans. There is currently also a test and learn pilot being undertaken in South Bristol Community Hospital. Reviews of other existing urgent care services are also being undertaken against the national standards, in order to develop options for future service configuration.

3.3.3.6. Community hospital inpatient beds

[32] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres–principles-standards.pdf

3.3.3.6.1 The Provider, under the scope of this Contract, will operate an indicative 155 community inpatient beds, subject to change based on need at the CCG's discretion. The indicative numbers are likely to comprise about 60 beds at South Bristol Community Hospital, 18 beds at South Bristol Rehabilitation Centre, 16 beds at East Bristol Rehabilitation Centre, 11 beds at Clevedon Community Hospital, 30 beds at Yate Skylark ward and 20 beds at Thornbury, all subject to change. Once the Frenchay site is redeveloped it is the intention of the CCG to relocate to Frenchay the community beds at Yate Skylark ward and Thornbury. It is important to note that not all of these beds are occupied by Bristol, North Somerset and South Gloucestershire CCG patients and that the Provider is expected to charge the CCG for their proportion of Community Hospital Bed occupancy only. Beds will also be protected solely for step-up use from Primary Care and the community, to be agreed with the Provider. For the first year of the Contract the Provider is required to subcontract operation of the beds at South Bristol Community Hospital to the Incumbent (University Hospitals Bristol). From year two onwards the Provider is free to deliver these beds as it wishes.

3.3.3.6.2 The Provider will engage fully with the development of the reactive care aspects of Clinical Hubs which may include management of additional step-up beds. The Provider will agree the model of management for step-up beds with Provider and commissioner partners.

3.3.3.6.3 The Provider will operate community beds against the following objectives:

- To provide a comprehensive, integrated adult inpatient rehabilitation service.
- To provide step down care for patients requiring further recovery and assessment before progressing to a homecare or long-term care package
- To facilitate the transition of patients with a variety of medical conditions from hospital to home or to divert admission from an acute care setting.
- Maximise patients' potential to live at home safely.
- To manage the complexity of adult rehabilitation needs.
- To assist patients to return home with a care package that utilises health, social care and Third Sector services where possible.
- To assist patients to make informed choices regarding future care and living arrangements and follow The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards as appropriate.
- Maximise patients' potential to live at their place of residence safely.
- To provide a facility for urgent temporary placement of patients with an acute dementia crisis that cannot be managed at home

3.3.3.6.3.1 *Admission and treatment*

The Provider will accept referrals into a community hospital bed from a range of sources including but not limited to:

- GPs
- Acute hospitals via the Integrated Care Bureau (as detailed in IACS002)
- Locality hubs
- Community service- Integrated Locality Teams / Acute and Reactive Care Function

3.3.3.6.3.1.1 The Provider will accept referrals for all patients with the following clinical presentations:

- Medical step-up needs and acute hospital admission avoidance
- Rehabilitation needs
- Pain control
- Polypharmacy review using relevant tools:
- Initiation or continuation of intravenous therapy for the treatment of infection
- Extensive wound care
- Post-operative rehabilitation
- Stroke rehabilitation
- Medical step-down needs following an acute episode
- Management of exacerbations of chronic disease: heart failure, COPD, etc.
- Correct skills and equipment are available to manage bariatric patients

3.3.3.6.3.1.2 The type and intensity of step down care offered should be flexible in accordance with the variety of needs of patients coming out of hospital, this should cover a spectrum of acuity from less intense social and reablement needs; rehabilitation and recovery; and the requirement of more complex health and nursing needs e.g. those awaiting assessment for Continuing Healthcare.

3.3.3.6.3.1.3 Following referral into the service, the multidisciplinary team will deliver:

- A comprehensive medical assessment to establish a diagnosis
- MDT discussion and discussion with the patient to establish treatment and rehabilitation goals
- A range of clinical and therapy interventions to enable the patients to reach their goals based on current evidence and best practice
- Delivery of diagnostics e.g. pathology, ECG, x-ray, urinalysis etc.
- Liaison with other services for the purposes of discharge planning e.g. GP practices, social care teams, Locality Hubs, Integrated Locality Teams.
- Referral to other services where further treatment is required.

3.3.3.6.3.1.4 Discharge planning will begin following admission to a community hospital bed. An Estimated Date of Discharge will be agreed with the patient in line with their treatment goals and interventions will progress at pace with the aim of meeting this discharge date.

3.3.3.6.3.2 *Response times and length of stay*
Referrals should be responded to and admission arranged on a same day basis, within four hours, whenever a bed is available.

3.3.3.6.3.2.1 Patients admitted should be discharged within the following maximum lengths of stay depending on their clinical presentation as outlined in Table 1:

Table1

Presentation	Maximum length of stay
Sub-acute- short term period of assessment, diagnosis and step-up treatment	3 days
Step-down admission following inpatient spell in acute hospital (rehabilitation and intermediate care)	21 days
Non-acute escalation for people who do not require intensive medical or nursing management but where a place of safety is needed e.g. where a person's social care package or functional status has broken down	7 days
Day Treatment- admitted as a day case e.g. for blood transfusion or IV therapy	24 hours

3.3.3.6.3.3 *Discharge process*
The patient will be discharged from a community hospital bed when:

- Agreed goals have been achieved and patient identified outcomes are in place
- The patient has met their full rehabilitation potential and is now able to self-manage their condition
- Further intervention will not impact the clinical outcome
- Referral to another service or specialists is required

3.3.3.6.3.3.1 Upon discharge the Provider will take the following actions:

- A discharge summary will be sent to the GP and or health professional who referred the patient and captured in the medical records
- A discharge report is sent to the patient or family (with consent) on request
- Patient records will be stored as required by the Data Protection Act 1998 and in line with local Information Governance policies and guidance (as described in IACS006)
- The patients episode will be coded for the purposes of data reporting to the Commissioner

3.3.3.6.3.3.2 Contract schedule 2J – Transfer of and Discharge from Care Protocols - contains further detail on the processes the Provider is expected to adhere to relating to discharge information.

3.3.3.6.3.4 *Management of surge capacity*
During periods of intense operational pressure across the urgent care system the Provider will be expected to purchase or operate additional step-down bed capacity across the local area.

3.3.3.6.3.4.1 Additional funding to purchase this capacity will be released based on the agreement of an annual allocation from the CCG's System Resilience Funds and a corresponding agreement from the relevant County Council; the number of beds the Provider is expected to source/operate and manage will be based on this allocation.

3.3.3.6.3.4.2 The Provider will be required to report data on the utilisation of these beds, the overall capacity, patient throughput and length of stay against contractual KPIs.

3.4 General service requirements

3.4.1 Referral process

3.4.1.1 The Acute and Reactive Care service will receive referrals from the single point of access as described below and detailed in IACS001. In terms of Acute and Reactive Care it is expected that patients appropriate for the service will be appropriate for a two hour or 48 hour response time. The Provider will accept referrals from GP practices and health and social care professionals directly involved in an individual's care and support. The Provider will ensure a single point of access for all of the clinical inputs and interventions detailed in this specification. This point of access will be provided in a way that maximises efficiency and integration with primary care ideally through interoperability with existing clinical systems. A single standard NHS.net email address and telephone number should also be provided. The Provider will need to work in partnership with the Bristol, North Somerset and South Gloucestershire Urgent Care Strategy and the aspiration to use 111 as a single point of access to services across Bristol, North Somerset and South Gloucestershire including the community service.

3.4.1.2 Upon receipt of referral the corresponding Integrated Locality Team will triage each case to determine the urgency and scale of service response required based on an evaluation of patient and carer need. Where an individual may have multiple health and care needs a thorough core assessment should be undertaken by a trained care coordinator or by any other member of the Integrated Locality Team acting as a trusted assessor.

3.4.1.3 As the Acute and Reactive Care Team is dealing with patients at imminent risk of admission it is expected that those referred will require response times linked to the Urgent and Emergency categories as detailed in IACS001. Urgent referrals should be processed within 48 hours and emergency referrals where an admission to hospital is otherwise imminent should be addressed with a corresponding action plan within two hours.

3.4.1.4 Where clinical advice is requested this should also be addressed within:

- 2 hours for cases prioritised as emergency after triage, where admission to hospital is otherwise imminent – considered core workload for the Acute and Reactive Care service
- 48 hours for cases prioritised as urgent after triage – potential for Acute and Reactive Care service to support this caseload also dependent upon patient need and skill mix of staff

3.4.1.5 The actual referral route and process should work seamlessly with existing GP systems e.g. EMIS Web. The Provider is required to co-design the referral process with CCG member practices as part of the mobilisation period. Further detail on the digital requirements and expectations for the Community Service are detailed in IACS006.

3.4.1.6 The Provider has direct responsibility for delivering medical cover to the community hospital inpatient beds, reactive care pathways and support to the Integrated Locality Teams as required. The Provider is not directly responsible for the provision of medical leadership and medical cover to the Locality Hubs or specialist medical input to the specialist services described in IACS002; however the Provider is expected to work with partners to deliver an integrated staffing model that provides medical input to where it is needed regardless of organisational boundary.

3.4.1.7 The Provider, therefore, has an explicit responsibility to design a medical model capable of delivering consistently high quality care across the range of service functions described in this specification and IACS001/2 as required. This will include working with partners to achieve flexible medical cover and support to the community hospital inpatient beds, reactive care pathways, Locality Hub services as well as support and input to the Integrated Locality Teams and Acute and Reactive Care Function.

3.4.2 Assessment and care coordination

3.4.2.1 Assessment and care planning

3.4.2.1.1 When a patient is identified on referral to the single point of access as having an emergency need meaning a hospital admission could be imminent, the Provider will ensure the patient has their core assessment completed by an appropriate member of the acute and reactive care service to evaluate the health and care needs of the individual. This core assessment can be completed by any member of the acute and reactive care team as a trusted assessor ensuring that appropriately skilled staff are deployed to assess relative to the complexity of the patient's needs. This core assessment will be developed jointly with the Provider and Primary Care Provider Locality Boards during the mobilisation period and be signed off by the CCG.

3.4.2.1.2 Results of the core assessment should be captured in a format that can be easily conveyed back to General Practice, ideally through interoperability with the prevailing GP clinical system. Upon completion of the core assessment the Acute and Reactive Care service working in conjunction with an individual's GP will develop a comprehensive care plan that appraises the health and care needs of the person and tailors a service response to meet those needs, with a focus on stabilising and supporting the patient as much as possible.

3.4.2.1.3 The format of this care plan will be agreed between the Provider and CCG practices but should evaluate the individual's:

- Key changes that need to/have taken place during the period of support from the Acute and Reactive Care service
- Physical environment, home adaptations and use of technology
- Medications management and compliance
- Management of long term conditions and symptom management
- Education, lifestyle and access to Third Sector services
- Mental health and emotional wellbeing
- Carer and family support
- A re-assessment of contingency planning and a response plan for periods of exacerbation or deterioration; if appropriate this should include Advance Care Planning for end of life care

3.4.2.1.4 The care plan will establish clear patient nominated goals and outcomes that will be agreed between the patient, carers, Acute and Reactive Care service, Integrated Locality Team and the individual's GP. The care plan will also be reviewed once the patient is stabilised to determine any changes in symptom management or contingency planning that will support carers and professionals in acting appropriately during any future phases of deterioration or exacerbation; ensuring a suitable clinical response and minimising unnecessary ambulance and hospital activity. Care plans should also be shared with the patient when initially completed, when any changes occur and when discharge occurs.

3.4.2.1.5 A copy of this updated care plan on stabilisation should be held at the home, by the Integrated Locality Team and by the patient's GP. The format of this is to be determined with commissioners and the ambulance service during the mobilisation period including digital solutions.

3.4.2.1.6 The care plan will document whether the patient has dementia and whether or not a formal diagnosis is recorded, where a formal diagnosis is not recorded this should be actioned for appropriate coding by the patient's GP.

3.4.2.2 Care coordination

3.4.2.2.1 Central to the delivery of a new model of integrated care is the way in which access to different services and professional inputs is planned and coordinated. The Provider will ensure that each person on the Acute and Reactive Care service caseload keeps a named care coordinator who acts as a consistent first point of contact facilitating access to services in line with the central care plan informed. This care coordinator may be a non-clinical or a clinical member of staff depending on the complexity of the patient and the Provider's judgement.

3.4.2.2.2 Care coordinators should be mapped and aligned to individual GP practices acting as a focal point for navigating the health system including social care, mental health and the third sector, identifying available support services, processing referrals and monitoring the on-going delivery of care. The care coordinator will carry out these activities in support of the patient's primary GP and will therefore have a direct working relationship on a day to day basis. There should also be a clear plan for continuity of care when a named care co-ordinator is not available.

3.4.2.2.3 It is the GP's primary role to make medical decisions, in collaboration with the patient and carers, as to the type and intensity of care and support an individual requires and the care coordinators role to manage the process by which services are accessed and delivered. The care coordinator will then act as a key point of liaison with the patient feeding back regularly to the GP on the progress of care delivery and any problems or issues arising.

3.4.2.2.4 The care coordinator will also act as a key conduit of communication between General Practice and the rest of the out of hospital care environment ensuring that onward referrals and the coordination of other care services is managed with the knowledge and direction of the GP. It is therefore vital that the care coordinator has a highly developed day to day working relationship with staff in General Practice. It is also expected that the Provider will ensure staff are able to take maximal clinical responsibility for the management of patients when they are being seen by the service.

3.4.2.3 Primary care engagement

3.4.2.3.1 The Acute and Reactive Care service and wider community services staff will work in close collaboration with primary care professionals. In practice this must mean the alignment of key Acute and Reactive Care service staff directly with GP practices.

3.4.2.3.2 These staff must develop strong working practices and regular contact with GPs and primary care colleagues whilst supporting a patient reactively ensuring that care plans are produced and managed jointly where appropriate. Acute and Reactive Care service staff have an active obligation to update the patient's GP on the progress of community services delivery once planned and initiated, this should ideally be in a succinct written format, interoperable with the prevailing clinical record system, to be accessed as required.

3.4.2.3.3 The Provider will establish regular, formal mechanisms for collecting primary care feedback on the quality, responsiveness and coordination of community services and will ensure senior GP representation on senior management boards responsible for service planning, quality and delivery.

3.4.3 Care delivery and review

3.4.3.1 Clinical care, in line with the holistic care plan and a risk stratification approach, will be delivered by the most appropriately skilled professional in accordance with the supporting specifications. The Provider should ensure that continuity of care is prioritised and the same staff are involved in a patient's care on a regular basis. The number of separate visits from different professionals should be minimised and the Provider will cultivate a multi-skilled workforce, with staff providing a high level of generalist support rather than operating in silos of specialisation.

3.4.3.2 The patient will have a single point of contact capable of dealing with queries relating to the individual's care plan, with the remit of contacting other professionals and organisations to answer questions and coordinate services.

3.4.3.3 The frequency and intensity of intervention will be dependent on the design of the initial care plan and the agreed goals between the acute and reactive care service and the individual.

3.4.3.4 A concise summary of feedback, changes made and any medical input required will then be fed back electronically to the patient's GP, ideally via direct interoperability with the clinical record system. The team will document progress against the agreed goals within the care plan and make adjustments to the level of support to reflect improvements or deterioration in wellbeing and independence.

3.4.3.5 Feedback on service delivery, changes to the care plan and progress against set goals will be communicated to the patient's GP upon completion of a care plan review. This is to include concerns about a patient's short term health status and any recommendations relating to changes to primary care medical management e.g. medications changes.

3.4.4 Skills

3.4.4.1 Regardless of the diversity of roles within the Acute and Reactive Care service response it is expected that staff have the required skills and competency to directly manage a full range of prominent long-term conditions prevalent across Bristol, North Somerset and South Gloucestershire (as defined in CCG Public Health Profiles[33][34][35] and detailed in IACS000).

3.4.4.2 This direct management of multiple long-term conditions should be delivered by core community professionals without an overreliance on a small number of specialist staff. A competency framework and training programme to support the management of multiple long-term conditions should be developed across Bristol, North Somerset and South Gloucestershire to ensure a consistent high standard of general nursing and other staff across Bristol, North Somerset and South Gloucestershire; such a framework should also include training in the associated mental health comorbidities and responsibilities under the Mental Capacity Act. The Provider is expected to work to Healthier Together's Workforce Strategy[36]. Staff will be equipped with the skills and confidence necessary to perform comprehensive needs assessments, develop care plans, coordinate services and deliver a range of health and care interventions.

3.4.4.3 Specifically Acute and Reactive Care staff will have the capability to deliver:

[33] https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132696/pat/6/par/E12000009/ati/102/are/E06000023
[34] https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132696/pat/6/par/E12000009/ati/102/are/E06000024
[35] https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132696/pat/6/par/E12000009/ati/102/are/E06000025
[36] https://bnssghealthiertogether.org.uk/documents/item-4-workforce-visions-and-priorities/

- Rapid response and reactive care
- Comprehensive assessment and care planning
- Integrated Care Bureau, minor injury unit's, WIC, UTC's and community hospital beds
- Management of multiple long term conditions- including (but not limited to) heart failure, COPD/Respiratory infection, dementia and cognitive impairment, diabetes (including monitoring, advice, support and administering injectable therapies)
- End of life care – acute and reactive care service staff will form an important part of a network of end of life care professionals and organisations across Bristol, North Somerset and South Gloucestershire. Working in conjunction with the patient's GP, local hospices, the acute specialist palliative care team and key Third sector Providers. Acute and Reactive Care service staff will, as key frontline professionals, work with the patient's GP to coordinate the inputs of these organisations in accordance with clinical need. Staff will provide on-going assessment as required, monitoring deterioration and prognostic indicators as well as providing pain management and symptom control for terminally ill patients.
- The Acute and Reactive Care service will adopt a common, consistent form of advanced care planning that has been agreed and ratified by the Bristol, North Somerset and South Gloucestershire CCG End of Life Care Programme Board and *Healthier Together*. This is currently ReSPECT.
- Emotional wellbeing – Acute and Reactive Care service staff should have an appropriate level of mental health training and expertise to provide emotional wellbeing support for patients with common mental health conditions. Particularly those conditions that correlate with the presence of physical long-term conditions or disability e.g. anxiety and depression and those prevalent in older people such as dementia. Acute and Reactive Care service staff should be able to provide basic dementia screening and depression screening and coordinate a service response from other health service professionals, the Third sector or specialist mental health services as required.
- Continuing healthcare assessment – Acute and Reactive Care service professionals will facilitate access to Continuing Healthcare. The Provider should establish a clear formal process with the local Continuing Healthcare Team clearly articulating the means of accessing continuing healthcare assessment packages of care and the responsibilities of key professionals within the assessment and care initiation pathway.
- Provision of advice, education and support to maintain independence – all Acute and Reactive Care service professionals have an overarching responsibility to provide advice, education and support to individuals to support overall wellbeing and independence. This includes lifestyle advice and signposting to supporting services beneficial to overall health and wellbeing.
- Catheter care – Acute and Reactive Care service staff will provide highly responsive and effective catheter care eliminating unnecessary AandE attendances and avoidable emergency admissions. Such care is to include the flushing, replacement, insertion and on-going active management of urethral and supra-pubic catheters for both sexes. This provision also includes the bypassing of blocked catheters. Management of complex catheters e.g. chest drains or complex urinary catheters is to be supported under this specification with relevant training and clinical support from other professionals if necessary. Regular reviews and planned catheter changes should also be delivered in line with the agreed care plan, utilising other related services e.g. the Locality Hubs as appropriate. This care will be delivered in line with local guidelines and include the issuing of catheter passports.

3.4.5 Telehealth and technology

3.4.5.1 The Provider is expected to engage fully with the development of new technology for the improvement of efficiency and patient outcomes. Across the services described and delivered under this specification the Provider should utilise new technology and telehealth to:

- Maximise efficiency, enabling health care professionals to care for a larger caseload remotely and reducing wasted time and resources
- Provide access to remote advice, monitoring and treatment providing the most timely care possible
- Facilitate access to remote advice from other health care professionals and specialists to support the provision of high quality care
- Maintain patient independence, improve health outcomes and prevent admission to hospital
- Empower individuals to manage their own health and wellbeing without delaying access to health and care services as the need arises

3.4.5.2 The Provider will be expected to meet the requirements of the digital specification in IACS006.

3.4.6 Discharge and outcomes capture

3.4.6.1 Following achievement of the established goals within a patient's care plan or the completion of the required clinical intervention from the Acute and Reactive Care service, the patient will be discharged back to the GP as the primary physician; this should be communicated and agreed between the Acute and Reactive Care service professionals and primary care staff (and the Integrated Care Team as appropriate).

3.4.6.2 This discharge process is to be completed in communication with the GP practice agreed at the practice based multi-disciplinary team meetings and will include a concise electronic summary of the clinical interventions delivered, the outcomes, progress against agreed goals and future care requirements. This summary is to be provided in a format that is interoperable with the prevailing GP clinical system and, for completeness of data, should be documented in a way that supports efficient clinical coding in General Practice. The Provider should have the capability to provide a similar discharge summary to other agencies e.g. social care or mental health.

3.4.6.3 Further detail on discharge information the Provider is expected to adhere to can be found in Contract Schedule 2J – Transfer of and Discharge from Care Protocols.

3.4.6.4 Given the range of clinical inputs potentially delivered under the care plan a concise summary of key changes, progress and further intervention required should be presented and easily accessible. The Provider will work with CCG member practices during the mobilisation period to agree the format and method for conveying discharge summaries.

3.4.6.5 Complex patients with multiple needs should only be discharged following multidisciplinary discussions involving the Integrated Locality Team, other health and care agencies and the individual's GP practice.

3.4.6.6 Upon discharge the Provider will ensure the collection of all relevant data to support the appraisal of the service and the monitoring of contractual KPIs this is to include:

- Information on clinical outcomes and the control of long-term conditions
- Information on independence, wellbeing and social health
- Information on care goals, progress and achievement
- Information on care and family support; carer and patient satisfaction
- Information on how the patient or GP can re-access the service in the cases of relapse or persistent problems. This should not require a new referral for persistent problems within a 6-month timeframe.
- A granular break down of all clinical contacts with the individual during that care planning cycle, the frequency, intensity, length of time and attending professional to inform future service design and distribution of resources
- Activity and the involvement of other parts of the health and social care system - hospitals, mental health, social care, Third sector

3.4.6.7 Details on data collection are included in the Quality Requirements and Information Requirements schedules of the Contract.

3.4.7 Hours of operation

3.4.7.1 The Provider is expected to deliver a comprehensive, integrated community service response to clinical need on a 24 hours a day, 7 days a week, 365 days a year basis. This response may be delivered through a combination of the Integrated Locality Team, Locality Hub services or the Acute and Reactive Care service.

3.4.7.2 It is then expected that the reactive and urgent care functions of the Acute and Reactive Care service are available 24/7 to a suitable level of expertise and capacity to meet clinical need and levels of demand within a year of contract inception. This level of 24/7 functionality will be targeted to ensure the continuous functioning of all service elements relating to acute admission prevention and swift discharge from hospital e.g. urgent visiting, emergency care packages, clinical advice and reassurance, hospital in-reach. This 24/7 coverage should be configured in a way that minimises unnecessary fragmentation in care pathways and unnecessary handovers of care, negatively impacting on continuity and quality.

3.4.8 Patient choice and personal health budgets

3.4.8.1 The Provider has a defined remit to actively offer patient choice and alternative forms of service provision, including the delivery of personal health budgets. This particularly applies should any instances occur where there are unacceptable delays in treatment or significant waiting times. Should waiting times become excessive for a particular provision the Provider should actively seek to offer patients a choice of alternatives or redirect to a Provider with available capacity.

3.4.9 Working across other services

3.4.9.1 The Acute and Reactive Care service will have a fundamental role in coordinating care across different clinical professionals within community services and other external agencies. The Provider should define specifically how the service and other community interventions detailed in the supporting specifications will interact with:

3.4.9.1.1 Locality hubs

In Bristol, North Somerset and South Gloucestershire the Provider will deliver holistic and proactive care deploying Integrated Locality Team resources through the developing Locality Hubs to a defined cohort of patients in line with the development of locality transformation in Primary Care and the development of integrated localities outlined in IACS000. The Integrated Locality Teams, under the leadership of primary care, must establish seamless clinical and operational processes with the emerging Locality Hubs including standardised assessments and pathways, interoperable systems and data-sharing as well as the sharing and rotation of clinical staff to optimise efficiency. This ensures a highly educated and resilient workforce is developed with a broad knowledge of the local health and social care economy and aligns with Healthier Together's workforce strategy.

3.4.9.1.2 Primary Care

3.4.9.1.2.1 The Acute and Reactive Care service is to work as one with Primary Care professionals across Bristol, North Somerset and South Gloucestershire. This will include joint decision making and care planning around the needs of an individual patient. Shared resource and workforce planning and joint processes covering information sharing, clinical governance, assessment and data recording.

3.4.9.1.2.2 In addition each GP Locality will identify a named GP lead to provide strategic support to the community service Provider and the Acute and Reactive Care service. These GP Locality Leads will provide expertise and support to service development, collecting primary care feedback, monitoring quality and managing demand. Operationally, Locality Lead GPs will also be available to the Acute and Reactive Care service for general advice and support. The provider will need to adapt this accordingly with the development of Primary Care Networks locally to ensure there is a consistent approach to GP support in partnership with GP's (https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf). In the out of hours Primary Care period (6.30pm-8am) there will be a contact identified at the Integrated Urgent Care Service (IUCS) to ensure a 24/7 coverage of this advice and support.

3.4.9.1.3 Mental health services

3.4.9.1.3.1 The Provider will work seamlessly with mental health services ensuring that mental health professionals are fully involved in the care planning process for any individual requiring non-acute care in the community.

3.4.9.1.3.2 The Provider will agree a process with relevant mental health teams for ascertaining mental health professional input into the care planning process. Effective data sharing processes between mental health and community services should exist to facilitate:

- The capture of agreed health and care goals
- Tracking progress and achievement of goals
- Monitoring changes in a patient's condition and altering service response

3.4.9.1.3.3 The Provider should seek to align key link staff, particularly community mental health nurses, from the mental health Provider to the Acute and Reactive Care service and put in place robust processes for communication with the mental health trust.

3.4.9.1.4 Social care services

3.4.9.1.4.1 The Provider will agree a process with relevant social care locality teams for ascertaining professional input into the care planning process and the provision of support in a timely manner to those patients considered at imminent risk of a hospital admission. Effective data sharing processes between social care and community services should exist to facilitate:

- The capture of agreed health and care goals
- Tracking progress and achievement of goals
- Monitoring changes in a patient's condition and altering service response

3.4.9.1.4.2 Of particular importance is the ability to monitor on-going need and changes in an individual's condition or carer support network to ensure that a social services response can be mobilised proactively in the timeliest way possible.

3.4.9.1.5 End of life care services

3.4.9.1.5.1 Individuals with complex needs may deteriorate to the point where effective and high quality end of life care becomes the priority. The Provider will ensure end of life care skills are embedded as a fundamental tenet of the Acute and Reactive Care service and wider community staffing capabilities.

3.4.9.1.5.2 The Provider will act as a champion of comprehensive Advance Care Planning and will utilise a standard care planning approach transferrable across other end of life care services e.g. hospices, acute specialist palliative care teams, and Third Sector organisations.

3.4.9.1.5.3 The Provider will work with acute trusts, hospices and other organisations as part of local and Bristol, North Somerset and South Gloucestershire-wide end of life care networks to agree standard operational processes, documentation and information sharing across the entire end of life care pathway. Currently the method of advanced care planning documentation has been agreed locally to be ReSPECT. In addition the Provider will make use of current and future agreed end of life care protocols to ensure the wishes of the patient are agreed, shard and met e.g.: EPAaCS and the Bristol, North Somerset and South Gloucestershire Anticipatory Prescribing Drug chart. The Provider will also take a leading role in advocating effective end of life care and training the wider health and social care workforce in high quality palliative care.

3.4.9.1.6 Third Sector services

3.4.9.1.6.1 The Provider will have an explicit responsibility for building a comprehensive awareness of Third sector provision at a given locality level; and for coordinating those Third sector services around the needs of an individual patient.

3.4.9.1.6.2 The Acute and Reactive Care service should have direct access to an existing directory of services detailing the available Third sector services. Specific staff should be trained in how to navigate and facilitate access to these services through a defined model of care coordination or social prescribing. The Provider will build networks and links with a range of localised Third and faith organisations to facilitate access to on-going support. This should align, work with and seek not to duplicate existing social prescribing developments across the CCG geography e.g.: in Primary Care.

3.4.9.1.6.3 The Provider will have the autonomy to agree set processes and pathways for accessing local Third sector organisations and the will have the capability to source, manage and

maintain any relevant sub-contractual arrangements that can demonstrate an evidence based benefit to the achievement of a patient's or carers health and wellbeing goals. It is anticipated that particular opportunities for collaboration exist in the following areas:

- Maintaining independence, mobility and physical exercise; active involvement in community based activities and exercise
- Prevention, health coaching, education and lifestyle intervention
- Emotional wellbeing and combating social isolation
- End of life care
- Carer and family support

3.4.9.1.7 Hospital specialists

3.4.9.1.7.1 To proactively manage the holistic needs of an individual effectively, community and primary care professionals should have access to support, advice and intervention from secondary care specialists. The Provider will work with local acute trusts and commissioners to agree defined access to support and advice from consultant teams most beneficial to meeting the needs of patient's in the community.

3.4.9.1.7.2 This specialist support and intervention should go beyond the relocation of outpatient clinics but should fully engage specialist teams in providing expertise and education to the wider workforce, building working relationships that can ultimately reduce the demands on acute medical services and provide prompt clinical input to complex cases across the community.

3.5 Information sharing and signposting

3.5.1 The Provider will ensure that the information management and technology capabilities of all services within this specification are fundamentally designed with the central priority of interoperability with other Providers and agencies across Bristol, North Somerset and South Gloucestershire. Of paramount importance is the direct interoperability with prevailing GP IT systems across Bristol, North Somerset and South Gloucestershire (EMIS). The Provider will be expected to act as a key partner in the Bristol, North Somerset and South Gloucestershire Digital Strategy, including the development of a shared care record and full interoperability portal as described in IACS006.

3.5.2 The Provider should ensure that system interoperability is optimised with the following key partners, as a minimum, including:

- GP Practices
- SWAST Ambulance Trust
- Acute Hospitals
- Social Services
- GP Out of Hours Service and NHS 111 – Severnside Integrated Urgent Care Service (IUCS) as of April 2019

3.5.3 Further digital requirements are detailed in IACS006.

3.6 Medicines management

3.6.1 Clinicians providing NHS-commissioned care within the Provider organisation should:

- Prescribe for adults in accordance with the Bristol, North Somerset and South Gloucestershire Joint Formulary[37] and other relevant local prescribing guidance.
- Prescribe for children in accordance with the paediatric updates in the Bristol, North Somerset and South Gloucestershire Joint Formulary, or the Bristol, North Somerset and South Gloucestershire Paediatric Joint Formulary[38]
- Practice antibiotic stewardship in line with national and local guidance
- All clinicians should follow the process outlined in the Bristol, North Somerset and South Gloucestershire Formulary for new drug requests and shared care protocols that can be found on the formulary website
- A prescribing budget for certain areas will be included in the provider contract (see individual service details) and the provider will manage spend within that budget
- Provider services are responsible for the production and updates of any necessary Patient Group Directions for their services, in line with the Bristol, North Somerset and South Gloucestershire Patient Group Directions Policy
- All dressings will be supplied or prescribed in line with the Pan Avon Dressings Formulary
- Provider services will work with commissioners to minimise the impact of medicines waste
- Specialist clinicians will engage with the commissioner and other providers in the development of pathways and guidelines involving medicines
- Medicine Incidents themes should be shared with the CCG Medicine Optimisation team via agreed route
- A Controlled Drug accountable officer should be nominated
- A senior pharmacist or healthcare professional is required to represent the organisation at system Medicine Optimisation groups such as Bristol, North Somerset and South Gloucestershire Drugs and therapeutics committee and STP Medicine optimisation board

3.6.2 There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. The CCG and Provider will work collaboratively to ensure that patient care in relation to medication is safe, effective and sustainable; especially when patients transfer between care settings.

3.6.3 In the case of discharge from a Community Service it is normal for prescribing responsibility to transfer from a specialist to a general practitioner following discharge, but prescribing responsibility will remain with the specialist team when:

- Treatment is a medicine not reimbursed though national prices (excluded from the PbR tariff) and directly commissioned by NHS England, rather than a CCG
- Treatment is being provided as part of a clinical trial
- Medicines or medical devices cannot be prescribed on form FP10 by GPs
- Medicines are categorised as ‘red’ in the Bristol, North Somerset and South Gloucestershire Joint Formulary
- Medicines are categorised as ‘amber’ in the Bristol, North Somerset and South Gloucestershire Joint Formulary with a shared care protocol (SCP), but the conditions in SCP have not been met
- Treatment is being provided as part of a service that has been commissioned in such a way that arrangements are in place for ongoing supply to the patients under the direction of a secondary care clinician (e.g. homecare, home enteral tube feeds)
- Medicines are unlicensed or used outside the terms of their licence, unless these are listed in the Bristol, North Somerset and South Gloucestershire Joint Formulary for these indications

[37] https://www.bnssgformulary.nhs.uk/
[38] https://www.bnssgpaediatricformulary.nhs.uk/

3.6.4	The prescriber is responsible for ensuring that appropriate clinical monitoring arrangements are in place for the medicines that they prescribe and that the patient and other healthcare professionals involved understand them.
3.7	**CCG authorised access to FP10 prescription Pads for Providers and responsibilities**
3.7.1	The Provider should have a nominated accountable office for controlled drugs or equivalent senior officer responsible for oversight of all prescription usage by the service including audit and raising appropriate concerns around controlled drug management.
3.7.2	The Provider is expected to ensure robust governance of all prescribing activity, including the use of policies and procedures relating to prescribing activity to support high quality, safe and appropriate prescribing and may periodically be asked to demonstrate this is the case.
3.7.3	The Provider is responsible for funding all prescribing activity undertaken on FP10 prescription pads. The provider will periodically be expected to provide data on the medication prescribed on FP10 prescription pads from the epact system.
3.7.4	The Provider should ensure it is fully compliant with the NHS Counter Fraud Authority guidance on Management and control of prescription forms, including prescription pad destruction as part of contract termination. For clarity Bristol, North Somerset and South Gloucestershire CCG will not be liable for any costs of inappropriately used prescriptions.
3.7.5	The following link[39] provides NHS provider organisations with the information needed to obtain and maintain prescribing codes for your organisation and prescribers, order prescription forms (FP10), reconcile invoices, access data about your prescribers and services. Providers should liaise with Bristol, North Somerset and South Gloucestershire CCG's Medicines Optimisation Team who contains the necessary CCG signatories to complete the process
3.7.6	During contract termination the prescription services department of NHS Business Services Authority (NHS BSA) must be informed of the Provider's Organisational Data.
3.8	**Safeguarding children and adults at risk**
3.8.1	The Provider will ensure that Making Safeguarding Personal is integral to the service delivery to ensure that adults at risk are protected and that their views are heard within the safeguarding process.
3.8.2	The Provider will also ensure that all staff in contact with patients and the public have been appropriately trained in local safeguarding procedures and regularly maintain these competencies. The Provider will ensure that staff are appropriately supported to implement safeguarding procedures where concerns have been identified.
3.8.3	The Provider shall ensure:

39 https://www.nhsbsa.nhs.uk/sites/default/files/20172/Local_Authority_and_Provider_Welcome_Pack_v1.5.pdf

- Up to date appropriate policies and procedures on safeguarding children and vulnerable adults are in place. These will adhere to all relevant legislation, Care Act 2014, codes of practice, statutory guidance and good practice guidance published by the Department of Health and the local safeguarding boards as appropriate, including Children Act 2014 and Working Together to Safeguard Children, 2018.
- Safeguarding policies are effectively communicated to its employees (including trustees, volunteers and beneficiaries).
- All staff are up to date with appropriate level of safeguarding training (for both children and adults) relevant to their role in the organisation safeguarding children and vulnerable adults at risk —as recommended in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Paediatrics and Child Health, 2014) and Adult Safeguarding: Roles and Competencies for Health Care Staff (Royal College of Nursing 2018)
- Compliance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards Accountability and assurance framework for adults at risk, also training and competency framework for Prevent.

3.8.4 The Provider shall fulfil its legal obligations concerning the gaining of Disclosure and Barring Service (DBS) checks and checking employees through the Independent Safeguarding Authority (ISA) and the relevant national or local safeguarding authority where applicable, evidenced by a Safer Recruitment policy; the provider will supply evidence of adherence to this to the commissioners, on request.

3.8.5 The Provider shall ensure that there are clear and appropriate policies and procedures in place to support:

- The immediate reporting of safeguarding concerns;
- The encouragement of Raising Concerns ('whistle blowing') where appropriate, including allegations against staff;
- Effective working practices to prevent abuse and neglect, and to protect individuals.

3.8.6 Policies shall highlight:

- the inappropriate nature of private arrangements of any sort between the carer and the patient, including the potential for gross misconduct, recognising the role is a position of trust; and
- actions necessary to participate in a multi-agency safeguarding environment, including attendance at the Safeguarding Boards or subgroups and the mandatory participation in strategy meetings, safeguarding adults reviews (SARs), serious case reviews (SCRs), domestic homicide reviews (DHRs) and other investigations pertaining to the safeguarding of adults or children at risk.

3.8.7 The Provider shall take responsibility for providing care only to the named service user, and this may not include care for any other adults or children (such as 'baby-sitting') even for short periods of time.

3.8.8 The Provider shall have a written policy of confidentiality that is compliant with the General Data Protection Regulation (GDPR) 2016 and Data Protection Act 2018 (Data Protection Legislation). Where appropriate, confidential information will only be disclosed with the consent of the patient concerned, though there are circumstances where consent should not be sought or is only sought under the common law duty of confidentiality. Examples include circumstances where disclosure is required by law or to safeguard children or adults at risk of harm. The Provider shall also ensure that all employees are trained and understand the importance of patient confidentiality.

3.8.9 *Children*

3.8.9.1 The Provider shall:

- Publish contact information for a named local lead for Safeguarding and Child Protection, who will undertake a local governance role, attend NHS safeguarding children advisory groups and liaise with local agencies to keep children safe.
- Ensure that processes are in place to support professionals making appropriate referrals to safeguard children at risk of harm.
- Establish a system for accessing information for children subject to a child protection plan with the local authorities in their area and ensure governance arrangements are in place and that this record system is kept up to date.

3.8.10 *Adults*

3.8.10.1 The Provider shall:

- Adhere to the Care Act 2014[40], which advises that the first priority in safeguarding should always be the safety and well-being of the adult – Making Safeguarding Personal, in line with the six statutory safeguarding principles.
- The Provider shall adhere to all guidance and legislation and have procedures in place to safeguard and promote the welfare and wellbeing of adults at risk.

3.8.10.2 The Provider shall evidence that it has:

- Published contact information for a named lead for adults at risk, who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named lead for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named Prevent lead who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- Up to date policies for Safeguarding Adults at Risk, MCA, DoLS and Prevent, which will be shared with the Commissioner on request;
- Systems in place to ensure that all staff have the appropriate level of safeguarding training, including MCA, DoLS and Prevent and evidence figures for training to meet required standards;
- Systems in place to record safeguarding supervision, with provision of data on request.
- Systems in place to record data relating to referrals, concerns raised and involvement in strategy meetings and Safeguarding Adult Reviews; and
- Met the requirement under Making Safeguarding Personal, providing evidence that the voice of the adult at risk has been heard, on request.

3.9 Population covered

3.9.1 All services are to be accessible to the population over the age of 18 registered with a GP practice in Bristol, North Somerset and South Gloucestershire CCG with provision of transitional care for those aged 16-18 as detailed within specification IACS001. There may also be cases where it is clinically appropriate for adult services to provide treatment to those under the age of 16 e.g. complex wound care and continence issues. This provision should be appraised on a case by case basis in conjunction with the referring GP and relevant paediatric services; the Provider should deliver care where it is safe and clinically appropriate for an adult service clinician to do so. Unregistered patients living in the Bristol, North Somerset and South Gloucestershire area should also have equitable access to services and should be encouraged and facilitated to register with a GP.

3.9.2 Referrals for patients registered with a GP practice in another CCG should be directed to the equivalent commissioned service in that local area.

3.10 Acceptance and exclusion criteria and thresholds

[40] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

3.10.1 All people in Bristol, North Somerset and South Gloucestershire will have access to integrated community services on referral for assessment, care planning and coordination functions. Where, following assessment, it is thought a patient is clinically unsuitable to be managed by the Acute and Reactive Care service or other service described in this specification this is to be discussed with the referring clinician and the Provider is to support and coordinate access to the right alternative service provision.

3.10.2 All services described are for adults with the exception of Minor Injury Units and the WIC which see children.

3.10.3 To ensure equitable access to services the Provider is required to provide access to interpretation and translation services for individuals who are unable to communicate in English. Written information should also be available in other languages in accordance with local demographics. Patients who are homeless and/or vulnerably housed should also be able to access services equitably and support given to them to reconnect with Primary and Community Care to support their health and social care needs.

3.11 Managing demand

3.11.1 There may be occasions where surges in demand for one or multiple community services outpaces available capacity or causes excessive delays and waiting lists. During these times the community service Provider, in agreement and partnership with the CCG may initiate a mutually agreed triage and prioritisation process to ensure care is received where clinical need is greatest and that non-urgent or inappropriate referrals are suitably redirected.

3.11.2 In addition Primary care Locality Lead(s) will have a role in investigating, challenging and agreeing actions around abnormally high referral rates, inappropriate referral behaviours and irregular patterns of demand at an individual GP practice or locality level.

3.12 Interdependence with other services

3.12.1 The Provider will be required to work closely with a wide range of stakeholders, professionals and health and care agencies; including but not limited to:

- Primary care services
- General Practice
- Secondary Care services
- SWAST ambulance service
- Care homes
- Any locally determined Providers
- Local authority – social services and care agencies
- Mental health services
- Medicines management teams
- Third Sector
- Patients, carers, relatives.

3.12.2 In addition there are a number of specific service aspects that are not commissioned within the scope of this contract but are referred to within the specifications. These related services will be commissioned separately by the CCG and the Provider is not expected to deliver these under the scope of this specifications; such services include:

- GP cover to the Locality Hubs
- GP Medical Director role within the Locality Hubs and GP Locality Leads who will act as key strategic partners for the community service Provider
- Locality hub pharmacists and primary care pharmacists
- Delivery of continence products
- Wheelchair services
- Patient transport services, relating to the Locality Hub or otherwise

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

There is a wide range of national and clinical guidance applicable to the delivery of the breadth of service functions described above; such guidance, for example, relates to management of long-term conditions, end of life care, wound care, catheter care, rehabilitation and physiotherapy, speech and language therapy, dietetic intervention and screening, effective provision of care to care home residents. Relevant guidance can be accessed via the NICE website: https://www.nice.org.uk/guidance

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The Provider is required to consider all relevant evidence and guidance from appropriate Royal Colleges in the development and delivery of services.

4.3 Applicable local standards

Applicable local quality and reporting standards are detailed in the relevant quality requirements and information requirements schedules of the Contract.

The Contract also provides clauses about standards that apply to all Service Specifications.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

Defined within the Schedule 4A-D

5.2 Applicable CQUIN goals

Defined within Schedule 4E

6. Location of Provider Premises

The Provider's Premises are located at:

To be inserted prior to contract award

7. Individual Service User Placement

Service Specification No.	IACS004
Service	Integrated Adult Community Services – Locality Hubs and Collocated Services
Commissioner Lead	NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

1.1.1 This specification sets out the requirements of the Provider in relation to the Locality Hub model and associated collocated services. This covers a proportion of the overall service contract and should be delivered in conjunction with specifications IACS001, IACS002 and IACS003 and within the context of the overall model of care, strategic landscape and specifications for enablers set out in IACS000 and IACS006. Each specification is expected to work integrally together as one service to meet the needs of the population.

2. Outcomes

2.1 The CCG expects the Locality Hub service to contribute to the achievement of the following domains. These are subject to change following the national annual review.

2.1.1 NHS Outcomes Framework Domains & Indicators

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

2.1.2 Adult social care domains

13. Enhancing quality of life for people with care and support needs
14. Delaying and reducing the need for care and support
15. Ensuring that people have a positive experience of care and support
16. Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

2.1.3 Public health outcome domains:

13. Improving the wider determinants of health
14. Health improvement
15. Health protection
16. Healthcare, public health and preventing premature mortality

2.1.4 Local defined outcomes

2.1.4.1 The CCG wants Community Services to be seamless, coordinated and holistic, based on the principles set out in Reimagining community services: Making the most of our assets[41] (The King's Fund paper). This requires a shift away from focusing on an individual condition to care designed in partnership with the patient and their carers. Care will need to transcend historical boundaries of care setting, organisation or budgetary responsibility. Community Services will include a single core assessment process, completed once by a trusted assessor that evaluates the full spectrum of an individual's needs and coordinates a service response across different agencies and professionals. Another key principle is the development of seamless professional links and redefining organisational boundaries to instil collaboration with Primary Care and change the role of hospital specialists to support the wider health and social care economy. Community Services should promote an ethos of continuity of care and community involvement through the creation of dedicated locality teams and building operational links with the Third Sector and wider community organisations. The underpinning model of care is focused on supporting patients to achieve the best possible outcomes, in line with their needs and agreed goals.

2.1.4.2 It is expected that the realisation of these strategic aims will translate into a number of tangible outcomes including:

- Patients, carers and families will have a positive experience of care.
- A patient or carer with multiple needs will have a single, integrated care plan developed with them.
- A greater proportion of care will be provided closer to home in community settings.
- There will be a reduction of admissions to hospital and length of stay in hospital for those who are admitted; particularly for people over the age of 65.
- There will be a reduction in the number of potentially avoidable admissions (admissions with 0 to 48 hour length of stay for which no clinical procedure was carried out).
- Wellbeing will be maximised and independence maintained for longer, reducing the overall need for long-term care.
- Professional skills and expertise, including those of the Third Sector, will be effectively shared across services and organisations, building a more effective and resilient workforce.

2.1.5 Community-based outcomes framework

2.1.5.1 The CCG aims to build on national work to form a locally-based community outcomes framework, developing this with the Provider and patients so that the framework is tailored to local needs. This outcomes framework will encompass two domain types:

2.1.5.2 **Overarching domains** which cross the entire care pathway:

- Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient.
- Treating and caring for people in safe environment and protecting them from avoidable harm.
- Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information sharing that links seamlessly with other services provided within the community.

2.1.5.3 **Pathway domains** which align to key stages of the care pathway:

- Early intervention with a focus on prevention to promote health, well-being and independence.
- Treatment and / or support during an acute episode of ill health.
- Long-term recovery and sustainability of health.
- Care and support for people at the end of their lives.

3. Scope

[41] https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf

3.1 Objectives

3.1.1 This specification sets out prominent service models that will work interdependently to create a comprehensive health and social care experience at key community based sites within Bristol, North Somerset and South Gloucestershire. The Locality Hub is a sophisticated model of proactive management for our population including frail patients with complex long-term conditions, social prescribing and self-care support with multiple organisations based in key sites across localities that work cross organisationally to ensure access to a wide range of support services within one geographical location. It is anticipated in the future that community services will be co-located at central geographical sites within Bristol, North Somerset and South Gloucestershire's six GP Localities and will operate seamlessly together, and work towards the achievement of sharing staff, expertise and resources to create a fluid and high quality experience for our population that can respond to the broadest possible spectrum of complexity and need. There will be a focus on proactive care and our population will be able to access these services independent of whether they have a health condition, to enable people to support themselves to prevent chronic ill health. The development of these sites will enable the achievement of key system objectives including:

- Reduction of emergency admissions and attendances at A&E
- Improved access to 7 day services particularly intermediate care and crisis intervention
- Ensure patients, their families and carers have a high quality experience of care designed around the outcomes they identify
- Work seamlessly with primary care professionals, implementing comprehensive Locality Hubs and jointly identifying and managing patients in conjunction with General Practice using a risk stratification approach through multi-disciplinary teams. Predictive risk stratification modelling e.g.: (PRiSM) estimates the risk that individuals will have an emergency admission to hospital within 12 months and selects patients for proactive community care to avoid admissions. The successful Provider will be required to adopt partnership working with Primary Care colleagues to use an agreed Risk stratification algorithm within Patient records (triangulated by professional insight and experience) to proactively identify patients at risk of an acute admission and via a multidisciplinary approach identify actions to delay the predicted acute episode of care. We also expect the Provider through this approach to improve independence and reduce frailty
- To minimise duplication, fragmentation and confusion through a single focal point within each Locality whereby patients can rapidly access enhanced health and care services and support from a range of organisations to stay healthy, well and independent in the community. The Provider will be required to design a clear process for tracking progress and achievement of health outcomes for individuals as well as to evaluate the impact of specific interventions
- To consider the efficiency of digital communications and assistive technologies that support the delivery of integrated care across the organisations and seek to include the patient as a partner in care
- To work towards the aspiration of collaborating with primary care, social care, mental health and Third Sector agencies to ensure individuals can access a comprehensive health and social care support and improve knowledge of the population to self-care and improve wellbeing (as seen in the diagram below of working towards an integrated care system)
- To provide a comprehensive care response at all stages of the patient pathway from proactive care through to end of life care; to improve the proportion of people who die in their preferred place of death
- To delay the need for long term care through effective proactive care and intervention designed around patient identified outcomes
- To manage resources efficiently to deliver an excellent standard of service within the financial envelope available

3.1.2 The CCG's aim is to implement a vision of improved care for patients by bringing specialist medical resources closer to the patient, wherever they are and forging strong relationships

and integrated working across organisations in health and social care and the Third Sector. This aligns with the future vision of an integrated approach to care which has been developed by Bristol, North Somerset and South Gloucestershire's Sustainability and Transformation Partnership *Healthier Together*. Over the life of the community contract we expect the community Provider to take a key system partnership role in this increasing integration and support patients to stay healthy, well and independent in the community (as described in IACS000). The Provider will therefore need to work collaboratively with the CCG, Healthier Together, locality GP practices, secondary care, mental health services, the Third Sector, social care and public health to develop the locality hub model in alignment with Bristol, North Somerset and South Gloucestershire's health, social care and Third Sector partners.

3.2 Service description

3.2.1 Specification interdependencies

3.2.1.1 This specification is designed to be read and implemented in conjunction with the other four Community Service Specifications. Specifications IACS001 and IACS003 are particularly important as they describe the requirements for the different professional inputs the Provider is required to deliver e.g. community nursing, dietetics, SALT, physio etc. This specification will not repeat those requirements but will set out the Commissioner's vision for new service models that will set out the methodology by which care is designed and delivered and the way in which healthcare professional resources are deployed across the local area.

3.2.1.2 The Provider will be required to deliver the model of care described below in conjunction with the Integrated Locality Teams and Acute and Reactive Care function set out in IACS001 and IACS003 and the full range of specialist and supporting services set out in both specifications IACS001 and IACS002. The Provider will ensure that their staff operate fluidly and flexibly across these service models, building a robust multi-skilled workforce and minimising duplication. The workforce will be developed in line with Healthier Together's workforce strategy[42]. In particular the commissioner expects professionals to be deployed flexibly across the Integrated Locality Teams and relevant Locality Hub site(s) (including care home support functions) rotating through different service aspects to build a holistic knowledge of the local health and care system and maximising the capabilities of the clinical workforce.

3.2.1.3 It is required that the Provider will utilise modern technology to be able to optimise the efficiency of staff including the scheduling of on site and off site activity as well as travel time. The Provider will need to consider how the availability booking and referral processes will work across digital, clinical and physical estates. We are seeking these locations to be facilities that embed the use of digital technology to ensure the patient journey can be tracked and optimised.

3.2.1.4 We want to embed the key concept of customer services as part of the service so that people feel they are being engaged in a considerate and meaningful way and that feedback and the ideas that patients have for improving and shaping the service are considered from design through into operation and ongoing improvement cycles. The ethos of the service should be one that is owned by the local community. The ambition is for locality hubs to become centres of innovation around supporting independence and reducing the impacts of frailty linked to the local community through a range of networks AHSN, academic partners, local business and so on and innovative approaches. The services and models of care to be delivered under the specification are set out in subsequent sections.

3.2.2 Locality Hubs

[42] https://bnssghealthiertogether.org.uk/documents/item-4-workforce-visions-and-priorities/

3.2.2.1 The aim of Locality Hubs across localities are to have geographical locations across Bristol, North Somerset and South Gloucestershire that are able to support people to access a range of services provided by a range of organisations across sectors in one place. It will support patients who would otherwise access secondary care, and ensures that care and services are available close to a person's home. This is an area for development and key services need to be considered by the Provider to support this work both at the inception of the contract and throughout the life of the contract. We would expect a service to be placed in a geographical location where it makes sense to meet out populations needs and for that service to consider the local populations demographics in order to best meet their needs.

3.2.2.2 In the future we want the Provider to work with system partners to develop services available at geographical locations and virtually as appropriate across localities that meet the needs of the population in line with the Bristol, North Somerset and South Gloucestershire estates strategy and other system developments with a key focus on what services are needed to ensure proactive care and support to our community is maximised.

3.2.3 Frailty model

3.2.3.1 As an example of work currently being undertaken at a geographical location, Healthy Weston is developing a frailty hub and model that the Provider will need to be aligned with and develop. In addition the Provider will need to work with key stakeholders to ensure this model is adapted across Bristol, North Somerset and South Gloucestershire to have one integrated frailty model across the area. The primary objective of an integrated frailty service is to provide person centred care for people living with frailty. The development of the integrated service will support the reduction of admissions to hospital, by increasing the quality of care within the community and support a shorter length of stay and rapid discharge of frail patients. In Weston this model is being developed as part of 'Healthy Weston' and is situated in the acute trust there. This model will need to be adapted across Bristol, North Somerset and South Gloucestershire and sited geographically or virtually in accordance with local population need.

3.2.3.2 Key features of the model are:

- Person- centred, personalised care designed around individual needs depending on where the individual is on the frailty pathway through integrated and collaborative working
- Early intervention and prevention to support people living independently for longer in the community setting
- Profiling and risk stratification to determine appropriate place on the frailty pathway based on frailty score
- Shared care plan, based on a comprehensive geriatric assessment, ensuring the provision of holistic care and advanced care planning
- Supported self-care and involvement of family and carers
- Home first approach based around primary and community care clusters

3.2.3.3 Key to delivery of this service is close multidisciplinary working across hospital services, out of hospital services, social services and with the Third Sector. This will be promoted by good communication, and 'trusted assessment', regular face-to-face meetings and discussion between teams and work with Bristol, North Somerset and South Gloucestershire partners. The future vision is to have an integrated frailty team spanning all organisations and providing a constant contact for patients living with frailty regardless of their considered level of frailty need. Working harmoniously and seemlessly regardless of employing organisation, to deliver best care for patients living with frailty and their families.

3.2.4 Service delivery

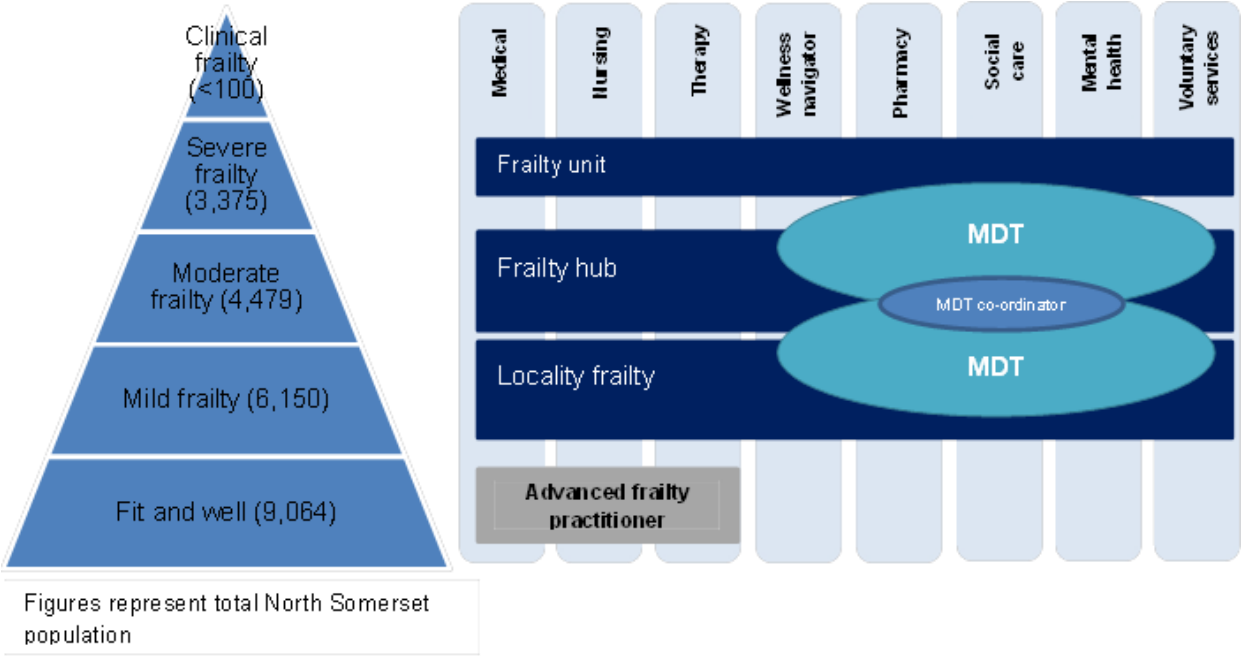
3.2.4.1 Integrated care takes many different forms from formal integration, in which organisations merge their services, to virtual integration, in which Providers work together through networks and alliances. Our model will see services working in an integrated, collaborative way to co-ordinate their work more effectively to deliver joined-up, person- centred, personalised care which is designed around individual needs, depending on where the individual is on the frailty pathway. The service will be provided in a variety of settings and ways including: clinics, home visits, the frailty hub, care homes and at hospital. It will involve integrated working with other Providers across primary, acute, community, mental health, social care and Third Sector organisations, supported by or coordinated by the multi-disciplinary team.

3.2.4.2 The service will comprise a multidisciplinary team of health and social care staff and include advanced frailty practitioners (nurses and therapists) frailty doctors, (consultant geriatrician, GP, senior clinicians), social care staff, mental health nurse, pharmacist, falls specialist physiotherapist and nurse, wellness navigators and volunteers. The team will work between the frailty hub, frailty unit and locality community settings.

3.2.4.3 The current Healthy Weston model of the frailty hub is detailed in Figure 1 which the community service supports with staffing and expertise.

3.2.4.4 The Provider is required to work with services in existence at the inception of the contract and further develop this to work towards a Bristol, North Somerset and South Gloucestershire approach with Bristol, North Somerset and South Gloucestershire system partners.

Figure 1: Healthy Weston frailty hub model



3.2.5 Service development

3.2.5.1 The Provider is required to play a key system partner role in the development and transformation of locality hubs and what they offer throughout the life of the contract in discussions and agreement with commissioners and key system partners. The objective is for locality hubs to offer a broad range of health, social care and Third Sector services easily accessible to the local population that meets their needs. Key principles of working that will help achieve this are:

3.2.5.1.1 *Model of care*
As an example the ChenMed[43] model of care focuses on having a geographical location where multiple services can act as a 'one stop shop' for the population to onsite clinical professionals, wellness focused activities and access to specialist services as appropriate to population need, including having the capacity to keep people out of hospital e.g.: intravenous antibiotics. A key part of the model is that it also considers how to support the population to access services through the provision of door to door transportation. It has shown to be effective in enhancing co-ordination, collaboration, convenience and compliance.

3.2.5.1.2 *Meeting local population need*
It is vital in the development of Locality Hubs that the Provider as a system partner has the responsibility to understand the needs of the local population throughout the life of the contract. This should take into account but is not limited to an annual review of public health profiles, GP information about ill health and chronic disease, patient, carers and population feedback and data relating to issues that are linked to high urgent care demand. It is anticipated that there will be developments in data collection that move to real time and prospective data collection during the life of the contract.

3.2.5.1.2.1 Services should be designed around this information and alongside GP locality provider boards and GP Networks in agreement with the commissioner to support people to remain well in the community. The objective is that each locality hub meets the local issues relating to the population within that locality. It is vital that the health and wellbeing of carers is also accounted for as they provide a significant resource to keeping patients in their own homes which needs to be recognised and that services are designed to allow them access to support. Although the community service is for adults, there should be a consideration of the needs of children and families within locality hubs, through working with other commissioners e.g.: public health, that supports parenting skills, healthy eating, being active, access to health and social care information and access to groups to reduce social isolation.

3.2.5.1.2.2 If there are services provided to children under 5 years of age, the provider should have access to the eRedbook as detailed in IACS006.

3.2.5.1.3 *Support to vulnerable groups*
It is required that the community service will provide equitable access to services across Bristol, North Somerset and South Gloucestershire and in particular take account of vulnerable groups. The service will need to ensure that the services available in locality hubs are provided for these vulnerable groups relating to locality information as described above. These services should include those offered by health and social care and the Third Sector. Vulnerable groups that should be considered and services adapted and offered accordingly are:

- **People who are frail**

The development of a Bristol, North Somerset and South Gloucestershire integrated frailty model will help support those people who are frail across localities in the area. The service also needs to account for how access to a broader range of services will be made easier for those who are frail e.g.: using transport solutions to support access and reduce social isolation or group sessions in central locations. It is vital that the needs of carers are also accounted for to enable them to continue supporting the person they care for at home. Although frailty generally affects those who are elderly, the Provider needs to consider frailty associated with social deprivation, ethnicity and substance misuse that means patients in some localities may be considered frail at a much younger age.

- **Ethnicity**

[43] https://www.nuffieldtrust.org.uk/media/chenmed-care-model-creating-change-and-transformation-in-general-practice

There are key areas across Bristol, North Somerset and South Gloucestershire that have a higher proportion of the population who are from Black and minority ethnic groups where there are higher levels of deprivation and people who speak English as a second language. This needs to be taken into account in the services provided to that population within the hub so that they are easy to access and meet population need.

- **Disability**

Access to services and information about other services that support people to stay well should be accessible to all people, including those with a physical or mental health disability.

- **Homelessness**

Homelessness includes not just people who have 'no fixed abode' but also those who are vulnerably housed e.g.: in hostel placements. They find it difficult to engage with traditional services and the Provider should ensure services are tailored to meet their needs including but not limited to drop in services with no fixed appointments and access to Third Sector and social care support. It is vital that there is close partnership working with housing and social services to link this population group back to services they require to improve their health and wellbeing. The Provider is required to develop in partnership with the CCG an approach to the community management of these people alongside an approach to dealing with issues relating to homelessness and high impact users.

3.2.6 Links with other organisations

3.2.6.1 The Community Services Provider will work to ensure that services are accessible within the hub across a range of organisations and sectors to meet population need and taking into account each locality's demographics as described above. These will include but are not limited to:

3.2.6.1.1 *Primary care services*
Increasingly GP's are working at scale and through the locality transformation scheme and Primary Care Networks[44] (as detailed in IACS000) to develop integrated localities and 7 day access to services. The community services Provider will work in partnership with locality provider boards and the commissioner to develop a Primary Care service presence within locality hubs.

3.2.6.1.2 *Mental health services*
There should be parity for people presenting with mental health needs. Mental health issues are an issue for the whole population of Bristol, North Somerset and South Gloucestershire. As such locality hubs should work in partnership with mental health services and the Third Sector to ensure services are available that support our population to improve their mental health as well as their physical health. The Provider should also ensure it engages with key programmes of work across Bristol, North Somerset and South Gloucestershire e.g.: Thrive Programme https://www.bristol.gov.uk/mayor/thrive-bristol

3.2.6.1.3 *Local authorities*
The Community Services Provider will need to work closely with our three Local Authorities to enable a better understanding of population health with Public Health, and forge close partnerships with social care that enables people visiting the hub to have access to the information and support they need.

3.2.6.1.4 *Third Sector*

[44] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

The Third Sector presence in locality hubs is vital in providing a focus on remaining well and proactive care. This needs to relate to population need and cover a range of specific services as well as access to wellbeing activities such as exercise, preparing healthy food and group support.

3.2.7 Hours of operation

3.2.7.1 The locality hub model when fully implemented will operate within the core hours of 8am to 8pm seven days a week. The Provider will flex the deployment of resources and clinical expertise available based on levels of demand and the case mix of presenting patients.

3.2.8 Workforce

3.2.8.1 The Provider is required to develop an innovative staffing and medical model capable of sharing resources across the service models described within this specification and within counterpart specifications comprising this Contract (IACS001 and IACS002). This model should make the right level of professional available to patients at the right time based on demand and clinical need.

3.2.9 Information sharing and signposting

3.2.9.1 The Provider will ensure that the information management and technology capabilities of all services within this specification are fundamentally designed with the central priority of interoperability with other Providers and agencies across Bristol, North Somerset and South Gloucestershire. Of paramount importance is the direct interoperability with prevailing GP IT systems across Bristol, North Somerset and South Gloucestershire. The Provider will agree a joint interoperability strategy with the commissioner's information management and technology delivery team as part of the mobilisation period.

3.2.9.2 The Provider should ensure that system interoperability is optimised with the following key partners as a minimum, including:

- GP practices
- SWAST ambulance trust
- Acute hospitals
- Social services
- GP out of hours service and NHS 111 – Severnside from April 2019
- Third Sector

3.2.9.3 Further detail on the digital requirements is described in IACS006.

3.2.9.4 *Signposting*
The Provider will ensure staff are trained in signposting to local services beneficial to overall health and wellbeing, including local community, Third Sector and faith sector organisations. This will be particularly important in the locality hubs with a core focus on proactive care. Staff should have an awareness of supplementary services available in their local area of operation. The Provider should consider comprehensive and innovative ways to provide the most effective signposting and service coordination; potentially including the development of Social Prescribing.

3.2.9.5 The Provider at a corporate level will ensure the development of a comprehensive directory of services for local Third Sector services including smaller, highly localised services. The Provider may choose to use an existing service portal.

3.2.10 Medicines management

3.2.10.1 Clinicians providing NHS-commissioned care within the Provider organisation should:

- Prescribe for adults in accordance with the Bristol, North Somerset and South Gloucestershire Joint Formulary[45] and other relevant local prescribing guidance.
- Prescribe for children in accordance with the paediatric updates in the Bristol, North Somerset and South Gloucestershire Joint Formulary, or the Bristol, North Somerset and South Gloucestershire Paediatric Joint Formulary[46]
- Practice antibiotic stewardship in line with national and local guidance
- All clinicians should follow the process outlined in the Bristol, North Somerset and South Gloucestershire Formulary for new drug requests and shared care protocols that can be found on the formulary website
- A prescribing budget for certain areas will be included in the provider contract (see individual service details) and the provider will manage spend within that budget
- Provider services are responsible for the production and updates of any necessary Patient Group Directions for their services, in line with the Bristol, North Somerset and South Gloucestershire Patient Group Directions Policy
- All dressings will be supplied or prescribed in line with the Pan Avon Dressings Formulary
- Provider services will work with commissioners to minimise the impact of medicines waste
- Specialist clinicians will engage with the commissioner and other providers in the development of pathways and guidelines involving medicines
- Medicine Incidents themes should be shared with the CCG Medicine Optimisation team via agreed route
- A Controlled Drug accountable officer should be nominated
- A senior pharmacist or healthcare professional is required to represent the organisation at system Medicine Optimisation groups such as Bristol, North Somerset and South Gloucestershire Drugs and therapeutics committee and STP Medicine optimisation board

3.2.10.2 There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. The CCG and Provider will work collaboratively to ensure that patient care in relation to medication is safe, effective and sustainable; especially when patients transfer between care settings.

3.2.10.3 In the case of discharge from a Community Service it is normal for prescribing responsibility to transfer from a specialist to a general practitioner following discharge, but prescribing responsibility will remain with the specialist team when:

- Treatment is a medicine not reimbursed though national prices (excluded from the PbR tariff) and directly commissioned by NHS England, rather than a CCG
- Treatment is being provided as part of a clinical trial
- Medicines or medical devices cannot be prescribed on form FP10 by GPs
- Medicines are categorised as 'red' in the Bristol, North Somerset and South Gloucestershire Joint Formulary
- Medicines are categorised as 'amber' in the Bristol, North Somerset and South Gloucestershire Joint Formulary with a shared care protocol (SCP), but the conditions in SCP have not been met
- Treatment is being provided as part of a service that has been commissioned in such a way that arrangements are in place for ongoing supply to the patients under the direction of a secondary care clinician (e.g. homecare, home enteral tube feeds)
- Medicines are unlicensed or used outside the terms of their licence, unless these are listed in the Bristol, North Somerset and South Gloucestershire Joint Formulary for these indications

[45] https://www.bnssgformulary.nhs.uk/
[46] https://www.bnssgpaediatricformulary.nhs.uk/

3.2.10.4	The prescriber is responsible for ensuring that appropriate clinical monitoring arrangements are in place for the medicines that they prescribe and that the patient and other healthcare professionals involved understand them.
3.2.11	**CCG authorised access to FP10 prescription Pads for Providers and responsibilities**
3.2.11.1	The Provider should have a nominated accountable office for controlled drugs or equivalent senior officer responsible for oversight of all prescription usage by the service including audit and raising appropriate concerns around controlled drug management.
3.2.11.2	The Provider is expected to ensure robust governance of all prescribing activity, including the use of policies and procedures relating to prescribing activity to support high quality, safe and appropriate prescribing and may periodically be asked to demonstrate this is the case.
3.2.11.3	The Provider is responsible for funding all prescribing activity undertaken on FP10 prescription pads. The provider will periodically be expected to provide data on the medication prescribed on FP10 prescription pads from the epact system.
3.2.11.4	The Provider should ensure it is fully compliant with the NHS Counter Fraud Authority guidance on Management and control of prescription forms, including prescription pad destruction as part of contract termination. For clarity Bristol, North Somerset and South Gloucestershire CCG will not be liable for any costs of inappropriately used prescriptions.
3.2.11.5	The following link[47] provides NHS provider organisations with the information needed to obtain and maintain prescribing codes for your organisation and prescribers, order prescription forms (FP10), reconcile invoices, access data about your prescribers and services. Providers should liaise with Bristol, North Somerset and South Gloucestershire CCG's Medicines Optimisation Team who contains the necessary CCG signatories to complete the process
3.2.11.6	During contract termination the prescription services department of NHS Business Services Authority (NHS BSA) must be informed of the Provider's Organisational Data.
3.2.12	**Safeguarding children and adults at risk**
3.2.12.1	The Provider will ensure that Making Safeguarding Personal is integral to the service delivery to ensure that adults at risk are protected and that their views are heard within the safeguarding process.
3.2.12.2	The Provider will also ensure that all staff in contact with patients and the public have been appropriately trained in local safeguarding procedures and regularly maintain these competencies. The Provider will ensure that staff are appropriately supported to implement safeguarding procedures where concerns have been identified.
3.2.12.3	The Provider shall ensure:

47 https://www.nhsbsa.nhs.uk/sites/default/files/20172/Local_Authority_and_Provider_Welcome_Pack_v1.5.pdf

- Up to date appropriate policies and procedures on safeguarding children and vulnerable adults are in place. These will adhere to all relevant legislation, Care Act 2014, codes of practice, statutory guidance and good practice guidance published by the Department of Health and the local safeguarding boards as appropriate, including Children Act 2014 and Working Together to Safeguard Children, 2018.
- Safeguarding policies are effectively communicated to its employees (including trustees, volunteers and beneficiaries).
- All staff are up to date with appropriate level of safeguarding training (for both children and adults) relevant to their role in the organisation safeguarding children and vulnerable adults at risk —as recommended in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Paediatrics and Child Health, 2014) and Adult Safeguarding: Roles and Competencies for Health Care Staff (Royal College of Nursing 2018)
- Compliance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards Accountability and assurance framework for adults at risk, also training and competency framework for Prevent.

3.2.12.4 The Provider shall fulfil its legal obligations concerning the gaining of Disclosure and Barring Service (DBS) checks and checking employees through the Independent Safeguarding Authority (ISA) and the relevant national or local safeguarding authority where applicable, evidenced by a Safer Recruitment policy; the provider will supply evidence of adherence to this to the commissioners, on request.

3.2.12.5 The Provider shall ensure that there are clear and appropriate policies and procedures in place to support:

- The immediate reporting of safeguarding concerns;
- The encouragement of Raising Concerns ('whistle blowing') where appropriate, including allegations against staff;
- Effective working practices to prevent abuse and neglect, and to protect individuals.

3.2.12.6 Policies shall highlight:

- the inappropriate nature of private arrangements of any sort between the carer and the patient, including the potential for gross misconduct, recognising the role is a position of trust; and
- actions necessary to participate in a multi-agency safeguarding environment, including attendance at the Safeguarding Boards or subgroups and the mandatory participation in strategy meetings, safeguarding adults reviews (SARs), serious case reviews (SCRs), domestic homicide reviews (DHRs) and other investigations pertaining to the safeguarding of adults or children at risk.

3.2.12.7 The Provider shall take responsibility for providing care only to the named service user, and this may not include care for any other adults or children (such as 'baby-sitting') even for short periods of time.

3.2.12.8 The Provider shall have a written policy of confidentiality that is compliant with the General Data Protection Regulation (GDPR) 2016 and Data Protection Act 2018 (Data Protection Legislation). Where appropriate, confidential information will only be disclosed with the consent of the patient concerned, though there are circumstances where consent should not be sought or is only sought under the common law duty of confidentiality. Examples include circumstances where disclosure is required by law or to safeguard children or adults at risk of harm. The Provider shall also ensure that all employees are trained and understand the importance of patient confidentiality.

3.2.12.9 *Children*

3.2.12.9.1 The Provider shall:

- Publish contact information for a named local lead for Safeguarding and Child Protection, who will undertake a local governance role, attend NHS safeguarding children advisory groups and liaise with local agencies to keep children safe.
- Ensure that processes are in place to support professionals making appropriate referrals to safeguard children at risk of harm.
- Establish a system for accessing information for children subject to a child protection plan with the local authorities in their area and ensure governance arrangements are in place and that this record system is kept up to date.

3.2.12.10 *Adults*

3.2.12.10.1 The Provider shall:

- Adhere to the Care Act 2014[48], which advises that the first priority in safeguarding should always be the safety and well-being of the adult – Making Safeguarding Personal, in line with the six statutory safeguarding principles.
- The Provider shall adhere to all guidance and legislation and have procedures in place to safeguard and promote the welfare and wellbeing of adults at risk.

3.2.12.10.2 The Provider shall evidence that it has:

- Published contact information for a named lead for adults at risk, who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named lead for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named Prevent lead who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- Up to date policies for Safeguarding Adults at Risk, MCA, DoLS and Prevent, which will be shared with the Commissioner on request;
- Systems in place to ensure that all staff have the appropriate level of safeguarding training, including MCA, DoLS and Prevent and evidence figures for training to meet required standards;
- Systems in place to record safeguarding supervision, with provision of data on request.
- Systems in place to record data relating to referrals, concerns raised and involvement in strategy meetings and Safeguarding Adult Reviews; and
- Met the requirement under Making Safeguarding Personal, providing evidence that the voice of the adult at risk has been heard, on request.

3.2.13 Population covered

3.2.13.1 All services are to be accessible to the population registered with a GP practice in Bristol, North Somerset and South Gloucestershire CCG. Unregistered patients living in the Bristol, North Somerset and South Gloucestershire area should also have equitable access to services and should be encouraged and facilitated to register with a GP.

3.2.14 Acceptance and exclusion criteria

3.2.14.1 Population coverage and exclusion criteria are as defined earlier in this specification. To ensure equitable access to services the Provider is required to provide access to interpretation and translation services for individuals who are unable to communicate in English. Written information should also be available in other languages in accordance with local demographics.

3.2.14.2 *Managing demand*

[48] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

There may be occasions where surges in demand for one or multiple community services outpaces available capacity or causes excessive delays and waiting lists. During these times the community service Provider, in agreement and partnership with the CCG may initiate a mutually agreed triage and prioritisation process to ensure care is received where clinical need is greatest and that non-urgent or inappropriate referrals are suitably redirected.

3.2.14.3 In addition GP Locality Lead(s) will have a role in challenging abnormally high referral rates, inappropriate referral behaviours and irregular patterns of demand at an individual GP practice or locality level.

3.2.15 Interdependence with other services

3.2.15.1 The Provider's obligations with regards to collaboration with partner organisations across the health and social care economy have been set out in detail within the core services specification (IACS001).

3.2.15.2 The Provider will be required to work closely with a wide range of stakeholders, professionals and health and care agencies; including but not limited to:

- Primary Care services
- General Practice
- Secondary Care services
- SWAST ambulance service
- Care Homes
- IUC CAS - Severnside
- Any locally determined providers
- Local authority – social services and care agencies
- Mental health services
- Medicines management teams
- Third Sector
- Patients, carers, relatives.

3.2.15.3 In addition there are a number of specific service aspects that are not commissioned within the scope of this contract but are referred to within the specifications. These related services will be commissioned separately by the CCG and the Provider is not expected to deliver these under the scope of this specifications; such services include:

- GP cover to the locality hubs
- GP lead role within the locality hubs and GP locality leads who will act as key strategic partners for the community service Provider
- Locality Hub pharmacists and Primary Care pharmacists
- Delivery of continence products
- Wheelchair services
- Patient transport services, relating to the locality hub or otherwise

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

There is a wide range of national and clinical guidance applicable to the delivery of the breadth of service functions described above; such guidance, for example, relates to management of long-term conditions, end of life care, wound care, catheter care, rehabilitation and physiotherapy, speech and language therapy, dietetic intervention and screening, effective provision of care to care home residents. Relevant guidance can be accessed via the NICE website: https://www.nice.org.uk/guidance

4.2	**Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)** The Provider is required to consider all relevant evidence and guidance from appropriate Royal Colleges in the development and delivery of services.
4.3	Applicable local standards Applicable local quality and reporting standards are detailed in the relevant quality requirements and information requirements schedules of the Contract. The Contract also provides clauses about standards that apply to all Service Specifications.

5. Applicable quality requirements and CQUIN goals

5.1 **Applicable Quality Requirements**

Defined within the Schedule 4A-D

5.2 **Applicable CQUIN goals**

Defined within Schedule 4E

6. Location of Provider Premises

The Provider's Premises are located at:

To be inserted prior to Contract Award

7. Individual Service User Placement

Service Specification No.	IACS005
Service	Fixed term and pilot projects
Commissioner Lead	BNSSG CCG
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Fixed term and pilot projects each have specific drivers and local needs.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

These are defined by each project individually.

3. Scope

3.1 Service description/care pathway

3.1.1 This specification lists fixed term projects and pilots underway within the CCG geography at the time of contract award. This list may not be comprehensive.

3.1.2 **I**t is the CCG's intention that if the projects listed continue, the adult community service provider would be expected to provide them as a variation to the contract, with the financial amount for delivery to be added to the financial envelope. The budget would be decided based on the CCG's decisions about the scope and scale of any service rollout or continuation.

3.1.2 The CCG is also aware of new pilot schemes in development within the CCG and the Sustainability and Transformation Partnership (STP) which may be delivered wholly or partly in the community. Further discussion will be needed to agree whether it is appropriate to commence such pilots with current adult community service providers and/or the provider of community services from 1st April 2020.

3.2 Population covered

3.2.1 Fixed term projects and pilots deliver services for specific elements of the population as defined by the individual project aims and objectives.

3.3 **Any acceptance and exclusion criteria and thresholds**

As per the project criteria.

3.4 **Interdependence with other services/providers**

3.4.1 All the fixed term projects and pilots highlighted in this schedule are delivered by or have key interdependencies with adult community service providers.

4. Current Fixed Term and Pilot Projects

4.1 The table below outlines the current known projects operating within the CCG area with operational requirements for the adult community provider or key interdependencies with them.

Living Well With and Beyond Cancer

MacMillan - Living Well is funded by the Cancer Transformation Fund currently and consists of a suite of interventions provided by UHB, NBT, WAHT and Bristol Community Health. The aim is to enable personalised care and support for patients living with and beyond cancer. A QI project for GPs and practice nurses is also part of this and is being managed by BNSSG and led by the Macmillan GPs.

Contractual obligations	Future options	Finance Impact
Two year contract from November 2018, with review after one year. Staff working solely on this project are not included in TUPE list.	The intention is to novate this contract to the new provider. Commissioning lead to confirm evaluation requirements	The CCG currently receives funding for circa. 4 WTE staff that are employed directly by the CCG. This is not in current community contracts or financial envelope.

Medicines optimisation in care homes

The Medicines Optimisation in Care Homes (MOCH) programme focuses on care home residents, across all types of care home settings and aims to deploy dedicated clinical pharmacy teams that will:

- Provide care home residents with equity of access to a clinical pharmacist prescriber as a member of the multidisciplinary team, with the supporting infrastructure for achieving medicines optimisation according to need
- Provide care homes with access to pharmacy technicians who will ensure the efficient supply and management of medicines within the care home, supporting care home staff and residents to achieve the best outcomes from medicines.

Contractual obligations	Future options	Finance Impact
Team of four staff hosted by NSCP to support care homes across BNSSG Pilot as funded through the Pharmacy Integration Fund	The intention is to include this pilot in the new contract with review after two years. Commissioning lead to confirm evaluation requirements	Funded by NHSE. 2019/20 funding is £217,000. No funding has been confirmed beyond 31 March 2020.

Latent TB Infection

Bristol has been identified as a high TB incidence area (defined as ≥20 per 100,000 population). In order to address this an LTBI Testing and Treatment Programme has been established in the areas of highest prevalence. In 2019/20 the programme will be delivered by the community TB service in the Bristol locality.

Contractual obligations	Future options	Finance Impact
NHSE funded scheme for 2019/20.	Dependent on NHSE commissioning intentions	Funded by NHSE. 2019/20 funding is £22,500. No funding has been confirmed beyond 31 March 2020.

Diabetes Treatment Targets

This pilot project is currently funded through the central Sustainability and Transformation Fund. This funding covers the input of community provider staff to:

- Delivery of Educational Sessions to GP Practices
- Diabetes Specialist Nurse
- Dietetic Support at Virtual Clinics
- Rapid Access Dietetic sessions for type 2 diabetes - Eatwell 2 hour sessions

Contractual obligations	Future options	Finance Impact
NHSE funded scheme for 2018/19. Funding also expected for 2019/20.	Commissioning intentions for 2020/21 onwards to be clarified.	In contracts non-recurrently for 2018/19, not in 2019/20 contract or contract envelope. If NHSE confirm funding then add to service spec and envelope on pass through NHSE funding.

Service Specification No.	IACS006
Service	Adult community health services – enablers
Commissioner Lead	NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

1.1.1 This specification sets out the Requirements of the Provider in relation to enablers for delivering adult community health services set out in the service specifications IACS001, IACS002, IACS003 and IACS004. It should be read in conjunction with those specifications. Each specification is expected to work integrally together as one service to meet the needs of the population.

2. Outcomes

2.1 The CCG expects the enablers supporting the adult community health service to contribute to the achievement of the following domains. These are subject to change following the national annual review.

2.1.1 NHS Outcomes Framework Domains & Indicators

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

2.1.2 Adult social care domains

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

2.1.3 Public health outcome domains:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare, public health and preventing premature mortality

2.1.4 Local defined outcomes

2.1.4.1 The CCG wants Community Services to be seamless, coordinated and holistic. This requires a shift away from focusing on an individual condition to care designed in partnership with the patient and their carers. Care will need to transcend historical boundaries of care setting, organisation or budgetary responsibility. This requires robust infrastructure and enablers.

2.1.5 Community-based outcomes framework

2.1.5.1 The CCG aims to build on national work to form a locally-based community outcomes framework, developing this with the Provider and patients so that the framework is tailored to local needs. This outcomes framework will encompass two domain types:

2.1.5.2 **Overarching domains** which cross the entire care pathway:

- Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient.
- Treating and caring for people in safe environment and protecting them from avoidable harm.
- Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information sharing that links seamlessly with other services provided within the community.

2.1.5.3 **Pathway domains** which align to key stages of the care pathway:

- Early intervention with a focus on prevention to promote health, well-being and independence.
- Treatment and / or support during an acute episode of ill health.
- Long-term recovery and sustainability of health.
- Care and support for people at the end of their lives.

3. Scope

3.1 This specification sets out requirements in the following areas:

- Digital
- Workforce
- Estates
- Communications

4. Digital specification

4.1 Overarching principles

4.1.1 The Provider will comply with and facilitate the CCG's vision for digital enablers. Key principles include:

- The Provider will empower people to take control of their health and care, including through secure online access to health records personalised health information, digital tools and solutions, and advice that helps patients to better manage their conditions.

- Technology needs to be available to help patients tell their story once. Staff across the *Healthier Together* partnership need to able to access the digital information and services they need to do their job, regardless of location.

- The Community Services Contract will be delivered using a single digital solution and connectivity architecture model for all devices. The Community Services systems must be digital and adhere to cloud and mobile first principles. The aim is to optimise patient outcomes and quality of care by sharing real time information between health and social care settings, organisations and geographies, as well as between professionals and patients. The fundamental requirement is that all information will be digital, structured in appropriate coded formats and shared electronically by default.

- Efficient data management is crucial. The Provider will store data once and make it available, where appropriate, over open data sharing interfaces. A common approach to digital security will be agreed by the *Healthier Together* Digital Delivery Board and adopted by all providers to create a virtual single authentication. The Provider workforce must be able to access information from health and social care records, including access to test results, care plans, discharge information, primary care and mental health notes. They will capture information directly into digital systems as part of their workflow. Digital solutions must eliminate the requirement to enter the same information into multiple IT systems.

- The Provider will actively engage with the local health community to ensure digital capabilities are delivered and implemented in line with local and national strategy.

- The *Healthier Together Partnership* is progressing towards a population health solution. The Provider is required to support sharing of identifiable, pseudo-anonymised and de-personalised data to ensure wider population health planning, management and development of pathways.

- The Provider is expected to meet digital requirements within the NHS Standard Contract as and when they are published.

- The Provider will ensure that all staff are appropriately and regularly trained to make best use of digital technologies.

4.2 Minimum requirements from Service Commencement

4.2.1 Appropriate agreements will be in place from Service Commencement to enable safe transfer of services and allow staff to continue to deliver the service using the same systems and tools they were using the day before service transfer unless new arrangements are in place. This includes but is not limited to:

- Data Networks at all operational sites including access to HSCN
- Telephony including management of existing DDI ranges and public numbers
- Managed end user devices including desktops, printers, scanners and mobile devices
- Enabling new staff to access appropriate software, systems, networks and infrastructures
- Service desk support including upgrades and security patches and incident reporting in line with Cyber Security good practice
- Administration of smart cards
- Access to partner site networks and clinical systems where services are delivered
- Existing data shared across partners and within the service to continue uninterrupted
- General maintenance and changes to systems and operational process
- Assistive technology currently supporting patients and several pilots underway in Bristol and North Somerset, working in partnership with the council, voluntary sector, Universities and Assistive technology providers.
- Access to document management systems
- Access to Electronic Patient Health Records
- Access to Clinical systems including bed-based care
- Access to Rota management systems
- Performance reporting including access and export of data to continue performance reporting

4.3 ***Healthier Together*** **Digital Delivery Board**

4.3.1 The *Healthier Together* Sustainability and Transformation Partnership includes a Digital Delivery Board. The Chief Executive of the Provider will be a member of the *Healthier Together* Digital Delivery Board which reports into the Sponsoring Board. The Chief Executive will attend the monthly board meetings and send appropriate senior representation to the monthly digital delivery working groups.

4.3.2 Digital enablers (software, systems, infrastructure and telephony) will need to be agreed by the appropriate *Healthier Together* working groups.

4.4 **Digital transformation**

4.4.1 All functionality listed in the clauses below may not be available at Service Commencement, but where functionality is available it must be used, or developed according to the transformation plan that forms part of the Contract.

4.4.2 Interoperability

4.4.2.1 The Provider will develop and implement a robust plan to have a single consistent digital system for Community Services across Bristol, North Somerset and South Gloucestershire. The community services Incumbents and Primary Care use EMIS so any proposed solution must be fully interoperable with EMIS and have data sharing agreements in place. Community hospital beds at University Hospitals Trust use a different system (Medway). The timing of implementing transformed digital solutions will be in line with the mobilization and transformation plans that form part of the Contract.

4.4.2.2 The Provider's digital solution is required to:

- Use Open Application Programming Interfaces (API) to NHS Digital standards
- integrate with NHS-approved mobile apps and desktop applications which meet the required clinical and information governance standards
- be fully interoperable with the Bristol, North Somerset and South Gloucestershire digital care record system (Connecting Care at the time of Contract Award but subject to change)
- use NHS number as the primary patient identifier, including when transferring patient record data between services
- be interoperable with the key provider systems across Bristol, North Somerset and South Gloucestershire now and in the future. Current systems include EMIS, Medway, Adastra, Lorenzo, Liquidlogic, Connecting Care, Rio, IAPTUS

4.4.2.3 The CCG is part of the South West Local Health Care Record Exemplar Programme. The Provider is required to support this Programme through sharing patient data and enabling the data to follow the patient.

4.4.2.4 The Provider will use a single core system Patient Administration and Clinical Management System for health care records for all Community Services. The Provider's digital solution should be paper free, support multiple care pathways and allow the evolution of care pathways as new treatments become available. The CCG is willing to accept a need for very specialist services to have additional case recording systems however the core demographic and encounter information for all services should be in the core records system and link to Personal Health Record solutions (when available)

4.4.2.5 The Provider will support Personal Health Record initiatives whereby agreed care plans can incorporate information added by the patient themselves or their authorised carers

4.4.2.6 Data sharing arrangements are in place to share information from Incumbents and Primary Care providers using EMIS. Where in place, these arrangements will need to be updated and maintained.

4.4.2.7 Over the Contract term, the systems of choice across the local health community may change. The Provider may change systems over the life of the Contract, subject to a business case, where this is in line with *Healthier Together* digital strategy, agreed by the Digital Delivery Board and with the explicit agreement of the CCG.

4.4.2.8 The Provider will support the Bristol, North Somerset and South Gloucestershire integrated health and care system in holding IT suppliers to account and being clear with them about meeting legislative requirements, NHS Digital information standards, and interoperability.

4.4.3 Connecting Care

4.4.3.1 Connecting Care is a digital care record system for sharing information across Bristol, North Somerset and South Gloucestershire. It allows instant, secure access to patient health and social care records for the professionals involved in direct patient care. The Provider is required to use Connecting Care from the beginning of the Contract. The Provider is mandated to use the preferred digital care record system set out by the CCG and to share patient data with the preferred systems for the duration of the Contract.

4.4.3.2 From Service Commencement and throughout the duration of the Contract, the Provider is required to:

- be an active part of governance and member of the Connecting Care board, management group, information governance group or any other relevant group as specified by the CCG
- contribute to Bristol, North Somerset and South Gloucestershire digital care record costs. At the time of procurement these were £213,000 per year.
- sign-up to the current Data Sharing Agreement on Connecting Care
- adhere to all conditions of the NHS Standard Contract, including those relating to the use of information and IT systems
- ensure real-time data sharing of all key patient data, including but not limited to NHS number, patient records, care plans, medications, appointments, key workers, discharge letters and advice, all appropriate data fields to support the triage and management of patients, diagnostic coding (SNOMED CT across records)
- ensure the data can be shared in full, to support population health and service design directly into the CCG preferred provider
- ensure the appropriate workforce have access to eRedbook and maintain data entry into the current (EMIS) template that is common across Bristol, North Somerset and South Gloucestershire in line with whatever standards the CCG specifies
- enable the appropriate workforce to access the Bristol, North Somerset and South Gloucestershire care record from any location.

4.4.4 Optimisation

4.4.4.1 The Provider's digital solution is required to enable:

- patient flow to be tracked digitally in real time across all departments and sites, including bed-based care, to identify bottlenecks and delays
- share capacity information across the health and social care system in real time
- track and register the location of key clinical assets such as medical equipment, devices and prostheses, throughout Community Services (all sites, buildings, departments, wards)
- management of workforce rostering throughout Community Services
- management of community bed capacity
- management and co-ordination of patient pathways across multiple organisations and sectors
- integration of records using an appropriate structure

4.4.4.2 The Provider's digital solution will:

- ensure clinicians and patients can communicate with each other using a shared digital record that is be easily accessed by patients and clinicians alike, using mobile technology
- ensure all clinical communication is secure, encrypted in line with NHS Digital standards
- allow patients to have remote/virtual clinical consultations and receive clinical advice using tools such as online meetings, videoconferencing, email or instant messaging
- enable health and care professionals to contribute remotely to discussions about patient care with colleagues outside Community Services using tools such as online meetings, videoconferencing and e-mail
- use Careflow, a messaging tool the CCG has agreed to pilot as a single clinical messaging tool for all providers, as part of the Universities Hospital Global Digital Exemplar Programme. The Provider will support the use of the tool within their teams to link up Primary Care, community, social care and acute teams. The tool will also be used to link multidisciplinary team based around the local Primary Care team to enable fast interaction between the GP, locality team (including community and social care teams) and acute teams. This includes task management and tracking, requests and referrals, instant messaging, structure handover, image capture outside of device, link local patient index and link local clinical workflows
- provide access to the community patient record for all appropriate workforce assessing, managing or supporting patients including mobile access when working from any location
- enable staff to make contemporaneous notes and update records in real-time

4.4.4.3 Regarding assistive technology, the Provider's digital solution must:

- enable the use of assistive technology to remotely monitor patients in specific cohorts, including those who have been discharged home but are at high risk of readmission
- support self-care, independence and social participation
- allow uploading of verified data from monitoring devices into patient records or charts automatically, avoiding the need for manual recording
- allow patient data from assistive technology to be shared with *Healthier Together* partners through open APIs and Bristol, North Somerset and South Gloucestershire digital care record system and Patient Health Record systems

4.4.4.4 Regarding appointment booking, the Provider's digital solution will enable professionals to electronically refer and book patients directly into appointments, including but not limited to professionals from Community Services, 999, acute, Primary Care, integrated urgent care clinical assessment service, social care, voluntary services and mental health. There should be a single point of access for Community Services to directly book all appointments.

4.4.4.5 In terms of self-care support, the Provider's digital solution will enable patients, subject to authentication as appropriate, to:

- view, change and cancel their own appointments
- self-assess their care requirements using locally agreed assessment criteria and evidence from other sources, such as approved applications.
- make decisions about their self-management based on their self-assessment, set goals and make plans for self-care based on their self-assessment.
- register for local initiatives for self-management
- refer themselves to a community service where appropriate and receive an acknowledgement that the referral has been received.
- view and download information from their digital care record
- hold personal information about themselves

4.4.4.6 Regarding referrals into Community Services, including a single point of access, the Provider is required to receive electronic referrals directly into the clinical management system and have the capability to:

- provide each referral and case type in the queue with a priority code based on clinical urgency and the skillset required to manage the case
- prioritise referrals based on need, time of referral and type of referral
- enable direct electronic booking and referrals across all community services, without the need to make a call.
- provide decision support tools for clinical triage by both clinical and non-clinical workforce
- enable clinicians to access the referral queues and triage patients remotely

4.4.4.7 The Provider's digital solution will support requests for advice from the Integrated Urgent Care Clinical Assessment Service, assessment for domiciliary care and make and record clinical assessments.

4.4.5 Treatment and management

4.4.5.1 The Requirements for digital solutions to support treatment and management are set out here. The Provider will be committed to digital solutions and supporting infrastructures that support fully integrated community based health care including multidisciplinary teams working across primary care and hospital sites

4.4.5.2 The Provider will be committed to digital solutions and supporting infrastructures that support virtual clinic sessions, decision support and solutions that support artificial intelligence

4.4.5.3 The Provider will be committed to digital solutions and supporting infrastructures that support providing care to people in their own homes as alternatives to hospitalisation including self care for patients with long term conditions, mobile apps, interoperability, mobile monitoring devices and use of connected homes technologies

4.4.5.4 The Provider will support the national target of 2020, where every patient with a long-term condition will have access to their health record through the Summary Care Record accessed via the NHS App.

4.4.5.5 The Provider will be committed to digital solutions and supporting infrastructures that support care for people living in care homes including wearable devices.

4.4.5.6 Investigations and diagnostic tests must be requested through a digital order system, created in a structured format and held as part of the patient's electronic health record including bloods and x-rays. Test results must return to the requesting clinician and any person that the patient has identified to be notified.

4.4.5.7 Patient consultations that professionals request from other clinical colleagues or specialties must be ordered digitally. Digital orders must be pre-populated with information already collected at the point of care so professionals do not have re-enter the same information.

4.4.5.8 Healthcare professionals must be able to track the status of requests at all times, including receipt, authorisation, scheduling and completion. Requests received by diagnostic services must be automatically integrated into digital workflows to enable booking, triaging or scheduling. Professionals should have digital access to all relevant diagnostic test results and images for patients under their care, including those undertaken by other providers at the point of care. Professionals should be automatically alerted of all results that require acknowledgement. An audit trail should exist to demonstrate the acknowledgement process and actions taken. Professionals should also have access to electronic prescribing.

4.4.5.9 Digital results must be held in a structured format to enable clinical decision support and data extraction.

4.4.5.10 All diagnostics, clinical assessments, treatments and personalised care plans must be recorded as structured coded data.

4.4.5.11 Healthcare professionals are required to receive digital alerts about patient preferences and specific patient risks; to alert healthcare professionals of patients whose clinical observations, or early warning scores, are deteriorating and need review; to prompt automatically for the next action required by multi-step care plans, pathways and protocols; to prompt to complete or remind patients about overdue care actions and/or missing information; to indicate patients who are ready for discharge to a different setting; to direct staff to relevant and evidence-based reference material as part of digital clinical workflows and care pathways and to alert professionals outside the organisation to relevant operational information about their patients.

4.4.5.12 The Provider's digital solution must monitor the overruling of alerts and the reasons recorded, work with healthcare professionals to refine decision support rules where appropriate and support patient discharge and multidisciplinary discharge planning

4.4.5.13 The Provider's digital solution must ensure that referrals are automatically integrated into digital workflows to enable viewing, triaging and scheduling of appointments and investigations. Patient information relating to handovers of care should be shared digitally. For example, at patient discharge, care summaries must be shared digitally with GPs and other local professionals.

4.4.5.14 New care summaries must be created in a consistent structured digital format across Community Services, generated in real time and shared digitally with other relevant care providers as soon as completed

4.4.5.15 The Provider's digital solution must enable direct booking and referrals across all community services, without the need to make a call. This may include, but need not be limited to social care, urgent equipment to avoid hospital admission, acute referral for consultant lead out-patient clinics, mental health, patient's own GP, admission to community bed-based service, care homes, urgent treatment centre, Primary Care extended hubs, end of life services, Third Sector services.

4.4.6 Local Health and Care Records

4.4.6.1 The move towards integrated models of care in which health and care services are more closely organised around the person is a key feature of the long term plan and the Integrated Care Systems emerging across the country. Such integration depends on timely access to a complete view of patients' records from all of the health and care services they use (the 'longitudinal' record). Local Health and Care Records will provide the underlying technology required to do this efficiently and effectively across local health systems. By enabling a longitudinal data capability, Local Health and Care Records will also provide an opportunity to analyse that data at scale to support a shift from reactive to proactive models of care that improve healthcare outcomes across a population and guide long-term planning decisions.

4.4.6.2 The CCG and partners are part of the South West Local Health and Care Record that will eventually link with other Local Health and Care Records across the country and our community service provider will commit to supporting the programme and sharing patient records, data and meeting national standards.

4.4.6.3 The South West Local Health and Care Record will support the key programmes including continued sharing of records with the local patient record 'Connecting Care'. Ultimately, the Local Health and Care Record programme has the aim of achieving a situation where people across the whole of England can have confidence that the health and care professionals that they interact with have near real-time access to the information that they need, regardless of where it was captured, to help them make the best decisions about their care. A consolidated longitudinal care record will be created that has been normalised (linked, standardised and also reduplicated and cleansed) to standard coding terminologies, comprising the pertinent individual level information they need to inform their care decisions, fed from local systems and with links to the other Local Health and Care Record localities. Health and care professionals within multiple care settings can, at the point of care, use data acquired and accessed from a persistence layer within the core architecture.

4.4.6.4 Access to the data should be provided by single, sign-on, in context launch. Where data is to be integrated into clinical systems, this should be retrieved via FHIR-based interface. Health and care professionals within multiple care settings will be able to view at the point of care data a consolidated view of medications, observations, test results and appointments for the individual receiving treatment.

4.4.6.5 The Provider will support the required sharing of information into the longitudinal record. A longitudinal record is expected to address the following common core datasets demographics, examinations, care plans, procedures, assessments, diagnoses, allergies, investigations, correspondence, problems, medication, end of life plans, social care, link to genomic reports.

4.4.6.6 Key system requirements relating to Local Health and Care Records for the Provider include:

- implement the CareConnect specifications (amongst others) for messaging as published by NHS Digital though InterOpen. This will be in line with the Open APIs capability definition and using APIs using TLS, OAuth2 based authorisation service
- achieve primary capture and subsequent bidirectional interoperation of problem, investigation, treatment and medications lists between hospital, primary and social care, encoded as SNOMED - as per the CCIO7. Some guidance included below:
- the full standard is at: https://digital.nhs.uk/data-andinformation/information-standards/information-standards-anddata-collections-including-extractions/publications-andnotifications/standards-and-collections/scci0034-snomed-ct
- primary capture and subsequent bidirectional interoperation of medications between hospital, primary and social care (as per the CCIO7 'structured medications'
- integrate with the National Record Locator Service (NRLS) in line with the capability definition for Record Location. NRLS will deliver the retrieval of patient records in both structured and unstructured formats by connecting to Localities and Shared Care Record initiatives and will use CareConnect APIs where they exist to facilitate a standards-based approach whilst helping to facilitate integrating care.
- use of Events Management Services to proactively notify events occurring across Localities. In this way the Events Management Service will be used to notify a set of agreed events occurring across Localities e.g. A&E discharge summary generated and the Record Locator for the location of records for unknown events
- utilise the nationally delivered component which is deployed locally for the de-identification, re-identification and retokenisation of data
- maintain a LOCALITY record locator index to enable record discovery across local footprint
- a capability to allow events to be published into an event management service, which routes the event notification to other interested parties across the health and social care system

- a capability for patients to select, from a range of PHR products, the one that best meets their needs and circumstances that they can use to manage their online relationship and the personalisation of care. Specific capabilities include input of data by patients, access to test results, managing care plans and care preferences, and subscribing to receive alerts.
- must support the incorporation of reference data. Must support at least the following reference data: ODS SDS
- adoption of Information Standard Notices (ISNs) to effect adoption of specific information standards across the service
- support the checking of data quality and other rules based checks on the data
- services required to support, as per ICO guidelines for DEidentification, the ability to remove potentially patient identifiable information from a patient's clinical record so that it can be used for secondary purposes.
- a capability for patients to define their care preferences and information sharing consents, and for professionals to manage preferences and consents on their behalf

4.5 Digital readiness

4.5.1 The Provider is required to have a clearly defined digital strategy which is aligned to clinical, operational and corporate objectives. Implementation of the digital strategy must be fully aligned to, and supported by, a service transformation programme(s). The Provider must have effective processes in place to prioritise investment in digital technology and support ideas through to implementation based on the agreed plan. Digital technology should be used to support improved collaboration and coordination across Community Services.

4.5.2 The Provider's senior leadership, such as the Board, must own the digital strategy and receive regular updates about progress. The team leading the implementation of the Provider's digital transformation plans must include an accountable board-level sponsor. The Provider should also evidence strong clinical leadership through a nominated Chief Clinical Information Officer, Chief Nursing Information Officer or equivalent. This person should have adequate protected time as part of their job plan to undertake the requirements of the role.

4.5.3 The Provider's Board-led digital programme(s) must be supported by effective operational IT delivery and assurances. Project and programme boards should follow standard project management methodologies, ensuring effective allocation of roles and responsibility. Digital projects should be underpinned by valid business cases and fully-engaged business owners.

4.5.4 The Provider is required to monitor emerging digital technologies, using regular horizon scanning to keep the digital strategy up to date. The Provider is required to routinely adopt principles outlined in best practice guidelines relating to digital services.

4.5.5 The Provider is required to routinely evaluate the benefits of digital projects using a consistent approach.

4.5.6 The Provider should have financial plans in place for investment in digital technology to deliver the digital strategy.

4.5.7 The Provider will:

- have the buying, contracting, and supplier management capability and expertise it needs to manage technology suppliers
- undertake quantitative and qualitative benefits identification in conjunction with commercial suppliers
- ensure adequate resources are available for technology implementation and change management
- have a clinical safety officer or equivalent and routinely undertake assessment of clinical safety and risk for all digital projects

4.5.8	The Provider is required to commit to supporting digital pilots in line with the priorities of *Healthier Together*.
4.5.9	Information governance and cyber security
4.5.10.1	The Provider is required to be registered for use of the Data Security and Protection Toolkit or to clearly set out a timeline agreed by the CCG for doing so.
4.5.10.2	The Provider must have a strategy for active identification, monitoring and review of cyber security risks. The Board or equivalent should have regular assurance that the organisation's key information is being properly managed and is safe from cyber threats. The Board or equivalent should also receive regular assurance the workforce understands and follows the organisation's information governance policies and processes. The Board or equivalent should receive assurance on a regular basis that suppliers and digital assets are secure, including penetration testing and patching.
4.5.10	The CCG requires the Provider to have robust due diligence mechanisms in place to ensure all third parties comply with the law and central guidance and provide sufficient guarantees that personal data is handled safely and protected from unauthorised access, accidental loss, damage and destruction. Information governance requirements must be articulated in third party contracts and monitored on an ongoing basis. The Community Services Provider will have a programme to develop and maintain digital skills across the workforce so staff can make effective use of digital tools and mobile access to allow health and care workers to work more flexibly
4.5.11	Enabling infrastructure
4.5.12.1	The Provider must ensure that an appropriate digital solution is in place prior to commencement of the Contract. This includes all of the hardware, software, networking, training, documentation, support and maintenance necessary to deliver Community Services on day one, any data migration required and plans for any harmonisation of systems required.
4.5.12.2	From day one, IT Infrastructure support, maintenance, refreshment and management to IT Infrastructure Library standards should be in place, under service level agreements or contracts, to ensure system availability and performance for both voice and data services. All related aspects of the IT system, including any outsourced or remote components such as data hubs or data warehouses are required to be covered by support arrangements to ensure the full operational service is not affected and can be delivered 24 hours a day, seven days a week as required.
4.5.12.3	Digital services must be supported by an IT support service desk that prioritises incidents using a consistent approach. The IT support service desk is required to follow an IT Infrastructure Library-aligned or equivalent incident management process that lets users track issues through to resolution. The support service desk should be available during the contracted hours of Community Services.
4.5.12.4	The Provider is required to have systems in place so staff across Community Services can have technical and user issues resolved and prioritised, with specified time frames. Critical software, systems, infrastructure that impact the ability of staff to deliver the services must have 30 minute response times, with the ability to resolve immediately. Systems should be monitored and managed for early identification of failure.
4.5.12.5	The Provider's system infrastructure must: • demonstrate IT Infrastructure Library maturity levels or equivalent • have robust systems in place to monitor infrastructure and ensure full operation can be maintained, with back-up of service data in real time • have a technical solution which is able to meet peak service demands to ensure bandwidth and capacity without slowing the system or operational process down • have the ability to scale with future demand, up to and beyond predicted activity levels

4.5.12.6 The Provider's network will support health and social care partners across *Healthier Together* to work from the Provider's sites and enable the devices of the workforce from partner organisations (desktops, laptops and tablets) to access local facilities such as printers and their own networks, without the requirement for separate logins.

4.5.12.7 The Provider is required to have in place technical architecture and topology diagrams for the system and provide detailed monthly information management and technology and telephony system service management reports in accordance with IT Infrastructure Library or equivalent best practice containing the following as a minimum:

- system availability reports
- system capacity reports
- planned system maintenance (including software updates)
- system incident reports
- system change control reports
- system failure test reports

4.5.12.8 The Provider's system infrastructure must include:

- a single connectivity model for all devices
- connection to HSCN
- secure Wi-Fi connectivity for healthcare professionals across all operational bases

4.5.12.9 The Provider will be responsible for the provision, maintenance and cost of all information management and technology hardware, network, software, licenses and IT support services to meet the needs of this Service. Information management and technology provision must meet local and national standards and support interoperability for the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership and appropriate integration to national / regional systems.

4.5.12.10 The Provider is required to meet the recommended ideal warrantied specifications for hardware provision for all systems being run.

4.5.12.11 The workforce should have single sign-on access and authentication to clinical applications using smart cards or and agreed local process. When accessing other provider's systems, context launching should be available. System(s) should connect with the NHS Spine and National Applications. All patients must be matched against the Spine in real time.

4.5.12.12 The Provider is required to have a robust 365 days a year smart card issuing and resetting service in place during operational hours.

4.5.12 Telephone system

4.5.13.1 The Provider is required to use a single automated caller distribution system across all services to queue calls that cannot be delivered directly, report on performance in real time and enable Interactive Voice Response (IVR).

4.5.13.2 To facilitate remote working the Provider is required to securely extend the contact centre telephony and desktop in such a way as to emulate the contact centre experience. This solution must utilise HSCN circuits where available with any traffic over the public internet being encrypted using appropriate levels of encryption. To achieve this requirement an accredited VPN token authenticated solution should be used.

4.5.13 Asset registers

4.5.14.1 The Provider will ensure that the CCG has a full and up to date inventory list of all information management and technology assets quarterly for the first year and six monthly thereafter. The inventory will specify both hardware and software assets, and stand alone or components of a central system including but not limited to purchase date, scheduled renewal date, asset number, name of product and quantity.

4.5.14.2	Software (including operating systems) used on infrastructure must be approved and recorded on a software asset and license register that confirms it is appropriately licensed for use.
4.5.14	Business continuity plans / disaster recovery
4.5.15.1	The Provider must ensure that comprehensive business-critical digital services are supported by documented disaster recovery processes, schedules, with clear roles and responsibilities assigned. Comprehensive, detailed methods and procedures must be in place that will be followed in the event of service failure.
4.5.15.2	Disaster recovery processes must be tested and audited at least yearly. The Provider must provide evidence of previous tests and lessons learnt regardless of the outcome. Disaster recovery test schedules must also be provided.
4.5.15.3	Business-critical digital services must be supported by IT infrastructure with multi-site redundancy so normal operations are maintained in the event of an outage at any location as resilience is 'built in' to the technical infrastructure. There should be no single points of failure.
4.5.15	Access to the National Directory of Services: The Community Services workforce must have access to search the NHS Pathways Directory of Services interface providing real time information about services and clinicians across all care settings that are available to support a patient as close to a patient's home as possible. The Provider will work with the Directory of Services team to ensure all Community Services are included on the Directory of Services and updated to reflect any changes to services.

5.	**Workforce specification**
5.1	The Provider is required to develop a workforce that is competent, confident and comfortable operating within a whole system approach that prioritises integrated working. This will necessitate a step-change in organisational culture and design and the approach to the management and supervision of the workforce in order to build relationships with service users, Primary Care referrers and the CCG.
5.2	Robust integrated governance arrangements must be in place to ensure the workforce is of sufficient size, with appropriate skills, to have the capacity and capability to meet the range of services effectively and efficiently. A workforce plan, agreed by the Provider Board, should detail how sufficient staff will be recruited, retained and developed, including provision of clinical, operational and digital training. There must be clearly defined structures of accountability within the structure and proposed workforce models.
5.3	In the context of local workforce shortages, the Provider must demonstrate a commitment to work collaboratively with other health and social care providers in the recruitment and development of staff, and to engage with the *Healthier Together* workforce programmes to increase the supply pipeline.
5.4	It will be a condition precedent to the Contract that the Provider will give, or procure that any of its Subcontractors give, appropriate employment indemnities. For the avoidance of doubt the CCG will not offer any employment indemnities to the Provider.
5.5	The Provider is required to comply with the terms of the NHS Standard Contract regarding workforce, including terms regarding sufficiency, competence and supervision of staff, employment checks, equal opportunities, and workforce and human resource (HR) policies.

5.6 The Provider will be required to comply whenever applicable with the New Fair Deal for Staff Pensions (HM Treasury) and to be aware of the Principles of Good Employment Practice (Cabinet Office).

5.7 The Provider is required to participate in any agreed processes to passport training or recruitment checks in respect of staff being recruited from other Bristol, North Somerset and South Gloucestershire organisations if this has been endorsed by the *Healthier Together* , whilst still having responsibility for ensuring that new recruits have undertaken appropriate checks and training. The Provider must ensure that all recruitment practices meet the requirements mandated by the six NHS Employment Checks Standards.

5.8 The Provider shall be a member of the *Healthier Together* Redeployment Protocol or equivalent and play an active role in supporting smooth redeployment of "at risk" individuals within the system to avoid redundancies where possible and provide savings in public money whilst helping to bridge any skills or capacity gaps.

5.9 TUPE

5.9.1 The CCG is required to adhere to the Cabinet Office Statement on Staff Transfers in the Public Sector ("COSOP").

5.9.2 It is up to the Provider to assess the likely impact of the Transfer of Undertakings (Protection of Employment) Regulations 2006 ('TUPE') and to take account of the application of TUPE. This includes identifying any cost implications and setting out details for the future employment of transferring staff.

5.9.3 For the avoidance of doubt, the CCG gives no warranty of any kind regarding the extent to which TUPE applies, if at all, to the staff identified in the information provided by Incumbents or to the accuracy or completeness of such information. It will give no indemnity of any kind regarding any liabilities, payments or costs whatsoever which may be associated with any transfer or alleged transfer of staff from Incumbents under TUPE in connection with this Contract.

5.9.4 The Provider must ensure that any staff who access the NHS Pension Scheme are be able to retain access to the Scheme following any transfer under TUPE or COSOP as required under the provisions of the New Fair Deal for Staff Pensions.

5.10 Workforce policies

5.10.1 The Provider must ensure workforce policies, strategies, processes and practices comply with all relevant employment legislation applicable in the UK, any relevant NHS specific guidance including the provisions outlined in (and any future iterations to these documents or successor guidance):

- Safer Recruitment – A Guide for NHS Employers (May 2005)
- NHS Employment Check Standards (updated July 2013)
- NHS Standard Contract GC5.12

5.10.2 The Provider must ensure that good employment practice is adhered to in order to provide assurance of qualified staff, supervision, performance management, appraisal and personal development.

5.10.3 The Provider is required to ensure that all staffing incidents are dealt with in a timely fashion, following organisational policies and procedures and ensuring appropriate staff engagement.

5.10.4 The Provider must put in place sustainable workforce practices and measure, monitor and report on sustainability annually.

5.11 Education and training

5.11.1 The Provider's workforce will be trained to an appropriate standard to deliver Community Services as defined in the Contract, with updates at appropriate intervals and in accordance with Department of Health and all legal requirements.

5.11.2 All personnel (whether directly employed, subcontracted or volunteer) must receive and maintain appropriate training prior to undertaking their duties and must comply with current legislation and any other laws or requirements that apply to the operation of adult Community Services.

5.11.3 The Provider shall comply with all clauses of the NHS Standard Contract General Condition, (GC5) relating to staff recruitment and training, including safeguarding.

5.11.4 The Provider is required to work collaboratively with *Healthier Together* partners to implement a cohesive strategy for staff education and training, aligned with the *Healthier Together* Workforce Strategy, through membership of the Workforce Transformation Steering Group and participation in any relevant *Healthier Together* programmes.

5.11.5 Personnel providing care or support in patient homes must be trained and competent in, as a minimum first aid awareness, basic life support, conduct and attitude awareness training for staff working with patients, using equipment provided to them or present in patients' homes.

5.12 Strategic alignment

5.12.1 The Provider is required to have a clearly defined organisational development and workforce strategy and organisational training plan which is aligned to delivery of the Community Services Contract and *Healthier Together* workforce strategy, including digital skills training.

5.12.2 Implementation of the organisational development and workforce strategy must be fully aligned to the organisational culture and design of the Provider and supported by a service transformation programme(s).

5.12.3 *Healthier Together* includes a Workforce Transformation Steering Group leading workforce transformation across Bristol, North Somerset and South Gloucestershire. The Workforce Transformation Steering Group includes human resources directors from local acute, mental health and community providers, together with commissioners. The Community Services Provider will be part of this group or any similar group that emerges over the life of the Contract. The Workforce Transformation Steering Group has developed a 10-year workforce vision which currently includes:

- working together to maximise the potential benefit for the population, patients, workforce and the system
- workforce planning to ensure sufficient staff with the right skills delivering care in the right place, both now and in the future
- collaborative training and development providing consistent, quality training at scale through a Learning Academy
- Primary Care workforce development through multidisciplinary team working at locality/cluster level to reduce the burden on GPs
- joined up health and social care workforce to improve career pathways, reduce vacancies and integrate services
- collaborative temporary staffing, training and support functions offering flexible, cost-effective workforce options

5.12.4 The *Healthier Together* workforce programme has undertaken a baseline assessment, which indicates that the CCG geography has the highest employment rate of any of the eight "core cities" in the country, combined with the highest average house price. This means that it is harder to recruit and retain in Bristol, North Somerset and South Gloucestershire than in other areas because there are fewer potential staff available.

Recognising this gap between workforce demand and supply, three strategic workforce goals are the priority over the next two years, which the Provider is expected to work towards:

- Goal 1: A sustainable pipeline of highly skilled, motivated and flexible entry-level health and social care workers, recruited and developed at scale and across providers
- Goal 2: Sizeable expansion of the numbers of Band 5 registered clinicians both in post and in the pipeline
- Goal 3: Significant increased capability and capacity in Advanced Practice skills

5.12.5 There are a number of work programmes in place to deliver these goals, which include the development of an agreed career framework across Bristol, North Somerset and South Gloucestershire to support recruitment and retention and a schools project to increase the supply pipeline at all levels. The health and social care community is also collaborating on the delivery of education, training, leadership development and talent management, and has developed a track record in the joint procurement of apprenticeships. The Provider will be a key partner in this work.

5.12.6 The Provider is required to have a clear workforce plan, aligned with the *Healthier Together* workforce plan, which demonstrates how the workforce challenges of recruitment and retention will be addressed. The plan must include effective processes to prioritise investment in the workforce to support transformation. Workforce models must be developed to support improved collaboration and coordination across different parts of Community Services and the wider system.

5.12.7 The Provider's Board or equivalent must endorse both the organisational development and workforce strategy and workforce plan and receive regular updates regarding implementation. The team leading the organisational development and workforce strategy and workforce plan should include a board-level sponsor. The Provider must evidence strong strategic and management leadership through a nominated organisational development and workforce lead or equivalent

5.12.8 The Provider is required to participate in wider health and care community workforce initiatives through active engagement in the design and delivery of the *Healthier Together* workforce programme.

5.13 Resourcing

5.13.1 The Provider is required to have financial plans in place for investment in organisational development and workforce over the life of the Contract.

5.13.2 The Provider must:

- have capacity to provide appropriate human resources and workforce support
- report to the Board or equivalent on a regular basis about progress in implementing the workforce plan, including establishment levels, recruitment, sickness, turnover, vacancies including a breakdown by key staff groups, training and service delivery
- provide data to *Healthier Together* as requested to populate the human resources metrics dashboard to enable system wide monitoring
- participate in other *Healthier Together* data gathering exercises to support workforce planning and development

5.13.3 Organisational development and workforce developments or training must be underpinned by business cases that show a defined return on investment in respect to improvements in the quality and productivity of services.

5.13.4 The Provider must have effective engagement and communication mechanisms with staff, including opportunities for engagement with staff side representatives. The Provider must

participate in the Healthier Together Staff Engagement forum and undertake regular surveys and engagement activities to monitor staff morale and engagement and acts on the results of such feedback.

6. Estates specification

6.1 The CCG wants delivery of services to be more mobile, flexible and distributed across the CCG geographic area, The Provider is required to maximise the utilisation of available space (minimum of 70% utilisation increasing to 75% by 2024) or providing opportunities for rationalisation, created by services being more mobile or new ways of working being put in place.

6.2 Specifications IACS0001, IACS0002, IACS0003 and IACS0004 require management and operation of the following specified premises from Service Commencement:

Urgent care centres / minor injuries / walk in

South Bristol Community Hospital - South Bristol Urgent Care Centre
Yate West Gate Centre - Minor Injury Unit
Clevedon Community Hospital - Clevedon Minor Injury Unit
Broadmead Shopping Centre - Walk In Centre

Community beds (subject to change)

Clevedon Community Hospital
Grace Nursing Home
Skylark Rehabilitation Unit, the Meadows Care Home
South Bristol Community Hospital (to be subcontracted back to Incumbent for year one of the Contract)

6.3 South Bristol Community Hospital has facilities management services provided by University Hospital NHS Foundation Trust. The Provider will enter into a Service Level Agreement for these facilities management services.

6.4 The Provider will be responsible for some facilities management services within Clevedon Community Hospital. Were provided by a third party, the Provider will be required to enter into a Service Level Agreement for these facilities management services.

6.5 Diagnostic services that support delivery of the service are currently commissioned from acute hospitals. The Provider will need to ensure that Service Level Agreements are in place to continue to access these services and ensure that the opening hours align with any changes to Community Services.

6.6 Optimisation

6.6.1 There are a significant number of patient paper records (live and live archive) stored across the estate or off site using other storage arrangements. The Provider will inform the CCG where these records are located, ensuring these solutions represent value for money and meet the appropriate NHS information governance standards including record management guidelines. The CCG will accept no liability or price changes for inaccuracy or lack of proper due diligence on the part of Provider

6.6.2 Occupation of space in NHS buildings, including any tenant responsibilities, must be documented through a standard formal lease or licence between the landlord and the Provider, which the Provider will need to work with the respective landlords to put in place within six months of Contract Award.

6.6.3 Occupation of other space must be agreed with the individual landlords / organisations and documented through a standard formal lease or licence between the landlord and provider,

such that it provides security of tenure for the duration of the Community Services Contract.

6.6.4 All occupational arrangements must afford a degree of flexibility (including appropriate break clauses) to enable the model of care and service delivery to flex to meet the needs of the local health community and accommodate service transformation. The Provider should discuss any arrangements regarding break clauses with the CCG prior to entering into a formal arrangement.

6.6.5 The Provider is responsible for all estates-related costs including but not limited to setting up and running. The CCG will accept no liability or price changes for inaccuracy or lack of proper due diligence on the part of the Provider.

6.6.6 The proposed estates footprint will be discussed with Provider during the lifetime of the contract to ensure alignment with the CCG's overall strategic direction of travel. Any specific estates investment in service development during the Contract term (e.g. locality hub) would be discussed and agreed on a case by case basis and varied into the Contract net of any savings through exiting existing properties.

6.6.7 The Contract envelope has been calculated including estates costs on a like-for-like occupation basis. The CCG reserves the right to make a financial adjustment in respect of the costs associated with any premises that the Provider chooses not to occupy at the start of the Contract and/or de-occupies during the life of the Contract as directed by the CCG, where the CCG is left with a continuing financial liability.

6.6.8 To encourage the utilisation of the estate during the life of the Contract, the CCG will allow the Provider to retain the estate costs for any estate the Provider declares surplus to requirements for a 12-month period (unless the CCG has directed the Provider vacates). At the end of this period the CCG reserves the right to make a financial adjustment in respect of the estate costs, based on the annual costs associated with the occupation of that estate at the end of the 12-month period.

6.6.9 The CCG shall not provide any warranty or guarantee relating to the suitability or condition of the premises. Bidders are required to liaise directly with the landlord of the premises relating to their use and occupation of any premises and to comply with the provisions of the Contract in regard to suitability, including statutory and regularity compliance.

6.6.10 The Provider should ensure that where they are directly responsible for buildings they comply with all statutory and regularity obligations.

6.6.11 The Provider must put in place sustainable estates and workforce practices and measure, monitor and report on sustainability annually.

6.6.12 The Provider will be required to deliver to the CCG in writing annually a report on the estate occupied by the Provider to deliver adult Community Services, including a full list of premises, services provided from those premises, utilisation, a schedule of condition and, if necessary, where it is the Provider's responsibility, a maintenance plan to keep the Premises in the required state of repair.

6.6.13 The Provider must develop business continuity plans to implement if building(s) are unavailable for use for key services e.g. failure of plant or utilities.

6.6.14 In line with the CCG's vision for integration, the Provider must actively promote and permit Third Sector and not for personal profit groups or any other system partner to use any part of the Community Services estate within their control that is not being fully utilised for the provision of Contracted Community Services. The Provider will be funded for their estate costs within the financial envelope so no charge should be made for this use without the

consent of the CCG.

6.7 Strategic alignment

6.7.1 The Provider is required to have a clearly defined estate strategy which is aligned to the priorities of *Healthier Together* and Community Services Contract. Implementation of the estate strategy should be aligned to, and supported by, a service transformation programme(s) setting out how the estate will be used to support improved collaboration and coordination across different parts of Community Services and the wider system

6.7.2 The Provider Board or equivalent must own the organisation's estate strategy and receive regular updates about progress regarding implementation. The team responsible for the organisation's estates function must include a board-level sponsor. The Provider should evidence strong strategic and management leadership through a nominated Estates and Facilities Lead or equivalent who will engage with other partners, including the CCG.

6.7.3 The Provider is required to participate in a wider health and care community estate initiatives including those within the *Healthier Together* partnership.

6.7.4 The Provider is not expected to lead on developing (building) future estate unless agreed with the CCG

6.7.5 The Provider must:

- have the buying, contracting, and supplier management capability and expertise it needs to manage estate suppliers and functions to enable delivery of services.
- undertake quantitative and qualitative benefits identification
- ensure adequate resources are available for implementation and change management
- routinely undertake assessment of clinical safety and risk for all estate projects
- have appropriate health and safety resource to routinely undertake assessments of estate related risks and provide appropriate assurances to the Board or equivalent regarding statutory compliance

6.8 Assets

6.8.1 The Provider must maintain equipment, furniture, furnishings, Transferring Assets (if applicable), Licenced Assets (if applicable) and consumables used in the delivery of the Community Services (collectively known in this section as equipment) in a fit and proper state. The equipment may include mobile and/or permanently installed equipment as well as equipment used in the maintenance and upkeep of the premises.

6.8.2 The Provider must ensure that equipment complies with statutory requirements and the latest relevant British Standard or European equivalent specification.

6.8.3 The Provider must provide, install, operate and maintain all equipment in accordance with all applicable laws and manufacturers' instructions, including doing annual PAT testing for electrical devices.

6.8.4 The Provider must ensure that equipment used to deliver adult Community Services would not cause interference with or damage to equipment used by others.

6.8.5 The Provider must ensure that equipment is fit for purpose and purchased with compatibility in mind.

6.8.6 The Provider will be expected to have in place an asset replacement programme.

6.8.7 Existing assets: any assets that the Provider receives from an Incumbent at market or nominal value are to be maintained or replaced throughout the life of the Contract, unless the CCG agrees in writing otherwise, and made available at the end of the Contract to the incoming provider on the same terms as originally received (i.e. current market or nominal value). The Provider is required to provide a full list of all existing assets used for the delivery of adult Community Services at any time within 20 working days of request. In addition, the Provider must supply an assets list quarterly in the first year and six monthly in subsequent years. In the final year of the contract lifecycle, the CCG requires quarterly submissions.

6.8.8 New assets: any assets that the Provider purchases during the life of the contract that could reasonably be expected to be purchased with funds associated with the Contract are to be maintained in good working order or replaced unless the CCG agrees in writing otherwise, and made available at the end of the Contract to the incoming provider at current market value. Any assets that are purchased with NHS capital or other funds secured by the CCG or STP or similar that the Provider uses to deliver the Contract are to be used under licence and maintained by the Provider and returned to the CCG (or other NHS body) at contract end.

6.8.9 Upon expiry or termination of the Contract, all of the rights and licences granted by the CCG in respect of any Licensed Assets shall terminate with immediate effect and the Provider shall leave the Licensed Assets in situ in the manner agreed by the parties, each acting reasonably.

7. Communications specification

7.1 General principles

7.1.1 Communications and engagement is a key component of service delivery and is instrumental to achieving the ambition of high quality Community Services. Community Services are required to be co-designed with patients and the public, responsive to the changing needs of the population and delivered by a Provider who will be a partner in developing a system-wide model of integrated care. This will require an integrated approach to communications and patient and public involvement, with the Provider, CCG and others working in partnership.

7.1.2 In line with the Requirements of NHS Identity (www.england.nhs.uk/nhsidentity/faq/how-do-we-brand-nhs-services-provided-by-a-third-party-2/), the Provider will adhere to national and local branding Requirements.

7.1.3 The CCG and the Provider will work closely to ensure the consistency and appropriateness of all communications with patients, the workforce and other stakeholders.

7.2 Communication during Mobilisation

7.2.1 The Provider is required to ring-fence an appropriate level of budget for communications and engagement activities during Mobilisation and throughout the Contract term.

7.2.2 The Provider is responsible for co-designing (with the CCG) and implementing a Communications and Engagement plan for Mobilisation, including but not limited to:

- a joint media release to launch the service
- the identification and training of media spokespeople
- a robust approach to engagement with diverse communities across Bristol, North Somerset and South Gloucestershire
- a robust approach to audience segmentation and channel management, including digital media
- inclusion of case studies, as well as significant patient and service user voice
- a robust approach to staff engagement

7.3 Communication during the Contract term

7.3.1 The Provider will at all times to work constructively with the CCG in managing media enquiries.

7.3.2 The Provider will promote Community Services to all stakeholders, including seldom heard groups, targeted communities and people who fall into the nine protected characteristics of the Equalities Act. The Provider will have systems to ensure that seldom heard groups are represented throughout their organisation, that their voices are heard and that views gathered form an integral part of the planning process.

7.3.3 The Provider will use a variety of communication approaches to support prevention and self-management and to address operational challenges such as attendance at appointments and social isolation.

7.3.4 The Provider will work collaboratively across the system with other providers and to ensure all communications and engagement reflect the *Healthier Together* vision and move towards being an Integrated Care System.

7.3.5 The Provider will have plans in place to ensure GPs are aware of and use the service - proactively engaging with all referrers; valuing staff and colleagues across the health system as a source of knowledge and ideas and regularly engaging to ensure stakeholders are involved in service design and development.

7.3.6 The Provider must follow the Accessible Information Standard, and provide evidence of compliance at quarterly meetings.

7.3.7 The Provider's public website must be up to date and comply with accessibility standards. It must incorporate the following functionality, at minimum:

- providing up-to-date information about aspects of Community Services including but not limited to: health information, local resources, pathway information, links to Third Sector programmes and advice about self-management
- patient referrals including self-referral
- booking and cancelling appointments
- decision support tools / self-assessment
- access to care records

7.3.8 The Provider will have robust structures in place to involve patients and the public in service design, governance and monitoring. This should include an engagement plan

showing engagement methods with internal and external stakeholders involved in the delivery of the services such as GPs, acute and mental health service providers as well as the public, patients, carers, families and the CCG. This engagement plan will be reviewed at quarterly meetings with the CCG.

7.3.9 The Provider will at all times be mindful of emerging best practice in engagement and consultation and NHS guidance (such as https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf) and apply these to operational planning and delivery.

7.3.10 The Provider is required to:

- allocate ongoing resources to public and patient/user engagement to ensure consistency in engagement across the CCG area
- have a strategy for patient, stakeholder and public engagement, insight and participation throughout adult Community Services in line with the aims and aspirations of the CCG
- assist the CCG to conduct any public consultation and engagement process needed in line with legal and regulatory requirements
- work with the CCG to ensure patient and public experience is captured and used to improve services, including the experience of patients transferring from children's to adult services
- use innovative methods, including digital approaches, to engage and consult people who are using services and demonstrate learning from people's feedback
- involve people in a variety of different ways, including at the strategic and corporate level of the organization
- provide case studies for the CCG and the Provider to share to help promote the benefits of Community Health Services. A case study is expected quarterly at review meetings

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

1.	The CCG's ambition is to move towards a more sophisticated system of recording activity over the course of year one of the Contract and this is a key deliverable as described in Schedule 6B (Data Quality Improvement Plan) for Year 1.
2.	For the avoidance of doubt the CCG will be using SC29 of the NHS Standard Contract to manage activity variations in the Contract.
3.	An Excel spreadsheet contains Schedule 2B historical activity. This is labelled Appendix 2, but for clarity is an integral part of the Contract and is appended only because it is an Excel spreadsheet and formatting precludes incorporation directly into this document. The spreadsheet provides detail of activity for the 2017/18 financial year unless otherwise stated. This activity information is provided in good faith based on the best information available, but previous activity was delivered based on different specifications.

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

1. The CCG's expectation is that by the end of the first full year of the contract the Provider will have established a detailed baseline level of activity as set out in Schedule 6B (Data Quality Improvement Plan) for each area of service provided. Activity will be monitored against this baseline as part of the Contract Management Process and annually the Contract will be reviewed and refreshed to include an activity plan for the forthcoming year.

2. The annual review will discuss levels of anticipated growth based on the previous financial year and planned changes in service provision. The CCG's expectation is that any annual growth in like-for-like activity of up to 5% is managed by the Provider within the current financial envelope.

3. The CCG is committed to discussing growth in activity levels of more than 5% but with the expectation that the Provider will be bring suggestions about how to cap or manage the increased demand within the current envelope rather than seek additional funding. The CCG does not intend to offer additional funding.

4. The CCG is committed to a risk / gain share approach with the Provider which will:

- review activity/expenditure against the following three metrics and discuss these with the Provider via the ICQPMG at least on a quarterly basis:
    - Admissions for ambulatory care sensitive conditions for spells with a length of stay of greater than one day. The CCG and Provider shall agree which ambulatory care sensitive conditions will be measured against within the first two months of the Contract year. The ICQPMG will make a recommendation within the first month.
    - Excess emergency bed days for those aged over 65 on the Provider caseload
    - Type 1 A&E attendances for patients over 65 years on the Provider caseload
- share agreed savings on a proportional basis between the CCG and the Provider as shown in table 1:

Table 1

Savings as proportion of baseline	**CCG share**	**Provider share**
First 2%	Retained by the CCG as deemed to be fortuitous variation	
2% to 5%	50%	50%
6% to 20%	40%	60%
Over 20%	30%	70%

- that the proportional savings achieved will be paid to the Provider annually in arrears in the agreed proportion
- the actual metrics used for the risk / gain share model may change over the Contract Term, subject to agreement between the Parties

SCHEDULE 2 – THE SERVICES

D. Essential Services (NHS Trusts only)

1. This schedule is being used to ensure that the Provider of Adult Community Health Services will be able to continue to deliver services as described below in the event of Business Continuity plans being enacted.

2. The following services are deemed by the Commissioner as Essential Services:

2.1 TIER 1:
These services are viewed as essential and are to be prioritised in terms of maintaining or enhancing service levels

- Single Point of Access
- Minor Injuries Units
- Community Nursing
- Community Hospitals
- Intermediate Care
- Respiratory Teams
- Palliative Care/End of Life Care
- Evening & Night Services

2.2 TIER 2:
These services and staffing should be maintained where possible. However, they have the potential to cease and staff redeployed to support Tier 1 services

- Diabetes Specialist
- Falls Teams
- Podiatry
- Therapies

2.3 TIER 3:
These services can potentially cease, with agreed suspension of targets, and staffing resources redeployed to support Tier 1 & Tier 2 services

- Phlebotomy
- Administration Staff

2.4 TIER 4:
Corporate functions to be preserved where possible in order to support business continuity, emergency planning and for the command and control of the incident. Clinical staff working within these areas can be re-deployed to support Tier 1 and Tier 2

- Human Resources
- Finance
- Business Planning & Performance
- Health & Safety
- Emergency Planning
- Risk Management
- Security
- Fire
- Estates Services
- Hotel Services
- IT
- Governance & Quality Team
- CEO/MD Office

SCHEDULE 2 – THE SERVICES

E. Essential Services Continuity Plan (NHS Trusts only)

1. This schedule is being used to ensure that the Provider of Adult Community Health Services will be able to continue to deliver services as described in Schedule 2D in the event of Business Continuity plans being enacted

2. The Provider will need to supply an essential services continuity plan for the services listed in Schedule 2D, if applicable. This will be inserted in to the Contract prior to Contract Award.

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

1. At minimum, the Provider is expected to participate in the following networks:

- All working groups within the South West Clinical Network http://www.swscn.org.uk/
- BNSSG Drugs and Therapeutics committee
- National Institute for Health Research Clinical Research Network https://www.nihr.ac.uk/about-us/how-we-are-managed/managing-centres/crn/
- Healthier Together workstreams

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

1. The Provider will be expected to comply with the following commissioner policies:

- Prescribe for adults in accordance with the BNSSG Joint Formulary and other relevant local prescribing guidance. https://www.bnssgformulary.nhs.uk/
- Prescribe for children (who attend urgent care settings) in accordance the BNSSG Paediatric Joint Formulary https://www.bnssgpaediatricformulary.nhs.uk/
- Exceptional Funding Requests https://bnssgccg.nhs.uk/individual-funding-requests-ifr/
- Bristol, North Somerset and South Gloucestershire Multi Agency Strategy for the Prevention and Management of Pressure Injuries https://bnssgccg.nhs.uk/library/bristol-north-somerset-and-south-gloucestershire-multi-agency-strategy-prevention-and-management-pressure-injuries/
- BNSSG CCG Urgent Care Strategy https://bnssgccg.nhs.uk/library/delivering-urgent-emergency-care/
- All standards, policies and procedures outlined in Schedule 2A of this Contract

2. BNSSG CCG expects the Provider to comply with other Local Agreements, Policies and Procedures that are developed over the life of the Contract, and these will be varied into the Contract in accordance with GC13.

*** i.e. details of and/or web links to local agreement, policy or procedure as at date of Contract. Subsequent changes to those agreements, policies or procedures, or the incorporation of new ones, must be agreed between the Parties.**

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

1. **The Provider will submit a mobilisation plan as part of its bid. The full mobilisation plan will be inserted into the Contract prior to Contract Award, following any refinements agreed with the Commissioner.**

2. Defined Term(s)

2.1 "**Mobilisation Plan**" the Provider's plan for achieving readiness for delivery of the Services from the Service Commencement Date and for achieving the Local Quality Requirements by transforming the delivery of the Services, applicable over the Contract Term per Part A of Schedule 5 (Documents Relied on) and as submitted by the Provider with its bid response and finalised between the Provider and the Commissioner to reflect the agreed mobilisation tasks.

2.2 "**Mobilisation Period**" means the term from Contract Award or Heads of Term Agreement to 31 March 2020.

2.3 "**Transfer Agreement**" means the transfer agreement agreed between the Incumbent Providers and the Provider relating to the transfer of Transferred Assets, and novation of contracts and any other matter they consider appropriate and necessary.

2.4 "**Transferred Assets**" means those assets that shall transfer from the Incumbent Providers to the Provider via a Transfer Agreement.

3. All set up / mobilisation costs shall be achieved by the Provider within the Contract Price and any additional set up costs shall be borne solely by the Provider. After the first year of the Contract, any remaining financial amount budgeted for set up costs in the baseline shall be used to further the quality and performance of service delivery.

4. The Provider shall mobilise during the Mobilisation Period ready for the Service Commencement Date. During the Mobilisation Period and for a period of at least six months after the Service Commencement Date, the Provider shall co-operate and fully engage with the Incumbent Providers and the Commissioner to ensure a smooth transfer of the Services from the Incumbent Providers to the Provider, including but not limited to attendance and active participation at pre-planned series of management meetings.

5. During the Mobilisation Period and for a reasonable period as requested by the Commissioner following the Mobilisation Period, the Provider shall, with the reasonable support and facilitation of the Commissioner, implement the Mobilisation Plan as referred to in the Documents Relied On.

6. The Provider shall be required to:

6.1 Implement the Mobilisation Plan in accordance with its provisions which shall include:

- Agreement of a Communication Plan with the Commissioner by 30 September 2019;
- Agreement of a final Quality Schedule by 31 October 2019. For avoidance of doubt this is with regards to where the method of measurement needs to be agreed for sections 2.1 (NHS Outcome Framework domains and indicators) and 2.2 (Service Specifications – Integrated Locality Teams, Specialist Advice and Support, Acute and Reactive Care and Locality Hubs), not the quality requirements themselves;
- Agreement of a final Service Development and Improvement Plan 2020/21 by 2 January 2020, such plan to include the Equality Impact Assessment Action Plan as an annex;
- Agreement of the final Transfer Plan by 2 January 2020;
- Agreement of the reporting method and format of financial sustainability metrics as described in Schedule 6A by 2 January 2020
- Agreement of a final Data Quality Improvement Plan by 1 February 2020;
- Agreement of documentation, roles and responsibilities and reporting requirements for Personal Health Budgets as described in Schedule 2M by 2 January 2020
- Completion of all relevant agreements, including the Transfer Agreement prior to service commencement
- Completion of an Organisational Development Strategy by 1 February 2020
- Completion of data sharing agreements with GP practices prior to service commencement

6.2 Ensure the Premises are fit for occupation from 1 month prior to the Service Commencement Date;

6.3 Completion of all the Provider's obligations in respect of all staff who might be affected by TUPE. The Provider shall lead the processes required to engage and communicate with current employers immediately following end of standstill, to communicate and meet new employees and follow TUPE measures, carry out assessment/workforce plan/recruit and apply contingencies;

6.4 During the Mobilisation Period, the Provider will supply an organisational structure identifying:

- Lines of accountability;
- On site/local service managers and contact details;
- Contract and Quality Assurance Manager;
- Confirmed numbers of operational staff and their responsibilities;
- Which staff are permanent and which are bank/agency;
- How the structure might fluctuate seasonally;
- Confirmation and evidence of agreements with third parties upon whose active participation as partners (including third sector, social services and primary care) the delivery of the Services is reliant by 31 January 2020 and create an Integrated Mobilisation Plan to include mechanisms for joint working with other providers including Neutral Partners;
- System management structures, contact numbers and individuals for BNSSG system management processes

7. The Provider will establish a formal integration workgroup with relevant system partners to allow for the further development and delivery of the Mobilisation Plan. This plan will define the required deliverables, timescales and resources for the Mobilisation Period and ensuring readiness for delivery from the Service Commencement Date.

8. The Provider shall create a Joint Community Services Mobilisation Board ("Mobilisation Board") with members from the CCG and the Provider to monitor Progress of the Provider against the Mobilisation Plan within two weeks of the end of the Preferred Bidder standstill period. The terms of reference for the Mobilisation Board shall be drafted by the Provider and agreed by the CCG prior to Contract Award. The Mobilisation Board will run from Contract Award until joint agreement from the Provider and the CCG to be stood down. The terms of reference for the Mobilisation Board will be included in Schedule 5A (Documents Relied On)

9. For the avoidance of doubt, time shall be of the essence in respect of completion of the Mobilisation Plan. If a Party does not complete its obligations in respect of the Mobilisation Arrangements (to include the timescales set out in the Mobilisation Plan unless agreed otherwise in writing) (the Mobilisation Obligations), either Party shall have the right to call an escalation meeting to review the impact on the Mobilisation Plan and as applicable on the Service Commencement Date. At such meeting the Parties shall use reasonable endeavours to resolve the issue(s) and enable the defaulting Party to meet its Mobilisation Obligations, such plan to be agreed by the Parties within 10 Working Days of the date of the escalation meeting.

10. If the Parties are unable to agree a plan to resolve the Mobilisation Obligations, or the Mobilisation Obligations cannot be resolved to the reasonable satisfaction of the non-defaulting Party, the non-defaulting Party shall have the right to terminate this Contract, in the case of the Commissioner, pursuant to GC 17.10.1. For the purposes of GC 17.10.1, the requirement to identify the breach in writing and the period of 40 Working Days in which to remedy the breach shall be deemed to have been waived by the Party in default of the Mobilisation Obligations.

11. To the extent that any failure by a Party to complete its Mobilisation Obligations is due to the unreasonable delay of the other Party, the termination provisions above shall not apply provided that the Party in default has taken all reasonable and timely steps to notify the other Party of its obligations in respect of the Mobilisation Arrangements (including the Mobilisation Plan) and the impact of its delay.

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

1. Purpose of Schedule

1.1 The Provider is required to ensure the orderly transition of the Services from the Provider to the Commissioner or any Replacement Provider(s) in the event of any termination (including partial termination) or expiry of this Contract. This Schedule is supplementary to GC18 (*Consequences of Expiry or Termination*) and sets out the principles of the exit and service transition arrangements which are intended to achieve this.

1.2 For the avoidance of doubt, the Provider is responsible for the overall management and costs incurred of the exit and Service transfer arrangements including ensuring that it continues to satisfy all its obligations under this Contract including but not limited to the duty to repair, replace and maintain the Assets until the point of expiry or termination (unless such obligations are expressly suspended by operation of this schedule).

2. Definitions

2.1 In this Schedule, the following definitions shall apply:

"Actual Termination Date"	means the date on which the Contract terminates (howsoever arising) which for the avoidance of doubt shall not include the Expiry Date;
"Assets"	the Exclusive Assets and Non-Exclusive Assets;
"Breakage Costs"	the amount(s) the Provider is required to pay to terminate (or, where commercially necessary, continue with until the Provider is reasonably able to novate to the Replacement Provider(s) any agreement(s) with premises provider(s), subcontractor(s) or supplier(s) engaged exclusively in connection with the Provider's provision of the Services;
"Commissioner Deliverables"	all documents, products and materials developed by the Commissioner in relation to the Services in any form and submitted by any Commissioner to the Provider under this Contract, including data, reports, policies, plans and specifications;
"Commissioner System"	the Commissioner's computing environment (consisting of hardware, software and/or telecommunications networks or equipment) used by the Provider in connection with this Contract which is owned by the Commissioner or licensed to it by a third party and which interfaces with the Provider System or which is necessary for the Commissioner to receive the Services;
"Commissioner Termination Event"	the termination by the Commissioner of the whole of this Contract in accordance with General Condition 17.2 or the termination by the Provider of the whole of this Contract in accordance with General Condition 17.9.1;

"Documentation"	all technical specifications, user manuals, operating manuals, process definitions and procedures, and all such other documentation as: (a) is required to be supplied by the Provider to the Commissioner to enable it to use the Services; and (b) is required to be developed by the Provider in order to provide the Services;
"Exclusive Assets"	those assets used by the Provider or a Material Sub-Contractor and which are used exclusively in the provision of the Services;
"Exit Information"	has the meaning given in Paragraph 7.1 of this Schedule 2I;
"Exit Manager"	the person nominated by each Party pursuant to Paragraph 3.4 of this Schedule for managing the Parties' respective obligations under this Schedule;
"Expiry Date"	the date on which the Contract expires (including any extension period, where notice to extend has been served in accordance with Schedule 1C) without the operation of a provision to terminate the Contract;
"Investment Expenses"	such out of pocket expenses as the Provider has incurred through investment, exclusively in connection with its delivery of the Services, between the Effective Date and the Actual Termination Date; as set out in the Provider's investment plan contained in its final bid submission in each case net of the amortization, or equivalent, against that investment expense;
"IT Environment"	the Commissioner System and the Provider System together;
"Key Contracts"	the Sub-Contracts, licences for Software or other agreements which are necessary to enable the Commissioner or any Replacement Provider(s) to perform the Services or the Replacement Services, including all relevant Documentation; and,
"Net Book Value"	the net book value of the Assets calculated in accordance with the depreciation policy of the Provider set out in the letter in the agreed form from the Provider to the Commissioner of the same date as this Contract;
"Non-Exclusive Assets"	those assets (if any) which are used by the Provider or a Material Sub-Contractor in connection with the Services on a non-exclusive basis;
"Procurement Losses"	the reasonable costs and expenses of the Commissioner in procuring a Replacement Provider(s) (including but not limited to, the costs and expenses to which the Commissioner is entitled, pursuant to General Condition 18.2);

"Provider Equipment"	the hardware, computer and telecoms devices and equipment used by the Provider or its Sub-Contractors (but not hired, leased or loaned from the Commissioner) for the provision of the Services;
"Provider System"	the information and communications technology system used by the Provider in implementing and performing the Services including the Software, the Provider Equipment, configuration and management utilities, calibration and testing tools and related cabling (but excluding the Commissioner System);
"Provider Termination Event"	the termination by the Provider of the whole of this Contract in accordance with General Condition 17.3, or the termination by the Commissioner of the whole of this Contract in accordance with General Condition 17.10;
"Registers"	the register and database referred to in Paragraphs 3.1.1 and 3.3.4 of this Schedule;
"Replacement Provider(s)"	any third party supplier of Replacement Services appointed by the Commissioner from time to time;
"Replacement Services"	any services which are the same or substantially the same as any or all of the Services and which the Commissioner receives in substitution for any of the Services following the termination or expiry of this Contract;
"Software"	software which is proprietary to any third party and that is used by the Provider in the provision of the Services;
"Termination Losses"	means in respect of any part or parts of the Services under the Contract: (a) Investment Expenses; and (b) Breakage Costs.
"Transferring Contracts"	has the meaning given in Paragraph 9.2.3 of this Schedule.

2.2 For the avoidance of doubt:

2.2.1 any additional defined terms used in this Schedule 2I will have the meaning given to such terms in the Contract; and

2.2.2 the provisions of this Schedule 2I Exit Arrangements shall survive termination of the Contract in accordance with General Condition 19.

3. Obligations during the Term to facilitate expiry or termination of the Contract

3.1 During the Contract Term, the Provider shall:

3.1.1 create and maintain a register of all:

3.1.1.1 Assets, including (where applicable) their:

(a) make, model and asset number;

(b) ownership (e.g. lease/hire/licensed terms as appropriate) and status as either Exclusive or Non-Exclusive Assets;

(c) Net Book Value;

(d) condition and physical location;

(e) true-up licences / be responsible for the management of licence assets ensuring that no product will be used unlicensed – neither will they over licence;

(f) use (including technical specifications); and

(g) maintenance history, which should include a recommended replacement date when the Assets would ordinarily become obsolete and should be replaced by the Provider (which for the avoidance of doubt shall be the earlier of the manufacturer's recommended date (if applicable) or good industry practice);

3.1.1.2 Sub-Contracts and other relevant agreements (including software licences, maintenance and support agreements and equipment rental and lease agreements) required for the delivery of the Services.

3.2 The Registers must also include a schedule of all Assets that have become obsolete (by virtue of Paragraph 3.1.1.1(g) of this schedule) as well as a schedule of all Sub-Contracts and relevant agreements that have or are about to expire.

3.3 The Provider shall ensure that throughout the Contract Term (up to and including the Expiry Date or the Actual Termination Date):

3.3.1 the Net Book Value of Assets which are deemed to be obsolete should not account for more than 20% of the Net Book Value of all Assets; and

3.3.2 the Registers indicate which of the Assets are Exclusive Assets;

3.3.3 the Provider System should be subject to maintenance and/or service agreements, the duration of which continue for at least 12 months after expiry or termination of this Contract.

3.3.4 that it creates and maintains a database detailing:

3.3.4.1 the Provider's technical infrastructure through which the Services are delivered; and,

3.3.4.2 any other operating processes and procedures through which the Provider provides the Services,

which shall contain sufficient detail to enable the Commissioner and/or the Replacement Provider(s) to understand how the Provider provides the Services and to enable the smooth transition of the Services with the minimum amount of disruption upon the Expiry Date or the Actual Termination Date (as the case may be);

3.3.5 that it agrees the format of the Registers with the Commissioner prior to the Service Commencement Date or, in the event that the Parties are unable to agree the format by the Service Commencement Date, shall comply with any instructions of the Commissioner as to the required format; and

3.3.6 that at all times it keeps the Registers up to date, in particular in the event that Assets, Sub-Contracts or other relevant agreements are added to or removed from the Services.

3.4 Each Party shall nominate a person for the purposes of managing the Parties' respective obligations under this Schedule and provide written notification of such appointment to the other Party within 3 months of the Service Commencement Date. The Provider shall ensure that its employees, agents and Sub-Contractors comply with this Schedule. The Provider shall ensure that its Exit Manager has the requisite authority to arrange and procure any resources of the Provider as are reasonably necessary to enable the Provider to comply with the requirements set out in this Schedule. The Parties' Exit Managers will liaise with one another in relation to all issues relevant to the termination or expiry of this Contract and all matters connected with this Schedule and each Party's compliance with its terms.

4. Commissioner Termination Event

4.1 Upon termination of the Contract due to a Commissioner Termination Event the Provider may invoice the Commissioner for the Termination Losses (and will supply any reasonable supporting documentation requested by the Commissioner) and the Commissioner shall pay to the Provider the amount(s) set out in that invoice (subject to the Provider Costs Cap below).

4.2 The Provider shall use its reasonable endeavours to mitigate any effects and financial impact of termination in respect of a Commissioner Termination Event.

4.3 The maximum aggregate amount of Termination Losses payable by the Commissioner to the Provider shall be the applicable amount set out in Table A below for the period in which the Commissioner Termination Event arises (the “Provider Costs Cap”).

Table A

Relevant year (indicated by months starting on the Service Commencement Date)	Provider Costs Cap
1 – 12 months	[NOTE TO BIDDERS] £ to be calculated from the successful bidder’s investment schedule in final bid submission on a reducing balance and as agreed by the Commissioner.
13 – 24 months	
25 – 36 months	
Etc..	

5. Provider Termination Event

5.1 Upon termination of the Contract due to a Provider Termination Event occurring within 3 years of the Service Commencement Date, the Commissioner may invoice the Provider for the Procurement Losses (and will supply any reasonable supporting documentation requested by the Provider) and the Provider shall pay to the Commissioner the amount(s) set out in that invoice (subject to the Commissioner Costs Cap below).

5.2 The Commissioner shall use its reasonable endeavours to mitigate any effects of termination in respect of a Provider Termination Event.

5.3 The maximum aggregate amount of Procurement Losses payable by the Provider to the Commissioner is £500,000 (the "Commissioner Costs Cap").

6. Payment of Invoices

6.1 Except where expressly stated otherwise (and subject to Paragraphs 6.2 and 6.3 below), any payment due under the provisions of this Schedule 2I Exit Arrangements, shall be made to the Party to which it is due within 30 days of deemed receipt of an undisputed invoice in respect of that payment on the Party due to make that payment.

6.2 Where an invoice is submitted by either Party, pursuant to Paragraphs 4.1 or 5.1 above (the "Invoicing Party"), the receiving Party from whom payment is due (the "Receiving Party"), shall be entitled to request such information and supporting documentation as it shall reasonably require in connection with its review of the Termination Losses set out in that invoice and the Invoicing Party shall supply that information and/or documentation to the Receiving Party within 5 Operational Days of receiving the request.

6.3 Where, following receipt of any information and/or documentation requested by a Receiving Party in accordance with Paragraph 6.2 above, the Receiving Party wishes to dispute the invoice raised by the Invoicing Party, it shall be entitled to refer the matter for resolution by an accountant (either jointly appointed by the Commissioner and the Provider or, if the Parties cannot agree a joint appointment, appointed in accordance with the dispute resolution procedure set out in this Contract. Once the allocation of cost and quantum are agreed or resolved or determined (as the case may be) the Invoicing Party shall (if necessary) re-submit an amended invoice to the Receiving Party which shall be due for payment within 30 Operational Days of receipt by the Receiving Party.

7. Obligations to Assist on Re-Tendering or Re-Commissioning of Services

7.1 On reasonable notice at any point during the Contract Term, the Provider shall (in addition to any information supplied pursuant to the terms of GC18 (*Consequence of Expiry or Termination*) provide to the Commissioner and/or its potential Replacement Provider(s) (subject to the potential Replacement Provider(s) entering into reasonable written confidentiality undertakings), the following material and information in order to facilitate the preparation by the Commissioner of any invitation to tender and/or to facilitate any potential Replacement Provider(s) undertaking due diligence:

7.1.1 details of the Services;

7.1.2 a copy of the Registers, up to date and accurate as at the date of delivery of such Registers;

7.1.3 an inventory of Commissioner Deliverables in the Provider's possession or control;

7.1.4 details of any key terms of any Sub-contracts, third party contracts and licences, particularly as regards charges, termination, assignment and novation;

7.1.5 a list of on-going and/or threatened disputes in relation to the provision of the Services;

7.1.6 accurate and up to date finance and activity information for the Services and by commissioner;

7.1.7 the information required to be provided pursuant to the provisions of General Condition 5.13; and

7.1.8 to the extent permitted by applicable Law, all information relating to individuals employed or engaged in the delivery of the relevant Services by the Provider that the Commissioner might reasonably require to be provided by the Provider for the purposes of this Paragraph 7 under this Contract; (together, the "Exit Information").

7.2 The Provider acknowledges that the Commissioner may disclose the Provider's Confidential Information to an actual or prospective Replacement Provider(s) or any third party whom the Commissioner is considering engaging to the extent that such disclosure is necessary in connection with such engagement and provided that the Replacement Provider(s) enter into appropriate confidentiality obligations (except that the Commissioner may not under this Paragraph 7.2 disclose any Provider's Confidential Information which is information relating to the Provider's or its Sub-Contractors' prices or costs).

7.3 The Provider shall:

7.3.1 notify the Commissioner within 5 Operational Days of any material change to the Exit Information which may adversely impact upon the potential transfer and/or continuance of any Services and shall consult with the Commissioner regarding such proposed material changes; and

7.3.2 provide complete updates of the Exit Information on an as-requested basis as soon as reasonably practicable and in any event within 10 Operational Days of a request in writing from the Commissioner.

7.4 The Exit Information shall be accurate and complete in all material respects and the level of detail to be provided by the Provider shall be such as would be reasonably necessary to enable a third party to:

7.4.1 prepare an informed offer for those Services; and

7.4.2 not be disadvantaged in any subsequent procurement process compared to the Provider (if the Provider is invited to participate).

7.5 With effect from the Actual Termination Date or the Expiry Data or such other date as the Commissioner shall determine, the Provider shall:

7.5.1 transfer leases for Services Environment as the Commissioner may direct;

7.5.2 establish an Information Sharing Agreement that enables the Provider and the Replacement Provider(s) to develop, implement and test the migration process for patient data;

7.5.3 assess the risks, impact assessments, liabilities and responsibilities in relation to the safeguard of patient confidentiality and detailed at an early stage by the Provider. The resulting risk plan will be agreed by the Provider, the Commissioner and the Replacement Provider(s). The information governance teams of Provider and Replacement Provider(s) will play an active and pivotal role in the definition of the document;

7.5.4 migrate electronic clinical and business records to new IT systems and handover of paper records (including any archived records) in a systematic format ensuring data integrity, information security, and that patient confidentiality is not compromised at any point in the process;

7.5.5 liaise with the Replacement Provider(s) to ensure a smooth transition and in turn ensuring data integrity, information security, and that patient confidentiality is not compromised at any point in the process;

7.5.6 enter into a transfer agreement from the Provider to any successor provider to transfer the Transferred Assets, sub contracts and/or liabilities on terms approved by the Commissioner;

7.5.7 develop with the successor provider a communication plan (approved by the CCG) which will be used to inform patients, staff, GPs and CCG of the data/system migration; along with its associated timescales;

7.6 The Provider will support the Commissioner in maintaining service continuity and standards during the transition period to the Replacement Provider(s) by ensuring accurate and timely communications with Staff and Service Users.

7.7 The Provider will ensure that Staff are kept fully informed of the transfer process and have opportunities to raise any issues of concern.

7.8 All communications with Service Users, including letters, e-mails, presentations and press releases must be signed off by a senior manager (Director level). Staff should be made aware that any unauthorised communications with Service Users or contact with the media should be treated as a disciplinary offence by the Provider.

8. Termination Obligations

8.1 Upon the Actual Termination Date or Expiry Date (as the case may be), the Provider shall:

8.1.1 cease to use the Commissioner Deliverables;

8.1.2 provide the Commissioner and/or the Replacement Provider(s) with a complete and uncorrupted version of the Commissioner Deliverables in electronic form (or such other format as reasonably required by the Commissioner);

8.1.3 erase from any computers, storage devices and storage media that are to be retained by the Provider after the Expiry Date or the Actual Termination Date (as the case may be) all Commissioner Deliverables and promptly certify to the Commissioner that it has completed such deletion;

8.1.4 return to the Commissioner such of the following as is in the Provider's possession or control:

8.1.4.1 all materials created by the Provider under this Contract in which the IPRs are owned by the Commissioner;

8.1.4.2 any parts of the IT Environment and any other equipment which are owned and/ or leased by the Commissioner;

8.1.4.3 any items that have been charged to (and paid for) by the Commissioner, such as consumables;

8.1.5 provide access during normal working hours to the Commissioner and/or the Replacement Provider(s) for up to 12 months after expiry or termination to:

8.1.5.1 such information relating to the Services as remains in the possession or control of the Provider; and

8.1.5.2 such members of the Staff as have been involved in the design, development and provision of the Services and who are still employed by the Provider, provided that the Commissioner and/or the Replacement Provider(s) shall pay the reasonable costs of the Provider actually incurred in responding to requests for access under this Paragraph.

8.2 Upon the Actual Termination Date or Expiry Date(as the case may be), each Party shall return to the other Party (or if requested, destroy or delete) all Confidential Information of the other Party and shall certify that it does not retain the other Party's Confidential Information save to the extent (and for the limited period) that such information needs to be retained by the Party in question for the purposes of providing or receiving any Services or Termination Services or for statutory compliance purposes.

9. Assets, Sub-Contracts and Software

9.1 Following notice of termination of this Contract and within [6] months before the Expiry Date, the Provider shall not, without the Commissioner's prior written consent:

9.1.1 terminate, enter into or vary any Sub-Contract except to the extent that such change does not or will not affect the provision of Services or the Estimated Annual Contract Value;

9.1.2 (subject to normal maintenance and replacement requirements) make material modifications to, or dispose of, any existing Assets or acquire any new Assets; or

9.1.3 terminate, enter into or vary any licence for software in connection with the Services.

9.2 Within 20 Operational Days of receipt of the up-to-date Registers provided by the Provider pursuant to Paragraph **Error! Reference source not found.**, the ommissioner shall provide written notice to the Provider setting out:

9.2.1 which, if any, of the Assets the Commissioner requires to be transferred to the Commissioner and/or the Replacement Provider(s) (the “Transferring Assets”);

9.2.2 which, if any, of the Assets the Commissioner and/or the Replacement Provider(s) require the continued use of; and

9.2.3 which, if any, of Key Contracts the Commissioner requires to be assigned or novated to the Commissioner and/or the Replacement Provider(s) (the “Transferring Contracts”),

in order for the Replacement Provider(s) to provide the Services or Replacement Services with effect from the Actual Termination Date or Expiry Date (as the case may be).

9.3 Where requested by the Commissioner and/or the Replacement Provider(s), the Provider shall provide all reasonable assistance to the Commissioner and/or the Replacement Provider(s) to enable it to determine which Transferable Assets and Transferable Contracts the Commissioner and/or the Replacement Provider(s) require to provide the Services or Replacement Services.

9.4 With effect from the Actual Termination Date or Expiry Date (as the case may be, the Provider shall sell the Transferring Assets to the Commissioner and/or its nominated Replacement Provider(s) for a consideration equal to their Net Book Value, except where the cost of the Transferring Asset has been partially or fully paid for as part of the Services at the time of expiry or termination of this Contract, in which case the Commissioner shall pay the Provider the Net Book Value of the Transferring Asset less the amount already paid.

9.5 Risk in the Transferring Assets shall pass to the Commissioner or the Replacement Provider(s) (as appropriate) with effect from the Actual Termination Date or Expiry Date (as the case may be) and title to the Transferring Assets shall pass to the Commissioner or the Replacement Provider(s) (as appropriate) on payment for the same.

9.6 Where the Provider is notified in accordance with Paragraph [9.2.2] of this Schedule that the Commissioner and/or the Replacement Provider(s) require continued use of

any Assets that are not capable of being Transferable Assets, the Provider shall as soon as reasonably practicable:

9.6.1 procure a non-exclusive, perpetual, royalty-free licence (or licence on such other terms that have been agreed by the Commissioner) for the Commissioner and/or the Replacement Provider(s) to use such Assets (with a right of sub- licence or assignment on the same terms); or failing which

9.6.2 procure a suitable alternative to such Assets and the Commissioner or the Replacement Provider(s) shall bear the reasonable proven costs of procuring the same to the extent that.

9.7 Where the Provider is notified in accordance with Paragraph [9.2.2] of this Schedule that the Commissioner and/or the Replacement Provider(s) require continued use of any Exclusive Assets which have been enhanced or modified by the Provider and as such for logistical and/or practical reasons are not capable of being Transferable Assets, then the Parties shall take reasonable steps to reach an alternative agreement regarding such Exclusive Assets. In the absence of an agreement between the Parties on how to deal with such Exclusive Assets, the Commissioner shall at a minimum be entitled to recover any residual value in such Exclusive Assets which have been paid for by the Commissioner during the Contract Term. In the event that the relevant Exclusive Asset has been fully paid for by the Commissioner as at the Actual Termination Date or the Expiry Date, then the residual value shall at least be equal to the Net Book Value of the relevant Exclusive Asset.

9.8 The Provider shall as soon as reasonably practicable assign or procure the novation to the Commissioner and/or the Replacement Provider(s) of the Transferring Contracts. The Provider shall execute such documents and provide such other assistance as the Commissioner reasonably requires to effect this novation or assignment.

9.9 The Commissioner shall:

9.9.1 accept assignments from the Provider or join with the Provider in procuring a novation of each Transferring Contract; and

9.9.2 once a Transferring Contract is novated or assigned to the Commissioner and/or the Replacement Provider(s), carry out, perform and discharge all the obligations and liabilities created by or arising under that Transferring Contract and exercise its rights arising under that Transferring Contract, or as applicable, procure that the Replacement Provider(s) do the same.

9.10 The Provider shall hold any Transferring Contracts on trust for the Commissioner until such time as the transfer of the relevant Transferring Contract to the Commissioner and/or the Replacement Provider(s) has been effected.

9.11 The Provider shall indemnify the Commissioner (and/or the Replacement Provider(s), as applicable) against each loss, liability and cost arising out of any claims made by a counterparty to a Transferring Contract which is assigned or novated to the Commissioner (and/or Replacement Provider(s)) pursuant to Paragraph [9.7] of this Schedule in relation to any matters arising prior to the date of assignment or novation of such Sub-Contract.

10. Apportionments

10.1 All outgoings and expenses (including any remuneration due) and all rents, royalties and other periodical payments receivable in respect of the Transferring Assets and Transferring Contracts shall be apportioned between the Commissioner and the Provider and/or the Replacement Provider(s) and the Provider (as applicable) as follows:

10.1.1 the amounts shall be annualised and divided by 365 to reach a daily rate;

10.1.2 the Commissioner shall be responsible for (or shall procure that the Replacement Provider(s) shall be responsible for) or entitled to (as the case may be) that part of the value of the invoice pro rata to the number of complete days following the transfer, multiplied by the daily rate; and

10.1.3 the Provider shall be responsible for or entitled to (as the case may be) the rest of the invoice.

10.2 Each Party shall pay (and/or the Commissioner shall procure that the Replacement Provider(s) shall pay) any monies due under Paragraph [10.1] of this Schedule as soon as reasonably practicable.

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

1. **Discharge Summary to Service User**

The Provider must at the time of the Service User's transfer and/or discharge give a Discharge Summary to the Service User (and if appropriate to the Legal Guardian of the Service User).

2. **Discharge Summary to GP/Referrer**

The Provider should issue the Discharge Summary to the Service User's GP and/or Referrer and to any third party provider within the timescales in clause SC11.

2.1 An annual audit of compliance of all standards within this schedule will be required.

2.2 The Discharge Summary should include the following information, as appropriate:

- Patient identification
- Admission date
- Admission source
- Admission method
- Discharge date
- Sex
- Date of birth
- Marital status
- NHS number
- Presenting symptoms
- Diagnosis (primary and secondary)
- Significant
    - in-hospital investigations
    - treatment
    - radiology with results
- Care, management and complications
- Discharge destination
- Inpatient/outpatient follow-up arrangements including named Consultant or GP
- Consultant on discharge
- Further action recommended for Primary Care Team e.g. Practice Nurse/GP/District Nurse
- Infection control status: C.difficile/MRSA/Norovirus/outstanding results
- Allergies and sensitivities
- Medicines - started/changed/stopped including vaccinations given where applicable, and rationale for this
- Discharge summary and TTO completed by (Name, Bleep or Contact number)
- Does this person have dementia – Y/N?

3. **Discharge Letter**

Where required (e.g. for the communication of the results of investigations), a Discharge Letter should be issued to the Service User's GP and/or Referrer and to any third party provider, within a timeframe appropriate to further information being provided.

4. Discharge Summary post Minor Injuries Unit (MIU) attendance

Within 24 hours of the Service User attending the MIU, the Provider should issue an MIU Discharge Summary. This should include the following information:

- Patient identification
- Attendance date
- Date of birth
- NHS number
- Presenting complaint
- Investigations, where performed
- Treatments and procedures, where performed
- Medications, where prescribed
- Provisional diagnosis
- Disposition/outcome or follow-up arrangements

5. Specialist Services Clinic / Patient Visit Letter

The Provider must issue the clinic / patient visit letter in accordance with the timeframes documented within the Service Conditions.

5.1 This should include the following:

- Patient identification
- Attendance date
- Discharge date, if relevant
- Date of birth
- NHS number
- Known drug hypersensitivity, if applicable
- Medications prescribed, stopped or changed, as applicable
- Presenting problem
- Diagnosis (including Dementia if applicable)
- Support services arranged, if applicable
- Where applicable, significant risks and warnings to notify GP
- Clinic follow-up, if applicable

6. Definitions

6.1 The following terms are defined within the "definitions and interpretation" section of the Contract:

- Discharge Summary
- Legal Guardian
- Operational Day
- Service User

6.2 In addition, third party provider is defined to mean in this schedule:

- the healthcare provider into whose care the Service User is discharged.

6.3 In addition Provider's Care is defined to mean in this schedule:

- any period during which the Service User is or remains under the clinical care of the Provider

7. Discharge prescribing: medication/medical device supply

On discharge, following an inpatient stay of greater than 48 hours, the Provider shall ensure that patients have sufficient supplies of medication so as not to compromise their ongoing care. The general practice with which the patient is registered should not be expected to issue further prescriptions in the first 14 days following discharge (but see points on compliance aids and short-stay patients below).

7.1 Any dispensing of medication on discharge should follow the rules below

- Regular (repeat) medication (see table)

How many days' supply of a regular medication does the patient have?	Quantity to dispense on discharge
Zero (e.g. medication started during admission or no PODs)	28 day supply
Less than 14	28 day supply
More than 14	Nothing

- Acute medication - supply a full course of treatment or a 28 day supply (whichever is the shorter).

7.2 The points above apply also to dressings, medical devices, and 'borderline substances', including nutritional supplements. Note that there is a local (pan Avon) formulary for dressings, now embedded in the Joint Formulary.

7.3 The patient (or their carer) will be given the information they require to manage their medication following discharge.

7.4 If the patient's own drugs (PODs) are with them in hospital then they may form part of the discharge supply if assessed as appropriate by pharmacy staff - PODs should be returned to the patient if appropriate. If a patient has brought their own medication into hospital with them, the patient should be advised as to what medication changes have taken place and their permission should be sought to dispose of any medication that is no longer indicated.

7.5 The Provider shall not request prescriptions for discharge medication from general practitioners. In exceptional circumstances where this does occur, the provider should inform the commissioner.

8. Medicines reconciliation

8.1 To be able to reconcile medicines in a primary care setting post discharge, providers will make best endeavours to provide the following minimum dataset of information available to the General Practice with which the patient is registered, by secure electronic communication which should include:

- Complete and accurate patient details i.e. full name, date of birth, NHS number, lead clinician, ward, date of admission, date of discharge
- The diagnosis of the presenting condition plus co-morbidities
- Procedures carried out during admission
- A complete list of all the medicines prescribed for the patient on discharge from hospital (not just those dispensed at the time of discharge)
- Dose, frequency, and route of all the medicines listed
- Formulation of all the medicines listed (where possible)
- Details of medicines stopped and started during the admission, with a clear explanation for doing so
- The intended duration of treatment for medicines where this is appropriate (e.g. antibiotics, short course corticosteroids, hypnotics)
- Details of variable dosage regimens (e.g. oral corticosteroids, warfarin, etc.)
- Known allergies, hypersensitivities and previous drug interactions
- Any additional patient information provided such as corticosteroid record cards, anticoagulant books, etc. (where possible)
- Date of last administration of any medication prescribed for administration less frequently than once a day

8.2 This information should be clear, unambiguous and legible and should be available to the GP (or other primary care prescriber) as soon as possible.

8.3 If dressings are provided on discharge it should be stipulated how often these will need to be changed.

8.4 If nutritional supplements are provided on discharge, and the General Practice with which the patient is registered is expected to make continuing supplies, these should be for a stated ACBS indication (see Drug Tariff), and the MUST score, indication, length of course and review date (for all patients) should be communicated to the patient's GP.

9 Multi-compartment compliance aids (MCA)

9.1 Although MCA may be of value to help some patients with problems managing their medicines and maintaining independent healthy living, they are not the best intervention for all patients and many alternative interventions are available. Provision of MCA on discharge should only occur in the following circumstances:

- Patients were already using a MCA when they were admitted, and there is no reason to discontinue its use at the point of discharge
- The provider organisation has deemed it appropriate to supply a MCA on discharge following a documented assessment of the patient's needs

9.2 Provision of MCA on discharge should NOT occur when

- A patient is being discharged into a care setting where their medication will be administered by a nurse
- A patient is able to self-administer their own medication independently without an MCA in the care setting they are being discharged into

9.3 For the avoidance of doubt, there is no requirement to provide an MCA when a patient is being discharged into a care setting in which non-nursing staff will be 'prompting' a patient to self-administer their own medication, unless the provider organisation has deemed that the patient is unable to self-administer their own medication independently without an MCA in the care setting they are being discharged into.

9.5 The provider is not expected to provide a 28 day supply of any medication that has been packed into an MCA. The provider should supply medication that has been packed into an MCA however, and be assured that arrangements have been made for ongoing supplies of medication so as not to compromise the patient's care.

9.6 If the provider is only able to make a 7 day supply of discharge medication in a compliance aid, they must make every effort to satisfy themselves that the practice with which the patient is registered (and the patient's usual community pharmacy) has all the information they need, provided in a timely fashion to ensure continuity of care.

9.7 BNSSG CCG guidance on managing Compliance Aids in Primary Care provides support https://www.bnssgformulary.nhs.uk/

10. Specialist Services - Clinic Setting / Patient Visit: Prescribing

10.1 The provider shall ensure that patients receive a supply of any treatment that has been deemed necessary for them by a clinician who has consulted that patient in a clinic or patient visit setting within an appropriate period of time so as not to compromise their care. This will either be by supplying that medication to the patient, or may be by requesting that the patient's GP prescribe it in future.

10.2 Where a patient has an immediate clinical need for medication to be supplied following clinic attendance or patient visit, the Provider must itself supply to the patient an adequate quantity of that medication to last for the period until the patient's GP receives the relevant communication and can prescribe accordingly (Service Condition 11.10). The Provider must send the communication as soon as reasonably practicable and in any event within 10 operational days (Service Condition 11.7). If the 10 operational day requirement is not being delivered the Provider will need to issue medication to last the period until the communication is received by patient's GP.

10.3 Where a patient does not have an immediate clinical need for medication to be supplied following clinic attendance or patient visit, the Provider must explain to the patient that a delay to the start of their treatment is appropriate and tell the patient when their GP can expect to receive the relevant communication and therefore when the GP can be expected to prescribe accordingly.

10.4 The patient (or their carer) should be given the information they require to manage their medication following their clinic appointment or patient visit.

10.5 The general practice with which the patient is registered should not be expected to issue a prescription for any treatment that has been deemed necessary for them by a clinician who has consulted that patient in a clinic or patient visit setting where it is clinically urgent.

10.6 The general practice with which the patient is registered should not be expected to issue prescriptions following a clinic appointment or patient visit routinely until they have received the relevant communication. They should receive a secure electronic communication from the provider that includes:

- Complete and accurate patient details i.e. full name, date of birth, NHS number, consultant, date of appointment
- The diagnosis of the presenting condition
- Procedures carried out
- A list of the medicines prescribed/recommended for the patient following the consultation
- Dose, frequency, and route of all the medicines listed
- Formulation of all the medicines listed (where possible)
- Details of any medicines stopped with a clear explanation for doing so
- The intended duration of treatment for medicines where this is appropriate (e.g. antibiotics, short course corticosteroids, hypnotics)
- Details of variable dosage regimens (e.g. oral corticosteroids, warfarin, etc.)
- Date of last administration of any medication prescribed for administration less frequently than once a day
- Known allergies, hypersensitivities and previous drug interactions
- Any additional patient information provided such as corticosteroid record cards, anticoagulant books, etc. (where possible)

10.7 This information should be clear, unambiguous and legible and should be available to the GP (or other primary care prescriber) as soon as possible.

10.8 The patient should be advised of when their GP can be expected to have received the relevant communication before requesting (from their General Practice) a prescription for any medication recommended during a clinic visit or patient visit. The patient should be advised to request a prescription rather than to make an appointment unless their practice requests that they do so.

10.9 The patient should also be advised who they should contact if their condition worsens.

10.10 Where a clinically urgent item is required, the provider shall ensure that this is provided in a timely fashion. If this necessitates that the patient be issued with an FP10 prescription which can be dispensed by a community pharmacy, the patient should receive one.

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

1. The Provider must adhere to the policies listed here, in delivering the Contract:

1.1 Provider:

1.1.1 Provider Safeguarding Adults Policy to be be provided before Contract Award
1.1.2 Provider Safeguarding Children Policy to be provided before Contract Award
1.1.3 Provider Mental Capacity Act policy to provided before Contract Award

1.2 Commissioner:

1.2.1 BNSSG CCG Safeguarding Adults and Children Policy:
https://bnssgccg.nhs.uk/library/adults-and-childrens-safeguarding-policy/

1.2.2 BNSSG CCG Mental Capacity Act and Deprivation of Liberty Standards Policy:
https://bnssgccg.nhs.uk/library/mental-capacity-act-and-deprivation-liberty-safeguards-policy/

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

1. Background

1.1 A Personal Health Budget (PHB) can be defined as an amount of money identified to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. PHB'S can be arranged for adults over 18 or for a child or young person in receipt of health funding.

1.2 NHS England[49] have shared that from April 2019 CCGs must ensure that all individuals living in their own home and who become eligible for CHC funding must have a PHB and from April 2020 all patients who in receipt of CHC funding prior to April 2019 in this group must be converted to a PHB, this excludes fast track patients.

2. Eligibility

2.1 Eligibility for a PHB is determined by national legislation, along with local health needs, financial constraints and other factors. Within Bristol, North Somerset and South Gloucestershire, we have identified the following groups of people to be eligible to apply for a personal health budget at this time:

- Children's NHS continuing care (CC), including children with special educational needs and disabilities as part of their Education, Health and Care plans (EHCP)
- NHS continuing health care
- Joint Funded adults including Mental Health and Learning Disabilities
- Those eligible for S117 Mental Health Act Aftercare
- Those with complex Learning Disabilities and/or autism, including all those in inpatient care and those living in the community but at risk of being admitted to inpatient care.

3. Provider requirements

3.1 The provider is required to identify all newly eligible patients according to the above eligibility criteria. After this they are to be offered a detailed conversation by the providers' staff relating to PHBs. This conversation should allow clinicians to explore with the individual and their carers:

- how care can be supported
- what aspects of an individual's care would best be met under a PHB
- how a PHB could be arranged.
- agree next steps

3.2 This conversation should be documented using agreed assessment paperwork and public facing leaflets which underpin personalised conversations between patients and provider staff.

3.3 It is the responsibility of the provider to ensure that all front line staff are trained to hold these conversations. In addition to this, staff should continue to adhere to current regulatory requirements, such as those of the Nursing and Midwifery Council and the Health Professions Council relating to personalised care.

[49] https://www.england.nhs.uk/personal-health-budgets/

4. Working with the CCG

4.1 During mobilisation the Provider will work with the commissioner to agree:

- documentation used by Providers for PHB conversations
- roles and responsibilities between providers and CCG staff e.g. CHC team
- the detailed reporting requirements for Personal Health Budgets.

5. Reporting requirements

5.1 Reporting will be on a quarterly basis, with standard time frames for this being:

- Quarter 1 Report (April-June) data received and reported by the 1st week of August
- Quarter 2 Report (July-September) data received reported by 1st week of November
- Quarter 3 Report (October-December) data received and reported by 1st week of February
- Quarter 4/Year End Report (January-March) data received and reported by 2nd week of May
- Annual reporting is expected to report work undertaken for the period between 1st April and 31st March, with the report being presented to by the 2nd week in May.

SCHEDULE 3 – PAYMENT

A. Local Prices

1.	The Provider will be paid on a block payment basis in accordance with SC36. The Provider must supply a monthly invoice before the first day of each month setting out the amount to be paid by that Commissioner for that month. The amount to be paid will be one twelfth of the individual Expected Annual Contract Value. Subject to receipt of a valid and uncontested invoice, on the fifteenth day of each month after the Service Commencement Date, the Commissioner will pay the Provider.
2.	The price for each service line will be inserted in to the Contract prior to award and will be based on the Provider response to the Financial Model Template. Service lines may be decommissioned and the total price altered accordingly.
3.	Prices will be adjusted each year by the published rate for the NHS inflation and efficiency requirements in line with national guidance as published each year.

SCHEDULE 3 – PAYMENT

B. Local Variations

Not Applicable

SCHEDULE 3 – PAYMENT

C. Local Modifications

Not Applicable

SCHEDULE 3 – PAYMENT

D. Emergency Care Rule: Agreed Blended Payment Arrangements

Commissioner	**Value of Planned Activity (£)**	**Blended Payment applies** (see footnote 1)	**Emergency Care Threshold(s)** (see footnote 2)	**Emergency Care Marginal Price Percentage (being the percentage of Unit Price to be paid or deducted for Emergency Care Services delivered above or below the Value of Planned Activity)**
[ ] CCG	[ ]	NO	Where the Emergency Care Activity Value:	
			<[ ] % of the Value of Planned Activity	*[( )]*
			>[ ]% - [ ]% of the Value of Planned Activity	*[( )]*
			>[ ]% - <100%* of the Value of Planned Activity * (see footnote 3)	(20)
			>100%* - [ ]% of the Value of Planned Activity * (see footnote 4)	20
			>[ ]% - [ ]% of the Value of Planned Activity	*[ ]*
			>[ ]% of the Value of Planned Activity	*[ ]*
			Not applicable as at the time of the release of the draft contract	Not applicable

Footnotes

1. See Rule 5, Section 7 National Tariff
2. See Rules 3c, 3d, 4c, Section 7 National Tariff
3. May be a figure less than 100 if Parties have agreed a tolerance within which only the Value of Planned Activity will be payable: see Rule 4b, Section 7 National Tariff
4. May be a figure greater than 100 if Parties have agreed a tolerance within which only the Value of Planned Activity will be payable: see Rule 4b, Section 7 National Tariff

[INSERT TABLE AS ABOVE FOR EACH ADDITIONAL CCG]

For those Commissioners to whom Blended Payment does not apply, as identified in the tables above, the National Tariff Payment System guidance envisages that there will need to be, in some cases, a fixed reduction to payment for emergency acute care for 2019/20 only. This will be set at the value of the 2017/18 outturn adjustments for MRET and emergency readmissions, taken from the autumn 2018 data collection from providers and commissioners. The relevant financial adjustments should be set out, as required, in an additional table below, by Commissioner, with the values then being carried forward to Schedule 3F (Expected Annual Contract Values).

SCHEDULE 3 – PAYMENT

E. Intentionally omitted

SCHEDULE 3 – PAYMENT

F. Expected Annual Contract Values

Commissioner: NHS Bristol, North Somerset and South Gloucestershire CCG	**Expected Annual Contract Value** **1.** Note the amounts below include estimated inflation and efficiencies as set out in the Financial Model Template. The Contract values are subject to alter based on nationally agreed inflation tariffs and local efficiencies and in line with risk/gain share approaches agreed. **2.** They exclude any expected CQUIN payments, which are subject to change. CQUIN on account payments are set out separately in Table 2 of Schedule 4D, as required under SC38.3.	
	2020/21	£104,856,100
	2021/22	£104,961,000
	2022/23	£105,066,000
	2023/24	£105,171,100
	2024/25	£105,276,300
	2025/26	£105,381,600
	2026/27	£105,487,000
	2027/28	£105,592,500
	2028/29	£105,698,000
	2029/30	£105,803,700
Total	£1,053,293,300	

SCHEDULE 3 – PAYMENT

G. Timing and Amounts of Payments in First and/or Final Contract Year

Not Applicable

4. SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	RTT waiting times for non-urgent consultant-led treatment					
E.B.3	***Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral***	***Operating standard of 92% at specialty level (as reported to NHS Digital)***	***See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/***	***Where the number of Service Users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the threshold, £300 in respect of each such Service User above that threshold***	***Monthly***	***Services to which 18 Weeks applies***
	Diagnostic test waiting times					
E.B.4	***Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test***	***Operating standard of no more than 1%***	***See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/***	***Where the number of Service Users waiting 6 weeks or more at the end of the month exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold***	***Monthly***	***A CS CR D***
	A&E waits					

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.B.5	***Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department***	***Operating standard of 95%***	***See A&E Attendances and Emergency Admissions Monthly Return Definitions at: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/***	***Where the number of Service Users in the month not admitted, transferred or discharged within 4 hours exceeds the tolerance permitted by the threshold, £120 in respect of each such Service User above that threshold. To the extent that the number of such Service Users exceeds 15% of A&E attendances in the relevant month, no further consequence will be applied in respect of the month***	***Monthly***	***A+E U***
	Cancer waits - 2 week wait					
E.B.6	***Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment***	***Operating standard of 93%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
E.B.7	***Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment***	***Operating standard of 93%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
	Cancer waits – 31 days					

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.B.8	***Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers***	***Operating standard of 96%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
E.B.9	***Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery***	***Operating standard of 94%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
E.B.10	***Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen***	***Operating standard of 98%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
E.B.11	***Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy***	***Operating standard of 94%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	Cancer waits – 62 days					
E.B.12	***Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer***	***Operating standard of 85%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
E.B.13	***Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers***	***Operating standard of 90%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users in the Quarter who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
	Ambulance Service Response Times					
	Category 1 (life-threatening) incidents – proportion of incidents resulting in a response arriving within 15 minutes	***Operating standard that 90th centile is no greater than 15 minutes***	***See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/***	***For each second by which the Provider's actual 90th centile performance exceeds 15 minutes, £5 per 1,000 Category 1 incidents received in the Quarter***	***Quarterly***	***AM***
	Category 1 (life-threatening) incidents – mean time taken for a response to arrive	***Mean is no greater than 7 minutes***	***See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-***	***Issue of a Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***AM***

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
			work-areas/ambulance-quality-indicators/			
	Category 2 (emergency) incidents – proportion of incidents resulting in an appropriate response arriving within 40 minutes	***Operating standard that 90th centile is no greater than 40 minutes***	***See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/***	***For each second by which the Provider's actual 90th centile performance exceeds 40 minutes, £3.50 per 1,000 Category 2 incidents received in the Quarter***	***Quarterly***	***AM***
	Category 2 (emergency) incidents – mean time taken for an appropriate response to arrive	***Mean is no greater than 18 minutes***	***See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/***	***Issue of a Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***AM***
	Category 3 (urgent) incidents – proportion of incidents resulting in an appropriate response arriving within 120 minutes	***Operating standard that 90th centile is no greater than 120 minutes***	***See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/***	***For each second by which the Provider's actual 90th centile performance exceeds 120 minutes, £2 per 1,000 Category 3 incidents received in the Quarter***	***Quarterly***	***AM***
	Category 4 (less urgent "assess, treat, transport" incidents only) – proportion of incidents resulting in an appropriate response arriving within 180 minutes	***Operating standard that 90th centile is no greater than 180 minutes***	***See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/***	***For each second by which the Provider's actual 90th centile performance exceeds 180 minutes, £1 per 1,000 Category 4 incidents received in the Quarter***	***Quarterly***	***AM***
	Mixed-sex accommodation breaches					
E.B.S.1	Mixed-sex accommodation breach	>0	See Mixed-Sex Accommodation Guidance,	£250 per day per Service User affected	Monthly	A CR

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
			Mixed-Sex Accommodation FAQ and Professional Letter at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/			MH
	Cancelled operations					
E.B.S.2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	Number of Service Users who are not offered another binding date within 28 days >0	See Cancelled Operations Guidance and Cancelled Operations FAQ at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	Monthly	A CR
	Mental health					
E.B.S.3	***Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge***	***Operating standard of 95%***	***See MHPC Guidance at: https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/***	***Where the number of Service Users in the Quarter not followed up within 7 days exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold***	***Quarterly***	***MH*** ***MHSS***

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	from psychiatric in-patient care					

The Provider must report its performance against each applicable Operational Standard through its Service Quality Performance Report, in accordance with Schedule 6A.

In respect of those Operational Standards shown in ***bold italics***, the provisions of SC36.38 apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.A.S.4	Zero tolerance methicillin-resistant *Staphylococcus aureus*	>0	See Contract Technical Guidance Appendix 3	£10,000 in respect of each incidence in the relevant month	Monthly	A
E.A.S.5	Minimise rates of Clostridium difficile	[Insert baseline threshold identified for Provider: see Schedule 4F]	See Contract Technical Guidance Appendix 3	As set out in Schedule 4F, in accordance with applicable Guidance	Annual	A
E.B.S.4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	>0	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	£2,500 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	Monthly	Services to which 18 Weeks applies
E.B.S.7a	***All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes***	***>0***	***See Contract Technical Guidance Appendix 3***	***£200 per Service User waiting over 30 minutes in the relevant month***	***Monthly***	***A+E***
E.B.S.7b	***All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 60 minutes***	***>0***	***See Contract Technical Guidance Appendix 3***	***£1,000 per Service User waiting over 60 minutes (in total, not aggregated with E.B.S.7a consequence) in the relevant month***	***Monthly***	***A+E***

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.B.S.8a	***Following handover between ambulance and A & E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 30 minutes***	***>0***	***See Contract Technical Guidance Appendix 3***	***£20 per event where > 30 minutes in the relevant month***	***Monthly***	***AM***
E.B.S.8b	***Following handover between ambulance and A&E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 60 minutes***	***>0***	***See Contract Technical Guidance Appendix 3***	***£100 per event where > 60 minutes (in total, not aggregated with E.B.S.8a consequence) in the relevant month***	***Monthly***	***AM***
E.B.S.5	***Waits in A&E not longer than 12 hours***	***>0***	***See A&E Attendances and Emergency Admissions Monthly Return Definitions at: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/***	***£1,000 per incidence in the relevant month***	***Monthly***	***A+E***
E.B.S.6	No urgent operation should be cancelled for a second time	>0	See Contract Technical Guidance Appendix 3	£5,000 per incidence in the relevant month	Monthly	A CR
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	***95%***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***A***
	Duty of candour	Each failure to notify the	See CQC guidance on Regulation 20 at:	Recovery of the cost of the episode of care, or £10,000 if	Monthly	All

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
		Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour	the cost of the episode of care is unknown or indeterminate		
E.H.4	***Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care***	***Operating standard of 56%***	***See Guidance for Reporting Against Access and Waiting Time Standards and FAQs Document at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***MH***
E.H.1	***Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment***	***Operating standard of 75%***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***MH***

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.H.2	***Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment***	***Operating standard of 95%***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***MH***
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumour sites	***Failure to achieve full implementation as described under Service Specification B15/S/a Cancer: Chemotherapy (Adult)***	***Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Monthly***	***Where both Specialised Services and Cancer apply***
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider dealing with children, teenagers and young adults across all tumour sites	***Failure to achieve full implementation as described under Service Specification B15/S/b Cancer: Chemotherapy (Children, Teenagers and Young Adults)***	***Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Monthly***	***Where both Specialised Services and Cancer apply***

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	***Operating standard of 90% (based on a sample of 50 Service Users each Quarter)***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***A, A&E***
	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	***Operating standard of 90% (based on a sample of 50 Service Users each Quarter)***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***A***

The Provider must report its performance against each applicable National Quality Requirement through its Service Quality Performance Report, in accordance with Schedule 6A.

In respect of the National Quality Requirements shown in ***bold italics,*** the provisions of SC36.38 apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

A key principal of the quality schedule is to develop outcomes according to local population segment activity metrics e.g.: multiple long term conditions, frailty, end of life. Where indicated and possible the CCG will provide these metrics to enable the Provider to focus on how they will use this data to improve outcomes for the population and develop services.

The reporting times for these indicators will vary from quarterly to annually. The standard quarterly reporting time frames are:

- **Quarter 1 Report (April-June) data received and reported by the 1st week of August**
- **Quarter 2 Report (July-September) data received reported by 1st week of November**
- **Quarter 3 Report (October-December) data received and reported by 1st week of February**
- **Quarter 4/Year End Report (January-March) data received and reported by 2nd week of May**
- **Annual reporting is expected to report work undertaken for the period between 1st April and 31st March, with the report being presented to by the 2nd week in May.**

Developing Whole System Measures and Partnership Working: We expect system metrics may form a core element of a risk/gain share model in the future and that over time, revisions to the annual quality schedule would expect to move to more system-level outcomes as integration and transformation progresses. For year one of the contract we will use 'basic measures' / service measures as per the schedule. By year 3 it is a deliverable to have moved towards system outcomes. Metrics will focus on the community service's role and work undertaken in supporting system working across BNSSG.

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
Measuring Quality in Community Services • **Community health services are an essential component of providing a large range of different services and often are dependent on partners in other health services for the success of their interventions in achieving outcomes** • **There is a lack of robust, comparable national indicators for community services to benchmark against however BNSSG is developing an approach of local quality measures with a focus on outcomes, the things that matter to people/patients, and rely on whole system, integrated working to deliver** • **Whole system measures are being developed for BNSSG and it is anticipated areas contained within this schedule will form the basis of these measures and be dependent on working with partners in the system to deliver**		Quality dataset agreed on the basis of this quality schedule and related outcome measures, for example mortality rates; incident rates; patient satisfaction **Reporting to: Provider Quality Sub Group/ICQPMG (on an exception basis only)**	Subject to General Condition 9 (Contract Management) Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly reporting with annual reporting of lessons learnt and changes made as a consequence

1 Preventing people from dying prematurely				
Quality Requirement – Description	**Threshold (where applicable)**	**Method of Measurement**	**Consequence of breach**	**Timing of application of consequence**
1.1 Learning from Deaths Support the acute providers, where relevant in the review of 'in hospital' deaths including thematic review. Medical Director assurance regarding the monitoring arrangement on mortality, identifying and considering emerging trends and themes of reviews. **Compliance with the national requirements for:** **1.1.1 Learning from Death Reviews –** National Quality Board Guidance July 2018 requiring working in conjunction with acute providers where patients have received community provision at the time of death or shortly before this. **1.1.2 Learning Disabilities Mortality Review (LeDeR) programme -** Compliance with the LeDeR process and associated guidance including trained reviewers (*training can be arranged through request to commissioner*) ***Medical Examiner Role. National guidance is expected. Assurance of adoption of role will be discussed once released.***		Report evidencing the actions taken to share and embed learning as a result of investigating the incident(s), triangulated with other quality measures (e.g. complaints, adverse incidents and patient feedback) in line with identified trends. Report to include evidence of reporting of exceptional findings to Board level meetings Current mortality review policy **Reporting to: Provider Quality Sub Group/IQPMG**	Subject to General Condition 9 (Contract Management) Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Annual Reporting of lessons learnt Quarterly Annual
***1.2 Venous Thrombo-Embolism (*VTE) risk assessment**: All inpatient service users to undergo risk assessment for VTE • Requirement to undertake root cause analyses (using agreed 'mini' template) • Report compliance with:	95% 100%	Evidence of delivering: • compliance with completion of VTE risk assessment • provision of prophylaxis	As set out in General Condition 9 Local Improvement Plan (with agreed trajectory /	Monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
- Completion of VTE risk assessment - provision of prophylaxis for all cases of hospital acquired VTE - Where harm has occurred the SI process should be followed.		Receipt of RCA reports for all cases of hospital acquired VTE and hospital acquired thrombosis with quarterly thematic analysis **Reporting to:** **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	tailored timeframe for completion)	Quarterly
1.3 Seven (7) Day Working Model As described in the Open 7 Days a Week Report, Providers are expected to move towards a 7 day working approach. The trajectory towards this is to be agreed as part of the procurement process. The plan towards this will include: • Undertaking of a gap analysis • Planning of what services need to be delivered over 7 days • Identification of areas relating to interdependencies with partners across the system and future integration opportunities across 7 days • Development of improvement plans to test • Monitoring/overseeing of approach via the appropriate sub-committee		Annual report detailing progress; inclusion of: Evidence of reports to appropriate Board committee regarding development and testing of improvement plans for moving towards a 7 day service Evidence of identified interdependence with partners across the system and integration opportunities Evidence of improvement to service provision **Reporting to: Provider Quality Sub-Group / ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Annually

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
1.4 Dementia and Delirium – Find, Assess, Investigate, Refer and Inform (FAIR). Provider to ensure a continued focus on dementia to ensure: • Measurement of the proportion of patients who : - **have an emergency admission for avoidable conditions:** o **Urinary Tract Infections** o **Severe constipation and incontinence** o **Pressure Ulcers** o **Fragility Fractures** - are aged 75 years and in whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services, - are identified as potentially having dementia or delirium who are appropriately assessed and identified, assessed and referred for further diagnostic advice in line with local pathways, who have a care plan on discharge (shared with the patient's GP) - **who have delirium and fall** • Appropriate dementia training is available to all staff; collaborative training programme across local healthcare economy (including care homes) • Care plan on discharge (shared with Primary Care) • Support for carers: local process for seeking views of carers of people with dementia and delirium (integrated service) and identification and implementation of changes needed relating to the feedback	95%	Evidence of audit of compliance with FAIR and improvement measures taken Evidence of progress with training programme Demonstrate improvements in service delivery related to findings of carer survey/consultation Compliance to Training Linked data sets for patient measurements will be provided by the CCG for the areas in **bold** as a single composite measure. The provider is to evidence how this data is changing their practice and supporting the development of services **Reporting to: Provider Quality Sub Group / ICQPMG (on an exception basis only)**	Provider breach as outlined in NHS Standard Contract Clause Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	6 monthly Quarterly Quarterly Training data collected monthly and reported quarterly Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
1.5 Participation of providers in organised Thematic Call Reviews For the purpose of identifying, investigating and responding to issues (acute providers, Severnside, primary care and SWAST). Thematic Call Reviews to take into account the whole patient journey through the healthcare system from the first to last contact, including all contacts and involvement by each healthcare providing organisation.		Evidence of participation in multi-agency Thematic Call Reviews Evidence of responding to issues identified during Thematic call reviews **Reporting to: Provider Quality Sub Group/ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly Quarterly
1.6 Provider to ensure the development of the Integrated Care Bureau (ICB): • Ensuring pathways are continually developed alongside partner organisations to improve discharge from hospital to the community/patients home • Ongoing quality improvement work to refine the information fields and quality of data entered with a focus on sharing data across organisations, and working towards a community data set to allow the tracking of patients across the system • Ongoing improvement to care pathways for patients and carers to ensure the patient is cared for in a way that meets their identified needs and goals • **Time spent at home for people with frailty/dementia** • **Days disrupted by care for people with long term conditions**		Providing a report of developing the ICB – identifying maximal usage of community pathways to support discharge, utilisation of pathway 1 and the short term bed base in the community, and inputting data to enable analysis of the ICB Documented evidence of liaison and agreement with ICB partners Evidence of the use of patient and carer engagement to identify care pathway improvements and implementation of changes Linked data sets for patient measurements will be provided by the CCG for the areas in bold. The provider is to provide written evidence of how this data is being used to develop and utilise pathways, support system working to reduce pressure in the system, and how patient outcomes are being improved to help people stay healthy, well and independent in the community	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly Quarterly Quarterly Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
		Reporting to: - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**		
2.1 Service Specifications – Description Across **all** service specifications the provider is required to meet the achievement of the following domains: **<u>NHS Outcomes Framework domains and indicators</u>** **NHS outcomes domains:** 1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions including frailty 3. Helping people to recover from episodes of ill health or following injury 4. Ensuring that people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm **Adult social care outcome domains:** 17. Enhancing quality of life for people with care and support needs 18. Delaying and reducing the need for care and support 19. Ensuring that people have a positive experience of care and support 20. Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm **Public health outcome domains:** 17. Improving the wider determinants of health 18. Health improvement		Year 1 measures to be determined by 31st October 2019	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	6 monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
19. Health protection 20. Healthcare, public health and preventing premature mortality **<u>Community Based Outcomes Framework</u>** Overarching domains which cross the entire care pathway: • Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient. • Treating and caring for people in safe environment and protecting them from avoidable harm. • Developing an organisational culture of joined-up working, patient-centred care, empowered staff, effective information sharing that links seamlessly with other services provided within the community. It is expected that the strategic aims of the specifications will translate into a number of tangible outcomes including: • Patients, carers and families will have a positive experience of care. • A patient or carer with multiple needs will have a single, integrated care plan developed with them. • A greater proportion of care will be provided closer to home in community settings. • There will be a reduction of admissions to hospital and length of stay in hospital for those who are admitted; particularly for people over the age of 65. • There will be a reduction in the number of potentially avoidable admissions (admissions with 0 to 48 hour length of				

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
stay for which no clinical procedure was carried out). • Wellbeing will be maximised and independence maintained for longer, reducing the overall need for long-term care. • Professional skills and expertise, including those of the Third Sector, will be effectively shared across services and organisations, building a more effective and resilient workforce.				
2.2 Service Specifications – Description There is a requirement for each individual service specifications outcomes to be reported as below: **Integrated Locality Teams:** • To provide a comprehensive response at all stages of the patient pathway from proactive care through to end of life care; supporting individuals to remain in their usual place of residence and to improve the proportion of people who die in their preferred place of death. The community service should be responsible for helping patients and carers to navigate the services they require relating to their needs and identified goals • To delay the need for long term care through effective preventative care and intervention.		Year 1 measures for all areas described to be determined by 31st October 2019	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	To be determined when measures are agreed
2.2 Service Specifications – Description There is a requirement for each individual service specifications outcomes to be reported as below: **Acute & Reactive Care:** **Community Beds**		Community bed measures to be determined by 1st April 2021 in line with the transfer of services from UHB	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	To be determined when measures are agreed

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
The Provider will operate community beds against the following objectives: • To provide a comprehensive, integrated adult inpatient rehabilitation service. • To provide step down care for patients requiring further recovery and assessment before progressing to a homecare or long-term care package • To facilitate the transition of patients with a variety of medical conditions from hospital to home or to divert admission from an acute care setting. • Maximise patients' potential to live at home safely. • To manage the complexity of adult rehabilitation needs. • To assist patients to return home with a care package that utilises health, social care and Third Sector services where possible. • To assist patients to make informed choices regarding future care and living arrangements and follow The Mental Capacity Act 2005 and deprivation of Liberty Safeguards as appropriate. • Maximise patients' potential to live at their place of residence safely. • To provide a facility for urgent temporary placement of patients with an acute dementia crisis that cannot be managed at home				
2.2 Service Specifications – Description There is a requirement for each individual service specifications outcomes to be reported as below: **Discharge from Acute & Reactive Care**		Year 1 measures for all areas described to be determined by 31st October 2019	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	To be determined when measures are agreed

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
Upon discharge the Provider will ensure the collection of all relevant data to support the appraisal of the service and the monitoring of outcomes, this is to include: • Information on clinical outcomes and the control of long-term conditions • Information on independence, wellbeing and social health • Information on care goals, progress and achievement • Information on care and family support; carer and patient satisfaction • Information on how the patient or GP can re-access the service in the cases of relapse or persistent problems. This should not require a new referral for persistent problems within a 6-month timeframe. • A granular break down of all clinical contacts with the individual during that care planning cycle, the frequency, intensity, length of time and attending professional to inform future service design and distribution of resources • Activity and the involvement of other parts of the health and social care system - hospitals, mental health, social care, Third sector				
2.2 Service Specifications – Description There is a requirement for each individual service specifications outcomes to be reported as below: **Specialist Advice and Support:** There are specific objectives within specialist services that the provider is required to report upon:		Year 1 measures for all areas described to be determined by 31st October 2019 Linked data sets for patient measurements will be provided by the CCG for the areas in bold. The provider is to provide written evidence of how this data is being used to develop and utilise pathways, support system working to reduce pressure in the	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	To be determined when measures are agreed

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
COPD/Pulmonary Rehabilitation Expected long-term outcomes include: • **Reductions in A&E attendance and hospitalisations for chronic respiratory conditions including COPD exacerbations over 12 months** • **Reductions in recurrent acute exacerbations of COPD over 12 months** • **Number of emergency readmissions within 60 days of discharge in people with COPD** • **Premature mortality in people with COPD** • **Potential Years of Life Lost (PYLL) in people with COPD** • **Average age at death in people with COPD** • **Smoking in people with COPD (requires primary care data for baselines)** • **Episodes of ill health requiring emergency admission in people with COPD** • **Days disrupted by care in people with COPD** • **Acute exacerbations of COPD** • **Recurrent exacerbations of COPD (people with 2/3/4 or more exacerbations in the last 12 months)** • **Emergency readmissions within 30/60/90 days of discharge in people with COPD** • **Oxygen dependence in people with COPD (dependent on primary care/community care data)**		system, and how patient outcomes are being improved to help people stay healthy, well and independent in the community		

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• **Dying in preferred place of death in people with COPD** • **Time spent at home in last 60 days of life in people with COPD** The Provider shall send each patient an appropriate objective feedback survey that will request feedback about the patient's experience of the service. The Provider shall collate and analyse the results of the survey and produce a report as part of the wider annual evaluation of outcomes for the community respiratory service **Tissue viability** The tissue viability service should use a range of approaches to maximise engagement with training and this may include delivery of education across clusters of organisations and professionals or the focused training of specific staff/organisations within their regular clinical setting. Delivery of training to a specific organisation on-site at their place of practice may be particularly appropriate for sectors that find it difficult to release staff for training, particularly care homes and primary care. Training delivered in this way should be targeted to achieve the most significant improvement in outcomes **Continence Service** Evaluation of the bowel management plan using a range of clinical outcome measures				
2.2 Service Specifications – Description There is a requirement for each individual service specifications outcomes to be reported as below: **Locality Hubs:**		Year 1 measures to be determined by 31st October 2019	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	To be determined when measures are agreed

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
The development of locality hub sites is expected to enable the achievement of key system objectives including: • To work towards the aspiration of collaborating with primary care, social care, mental health and Third Sector agencies to ensure individuals can access a comprehensive health and social care support and improve knowledge of the population to self-care and improve wellbeing • To delay the need for long term care through effective proactive care and intervention designed around patient identified outcomes				
3.1 End of Life / Palliative Care Provider has a clear strategy in place to drive forward Ambitions for Palliative and End of Life Care - the National Palliative and End of Life Care Partnership and in adopting the approach to ReSPECT. This includes: • Organisational leadership; clear governance at Board level • Personalised care planning – for all approaching end of life • Sharing of records with person for review, change and updating themselves. With person's consent, sharing of records with those involved in their care • Involving, supporting and caring for those important to the dying person - good bereavement and pre-bereavement care, including for children and young people • Framework for staff education, training and continuing professional development including maintenance of skills such as using syringe drivers and non-medical prescribing.		Evidence of strategy development Evidence of reports to Trust Board pertaining to measures being taken to drive forward the ambitions Evidence of framework for education Examples of use of person-centered tools for measuring the quality and impact of care e.g. PROM's (patient related outcome measures); results of audits undertaken Attending and participating in BNSSG End of Life Programme Board as part of Healthier Together Linked data sets for patient measurements will be provided by the CCG for the areas in bold. The provider is to provide written evidence of how this data is being used to develop and improve outcomes through the utilisation of staff, improving pathways and	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	6 monthly 6 monthly 6 monthly Annually Every 2 months 6 monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• Adopting use of appropriate use of person-centered tools to measure the quality and impact of care on the dying person within the context of local audit and reflection • Access to Specialist Palliative Care when required • **Measurement of the following EOL metrics:** o **Patients who die in their preferred place, increasing the proportion of those expected to die who are on the palliative care register** o **Time spent at home in the last 60 days of life** o **The need for emergency hospital admissions in the last 30 days of life for people on the palliative care register**		services, and supporting people to achieve their preferences for end of life **Reporting to:** **Provider Quality Sub Group/ICQPMG (on an exception basis only)**		
3.2 Frailty Models of Care Provider to ensure a continued focus on frailty identification & care planning • Engagement in BNSSG frailty programme with senior clinician and management level representation and active participation in strategic meetings • All staff are aware and able to deal with issues relating to frailty and proactively manage patients to enable them to remain independent • Progression of the awareness raising plan with reference to activities that will include elements of how to manage frailty in ED and include areas outside of care of elderly • **Measurement of :** o **Serious falls in people with frailty and/or dementia**		Evidence of minutes from BNSSG Frailty Programme meetings Evaluate effectiveness of awareness raising activities and the usefulness of Stranded Patient index Evidence of staff training, monitoring of falls and referrals to the falls service. Case study analysis of frail patients including patient/carer feedback to identify areas for improvement in enabling independence with an action plan for implementation Linked data sets for patient measurements will be provided by the CCG for the areas in bold. The provider is to provide written evidence of how this data is being used to	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly 6 monthly 6 monthly 6 monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
○ **Urinary tract infections, severe constipation and incontinence requiring hospital admission**		improve patient outcomes and measures taken/proposed to improve them **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**		
3.3 Shared Decision Making Provider to work with the concept of a BNSSG shared decision making and decision making tool in services: • Working in partnership with other providers • Evidence of a provider wide approach to empowering patients to be informed decision makers about their care		Case studies, examples of service approaches and expansion of decision making tools and evaluation i.e. care plan for reporting **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly
4.1 National Institute for Health and Care Excellence (NICE) helps improve outcomes for people using the NHS and other public health and social care services. Provider to assess position with regard to recommendations outlined within clinical guidelines (CGs) issued by NICE to improve outcomes for people using the NHS and other public health and social care services	100% of NICE Guidelines to be fully monitored &reviewed where appropriate (excluding those published in previous quarter)	Evidence of monitoring compliance with NICE recommendations and reasons for any non-compliance **Reporting to:** - **Provider Quality Sub Group/IQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly
4.2 Avoidable / Delayed Transfers of Care There is frequently the requirement to transfer patients during their care pathway for reasons such as change in clinical condition or speciality.		Evidence of policy/standard for defined care pathways to include an approved process describing the management of risks associated with the inappropriate transfer of patients	Local Improvement Plan (with agreed trajectory /	Annually

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• Policy/standard to be in place for transfers; to include an approved process describing the management of risks associated with the inappropriate transfer of patients • System to be in place for the monitoring of non-clinical patient transfers (Stranded Patient Index review) • Monitoring of instances of patient harm arising as a consequence of inappropriate transfers (via incident reporting) • Tracking variances to care pathways to include the patient experience in terms of patient related outcome measures		Evidence of system in place for the regular review of non-clinical transfers of care. Evidence of monitoring instances of patient harm arising from inappropriate/delayed transfers **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	tailored timeframe for completion)	6 monthly Monthly
a. Friends and Family Test (FFT) Provider to demonstrate use of FFT as a way of gaining patient views of recommending the Trust to a friend or family member for treatment To ensure: • Inclusion of at least one follow-up, free-text question after the standard FFT question • Monitoring of response rates - Patients seen at home or in Clinic (quarterly) - Urgent Care Centres/Walk in Centre (monthly) • Robust mechanisms are in place to ensure development and monitoring of action plans as a result of feedback • Provision of visible evidence in public places to demonstrate what actions have taken place as a result of feedback • Use feedback from FFT alongside other measures of quality	30% 15%	Evidence of compliance with monthly response rates, as published on NHS England website Examples of progress with action plans arising from patient feedback Evidence of triangulating the FFT feedback against other quality measures i.e. patient experience (complaints, PALS, surveys, patient stories, compliments), clinical effectiveness (patient outcomes) and safety (incident reporting) **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only) (Patient Experience report)**	As set out in General Condition 9 Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly Quarterly Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
This measure is nationally defined and is due for review in 2019/20				
5.2 Making the FFT Inclusive: Provider will ensure inclusion of all patient groups: - children and young people - people with a learning disability - people who have dementia - who are profoundly deaf/use sign language - people who are deaf / blind, - people who are blind or have vision loss - People with little/no English or low literacy levels - Use of the adapted version of the FFT question with these patient groups in place of the standard FFT question ***This measure is nationally defined and is due for review in 2019/20***		Evidence of inclusion of all following patient groups: Race, Disability, Sexual Orientation, religion & belief, Age. Further development subject to available resource to implement systems to collect & review data. **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	In year plan and delivery Annual Review
5.3 Accessible Information Standard Provider to ensure people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand • Ensure information available in different formats, i.e. large print, braille or via a British Sign Language (BSL) interpreter. • Ask people if they have information or communication needs and find out how to meet their needs; clearly document/highlight/flag within the person's file/notes • Ensure BSL interpreters are booked for patients who require this and report the number of occasions when this requirement has not been met		Evidence of assessing compliance using the Accessible Information Standard's conformance criteria and reporting breaches. Evidence of implemented accessible complaints policy Evidence of published accessible communications policy **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	In year plan and delivery Annual Review Annual

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• Share information about people's needs with other NHS/Adult Social Care providers (when they have consent/permission to do so) • Assessment of compliance using the Specification for the Standard's conformance criteria • Publishing of an accessible communications policy, to implement an accessible complaints policy and to support individuals with information and communications needs to provide feedback on their experience of services and of receiving information in appropriate formats and / or communication support				
5.5 Patient Experience Provider has robust processes for understanding and learning from the experiences of patients (triangulated with other quality related information): • Utilisation of different approaches/data sources to provide information about what is being done well and where improvement is required i.e.: - National and local reviews/surveys - Friends and Family Test scores and patient comments - The use of PROM's (patient related outcome measures) - Local patient participation and engagement work - Compliments, PALS concerns, MP enquiries and complaints - Social media - NHS Choices, Patient opinion, Twitter, Facebook		Evidence of systems in place to monitor patient experience Evidence of how patient forums /Citizens Assembly feed into the Trust board and inform decision making e.g. Quality Impact Assessments Examples of improvement to service provision as a result of learning from patient experience Quarterly Patient Experience Report detailing triangulated information and learning identified within the reporting period Breaches of national standards to be reported in line with the required frequency	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly Annual Review Quarterly Quarterly Adhoc

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
- CQC patient experience portal • Provider Board listens to patient experience Quality Impact Assessments(QIA) completed for new services and significant changed service provisions		(e.g. monthly, quarterly, annually) Quality Impact Assessments undertaken **Reporting to:** - **Provider Quality Sub Group/ICQPMG**		
5.6 Customer Services Provider to respond to patient feedback in a timely way and ensure complaints are handled in line with national regulations Ensure lessons learnt are embedded within the wider organisation / integrated system.	90%	Evidence of compliance in responding to individually agreed response times Evidence of learning and changes made to services where required are shared. Patient feedback following completion of the complaint Evidence the changes that have occurred relating to lessons learnt **Reporting to:** - **Provider Quality Sub Group/ICQPMG**	As set out in General Condition 9 Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly Monthly
5.8 Complaints Outcomes Assurance that complainants are satisfied with the process and outcomes of their complaint. where possible equality information is collected as part of the patient and carer satisfaction survey. Share any cases upheld by the Parliamentary Health Service Ombudsman (PHSO).		Patient and carer complainant satisfaction survey Outcomes of PHSO **Reporting to:** - **Provider Quality Sub Group/ICQPMG**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Annually Quarterly

2 Treating and caring for people in a safe environment and protecting them from avoidable harm			Services are: Safe	
Quality Requirement – Description	**Threshold (where applicable)**	**Method of Measurement**	**Consequence of breach**	**Timing of application of consequence**
6.1 Safety Culture Provider to ensure a system-wide approach to foster a positive patient safety culture (staff/organisational awareness of the potential for things to go wrong and the ability to acknowledge mistakes, learn from them, and take action to put things right): • Provision of staff training to include: root cause analysis, human factors and incident analysis. • Measuring the safety culture: using tools such as climate surveys to monitor the attitudes of staff to safety issues and identify areas for development • Compliance with National MRHA/CAS alerts. • Executive and clinical leaders commitment to developing a positive safety culture • Provider to ensure a continued commitment to a Safety Quality Improvement Programme. - Monitoring of progress against actions contained within the devised local Safety Improvement Plan		Annual report to reflect progress: Evidence of a system-wide approach to fostering a positive patient safety culture Compliance to MRHA/CAS Evidence of senior leadership commitment to safety Outcome of safety surveys and improvement measures taken Evidence of regular review of the Safety Improvement Plan and progress against actions (to demonstrate how expectations of the five domains of safety and quality are being met) Evidence of deep dives undertaken and patient stories **Reporting to:** - **Provider Quality Sub Group/ ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Annually Quarterly Quarterly Quarterly Quarterly Quarterly Quarterly
6.2 Patient Safety Framework			Local	6 monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
Provider to have a framework/strategy detailing the structure and processes in place for the assessment and management of clinical risk. Inclusion of: • Incident reporting (near misses, adverse and serious incidents) • Promotion of incident reporting with the aim of ensuring an 'open and fair blame' culture in order to encourage openness, honesty, reporting and, in doing so, facilitate staff and organisational learning • Training for staff who are involved in the assessment and management of clinical risk • Being Open (Duty of Candour) policy to ensure that when unintentional harm occurs patients are offered the opportunity of actively participating in the investigation and subsequent recommendations that are made to reduce the likelihood of a recurrence • Sharing lessons and embedding learning • Implementation of solutions to prevent harm • Awareness of safety issues through the active dissemination and monitoring of safety alerts • Involving and communicating with patients the public and stakeholders • Board receives reports on key clinical risks, serious untoward and clinical incidents and patient safety trends and activity		Evidence of arrangements in place the management of clinical risk Evidence of lessons learnt and improvement solutions taken to manage clinical risk Evidence of reports to Board on key clinical risks, serious untoward and clinical incidents and patient safety trends and activity **Reporting to:** **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	Improvement Plan (with agreed trajectory / tailored timeframe for completion)	6 monthly Quarterly
6.3 Sepsis Provider to ensure a continued focus on the early recognition and management of sepsis: adoption of the NICE guidance Sepsis: recognition, diagnosis and early management (NG51). To ensure:		Evidence of local sepsis protocol (and regular review of this) Evidence of audit activity pertaining to patients who met local protocol criteria and	Local Improvement Plan (with agreed trajectory / tailored	Monthly Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• Established local protocol in place defining which emergency patients require sepsis screening • Screening to include NEWS2 in line with agreed rollout with AHSN • Screening of all patients for whom sepsis screening is appropriate • Early escalation of the deteriorating patient in line with the Community Sepsis Screening tool and NEWS2 score • Staff trained in use of the community sepsis screening tool and community escalation procedures depending on NEWS2 score • Auditing of: - percentage of patients who met the criteria of the local protocol and were screened for sepsis - compliance with staff training		compliance with staff training and Sepsis 6 Evidence of measures undertaken to ensure adherence to Nice Guidance Evidence of implementation and compliance with utilisation of NEWS2 **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	timeframe for completion)	 6 monthly 6 monthly
6.4 Serious Incidents Provider to report and investigate Serious Incidents (SIs) in line with National SI Framework (2015) and local policies/procedure Compliance to reporting. - Initial reporting 2 days of identification as an SI - 72 hour report provided 3 days of identification of SI - RCA report provided 60 days from reporting onto STEIS. Thematic reviews to be undertaken quarterly ***(New national guidance is due 2019/20)***	100%	Evidence of provider policy Compliance to guidance Thematic review **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Annual Monthly Quarterly
6.5 Never Events	0%		See national guidance.	Exception reports

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
Evidence of provider learning from Never Events, particularly with regard to same events recurring within the same service to support prevention of any subsequent Never Events		Evidence of thematic review of Never Events with recurring theme, along with evidence of learning and actions implemented. This will be supplemented by a CCG assurance visit as required **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**		
6.6 Harm Free Care – Falls Provider to ensure a continued focus on reducing patient falls that result in severe harm. Adherence to best practice as recommended within NICE Quality Standard 86: Falls in older people: assessment after a fall and preventing further falls • Evidence of local arrangements to ensure: - older people who present for medical attention because of a fall have a multifactorial falls risk assessment - Falls screen within 24 hours of admission for all patients - At risk patients should then have full falls assessment - Older people living in the community who have a known history of recurrent falls are referred for strength and balance training - Ambulance Callouts - Older people who are admitted to hospital after having a fall offered a home hazard assessment and safety interventions • Ensuring staff are:		95% patients identified as being at risk of falls should have a falls care plan within 24 hours Evidence of local arrangements in place Evidence of local arrangements in place for rapid post fall assessment and prevention of further falls Evidence of progress against actions to reduce falls and embedding of learning Evidence of staff training Data pertaining to the rate of falls resulting in moderate or severe harm (rate of falls per 1000 bed days)		Monthly 6 monthly 6 Monthly Monthly Monthly Monthly Monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
- trained to undertake multifactorial falls risk assessments - trained to deliver and monitor strength and balance training programmes - have the expertise to perform home hazard assessments and in which the assessment is followed up with the offer of safety interventions and/or modifications as appropriate • Processes in place to ensure learning from falls, particularly with regard to same events recurring over a period of time within the same ward/service • Monitoring of rate of falls resulting in moderate or severe harm		Evidence of Harm Free Care reports to Provider (Quality & Risk Management Committee) **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**		
6.7 Harm Free Care – Pressure Injury Provider to ensure a continued focus on reducing incidences of avoidable category 2, 3 and 4 Pressure Injuries. Adherence to best practice as recommended within NICE Quality standard 88: Pressure Injuries: • Evidence of engagement with BNSSG Strategy to ensure: - Pressure Injury risk assessment undertaken within 6 hours of admission to hospital - risk of developing Pressure Injuries reassessed after a surgical or interventional procedure, or after a change in care environment following a transfer - healthcare professionals are trained in assessing Pressure Injury risk - skin assessment undertaken if a person is identified as high risk of developing Pressure Injuries		Evidence of local arrangements in place Evidence of progress against actions to reduce prevalence of Pressure Injuries and embedding of learning Evidence of compliance with completion of risk assessment and skin checks Evidence of BNSSG Pressure Injury Programme Board, participation (partnership working) and progress with actions Number of identified Pressure Injuries per month inclusive of MASD	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly Monthly 6 monthly Bi-monthly Monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
- family members and carers are involved in the decision-making process about investigations, treatment and care - people at high risk of developing Pressure Injuries, and their carers, receive information on Pressure Injury prevention - people at high risk of developing Pressure Injuries are provided with pressure redistribution devices • Participation in the BNSSG Pressure Injury Programme Board: joint partnership working across the health economy (involving Primary Care, Community Services, Commissioners and Local Authority) • Auditing of compliance against Pressure Injury risk assessment and skin checks in line with BNSSG strategies. • Monitoring rate of hospital acquired Pressure Injuries grade 2 and above per 1000 bed days • Pressure Injuries occurring within the organisation are deemed community acquired and those acquired from other healthcare provider or patients home (when unknown to the community service) are referred to as inherited: - Monitoring of rate of community acquired Pressure Injuries (grade 2>) - Reporting details to include numbers of acquired pressure injuries against caseloads per 10,000 population to be agreed at part of the BNSSG Pressure Injury Board - Reporting of grade/category 3 & 4 healthcare acquired pressure injuries where lapse in care has been identified to		Reporting number of grade 3 and 4 pressure Injuries identifying numbers reported as an SI. Thematic review against BNSSG standards and evidence of action plan. **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**		Quarterly Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
be reported as serious incidents on to the STEIS - Reporting monthly Moisture Associated Skin Damage (MASD) that presents as Incontinence Associated Dermatitis (IAD) -				
6.8 Duty of Candour Compliance with national guidance where the provider must inform patients where there has been a significant failure in their care or treatment; Involvement of patients and relatives in the investigation of serious incidents and informing them of the outcome where desired. As per CQC requirements: • Provider must promote a culture that encourages candour, openness and honesty at all levels. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body • Robust system to be in place to meet the Duty of Candour Regulation; to include: - training for all staff on communicating with people who use services about notifiable safety incidents - incident reporting forms which support the recording of a duty of candour notification - support for staff when they notify people who use services when something has gone wrong - oversight and assurance • Record in patient notes and RCA investigation reports: - Compliance with the Duty of Candour process including open communication	100%	Evidence of robust system in place to meet the duty of candour regulation Evidence of how the leadership and culture reflects the vision and values and encourages openness and transparency including reports to Trust Board (via Quality & Risk Management Committee) RCA quality reviewing process: checking against Duty of Candour Checklist CCG Serious Incident Review Panel Discussion of breaches at Quality Sub-Group / IQPM **Reporting to:** - **Provider Quality Sub Group/ICQPMG (on an exception basis only)**	National penalty will apply	6 monthly Annual Monthly Monthly Adhoc

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
with affected individual(s) and/or their next of kin - Exception to patient contact: where individuals cannot be contacted/traced, to record of attempts to make contact or individuals decline contact or do not wish to discuss at this point in their lives. Where sufficient effort has been made but contact has not been achieved, this will not constitute a breach (in line with guidance) • Relevant Trust policies to include responsibility to fulfill Duty of Candour i.e. Being Open Policy				
6.9 Commissioning Excellent Nutrition and Hydration 2015-18 Provider to ensure excellent nutrition and hydration care in acute services in line with NHSE guidance. To encompass: • Identification when malnutrition has occurred through the use of active nutritional screening e.g. the Malnutrition Universal Screening Tool ('MUST') for adults and an appropriate pediatric tool • Treating those at risk from malnutrition or dehydration using documented, appropriate, NICE compliant care pathways with ongoing specific care spanning organisational boundaries where needed • Educating all staff, voluntary workers, patients and carers on the importance of good nutrition and hydration in maintaining better health and wellbeing, improving recovery from illness or injury and in the management of long-term conditions	90%	Evidence of strategy development/relevant policies. Evidence of evaluation of outcomes relating to delivery of strategy Monitoring of outcome measures: - Patients screened within 48 hours of admission to hospital (total & %) - Regular monitoring of agreed % of patients over 65 years who are malnourished or at risk of malnutrition who receive a management plan that aims to meet their nutritional requirements - Evidence of briefings for staff, voluntary workers, patients and	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	6 monthly 6 monthly Monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• Identification of outcome measures (in agreement with CCG) and in line with 'Keeping people healthy, well and independent in the community'. ***New strategy is expected for 2019***		carers on the importance of good nutrition and hydration in maintaining better health and wellbeing, improving recovery from illness or injury and in the management of long-term conditions **Reporting to:** - **Provider Quality Sub Group/ICQPMG on an exception basis only)**		
6.10 Improving Safety in Medicines Management **<u>Omitted doses</u>** Trusts are asked to reduce the overall number of omitted doses. This will include standardisation of approach to define what 'omitted' means within agreed parameters, through the BNSSG STP Medicines Quality and Safety Group **<u>Safe management of Controlled Drugs</u>**		Omitted dose definition and detailed qualification of data metrics for submission to be agreed in collaboration between provider and commissioner in quarter one 2019/20 Monitor omitted doses trends across the Trust to identify trends such as the specific areas within which doses are being omitted, as this is the primary driver of errors. Evidence that learning from themes related to a specific medicine or a medicine related processes is being disseminated within the Trust by various methods to upskill and re-educate staff including staff training where necessary.	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarter 1 Annual Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
Processes need to be in place to support safe use and management of controlled drugs, including the reporting and investigating of concerns and sharing learning.	75% compliance with audit standards, aiming for 100% compliance 75% compliance with audit standards, aiming for 100% compliance.	Monitor Controlled Drugs of schedule 1, 2, 3, supply/usage trends to all locations supplied by the Trust (including supply external to the Trust) to identify excessive ordering/use and investigate to confirm usage is clinically appropriate. Monitoring will include sub-contracted pharmacy services e.g. prescribing on FP10 and outpatient prescription services. Monitoring report to include areas of concern identified and actions taken with planned timescales. Undertake quarterly Controlled Drugs audit of ward storage Undertake quarterly reporting of Controlled Drugs related incidents to NHS England Engage with the Controlled Drugs Local Intelligence Network through attendance at Controlled Drugs Local Intelligence Network meetings. Sharing learning identified by the Controlled Drugs Local Intelligence Network within your organisation to improve patient safety. Audit program to monitor compliance with recommendations at least quarterly		Quarterly Quarterly Quarterly Annually Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
Medicines reconciliation Medicines reconciliation to be undertaken within 24 hours of admission to hospital for all in-patients Work will be undertaken across BNSSG to standardise the definition of 'medicines reconciliation' through the BNSSG STP Medicines Quality and Safety Group, this will take account of the need for 7 day service provision.	Monthly audit showing improvement, aiming for a minimum of 75% (NHSI national median) compliance 75% compliance with audit standards, aiming for 100% compliance	Audit program to monitor compliance with recommendations at least quarterly		Quarterly
Antimicrobial Stewardship Organisation has an antimicrobial stewardship lead and program Antibiotic prescribing for inpatient beds adheres Start Smart – the Focus Antimicrobial Stewardship Toolkit for English Hospitals (PHE 2015) including: compliance with prescribing guidelines or appropriate documented reason for non-compliance; documentation of clinical indication included on drug chart; a review at 48-72 hours with a documented clear plan of action. Evidence that results are feedback to prescribers Broad spectrum antibiotic (Cephalosporins, quinolones and co-amoxiclav) prescribing is reviewed at least 3 monthly ensuring prescribing is appropriate for example, following guidelines, based on culture and sensitivity results.	75% compliance with audit standards, aiming for 100% compliance.	Robust stewardship plan shared with CCG Audit program to monitor compliance with recommendations at least quarterly Audit program to monitor compliance with recommendations at least quarterly **Reporting to:** - **Provider Contract/Performance and Quality Group Meeting (by exception)** - **CCG Medicines Management Steering Group**		Annually Quarterly Quarterly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
6.11 Infection Control Measures inclusive of Healthcare Acquired Infections (HCAI) Provider must ensure compliance with Health & Social Care Act 2008 – Control of infection. **Please see separate HCAI SCHEDULE (Annex A)**		**Reporting to:** - **Provider Contract/Performance and Quality Group Meeting (by exception)**		
6.12 Working with the CCG / System working To ensure close partnership working between the CCG, patients/carers, other providers and the third sector across BNSSG; a visible CCG presence to providers and patients: • Programme of formal quality assurance and improvement visits to the provider organisation and visits in response to issues raised. Prioritised visits will be based on risks and issues identified through reported serious incidents and never events, data provided from the provider in relation to quality and safety (including failure to meet national targets), patient experience, CQC inspection reports and feedback/intelligence from the Quality Surveillance Group • Provider to develop actions in response to issues raised during quality assurance and improvement visits • Undertaking of selective deep dive audits to support knowledge of assurance processes pertaining to quality issues		CCG/provider discussion of quality assurance and improvement visits Evidence of progress with improvement actions in response to issues identified during CCG quality assurance and improvement visits Evidence of deep dive audits Report detailing partnership working – the benefits, challenges and changes implemented as a result relating to integrated working and its development. Evidence of regular engagement with all partners, their feedback on services and pathways and changes implemented as a result. **Reporting to:**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Adhoc as agreed Quarterly 6 monthly 6 monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• Evidence of working in partnership with patients/carers, General Practice, other provider organisations and the third sector to improve pathways and the health and independence of people across BNSSG		- **Provider Quality Sub Group / ICQPMG (on an exception basis only)** - **CCG QAG/Governing Body meetings (on an exception basis only)**		
6.13 Safeguarding Standards To ensure the securing of good quality services for safeguarding children and adults at risk of abuse and neglect. ***Please see attached Safeguarding Standards attached as Annex 2. Currently under review for 2019.***		Evidence of meeting these standards including a review of cases where safeguarding concerns have been raised		6 monthly
7.1 Freedom to Speak Up. Provider to adopt the NHSI Freedom to Speak Up: Whistleblowing Policy for the NHS as a minimum standard to help to normalise the raising of concerns for the benefit of all patients**:** • encourage staff to speak up and set out the steps they will take to get to the bottom of any concerns • appoint a whistleblowing guardian, an independent and impartial source of advice to staff at any stage of raising a concern • any concerns not resolved quickly through line managers are investigated • investigations will be evidence-based and led by someone suitably independent in the organisation, producing a report which focuses on learning lessons and improving care • whistleblowers will be kept informed of the investigation's progress		Evidence of adopting of the NHSI Freedom to Speak Up: Whistleblowing Policy for the NHS Evidence of appointment of Freedom to Speak Up Guardian role Example of any concerns raised and how addressed **Reporting to:** - **Provider Quality Sub Group / ICQPMG (on an exception basis only)**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	6 monthly 6 monthly 6 monthly

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
• high level findings are provided to the organization's board and the policy will be annually reviewed and improved				
7.2 Staff Friends and Family Test Provider to have an in-depth understanding of factors affecting staff satisfaction and how plans will ensure measurable improvements in staff experience in order to improve patient experience including: - Staff FFT – Score of staff who would recommend the provider to friends or family if they needed care or treatment - Staff FFT – Score of staff who would recommend their organization as a place of work		NHS Survey and improvements evidenced to influence change on previous years Improvement measure on previous year score Improvement measure on previous year score **Reporting to:** - **Provider Quality Sub Group / ICQPMG (on an exception basis only)**		Annually
7.3 Safer Staffing and work force monitoring Ensuring services are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality and **safe** care. Best practice guidance should be applied where relevant. Staffing data should be shared monthly in line with the requirements of Healthier Together ***Workforce Minimum Dataset agreed for BNSSG as a separate specification and is subject to an information sharing agreement between BNSSG organisations***	Monthly Ad Hoc	Staffing and HR reports shared with Healthier Together and board level reporting Skill mix methodology evidenced. **Reporting to:** **Provider Contract/Performance and Quality Group Meeting (on an exception basis only)**	Subject to General Condition 9 (Contract Management)	Monthly Ad Hoc

Quality Requirement – Description	Threshold (where applicable)	Method of Measurement	Consequence of breach	Timing of application of consequence
Any skill mix undertaken should be transparent to include the methodology and best evidence used				
8.1 Equality and Diversity Provider's Board to discuss and consider diversity, including consideration of board members reflecting the diversity of their geographical locality. Provider's Board to have a clear strategy centered around EDS2 goals to deliver on key nationally mandated equality requirements (WRES: Workforce Race Equality Standards, Accessible Information Standards, and upcoming NHS Disability Standard) Community involvement activity to be delivered in an inclusive manner - Provider to comply with the Workforce Race Equality Standard - Provider comply with the Equality Delivery System 2 ***Workforce Minimum Dataset agreed for BNSSG as a separate specification and is subject to an information sharing agreement between BNSSG organisations***	Meeting race equality standard	Annual audit of board/detail in annual quality account. Detailed WRES and EDS2 action plans and milestones Workforce data and appropriate training in place (Induction, anti-bullying and harassment, management training) Acquiring Disability Confident Standard PPI Plans Minimum dataset **Reporting to:** - **Provider Quality Sub Group / ICQPMG** - **Safeguarding committee**	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Annually Annually Monthly Annually Annually Monthly

Annex A: HCAI Quality Requirements Summary

Section 1 – National Framework Guidance				
Quality requirement	**Threshold (per year)**	**Method of measurement**	**Consequence of breach**	**Reporting frequency**
1.1 Code of Practice Implementation of the DOH Code of Practice on the Prevention & Control of Infections and related Guidance (revised 2015).	Compliant/ non-compliant plus milestones	Implementation plan and audit of the elements	As per schedule 9.	Quarterly to the Contract Quality Group

The Code of Practice applies to all Providers of Healthcare and Adult Social Care

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation facilities.
8. Secure adequate access to laboratory support as appropriate.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Quality requirement	Threshold (per year)	Method of measurement	Consequence of breach	Reporting frequency
1.2 Ward/Service Culture Evidence of Board to ward /service culture : • Establish a clear vision • Provide effective leadership • Ensure competence and measure compliance • Communicate clear accountability (and escalation policies) • Learn from others, both inside the organisation as well as outside of it	Ref: Board to Ward, DH, 2008	Board monthly KPIs	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	Providers infection Prevention and control Board report includes evidence of this (via Trust Integrated Performance report)
1.3 Policy & procedures Provider to will be able to evidence that infection control policies and procedures are: a) Evidenced based b) Regularly reviewed c) Updated d) In Date e) Accessible to staff.		Provider Policies/procedures.	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	Ad hoc via visits/ planned assurance visits 6 month assurance report noting exceptions.

Section 2 – Quality Requirements Summary				
Quality requirement	**Threshold (per year)**	**Method of measurement**	**Consequence of breach**	**Reporting frequency**
2.1 MRSA bacteraemia	Zero avoidable cases attributed to provider	Monthly review of cases attributed to provider on Public Health England DCS	As per contract schedule 4B	via the IPR Details of exceptions in 6 monthly assurance report.
2.2 Clostridium difficile **<u>Acute Providers</u>** 2018/19 thresholds noted to be: NBT: 42 UHB: 44 WAHT: 17 **<u>Community Providers</u>** A BNSSG system wide threshold exists for C.difficile. But currently there are no threshold targets for community providers**.**	CDI limits for acute organisations (and CCGs) for 2019/20 will be announced following national guidance and will continue to deliver realistic improvement objectives NBT – 57 UHB – 57 WAHT -14 (CCG – 201)	Monthly review of cases attributed to provider on Public Health England DCS	As per contract schedule 4B	Monthly numbers via IPR.
2.3 E. coli bloodstream infections **<u>The NHS ambition target</u>** The E.coli blood stream infection quality premium for 2017 – 19 sought to reduce cases by 10%, 15% and 20 %. (Baseline – Jan – Dec 2016 data).	Expected target - 10% reduction for 2019/20. Baseline – year end provider attributed cases as at 31/03/2019.	Monthly review of cases attributed to provider on Public Health England DCS	As per schedule 9	Monthly numbers via IPR.

Quality requirement	Threshold (per year)	Method of measurement	Consequence of breach	Reporting frequency
2.4 MSSA 2018/19 MSSA bacteraemia apportioned to provider limits were as follows: UH Bristol = 28, NBT = 26 WAHT 5. **<u>Community Providers</u>** Currently there are no threshold targets for community providers	2019/20 thresholds to be advised.	Monthly review of cases logged on Public Health England DCS	As described in this schedule.	Monthly numbers
Section 3 – Quality HCAI schedule				
3.1 MRSA Number of avoidable bacteraemia infections attributed to provider. (See section 1)	Local provider target per year: NBT = 0 UH Bristol = 0 WAHT = 0 The zero target applies to community providers BCH = 0	Number of infections in period. Reported in the Clinical Quality Performance Report and reviewed as part of the Clinical Quality Review contract monitoring processes.	Breach leads to request for implementation of an improvement plan if plan is not achieved, then commissioners reserve the right to treat this as a material breach of contracted quality standards and pursue the contractual contract management process, however no further financial penalties will be associated with this, given the national penalties in Schedule 4B. The Provider and the Commissioner will work together to jointly agree a robust action plan. Failure to implement the action plan	Monthly (via Trust Integrated Performance report)

	Sirona = 0 NSCP = 0.			
3.1a MRSA **<u>Acute Providers</u>** Focused Screening of elective patients (who are being admitted) at the Pre-Operative assessment Clinic for MRSA. Screening of all high risk patients as described in national guidance/local policies. **<u>Community Providers</u>** Screening for MRSA colonisation for all patients in an inpatient /rehabilitation facility. Guidance: Department of Health (2014) Implementation of modified admission MRSA screening guidance for NHS.	95% for BNSSG patients who attend pre-op assessment (focused screening). 95% 95%	Audit Reported in Infection Control Group Report and shared with commissioners. Audit Individual patient metrics reported via RCA/PIR as appropriate.	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	6 month assurance report noting exceptions. report
3.1b MRSA **<u>All providers</u>** Decolonisation arrangements for MRSA - evidence of compliance with Trust/ Provider	95%		Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	

policies.		Point prevalence Audit – To be determined and agreed locally. Sample size to be agreed.		6 month exception report for acute and community providers.
3.2 CDI Number of cases apportioned to provider. (See section 1) There are changes to the CDI reporting algorithm for financial year 2019/20, which reduces the number of days to identify hospital onset healthcare associated cases from ≥3 to ≥2 days following admission New assignment criteria for healthcare onset and community onset is noted.	2018/19 Acute provider thresholds were: NBT: 42 UHB: 44 WAHT: 17 Currently awaiting guidance regarding 2019/20 – to be advised. **<u>Community Providers</u>** BNSSG CCG has a system target for CDI	Number of infections in period. Reported in the Clinical Quality Performance Report and reviewed as part of the Clinical Quality Review contract monitoring processes. Evidenced in post infection reviews and discussed through HCAI group and Contract review meetings	As per national contract.	Monthly (via Trust Integrated Performance report)

(NHS Improvement (2018) Clostridium difficile infection objectives for NHS organisations in 2018/19, guidance on sanction implementation and notification(NHS Improvement of changes to case attribution definitions from 2019 March) . Community providers participate and collaborate with acute providers in post infection reviews where the provider has been involved in providing care prior to the infection. All providers will participate and collaborate in post infection reviews	However there is currently no reduction target for each community provider			
3.3 E coli Bloodstream infections apportioned to provider	Ongoing monitoring. Expected target - 10% reduction for 2019/20. Baseline – year end	Number of infections in period. Reported in the Clinical Quality Performance Report and reviewed as part of the Clinical Quality Review contract monitoring processes	Where increasing trends are identified, the Provider and Commissioner will agree evidence-based actions required to reverse the trend. Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	Monthly (via Trust Integrated Performance report)

	provider attributed cases as at 31/02/2019.			
3.3a Urinary Catheter **<u>All providers</u>** Evidence of compliance with urinary catheter insertion standards (Standards determined by national guidance and/or local policy).	85% of an agreed sample size	Local process to measure compliance with urinary catheter standards.	Target is breached when there is 3 rolling months failure to achieve target. Breach leads to request for implementation of an improvement plan, if plan is not achieved, then commissioners reserve the right to treat this as a material breach of contracted quality standards and pursue the contractual contract management process however no financial penalties will be associated with this.	6 month exception reporting
3.3b Urinary Catheter Passport **<u>Acute Providers</u>** All acute providers will ensure that all patients discharged with a urinary catheter have a catheter passport that is completed at the point of discharge. **<u>Community Providers</u>**	85% of agreed sample size determined at provider review meeting	Audit process to demonstrate completion of the passport and to include evidence that there is a continuing indication of clinical need for and that Trial without catheter (TWOC) has been reviewed	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	6 month exception report. Enhanced reporting during introduction/roll out phase -

Community providers to ensure that catheter passport is issued/completed at the point of each insertion of a catheter and is updated at the point of ongoing care				To be agreed with providers
3.4 MSSA Number of bacteraemia apportioned to provider. (To be advised). **<u>Community Providers</u>** Currently there are no threshold targets for community providers	2018/19 MSSA bacteremia apportioned to provider limits were as follows: UH Bristol = 28 NBT = 19 WAHT = 5 2019/20 thresholds to be advised.	Number of infections in period. Reported in the Clinical Quality Performance Report and reviewed as part of the Clinical Quality Review contract monitoring processes	Breach leads to request for implementation of an improvement plan, if plan is not achieved, then commissioners reserve the right to treat this as a material breach of contracted quality standards and pursue the contractual contract management process; however no financial penalties will be associated with this. The Provider and the Commissioner will work together to jointly agree a robust action plan.	Monthly (via Trust Integrated Performance report).
4. Local and National Reporting				
4.1 RCA and PIR submission As agreed HCAI group.	RCA (where required) to be submitted within 60 working day time frame.	Reported in the Clinical Quality Performance	Breach defined as failure to notify within national timescales. Breach leads to request for	As incident occurs

Agreement to adopt a single RCA/PIR tool across all acute providers, based on national guidance to include: (1)Clinician review, (2) Antibiotics pre-admission (3) Screening if appropriate (4) Audit results related to month of incident and month before. (5) Mandatory training data. The review should include whether a lapse in care has been identified and whether lapses of care are contributory or no-contributory to the case under review. **<u>All Providers</u>** Providers will work collaboratively to complete reviews where patients have been receiving care from different providers prior to the infection The process and outcome should be reported to	Wherever possible, RCAs should be completed significantly more quickly. HCAIs that are rated as serious incidents to follow the Serious incident reporting and completion timescales	Report and reviewed as part of the Clinical Quality Review contract monitoring processes.	implementation of an improvement plan, if plan is not achieved, then commissioners reserve the right to treat this as a material breach of contracted quality standards and pursue the contractual contract management process; however no financial penalties will be associated with this. The Provider and the Commissioner will work together to jointly agree a robust action plan.	

commissioner.				
4.2 Re-admittance **Acute Providers** Patients readmitted with surgical site infection within 30 days of operation		Mandatory surveillance (categories as reported by participating hospital)	Where there are adverse trends, the Provider and the Commissioner will work together to jointly agree a robust action plan	Monthly cases/ Quarterly trend data via Quality Sub Group.
4.3 Hospital/ Provider Mortality Where the patient has been in an in-patient facility an RCA process will be undertaken. MRSA/CDI RCA should: Identify whether the patient died within 30 days of the MRSA bacteraemia or CDI diagnosis. Record if MRSA/CDI appears on the death certificate (which part).	Based on local determination	MRSA/C.Diff RCA will be shared with the Commissioner. Process to be agreed.	Each serious incident report will be separately assessed and the provider will provide assurance to the CCG that recommendations/actions have been completed/embedded	. Ad Hoc Reporting The annual HCAI report should state the number of patient deaths where CDI has been confirmed, through the RCA process, to have been a significant factor in the death.

Provide details of all conditions listed on the death certificate				
4.4 Provider Compliance. Whilst the CCG and healthcare providers recognise the overarching code of practice for the prevention and Control of Healthcare Associated Infections (2015). It is recognised that the High Impact Interventions (HII) 2017 provide a means of assurance and therefore apply to the following key procedures(note some providers may use an alternative evidence based tool i.e.IPS): Audit tools are available from the HII and audits are only required where patients are in receipt of specific care as detailed below:- 1. Ventilator Care.	95% as per patient safety initiative aiming for 100% compliance	Audits Standards and escalation procedures to be agreed locally	Target is breached when there is 3 rolling months failure to achieve target. Breach leads to request for implementation of an improvement plan, if plan is not achieved, then commissioners reserve the right to treat this as a material breach of contracted quality standards and pursue the contractual contract management process The Provider and the Commissioner will work together to jointly agree a robust action plan. Failure to implement the action plan will result in the introduction of local penalties for HCAI targets	6 monthly exception report.

2. Peripheral Vascular Devices. 3. Central venous Access Devices. 4. Surgical Site Infection. 5. Urinary Catheter Care.				
4.5 Environmental cleaning **<u>All Providers</u>** The provider will have in place cleaning schedules which describe the expected processes and standard. Environmental cleaning audits will demonstrate a local compliance against thresholds.	Audit sample and frequency to be agreed.in line with		Local Improvement Plan (with agreed trajectory / tailored timeframe for completion Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	6 monthly exception report.

	national guidance (e.g. C4C national cleanliness guidance)			RCA/PIR Documents
4.5a– Cleaning and Decontamination of Clinical Equipment. **<u>All Providers</u>** Evidence that equipment cleaning and decontamination policy and processes are in place.	95%	Audit	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	6 monthly exception report. RCA/PIR Documents
4.6 Hand Hygiene **<u>All Providers</u>** Evidence that I staff in clinical areas or where clinical care is being provided are compliant at	95%	Monthly audit –	Target is breached when there is 3 rolling months failure to achieve target. Breach leads to request for implementation of an improvement	Monthly audit results via IPR RCA/PIR

Hand Hygiene			plan, if plan is not achieved, then commissioners reserve the right to treat this as a material breach of contracted quality standards and pursue the contractual contract management process however no financial penalties will be associated with this. The Provider and the Commissioner will work together to jointly agree a robust action plan.	6 monthly exception report.
5. Training				
5.1 Staff Training **<u>All Providers</u>** Evidence that all clinical staff have received infection control training (Gram negative BSI including E.coli should now be included in mandatory training). Compliance measured by safety thermometer, hand	**90%**	Attendance at training monitored monthly and included in Board report.	Target is breached when there is 3 rolling months failure to achieve target. Breach leads to request for implementation of an improvement plan, if plan is not achieved, then commissioners reserve the right to treat this as a material breach of contracted quality standards and pursue the contractual contract management process however no financial penalties will be associated with this. The Provider and the	Monitored monthly via IPR/ICQPM RCA/PIR documents

hygiene audits, cleanliness audits. Mandatory surveillance reports Post Infection Reviews			Commissioner will work together to jointly agree a robust action plan.	
6. Partnership Working				
6.1 HCAI BNSSG Meeting **<u>All Providers</u>** Representing the organisation at a whole health community HCAI quarterly meeting. The provider will work collaboratively with providers across BNSSG to reduce the incidence of MRSA, C.difficile, Gram negative blood stream infections (GNBSI) including E.coli and participate in the post infection review process of all cases across BNSSG	To attend/dial in to all meetings, this may include a nominated representative. Additionally, providers will be asked to attend/contribute to task and finish groups, which will be both subject and time specific.	Meeting agenda, minutes & action plan	Target is breached when representative for the organisation has not attended more than 1 meeting in a year. Breach leads to request for improved attendance. If attendance does not improve Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	Quarterly (Proposed)

where they are/have been involved in the patients care.				
7. Seasonal Risk				
7.1 Flu Vaccination **<u>All Providers</u>** Seasonal Influenza Frontline Healthcare workers' vaccination in line with national guidance.	80% of all frontline staff 2019/20 CQUIN (may be subject to change)	Data collection by providers	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	Weekly/monthly. Reporting is required weekly during the vaccination period. It is recognised that weekly data us subject to validation. Comment check national guidance
7.2 Bed Closure **<u>All Providers</u>**				

Where a provider closes beds, ward or unit due to infection control reasons, e.g. Influenza, Norovirus the CCG will receive daily updates.	All incidences	Alamac – daily reporting tool.	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	Alamac – daily reporting tool.
8. New Build/New Services				
8.1 New Services **<u>All Providers</u>** Infection prevention and Control risks for existing services, new services and new builds to be incorporated into corporate risk assessment. All new buildings and significant service development to be formally risk assessed for HCAI/IPC components.	Quarterly register of Infection Prevention and control risk assessments undertaken. Risk score over 15 logged on Corporate risk register		Provider to effectively manage assessed risks.	By exception.

9. Appropriate Anti-Microbial Use				
9.1. Improving Safety in Medicines Management **Acute Providers** **Please refer to main Quality Schedule**				
10.Patient Experience				
10.1 Patient Experience Using the NHS Adult Inpatient Survey Q16 In your opinion, how clean was the hospital room or ward that you were in?	Complete – Yes/NO Threshold set related to survey results	Trust based survey – methodology and sample size to be agreed. Reported in the clinical quality performance report and reviewed as part of the clinical quality review contract monitoring processes	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion	Annual

Q17 Did you get enough help from staff to wash or keep yourself clean? (Aim to achieve rating of better or about the same in both metrics.) Where the provider has an inpatient bed base, but does not participate in the National NHS Inpatient Survey, there is an expectation that providers will include the above questions in their local survey.				

5.

Reporting to: -Provider Quality Sub Group / IQPMG -CCG Medicines Management Steering Group, HCAI BNSSG Providers Meeting

6.

References

DH The Health & Social Care Act 2008: Code of Practice on the Prevention & Control of Infections and related Guidance (revised 2015)

DH (2014) Implementation of modified admission MRSA screening guidance for NHS.

Infection Prevention Society (IPS)/NHS Improvement (2017) High Impact Interventions – Care processes to prevent infection, 4th Edition of Saving Lives: High Impact Interventions.

NHS England 2015/16 Five Year Forward View

NHS Improvement (2018) Update on the reporting and monitoring arrangements and post-infection review process for MRSA bloodstream infections.

NHS Improvement (2018) Clostridium difficile infection objectives for NHS organisations in 2018/19, guidance on sanction implementation and notification of changes to case attribution definitions from 2019 March

Public Health England National Surveillance Programme: MRSA bacteraemia, MSSA bacteraemia and Clostridium difficile infection (CDI) reporting data (published quarterly 2015/16)

Public Health England. B 29 - Investigation of Specimens for Screening for MRSA. (2014)

Public Health England Protocol for the Surveillance of Surgical Site Infection Surgical Site Infection Surveillance Service (2013).

ANNEX 2: Safeguarding Standards

	Description of Quality Requirement	**Method of Measurement (where applicable)**		**Target**	**Frequency of Review**	**Comments**
1	There is a board level executive director who holds accountability within the organisation for safeguarding and reports issues to the board as appropriate.	Name of board level executive director is provided, with job description and organisational structure.			Annually	
2	The organisation employs named professionals to provide expertise for adult and Children safeguarding.	Names of safeguarding leads are provided, with job descriptions and organisational structure.			Annually	
3	The organisation has a recruitment policy which includes safeguarding requirements and is relevant to volunteers (paid or unpaid), charity fund raisers or celebrities and that third party contractors are required to be compliant with this policy.	Copy of organisation's safer recruitment policy is provided.			Annually	
4	The organisation has a policy in place for the management of visits by celebrities, VIPs and other official visits.	Policies, procedures or guidance documents pertaining to visits from celebrities, VIPs and other official visitors are in place. The necessary protocols may be included within broader policy documents, such as safeguarding policies.			Annually	
5	The organisation has a policy for managing allegations of abuse made against their staff. The policy will be line with the Local Safeguarding Adult and Children Boards policy and reviewed in line	Evidence of relevant policy is provided by the organisation.			Annually	

	Description of Quality Requirement	Method of Measurement (where applicable)		Target	Frequency of Review	Comments
	with the organisations policies, or at a minimum following any major legislative change. This may be incorporated within wider policies, such as safeguarding policies.					
6	The organisation has a training strategy for safeguarding adults which identifies the level of competencies required for all posts. Training delivered should range from level one to level four as is commensurate with the nature of the role as reflected in the intercollegiate document.	The total number and percentages to date of staff requiring and completing training for level 1,2,3 and 4 competencies to be provided.		90% for each level from 1-4 (to be reported separately) RAG rating will be used - green 90%+, amber 75% -89%, red below 75%	Annual compliance Training data collected Monthly reported Quarterly	
7	That safeguarding training ensures staff are appropriately competent in applying the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) at a level commensurate with their role and in accordance with the intercollegiate competences.	Evidence is provided that safeguarding training includes appropriate competencies in MCA and DoLS or evidence or separate training.		90% compliance with MCA/DOLS training for relevant staff. RAG rating will be used - green 90%+, amber 75% -89%, red below 75%	Monthly Training data collected Monthly reported Quarterly	
8	The organisation has a training strategy for safeguarding children which identifies the level of competencies required for all posts. Training delivered should range from level one to level four as is commensurate with the	The total number and percentages to date of staff requiring and completing training for level 1,2,3 and 4. Competencies to be provided.		90% for each level from 1-4 (to be reported separately) RAG rating will be used - green 90%+, amber	Monthly Training data collected Monthly reported Quarterly	

	Description of Quality Requirement	Method of Measurement (where applicable)		Target	Frequency of Review	Comments
	nature of the role as reflected in the intercollegiate document.			75% -89%, red below 75%		
9	To ensure all allegations against their staff are appropriately reported in line with the Local Safeguarding Adults policy.	The number of allegations made in each category will be provided as follows: - The number of allegations regarding staff working with adults reported to the Local Authority. - The number of investigations completed by the Local Authority, following the reports above.		100% of allegations against staff working with adults to be reported to the Local Authority.		
10	The organisation has an annual safeguarding work plan which reflects the LSAB business plans. This will include an annual safeguarding audit plan.	Copy of safeguarding work plan, to include annual audit plan, has been provided.			Annually	
11	The organisation has a Safeguarding governance forum that meets on a regular basis and has arrangements to escalate issues where required. BNSSG CCG representative to be invited to attend the forum.	Reports demonstrating activity of Safeguarding Committee, minutes of meetings and evidence of escalation where required.			Annually	
12	The organisation complies with requests where practical for information from the local Safeguarding Adult Board.	Copies of safeguarding adults audits are submitted to the Safeguarding Boards. To include, multi-agency audits submitted to Safeguarding Boards.			Annually	

	Description of Quality Requirement	Method of Measurement (where applicable)		Target	Frequency of Review	Comments
13	The organisation ensures regular attendance at Local Safeguarding Adult Boards by senior staff with the necessary organisational authority to make decisions. Associated Safeguarding Board sub-groups are also attended as required by appropriate staff members.	Appropriate staff members will attend the required board meetings. Safeguarding Board minutes and sub group minutes demonstrate active engagement.		75% attendance at both the Local Safeguarding Adult Boards.	Annually	
14	The organisation has a clear statement of their commitment to their safeguarding responsibilities which is easily accessible to the public.	Clear statement of the organisations commitment to their safeguarding responsibilities is evident. Examples may include sections within websites, posters, leaflets, information on visual display nits in patient waiting areas.			Annually	
15	That staff are appropriately trained to recognise and identify potential signs of children and / or adults who may be affected by: - Domestic Abuse - Child Sexual Exploitation (CSE) - Modern Slavery - Female Genital Mutilation (FGM) - Radicalisation (PREVENT WRAP training) - Organisational Abuse	Evidence will be provided in narrative form, that safeguarding training includes appropriate competencies in the specific areas or evidence or separate training is available. Staff have been trained in PREVENT following NHS England and Home Office guidance.		50% of relevant staff undertaken PREVENT training by 2018, 90% by 2019. This may be captured via the NHS England Quarterly return.	Monthly data reported Quarterly	
16	The organisation has responded to safeguarding recommendations contained in reports from external inspections (CQC/Ofsted) and external reviews by auditors.	Action plans are provided in response to recommendations from external inspections. Evidence is provided that demonstrates that			Quarterly	

	Description of Quality Requirement	Method of Measurement (where applicable)		Target	Frequency of Review	Comments
		changes have been embedded in practice.				
17	The organisation monitors allegations of adult abuse or neglect which arise relating to external organisations.	Organisation submits number of safeguarding adult alerts raised to the Local Authority, which related to external organisations.			Quarterly	
18	The organisation has engaged in internal and multi-agency safeguarding audits. To include audits conducted or requested by BNSSG.	Audit reports and action plans are provided in response to audit findings. Evidence is provided which demonstrates that changes have been embedded in practice.		A minimum of x2 audits related to adults	Quarterly	
19	The organisation has initiated or engaged in Safeguarding Adult Reviews, Mental Health Homicide Reviews or Domestic Homicide Reviews, where appropriate.	The organisation will fully participate in Safeguarding investigations as necessary. Each provider will complete an internal review of practice and action plans will be developed in response to investigation or case review findings. The organisation will provide any other evidence when required, that demonstrates that changes have been embedded in practice.		100% engagement in DHR, SAR	Quarterly	

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

CQUIN Table 1: CQUIN Indicators

1.	The CQUIN indicators for the Contract will be defined by the planning guidance issued annually year and will apply from 1 April 2020. No CQUIN scheme will be relevant to 2019/20 prior to Service Commencement. A contract variation incorporating CQUIN indicators will be issued when the 2020/21 NHS Standard Contract is published.
2.	The CQUIN scheme and its value will be derived in each financial year of the Contract, subject to the continuation of the national scheme requirements and its guidance.

CQUIN Table 2: **CQUIN Payments on Account**

Commissioner	Payment	Frequency/Timing	Agreed provisions for adjustment of CQUIN Payments on Account based on performance
NHS BNSSG CCG	25% of the annual CQUIN value	Quarterly in arrears. Pre-payment will not be made	Full or partial payment is subject to achievement and as defined in the scheme

SCHEDULE 4 – QUALITY REQUIREMENTS

E. Local Incentive Scheme

To be inserted prior to Contract Award if required and agreed with the Provider

SCHEDULE 4 – QUALITY REQUIREMENTS

F. Clostridium difficile

Clostridium difficile adjustment: NHS Foundation Trust/NHS Trust (Acute Services only)

The financial adjustment (£) is the sum which is the greater of Y and Z, where:

Y = 0

Z = ((A – B) x 10,000) x C

where:

A = the actual number of cases of Clostridium difficile in respect of all NHS patients treated by the Provider in the Contract Year

B = the baseline threshold (the figure as notified to the Provider and recorded in the Particulars), being the Provider's threshold for the number of cases of Clostridium difficile for the Contract Year, in accordance with Guidance:

https://www.england.nhs.uk/patientsafety/associated-infections/clostridium-difficile/)

C = $\frac{\text{no. of inpatient bed days in respect of Service Users in the Contract Year}}{\text{no. of inpatient bed days in respect of all NHS patients treated by the Provider in the Contract Year}}$

The financial adjustment is calculated on the basis of annual performance. For the purposes of SC36.37 (*Operational Standards, National Quality Requirements and Local Quality Requirements*), any repayment or withholding in respect of Clostridium difficile performance will be made in respect of the final Quarter of the Contract Year.

Clostridium difficile adjustment: Other Providers (Acute Services only)

The financial adjustment (£) is the sum equal to A x 10,000, where:

A = the actual number of cases of Clostridium difficile in respect of Service Users in the Contract Year.

The financial adjustment is calculated on the basis of annual performance. For the purposes of SC36.37 (*Operational Standards, National Quality Requirements and Local Quality Requirements*), any repayment or withholding in respect of Clostridium difficile performance will be made in respect of the final Quarter of the Contract Year.

7. SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Date	Document
	Certificate of Employers Liability Insurance, Public Liability Insurance and all other Insurance required by the CCG as set out in the Request for Proposals
	Information Governance Compliance Document
	CQC registration
	Transfer Agreement(s)
	Proposal accepted by CCG in response to Request for Proposals
	Evidence of appropriate Counter Fraud and Security Management measures: • Fraud Policy • Security Policy

Documents supplied by Commissioners

Date	Document
January 2019	OJEU Notice
January 2019	Request for Proposals and all clarifications and associated documents
	Preferred Bidder Appointment Letter
	Contract Award Letter
April 2019	Round 2 documentation issued
	Provider information pack (including terms of reference for ICQPMG and sub groups, updated from those issued with the RFP)
	Terms of reference for Joint Community Services Mobilisation Board

SCHEDULE 5 - GOVERNANCE

B. Provider's Material Sub-Contracts

Sub-Contractor [Name] [Registered Office] [Company number]	Service Description	Start date/expiry date	Processing Personal Data – Yes/No	If the Sub-Contractor is processing Personal Data, state whether the Sub-Contractor is a Data Processor OR a Data Controller OR a joint Data Controller
To be completed prior to Contract Award if required				

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group	The CCG will act as the sole commissioner for the purpose of this Contract

8. SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
2. Patient Reported Outcome Measures (PROMS) https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
National Requirements Reported Locally				
CN1 Activity and Finance Report (*note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider by the First Reconciliation Date under SC36.28, or under SC36.31*)	Monthly	See items CL1 and CL3 in the Local Requirements Reported Locally for further details	By no later than the First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable	**All**
CN2 Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation: a. details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; b. details of all requirements satisfied; c. details of, and reasons for, any failure to meet requirements; d. the outcome of all Root Cause Analyses and audits performed pursuant to SC22 (*Assessment and Treatment for Acute Illness*); e. report on performance against the HCAI Reduction Plan	Monthly	Template to be supplied by CCG	Within 15 Operational Days of the end of the month to which it relates.	**All** **All** **All** **A** **All except 111**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
CN3	CQUIN Performance Report and details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Incentive Scheme Indicators satisfied or not satisfied	Quarterly	A written report with evidence provided demonstrating achievement against the scheme indicators	Within one calendar month of the end of the quarter, via email to: bnssg.cquins@nhs.net	**All**
CN4	NHS Safety Thermometer Report, detailing and analysing: a. data collected in relation to each relevant NHS Safety Thermometer; b. trends and progress; c. actions to be taken to improve performance.	[Monthly, or as agreed locally]	[For local agreement], according to published NHS Safety Thermometer reporting routes	[For local agreement], according to published NHS Safety Thermometer reporting routes	**All (not AM, CS, D, 111, PT, U)**
CN5	Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Quarterly	Written evidence to be included in the Provider Quality Report	Submission via email to the nominated CCG representative 5 working days before the Quality sub group meeting. Dates of meetings are as per the schedule in the Provider Information Pack	**All**
CN6	Report against performance of Service Development and Improvement Plan (SDIP)	In accordance with relevant SDIP	In accordance with relevant SDIP	In accordance with relevant SDIP	**All**
CN7	Summary report of all incidents requiring reporting	Monthly	Written evidence to be included in the Provider Quality Report	Submission via email to the nominated CCG representative 5 working days before the Quality sub group meeting. Dates of meetings are as per the schedule in the Provider Information Pack	**All**
CN8	Data Quality Improvement Plan: report of progress against milestones	In accordance with relevant DQIP	In accordance with relevant DQIP	In accordance with relevant DQIP	**All**
CN9	Report and provide monthly data and detailed information relating to violence-related injury resulting in treatment being sought from Staff in A&E departments, urgent care and walk-in centres to the local community safety partnership and the relevant police force, in accordance with applicable Guidance (Information Sharing to Tackle Violence (ISTV)) Initial Standard Specification https://digital.nhs.uk/isce/publication/isb1594	Monthly	As set out in relevant Guidance	As set out in relevant Guidance	**A** **A+E** **U**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
CN10	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (*Staff*)	Six monthly (or more frequently if and as required)	Written evidence to be included in the Provider Quality Report	Submission via email to the nominated CCG representative 5 working days before the Quality sub group meeting. Dates of meetings are as per the schedule in the Provider Information Pack	**All**
CN11	Report on compliance with the National Workforce Race Equality Standard.	Annually	Written evidence to be included in the Provider Quality Report	Submission via email to the nominated CCG representative 5 working days before the Quality sub group meeting. Dates of meetings are as per the schedule in the Provider Information Pack	**All**
CN12	Specific reports required by NHS England in relation to Specialised Services and other services directly commissioned by NHS England, as set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting (where not otherwise required to be submitted as a national requirement reported centrally or locally)	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	**Specialised Services**
CN13	Report on performance in reducing Antibiotic Usage in accordance with SC21.4 *(Antimicrobial Resistance and Healthcare Associated Infections)*	Annually	[For local agreement]	[For local agreement]	**A**
CN14	Report on progress against sustainable development management plan in accordance with SC18.2	Annually	Written evidence in a separate report 'sustainable development management plan.' This report must include milestones and progress made against these covering the following aspects of sustainable development: • social	Report to be submitted twice a year with an annual summary included in advance of year end.	**All**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
			• economic • environmental Outlining the benefits on: • climate change adaptation and mitigation • air pollution • minimising wastes • minimising use of plastics		
Local Requirements Reported Locally					
CL1	**Minimum Dataset: validated** The Provider is required to submit a monthly validated patient level activity report, as outlined in Appendix 3 – Schedule 6A.1. This is in addition to any national reporting requirements. This is labelled Appendix 3, but for clarity is an integral part of the Contract and is appended only because it is an Excel spreadsheet and formatting precludes incorporation directly into this document	Monthly	Locally defined report, agreed with CCG e.g. csv	Report to be submitted monthly via CCG designated data warehouse for pseudonymisation by 15th of the following month	**CS**
CL2	**Contract Monitoring Requirements: Other KPIs** The Provider is required to report a key set of activity and performance measures as outlined in Appendix 4 – Schedule 6A.2. This is labelled Appendix 4, but for clarity is an integral part of the Contract and is appended only because it is an Excel spreadsheet and formatting precludes incorporation directly into this document	Monthly	Locally defined report, e.g. to be incorporated into existing performance reporting OR supplied as a separate report as agreed with Providers.	To be distributed monthly or quarterly as specified to named BNSSG contacts and / or specified team inbox from the start of the contract, by 15th of the following month	**CS**
CL3	**Minimum Dataset: un-validated** The Provider is required to submit a daily patient level activity report, for urgent care as outlined in Appendix 5 – Schedule 6A.3. This will enable BNSSG to actively monitor daily activity across the whole local health community. This is labelled Appendix 5, but for clarity is an integral part of the	Daily	Locally defined report, agreed with CCG e.g. csv	Report to be submitted daily via CCG designated data warehouse for pseudonymisation by 15th of the following month	**CS**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
	Contract and is appended only because it is an Excel spreadsheet and formatting precludes incorporation directly into this document				
CL4	**Financial Reporting Requirements** The Provider is to supply financial reporting in accordance with data fields stipulated in the template in Appendix 6 – Schedule 6A.4 This is labelled Appendix 6, but for clarity is an integral part of the Contract and is appended only because it is an Excel spreadsheet and formatting precludes incorporation directly into this document In addition to the detail required above, additional detail about the organisation's finances is required as follows, and will be treated as commercially sensitive: • Income and expenditure • Cash flow • Balance sheet • Proportion of income gained via the Adult Community Services Contract.	Quarterly	Excel Document. See Appendix 6 for template. Reporting format for financial sustainability measures to be agreed with Provider by 2 January 2020	To be emailed quarterly to named CCG contacts, with the first report due by 15 July 2020. Subsequent reports are due within 15 operational days of the end of the quarter	**CS**
CL5	**Integrated Care Bureau Reporting** The Provider is required to contribute to the Integrated Care Bureau reporting.	In development	Locally defined report, currently in development (see also CL2)	In development	**CS**
CL6	**Secondary User Service (SUS)** The Provider is required to submit all relevant data to Secondary User Service (SUS) Relevant services: • Community Musculoskeletal service • Any other service that becomes part of an 18 week pathway This is to facilitate an understanding of 18 week delivery across the health community	As set out at https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance	As set out at https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance	As set out at https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance	**CS**

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

Ref	Data Quality Indicator	Description of indicator	Data Quality Threshold	Method of Measurement	Milestone date	Consequences
CDQ1	Data Quality Maturity Index	Provider to report on completeness of Community Services Data Set submissions with reference to Data Quality Maturity Index in accordance with SC28.2.7 and provide a detailed report in relation to any under-achievement.	Overall CSDS Score = 100% Specific data item proportion valid, complete = 100%, with zero use of default codes • Ethnic category • General medical practice code • NHS number • Person birth date • Person stated gender code • Postcode of usual address • Source of referral for community	Quarterly monitoring via the NHSD publication https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality	Data period – Report published Q1 2020/21– Nov 2020 Q2 2020/21 – Feb 2021 Q3 2020/21 – May 2021 Q4 2020/21 – Aug 2021	General Condition 9 (Contract Management)
CDQ2	Healthcare Clinical Software System: Data fields	Provider to routinely assess and identify issues with the accuracy and completeness of data entry in the healthcare clinical system they use, which have a direct impact on the Provider's ability to reliably report against agreed KPIs. Resulting quality reports to be shared and reviewed at contractual meetings or dedicated data quality meetings.	Data Quality items to be assessed against 18/19 provider benchmark	Provider Data Quality report produced on a quarterly basis.	To be reported through quarterly Finance and Information Group.	General Condition 9 (Contract Management)
CDQ3	Other KPI reporting	Provider to set up systems to enable monthly (or quarterly as specified) reporting to be produced as set out in Appendix 4 Schedule 6A.2 by the start of the contract term. This is labelled Appendix 4, but for clarity is an integral	As set out in Appendix 4 Schedule 6A.2	Provider Data Quality Report on completeness and accuracy of Other KPI reporting	To be reported through monthly Finance and Information Group.	General Condition 9 (Contract Management)

Ref	Data Quality Indicator	Description of indicator	Data Quality Threshold	Method of Measurement	Milestone date	Consequences
		part of the Contract and is appended only because it is an Excel spreadsheet and formatting precludes incorporation directly into this document. Provider to ensure timelines, completeness and accuracy of SLAM data flows. Where reporting requirements cannot be satisfied as stipulated in Appendix 4 6A.2, providers will produce a plan by end of Q1 outlining the gaps in provision and the milestones for achieving compliance.				
CDQ4	Financial Open Book Reporting	Provider to set up systems to enable annual financial reporting to be produced as set out in Appendix 6 Schedule 6A.4 by the start of the contract term. This is labelled Appendix 6, but is an integral part of the Contract and is appended only because it is a spreadsheet and formatting precludes incorporation into this document	As set out in Appendix 6 Schedule 6A.4	Provider Quarterly Open Book reporting	To be reported quarterly through Finance and Information Group.	General Condition 9 (Contract Management)

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) other Patient Safety Incidents	
1	The Provider is required to follow the CCG's policy regarding serious incidents requiring reporting: https://bnssgccg.nhs.uk/library/serious-incidents-requiring-investigation/
2.	The Provider policy for the management of incidents requiring reporting will be inserted into the Contract prior to Contract Award.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Service Development and Improvement Plans

The Provider's transformation plan as submitted within the Proposal and amended and agreed by the CCG will be inserted in to the Contract prior to Contract Award. The Provider will be expected to deliver it within the timescales agreed and this will be performance monitored as part of regular review meetings. In addition, the CCG has provided minimum expectations below, to be updated based on year one of the Provider's transformation plan.

BNSSG CCG Service Development and Improvement Plan for Adult Community Health Services

Progress against the areas in this plan will be monitored on a quarterly basis via a report to the respective IQPM, unless more frequent reporting is agreed.

Service Development	Description of provider input	Milestones	Timescales	Consequence of Achievement/ Breach
Staff Mental Health and Wellbeing Plan	As required under s41.6 of the Technical Guidance which states that: Commissioners are required to agree with all providers operating under the full-length version of the Contract, to set out how the provider will produce, implement and communicate a staff mental health and wellbeing plan in line with the recommendations set out in the report of the Stevenson / Farmer review, Thriving at work.	To be agreed	To be agreed	Ongoing performance to be managed through GC9 of standard contract.
Integrated Locality Teams	Full implementation of Multi-Disciplinary Teams across BNSSG	To be agreed	30 October 2020	Ongoing performance to be managed through GC9 of standard contract.
Integrated Locality Teams	Single Point of Access across BNSSG	To be agreed	1 April 2020	Ongoing performance to be managed through GC9 of standard contract.
Integrated Locality Teams	Implementation of consistent care plan across BNSSG	To be agreed	30 June 2020	Ongoing performance to be managed through GC9 of standard contract.
Integrated Locality Teams	Implementation of Care Home Support Model across BNSSG	To be agreed	31 March 2021	Ongoing performance to be managed through GC9 of standard contract.
Integrated Locality Teams	Consistent information for discharge in line with Schedule 2J	To be agreed	30 June 2020	Ongoing performance to be managed through GC9 of standard contract.
Acute and Reactive Care	Harmonised operating hours for Rapid Response across BNSSG	To be agreed	30 September 2020	Ongoing performance to be managed through GC9 of standard contract.
Acute and Reactive Care	Minor Injuries Units / Walk In Centre transformation in line with the BNSSG Urgent Care Strategy	To be agreed	1 April 2020	Ongoing performance to be managed through GC9 of standard contract.
Acute and Reactive Care	Transformation of Community Bed model in line with BNSSG Urgent Care Strategy	To be agreed	1 April 2020	Ongoing performance to be managed through GC9 of standard contract.
Specialist Advice and Support	Implementation of harmonized operating hours and staffing model across all aspects of the specification	To be agreed	1 Oct 2020	Ongoing performance to be managed through GC9 of standard contract.

Service Development	Description of provider input	Milestones	Timescales	Consequence of Achievement/ Breach
Locality Hubs	Integrated frailty model – future transformation in line with the BNSSG frailty approach and model across BNSSG	To be agreed	1 April 2021	Ongoing performance to be managed through GC9 of standard contract.
Locality Hubs	Working alongside key system partners, including locality provider boards, development of locality hub model across BNSSG localities to support prevention	To be agreed	1 April 2021	Ongoing performance to be managed through GC9 of standard contract.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

Type of Survey	Frequency	Method of Reporting	Method of Publication	Application
Friends and Family Test (where required in accordance with FFT Guidance)	As required by FFT Guidance	As required by FFT Guidance	As required by FFT Guidance	**All**
Service User Survey	Annually	Annually to the ICQPMG	Published on the Provider website	**All**
Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance)	Annually	Annually to the ICQPMG	Summary of results included in the Provider Quality Account. Full report and action plan to be shared with the Commissioner via ICQPMG	**All**
Carer Survey	Annually	Annually to the ICQPMG	Published on the Provider website	**All**
360 Degree Partner Survey	Annually	Annually to the ICQPMG	Full report to be shared with Commissioner via ICQPMG	**CS**

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

[NOTE: This Schedule 6F applies only where the Provider is appointed to act as a Data Processor under this Contract]

1. SCOPE

1.1 The Co-ordinating Commissioner appoints the Provider as a Data Processor to perform the Data Processing Services.

1.2 When delivering the Data Processing Services, the Provider must, in addition to its other obligations under this Contract, comply with the provisions of this Schedule 6F.

1.3 This Schedule 6F applies for so long as the Provider acts as a Data Processor in connection with this Contract.

2. DATA PROTECTION

2.1 The Parties acknowledge that for the purposes of Data Protection Legislation in relation to the Data Processing Services the Co-ordinating Commissioner is the Data Controller and the Provider is the Data Processor. The Provider must process the Processor Data only to the extent necessary to perform the Data Processing Services and only in accordance with written instructions set out in this Schedule, including instructions regarding transfers of Personal Data outside the EU or to an international organisation unless such transfer is required by Law, in which case the Provider must inform the Co-ordinating Commissioner of that requirement before processing takes place, unless this is prohibited by Law on the grounds of public interest.

2.2 The Provider must notify the Co-ordinating Commissioner immediately if it considers that carrying out any of the Co-ordinating Commissioner's instructions would infringe Data Protection Legislation.

2.3 The Provider must provide all reasonable assistance to the Co-ordinating Commissioner in the preparation of any Data Protection Impact Assessment prior to commencing any processing. Such assistance may, at the discretion of the Co-ordinating Commissioner, include:

(a) a systematic description of the envisaged processing operations and the purpose of the processing;

(b) an assessment of the necessity and proportionality of the processing operations in relation to the Data Processing Services;

(c) an assessment of the risks to the rights and freedoms of Data Subjects; and

(d) the measures envisaged to address the risks, including safeguards, security measures and mechanisms to ensure the protection of Personal Data.

2.4 The Provider must, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F:

(a) process that Personal Data only in accordance with Annex A, unless the Provider is required to do otherwise by Law. If it is so required the Provider must promptly notify the Co-ordinating Commissioner before processing the Personal Data unless prohibited by Law;

(b) ensure that it has in place Protective Measures, which have been reviewed and approved by the Co-ordinating Commissioner as appropriate to protect against a Data Loss Event having taken account of the:

(i) nature, scope, context and purposes of processing the data to be protected;

(ii) likelihood and level of harm that might result from a Data Loss Event;

(iii) state of technological development; and

(iv) cost of implementing any measures;

(c) ensure that:

(i) when delivering the Data Processing Services the Provider Staff only process Personal Data in accordance with this Schedule 6F (and in particular Annex A);

(ii) it takes all reasonable steps to ensure the reliability and integrity of any Provider Staff who have access to the Personal Data and ensure that they:

(A) are aware of and comply with the Provider's duties under this paragraph;

(B) are subject to appropriate confidentiality undertakings with the Provider and any Sub-processor;

(C) are informed of the confidential nature of the Personal Data and do not publish, disclose or divulge any of the Personal Data to any third party unless directed in writing to do so by the Co-ordinating Commissioner or as otherwise permitted by this Contract;

(D) have undergone adequate training in the use, care, protection and handling of Personal Data; and

(E) are aware of and trained in the policies and procedures identified in GC21.11 (*Patient Confidentiality, Data Protection, Freedom of Information and Transparency*).

(d) not transfer Personal Data outside of the EU unless the prior written consent of the Co-ordinating Commissioner has been obtained and the following conditions are fulfilled:

(i) the Co-ordinating Commissioner or the Provider has provided appropriate safeguards in relation to the transfer as determined by the Co-ordinating Commissioner;

(ii) the Data Subject has enforceable rights and effective legal remedies;

(iii) the Provider complies with its obligations under Data Protection Legislation by providing an adequate level of protection to any Personal Data that is transferred (or, if it is not so bound, uses its best endeavours to assist the Co-ordinating Commissioner in meeting its obligations); and

(iv) the Provider complies with any reasonable instructions notified to it in advance by the Co-ordinating Commissioner with respect to the processing of the Personal Data;

(e) at the written direction of the Co-ordinating Commissioner, delete or return Personal Data (and any copies of it) to the Co-ordinating Commissioner on termination of the Data Processing Services and certify to the Co-ordinating Commissioner that it has done so within five Operational Days of any such instructions being issued, unless the Provider is required by Law to retain the Personal Data;

(f) if the Provider is required by any Law or Regulatory or Supervisory Body to retain any Processor Data that it would otherwise be required to destroy under this paragraph 2.4, notify the Co-ordinating Commissioner in writing of that retention giving details of the Processor Data that it must retain and the reasons for its retention; and

(g) co-operate fully with the Co-ordinating Commissioner during any handover arising from the cessation of any part of the Data Processing Services, and if the Co-ordinating Commissioner directs the Provider to migrate Processor Data to the Co-ordinating Commissioner or to a third party, provide all reasonable assistance with ensuring safe migration including ensuring the integrity

of Processor Data and the nomination of a named point of contact for the Co-ordinating Commissioner.

2.5 Subject to paragraph 2.6, the Provider must notify the Co-ordinating Commissioner immediately if, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F, it:

(a) receives a Data Subject Access Request (or purported Data Subject Access Request);

(b) receives a request to rectify, block or erase any Personal Data;

(c) receives any other request, complaint or communication relating to obligations under Data Protection Legislation owed by the Provider or any Commissioner;

(d) receives any communication from the Information Commissioner or any other Regulatory or Supervisory Body (including any communication concerned with the systems on which Personal Data is processed under this Schedule 6F);

(e) receives a request from any third party for disclosure of Personal Data where compliance with such request is required or purported to be required by Law;

(f) becomes aware of or reasonably suspects a Data Loss Event; or

(g) becomes aware of or reasonably suspects that it has in any way caused the Co-ordinating Commissioner or other Commissioner to breach Data Protection Legislation.

2.6 The Provider's obligation to notify under paragraph 2.5 includes the provision of further information to the Co-ordinating Commissioner in phases, as details become available.

2.7 The Provider must provide whatever co-operation the Co-ordinating Commissioner reasonably requires to remedy any issue notified to the Co-ordinating Commissioner under paragraphs 2.5 and 2.6 as soon as reasonably practicable.

2.8 Taking into account the nature of the processing, the Provider must provide the Co-ordinating Commissioner with full assistance in relation to either Party's obligations under Data Protection Legislation and any complaint, communication or request made under paragraph 2.5 (and insofar as possible within the timescales reasonably required by the Co-ordinating Commissioner) including by promptly providing:

(a) the Co-ordinating Commissioner with full details and copies of the complaint, communication or request;

(b) such assistance as is reasonably requested by the Co-ordinating Commissioner to enable the Co-ordinating Commissioner to comply with a Data Subject Access Request within the relevant timescales set out in Data Protection Legislation;

(c) assistance as requested by the Co-ordinating Commissioner following any Data Loss Event;

(d) assistance as requested by the Co-ordinating Commissioner with respect to any request from the Information Commissioner's Office, or any consultation by the Co-ordinating Commissioner with the Information Commissioner's Office.

2.9 Without prejudice to the generality of GC15 *(Governance, Transaction Records and Audit),* the Provider must allow for audits of its delivery of the Data Processing Services by the Co-ordinating Commissioner or the Co-ordinating Commissioner's designated auditor.

2.10 For the avoidance of doubt the provisions of GC12 *(Assignment and Sub-contracting)* apply to the delivery of any Data Processing Services.

2.11 Without prejudice to GC12, before allowing any Sub-processor to process any Personal Data related to this Schedule 6F, the Provider must:

(a) notify the Co-ordinating Commissioner in writing of the intended Sub-processor and processing;

(b) obtain the written consent of the Co-ordinating Commissioner;

(c) carry out appropriate due diligence of the Sub-processor and ensure this is documented;

(d) enter into a binding written agreement with the Sub-processor which as far as practicable includes equivalent terms to those set out in this Schedule 6F and in any event includes the requirements set out at GC21.16.3; and

(e) provide the Co-ordinating Commissioner with such information regarding the Sub-processor as the Co-ordinating Commissioner may reasonably require.

2.12 The Provider must create and maintain a record of all categories of data processing activities carried out under this Schedule 6F, containing:

(a) the categories of processing carried out under this Schedule 6F;

(b) where applicable, transfers of Personal Data to a third country or an international organisation, including the identification of that third country or international organisation and, where relevant, the documentation of suitable safeguards;

(c) a general description of the Protective Measures taken to ensure the security and integrity of the Personal Data processed under this Schedule 6F; and

(d) a log recording the processing of the Processor Data by or on behalf of the Provider comprising, as a minimum, details of the Processor Data concerned, how the Processor Data was processed, when the Processor Data was processed and the identity of any individual carrying out the processing.

2.13 The Provider warrants and undertakes that it will deliver the Data Processing Services in accordance with all Data Protection Legislation and this Contract and in particular that it has in place Protective Measures that are sufficient to ensure that the delivery of the Data Processing Services complies with Data Protection Legislation and ensures that the rights of Data Subjects are protected.

2.14 The Provider must comply at all times with those obligations set out at Article 32 of the GDPR and equivalent provisions implemented into Law by DPA 2018.

2.15 The Provider must assist the Commissioners in ensuring compliance with the obligations set out at Article 32 to 36 of the GDPR and equivalent provisions implemented into Law, taking into account the nature of processing and the information available to the Provider.

2.16 The Provider must take prompt and proper remedial action regarding any Data Loss Event.

2.17 The Provider must assist the Co-ordinating Commissioner by taking appropriate technical and organisational measures, insofar as this is possible, for the fulfilment of the Commissioners' obligation to respond to requests for exercising rights granted to individuals by Data Protection Legislation.

Annex A

Data Processing Services

Processing, Personal Data and Data Subjects

1. The Provider must comply with any further written instructions with respect to processing by the Co-ordinating Commissioner.

2. Any such further instructions shall be incorporated into this Annex.

Description	Details
Subject matter of the processing	*[This should be a high level, short description of what the processing is about i.e. its subject matter]*
Duration of the processing	*[Clearly set out the duration of the processing including dates]*
Nature and purposes of the processing	*[Please be as specific as possible, but make sure that you cover all intended purposes. The nature of the processing means any operation such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction of data (whether or not by automated means) etc. The purpose might include: employment processing, statutory obligation, recruitment assessment etc]*
Type of Personal Data	*[Examples here include: name, address, date of birth, NI number, telephone number, pay, images, biometric data etc]*
Categories of Data Subject	*[Examples include: Staff (including volunteers, agents, and temporary workers), Co-ordinating Commissioners/ clients, suppliers, patients, students / pupils, members of the public, users of a particular website etc]*
Plan for return and destruction of the data once the processing is complete UNLESS requirement under union or member state law to preserve that type of data	*[Describe how long the data will be retained for, how it be returned or destroyed]*

9. SCHEDULE 7 – PENSIONS

1. **Definitions**

1.1 Terms not defined at the end of this Schedule are to be interpreted in accordance with the Definitions and Interpretation section of the Contract.

2. **Pension Protection For Eligible Employees**

2.1 **Continued membership of the NHS Pension Scheme**

2.1.1 In accordance with Fair Deal for Staff Pensions, the Provider and/or each Sub-Contractor to which the employment of any Eligible Employee compulsorily transfers as a result of the award of this Contract, if not an NHS Body or other employer which participates automatically in the NHS Pension Scheme, must each secure a Direction Letter/Determination to enable the Eligible Employees to retain either continuous active membership of or eligibility for, the NHS Pension Scheme, for so long as they remain employed in connection with the delivery of the Services under this Contract.

2.1.2 Where it is not possible for the Provider and/or each Sub-Contractor (if relevant) to secure a Direction Letter/Determination on or before the Transfer Date, the Provider must secure a Direction Letter/Determination as soon as possible after the Transfer Date, and in the period between the Transfer Date and the date the Direction Letter/Determination is secure, the Provider must ensure that:

2.1.2.1 all employer's and Eligible Employees' contributions intended to go to the NHS Pension Scheme are kept in a separate bank account; and

2.1.2.2 the Pension Benefits and Premature Retirement Rights of Eligible Employees are not adversely affected.

2.1.3 The Provider must supply to the Co-ordinating Commissioner a complete copy of each Direction Letter/Determination within 5 Business Days of receipt of the Direction Letter/Determination.

2.1.4 The Provider (or its Sub-Contractor if relevant) will comply with the terms of the Direction Letter/Determination (including any terms which change as a result of changes in legislation) in respect of the Eligible Employees until the day before the Exit Transfer Date for so long as they are employed on the delivery of the Services.

2.1.5 Where any member of Staff omitted from the Direction Letter/Determination supplied in accordance with paragraph 2.1.3 above is subsequently found to be an Eligible Employee, the Provider (or its Sub-Contractor if relevant) will ensure that that person is treated as an Eligible Employee from the Transfer Date so that their Pension Benefits and Premature Retirement Rights are not adversely affected.

[***DRAFTING NOTE**: **The Paragraph below, 2.2 (Broadly Comparable Pension Benefits) will not be relevant and may be deleted where the Provider and/or any relevant Sub-Contractor(s) either participate automatically in the NHS Pension Scheme or have each secured a letter of comfort relating to obtaining a Direction Letter/Determination in respect of all Eligible Employees by the time the Contract is entered into. If the Provider is not automatically an employer in the NHS Pension Scheme, it is anticipated that Direction Letter/Determination(s) will be secured in the vast majority of cases.***]

2.2 **Broadly Comparable Pension Benefits**

2.2.1 If the Co-ordinating Commissioner in its sole discretion (having considered the exceptional cases provided for in Fair Deal for Staff Pensions) agrees that the Provider (or any Sub-Contractor) need not provide the Eligible Employees with access to the NHS Pension Scheme, the Provider (or any Sub-Contractor) must ensure that, with effect from the Transfer Date until the day before the Exit Transfer Date, the Eligible Employees are offered access to a scheme under which the Pension Benefits are Broadly Comparable to those provided under the NHS Pension Scheme.

2.2.2 The Provider must supply to the Co-ordinating Commissioner details of its (or its Sub-Contractor's) Broadly Comparable scheme and provide a full copy of the valid certificate of Broad Comparability covering all Eligible Employees, as soon as it is able to do so and in any event no later than [28] days[50] before the Transfer Date.

2.3 **Transfer Option**

As soon as reasonably practicable and in any event no later than [20 Operational Days][51] after the Transfer Date, the Provider must provide the Eligible Employees with the Transfer Option, where the former provider offered, or the Provider offers, a Broadly Comparable scheme.[52]

2.4 **Calculation of Transfer Amount[53]**

2.4.1 The Commissioners will use reasonable endeavours to procure that [20 Operational Days][54] after the Transfer Option Deadline, the Transfer Amount is calculated by the former provider's Actuary[55] on the following basis and notified to the Provider along with any appropriate underlying methodology.

[50] 28 days is a suggested timescale. Please select a timescale which is in accordance with the circumstances of your particular Contract.
[51] This is a suggested timescale bearing in mind that the whole process for the bulk transfer should take no more than 6 months.
[52] This Paragraph 2.3 can be deleted if neither the former provider nor the Provider nor any Sub-Contractor offered/are offering a Broadly Comparable scheme. In these circumstances Paragraphs 2.4 – 2.6 can also be deleted.
[53] In accordance with B.4 of Fair Deal for Staff Pensions, the terms of the bulk transfer should be determined by the former provider's Actuary at the outset of the procurement process.
[54] This is a suggested timescale. It is not unreasonable if all the data is available and agreed well in advance of the Transfer Date.
[55] If the former provider is an NHS Employer within the meaning of the NHS Pension Scheme Regulations, the former provider's Actuary will be the NHS Pension Scheme Actuary (currently the Government Actuary's Department).

2.4.1.1 If the former provider offers a Broadly Comparable scheme to Eligible Employees:

2.4.1.1.1 the part of the Transfer Amount which relates to benefits accrued in that Broadly Comparable scheme other than those in sub-paragraph 2.4.1.1.2 below must, as a minimum, be aligned to the funding requirements of that scheme; and

2.4.1.1.2 the part of the Transfer Amount which relates to benefits accrued in the NHS Pension Scheme (having been previously bulk transferred into the former provider's Broadly Comparable scheme), must be aligned to whichever of (a) the funding requirements of the former provider's Broadly Comparable scheme; or (b) the principles[56] under which the former provider's Broadly Comparable scheme received a bulk transfer payment from the NHS Pension Scheme (together with any shortfall payment)[57], gives the higher figure,

provided that where the principles require the assumptions to be determined as at a particular date, that date will be the Transfer Date.

2.4.1.2 If the former provider offers the NHS Pension Scheme to Eligible Employees, the Transfer Amount will be calculated by the NHS Pension Scheme's Actuary on the basis applicable for bulk transfer terms from the NHS Pension Scheme set by the Department of Health from time to time[58].

2.4.2 Each party will promptly provide to any Actuary calculating or verifying the Transfer Amount any documentation and information which that Actuary may reasonably require.

2.5 **Payment of Transfer Amount**

Subject to:

2.5.1 the period for acceptance of the Transfer Option having expired; and

[53] The principles should be set out in a formal bulk transfer note issued on behalf of the NHS Pension Scheme. Where a shortfall applied, further principles should be set out in a separate note that is subject to the terms of the contract for services with the former provider.

[57] B8 to B14 inclusive of Fair Deal for Staff Pensions which deal with price adjustments/shortfall requirements are relevant here and are discussed in section 2 of Stage 2 of the guidance issued in February 2014 by the Department of Health in respect of the impact of Fair Deal for Staff Pensions on NHS Pension Scheme participation.

[58] Commissioners should obtain a signed note from the NHS Pension Scheme Actuary during the procurement specifying the bulk transfer terms that apply.

2.5.2 the Provider having (and/or having procured that any relevant Sub-Contractor has) provided the trustees or managers of the former provider's pension scheme (or NHS Business Services Authority, as appropriate) with completed and signed forms of consent in a form acceptable to the former provider's pension scheme from each Eligible Employee in respect of the Transfer Option; and

2.5.3 the calculation of the Transfer Amount in accordance with Paragraph 2.4 (*Calculation of Transfer Amount*); and

2.5.4 the trustees or managers of the Provider's (or any Sub-Contractor's) Broadly Comparable scheme (or NHS Business Services Authority, as appropriate) having confirmed in writing to the trustees or managers of the former provider's pension scheme (or NHS Business Services Authority, as appropriate) that they are ready, willing and able to receive the Transfer Amount and the bank details of where the Transfer Amount should be sent, and not having revoked that confirmation,

the Co-ordinating Commissioner will use reasonable endeavours to procure that the former provider's pension scheme (or the NHS Pension Scheme, as appropriate) will, on or before the Payment Date, transfer to the Provider's (or Sub-Contractor's) Broadly Comparable scheme (or NHS Pension Scheme) the Transfer Amount in cash, together with any cash or other assets which are referable to additional voluntary contributions (if any) paid by the Eligible Employees which do not give rise to salary-related benefits.

2.6 **Credit for Transfer Amount**

Subject to prior receipt of the Transfer Amount (and any shortfall payable),[59] by the trustees or managers of the Provider's (or Sub-Contractor's) Broadly Comparable scheme (or NHS Business Services, as appropriate), the Provider must procure that year-for-year day-for-day service credits are granted in the Provider's (or Sub-Contractor's) Broadly Comparable scheme (or NHS Pension Scheme), or an actuarial equivalent agreed by the Commissioners' Actuary (and NHS Pension Scheme Actuary) in accordance with Fair Deal for Staff Pensions as a suitable reflection of the differences in benefit structure between the NHS Pension Scheme and the Provider's (or Sub-Contractor's) pension scheme.

3. **Premature Retirement Rights**

3.1 From the Transfer Date until the day before the Exit Transfer Date, the Provider must provide (and/or must ensure that any relevant Sub-Contractor must provide) Premature Retirement Rights in respect of the Eligible Employees that are the same as the benefits they would have received had they remained employees of an NHS Body or other employer which participates automatically in the NHS Pension Scheme.

4. **Cancellation of any Direction Letter/Determination(s) and Right of Set-Off**

4.1 If the Co-ordinating Commissioner is entitled to terminate this Contract under GC17.10.16 (*Termination: Provider Default*), the Co-ordinating Commissioner may in its sole discretion instead of exercising its right under GC17.10.16 (*Termination: Provider Default*) permit the

[59] In terms of shortfalls, please see section 2 of Stage 2 of the guidance issued in February 2014 by the Department of Health in respect of the impact of Fair Deal for Staff Pensions on NHS Pension Scheme participation.

Provider (or the relevant Sub-Contractor, as appropriate) to offer Broadly Comparable Pension Benefits, on such terms as decided by the Co-ordinating Commissioner.

4.2 If any Commissioner is notified by NHS Business Services Authority of any NHS Pension Scheme Arrears, the Commissioners will be entitled to deduct all or part of those arrears from any amount due to be paid by that Commissioner to the Provider having given the Provider 5 Operational Days' notice of its intention to do so, and to pay any sum deducted to NHS Business Services Authority in full or partial settlement of the NHS Pension Scheme Arrears. This set-off right is in addition to and not instead of the Co-ordinating Commissioner's right to terminate the Contract under GC17.10.16 (*Termination: Provider Default*).

5. **Compensation**

5.1 If the Provider (or any Sub-Contractor) is unable to provide the Eligible Employees with either:

5.1.1 membership of the NHS Pension Scheme (having used its best endeavours to secure a Direction Letter/Determination); or

5.1.2 a Broadly Comparable scheme,

the Commissioners may in their sole discretion permit the Provider to (or procure that the relevant Sub-Contractor) compensate the Eligible Employees in a manner that is Broadly Comparable or equivalent in cash terms, the Provider (or Sub-Contractor as relevant) having consulted with a view to reaching agreement any recognised trade union or, in the absence of such body, the Eligible Employees. The Provider must (or must procure that the relevant Sub-Contractor) meets the costs of the Commissioners in determining whether the level of compensation offered is reasonable in the circumstances.

5.2 This flexibility for the Commissioners to allow compensation in place of Pension Benefits is in addition to and not instead of the Co-ordinating Commissioner's right to terminate the Contract under GC17.10.16 (*Termination: Provider Default*).

6 **Provider Indemnities Regarding Pension Benefits and Premature Retirement Rights**

6.1 The Provider must indemnify and keep indemnified the Commissioners and any new provider against all Losses arising out of any claim by any Eligible Employee that the provision of (or failure to provide) Pension Benefits and Premature Retirement Rights from the Transfer Date, or the level of such benefit provided, constitutes a breach of his or her employment rights.

6.2 The Provider must indemnify and keep indemnified the Commissioners, NHS Business Services Authority and any new provider against all Losses arising out of the Provider (or its Sub-Contractor) allowing anyone who is not an Eligible Employee to join or claim membership of the NHS Pension Scheme at any time during the Contract Term.

6.3 The Provider must indemnify the Commissioners, NHS Business Services Authority and any new provider against all Losses arising out of its breach of this Schedule 7 and/or the terms of the Direction Letter/Determination.

7 Sub-contractors

7.1 If the Provider enters into a Sub-contract it will impose obligations on its Sub-Contractor in the same terms as those imposed on the Provider in relation to Pension Benefits and Premature Retirement Benefits by this Schedule 7, including requiring that:

7.1.1 If the Provider has secured a Direction Letter/Determination, the Sub-Contractor also secures a Direction Letter/Determination in respect of the Eligible Employees for their future service with the Sub-Contractor as a condition of being awarded the Sub-Contract; or

7.1.2 If the Provider has offered the Eligible Employees access to a pension scheme under which the benefits are Broadly Comparable to those provided under the NHS Pension Scheme, the Sub-Contractor either secures a Direction Letter/Determination in respect of the Eligible Employees or provides Eligible Employees with access to a scheme with Pension Benefits which are Broadly Comparable to those provided under the NHS Pension Scheme and in either case the option for Eligible Employees to transfer their accrued rights in the Provider's pension scheme into the Sub-Contractor's Broadly Comparable scheme (or where a Direction Letter/Determination is secured by the Sub-Contractor, the NHS Pension Scheme) on the basis set out in Paragraph 2.6 (*Credit for Transfer Amount*), except that the Provider or the Sub-Contractor as agreed between them, must make up any shortfall in the transfer amount received from the Provider's pension scheme.

8 Direct Enforceability by the Eligible Employees

8.1 Notwithstanding GC29 (*Third Party Rights*), the provisions of this Schedule may be directly enforced by an Eligible Employee against the Provider and the Parties agree that the Contracts (Rights of Third Parties) Act 1999 will apply to the extent necessary to ensure that any Eligible Employee will have the right to enforce any obligation owed to him or her by the Provider under this Schedule in his or her own right under section 1(1) of the Contracts (Rights of Third Parties) Act 1999.

8.2 Further, the Provider must ensure that the Contracts (Rights of Third Parties) Act 1999 will apply to any Sub-Contract to the extent necessary to ensure that any Eligible Employee will have the right to enforce any obligation owed to them by the Sub-Contractor in his or her own right under section 1(1) of the Contracts (Rights of Third Parties) Act 1999.

9 Pensions on Transfer of Employment on Exit

9.1 In the event of any termination or expiry or partial termination or expiry of this Contract which results in a transfer of the Eligible Employees, the Provider must (and if offering a Broadly Comparable scheme, must use all reasonable efforts to procure that the trustees or managers of that pension scheme must):

9.1.1 not adversely affect pension rights accrued by the Eligible Employees in the period ending on the Exit Transfer Date;

9.1.2 within 30 Operational Days of being requested to do so by the new provider, (or if the new provider is offering Eligible Employees access to the NHS Pension Scheme, by NHS Business Services Authority), provide a transfer amount calculated in accordance with Paragraph 2.4 (*Calculation of the Transfer Amount*); and

9.1.3 do all acts and things, and provide all information and access to the Eligible Employees, as may in the reasonable opinion of the Commissioners be necessary or desirable and to enable the Commissioners and/or the new provider to achieve the objectives of Fair Deal for Staff Pensions.

DEFINITIONS

Actuary	a Fellow of the Institute and Faculty of Actuaries
Broadly Comparable	certified by an Actuary as satisfying the condition that there are no identifiable Eligible Employees who would overall suffer material detriment in terms of their future accrual of Pension Benefits under the scheme compared with the NHS Pension Scheme assessed in accordance with Annex A of Fair Deal for Staff Pensions
Eligible Employee	each of the Transferred Staff who immediately before the Transfer Date was a member of, or was entitled to become a member of, or but for their compulsory transfer of employment would have been entitled to become a member of, either the NHS Pension Scheme or a Broadly Comparable scheme as a result of their employment or former employment with either an NHS Body (or other employer which participates automatically in the NHS Pension Scheme) and being continuously engaged for more than 50% of their employed time with the former provider in the delivery of the Services For the avoidance of doubt a Staff member who is or is entitled to become a member of the NHS Pension Scheme as a result of being engaged in the Services and being covered by an “open” Direction Letter/Determination or other NHS Pension Scheme “access” facility but who has never been employed directly by an NHS Body (or other body which participates automatically in the NHS Pension Scheme) is not an Eligible Employee entitled to Fair Deal for Staff Pensions protection under this Schedule
Exit Transfer Date	the date on which the Eligible Employees transfer their employment to a new provider at the end of the Contract Term
Fair Deal for Staff Pensions	the guidance issued by HM Treasury entitled 'Fair Deal for staff pensions: staff transfer from central government', October 2013
NHS Pension Scheme Actuary	the Government Actuary’s Department or any successor Actuary

NHS Pension Scheme Arrears	any failure on the part of the Provider or any Sub-Contractor to pay employer's or deduct and pay across employee's contributions to the NHS Pension Scheme or meet any other financial obligations under the NHS Pension Scheme or any Direction Letter/Determination in respect of the Eligible Employees
Payment Date	[20 Operational Days] after the last of the conditions in Paragraph 2.5 of this Schedule (*Payment of Transfer Amount*) has been satisfied
Pension Benefits	any benefits (including but not limited to pensions related allowances and lump sums) relating to old age, invalidity or survivor's benefits provided under an occupational pension scheme
Premature Retirement Rights	rights to which the Transferred Staff (had they remained in the employment of an NHS Body or other employer which participates automatically in the NHS Pension Scheme) would have been or is entitled under the NHS Pension Scheme Regulations, the NHS Compensation for Premature Retirement Regulations 2002 (SI 2002/1311), the NHS (Injury Benefits) Regulations 1995 (SI 1995/866), and Section 45 of the General Whitley Council conditions of service, or any other legislative or contractual provision which replaces, amends, extends or consolidates the same from time to time
Transfer Amount	an amount paid in accordance with Paragraph 2.5 of this Schedule (*Payment of Transfer Amount*) and calculated in accordance with the assumptions, principles and timing adjustment referred to in Paragraph 2.4 of this Schedule (*Calculation of Transfer Amount*) in relation to those Eligible Employees who have accrued defined benefit rights in the NHS Pension Scheme or former provider's Broadly Comparable scheme and elected to transfer them to the Provider's Broadly Comparable scheme under the Transfer Option
Transfer Date	the Transferred Staff's first day of employment with the Provider (or its Sub-Contractor)

Transfer Option	an option given to each Eligible Employee with either: accrued rights in the NHS Pension Scheme; or) accrued rights in a Broadly Comparable scheme, as at the Transfer Date, to transfer those rights to the Provider's (or its Sub-Contractor's) Broadly Comparable scheme or back into the NHS Pension Scheme (as appropriate), to be exercised by the Transfer Option Deadline, to secure year-for-year day-for-day service credits in the relevant scheme (or actuarial equivalent, where there are benefit differences between the two schemes)
Transfer Option Deadline	the first Operational Day to fall at least [3 months][60] after the notice detailing the Transfer Option has been sent to each Eligible Employee
Transferred Staff	those employees whose employment compulsorily transfers to the Provider or a Sub-Contractor by operation of TUPE, COSOP or for any other reason, as a result of the award of this Contract

[60] B.7 of Fair Deal for Staff Pensions indicates that Eligible Employees should normally be given a 3 month period in which to exercise their Transfer Option.

11. SCHEDULE 8 – LOCAL SYSTEM OPERATING PLAN OBLIGATIONS

This wording will be updated in advance of 20/21 contract agreement. The wording below is taken from the 19/20 contracts held by the CCG.

1. System Planning & System working:

1.1 The Parties to this contract must at all times use all reasonable endeavours to contribute towards the implementation of any Local System Operating Plan to which both the Provider and Commissioners are party and must perform any specific obligations on their respective parts agreed as part of or pursuant to that Local System Operating Plan from time to time, as set out below in the local system ambitions and indicative milestones. Organisations within the STP will be expected to take collective responsibility for the delivery of the system operating plan, working together to ensure best use of their collective resources. The organisations will collaborate to ensure that services are organised and delivered in such a way as to integrate effectively with the local configuration of any Primary Care Networks established in the geographical area within which services are to be delivered.

System Ambitions

2020/21 Ambition	2019/20 milestone
Be accountable to one another for the delivery of services and use of resources	Establish a system performance management framewo for delivery of all key Constitutional standards, building i peer review as a core element
Work to a shared vision within a single plan, built from one version of the truth and consistent ways of working	Publish a single system plan for 2019/20 that is jointly owned
Operate a single budget, making decisions together that enable the flow of resources to deliver our vision within the allocation available	Operate a single budget for urgent care, establishing a framework to jointly manage performance, delivery and clinical and financial risk
Establish a governance infrastructure which enables and embeds shared decision making with delegated accountability from each organisation	Establish a shared governance infrastructure to work in shadow form during 2019/20
Establish our vision and definition of the ICS in BNSSG.	A full roadmap for delivery of ICS.
Develop and abide by a set of behaviours to establish trust, mutual respect and interdependence	Secure Board sign up from each sovereign organisation to a Memorandum of Understanding. This will include ar agreed statement of ambition and behavioural code to guide our work, and a framework for how we will hold one another to account for how we abide by it

2. Supporting Change

2.1 Planning, implementing and delivering service developments across the BNSSG system is a key way we can improve the quality and affordability of services provided to our population. A number of 'Change Initiatives' have been identified as part of the planning process for 2019/20 however, in many instances, significant additional work is required from both the commissioner and providers to agree the roll-out and subsequent impacts of these. The commissioner and the provider agree to work together collaboratively and agree joint approaches for developing initiatives with particular importance given to mutually agreeing the planned impact of changes on activity and financial flows within the system. A sub-component of these initiatives includes commissioner QIPP where specific areas for further development are described within the SDIP schedule.

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