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**HHASC Service Specification Outcome 3:**

**Supporting People to Improve their Health and Wellbeing and Improving Self-management**

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**HHASC Service Specification Outcome 3:**

**Supporting People to Improve their Health and Wellbeing and Improving Self-management**

1. **Introduction**

The changing pattern of care needs requires greater integration – that is, much better alignment – in the commissioning of health and social care services. In view of this the London Borough of Enfield is to commission prevention and early intervention services meeting the care and support needs of the communities in the borough. These services will require collaborative and joined up working from the voluntary and community sector in order to meet the requirements of the commissioning process.

As part of this process, the Council wishes to work with organisations able to demonstrate an ability to support the care needs of service users to focus on outcomes, using a person-centred approach. Organisations are encouraged to work together as partners within a consortium structure to deliver support flexibly meeting individual service user’s needs. This will be our key driver in procuring services for vulnerable people in Enfield.

The purpose of this specification is to set out the minimum standards and requirements that the Council will expect from the successful organisation/consortium who are delivering preventatives services and interventions for vulnerable people residing in the borough of Enfield.

1. **Outcome Rationale**

It is recognised that one of the best ways to maximise the social care and health budgets is through prevention and self-management of common conditions. Whilst healthy living for the general population is covered by Public Health, the voluntary and community sector has an important part to play in supporting people vulnerable to, and those just diagnosed, with long term health conditions.

The national picture shows us that:

* 70% NHS budget is spent on long-term conditions (approx. £72 billion)
* Diabetes nationally costs the £25,000 per minute
* Two thirds of Enfield’s adults are either overweight or obese
* Diabetes prevalence has risen 10% in last 4 years
* Long-term conditions can be either prevented or eased through lifestyle change
* Long-term conditions can be reduced by 20–40% by physical activity

**2.1 Prevention and Public Health**

The message from Public Health is encouraging Enfield residents to take their ‘MEDS’. MEDS simply means

* **M**oving regularly

For a good standard of health and well-being, it is essential to get people moving. It is advised to include 150 minutes a week of moderate activity and/or 75 minutes of vigorous activity. This does not mean everyone has to go to the gym, but need to be more active including walking and gentle exercise. By including two days a week of physical activity muscle strength also improves.

This is a key area because as a Borough, Enfield has a very low rate of physical exercise uptake. Health Survey for England (2008) self-report data indicated that 39% of males and 29% of females aged 16+ met the then Chief Medical Officer (CMO) guidelines of five bouts of moderate intensity physical activity of at least 30 minutes per week. However, objective data from participants who had agreed to wear accelerometers for 10 hours/day for a week indicated that only 6% of males and 4% of females actually met this recommendation.

* **E**ating

A healthy diet is also important to good and improved health and wellbeing. Eating 5 pieces’ fruit and/or veg a day is recommended. However, this is the minimum – for example guidance differs throughout the world with Canada advising 5 –10 portions and Japan a huge 17 servings. A quarter of adults in Enfield are obese and almost a

quarter of children aged 10-11years are obese.

* **D**rinking

For better health and wellbeing, it is advised not to consume more than 14 units of alcohol per week. It is also advised to spread that throughout the week and having drink free days. Alcohol misuse is the third largest contributor to ill-health after cardiovascular disease and smoking; Between 2007/08 and 2011/12, the rate of alcohol related hospital admissions in Enfield increased by 114%.

* **S**moking

Advice on smoking is very clear -Don’t! And also, persuade your family/friends to follow that example. Smoking contributes to 1 in 5 deaths in Enfield. Smokers have a life expectancy ten years less than non-smokers.

**2.2 Self-management**

Self-Management UK defines self-management as

“a term that covers a whole range of things you can do to help yourself live a better life if you have a long-term health condition, either a physical or mental condition.

Self-management encourages you to:

* find out more about your condition
* learn new skills and tools to help you manage your health
* work better, and in partnership, with your health care professionals
* take charge of your health care and choose what is right for you
* get support from other people in a similar situation to you”

Self-management maybe as simple as an individual keeping a journal of the condition and finding triggers to supported self-management where professionals teach service users and carers skills and techniques to be able to self-manage at home.

**2.3 Population Needs – Vulnerable People of Enfield**

The target groups are those from the list below and who do not meet the thresholds for specialist statutory support. This service is not to replicate

The focus of this service will be on:

* Early diagnosis of long term conditions – dementia, diabetes, COPD, HIV, mental health
* Identification of those who would benefit from public health services – weight management, stop smoking, sexual health, alcohol and substance misuse services
* People living with early onset dementia
* People with diabetes or at risk of developing diabetes and linked conditions
* People with COPD or at risk of developing COPD and linked conditions
* People with mental health issues being treated within primary care or at risk of developing mental health conditions, including perinatal mental health
* People at risk of social isolation
* Carers of the above groups
* Partnership working with Public Health to promote and refer to existing services

**Dementia** - In Enfield, the number of expected cases of dementia (around 3,100) is

significantly higher than the number of cases diagnosed, with 60% of people living

with dementia diagnosed at end Mar-15. Improving the rate of dementia diagnosis in

the population is a key performance indicator in Enfield’s Better Care Fund Plan, with

the target 66% for Mar-16.

This will require partnership working with the lead partner of ‘*Outcome 2: Supporting Vulnerable Adults to Remain Living Healthily and Independently in the Community Including Avoiding Crises’ which* also provides support to dementia patients.

**Diabetes -** The rate of diabetes in Enfield is increasing and is likely to continue to

rise because of obesity. If obesity continues to rise in Enfield, an additional 2,000

adults could develop diabetes. In addition, an additional 30,000 adults in Enfield are

at increased risk of developing diabetes (known as prediabetes). Unmanaged

diabetes can lead to serious complications that could limit people’s independence

and quality of life.

Diabetes is one of the most common co-morbidity amongst unplanned admission

due to amputation (228 cases), angina (129 cases), heart attack (311 cases), renal

failure (266 cases) and stroke (575 cases). Almost three quarters of amputation

cases had diabetes as comorbidity while almost two fifth of the renal failure also had

diabetes. Some of these cases could have been prevented if diabetes was

prevented in the first place. It is estimated that more than half of new cases of type 2

diabetes can be prevented. Being overweight or obese, smoking, drinking excess

amounts of alcohol are all risk factors for developing diabetes.

For more information please refer to the Annual Public Health Report 2016 –Diabetes in Enfield

<https://new.enfield.gov.uk/services/health/public-health/health-publications/annual-public-health-report/health-information-enfield-annual-ph-report-2016-diabetes-in-enfield.pdf>

This will require partnership working with the lead partner of *‘Outcome 2: Supporting Vulnerable Adults to Remain Living Healthily and Independently in the Community Including Avoiding Crises’* which also provides support to diabetes patients.

**COPD** – Chronic obstructive pulmonary disease (COPD) is one of the most common respiratory diseases in the UK. It’s a name used to describe a collection of lung conditions. People with COPD have difficulties breathing, primarily due to airflow obstruction, which is a narrowing of their airways. COPD is a condition which is

predominantly found in people who smoke. It is also prevalent in passive smokers and in people who have been exposed to pollutants over a significant period of time.

In Enfield, 3,000 people have been diagnosed with COPD and a further 6,500 people are estimated to be undiagnosed. Roughly 50 people under 75 years die from respiratory disease (includes COPD) in Enfield each year. Almost half of these deaths are considered preventable. Late diagnosis results in poorer outcomes and hospital admissions.

**HIV -** Earlier HIV diagnosis reduces both morbidity and mortality and ensures that newly diagnosed people with HIV can receive effective treatment and support to reduce onward transmission. More than 1 in 2 people with HIV were diagnosed late in Enfield. HIV late diagnosis in Enfield is ranked 10th highest in London. Over 800 people with HIV accessing HIV services in Enfield.

**Mental Health -** This service will support those who do not meet the threshold for statutory support through social care but require support to prevent developing a mental health condition or managing a condition where support is provided through primary care (e.g. a GP).

In Enfield over 32,000 adults are estimated to be living with a common mental

health disorder with 3,400 additional adults will be living with a common mental health disorder by 2020. 4.3% of people over 18 years are recorded as suffering from depression by Enfield GPs. Mental illness accounts for 23% of all years

of healthy life lost in high income countries.

In addition, parental mental health is a significant indicator for children developing mental health issues themselves. Many parents do not meet eligibility for statutory support but are experiencing significant mental health issues which can have a long-term effect not only on themselves, but also their children. Ensuring the adult is identified and supported early limits the impact on the family as a whole.

Research shows that peer support is particularly effective for mental health prevention and management. Due to the stigma of mental health conditions many do not wish to speak openly about their experiences. Meeting others that understand in a safe and non-judgemental environment can be key to recovery.

**Social Isolation** – In Enfield there are around 12,108 adults over the age of 65 who reported themselves as living alone. This equates to 31% of the total population of residents aged over 65 in Enfield. The areas with higher proportions of older people living alone are predominately in the North West of Enfield, with 15.1% of all households in Cockfosters being lived in by a lone person aged 65 or over, with similarly high proportions in Highlands (14.3%), Grange (13.5%) and Bush Hill park (13.4%). Social isolation and loneliness is a key determinant of the current and future health and social care needs of the older population. Loneliness and social isolation have been shown to have significant negative impacts on people’s health status, including a demonstrable effect on blood pressure and a strong association with depression

For further information please access the Enfield’s Joint Strategic Needs Assessment which can be found at

<http://www.enfield.gov.uk/healthandwellbeing/info/56/introduction>

**3 Contract Value**

Applications are invited up to the value of £130,000.00

As stated in the guidance this must cover the outcomes stated in this specification.

The successful organisation will be invited to bid for an additional £10,000 towards strategic leadership of the service and to promote the services outcomes across the borough. This will be awarded to the Lead Partner to cover additional management and administrative costs, and for service promotion.

1. **Aims and Objectives of the Contract**

The key objective is to provide suitable interventions so that service users, potential service users and their carers can prevent or self-manage the mentioned conditions (not exhaustive) and improve their wellbeing. This is turn will relieve pressures upon primary and secondary care, reduce crisis or A&E presentation and/or hospital admission. Service pathways will be co-ordinated and close working is required with the Public Health teams in prevention work.

1. **Outcomes**

Support will be personalised to the individual and is high quality and responsive so that users of the service are confident to self -manage and carers feel they are trained, healthy and able to undertake their caring role.

A partnership response to meeting need is key to achieving the outcomes expected

within this specification with providers working as part of a consortium in an

integrated way together with health and social care professionals.

**Expected Outcomes**

* Increased confidence and ability to self-manage health conditions
* Increased opportunity and people accessing monitoring of health conditions in non-medical settings
* Increased ability, confidence and skills for preventative self-care – e.g. healthy eating, exercise, peer support, creative therapies
* Increased education and information around preventative and self-care
* Decrease in numbers of people accessing primary and secondary care due to LTC
* Reduction in emergency hospital admissions associated with existing conditions
* Increased numbers of health checks/monitoring –PH
* People reporting better levels of self-management confidence
* Evidence of increased working with Children’s Services to support a whole family approach
1. **Definition and Eligibility**
	1. **Definition**

Service provision is focused at low level support helping people who need support to

prevent or self-manage the identifying conditions. The low-level support service

for service users identified as at risk will be one of several newly commissioned services designed to shift the emphasis of health and adult social care services

towards preventing the onset of chronic health conditions and intervening early to contain these conditions once they arise. In particular, the low-level support service

would focus on primary prevention i.e. maintaining independence, educating and

promoting good health and wellbeing and some secondary prevention i.e. identifying

individual at risk or living with specific health conditions

Services will help maintain independence, health and wellbeing by improving access to universal good quality information about local services, promoting health and active lifestyles. This will be done through links with *Outcome 6 ‘Increased and Improved Information Provision’.*

In addition, services will facilitate access to local services that are important to vulnerable people and their carer e.g. transport, leisure, health services, housing services, libraries, information and advice and services that support people to maintain a sense of health and wellbeing.

Secondary Prevention – Services will act as an ‘early warning’ system by putting

mechanisms in place to ensure that those ‘at risk’ of suffering health related

problems, or those struggling with self-management of their conditions.

Services will refer to the appropriate agency should risk to a service user’s wellbeing increases or as and when required.

* 1. **Eligibility**

This service will be accessible for all residents in Enfield. Carers who live in another borough but care for a resident in Enfield will also be eligible.

However, services available through this specification must not duplicate provision given to those with a diagnosis through health and social care services e.g. If a patient is receiving support from a professional on a regular basis. This is to ensure consistent care and that the provider does not provide conflicting activities and/or information.

1. **Service Description**

From consultation, the following areas for development were suggested:

**7.1 Community Health champions**

Enfield has a wide range of resources, both through statutory and voluntary organisations, to support resident’s health and wellbeing. The role of a Community Health Champion would be to collate and coordinate the information on services available and promote them to both the community and professionals and signpost/refer when necessary.

**7.2 Health checks and Monitoring Technology**

Health checks to monitor risk factors for ill health should be encouraged or provided. When a person is entitled to an NHS Health Check (aged 40-74 years of age) they must be directed towards their GP.

People should be encouraged to use the Wellness Kiosks based at GPs and community locations in Enfield. People should also be introduced to helpful websites, apps and other technology to enable them to enhance their health and wellbeing.

Promotion of Enfield Connected, and assistive technology, as a whole must be incorporated into the service.

**7.3 Healthy Lifestyle Classes and Activities**

Classes and activities should be provided to complement the MEDS Public Health model. Managing your diet, taking regular exercise, reducing alcohol intake and stopping smoking all has a significant impact on a person’s health and wellbeing and can even prevent the development of some long-term conditions. Any activities should be accessible and appropriate for the diverse Enfield community.

**7.4 Peer Support Networks**

Peer support networks should be run to support those with diagnosed conditions. Such networks should provide information, support and a chance to meet others with similar conditions.

Carers peer support groups will be provided through Outcome 1 and not this contract.

**7.5 GP Outreach and Socials**

The service should be promoted through the GP surgeries and networks within Enfield. GPs and practice staff should also be briefed and trained on the services available so they know how to refer. Referrals pathways should be designed to ensure ease of referral.

Support should be given to practices who wish to engage further with their patients and to promote self-management and appropriate discussions at appointments. In addition, the service could look at providing services and information through GP presence or events hosted jointly with the practices.

**7.6 Whole Family Support**

The service will look at providing support to the whole family, not just the service user and carer. This is to recognise the need for a coordinated approach, the impact of the family when there is a health condition and to identify risks to carers and family members, especially children.

**7.7 Carers**

Carers will be provided with education and training to support those to self-manage. They will also be encouraged to look at their own health and wellbeing.

Organisations/consortium of this specification will engage with the wider carers agenda, and will link into the main *Outcome 1 – ‘Helping people to Continue Caring’*

The following principles underpin the desired approach:

• Promoting carers’ wellbeing: helping carers to remain in their caring role, cope with stress, to recognise their own health needs and to maintain a sense of well-being

• Enabling carers to recognise their status as carers and recognise their own personal limitations in preventing or delaying a crisis, helping carers to build networks of peer support, engaging with families, local communities, employers and external agencies to identify support.

• Provide information, advice through links with Outcome 6 Increased and Improved Information

**7.8 Premises**

Rent for any premises used by organisations/consortium are included within the contract price for this specification

1. **Quality Provision**
2. **Quality Assurance**

Organisations/consortium must achieve continuous improvement in the quality of service as measured by internal review and reviews by the Council and feedback from past and present Service Users.

Enfield Council will set targets for performance directly as demonstrated in Section 9 on page 12. Targets will be reviewed annually, or more frequently as necessary in response to performance issues.

Organisations/consortium will be expected to be proactive in monitoring their own performance against the contract and immediately report to the Contract Manager any areas where it is encountering difficulties in fulfilling the terms of the Contract; and proposing to the Council new ways of improving the services arising from technology and other developments.

Organisations/consortium will work to maximise the appropriate skills, awareness and qualifications of its paid staff and volunteers. It will agree with the Council minimum level of staff and volunteers and their qualifications for key areas including;

- Customer services

- Advice work

- Systems for monitoring

- Safeguarding Training

Organisations/consortium will undertake a programme of appropriate training for all their staff and ensure an on-going learning and development programme is in place.

1. **Confidentiality**

The service will have a written policy on confidentiality, stating that information about a person using the scheme is confidential and any circumstances under which confidentiality might be breached.

1. **Complaints**

The service will have a written policy describing how to make complaints or give feedback about the scheme or members of staff. Where necessary, the scheme will use its services to access external independent support to make or pursue a complaint.

1. **Safeguarding Policy and Procedures**

All organisations applying for this funding stream must have their own Safeguarding Policy and Procedures. All applicants must have a named dedicated Safeguarding Officer who has undertaken London Borough of Enfield Safeguarding Adults training. If applying as a consortium the Safeguarding Officer must be an employee of the lead organisation. In addition, all organisations directly delivering services to vulnerable people will have undertaken safeguarding training.

Organisations/consortium need to ensure that all individuals engaged in one to one and group activities with people accessing the service are subject to a valid enhanced disclosure check for regulated activity undertaken through the Disclosure and Barring Service (DBS); and: -

a) monitor the level and validity of the checks for each member of staff;

b) not employ or use the services of any person who is barred from, or whose previous conduct or records indicate that he or she would not be suitable to carry out Regulated Activity or who may otherwise present a risk to Service Users

c) shall immediately notify the Council of any information that it reasonably requests to enable it to be satisfied that its safeguarding obligations have been met.

d) shall refer information about any person carrying out the Service to the DBS where it removes permission for such person to carry out the Service (or would have, if such person had not otherwise ceased to carry out the Service) because, in its opinion, such person has harmed or poses a risk of harm to the Service Users.

e) maintain a policy regarding confidentiality of information about Service Users. Service staff and volunteers must have knowledge and understanding of this policy

1. **Performance Measures**

Performance Measures must be linked to all the outcomes under the Section 5 of this specification. Organisations/consortia are invited to create their own performance indictors using a mixture of outcomes and outputs measures. Good measures will combine both qualitative and quantitative information and data.

All targets must be **SMART**; **S**pecific, something you can **M**easure or observe and **A**chieve, something that is **R**ealistic, and have a **T**ime limit.

The Charities Evaluation Service has a number of tools and documents which can support you in establishing a performance measurement system:

<http://www.ces-vol.org.uk/tools-and-resources.html>

Performance Measures will be formally agreed following the contract award and in

partnership with the successful awardee and the Local Authority.

|  |  |
| --- | --- |
| **Outcomes** | **Outcome Indicator** |
| Increased confidence and ability to self-manage health conditions  | * Numbers of referrals to service
* Numbers pf people feeling more confident and able to self-manage
* Breakdown of demographic information of those accessing service
* Service user/family feedback
* Service user surveys
* Evidence of partnership working
* Number of referrals to other services and types of services
* Case study evidence
 |
| Increased opportunity and people accessing monitoring of health conditions in non-medical settings | * Numbers received monitoring in community locations
* Service user feedback
* Satisfaction level with service
* Numbers using community service instead of primary/secondary care

  |
| Increased ability, confidence and skills for preventative self-care e.g. healthy eating, exercise, peer support, creative therapies | * Number of people confidence to self-care
* Number reporting improved health and wellbeing
* Numbers referred to other service and types of services
* Service user feedback
* Case studies
 |
| Increased education and information around preventative and self-care | * Number of people who feel better informed about their condition
* Number of people who feel better informed about prevention and self-care
* Service user feedback
* Case studies
 |
| Decrease in numbers of people accessing primary and secondary care due to LTC | * Numbers for each condition accessing primary care
* Numbers for each condition accessing secondary care
* Service user feedback
* Case studies
 |
| Reduction in emergency hospital admissions associated with existing conditions | * Hospital data
* Service user feedback
* Case studies
 |
| Increased numbers of community health checks/monitoring  | * Numbers referred for a community health check
* Numbers receiving a community health check
* Numbers using community setting for health monitoring
* Number who felt they were better able to manage their health and wellbeing following the health check
* Summary of issues from analysis of health checks
* Reasons for requesting a health check
* Service user/family feedback
 |
| Demographic and Equalities Data | * Demographic profile of service users including equality characteristic profile
* Analysis of emerging patters of referrals and non-referrals that could indicate discrimination of any group
* Analysis of service users using accessible information
* Number of new services taken up from hard to reach group
* Evidence/case studies regarding impact on social isolation
 |

1. **Delivery Arrangements**

It is expected that the successful organisation/consortium will have a specific knowledge and understanding of Enfield, its populations and the challenges they bring. The organisation/Consortium must deliver the function in the Borough of Enfield.

It is encouraged that the successful organisation/consortium approach service delivery from a Hub and spoke model, including home visiting, to ensure accessibility for all.

Due to the broad nature of the outcome, and necessity to reach all elements of the diverse Enfield population, it is expected that applications will be from consortium or partnerships rather than singular organisations. This is to ensure specialism in the service provision and recognition of the good practice for individual client groups that currently exists in Enfield.

Applications will be expected to provide service to all residents of Enfield, paying focus on the following key risk groups:

* Older People
* Carers
* Vulnerable Children transitioning to adulthood
* End of Life;
* People with a Learning Disability;
* People on the Autistic Spectrum
* People with a Mental Health condition
* People with Dementia
* Physical Disability; and or a sensory impairment
* People with a long-term condition
* Challenging behaviour
* Muscular Dystrophy/Multiple Sclerosis
* Those not meeting eligibility criteria for statutory services

All services funding through this funding stream will also have to demonstrate how their work will help to reduce social isolation and reach people and communities otherwise not in contact with statutory services.

1. **Contract Period and Payment Terms**

This contract is for 3 years, from 1st December 2017 until 30th November 2020, with the option to extend for a further 2 years, 2022 + 2 years to 30th November 2024. Contracts will only be extended where all monitoring has been provided on time and outcomes have been fully met.

The organisation/consortium will be informed by April 2020 whether the contract will be extended until 30th November 2022, and again by April 2022 to confirm extension to 30th November 2024.

In the final contract year (Year 3, 2020 and Year 5, 2022 and Year 7 2024 if applicable) organisations/consortium must provide evidence of sustainability beyond the contract funding or how the service will be discontinued and transition of clients managed

Payment will be made quarterly, with the first quarter upfront. Other quarters funding will be released on receipt of satisfactory monitoring information.

1. **Contract Monitoring**

Contract monitoring will be expected every quarter. The Councils Care First system will be the operating model used for reporting monitoring information. The lead Provider will be the organisation responsible for reporting on the whole contract using the Council’s Care First system. The format of such monitoring will be agreed between the successful organisation/Consortium

Monitoring visits may take place at least once every six months, with an annual service report and review visit at the end of each financial year.

Demographic and equalities monitoring will be required every quarter.

Successful organisations/consortium must agree to submit all aspects of monitoring as requested, including personal details of the clients they work with obtaining their permission when necessary.

The successful organisation/consortium will be required to attend regular meetings for all contracted providers under this funding stream to feedback on their services, share good practice and develop formal working relationships and pathways. attendance is mandatory.

Any difficulty in providing said information or attendance at meetings must be discussed with the named Council Officer at the earliest opportunity.

Each successful organisations/consortium will have a named Council Officer throughout the length of the contract to ensure clear communication and service management from both parties. It is expected that issues may arise throughout the life of the contract with this new approach, particularly in the first year. Open and honest communication is encouraged between both parties and any difficulties must be flagged at the first possible opportunity.

1. **Key Risks**
	1. **Organisational Failure**

All organisations/consortium must produce a mobilisation plan demonstrating how they plan to work to meet the outcomes of this specification taking into consideration the deployment of resources required. In addition, organisation/consortium must produce an exit plan should the service become unsustainable.

All Consortia should have a formal written plan agreed between all partners on how to manage the failure or underperformance of each individual organisation within the Consortium. Expectations of delivery must be agreed between the organisations prior to contract award.

* 1. **Sustainability**

It is expected that the organisations/consortium, in particular the lead partner, will look to add value to this contract through additional fundraising and income generation. Each financial year the contract value will be reduced by 5% of the annual total cost. It is expected that the organisation will raise a minimum of 10% of the contract value in addition per annum from Year 2 onwards.

With local government and health resources reducing, all organisations/consortium should be providing a plan for alternative and supplemental funding streams.

1. **End of Contract**

In the final contract year (Year 3, 2020 and Year 5/7, 2022 and 2004 if applicable) organisations/consortium must provide evidence of sustainability beyond the contract funding or how the service will be discontinued and transition of clients managed