NHS Standard Contract

2017/18 and 2018/19 Particulars

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Prepared by: NHS Standard Contract Team

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NHS Standard Contract 2017/18 and 2018/19 Particulars (Full Length)

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Contract Reference	B&NES Council/CCG/Virgin Care Services Ltd 1718

DATE OF CONTRACT	**31st March 2017**
SERVICE COMMENCEMENT DATE	**1 April 2017**
CONTRACT TERM	**7 years commencing on 1 April 2017** **(or as extended in accordance with Schedule 1C)**
COMMISSIONERS	**BATH AND NORTH EAST SOMERSET CCG (ODS: 11E)** **BATH AND NORTH EAST SOMERSET COUNCIL**
CO-ORDINATING COMMISSIONER	**BATH AND NORTH EAST SOMERSET COUNCIL**
PROVIDER	**VIRGIN CARE SERVICES LIMITED (ODS: NDA)** **Principal and/or registered office address:** **Lynton House, 7-12 Tavistock Square, London WC1H 9LT** **Company number: 07557877**

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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

Sarah James
For and on behalf of
BATH AND NORTH EAST SOMERSET CLINICAL COMMISSIONING GROUP

Title : Chief Financial Officer

31/3/17
.....
Date

The Common Seal of Bath and North East Somerset Council was hereunto affixed in the presence of:

7927

.....
Signature

Ashley Ayre
For and on behalf of
BATH AND NORTH EAST SOMERSET COUNCIL

Title : Chief Executive

31.3.17
.....
Date

SIGNED by

.....

Signature

Bart Johnson for
and on behalf of
VIRGIN CARE SERVICES LIMITED

.....

Chief Executive

31.03.2017

.....

Date

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	**1 April 2017**
Expected Service Commencement Date	**1 April 2017**
Longstop Date	**1 June 2017**
Service Commencement Date	**1 April 2017**
Contract Term	**7 years commencing on 1 April 2017** **(or as extended in accordance with Schedule 1C)**
Option to extend Contract Term	**YES** **By 3 years**
Commissioner Notice Period (for termination under GC 17.2)	**12 months**
Commissioner Earliest Termination Date	**12 months after the Service Commencement Date**
Provider Notice Period (for termination under GC17.3)	**12 months**
Provider Earliest Termination Date	**12 months after the Service Commencement Date**

SERVICES	
Service Categories	**Indicate all that apply**
Accident and Emergency (A+E)	
Acute Services (A)	
Ambulance Services (AM)	
Cancer Services (CR)	
Continuing Healthcare Services (CHC)	
Community Services (CS)	✓
Diagnostic, Screening and/or Pathology Services (D)	✓
End of Life Care Services (ELC)	
Mental Health and Learning Disability Services (MH)	
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)	
Specialised Services and other services directly 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)	**NO**
Services to which 18 Weeks applies	**YES**
Prior Approval Response Time Standard	**1 month**

SERVICES	
PAYMENT	
Expected Annual Contract Value Agreed	**YES**
Must data be submitted by SUS for any of the Services?	**YES**
QUALITY	
Provider type	**Other**
Clostridium difficile Baseline Threshold (Acute Services only)	**Nil**
GOVERNANCE AND REGULATORY	**Note: contact details redacted**
Nominated Mediation Body	**CEDR**
Provider's Nominated Individual	**Regional Operations Director**
Provider's Information Governance Lead	**Head of Information Governance**
Provider's Caldicott Guardian	**Clinical Director**
Provider's Senior Information Risk Owner	**Chief Technology and Transformation Director**
Provider's Accountable Emergency Officer	**Regional Operations Director**
Provider's Safeguarding Lead	**Clinical Director**
Provider's Child Sexual Abuse and Exploitation Lead	**Lead for Safeguarding Children**
Provider's Mental Capacity and Deprivation of Liberty Lead	**Clinical Director**
Provider's Prevent Lead	**Clinical Director**
Provider's Freedom To Speak Up Guardian	**Head of Corporate Governance**
CONTRACT MANAGEMENT	
Addresses for service of Notices	**Co-ordinating Commissioner: Bath and North East Somerset Council**

SERVICES	
	Director, Integrated Health & Care Commissioning **B&NES Council and BaNES CCG** **Provider: General Counsel and Company Secretary**
Frequency of Review Meetings	**Monthly in year 1** **To be reviewed for year 2 onwards**
Commissioner Representative(s)	**People and Communities Department** **Address: Bath and North East Somerset Council/NHS Bath and North East Somerset CCG**
Provider Representative	**Regional Operations Director**

1. SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

1. Evidence of appropriate Indemnity Arrangements

2. Evidence of CQC registration in respect of Provider

3. Evidence of Monitor's Licence in respect of Provider

4. Copies of the Permitted Material Sub-Contracts, signed and dated and in a form approved by the Co-ordinating Commissioner in line with requirements set out in Schedule 2H (Transition)

5. Copies of the signed business transfer agreement entered into with Sirona Care & Health CIC:

to include the following:

- transfer of Equipment
- transfer of data, including patient records;
- transfer of and/or access to IT systems and support

6. Copies of signed agreements for those premises where the Provider shall deliver the Services.

7. Business Continuity Plans

8. Information Governance Evidence to local standards i.e. IG Toolkit Level 2 and Local Authority requirements

9. Data Protection and Records Management Policy

10. Whistleblowing Policy

11. Evidence of the Provider's board approval to commence delivery of the Services

The Provider must complete the following actions:

1. Agree plan with Co-ordinating Commissioner to achieve compliance against all requirements in the relevant Local Authority information governance toolkits.

2. The CQUINs that are applied to this Contract will be the nationally mandated CQUINs relevant to this Contract. By 30 April 2017, the parties will agree the indicators and milestones for each CQUIN.

3. In addition to the locally agreed SDIP, the SDIP applied to this Contract will include the nationally mandated SDIP items relevant to this Contract. By 30 April 2017, the parties will agree the indicators and milestones for each SDIP item.

4. The parties agree that Schedule 2C (Activity Planning Assumptions) shall be developed in line with the provisions set out in Schedule 3F by 30 April 2017

5. The parties agree that Schedule 3F (redacted **under FOIA exemptions: Section 43 (2) andSection 2)** shall be developed in the first three months;

6. The parties agree that Schedule 2A areas marked [Subject to Review] be developed in the first three months

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
31st March 2017	NHS Bath and North East Somerset Clinical Commissioning Group Commissioning Intentions	http://www.bathandnortheastsomersetccg.nhs.uk/
31st March 2017	NHS Bath and North East Somerset 5 Year Strategic Plan 2014/15 to 2018/19	http://www.bathandnortheastsomersetccg.nhs.uk/documents/strategies/five-year-plan
31st March 2017	NHS Bath and North East Somerset Joint Strategic Needs Assessment	http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics
31st March 2017	The most recent NHS Bath and North East Somerset Annual Public Health Report	http://www.bathnes.gov.uk/services/public-health/director-public-health-report
31st March 2017	Bath and North East Somerset CCG policies and standards	http://www.bathandnortheastsomersetccg.nhs.uk/
31st March 2017	Individual Funding Requests	http://www.bathandnortheastsomersetccg.nhs.uk/documents/what-we-do-and-do-not-fund/individual-funding-requests
31st March 2017	Better Care Plan (including any updates)	http://www.bathandnortheastsomersetccg.nhs.uk/documents/strategies/better-care-fund-plan
31st March 2017	Any relevant and approved Sustainability and Transformation Plans (STPs) for the area.	http://www.bathandnortheastsomersetccg.nhs.uk/get-involved/project/sustainability-and-transformation-plan
31st March 2017	Personal Health Budgets	http://www.bathandnortheastsomersetccg.nhs.uk/documents/links/personal-health-budgets-local-offer
31st March 2017	Integrated Personalised Commissioning	http://www.bathandnortheastsomersetccg.nhs.uk/documents/links/personal-health-budgets-integrated-personalised-commissioning

Date	Document	Description
31st March 2017	Your Care Your Way Outline Business Case	http://www.yourcareyourway.org/sites/default/files/20151124%20YCYW%20OBC%20FINAL.pdf
31st March 2017	Your Care Your Way Stakeholder Engagement Report	http://www.yourcareyourway.org/sites/default/files/20151113%20YCYW%20Phase%20Two%20Report%20FINALv3.pdf

NB: *The documents listed above are the most up-to-date at the time of producing the list. Should any of these documents be superseded, the most current document should be referred to.*

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C Extension of Contract Term

1. As advertised to all prospective providers before the award of this Contract, the Commissioners may opt to extend the Contract Term by 3 years.

2. If the Commissioners exercise the option to extend the Contract Term, the Co-ordinating Commissioner must give written notice to that effect to the Provider no later than 24 months before the original Expiry Date.

3. Where the Commissioners wish to extend the Contract Term, the Provider shall not be required to take any further action beyond that set out in GC9 (as applicable) for the extension to take effect.

4. The option to extend the Contract Term may be exercised:

    4.1 only once, and only on or before the date referred to in paragraph 2 above;

    4.2 only by all Commissioners; and

    4.3 in respect of some or all of the Services being provided by the Provider at the date of the notice to extend the Contract Term.

5. If the Co-ordinating Commissioner gives notice to extend the Contract Term in accordance with paragraph 2 above, the Contract Term will be extended by the period specified in that notice and the Expiry Date will be deemed to be the date of expiry of that period.

2. SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

PART 1

Service	Community Health and Care Services
Commissioner Lead	Mike MacCallam
Prime Provider Lead	Jayne Carroll
Period	1st April 2017 to 31st March 2024
Date of Review	1st April 2018

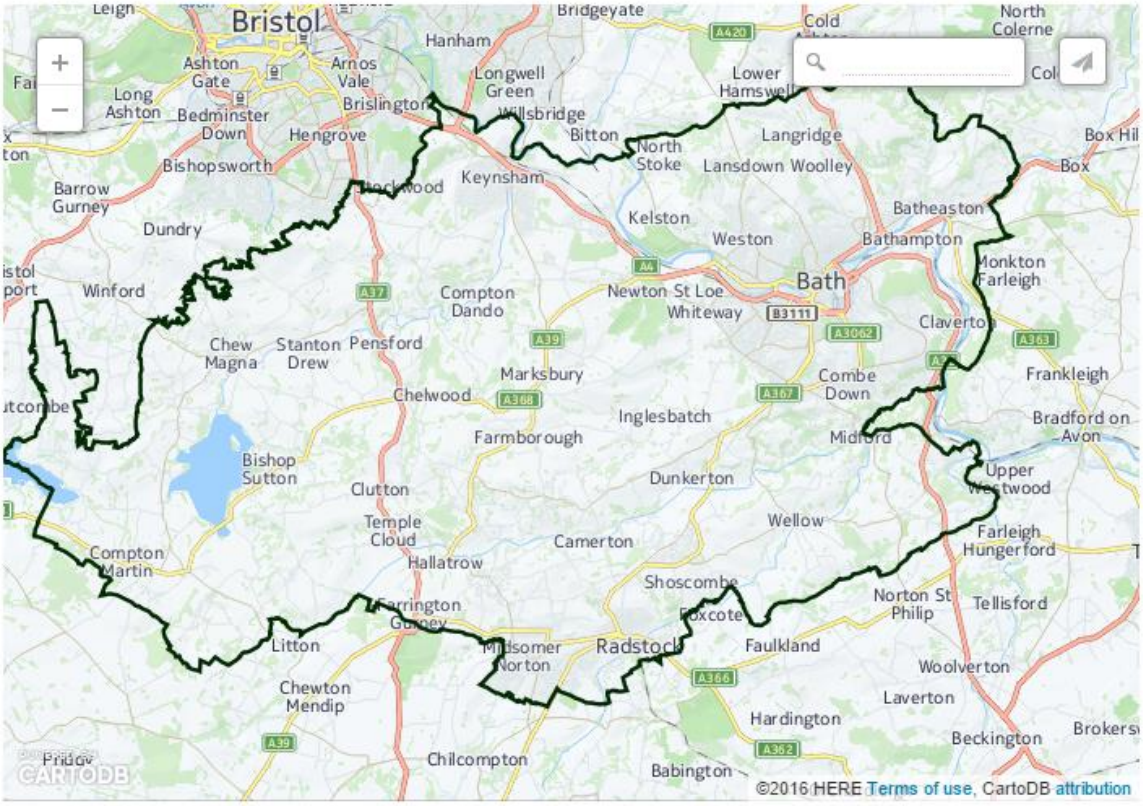
1. Population Needs

1.1 National/local context and evidence base

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

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

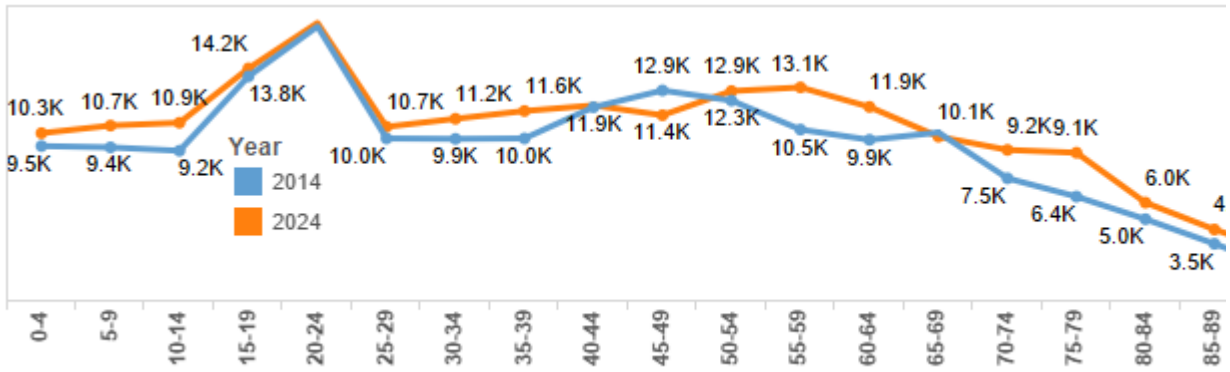
The GP registered population in Bath and North East Somerset as at March 2016 was 203,909



The Needs of Our Population

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

Comparative population change by age-range 2014-24



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

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

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

- Recent legislation and policy guidance including the Care Act 2014, the Children and Families Act 2014 and the NHS Five Year Forward View all promote the concept of 'wellbeing' and the duty to focus on delaying and preventing care and support needs whilst supporting people to live as independently as possible for as long as possible.
- In order to ensure that the principle of promoting wellbeing is embedded within community

health and care, and to meet the legislative requirements of the NHS and Council, it is envisaged that commissioners will use an **Outcome Based Accountability (OBA)** approach to plan and measure the performance of community health and social care services. This is a disciplined and practical framework for improving outcomes for whole populations, and also for measuring the performance of services which focuses on outcomes that the services are intended to achieve. Services will deliver improved person-centred and integrated care and support that will adopt a locality based approach with services 'wrapped around' users of community health and care. In addition, the model will aim to address the financial and demographic challenges facing the health and care economy.

- The OBA approach will seek to incentivise interventions that add most value for individuals, shift resources to community services, focus on keeping people healthy and in their own homes, and deliver co-ordinated care and support across settings and regions. It will encourage a focus on the experience of people using the services, and achieving the outcomes that matter to them through more integrated and person-centred services.

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

- The Outcomes Framework for Community Health and Care will be underpinned by the service Standards below which the Provider shall use its reasonable endeavours to achieve:

2.3 Local Population

In this section, the term "people" includes adults of working age, older people, children and young people, and carers in Bath and North East Somerset as appropriate.

Aims

- People will experience no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion, belief or socio-economic status.

- People are able to live free from social isolation and loneliness and feel welcomed and included in their local community and are able to make valuable contributions.

- People have a network of considerate and competent people who support them, including carers, family, friends, neighbours, volunteers as well as health and care staff.

- People have clear motivation, confidence and knowledge to help themselves to stay physically and mentally healthy and remain as independent as possible.

- People with care and support needs and/or those supporting them are aware and understand how technology can help them in their day to day lives. People are able to act on this knowledge and understanding to use technology to benefit their day to day lives.

- People feel in control of the decisions they are asked to make, either for themselves or on

behalf of their family or support network. This includes all age end of life care.

- People are enabled to set achievable goals e.g. returning to work, being part of their community, regaining strength or skills that enhance their physical or mental health.
- All people, especially children, young people and vulnerable people are safe and secure.
- People are supported to become more resilient to manage risks to their health and wellbeing and know how to stay healthy and remain as independent as possible.
- People have opportunities to train, study, work or engage in other community activities that match their interests, skills and abilities, and which support their needs, and they feel valued for the contribution that they make to the community.
- People can access support that promotes and sustains recovery and rehabilitation.
- Parents and children form strong positive attachments and parents are confident and able to meet the needs of their children.

2.4 System

In this section, the term “people” includes adults of working age, older people, children and young people, carers in Bath and North East Somerset as appropriate.

Standards

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

  NB: The Population and System Standards identified above can be illustrated as Individual Values using the ‘Markers for Change’ statements below.

2.5 Individual Values

- I am in control of planning my care and support.
- I can decide the kind of support I need and when, where and how to receive it.
- I feel safe, I can live the life I want and I am supported to manage any risks.
- I have systems in place so that I can get help at an early stage to avoid a crisis.
- I have access to easy to understand information about care and support which is consistent, accurate, accessible and up to date, and enables me to remain as independent as possible.
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
- I have a network of considerate and competent people who support me - carers, family, friends, community and if needed paid support staff.
- My support is co-ordinated, co-operative and works well together and I know who to contact to get things changed.
- I have good information and advice on the range of options for choosing my support staff.
- I have care and support that is directed by me and responsive to my needs
- I feel welcomed, and included in my local community.
- I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities.

3. Scope

3.1 Services in scope of YCYW but not transferred on Service Commencement Date to the Provider

- These services include, but are not limited to:
- Mental health provision;
- SDAS;
- GUM
- Domiciliary care
- Community Equipment
- Extra Care
- CRCs

The parties shall meet to discuss the process under which these services, and any other applicable services, may transfer either the responsibility or, or into the direct provision of the Prime Provider. The parties shall endeavour to agree this process or otherwise at least six months prior to any

transfer date.

3.1A Aims and objectives of service

Vision:

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

Objectives:

To achieve this Vision the Prime Provider must

- Care and support will be delivered in people's homes or in nearby local settings that enable them to remain independent as possible, for as long as possible, and to remain connected with their communities.
- Care and support will be accessible, equitable, integrated, sustainable and flexible for people of all ages.
- Care and support will connect and integrate across acute, primary care, mental health and community service boundaries.
- work in partnerships and with local communities to deliver services through a range of resources whilst maximising the potential of voluntary, community and social enterprise partners through an asset-based approach.
- Services are good value for money with as much resource as possible dedicated to front line services.
- Subcontractors have shared objectives and responsibility to ensure the integrated and seamless provision of services.
- Avoidable admissions to hospital are prevented through alternative community based options

and people are supported to be discharged from hospital with appropriate and sustainable support in community settings.

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

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

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

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

3.2 Service description/care pathway

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

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

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

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

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

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

5. **Maximising Independence**
   Focussing on maintaining someone in their own home as independently as possible. The

care is person centred and goal orientated, focused on rehabilitation/reablement and delivered by a combination of professional groups working together to common aims.

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

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

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

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

3.3 Care and Support Pathways

Services will be organised around four care and support pathways:.

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

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

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

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

Each of these is described in more detail below:

3.3.1 Core Functions of the Prime Provider ;

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

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

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

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

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

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

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

- In order to fulfil the requirements of the role, the Prime Provider will need to have project management capability, technical competence, financial standing and supply chain arrangements and shall use its reasonable endeavours to:

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

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

    - Work collaboratively across health and care systems (i.e. primary care, secondary care) with the aim of delivering an integrated and sustainable urgent care system which may reduce demand on primary care and hospital services and reducing hospital admissions.

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

    - Implement an integrated IT solution that enables individuals and the people involved in their care and support (be they professionals, friends or family) to work effectively

together. Clinical and administrative systems need to facilitate sharing of appropriate data and make best use of modern technologies.

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

- Operate a contractor governance arrangement with the other providers, including managing performance issues centrally. The Parties recognise that the management of subcontractor performance issues shall be performed by the Commissioner for the first six months of the Contract Term, and that this shall commence following that six month period. Clinical governance for the whole pathway will help to align the ambitions of different practitioners, commissioners and people with health and care needs as people have responsibility for a single goal. It provides a way to make continuous improvement.

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

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

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

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

Corporate Governance:

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

Statutory Functions:

- There are a number of mandatory statutory services where the Commissioner wishes to retain a direct means of intervention with the Prime Provider. These services are statutory functions of the CCG and/or the Local Authority and have been part delegated to the Prime Provider to fulfil on their behalf. These services can only be delivered by the Prime Provider and will not be subcontracted to any other provider

- Detailed service specifications will be agreed with the Prime Provider for each of the statutory services (detailed below) to be delivered by the Prime Provider

Adult Services:

- Provision of delegated social care functions for adults who have care and support needs or support needs as outlined in the Care Act 2014 including those with the financial means to

contribute to the cost of meeting those needs. This includes but is not limited to: advice and information on social care issues, the undertaking of statutory assessments for both service users and carers including those in transition to adulthood, risk assessments, undertaking eligibility determination for service users and carers, ensuring people who require advocacy support are identified and referred, support planning for both service users and carers, reviews for both service users and carers, undertaking social care hospital discharge responsibilities, assessments for Disabled Facilities Grants, manual handling assessments in both community and residential settings, minor works and the provision of equipment/aids that support independence.

- The Provider shall, under the Legal Advice Protocol set out in Schedule 2G, utilise the legal expertise of the Council for advice on those delegated functions set out above.

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

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

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

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

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

- Upon commencement of the services in respect of Mental Health, the Provider shall use its reasonable endeavours to provide staff with Approved Mental Health Practitioner (AMHP) qualifications to support the daily AMHP rota co-ordinated by the Council.

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

- **Continuing Health Care:**

The CCG will retain responsibility for authorising decisions regarding CHC, however the Prime Provider will undertake a range of functions in relation to Continuing Health Care (CHC) including:

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

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

- Ensure that all Continuing HealthCare assessments and reviews are completed within the NHS National Framework for Continuing Health Care & NHS Funded Nursing Care (November 2012) standard timeframes. This will include that social care practitioners work jointly with NHS staff throughout the NHS continuing healthcare eligibility process, and should be involved as part of the Multidisciplinary Team (MDT) wherever practicable in accordance with the National Framework. The MDT should comprise health and social care staff presently or recently involved in assessing, reviewing, treating or supporting the individual. Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the Framework makes it clear that the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs.

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

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

Children's Services:

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

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

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

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

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

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

- NB – the statutory children's services will be delivered as part of a range of community child health services and the Prime Provider will be expected to ensure that there is close alignment with the other services as outlined in the service description for Community Paediatrician services

Core Services:

- In addition to the statutory functions outlined above both the Council and the CCG have statutory duties to protect against provider failure and to ensure business continuity. Therefore certain services will be deemed as essential, or core, services because:
    - appropriate alternative providers of those services do not currently exist; or
    - removing them would increase health inequalities; or
    - removing them would make dependent or related services unviable.

- The Commissioner reserves the right to oblige the Prime Provider to continue to directly provide and not to make material changes to the way in which these services are provided without the agreement of the Commissioners.

3.3.2 Living Well and Staying Well

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

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

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

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

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

3.3.3 Early Intervention and Targeted Support – Regaining Health and Independence

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

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

- The risk of becoming ill or injured is not the same for everyone and is strongly influenced by a person's social circumstances, therefore targeted prevention includes activities aimed at

identifying and intervening early with people at highest risk of becoming ill or injured.

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

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

3.3.4 Enhanced and Specialist Support – Helping people to live well with complex or long term conditions;

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

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

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

3.3.5 Preparing for Adulthood

- Transition takes place at a pivotal time in the life of a young person, part of wider cultural and developmental changes that lead them into adulthood. Making this move can be difficult or provoke anxiety in young people and their carers. Young people need appropriate support during this period to ensure they continue to engage with services. Adverse effects can occur if young people disengage and this can be disruptive for young people, particularly during adolescence when they are at a higher risk of psychosocial problems.

- Particularly vulnerable groups are identified as those with complex health and social care needs, child and adolescent mental health service users, young people leaving residential care and young people with life-limiting conditions

- Preparing for adulthood means preparing for:

    - higher education and/or employment – this includes exploring different employment options, such as support for becoming self-employed and help from supported employment agencies

    - independent living – this means young people having choice, control and freedom over their lives and the support they have, their accommodation and living arrangements, including supported living

- participating in society, including having friends and supportive relationships, and participating in, and contributing to, the local community
- being as healthy as possible in adult life

The Prime Provider will:

- ensure that young people and their families and carers are treated as an equal partner in planning for the future and full account is taken of their needs and wishes
- support the young person to make decisions and builds their confidence to direct their own care and support over time is
- ensure that transition support is strengths-based and focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options
- identify the support available to the young person, which includes but is not limited to their family or carers.
- Include information about how young people will be supported to develop and sustain social, leisure and recreational networks within the transition plan.
- Include information and signposting to alternative non-statutory services, including condition-specific support services, in transition planning. This may be particularly important for people who do not meet the criteria for statutory adult services
- If the young person has long-term conditions, ensure they are helped to manage their own condition as part of the overall package of transition support. This should include an assessment of the young person's ability to manage their condition, self-confidence and readiness to move to adults' services.
- Ensure that young people have access to independent advocacy throughout the transition to adulthood as appropriate
- Ensure that a practitioner from the relevant adult services meets the young person before they transfer from children's services. This could be, for example, by:

  •arranging joint appointments

  •running joint clinics

  •pairing a practitioner from children's services with one from adults' services.

- give young people and their families or carers information about what to expect from services and what support is available to them. This information should be provided early enough to allow young people time to reflect and discuss with parents, carers or practitioners if they want to (for example 3 months before transfer).

For further guidance the Prime Provider should ensure that service delivery is in line with NICE guideline NG43 - Transition from children's to adults' services for young people using health or social care services;

And compliant with relevant Statutory legislation as outlined in the Care Act 2014; Children and Families Act 2014; Special Educational Needs and Disability Code of Practice: 0-25 years

3.4 Person Centred Services

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

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

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

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

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

3.5 Personal Budgets

To support a person centred approach, the Prime Provider will actively encourage and promote the use of personal budgets so that people have more control over their care and support, and can shape care and support that is effective and meaningful to them in their lives. Personal budgets will be available to meet both health and social care needs and/or a mixture of both, for adults and children, through an agreed framework for Integrated Personal Commissioning. The Prime Provider will be expected to incrementally increase the number of people accessing personal budgets as a Direct Payment and to stimulate a culture of using personal budgets in flexible and individualised ways whenever possible and appropriate

3.6 Locality Based Provision

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

- Services will be configured around groups of GP practices, and focused on delivering health and care outcomes.

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

3.7 Interdependence with other services/ Providers

System wide Strategies and Protocols

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

Service Accessibility and Responsiveness

- Services may be offered through a variety of settings and may be through one-to-one or group sessions and using innovative methods to reach particular vulnerable groups.

- A wide range of effective prevention information will be available to include self-help and signposting.

- The Prime Provider will use a strengths based approach.

- The Prime Provider will provide proactive outreach to those communities that may face barriers in accessing services, including homeless families, traveller families and asylum seekers.

- Staff will be responsible for ensuring that families who do not have English as their first language have access to interpreting and translation services as required.

- Staff will responsible for ensuring that people who require information in different formats such as British Sign Language, braille, large font, easy read or Makaton are able to access these.

- The Prime Provider will play an active part in providing integrated services to support troubled, struggling and vulnerable families; recognising that services may need to be configured differently to reach this small group of service users.

- There will be a clearly identified route for people who have previously used services to re-establish contact with the relevant service area.

- The Prime Provider will attend meetings as required by the Commissioner.

- The Prime Provider will ensure that it has one named representative on relevant strategy and planning groups relating to health and care promotion priorities and will attend the meetings. The Prime Provider will implement agreed changes to service delivery in line with these strategies.

3.8 Navigation

- The Prime Provider will create a system of care navigation which will act as a bridge between individuals with care and support needs and services/providers who have the skills and resources to meet those needs.

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

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

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

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

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

3.9 Information Management and Technology

3.9.1 Context

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

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

- All health and social care records will be kept digitally with the NHS number as the unique identifier and have the ability to communicate (only) relevant information automatically with other parts of the health and social care system, across organisational boundaries, whilst respecting individual consent. Subject always to applicable laws and regulations, this may include information processed in all health and care settings, remotely, in the field and in the

person's home.

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

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

- Clear milestones for deliverables in the Prime Providers IMT Strategy for this contract must be ordered so that the benefits of integrated data are delivered in line with the timescales set out in the SDIP to support better care.

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

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

3.9.2 General Responsibilities for IM&T

- The Parties agree that the Council will make services available to the Provider (including IT infrastructure and systems (the "Council IT")) on a reasonable endeavours basis, and will treat services to the Provider in the same way as they treat service delivery to any other Council department - service levels to be defined in a separate schedule.

- The Council shall provide reasonable support and training on the Council IT.

- To the extent that the Council IT is unavailable, or suffers any failure, the parties agree that owing to the Provider's reliance on part of the Council IT (in particular Liquid Logic) the Provider shall incur no penalties for any breaches of this Contract related to the failure or unavailability of the Council IT.

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

  The Prime Provider is absolutely responsible for ensuring that in delivering any aspect of this contract whether directly or indirectly through a third party that all data is held, managed and processed securely in accordance with the Data Protection Act 1998.The Provider shall ensure that in respect of the Services directly provided by the Provider all electronic data is backed up at least daily and that back-ups are retained for 12 months in the event of a requirement to do a data restore. Backup software and media should be held and accessed via standards and principles laid out in section 3.9.2 to protect against unlawful or unauthorised processing, or accidental loss or erasure. Processes must be in place to regularly test the integrity of all data backups.

- At least annual Penetration (PEN) Testing will be carried out by the Prime Provider their

significant subcontractors and partners. PEN testing will be undertaken by a CESG approved organisation and a report on issues found, remedial actions and a remediation plan shared with the Commissioner to provide assurance. The report must be provided within six weeks of the PEN test taking place. This test must report on all components providing external perimeter security and public internet facing services. It must also cover internal patch and firmware levels on internal IT devices and software that host or have access to the Liquid Logic system.

- Undertake as a minimum annual audits measuring effectiveness and compliance of the Prime Provider and any subcontractors on their IT security policy in its internal services and where appropriate with third parties

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

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

- There are appropriate access and leaver policy and controls in place.

- All data handling by the Prime Provider complies with all legislation, guidance and relevant standards relating to how this should be achieved and appropriate contractual safe guards are in place to ensure the same is in place with sub-contractors

- For access to Liquidlogic and any other Council application:

    - A Remote Access Agreement setting out responsibilities will need to be agreed between the Prime Provider and the Council for access to Liquidlogic.

    - This agreement will need to form part of any subcontract or partnering arrangements where Liquidlogic access will be required or facilitated.

    - Access to the Liquidlogic core application and data sets will only be from a Managed Device as defined by and in line with guidance on managed devices by The UK government's National Technical Authority for Information Assurance (CESG). Access for carers will be via a HTTPS encrypted in transit connection limited to their specific records with core data behind an appropriately scaled firewall.

    - Patient / client data will not be held in the Cloud unless explicit permission has been sought from the CCG and Council and assurances given on the security and integrity of any proposed solution.

- The Prime Provider has a responsibility to put in place systems and processes that ensure data is clean, timely and accurate at the point of entry, that there is no avoidable duplicate entry of data and that there are no unreasonable barriers to safe, secure and clean data processing.

- Cyber security must be adequately taken account of and the Prime Provider is responsible for assuring and ensuring that CESG guidance such as 10 steps to cyber security is applied (or an alternative suitable standard).

- Where any breaches in in cyber security occur, the Commissioner must be notified at the earliest opportunity by phone and the incident followed up in writing.

- The Prime Provider shall comply at all times with Data Protection Legislation and shall not perform its obligations under any Agreement in such a way as to cause the Commissioner to breach any of its applicable obligations under the Data Protection Legislation.

- The Prime Provider acknowledges that, in the event that it breaches (or attempts or threatens to breach) its obligations relating to Personal Data that the Commissioner may be irreparably harmed (including harm to its reputation). In such circumstances, the Commissioner may proceed directly to court and seek injunctive or other equitable relief to remedy or prevent any further breach (or attempted or threatened breach).

- The Prime Provider shall, at all times during and after the Agreement Period, indemnify the Commissioner and keep the Commissioner indemnified against all losses, damages, costs or expenses and other liabilities (including legal fees) incurred by, awarded against or agreed to be paid by the Commissioner arising from any breach of the Prime Provider 's obligations except and to the extent that such liabilities have resulted directly from the Commissioner's instructions.

The Prime Provider is responsible for treating all patient / service user data as the valuable and precious commodity that it is. **3.9.3 Electronic Care Records System for Health and Social Care (ECR)**

- Social Care records will be maintained on the Local Authority electronic care record system, currently provided by Liquidlogic which is managed by the Council on its own infrastructure. This is a new application designed to deliver an all age solution that supports effective case management of social care interactions and is Care Act compliant, and all the financial functionality required to underpin this.
- No other solutions for maintaining the social care record will be considered without the agreement of the Commissioner.
- The Commissioner is the Data Controller and the Prime Provider is the Data Processor.
- The Prime Provider shall comply at all times with the Data Protection Legislation and shall not perform its obligations under any Agreement in such a way as to cause the Commissioner to breach any of its applicable obligations under the Data Protection Legislation.

- The potential to develop and introduce other portals such as:
    - Information and Market Portal – Providing guidance for those looking for support, ability to submit assessments and review care services available.
    - Citizens Portal - Allowing citizens to review or feedback on aspect of the existing case such as personal budgets assessments and support plans.
    - MASH- Multi Agency Safeguarding Hub- which brings together a variety of agencies allowing information on children to be shared appropriately and securely.

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

- The Provider must engage with stakeholders in systems development and improvement of systems to ensure that services continue to support those delivering and receiving services

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

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

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

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

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

    - Patient/Service User centric, allowing a professional a simple view of all relevant information about an individual.
    - Flexible and locally configurable.
    - Ability to enable patients/service users and carers to manage their care and interactions with the health and social care system online including access to records.
    -
    - Provides an holistic view of an individual case record, allowing professionals to view all relevant information without the need to log-on to multiple systems.
    - Enables the extraction of case management, clinical and activity data for secondary use in an anonymised or pseudonymised way.
    - Allows the real time, contemporaneous collection of all notes, including appropriate clinical and non-clinical data at the point of contact with the patient/service user, including text, images and unstructured data.
    - Allows key information to be securely transferred electronically when patients/service users are referred to or discharged from services, in a clear consistent format. (This refers to messages that can be work-flowed by the receiver, ideally structured messages compliant with the NHS Interoperability Tool Kit (ITK). Use of email is not appropriate.)
    - Is mobile (including on and off-line working) to support taking of contemporaneous notes, and providing information to support care delivery at the point of care.
    - Is integrated with appropriate national systems including but not limited to the applications on NHS Spine e.g. CP-IS, SCR, E-referrals.
    - Is able to interoperate with other local systems and supported by resource to make this a reality.
    - Is able to exploit separate stand-alone innovative technologies.
    - Removes the need for paper at the point of care.
    - Reuses collected information to minimise duplication by professionals, individuals or carers.
    - Meets all relevant HSCIC information standards.
    - Wherever possible, avoids the need for professionals, individuals and carers to access multiple systems with multiple log-ins to get a holistic view of an individual record.
    - Includes Patient Administration System functionality.

Interoperability

- It is also the Prime Provider responsibility to ensure that all safeguarding, technical security,

information governance, data protection and assurance requirements are fully met, including gaining written permission on how information will be shared and with whom from both the CCG and the Council, such permissions will not unreasonably be withheld.

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

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

3.9.4 Business Intelligence and Performance Reporting

Context

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

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

Quality and Performance Information

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

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

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

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

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

- SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION

REQUIREMENTS

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

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

Information to support Performance Management of Services

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

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

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

Surveying

- The Prime Provider will be required to conduct regular surveying of local patient/service users. This is to be aligned with national reporting requirements as relevant.

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

Evaluation

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

Needs Assessment and Service Development

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

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

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

- In pursuance of this model, the Prime Provider will need to work collaboratively with the commissioner to ensure that the highest possible level of ethical practice is undertaken with regards new and innovative use of data.

3.9.5 Information Sharing

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

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

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

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

Access to Prime Provider systems and information

- The Prime Provider will:

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

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

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

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

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

Desktop Environment	Comments
Operating Systems	
Microsoft Windows 7 Professional SP1 (UAC enabled)	This is used on both physical PCs and Laptops and the Council's Virtual Desktops
For mobile and tablet devices IOS, Windows Mobile and Android devices are supported	must support all versions released in the last three years that are still under support
Microsoft Office	
Microsoft Office Professional 2010 (with SP2)	
Anti-Virus	
Trend Micro Office Scan	
Web Browser	
Microsoft Internet Explorer Version 11	Preferred version whilst in support
State other supported browsers e.g. Mozilla Firefox, Google Chrome	Externally facing options should support a wide range of browsers.
Citrix Virtual Desktop Environment	
All applications must work in both a traditional client/server environment and a Citrix XenDesktop 7.1 Virtual Desktop environment	
Applications should support delivery via application streaming using Microsoft App-V v5	Preferred delivery model
Applications should support delivery via Citrix XenApp 6.5 and later	
General Desktop Requirements	
Must provide MSI or similar installer package for silent client distribution	
Must not require local administrator or enhanced privileges on client PC's	
Applications must run in an environment supporting fixed size roaming profiles therefore they must not write or cache data to user profiles	
Provide a web enabled client.	
Java 7 Update 71 is available for client applications that require Java support however, the council is looking to move away from Java based applications.	Applications that do not require Java are preferred.

- The bandwidth over the network is generally good with even the most remote sites and home workers being up to 8Mb ADSL connections although some are on 2mb links. Nevertheless, where applicable, any solutions the Council is asked to utilise will be expected to operate across the Council network using the minimum amount of bandwidth;

- The Council has implemented a Citrix Access Gateway remote working solution enabling users to access Council ICT systems from any location and any device;
- The Council is PSN compliant and any data processed, held or managed by the Prime Provider must be in a similarly secured technical environment - evidence of this will need to be provided
- The Council's entire desktop PC estate is in a virtual desktop environment.

3.9.7 Standards

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

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

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

- The Prime Provider is expected to comply with other recognised industry standards (such as BS8766, BS7666, ISO 15489, e-GMS, FIPS 140-2) where the technological solutions in use require it.
    - For the avoidance of doubt, as an example, if data is being transmitted, it must satisfy the minimum of FIPS140-2.
    - The provider must comply with relevant industry standards its application of IMT. Further examples are listed below

2.1.1.
2.1.2.
2.1.3. 1) Telehealth services -- Quality planning guidelines ISO 13131

2) Cloud security ISO 27017

3) Business continuity ISO 22301 & 27017

4) Devices – Quality Management Systems ISO 13485

5) Telemed interoperability ISO/IEEE 11073

6) Risk Management ISO 27005

7) Records Management ISO 9001/27001

8) PERS /Communications BS 8521 Coms

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

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

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

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

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

- Over the length of the contract the required technical and service standards to deliver the contract will evolve. The SDIP process will be used to inform the Provider of changes required to keep pace with technological developments and emerging best practise.

Staff Recruitment & Training

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

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

3.9.8 Information Governance

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

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

- The Prime Provider will supply any Data Controller information requested for completion of their IG Toolkit. This shall be collated by the IG manager of either Bath and North East Somerset CCG or Bath and North East Somerset Council to avoid the Prime Provider

receiving a large number of requests.

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

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

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

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

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

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

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

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

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

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

- The Prime Provider will ensure that patients/service users are informed of any processing and changes to processing that occur. The Prime Provider will ensure that patients/service users are able to opt out of sharing where appropriate.

- Audit trails will be available on all systems.

Council Records

- The Commissioner will retain custody, control, ownership and management of all Existing (Dormant) Social Care Records.

- All Existing (Active) Social Care Records and Provider Social Care Records are to be managed by the Prime Provider for the purposes of fulfilling its obligations under the Community Services Contract but the ownership and control shall remain with

the Commissioner

Data Breaches

- All data breaches or security incidents regarding the Commissioner's data will be notified to the Commissioner as soon as practicable after becoming aware of the breach and the Prime Provider will keep the Commissioner informed of any investigation.

- The Prime Provider will also fully co-operate with the Commissioner in relation to any questions or investigations it carries out into the breach.

- The Prime Provider shall promptly notify the Commissioner of any regulatory action taken by the Information Commissioner's Office in relation to the services and data relating to the services.

3.9.9 Innovation

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

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

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

3.9.10 Efficiency and Adding Value

- The technologies already available to the Prime Provider and which the Prime Provider as a professional in the provision of community health and care services is expected to already have and be making use of should support wider transformation plans.
- As well as efficiency and innovation, the Prime Provider is expected to Add Value through its' use of IMT. This could be by providing technology to people in their homes which they can use to prevent or reduce feelings of social isolation, establishing something as simple as a friendship telephone calling circle or helping people of any age to participate in the digital world by providing access to a device with an internet connection to reduce digital inequalities.

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

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

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

3.10 Clinical Engagement

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

- The Prime Provider must continuously improve the quality of their services and safeguarding high standards of care and support by creating an environment in which (clinical) excellence will flourish, ensuring all professionals abide by the guidance of their professional self-regulatory body. Clinical Governance should be integrated into the Prime Provider 's whole governance arrangements. The Prime Provider is expected to outline clinical governance mechanisms to be applied when concerns about the quality of the service is raised and will be expected to comply with relevant clinical governance frameworks and to function under agreed operational and clinical policies.

- The Prime Provider will put in place a clinical audit programme to provide evidence of clinically and cost effective services appropriately implemented, and which will drive improvements in the quality, safety, consistency and value for money of the services.

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

3.11 Governance and Performance Management

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

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

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

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

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

- The Prime Provider will meet quarterly with the Commissioner to review performance.

- Measures may be revised over time to understand and meet changes in demand, and to reflect the development of local minimum data set requirements.

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

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

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

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

3.12 Medicines Optimisation

- The supply of medicines to people, the safe and secure handling of medicines by staff , and the provision of Strategic Medicines and Prescribing Advice and the need for Clinical Pharmacist input cuts across a large number of Community Health and Care Services.

- NHS Bath and North East Somerset CCG has set out a four year strategy for Medicines Optimisation, which can be found at the following link: http://www.bathandnortheastsomersetccg.nhs.uk/documents/strategies/medicines-optimisation-strategy-2016-20

- The document outlines national and local drivers; the CCG's approach to Medicines Optimisation and priorities of work to 2020.

- The Prime Provider will be responsible, in particular though its governance arrangements, for ensuring that the appropriate Medicines Optimisation Services are put in place for all its services.

- A detailed service specification for Medicines Optimisation, based on the CCG strategy, will be agreed with the Prime Provider in respect of the delivery of services.

3.12.1 Prescribing

- The Prime Provider shall prescribe evidence based medicines in accordance with the Bath Clinical Area Partnership (BCAP) Joint Formulary which can be found at: http://www.bcapformulary.nhs.uk/

- Prescribing costs are included within the financial envelope of the contract. New service developments which include prescribing will be charged to the commissioner until the service reaches steady state and then an appropriate value will be added into the contract value.

- The Prime Provider will provide assurance to the commissioner that appropriate processes are in place to review and monitor the medicines usage. Regular reports will be provided annually to the commissioner. The Prime Provider shall produce annual audits of Medicines Optimisation/ usage e.g. Medicines reconciliation.

3.13 Equality and Diversity

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

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

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

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

- Will implement the NHS Workforce Race Equality Standard and Equality and Diversity Sytems (EDS2). These will support compliance with the Public Sector Equality Duty

3.14 Workforce

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

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

- The Prime Provider will be able to define the workforce requirements locally, aggregating them across the localities where appropriate and using this information to better inform what and how providers train the health and care workforce.

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

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

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

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

3.15 Efficiency and Adding Value

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

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

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

- NICE Clinical Guidelines (CG)
- NICE Quality Standards (QS)
- NICE Technology Appraisal (TA)
- NICE Public Health Guidelines (PH)
- NICE TAs must be applied however NICE standards and guidance will be applied as detailed within the relevant individual service specifications or within the agreement of the Commissioner
- The Care Act 2014
- Children and Families Act 2014
- The Health and Social Care Act 2012
- Mental Capacity Act 2005
- Mental Health Act 1983
- Children Act 1989
- Children Act 2004
- Working Together to Safeguard Children 2015
- The Equality Act 2010
- The Disability Discrimination Act 1995

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

- To be agreed

4.3 Applicable local standards

- To be agreed

5. Applicable quality requirements and CQUIN goals

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

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

5.2 Applicable CQUIN goals (See Schedule 4E)

- To be agreed

6. Location of Prime Provider Premises

- The services will be locality and community focussed and should be delivered from a range of locations across Bath and North East Somerset.
- Equitable access across the locations is an important element in the estate solution.
- The Prime Provider will fully consider all potential access needs in the planning and delivery of the service.
- Services will be co-located where possible with other services e.g. local authority services, schools, voluntary sector and community groups etc.

- Services currently co-located in community hubs or with the local authority will continue to be delivered from these bases.
- Where formal leases are in place these will be assignable to a new Prime Provider .
- Accommodation will be provided in compliance with all statutory and mandatory regulations, guidance and good practice applicable to health and care accommodation for children, young people and adults.
- Accommodation will be maintained and serviced in accordance with statutory and health and care guidance which will be evidenced by due diligence testing.
- The Prime Provider will ensure that total costs of all accommodation are separately identified and listed.
- Lease and recharge arrangements will be in place for all properties not owned by the Prime Provider .
- Accommodation will meet privacy and dignity standards and to be compliant with segregation requirements for access to accommodation between children and adults.
- The Prime Provider will provide clinical equipment, medical supplies including medicines, drugs, instruments, appliances and material necessary for care which shall be adequate, functional and effective for all the services.
- The Prime Provider shall also provide non-clinical equipment to furnish the services including computers, telephones, desks, desk chairs, couches, trolleys, etc. This will include telephony and network provision at Kempthorne House at the St Martins site.

Annex A – Core Service Functions of the Prime Provider

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

Schedule 2A Part 2 : Adult Social Care Statutory Services
Schedule 2A Part 3 : Continuing Health Care/Funded Nursing Care
Schedule 2A Part 4 : Community Paediatricians and Looked After Children

Annex B – Service Descriptions

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

a) Prevention and Self-Management (Living well and staying well)

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

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

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

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

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

Services

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

Direct Payments	0-19 Public Health Nursing Service
Advocacy	Housing Related Support - Homelessness
Adult Carers Support Service	Prevention Pathway Services
Community Opportunities for Older People who are living with Dementia	Community Based Mental Health Pathway
	Integrated Sexual Health Service

Wellness Service - Lifestyle and Wellbeing Support

b) Early Intervention and Targeted Support (Regaining health and independence)

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

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

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

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

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

Schedule of services

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

Community Hospital Inpatients
Community Nursing (Adults)
Urgent Care Facility
Home from Hospital/Home Response Service
Community Opportunities for Older People who are living with Dementia
Care at Home Service (Domiciliary care)
Independent Living Service
Direct Payments
Intensive Service
Primary Care Talking Therapies Service
Community Based Mental Health Pathway
Integrated Reablement Service
Community Equipment

Housing Related Support - Homelessness Prevention Pathway Services

Podiatry

Wellness Service

Enhanced and Specialist Support (Helping you to live well with complex or long term conditions)

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

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

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

Schedule of services

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

End of Life Care
Community Bladder and Bowel Service
Paediatric Audiology Service
Community Based Adult Audiology and Hearing Therapy Services
Housing Related Support Homelessness Prevention Pathway Services Intensive Service
Community Mental Health Services for Older Adults and those with Dementia
Mental Health and Wellbeing Recovery Services
Community Based Mental Health Pathway
Orthopaedic Interface Service
Physiotherapy services
Lymphodema Nursing
Falls and Movement Disorders
Integrated Sexual Health Service
Specialist Cardiac and Respiratory Services (Adults)
Children's Community Nursing and Psychology Service
Specialist Neurology and Stroke Services (Adults)
Dementia Support Service
Specialist Diabetes Services (Adults)
Speech and Language Therapy
Substance Misuse Service
Community Learning Disabilities service

3. SCHEDULE 2 – THE SERVICES

Virgin Care service model redacted

FOIA exemptions: Section 43 (1), 43 (2) andSection 2

SCHEDULE 2 – THE SERVICES

A.1 Specialised Services – Derogations from National Service Specifications

Not Applicable

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

Redacted
FOIA exemptions: Section 43 (2) andSection 2

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

Redacted

FOIA exemptions: Section 43 (2) andSection 2

SCHEDULE 2 – THE SERVICES

D. Essential Services (NHS Trusts only)

The Parties recognise that the Provider is not an NHS Trust, however they agree to treat services PD01 (Adult Social Care Statutory Service), PD02 (Continuing Healthcare), and PD03 (Children's Statutory Services) as Essential Services for the purpose of Service Condition 5.

The Parties agree that NHS Improvement shall have no role in ensuring the continuity of the services defined under this Schedule 2D.

SCHEDULE 2 – THE SERVICES

E. Essential Services Continuity Plan (NHS Trusts only)

The Parties will work together to develop the necessary Essential Services Continuity Plans within the first 12 months of the Contract period

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

- Academic Health Science Network
- National Screening Programmes
- Bowel Screening
- Diabetic Retinal Screening
- Strategic Clinical Networks
- Maternity and Child Health Networks
- Mental Health, Neurological Conditions and Dementia
- Local Children's Safeguarding Board
- Local Safeguarding Adults Board
- Youth Offending Service Management Board
- Serious Case Review (SCR) sub group LSCB
- MASH Project Board

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Redacted
FOIA exemptions: Section 43 (2) andSection 2

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

The Provider shall provide to the Co-ordinating Commissioner the following:

1. Copies of the Material Sub-Contracts, signed and dated and in a form approved by the Co-ordinating Commissioner by the Longstop Date. For the avoidance of doubt, the Co-ordinating Commissioner acknowledges that such copies shall be redacted by the Provider, prior to submission to the Co-ordinating Commissioner, as required by the Law, in particular the DPA.

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

Redacted
FOIA exemptions: Section 43 (2) andSection 2

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

The Provider shall adhere to the transfer of and discharge from care obligations as detailed in NHS Standard Contract 2017/2018 Service Conditions and General Conditions. The provider will also adhere to Annex G of the Care Act with regard to managing transfers of care from hospital for patients with care and support needs and will be accountable to the Council for its performance in this area. Charges are well organized, safe and as far as possible in accordance with the service users' and families wishes, in line with the provider's Choice Policy.

Discharge is when a person leaves the service to either return home or move to alternative care provision i.e. community hospital, residential or nursing home.

Transfer is when a person is moved to another department within an existing service.

1. Principles of Transfer / discharge

1.1 Transfer and Discharge of patients can bring specific risks and issues that require careful consideration and planning in order to minimise and manage risks effectively and ensure continuity of care. General principles relating to communication, planning and implementation of care apply to both transfer and discharge of care happening across a wide variety of care settings. Specific considerations may be required depending upon the setting from which a patient's care is transferred or discharged to and from, and may vary depending upon the patient group e.g. Learning Disability, Mental Health, Frail and Elderly and end of life care

1.2 The provider must implement the Safer Patient flow Bundle (Breaking the cycle, safer flow, NHS England 2015) this is a combined set of rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. Elements of the bundle are included below, but include:

- Senior review
- All patients to have an expected date of discharge
- Flow of patients
- Early discharge
- Review

1.3 The provider must work in alignment to the national imperative of discharge to assess rather than the current process of assess to discharge. The ward teams must be aware of how to organise assistive technology, telecare and equipment so that people can be supported to stay at home so that patients can be assessed in their normal environment.

The provider must have a clear process and pathway for appropriate use of Continuing Health Care fast Track applications. These patients must be transferred to the setting of their choice within 24 hours.

It is important that patients are involved in the planning and decision-making about the transfer or discharge of their care and that this must take account of any preferences the patient or their representative may have. Staff must be familiar with the health community choice policy.

1.4 Patients must be given adequate notice, where possible, about transfer and discharge arrangements and given clear information about support options available following transfer or discharge, in order that joint and informed choices can be made. Clear expectations must be set with patients and families early in the admission and discussions documented in the patient notes.

1.5 Patients and carers should be provided with clear patient information introducing the concept that patients do not have the right to stay in an acute bed for treatment when are they assessed as ready for transfer to a more appropriate care setting, this should also include information about how they can access the service again, if arrangements following transfer or discharge are not successful or the patient's condition deteriorates.

1.6 Patients and carers must have clear information provided about the referral pathways and processes for any services they are being discharged from or transferred to (this should include information about possible waiting times, assessment process, intervention type, time-scale of intervention).

1.7 It should be acknowledged with patients, that discharges and transfers are often an anxiety provoking time. Patients should be provided with support through this process, having the opportunities to discuss concerns as well as other issues. Withdrawal or ending of treatment and transition from one service to another may evoke strong emotions and reactions and staff should ensure that such changes are discussed carefully with the patient and / or their representative beforehand and are structured and phased.

1.8 Family and carers should have the opportunity (with the agreement of the patient) to be involved in the planning of transfers or discharge, where possible. Involved family and carers must be notified before the patient is transferred or discharged.

1.9 Planning with regards to transfer and discharge must be fully and accurately documented in order that all parties relevant to the transfer or discharge can clearly understand the arrangements and refer to these when needed.

1.10 Clinical staff must engage with and communicate effectively and timely with others involved in the transfer and discharge process. E.g. staff from other agencies i.e. social care or NHS bodies, patients, their family and/or carers.

1.11 In many circumstances, transfer and discharge will follow similar procedures and general principles will apply.

1	**Discharge Planning**
a	**Estimated date of discharge** In line with good practice all patients must be given an estimated date of discharge within 24 hours of admission. The EDD must be reviewed daily.
b	**Senior review** Board rounds to undertake an initial early review of the sick and unstable patients first, reviewing those ready for discharge on that day or the next, review EDD for new patients. Delays and blockages to discharge to be escalated as appropriate.
	Daily multidisciplinary team meeting The daily MDT process within both acute and community and mental health wards to identify a patient is ready for transfer when: • A clinical decision has been made that patient is ready for transfer AND • A multi-disciplinary team decision has been made that patient is ready for transfer AND • The patient is safe to discharge/transfer. Appropriate coding as per national guidance must be updated on a daily basis following the MDT
c	**Flow early from assessment units** Wards that routinely have patients transferred to them from assessment units will 'pull' the first (and correct) patient before 10am every day to create the required capacity for incoming patients
d	**Review long length of stay patients** Check that all patients have clear plans for medical care, escalate any delayed test results, consider whether care can appropriately and safely be provided in an alternative setting?
e	**Appropriate application of Continuing Health Care Fast Track processes.** The agreed CHC Fast Track process must be followed. Administration issues must not delay discharge; all paperwork must be completed appropriately in readiness.

d	**Medical certificates/statement of fitness to work** The Provider will also issue a Medical Certificate (if required) for in-patient stays and/or a Statement of Fitness to Work (if required) by the patient to cover the period for which they are anticipated to be unable to work.

2	**Discharge medications/dressings/appliances**
a	**Discharge Medicines** As appropriate, each patient shall be discharged with sufficient medication to prevent a repeat request within twenty-eight (28) days of discharge or, in the case of the patient's own medication, sufficient medication to prevent a repeat request within fourteen (14) days of discharge, or less if risk assessment indicates otherwise. Where applicable, patients discharged with newly prescribed medications (for example, pain relief) will be given enough medication as clinically required (if less than 14 days' worth is required). Established and newly initiated Monitored Dosage System requests must be approved by a pharmacist with continued supplies then arranged through a community pharmacy prior to discharge. On discharge, 7 days' supply will be made by the provider in an appropriate device In summary, unless risk assessment indicates otherwise, patients will receive the following quantity of medicines to take out (TTO's) on discharge: • 14 days' worth (or less) for clinically indicated short courses (e.g. antibiotics, analgesia) • 28 days' worth for new medication that is not considered to be a short course and has been prescribed whilst the patient is an inpatient • at least 14 days for patients own medicines and medicines "dispensed for discharge" during the admission • 7 days' supply if using a Monitored Dosage System • The above may be varied as systems are in place at Circle Bath to discharge patients with appropriate levels of drugs especially Controlled Drugs, which may be less than the 14/28 days indicated above. Additional drugs are available to patients by contact to the hospital and not the GP.
b	**Anticoagulants** If the patient is prescribed anticoagulant drugs, the GP surgery will be sent/faxed the detailed treatment care plan for them. The information should be available at the GP surgery on day of discharge.
c	**Dressings/appliances** Sufficient supplies of dressings / appliances should be supplied to meet the clinical needs of the patient until he/she can obtain supplies in a non-urgent manner from their GP surgery / community.

3	**Patient's discharge summary to the patient's general practitioner**
a	**National Standards** The Commissioner requires the providers to comply with National Standards.
b	**Timescales for issuing discharge summary** The Provider shall issue the patient's discharge summary to the patient's GP and or supporting agencies within the timescales detailed in Service Conditions - SC11 (24 hours from discharge) or within 1 working day in cases where the patient has died. Verbal communication of a patient's death must be notified to the Patient's Practice/relevant agencies within 24 hours of the death. The commissioner sets down the following standards to support continuing improvements in the quality of discharge summaries
c	**Discharge summary to patients general practitioner (GP) and supporting agencies** When a patient is discharged/transferred out of hospital a clinical communication (discharge summary) must be provided by the lead clinician involved in the care of the patient to the patients' GP and any other supporting agencies, for example, Continuing Health Care Case Manager, Community Nurse Team, or care homes manager.
d	**Validation by responsible clinician** Discharge information should be validated by a responsible clinician.
e	**Clarity/legibility of discharge summaries** All discharge summaries will be computer generated, dated and will clearly record the author. The document should not include shaded boxes or any other format that reduces the clarity of the document when scanned. If the clinical communication (discharge summary) is duplicated using carbon copy paper then the duplicate sheets must be legible.
f	**Patient information and discharge summary** In accordance with General Medical Council (GMC) guidance, the patient must be informed as to what information will be communicated to other doctors involved in his/her care, and given the opportunity to object. The patient should be given/receive a copy of the clinical communication (discharge summary). If it is deemed inappropriate to provide the patient with this information, the decision with the reasons should be clearly documented in the patient's record. If a patient has a Treatment Escalation Plan form (TEP forms) this must be sent home with the patient.
g	**Copy of clinical communication** A copy of the clinical communication (discharge summary) must be kept in the patient's records.
h	**Delivery methods** The appropriate delivery methods for discharge summaries will be followed. In all cases where the GP Practice has the capability of receiving discharge summaries electronically, via the EDS system, then this system should be used. In those cases where a practice does not have the facility to receive discharge summaries electronically via EDS, then the following communication routes are contractually acceptable: • e-mail using an NHS.net secure account or; • direct automatic transfer to the GP practice electronic patient record system through a suitable secure interface;

Discharge Summary Information
In **all** cases, every discharge summary will, **without limitation**, contain the information as detailed below:

Table 1

Information required	**Information required**
Patient Name	Name of Lead Clinician (Include Speciality)
Patient date of Birth	Looked After Children Status (if applicable)
NHS Number	Known infections (for example, MRSA)
Patient Address (include telephone number)	Immediate requirements post discharge
Reason for admission	Future plans of care (including treatment plans)
Date of admission	Follow up arrangements
Source of admission	GP (include address, practice code)
Date of discharge	Name and designation/role person completing summary
Discharge method	Gender
Clinical Information (details of any services provided to the patient, including all relevant operation(s) and diagnostic procedures performed and their outcomes, including results)	Patients discharge location
Summary of key diagnosis	Medications stopped or started in hospital (include reason why)
Medications prescribed at time of discharge	Mental Capacity at time of discharge and Mental Health Act status if applicable
Length of time on medications/treatment plan	Results awaited
Medication recommendations (regarding future use of medication	Actions for General Practitioner
Adverse reactions/allergies	Next of Kin/ Power of attorney details
Safeguarding Status - Details of any alerts, referrals or investigations	DNAR status/ Treatment Escalation Plan form in place and sent with patient
Details of any Best Interest decisions	
Diagnosis of Acute Kidney injury if relevant and any subsequent actions taken/ required	

The discharge audit will measure against the following standards

4	**Patients attending outpatients**
a	**Outpatient consultation information** Following an outpatient attendance the GP will receive information within 7 days about the consultation which will include: • Patient demographics • Date of attendance • Details of clinical consultation • Name of the responsible lead clinician • Reason for any required follow up, diagnostic or treatment plan • Any other relevant or necessary information or instructions • Any significant clinical changes to medication or treatment will be notified to the GP by phone or email on the same day as the outpatient appointment

- The discharge audit will measure against the following standards

Table 2

Information required	**Information required**
Patient Name	Name of Lead Clinician (Include Speciality)
Patient date of Birth	Looked After Children Status (if applicable)
NHS Number	Known infections (for example, MRSA)
Patient Address (include telephone number)	Immediate requirements post discharge
Reason for admission	Future plans of care (including treatment plans)
Date of admission/ Discharge	Follow up arrangements
Source of admission	GP (include address, practice code)
Date of discharge- delete	Name and designation/role person completing summary
Discharge method	Gender
Clinical Information (details of any services provided to the patient, including all relevant operation(s) and diagnostic procedures performed and their outcomes, including results)	Patients discharge location
Summary of key diagnosis	Medications stopped or started in hospital (include reason why)
Medications prescribed at time of discharge	Mental Capacity at time of discharge and Mental Health Act status if applicable
Length of time on medications/treatment plan	Results awaited
Medication recommendations (regarding future use of medication	Actions for General Practitioner
Adverse reactions/allergies	Next of Kin/ Power of attorney details
Safeguarding Status - Details of any alerts, referrals or investigations	DNAR status / Treatment Escalation Plan form in place and sent with patient
Details of any Best Interest decisions	

5	**Monitoring quality of discharge processes**
a	Quality indicators to demonstrate the quality of provider discharge processes are included in this Schedule (see below). The Commissioner may also conduct audits against discharge standards within this Schedule and will expect the provider to agree and implement action plans to make continuous improvements, as appropriate.

Infection Control

When planning transfers and discharges or re-admission of any suspected or confirmed infectious patient's, advice must be sought from the Provider Infection Control Team to ensure that risks of cross infection are assessed and minimised.

Physical Health

All transfers should include assessment and planning of patients" physical health care to ensure that physical health care is continued and consistent following transfer. Full written information regarding physical health care should be provided at the point of transfer and where possible a verbal handover to the receiving service or team. Planning should take account of any special physical health care needs that may require additional planning on the part of receiving team or service

Safeguarding

Where there are concerns about possible safeguarding issues, it is particularly important that there is a multi-agency action agreed before a safeguarded adult/child leaves hospital.

- No adult/child/young person known to social services who is an in-patient in a hospital and about whom there are safeguarding concerns is allowed home until it has been established by social services that the home environment is safe, the concerns of health care professionals have been fully addressed, and there is a social worker plan for the on-going promotion and safeguarding of that individuals welfare.
- No adult/child about whom there are safeguarding concerns is discharged from hospital without a documented plan for the future care of that individual. The plan must include follow-up arrangements.
- The need to safeguard an adult/child should always inform the timing of their discharge, so that the likelihood of on-going harm can be assessed while he or she is still in hospital.
- Details of previous/current safeguarding activity must be clearly documented and communicated prior to discharge/transfer of care.

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Ref	Quality Requirement	Threshold	Method of Measurement	Consequence of Breach
Dis 1	Patients will receive the appropriate amount of medications on discharge, as per this Schedule.	Not applicable.	**By exception:** The provider will report cases where following provider investigation (i.e. after a complaint) it is confirmed that a patient has not been supplied with the appropriate amount/type of medication on discharge. Learning and action plan to be shared with Commissioners.	General Condition GC9
Dis 2	Discharge Summaries created by the provider contain key information required to facilitate safe transfer of and discharge from care	100% patients of discharge summaries contain the information as detailed in Table 1 of this Schedule.	**During Quarter 1:** Audit of 25 sets of notes (or provider to agree % of notes to be audited) against the detail given in Table 1 or Table 2 if the provider only provides services to day cases/ outpatients. Results of the audit together with action plans to be shared with Commissioner. In cases where 100% compliance not met, agreement of % increase in compliance during Qtr. 4, 2014/15 to be agreed. **During Quarter 4:** Audit of 25 sets of notes against the detail given in Table 1. Results of the audit together with action plans to be shared with Commissioner. Where applicable, the provider will demonstrate whether or not the % compliance increase agreed in Qtr. 1 has been achieved.	General Condition GC9

Reference/National Standards

- Royal College of Physicians Standards for record keeping – April 2008 (Signed off by the Academy of Medical Royal Colleges on behalf of the professions) http://www.rcplondon.ac.uk/resources/clinical-resources/standards-medical-record-keeping/structure-and-content-medical-notes/de

- Scottish Intercollegiate Guidelines Network – The Immediate Discharge Document (January 2003) http://sign.ac.uk/guidelines/fulltext/65/index.html

- Discharge Summary: Statutory Guidance for promoting the health and wellbeing of Looked after children , 2009; p 63 ;7.1 & 7.3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108592.pdf

- "Ready to Go? Planning the discharge and transfer of patients from hospital and intermediate care" (2010). www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_113950

- "Refocusing the care programme approach: policy and positive practice guidance" (2008). www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_083647

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies Adults and Children

Safeguarding Adults Standards, Key Performance Indicators & Reporting Schedule 2017 - 2018

1. Purpose of the Standards

1.1 These standards will apply to all specifications where a provider delivers a service to adults who may have contact with adults at risk *or* are the carers of adults at risk (this can include relatives, partners, paid and un-paid carers).

1.2 The Standards act as a benchmark for good practice and indicate the practice that is expected to be undertaken to safeguard adults at risk from harm, neglect and abuse, thereby supporting organisations to demonstrate their compliance and governance arrangements in relation to Safeguarding Adults.

1.3 Compliance with the standards will be monitored via:

- Provider annual Safeguarding Adults report
- Annual Safeguarding Adult audit (appendix 4) – to be received in May each year
- Quarterly reporting as per the Key Performance Indicators (appendices 2 and 3)
- Annual 15% safeguarding case file audit demonstrating making safeguarding personal is a priority and implemented – To be received in September each year
- Annual case file audit on all safeguarding cases which are repeat referrals (i.e individual s refered in more than once) over a12 month rolling period which demonstrates that appropriate actions were initially taken to keep the person safe. To be received in July each year
- Annual report on the experience and outcome for the service user (to include service user experience as well as involvement in safeguarding and DoLS arrangements)
- Monthly reporting on the Local Safeguarding Adult Board (LSAB) indicators.
- Bespoke reports or audits as required by the commissioner

1.4 The Council/ CCG must be informed of any non-compliance with these standards at the earliest opportunity and a detailed action plan negotiated to address these issues. If a provider reports non-compliance in relation to their safeguarding practice with any other regulatory bodies this must also be notified to the CCG/Council.

2. Care Act 2014

2.1 The Safeguarding Adults standards are informed by legislation and guidance (appendix 1), most significant of which is the Care Act which has replaced the 'No Secrets' guidance. It should be noted that that Appendix 1 is not exhaustive and providers will be expected to adhere to all new legislation and statutory guidance.

2.2 According to the Care Act, safeguarding duties apply to:

- any person who is aged 18 or over
- has needs for care and support (whether or not the local authority is meeting any of those needs)
- and is experiencing, or at risk of, abuse or neglect;
- and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

2.3 The following six principles from the Care Act apply to all sectors and settings, including healthcare services and should inform the ways in which professionals and other staff work with adults.

1. **Empowerment** – adults at risk are supported to make their own decisions
2. **Prevention** – It is better to take action before harm occurs
3. **Proportionality** – The least intrusive response appropriate to the risk presented.
4. **Protection** – Support and representation for those in greatest need.
5. **Partnership** – Local solutions through services working with their communities.
6. **Accountability** – Accountability and transparency in delivering safeguarding.

2.4 According to the Care Act, the following categories constitute abuse, although this list is not exhaustive:

- Physical abuse
- Domestic violence – this includes 'honour' based violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery (and human trafficking)
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

3. Criminal Justice and Courts Act 2015

3.1 Sections 20-25 created two new criminal offences of ill treatment or wilful neglect which apply both to individual care workers and care provider organisations. Previously, prosecutions for ill treatment or wilful neglect could only be undertaken where the victim lacked capacity or was receiving treatment for a mental disorder.

3.2 A new offence arises if a care worker ill-treats or wilfully neglects any individual of whom he has the care by virtue of being paid to provide health or social care for that person (whether a child or adult). Any neglect should be 'wilful' and 'ill treatment' requires a deliberate act or action that is reckless. The offence carries a maximum penalty of imprisonment of up to five years and/or an unlimited fine but it should be noted that genuine errors or accidents are not within the scope of the offence.

3.3 Organisations need to be ensure that their policies, procedures and training incorporate this new act and that cases that may fall within this new offence are referred to the police and Safeguarding (in accordance with the LSAB procedures).

4. Mental Capacity Act 2005

4.1 The provider must be able to demonstrate compliance with the Mental Capacity Act 2005 (MCA). The statutory principles of the Act will be embedded in all care delivery and people using services who lack capacity to make a specific decision are supported and decisions are made in their best interest in accordance with section 4 of the MCA.

4.2 The provider will ensure their MCA Policy aligns with their Safeguarding Adults Policy and all other relevant policies including research. Copies of policies will be made available to the commissioner on request.

4.3 The provider will ensure that their staff are aware of the role of an Independent Mental Capacity Advocate (IMCA),Care Act advocate, Independent Mental Health Advocate, and when the relevant advocate must be involved in decision making.

4.4 The provider will ensure that relevant staff will know when it may be appropriate to consider the need for a referral to the Court of Protection (e.g. when decisions regarding accommodation, care or contact are contested) The provider will ensure all required

information and reports for Court of Protection applicaitions are high quality and provided in a timely manner to the Council and CCG.

4.5 Records will demonstrate that consideration of capacity and use of best interest decision making have been applied where appropriate. They will also demonstrate evidence of partnership working with Health and Welfare attorneys including the extent of their delegated level of authority where appropriate.

4.6 The provider will ensure they have robust arrangements in place for checking and holding copies of advance decisions and powers of attorney and that these are clearly recorded in the person's records.

4.7 Do Not Attempt Resuscitation (DNAR) decisions will be compliant with the MCA and demonstrate that decisions have been made in partnership with the individual, family, health and welfare attorneys as appropriate.

4.8 All records demonstrate consideration of least restrictive treatment option in the person's best interest during the delivery of care and support.

4.9 Staff will have easy access to the MCA Code of Practice for reference.

4.10 If restraint is used, this will be appropriate, reasonable and proportionate to the level of risk, justifiable, respects dignity and protects human rights. Consideration of the Deprivation of Liberty Safeguards (DoLS) should be evident.

4.11 Where care and support delivery requires restriction /restraint this is supported by a risk assessment and care plan which are regularly reviewed and includes consideration of DoLS.

4.12 Staff have opportunities to talk about how they prevent and manage behaviour which challenges so that learning is shared and the risk of further incidents is reduced.

4.13 The Provider must ensure that they have sufficiently trained and approved staff to undertake required DoLS assessments and ensure DoLS timescales are achieved.

4.14 That a sufficient number of BIAs and MHAs are released from other aspects of their work in order to be part of the DoLS rota.

5. Corporate Standards

5.1 There is clear leadership and accountability at Board level for Adult Safeguarding. The provider will identify two named people with lead responsibility for safeguarding adults – one to be responsible for the statutory social care aspects and one responsible for other elements. The Board's Strategic Objectives will address safeguarding adults as core business and central to the practice of all staff.

5.2 The organisation will, therefore have two named professional leads for Safeguarding Adults. They will be responsible for leading on developing/maintaining organisational policy and training programmes for all staff. The Council/CCG must be informed which lead is also undertaking responsibility for the following areas: female genital mutilation, sexual abuse, domestic violence, modern slavery and human trafficking.

5.3 The provider will also nominate professionals with lead responsibilities for Prevent and the Mental Capacity Act and Deprivation of Liberty Safeguards. The Council and CCG will be informed of the identity (and any changes) of the leads.

5.4 The provider will report on the Adult Safeguarding Key Performance Indicators using the Reporting Schedule (Appendix 2 and 3). Additional narrative to support the formal KPI's will also be welcomed.

5.5 The provider will ensure that there is an effective system for identifying and recording all safeguarding concerns and enquiries. For recording of concerns and enquiries under the Adult Social Care specification this recording will be undertaken as detailed by the Council, onto the Council owned database. A separate record of concerns and enquiries relating to the Continuing Health Care and Children's specification will need to be maintained. The data for the CHC and Children's specification will need to be analysed for patterns/trends and outcomes addressed either locally or through collaboration with relevant partners e.g. other providers, the Safeguarding Adults Board (SAB) etc. This latter information should also be

included in the safeguarding reports submitted to both the Council/CCG and the provider's Board.

5.6 The provider must ensure that there is an effective system for monitoring complaints, PALS contacts, adverse incidents, service user feedback and human resource functions in order to identify any concerns indicating neglect, abuse or harm, whether this is intentional or unintentional. These will be duly referred in line with the SAB multi-agency safeguarding procedures. This information will also be included in quarterly safeguarding reports provided to both the CCG/Council and the provider's board.

5.7 The provider will ensure that, when an adult safeguarding alert or enquiry relates to their own organisation that the incident is immediately reported in accordance with the Safeguarding Adults Procedures. A report should also be made onto STEIS in accordance with the national Serious Incident reporting framework and that learning is identified and addressed through an approved Root Cause Analysis methodology with an improvement plan that is SMART.

5.8 The provider will ensure that there are effective processes for the assessment, application, recording and monitoring of Deprivation of Liberty applications.

5.9 The providers will complete an annual safeguarding board report and also submit this to the CCG and Council. The report must include as a minimum:

- Assurance that all local and national standards, including this policy, are being met
- Assurance that all legislative requirements are being met.
- Identification, analysis and management of risk relating to Adult Safeguarding
- Audit of safeguarding activity, improvement plans and outcomes.
- Evidence of involvement in Adult Safeguarding meetings and of improvement plans/strategies relating to the primes business
- Annual review of the organisations safeguarding arrangements
- Information on staff training in the MCA, Prevent, Domestic Abuse, Safeguarding (level 2 and 3) and FGM

5.10 The provider will ensure that all its services/departments are closely monitored for issues which may compromise the safety of vulnerable adults such as the level of needs of the individuals being supported, staffing and skill mix, team cultures and leadership capability.

5.11 The provider will ensure that there are systems for capturing the experiences and views of service users in order to identify potential safeguarding concerns and use this to inform continuous service improvement.

5.12 The provider will ensure that written information is available to the public and people using their services. This information describes adult safeguarding and how safeguarding referrals can be made and will be available at all times in all areas.

6. Policies and Procedures

6.1 The provider will have Adult Safeguarding policies and procedures which reflect The Care Act (2014) and Safeguarding Adults Board policies. The provider's procedures will need to distinguish between the requirements for staff undertaking activities under the Adult Social Care specification and those working in areas covered by the other specifications.

6.2 All Adult Safeguarding, Mental Capacity and Consent policies and procedures will be reviewed at least every 3 years and will be aligned to safeguarding legislation, national policy/guidance, local multi-agency safeguarding procedures and any Council or CCG safeguarding requirements.

6.3 The provider will have a restriction and restraint policy consistent with Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health, 2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

6.4 Organisational safeguarding policies and procedures will provide staff with clear guidance on how to recognise and refer adult safeguarding concerns and all staff will have access to the guidance and know how to use it.

6.5 The provider will have an up to date 'whistle-blowing' procedure compliant with the Public Interest Disclosure Act 2013. This will be referenced to local multi-agency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies.
https://www.gov.uk/government/publications/the-public-interest-disclosure-act/the-public-interest-disclosure-act

6.6 The provider will have robust annual audit programmes in place to assure itself that safeguarding systems and processes are working effectively and that practices are consistent with Safeguarding Adults guidance and the Mental Capacity Act (2005).

6.7 In line with the Deprivation of Liberty Safeguards (DoLS) and the Adult Social Care specification the provider will:

- Maintain an up to date DoLS policy and procedure which incorporates the Supreme Court Ruling (2014) and any new guidance/legislation.
- Ensure that staff practice in accordance with policy and legislation.
- Develop and maintain systems and processes to undertake, monitor and report on all Deprivation of Liberty related work
- Report all DoLS concerns to the Council Ensure that no person is unlawfully deprived of their liberty and that any such breaches are assessed against Safeguarding Adults criteria
- Ensure that any death while a patient is awaiting assessment for or is under a Deprivation of Liberty authorisation is referred to the Coroner.
  - release Health and Social Care staff to attend MCA and DoLS training as required
  - Support BIAs and MHAs to complete re-approval requirements to remain on the relevant rota and to keep updated on emerging case law and guidance

7. Recruitment and Employment

7.1 Providers can demonstrate that:

- Recruitment procedures protect and safeguard vulnerable adults
- Safe and appropriate staffing levels are maintained
- The recruitment policy is reviewed at least once every 3 years
- All staff with responsibility for recruiting and interviewing staff are appropriately trained.
- Recruitment policies and practices meet the NHS and the Council's employment check standards for all eligible staff. This includes staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees. This will include relevant staff having an up to date DBS check and having received two written references before a person commences work with an adult with care and support needs
- All staff employed in professional roles must be registered with the appropriate registration body and aware of the expectation of their relevant body regarding safeguarding. Employment practices meet the requirements of the Disclosure and Barring Service (DBS) and referrals are made to the DBS when necessary.
- All job descriptions and employment contracts ((including volunteers, agency staff and contractors) include an explicit responsibility for safeguarding adults. The Commissioner may request a sample of Job Descriptions to view.
- All allegations of neglect or abuse against members of staff (including staff on fixed term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) are referred into safeguarding adults procedures and that this is reported to the Council and CCG.
- To undertake safeguarding enquiries where asked to do so including those into allegations/complaints/concerns/incidents where a member of staff/ team/department may

have neglected, harmed or abused a service user .Disciplinary processes are concluded irrespective of a person's resignation. Such incidents will be assessed against Adult Safeguarding and Serious Incident criteria and reported/investigated accordingly

- An appropriate number of social work and other staff, commensurate with the size of the organisation and the requirements in the adult social care specification , are trained to level 3 in line with SAB training requirements to undertake adult safeguarding work including enquiries.

8. Training and Development

8.1 The provider will have a safeguarding adults training matrix and ensure that *all* staff attend safeguarding adults training commensurate with their roles as indicated by SAB.

8.2 The provider can identify the safeguarding adults training needs for their entire workforce (including volunteers, contractors and temporary staff) and can provide evidence of all staff adult safeguarding training. This will be reported to the CCG/Council as per the KPI's. An improvement plan will be sent to the CCG/Council to address any areas of non-compliance against the targets.

8.3 All safeguarding adults training is delivered by suitably qualified and experienced trainers and is formally evaluated.

8.4 All adult safeguarding trainers are appropriately supported and receive formal supervision. They have access to leadership courses and professional development specific to their role.

8.5 All staff are trained to appropriate levels according to their role and responsibility in line with the Safeguarding Adults Board's requirements.

8.6 All staff attend update training on safeguarding at least every 3 years.

8.7 The Provider will ensure that all staff, appropriate to their role and responsibility, undertake Mental Capacity Act, Deprivation of Liberty and consent training. This will be identified in an organisational training needs analysis and training plan. They will receive this on induction and every 1 or 3 years thereafter, depending on their role. There is an expectation that Best Interest Assessors and Approved Mental Health Practitioners undertake, at a minimum, the number of hours training to maintain their qualification and attend professional practice groups.

8.8 The provider will ensure that all staff are appropriately supported and supervised when undertaking an aspect of the safeguarding process.

8.9 The provider must ensure that all social workers undertaking work with adults have access to a source of additional "expert" advice and guidance, on safeguarding issues, outside of their normal supervisory arrangements.

8.10 The Provider must enable the Local Authority's Principal Social Worker for Adults to undertake their responsibility to provide professional leadership for social work practice in any organisation undertaking delegated adult social care functions.

9. Multi-Agency Working

9.1 Providers will:

- Ensure that all staff are aware of the need for inter-agency information sharing and adhere to the SAB Information Sharing protocol
- Provide appropriate information about their safeguarding adult's arrangement to the SAB as requested.
- Ensure regular Director level representation on the SAB board and actively support/contribute to subgroups.
- Contribute to the delivery of the SAB multi-agency training programme
- Actively support Adult Safeguarding enquiries/procedures e.g. attendance by appropriate representative at strategy or planning meetings.
- Have a policy on the management of Safeguarding Adults Reviews (SAR's) in accordance with SAB requirements.

- Contribute to multi-agency audits, enquiries and Safeguarding Adults Reviews including producing individual management reports (IMR's) when required.
- Consider the organisational implications of any Safeguarding Adults Review and submit a plan to the SAB/CCG or Council to ensure that lessons are learnt and appropriate improvements are implemented and evaluated across the organisation.
- Contribute to the statutory Domestic Homicide Review (DHR) process when required and make improvement plans available to the CCG.
- Effectively utilise and promote the 'passports' for all service users admitted with one e.g. Learning Disability passports.
- The Provider will support the work of the Multi Agency Safeguarding Hub by providing staff to work within the MASH and support its work by providing information when requested.

9.2 The provider will report on the number of adult safeguarding cases where the duty of candour has been applied.

10. Serious Incidents

10.1 The provider will maintain a policy and procedure for Serious Incidents and incidents will be reported and investigated in line with 'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation' (NRLS 2010).

10.2 Where there is there is an unexpected death or serious harm to a service user and abuse or neglect may be a factor, this will be referred into Adult Safeguarding procedures in addition to being reported as a Serious Incident.

10.3 The provider must make the Council and CCG aware of any case which it considers will be in the public interest or may generate media attention.

10.4 All falls and pressure ulcers of those in receipt of CHC or Council funding must be reviewed in respect of risk assessments, care plans, staffing, staff training etc. All falls and pressure ulcers causing significant harm e.g. fractures, category 3 or 4 pressure ulcers will be reported as a Serious Incident and a Root Cause Analysis investigation completed. These incidents must also be assessed against adult safeguarding criteria and referred into adult safeguarding procedures in accordance with these procedures.

11. Prevent

11.1 Both social care and healthcare organisations are required to deliver the Prevent agenda by the Counter Terrorism and Security Act (2015). This act requires the Council and the CCG to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at risk of radicalisation.

11.2 Prevent is also included within the NHS Standard Contract for 2015 / 2016 within Service Conditions paragraph 32, SC32 Safeguarding. Providers will:

- Comply with the principles contained in 32.5.1 Prevent; and 32.5.2 The Prevent Guidance and Toolkit and include these in its policies and procedures.
- Appoint and maintain a Prevent Lead who will be appropriately authorised and resourced to ensure the Provider meets its obligations as above.
- Deliver a programme of WRAP training and sufficiently resource that programme with accredited WRAP facilitators.
- Ensure that at least 75% of all staff have undertaken WRAP training.
- Submit quarterly 'Prevent' returns to the CCG as per NHS England guidance.
- Refer all Prevent concerns via: channelsw@avonandsomerset.pnn.police.uk. Notify the CCG and Council in writing of any change to the identity of the Prevent Lead within 10 working days of the change.

11.3 The Provider will complete annually and return to the CCG, the self-assessment tool from the Department of Health publication Building Partnerships, Staying safe:

https://www.gov.uk/government/publications/building-partnerships-staying-safe-guidance-for-healthcare-organisations

Appendix 1: Key Adult Safeguarding Legislation & Guidance

Key Legislation / Guidance	Links
The modern slavery Act 2015	http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted
The Lampard Report February 2015	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf
The Counter Terrorism and Security Act 2015	http://www.legislation.gov.uk/ukpga/2015/6/contents/enacted
Care Act (UK Gov. 2014)	http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf
Care & Support Statutory Guidance (UK Gov. 2014)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf
Mental Capacity Act 2005 (UK Gov 2005).	http://www.legislation.gov.uk/ukpga/2005/9/contents
Mental Capacity Act Code of Practice (UK Gov. 2016)	https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
Mental Health Act (1983) UK Gov. 2007)	http://www.legislation.gov.uk/ukpga/2007/12/contents
Mental Health Act (1983) Code of Practice (UK Gov. 2015)	https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
Safeguarding Adults Multi – Agency Policy (2014)	http://www.bathnes.gov.uk/sites/default/files/siteimages/joint_authority_multi-agency_safeguarding_adults_policy_-_approved_june_2014.pdf
The Public Interest Disclosure Act 2013	http://www.legislation.gov.uk/ukpga/1998/23/section/1
Mental Capacity Act: post-legislative scrutiny 2014 (Select Committee on the MCA)	http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf
CQC Regulation 20: Duty of Candour	http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
Domestic violence & abuse: how health services, social care and the organisations they work with can respond effectively (2014)	http://www.nice.org.uk/guidance/ph50/resources/guidance-domestic-violence-and-abuse-how-health-services-social-care-and-the-organisations-they-work-with-can-respond-effectively-pdf
Cheshire West judgment (P v Cheshire West, Supreme Court 2014)	https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf
Mid Staffordshire Public Inquiry Report, Executive summary (2013)	http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

Key Legislation / Guidance	Links
Safeguarding Vulnerable People in the Reformed NHS : Accountability & Assurance Framework (2013)	http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf
NHS Employers: Criminal record and barring checks (2013)	http://www.nhsemployers.org/RecruitmentAndRetention/Employment-checks/Employment-Check-Standards/CriminalRecordChecksStandard/Pages/CriminalRecordChecks.aspx
Disclosure & Barring Service (DBS)	https://www.gov.uk/government/organisations/disclosure-and-barring-service/about
Improving the Safety of Patients in England Berwick report (2013)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
Safeguarding Adults Multi-Agency Procedures	http://www.bathnes.gov.uk/services/adult-social-care-and-health/safeguarding-adults-risk-abuse/local-safeguarding-adults-board
Bath & North East Somerset Safeguarding Adults Staff Development Framework (2012)	http://www.bathnes.gov.uk/sites/default/files/sitedocuments/Social-Care-and-Health/Safeguarding-Adults/lsab_safeguarding_adults_staff_development_framework_june_2012_-_final.pdf
Clinical Governance and Safeguarding (DoH, 2011)	http://www.nmc-uk.org/Documents/Safeguarding/England/1/Clinical%20governance%20and%20adult%20safeguarding.pdf
Safeguarding Adults: The Role of Health Service Managers & their Boards (DoH, 2011)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215713/dh_125035.pdf
Prevent strategy: guidance for healthcare workers (HM Government 2011)	https://www.gov.uk/government/publications/the-health-sector-contribution-to-hm-government-s-prevent-strategy-guidance-for-healthcare-workers
CQC Fundamental Standard 13: Safeguarding service users from abuse and improper treatment	http://www.cqc.org.uk/content/regulation-13-safeguarding-service-users-abuse-and-improper-treatment#full-regulation
National Framework for Reporting & Learning from Serious Incidents Requiring Investigation (NRLS, 2010)	http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173
Care Act 2014 (Chapter 14, Section 42-46)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf
Criminal Justice and Courts Act 2015, Sections 20-25	http://www.legislation.gov.uk/ukpga/2015/2/pdfs/ukpga_20150002_en.pdf
Violence and aggression: short-term management in mental health, health and community settings. NICE 2015	https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-1837264712389

Appendix 2: Key Performance Indicators (KPI's) for Adult Safeguarding 2017-18

Name of Provider:
These Key Performance Indicators (KPI's) are to be used by all commissioned providers and reported as per the schedule below. Narrative can be added if you wish to clarify/explain your responses, particularly if improvement is required in a particular indicator.

	Q1	Q2	Q3	Q4	Annual report	Annual audit
Send to Council/CCG by:	3rd week of July	3rd week of October	3rd week of January	3rd week of April	1 September	1 June

Appendix 3: Reporting Template for Adult Safeguarding Key Performance Indicators 2017-18
Name of Provider:
These Key Performance Indicators (KPI's) are to be used by all commissioned providers and reported as per the schedule below. Narrative can be added if you wish to clarify/explain your responses, particularly if improvement is required in a particular indicator.

	Q1	Q2	Q3	Q4	Annual report	Annual audit
Send to Council/CCG by:	3rd week of July	3rd week of October	3rd week of January	3rd week of April	1 September	1 June

No	Performance Indicator	Evidence/Information Required	Q1	Q2	Q3	Q4
1.	Safeguarding adult standards are being fully met	• Annual Adult Safeguarding report • Annual Audit Return	Both reports to cover period between 1st April & 31st March			
2.	Provider to demonstrate that all staff have the skills and knowledge to effective deliver safeguarding practice	Target:	95%	95%	95%	95%
		• No. of staff require level 1 training • No. of staff who have received level 1 • % of staff who have received level 1				
		Target:	90%	90%	90%	90%
		• No. of staff require level 2 training • No. of staff who have received level 2 • % of staff who have received level 2				
		• No. of staff require level 3 training • No. of staff who have received level 3 • % of staff who have received level 3				
3.	Staff know how to recognise and report Domestic Abuse All reported cases of Domestic Abuse are assessed against safeguarding criteria	Target:	90%	90%	90%	90%
		• How many staff require training? • No./% of staff who have received training?				
		• Number of incidents reported to the provider Number of reported incidents assessed against safeguarding criteria				
4.	Demonstrate compliance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009	Target:	90%	90%	90%	90%
		• No. of staff *requiring* MCA/ DoLS training • No. of staff who have received training • % of staff who have received training				
		• Quarterly reports/case studies that demonstrate how lessons learned have led to improved application of the MCA				
		• Number of DoLS referrals				
		• Number of IMCA or Care Act advocate referrals due to safeguarding				

No	Performance Indicator	Evidence/Information Required	Q1	Q2	Q3	Q4
		• Number of identified service users/ patients who meet the criteria for a community DoLS.				
		• Number of community DoLs that have completed the court process				
		• Summary of learning & action taken to embed & improve application of MCA • Demonstrate how DoLS requirements are being met	Include in annual report			
5.	Demonstrate implementation of all actions relating to their organisation, from SAR's	• Provide details of actions/improvements required following SAR's/IMR's • Provide evidence that these have been implemented and evaluated	Report by exception	Report by exception	Report by exception	Report by exception
6.	Demonstrate robust processes to record, monitor and learn from all safeguarding activity	• Provide a summary of number, nature & outcome of all safeguarding alerts & investigations that relate to staff employed by the provider • Provide summaries of improvement plans to address patterns/trends • Demonstrate that the following are all assessed against safeguarding criteria: o Complaints/PAL's contacts o Adverse & serious incidents o Performance management cases • Evidence can include thematic reviews, case studies etc.	Include in annual report			
7.	Duty of Candour applied to all safeguarding cases relating to the organisation	Record and report all safeguarding cases involving the provider where Duty of Candour Applied				
8.	Safeguarding Adults criteria are applied to all new category 3 and 4 pressure ulcers	• No. of new category 3 & 4 pressure ulcers for period				
		• No. assessed against adult safeguarding criteria & screening tool completed				
		• No. referred into adult safeguarding				
9.	Demonstrate compliance with statutory & contractual 'Prevent' duties	• No. of Prevent referrals				
		Target:	95%	95%	95%	95%
		• No. of staff who *require* awareness training • No. & % of staff who have *received* awareness training				
		Target:	75%	75%	75%	75%
		• No. of staff who *require* WRAP				

No	Performance Indicator	Evidence/Information Required	Q1	Q2	Q3	Q4
		• No.& % of staff who have received WRAP				
		• No. of WRAP facilitators • Number/% outstanding				
		• Completion of Prevent self-assessment	Annual			
10.	▪ Demonstrate compliance with procedural timescales	Target:	95%	95%	95%	95%
		▪ % Decisions made in 4 working days (% of whole)				
		▪ % Planning Meetings / Discussion within 10 days				
		Target:	90%	90%	90%	90%
		▪ % Section 42 Enquiry Reports within agreed Chairs timeframe				
		Target:	85%	85%	85%	85%
		▪ % Review meeting held within 5 working days of Enquiry Report being received				
		▪ % Subsequent review meetings held within 3 months				
		Target:	90%	90%	90%	90%
		▪ % of overall activities / events to timescale				
11.	▪ Safer recruitment	Target:	100%	100%	100%	100%
		▪ % of relevant staff to have up to date DBS check				
		▪ % of staff with two written references before work commences.				

2016 Annual Safeguarding Adults Audit

Name of Organisation:		Date completed:		Completed by:	

Audit to be received by the Council/CCG by the 2nd week of May, together with completed improvement plan.

Question	Response/Evidence	RAG Rating
1. Governance		
Does your organisation have a board level lead for safeguarding adults and MCA?		
How does your organisation support the LSAB and its LSAB sub-groups?		
Does your organisation have a named Adult Safeguarding and MCA professional? Does this person have protected time and a job description?		
Do you have safeguarding adult's policy, procedures and guidelines? When were these last reviewed? How does your organisation communicate this to your workforce? Does your policy address the requirement to ensure safeguarding concerns regarding prime services are separated out and managed by the relevant team only?		
Does your organisation have a policy for managing visits by celebrities, VIPs and other official visitors?		
Has your organisation been involved with any inspection related to safeguarding adults? If yes, please give details		
Have you submitted an annual safeguarding report to the Council/CCG which has been reviewed internally by senior management?		
How does your organisation ensure all the following are assessed against safeguarding criteria? • Complaints/PALs contacts • Adverse & serious incidents • Performance management cases • Category 3 and 4 pressure ulcers		
2. Training , Skills & Competences		
• Do you have a training strategy which includes a matrix that identifies the safeguarding adults training needs for all staff incl. volunteers? • Do staff receive refresher/update training every 3 years?		
Does your training strategy include awareness raising for: • Domestic Violence • Human trafficking & modern slavery • Forced marriage • Female Genital Mutilation • Prevent		
Who provides the safeguarding adults training in your organisation?		
How do you monitor the impact of the training on practice and outcomes?		
3. Managing Adult safeguarding Concerns		

Are adults at risk referred to advocacy services when necessary? How do you monitor / record this?		
Are there opportunities for staff and volunteers to debrief and reflect following safeguarding concerns?		
Do you have robust systems that allow you to accurately record, monitor and report all safeguarding activity? Do you have a process for assessing and addressing safeguarding risks?		
How do you check/audit records for accuracy, relevance and timeliness? How often do you do this?		
4. Safe Recruitment & Retention of Staff		
Does your organisation have a safe recruitment policy that is reviewed annually?		
Does your recruitment policy include volunteers, charity fund raisers or celebrities?		
Do all job descriptions include a statement on the roles & responsibilities to safeguarding adults? If not, why not?		
How do you gain assurance that any contracted services or individuals follow safe recruitment processes?		
Do all of your staff, including volunteers, who have contact with adults at risk (i.e. regulated activity) have an enhanced DBS check? ▪ What number and % are outstanding? ▪ How are you addressing this?		
5. Managing Safeguarding Adult Allegations against Staff		
Does your organisation have a process in place for the management of allegations against staff?		
How does your organisation promote zero tolerance to abuse?		
Does your organisation report allegations to a designated officer who will support investigations?		
How do you ensure that all your staff know how to report a concern about a member of staff?		
Are all allegations reported to the Council and CCG If not, why not? How is this reported?		
Multi-Agency Working		
Does a senior manager (executive) from your organisation, who has decision-making authority, regularly attend the LSAB? Does a nominated deputy attend the LSAB in their absence?		
How does your organisation ensure that staff adhere to statutory information sharing guidance?		
Has your organisation been requested by the LSAB to complete an audit or report (e.g. Individual Management Report / Enquiry Report)? If yes, what was requested and was this completed within the required timeframes? If not, why not?		
Has progress against subsequent single agency action plans been reported to the Council's/CCG & LSAB?		
How does your organisation demonstrate that you have engaged with/implemented multi-agency		

recommendations from any Safeguarding Adults reviews (SAR's) you have been involved with?		
Can your organisation demonstrate that learning has been adopted from both national & local SAR's?		
6. Engaging Adults and their Carers/Families		
How does the organisation ensure that service users and their carers/family/carers are actively engaged in the safeguarding process?		
How does the organisation ensure that the voice of the vulnerable adult is heard at both individual team and Board level?		

Improvement Plan					
No.	**Improvement required**	**Action Required**	**Person Responsible**	**Complete by**	**RAG rating**
1					
2					
3					
4					
5					

SAFEGUARDING CHILDREN: STANDARDS & PERFORMANCE INDICATORS FOR PROVIDERS OF HEALTH SERVICES 2017 /19

Introduction

These safeguarding standards will apply to all NHS Bath & North East Somerset (BaNES) Clinical Commissioning Group (CCG) commissioned services, regardless of whether the service works with children, young people, families or adults. The term 'child/ children' will be used in these standards to cover all children and young people up to their 18th birthday. These standards are informed by legislation and statutory guidance and evidence from research. All Providers of services will be expected to comply with all statutory / national guidance related to safeguarding children, this includes:

- Children Act 1989
- Children Act 2004
- Working Together to Safeguard Children 2015
- Care Quality Commission Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment - Health & Social Care Act 2008 (Regulated Activities) Regulations 2014:Regulation 13
- RCCHPSafeguarding Children & Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014)

It is the Providers' responsibility to provide assurance that they meet the safeguarding children's standards and to submit reports/evidence as indicated in these standards to the NHS BaNES CCG Quality team by the deadlines set out in this schedule and in schedule 4, part C, local quality indicators , and copied to DSCRO via cscsu-dscro-box@nhs.net

The Quality team is supported by the expertise of the Designated Professionals Safeguarding Children to ensure that the standards have been met to a satisfactory level.

There are ten core Safeguarding Children Standards:

1. Governance and Commitment to Safeguarding Children
2. Policy, Procedures and Guidelines
3. Appropriate Training, Skills and Competences
4. Effective Supervision and Reflective Practice
5. Effective Multi-Agency Working
6. Reporting Safeguarding Children Serious Incidents & Incidents
7. Engaging in Serious Case Reviews
8. Safe Recruitment and Retention of Staff
9. Managing Safeguarding Children Allegations Against Members of Staff
10. Engaging Children and their Families

In addition to reporting annually on the safeguarding children standards, Providers are required to provide quarterly reports on performance indicators (PI's). These PI's are provided in appendix 2.Additional PI's maybe agreed between the Provider and the CCG Designated Nurse on an individual basis. For small Providers guidance from the CCG Designated Nurse should be sooughtt to ensure reporting is proportionate.

The Prime is responsible for meeting these standards as the prime provider but also for ensuring compliane with any sub-contracted services through the DPS arrangement.This will be done in collaboration with the CCG Designated Nurse

The methods of demonstrating compliance are varied for each standard and are described throughout the document; they include but are not limited to:

1. Submission of quarterly performance indicators (PI's) (Appendix 2) to the CCG.
2. Submission of an Annual Safeguarding Children Report to the CCG.
3. Submission of the Annual Audit of Standards (Appendix 1) to the CCG
4. Submission of an Annual LAC Report to the CCG
5. Submission of an quaterley LAC Report
6. Submission of any Section 11 audit undertaken for the Local Safeguarding Children Board.
7. Submission of safeguarding children audits agreed with the Designated Nurse, proposed audits 2017
    - Sexual Health Services Under 18 proforma audit

- Safeguarding Children Supervision Audit to include (PHN, MIU, Lifetime, Learning Disabilities, Sexual Health and LAC services)
- Looked After Children Intial Health Assessments audit
- Child Protection Medical audit

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8. Providing evidence as requested at clinical outcomes & quality assurance (CO&QA) meetings /contract quality review meetings (CQRM) or other appropriate contract meetings.
9. Inviting CCG designated professionals to attend Provider internal safeguarding children governance meetings.
10. Providing evidence to and responding to requests from the Local Safeguarding Children's Board (LSCB) meetings and sub groups.
11. Participating in CCG and LSCB case file audits, case reviews and inspections.
12. If the Provider requires advice on how to evidence their compliance with these safeguarding children standards they should contact the CCG Designated Professionals for Safeguarding Children.

Following submission of evidence to the CCG quality team assurance will be obtained from the CCG Designated Professionals Safeguarding Children that the standards have been met to an agreed level. If the standards are not met to an acceptable level the CCG Designated Professionals Safeguarding Children will advise on the action required to regain compliance and on the appropriate timescales needed.

If the Provider identifies non-compliance in relation to their safeguarding practice and or any providers sub-contracted via the prime they must notify the CCG nursing & quality team who will inform the CCG Designated Professionals Safeguarding Children and as appropriate of the level of non-compliance, include relevant regulatory bodies

Schedules for reporting

Reporting Period		
Safegaudring Children Annual Report	April - March	1st week of August
Safegaudring Children Annual Audit	April - March	1st week of August
Looked After Children Annual Report	April – March	1st week of August

If Provider is required to report on PI's:

Reporting Period		Report received by CCG by	Report to be presented at CO&QA Meeting or relevant Contract monitoring meeting in
Quarter 1	April - June	1st week of August	August
Quarter 2	July - September	1st week of November	November
Quarter 3	October - December	1st week of February	February
Quarter 4	January - March	1st week of May	May

Standard 1 – Governance and Commitment to Safeguarding Children

Standard Statement:

The Provider will ensure that their organisation is committed to safeguarding children and can demonstrate that robust governance structures and systems are in place in line with Working Together to Safeguard Children 2015 (WTTSC 2015)

Link to key information:

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Criteria	Report
1. The Provider must have a clear statement of their commitment to safeguard children, which is accessible to the public.	Annually
2. The Provider must have a Board Lead for safeguarding children who holds accountability within the organisation	Annually
3. The Provider must produce an Safegaudring Children Annual Report and LAC Annual Report which is internally scrutinised, signed off at Board level, published and submitted to the CCG	Annually
4. The Provider must ensure that all quarterly safeguarding children reports against specific performance indicators (as detailed in appendix 2) are scrutinised by the relevant internal quality assurance process prior to submission to the CCG	Quarterly
5. The Provider must have an identified named nurse/doctor/midwife/professional (as appropriate to organisation) to provide safeguarding children expertise as stated in WTTSC 2015	Annually
6. The Provider will comply with any requests by the LSCB to complete Children Act 2004, section 11 audits	Annually
7. The Provider must engage in all planning and preparation for any inspection related to safeguarding children	Annually
8. The Provider will submit agreed safegaudring children audits.	Quaterley

Standard 1 can be met by:

- Publishing a statement of commitment either in the Provider organisation's promotional literature and/or website. The statement should clearly identify who in the organisation is the executive (strategic) and operational lead responsible for safeguarding children. All NHS funded health services should identify 'named professionals' to promote good professional practice within their organisation.
- At the end of each financial year the Provider organisation should produce an annual report of the activity undertaken in relation to safeguarding children and LAC. It is an expectation that this annual report is sent to the CCG by the first week August .
- If the organisation is requested to complete a Section 11 audit by the LSCB, A copy should be reviewed by the CCG Designated Professionals.
- If the CCG or Provider receives notification that CQC or Ofsted are planning to undertake an inspection of safeguarding and looked after children, it is expected that the organisation will comply with any requests to prepare for and participate in the inspection.

Standard 2 - Policies, Procedures and Guidelines

Standard Statement:

The Provider will ensure all staff are aware of the safeguarding children's policy and any relevant guidance or procedures.

Examples of how to write and the required content of policies:

- https://www.nspcc.org.uk/globalassets/documents/information-service/factsheet-writing-organisational-child-protection-policies-procedures.pdf
- http://www.safenetwork.org.uk/resources/Pages/policies_and_procedures.aspx
- http://www.online-procedures.co.uk/swcpp/

Criteria	Report
1. The Provider will have a Safeguarding Children Policy which is revised 3 yearly and reviewed annually to ensure continued compliance with national and local guidance. The Provider should indicate in their safeguarding annual report they have reviewed their safeguarding policy.	Annually
2. The Provider Safeguarding Children Policy will include information on child sexual exploitation (CSE),female genital mutilation (FGM) domestic abuse (,DA) and safegaudring children escalation process, links to the LSCB CSE and FGM protocols and LSCB Safeguarding Children Escalation Policy should be maintained .	Annually
3. The Provider will have appropriate operational procedures and/or guidance, which are in line with those of the BaNES LSCB, LSCB and the South West Child Protection Procedures (SWCPP).	Annually
4. The Provider will ensure all staff are aware of all of the above and know how to access them.	Annually

5.	The Provider will have a Domestic Abuse Policy	Annually

Standard 2 can be met by:

- Producing and submitting a Safeguarding Children Policy to the CCG for review and endorsement by the Designated Professionals (endorsement to be documented in Policy). The policy should describe how the organisation manages the safeguarding children process; this may involve a single policy and supporting procedures. All of the procedures should make reference to and comply with the South West Child Protection Procedures. Links to internal procedures, South West Child Protection Procedures and BANES LSCB policies and procedures should be readily available to staff via their website.
- In addition, undertaking or participating in case audits (single or multi-agency) or case reviews and completing relevant actions in order to demonstrate compliance.

Standard 3 – Appropriate Training, Skills and Competences

Standard Statement:

The Provider will ensure all staff including board level for chief executive officers, Trust and Health Board executive and non-executive directors/members receive safeguarding children training at a level commensurate with their role as indicated in the Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014)

Link to relevant documents:

- http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3).pdf

Criteria		Report
1.	The Provider will have a training strategy for safeguarding children, that will include a training matrix which identifies the level of training required for all staff, and this should be reviewed annually	Annually
2.	The Provider will have an induction process in place for all staff that includes a mandatory session that provides key safeguarding /child protection information and appropriate action to take if there are concerns. This session should be of at least 30 minutes and be a face to face session.	Annually
3.	The Provider will produce data to evidence that all staff are compliant with the organisation's training matrix. The minimum expectation for training compliance is 90% across all levels	Quarterly
4.	The Provider will ensure that all safeguarding children training will be delivered by suitably qualified and experienced trainers	Annually
5.	The Provider will demonstrate that all training has been evaluated for its effectiveness	Annually
6.	The Provider will demonstrate the impact of training on practice and any improved outcomes	Annually
7.	The Provider will ensure any staff requiring specialist expertise in safeguarding children will be supported to access relevant training	Quarterly
8.	The Provider will promote and demonstrate a commitment to their staff attending the LSCB multi-agency training as appropriate	Annually
9.	The provider will provide a compliance report for Level 2 training by service	Quaterley
10.	The provider will provide a compliance report for Level 3 training by service , this includes any adult led services where staff are required to complete Level 3 training	Quaterley

Standard 3 can be met by:

- The Provider producing a strategy setting out their safeguarding training intentions for their staff, this could be a separate document or included in the safeguarding policy. A template should be produced; including a list of individual staff or for larger organisations a list of staff by professions or roles setting out the level of

competencies required for the role. All training intentions should link to the competencies as set out in the document 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff 2014. This should also include details of:
    - The organisations induction process for new staff
    - The training of staff requiring Level 4 or above (The organisation's named or lead professionals are able to deliver the training at Levels 1, 2 and 3 within the organisation if they possess the competencies at Level 4 or above and are skilled in providing training, and
    - The Provider board level training
- The Provider maintaining a record of all staff which clearly demonstrates that the expected level of training has been undertaken, the date undertaken and the renewal date. The use of a database is advisable and should be produced in a format that will enable the Provider to identify the percentage and number of staff at each level who are up to date with their training. The Provider should submit these figures in a quarterly report to the CCG, if the percentage of staff trained are not at the required levels details of the actions planned to ensure those staff are trained to the correct level should be included.
- The Provider including a section in their Annual Safeguarding Report on training with any exception reports if training has not met the agreed standards. The impact of training on practice should be evaluated to determine its effectiveness. An appropriate method of evaluation should be developed. For example, the use of pre and post training competency assessments of participants.
- The Provider will submit an annual audit to demonstrate effectiveness of training on practiceIn addition the Provider can demonstrate compliance through supervision or case consultations where staff decision making can be shown to have been directly influenced by their safeguarding children training.
- The Provider can demonstrate their compliance with this standard by submitting their safeguarding training strategy for review to the the CCG DesignatedNurse .
- Undertaking or participating in case audits and case reviews which provide evidence that staff are competent and following the correct procedures is another method of demonstrating compliance.

Standard 4 – Effective Supervision, Reflective Practice and Case Consultation

Standard Statement:

The Provider will ensure all staff have access to safeguarding children supervision; reflective practice or case consultations as appropriate. The type of supervision staff receive should be linked to the level of competencies required for their role as set out in Safeguarding Children and Young People: Roles and Competences for Health Care Staff 2014.

Criteria		Report
1. 2.	The Provider will have a Safeguarding Children Supervision Policy This Policy should include the safeguarding children supervision needs of their workforce including Named professionals, Designated Doctor. LAC Designated Nurse and LAC Designated Doctor	Annually
3.	Any supervision, reflective practice or case consultations provided to staff must include the 'think family' agenda	Annually
4.	The Provider can produce evidence that all staff have received or had access to safeguarding children's supervision and / or opportunities for reflective practice, as appropriate to their role	Quarterly
5.	The Provider will ensure all safeguarding children supervision is delivered by suitably skilled and experienced supervisors	Annually
6.	The Provider will ensure that staff providing safeguarding children supervision are also able to access their own supervision	Annually
7.	The Provider will submit an annual safeguarding children supervision, Audit should demonstrate compliance against safeguarding children supervision policy requirements and provide evidence of impact of supervision on improving case management.	Annually

Standard 4 can be achieved by:

- The Provider having a Safeguarding Children Supervision Policy on how they expect their staff to access safeguarding supervision/case reflection. This can be a separate document or included in the Safeguarding Children Policy The strategy may include a list of individual staff or a list of staff by professions or roles.
- The Provider can produce evidence that all staff have received or have had access to safeguarding children's supervision and / or opportunities for reflective practice, as appropriate to their role
- Staff who are identified as needing level 3 specialist competencies (and other levels, when relevant to work environment e.g. ED, sexual health etc.,) should have regular scheduled group or individual supervision or reflective practice sessions which should be facilitated by suitably skilled and experienced staff.
- Supervisors should have specialist level 3 competencies as a minimum and they should be able to evidence training or competencies for undertaking this role within 6 months of them starting to offer supervision.
- If the Provider does not directly employ staff with these competencies then external supervision should be available. If supervision is provided internally then the supervisors/facilitators should be provided with the opportunity to access their own supervision.
- The Provider can demonstrate their compliance with this standard by submitting their supervision policy for review by the CCG Designated Professionals.
- The Provider can demonstrate participation in case audits or case reviews which demonstrate that staff have received supervision on the relevant cases and will serve to demonstrate compliance.

Standard 5 – Effective Multi-Agency Working

Standard Statement:

The Provider will ensure all staff are aware of the importance of multi-agency communication and the sharing of information in order to effectively safeguard children.

Links to relevant documents:

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf
- http://www.online-procedures.co.uk/swcpp/?s=information+sharing

Criteria		Report
1.	The Provider will adhere to HM Government statutory guidance on information sharing	Annually
2.	The Provider will ensure that their staff are engaged in all stages of the safeguarding children process as appropriate	Quarterly
3.	The Provider will ensure that their staff are using Early Help/Common Assessment Framework (CAF) assessment tools to improve outcomes and are contributing to the LSCB's Early Help strategy	Quarterly
4.	The Provider will ensure all reports to other agencies about safeguarding children concerns will include an analysis of the information/risk and how this impacts on the child's safety	Annually
5.	The Provider will ensure all staff who undertake assessment of children will understand the importance of including the 'voice of the child' and the assessment of the child's day to day experience, cultural and diversity issues, and considers any disability or complex health needs	Annually
6.	The Provider will ensure all staff that undertake adult assessment will recognise the risk those adults may pose to children. Staff are required to demonstrate that the 'think family' principle has been applied in the assessment of any adult providing care or living in the child's home. These assessments must consider the impact of the adult's condition on the child's welfare. They must share information as appropriate and include an assessment of risk and an analysis of the adult's ability to care for the child	Annually
7.	The Provider must share information about their safeguarding children arrangements to the LSCB as/if requested.	Quarterly
8.	The Provider will ensure their staff fully engage in the Child Death Review process, as appropriate, by engaging in the local case review meetings, the child death overview panel and the sharing of relevant information	Annually

The provider can demonstrate that the guidance has been followed by:

- Undertaking case file audits and case reviews which clearly state the decision making processes related to sharing information in both cases where the information has been shared and where a decision not to share

the information has been made. The results of these audits and reviews should be submitted to the CCG and shared with the Designated Nurse.

- Local Safeguarding Children Boards have processes for providing support to families where concerns are below the threshold for social work intervention. The Provider will ensure that their staff are using Early Help/CAF assessment tools to improve outcomes and are contributing to the LSCB's Early Help strategy.
- The Provider can demonstrate that appropriate processes have been followed by submitting data on a quarterly basis on how many Early Help/CAF assessments have been undertaken by staff. Data should be submitted which demonstrates that an Early Help strategy has been offered when the organisation has undertaken an assessment which identifies that this is recommended. A section on Early Help/CAF should be included in the Providers safeguarding children annual report including exceptions and subsequent actions to be taken.
- All safeguarding children reports to other agencies should include an analysis of the information and how this impacts on the child's safety. Assessments of children should include the 'voice of the child', assess the child's day to day experience, cultural and diversity issues, and consider any disability or complex health needs.
- Assessments of adults should include routine questioning on whether the adult is providing care for or living in a child's home. This assessment should also include whether they come into contact with children in their employment. If so then consideration must be given to the safeguarding needs of any children.
- The Local Safeguarding Children Board (LSCB) has a statutory responsibility to coordinate and scrutinise the effectiveness of arrangements for safeguarding children; therefore the providers must comply with all requests made by LSCBs to share information.
- The Child Death Process is a statutory requirement which is placed on all providers. Organisations should ensure that their staff are fully aware of the Child Death Review process; this can be achieved by including this in safeguarding training. The CCG's Designated Professionals will scrutinise provider's engagement in the process by quality assuring engagement and by Designated Nurse membership of the South West Child Death Overview Panel. The organisation's annual report should include information as to how they have engaged in the child death process. The South West Child Death Overview Panel Annual Report can also demonstrate engagement in the process.

Standard 6 - Reporting Safeguarding Children Serious Incidents & Incidents

Standard Statement:

The Provider will ensure that serious incidents are reported and investigated in line with guidance provided by NHS England. Providers must ensure that serious incidents requiring investigation are reported on STEIS within two working days of the organisation identifying the serious incident. All requests or notifications to participate in any Serious Case Review (SCR) must be reported on STEIS and to the Designated Nurse.

Link to the relevant document:

http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

Criteria		Report
1.	The Provider will ensure that any serious incident related to safeguarding children is reported to the CCG through the STEIS reporting process as set out in their Safeguarding Children Policy.	Quarterly
2.	Providers of adult services will report serious incidents related to adult behaviour that causes a significant risk to children they have contact with.	Quarterly
3.	The Provider will carry out the required route cause analysis (RCA) and submit together with an action plan to the CCG	Quarterly
4.	The Provider will inform the CCG on the progress of any action plan resulting from an investigation into a serious incident related to safeguarding children.	Quarterly
5.	The Provider will submit a quarterly Safeguarding Children Incident Report This will cover incidents by numbers/ themes and actions taken as a result of the incidents	Quarterly

The Provider can demonstrate compliance by:

- Describing their reporting process in their Safeguarding Children Policy.
- Completing quarterly performance indicator regarding serious incidents/incidents and submitting to CCG

Standard 7 – Engaging in Serious Case Reviews (SCR)

Standard Statement:

The Provider will ensure that SCRs are undertaken in line with statutory guidance 'Working Together to Safeguard Children 2015 and LSCB processes.

Link to relevant documents:

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Criteria		Report
1.	The Provider can demonstrate that they have adopted the learning from both national and local SCR's	Annually
2.	The Provider will engage in the SCR process as identified by the CCG and the LSCB	Quarterly
3.	The Provider reports progress against action plans resulting from a SCR, to the CCG and LSCB	Quarterly
4.	The Provider can demonstrate that they have engaged with the multi-agency considerations/recommendations from a SCR that they have been involved in.	Quarterly

The provider can demonstrate compliance with this standard by:

- Completing quarterly performance indicator regarding SCR and submitting to CCG
- Demonstrating that organisations have adopted the learning from both national and local Serious Case Reviews can be achieved by reporting to the CCG on progress against any actions responding to requests for information by the SCR sub group of the LSCB; including narrative in their Annual Report and undertaking case file audits.

4. Standard 8 - Safe Recruitment and Retention of Staff

Standard Statement:

The Provider must demonstrate they have safe recruitment procedures that protect and safeguard children in line with guidance NHS employers.

Link to relevant documents:

- https://www.gov.uk/disclosure-barring-service-check/overview
- http://www.nhsemployers.org/RecruitmentAndRetention/Employment-checks/Employment-Check-Standards/Pages/Employment-Check-Standards.aspx

Criteria		Report
1.	The Provider has a Safe Recruitment Policy which is regularly reviewed. The provider should indicate in their Safeguarding Annual Report they have reviewed this policy	Annually
2.	The Provider can demonstrate that all job descriptions include a statement on the responsibility to safeguard children	Annually
3.	The Provider must ensure that their safe recruitment policy takes into account the work of any volunteers, charity fund raisers or celebrities as well as permanent, bank and temporary staff.	Annually
4.	The Providers are responsible for providing assurance that any contracted services or individuals follow safe recruitment processes	Annually

The provider can demonstrate compliance with this standard by:

- The Provider producing a safe recruitment policy.
- The Provider presenting the findings of any audits of the provider's adherence to their recruitment processes to the CCG. Audits can include reviewing the process for checking employment history and reviewing whether job descriptions contain a statement on requirements to safeguard children.

Standard 9 - Managing Safeguarding Children Allegations against Members of Staff

Standard Statement:

The Provider must be able to demonstrate that they adhere to statutory guidance in Working Together to Safeguard Children 2015 and the South West Child Protection Procedures (SWCPP). The Provider must report incidents where it has been identified that a member of staff has behaved in a way that has or may have harmed a child, acted inappropriately towards a child or committed a criminal offence against or related to a child.

Link to relevant documents:

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
- http://www.online-procedures.co.uk/swcpp/procedures/allegations-against-staff/
- http://www.bathnes.gov.uk/services/children-young-people-and-families/child-protection/local-safeguarding-children-board

Criteria		Report
1.	The Provider must have a process in place for managing allegations; this can be included in the safeguarding children policy	Annually
2.	The Provider must have a designated officer and a deputy to whom allegations should be reported and who will support any investigation	Annually
3.	The Provider must ensure their designated officer reports all allegations to the designated officer for allegation (DOFA)/ local authority designated officer LADO) as detailed in the SWCPP	Quarterly
4.	The Provider must inform the CCG of any allegations where the outcome of the LADO strategy discussion is to proceed with an investigation. These cases should be reported through the Serious Incident (SI) reporting process to the CCG	Quarterly
5.	The Provider must inform staff during their induction period of this policy and how to access it and report any concerns	Annually

The Provider can demonstrate compliance with this standard by:

- Ensuring that they have appropriate processes in place for managing allegations which are set out in their Safeguarding Children Policy.
- Submitting quarterly performance indicator data regarding allegations against members of staff.
- The Provider including information in their safeguarding annual report detailing the number of allegations reported to the DOFA/LADO) and the number of these which the outcome of the DOFA/ LADO strategy discussion was to proceed with an investigation. These cases should be reported through the serious incident STEIS reporting process to the CCG and compliance demonstrated by review of these reports.

Standard 10 – Engaging Children and their Families

Standard Statement:

The Provider must be able to evidence that they have engaged with a range of young people and parent/ carers (service users) about the quality of their service provision and how they work with families.

Links to relevant websites:

- http://www.healthwatch.co.uk/

Criteria		Report
1.	The Provider will include an equality impact assessment as part of their Safeguarding Children Policy	Annually
2.	The Provider will evidence how they have sought engagement from a range of service users (adult and children) and how this has impacted on practice to improve outcomes for children/ families	Annually

3.	The Provider will engage in multi-agency audit and learning which identifies how service users view the NHS role in safeguarding children	Annually
4.	The Provider will evidence how the voice of children is heard at Board and clinical level and how this has improved outcomes for children	Annually

The Provider can demonstrate compliance with this standard by:

- Undertaking audits which evidence how the views of young people and their carers are integral to assessments and how this influences the service they receive. The safeguarding children annual report should reflect how young people and parents/carers have been engaged in influencing the improvement of safeguarding services.

- The Provider can evidence that their organisations Board has heard the voice of the child; that case stories and patient reflections have been heard at Board and management level meetings. Improved outcomes for children can be evidenced by the response to those stories and any changes in service that are as a result of complaints, compliments and patient experiences.

APPENDIX 1

Annual Assurance of Compliance with Safeguarding Children Standards

This assessment should be completed and submitted alongside your annual report. The annual report should contain the information to confirm the response to the questions in this audit. The Evidence / Response column should indicate which page in the annual report the information is contained in.

Standard		Audit Question	Evidence/Response
1	Governance	• Does your organisation have a clear statement of their commitment to safeguarding children which is accessible to the public?	
		• Does your organisation have a board level lead for safeguarding children?	
		• Does your organisation have the relevant named professional(s) to provide safeguarding children expertise?	
		• Have you submitted an Annual Report which has been internally scrutinised by the organisation prior to submission to the CCG?	
		• If the LSCB have requested a section 11 audit report from your organisation, has this been submitted and a copy to the CCG	
		• Has your organisation been required to engage in any planning and preparation for any inspection related to safeguarding children? If yes, please give details	
2	Policies, Procedures & Guidelines	• Do you have a Safeguarding Children Policy and associated policies, procedures & guidelines? • Do you have a Domestic Violence Policy? • Do you have a Child Sexual Exploitation Policy and/or link to LSCB strategy and protocol in the Safeguarding Children Policy.? • ? • Do you have a Female Genital Mutilation Policy and/or link to LSCB FGM	

Standard		Audit Question	Evidence/Response
		policy/guidance in the Safeguarding Children Policy.? • Do you have a PREVENT policy? or link to LSCB policy • Does your Safeguarding Children Policy link with your Trust's Adult Safeguarding Policy?	
		• How does your organisation document and communicate the safeguarding children policy, related policies; procedures and guidelines to the whole workforce?	

3	Training , Skills & Competencies	• Do you have a Safeguarding Children Training Strategy which includes a training matrix that identifies the safeguarding children training needs for the whole workforce, including induction and training for Board members	
		How do you ensure that your work force are appropriately trained regarding: • Domestic Abuse • Child Sexual Exploitation • Female Genital Mutilation	
		• How many staff do you employ?	
		• How many staff require Level 1 training?	
		• % of staff that are trained to Level 1	
		• How many staff require Level 2 training?	
		• % of staff that are trained to Level 2?	
		• How many staff require Level 3 training?	
		• % of staff that are trained to Level 3	
		• How many staff require Level 3 (advanced) training?	
		• % of staff that are trained to Level 3advanced) (single agency)?	
		•	
		• Who provides the safeguarding children training in your organisation?	
		• What teaching skills and experience do they have?	
		• How is the training evaluated for its effectiveness?	
		• What is the impact of the training on practice and outcomes?	
4	Safeguarding supervision & Reflective Practice	• Do you have a Safeguarding Children Supervision Policy which includes a matrix that identifies the safeguarding children/reflective practice needs for the whole workforce.	
		• How do you evidence that all staff have received or had access to safeguarding children's supervision or the opportunities for reflective practice appropriate to role?	
		• Who provides safeguarding supervision in your organisation?	

		• What skills & experience in providing supervision do they possess?	
5	Multi-Agency Working	• How does the organisation ensure that their staff follow statutory guidance on information sharing?	
		• How does the organisation ensure that their staff are engaged in all stages of the safeguarding child process as appropriate?	
		• How does the organisation ensure that their staff are contributing to the LSCB Early Help strategy?	
		• How does the organisation ensure that their staff include an analysis of the information and how it impacts on the child(ren)'s safety in reports regarding safeguarding children concerns?	
		• How does the organisation ensure that all staff who undertake assessments of children understand the importance of including the 'voice of the child'?	
		• How does the organisation ensure that all staff who undertake assessments of adults recognise the risk those adults may pose to children.	
6	Reporting Serious Incidents (SIs)	• Does the organisation have a process set out in their Safeguarding Children Policy to ensure that any serious incident related to safeguarding children is reported to the CCG?	
7	Engaging in Serious Case Reviews (SCRs)	• Has your organisation been asked to complete any reports (e.g. individual management reviews - IMRs) for a serious case review? If yes, how many?	
		• Have these reports been completed within the CCG/LSCB timeframes? If not, please explain why.	
		• Has progress against subsequent single agency action plans been reported to the CCG & LSCB?	
		• How can the organisation demonstrate that they have engaged with/implemented the multi-agency recommendations from the serious case reviews they have participated in.	
		• How can the organisation demonstrate that they have adopted the learning from serious case reviews they have participated in.	
8	Safe Recruitment & Retention of Staff	• Do you have a Safe Recruitment Policy which also takes into account the work of any volunteers, charity fundraisers or celebrities?	
		• Is the Safe Rcruitment Policy reviewed annually?	
		• Do all job descriptions include a statement on the roles & responsibilities to safeguarding children?	

		If not, please explain why.	
		• Do all relevant staff have a DBS check before work commences (LSCB PI)	
		• Does your organization have a process that ensures two written refences are provided before work commences (LSCB PI)	
		• How do you gain assurance that any contracted services or individuals follow safe recruitment processes?	
9	Managing Safeguarding Children Allegations against Members of Staff	• Does your organisation have a process in place for the management of allegations against staff? If no please explain why not	
		• Does your organisation have both a designated and deputy designated officer to whom allegations should be reported and who will support any investigation?	
		• When the outcome of a DOFA/ LADO strategy discussion is to proceed with an investigation: • Does the organisation report to the CCG, via the serious incident reporting process? If not, please explain why	
10	Engaging Children & Families	• How does the organisation seek engagement from service users, both children and adults?	
		• What impact does this have on practice to improve the outcomes for children and families?	
		• Has the organisation engaged in any multi-agency audit and learning which identifies how service users view health's role in the safeguarding processes? What was the result of this?	
		• How does the organisation ensure that the voice of children is heard at Board and clinical level?	
		• How has this improved outcomes for children?	

APPENDIX 2

Quarterly Performance Indicators for Safeguarding Children Standards 2017-18

No	Standard no and performance indicator	Reporting criteria	Frequency of reporting
1	Standard 3 - (criteria 3,7& 8) The Provider will ensure all staff receive safeguarding children training at a level commensurate with their roles as indicated in the Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014) (the minimum expectation for training compliance is 90% across all level) An action plan must be submitted to address any shortfalls in compliance	The total number of staff requiring training	Quarterly
		The number of staff requiring level 1 training	
		The percentage of staff trained at level 1	
		The number of staff requiring level 2 training	
		The percentage of staff trained at level 2	
		The number of staff requiring level 3 core training	
		The percentage of staff trained at level 3 core	
		Level 3 compliance by service to include number of staff requiring training, staff who have completed training and compliance percentage	
		The number of staff requiring level 4 training	
		The percentage of staff trained at level 4	
		Number of relevant staff who require CSE awareness training	Quarterly
		Number of relevant staff who have undertaken CSE awareness training	Quarterly
		Percentage of relevant staff that have completed CSE awareness training	Quarterly
		Number of relevant staff who require FGM awareness training	Quarterly

No	Standard no and performance indicator	Reporting criteria	Frequency of reporting
		Number of relevant staff who have undertaken FGM awareness training	Quarterly
		Percentage of relevant staff that have completed FGM awareness training	Quarterly
		Number of relevant staff who require DA awareness training	Quarterly
		Number of relevant staff who have undertaken DA awareness training	Quarterly
		Percentage of relevant staff that have completed DA awareness training .	Quarterly
2	Standard 4-(criteria 3) The Provider will ensure all staff have access to safeguarding children supervision or reflective practice commensurate with their roles. The type of supervision staff receive should be linked to the level of competencies required for their role as set out in Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014).	Total number of staff in your organisation requiring scheduled 1:1 supervision	Quarterly
		Percentage of staff requiring 1:1 who have received this in the quarter	Quarterly
		Total number of staff in your organisation requiring scheduled group supervision	Quarterly
		Percentage of staff requiring group supervision who have received this in the quarter	Quarterly
		Number of requests for case consultations made to your safeguarding team, safeguarding supervisors or named professionals. (not including HV SHN and Midwives see below)	Quarterly
		The total number of Health Visitors who should have received 1:1 safeguarding supervision sessions (at a minimum of 3 months)	Quarterly
		The number of Health Visitors who have not received 1:1 safeguarding supervision in past 3 months (& reasons why not)	
		The number of Health Visitors who have not received 1:1 safeguarding supervision in past 6 months (& reasons why not).	
		The total number of School Health Nurses who should have received 1:1 or group safeguarding supervision sessions during this quarter	
		The number of School Health Nurses who have not	

No	Standard no and performance indicator	Reporting criteria	Frequency of reporting
		received safeguarding supervision in past 4 months (& reasons why not)	
		The number of School Health Nurses who have not received safeguarding supervision in past 6 months (& reasons why not)	
		The total number of Sexual Health Staff who should have received 1:1 safeguarding supervision sessions (at a minimum of 3 months)	Quarterly
		The number of Sexual Health Staff who have not received 1:1 safeguarding supervision in past 3 months (& reasons why not)	Quarterly
		The total number of Community Paeditricans who should have received 1:1 safeguarding supervision sessions (at a minimum of 3 months)	Quarterly
		The number of Community Paeditricans who have not received 1:1 safeguarding supervision in past 3 months (& reasons why not)	Quarterly
		The total number of Learning Disabilities Staff who should have received 1:1 safeguarding supervision sessions (at a minimum of 3 months)	Quarterly
		The number of Learning Disabilities Staff who have not received 1:1 safeguarding supervision in past 3 months (& reasons why not)	Quarterly
		The total number of MIU Staff who should have received 1:1 safeguarding supervision sessions (at a minimum of 3 months)	Quarterly
		The number of MIUStaff who have not received 1:1 safeguarding supervision in past 3 months (& reasons why not)	Quarterly
		The total number of PHN Team Mangers who should have received 1:1 safeguarding supervision sessions (at a minimum of 3 months)	Quarterly

No	Standard no and performance indicator	Reporting criteria	Frequency of reporting
		The number of PHN Team Mangers who have not received 1:1 safeguarding supervision in past 3 months (& reasons why not)	Quarterly
		The total number of Lifetime Nurses who should have received 1:1 safeguarding supervision sessions (at a minimum of 3 months)	Quarterly
		The number of Lifetime Nurses who have not received 1:1 safeguarding supervision in past 3 months (& reasons why not)	Quarterly

3			
	Standard 5 – (criteria 4, 6) **Section 5B of the 2003 Act (As inserted by section 74 of the Serious Crime Act 2015), introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. The duty applies from 31 October 2015 onwards.** **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory-Reporting-procedural-info-FINAL.pdf** **The FGM Enhanced Dataset Information Standard (SCCI2026) and the Multi-agency Practice Guidelines require all clinicians across all NHS healthcare settings to record in the clinical notes when a patient with FGM is identified**	Total Number of reported known cases of Female Genital Mutilation (FGM) in under 18's to the Police Total Number of cases recorded	Quarterly

	Standard 5- (criteria 2, 3) The Provider will ensure all staff are aware of the need for multi-agency communication and the sharing of information in order to effectively safeguard children. (criteria 7) The provider must share information about their safeguarding children arrangements to the Local Safeguarding Children Board (LSCB) as requested -The provider can demonstrate that they are identifying potential risks to children from assessments undertaken in Emergency Departments-ED, Minor Injury Unit-MIU, Walk In Centre-WIC, Urgent Care Centre-UCC)	Total number of children (0-18 years) seen in ED, MIU, UCC	
		Total number of referrals to the local children's social care referral process. If you work across several areas please list the number of referrals by Local Authority area	
		Total number of CSE related referrals to the local children's social care	Quarterly
		Number of cases escalated as per LSCB Escalation Policy, specifying level of escalation	Quaterley
		The number of young people attending related to Self-harm "Self-harm (e.g. overdose of medication or substances with the intent to harm, cutting or other forms of self-mutilation, other suicide attempts such as hanging, suffocation, drowning)" (by Local Authority area)	

		The number of young people attending related to Substance use (recreational use of substances without the intent to cause harm or suicide) (by Local Authority area) The number of young people attending related to Alcohol use (recreational use of alcohol without the intent to cause harm or suicide) (by Local Authority area)	
		The number of young people attending related to Sexual assault or sexual activity causing concern (sexual activity under 13 years, rape, sexual assault, sexual exploitation, sexual activity where no consent has been given or if consent has been given but there are concerns re power or age imbalance or coercion) (by Local Authority area) The number of young people attending related to DV	

		Number of new CAF assessments made for unborn children or women who are under 18yrs (please report this information by Local Authority areas)	
		Number of midwifery referrals to the Family Nurse Partnership, by Local Authority area	
	Health visitors (HV) The provider can demonstrate engagement from the Health Visiting service at all stages of the safeguarding children process (please report this information by Local Authority areas)	The number of Children who have a child protection plan and are seen by HV's	Quarterly
		The number of notifications to the GP practice by the HV involved in Strategy discussions/meetings or initial child protection conference , notification to report outcome of Strategy or child protection conference to GP practice within 24 hours.	
		The number of Children receiving a HV service who have a Social Worker because they are under section 17/ Child In Need	
		The number of children receiving	

		Universal Partnership Plus from HV who have a CAF	
		Number of children receiving Universal Partnership Plus from HV without a CAF & the reasons why	
		The number of new CAF's completed by the HV service	
		Number of CAF/TAC where the Health Visitor is the lead professional	
	School Health Nursing (SHN) The provider can demonstrate engagement from the school nursing service at all stages of the safeguarding children process (please report this information by Local Authority areas)	The number of Children who have a Child Protection plan and receive a SHN service	Quarterly
		The number of notifications notifications to the GP practice by the SHN following attendance at a strategy discussion or initial child protection conference , notification to report outcome of strategy or child protection conference to GP practice within 24 hours.	
		The number of Children receiving a SHN services who have a Social Worker because they are under Section 17/	

		Child In Need	
		The number of children receiving Universal Partnership Plus from SHN who have a CAF	
		Number of children receiving Universal Partnership Plus without a CAF and why not	
		The number of new CAF completed by the SHN service	
		The number of CAF/TAC where the School Nurse is the lead professional	
	All other Providers	Number of CAF's completed	Quarterly
4	Standard 6 Reporting Safegaudring Children Serious Incidents & Incidents (Criteria 2 & 3) The Provider will ensure that Serious Incidents will be reported and investigated in line with guidance from NHS England. Providers must ensure that Serious Incidents Requiring Investigation are reported on STEIS within two working days of the organisation identifying the serious incident. All requests or notifications to participate in any Serious Case Review (SCR) must be reported on STEIS and to the Designated Nurse. (this includes incidents that may impact on the organisation's reputation)	The number of Serious Incidents related to safeguarding children reported by Local Authority area Evidence on the progress of any action plan resulting from an investigation into a serious incident related to safeguarding children. Where the adult is the focus of the care the	Quarterly

		provider will need to record the number of cases where the adults behaviour has posed a risk to the child(ren) and there has been a report to children's social care (please report this information by Local Authority areas) The Provider will submit a quarterly safeguarding children incident report. This will cover incidents by numbers/ themes and actions taken as a result of incident	
5	Standard 7 (Criteria 2,3, 4 & 5) The provider will ensure that Serious Case Reviews are undertaken in line with Statutory Guidance 'Working Together to Safeguard Children 2013' and Local Safeguarding Children Board processes	Number of requests from LSCB SCR panel to provide information in order for the panel to make a decision if a case reaches the criteria for a SCR or another type of review – reported by Local Authority Area	Quarterly
		Number of requests to participate in SCRs reported by Local Authority Area	
		Evidence on the progress of any action plan resulting from an SCR related to	

		safeguarding children	
6	Standard 9- (criteria 3 &4) The provider must adhere to statutory guidance in Working Together to Safeguard Children 2015 and the South West Child Protection Procedures. The provider must report any incident where a member of staff has behaved in a way that has or may have harmed a child, acted inappropriately towards a child or committed a criminal offence against or related to a child.	The total number of safeguarding allegations against members of staff which have been reported to the organisations.	Quarterly
		Number of allegations reported to the DOFA/LADO which have led to an investigation following strategy discussion	

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Care Services

Not Applicable

5. SCHEDULE 3 – PAYMENT

A. Local Prices

Redacted
FOIA exemptions: Section 43 (2) andSection 2

SCHEDULE 3 – PAYMENT

B. Local Variations

For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by NHS Improvement (available at: https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

There are no Local Variations

SCHEDULE 3 – PAYMENT

C. Local Modifications

For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by NHS Improvement (available at: https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor). For each Local Modification application granted by NHS Improvement, copy or attach the decision notice published by NHS Improvement. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

There are no local modifications

SCHEDULE 3 – PAYMENT

D. Marginal Rate Emergency Rule: Agreed Baseline Value

Not Applicable

SCHEDULE 3 – PAYMENT

E. Emergency Re-admissions Within 30 Days: Agreed Threshold

Not Applicable

SCHEDULE 3 – PAYMENT

F. Expected Annual Contract Values

Redacted
FOIA exemptions: Section 43 (2) andSection 2

SCHEDULE 3 – PAYMENT

G. Timing and Amounts of Payments in First and/or Final Contract Year

Redacted
FOIA exemptions: Section 43 (2) andSection 2

6. SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

NB Shaded standards are Not Applicable to this contract

Ref	Operational Standards	Threshold	Method of Measurement	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 on Unify)***	***Review of Service Quality Performance Reports***	***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%***	***Review of Service Quality Performance Reports***	***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	Method of Measurement	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%***~~	~~***Review of Service Quality Performance Reports***~~	~~***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%~~	~~Review of Service Quality Performance Reports~~	~~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%~~	~~Review of Service Quality Performance Reports~~	~~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	Method of Measurement	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%~~	~~Review of Service Quality Performance Reports~~	~~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%~~	~~Review of Service Quality Performance Reports~~	~~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%~~	~~Review of Service Quality Performance Reports~~	~~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%~~	~~Review of Service Quality Performance Reports~~	~~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~~	~~Quarterly~~	~~A CR R~~

Ref	Operational Standards	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Application
				threshold		
	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%***	***Review of Service Quality Performance Reports***	***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%	Review of Service Quality Performance Reports	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
	Category A ambulance calls					
E.B.15.i	***Percentage of Category A Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes****	***Operating standard of 75%***	***Review of Service Quality Performance Reports***	***Where, for the Contract Year as a whole, the number of Red 1 calls where the emergency response did not arrive within 8 minutes exceeds the tolerance permitted by the threshold, £300 in respect of each call above that threshold***	***Annual***	***AM***
E.B.15.ii	***Percentage of Category A Red 2 ambulance***	***Operating standard of***	***Review of Service Quality Performance Reports***	***Where, for the Contract Year as a whole, the***	***Annual***	***AM***

Ref	Operational Standards	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Application
	~~***calls resulting in an emergency response arriving within 8 minutes****~~	~~***75%***~~		~~***number of Red 2 calls where the emergency response did not arrive within 8 minutes exceeds the tolerance permitted by the threshold, £100 in respect of each call above that threshold****~~		
~~***E.B.16***~~	~~***Percentage of Category A calls resulting in an ambulance arriving at the scene within 19 minutes****~~	~~***Operating standard of 95%***~~	~~***Review of Service Quality Performance Reports***~~	~~***Where, for the Contract Year as a whole, the number of calls where the response did not arrive within 19 minutes exceeds the tolerance permitted by the threshold, £100 in respect of each call above that threshold****~~	~~***Annual***~~	~~***AM***~~
	Mixed sex accommodation breaches					
E.B.S.1	Mixed sex accommodation breach*	>0	Review of Service Quality Performance Reports	£250 per day per Service User affected	Monthly	A CR 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~~	~~Number of Service Users who are not offered another binding date within 28 days >0~~	~~Review of Service Quality Performance Reports~~	~~Non-payment of costs associated with cancellation and non-payment or reimbursement (as applicable) of re-scheduled episode of care~~	~~Monthly~~	~~A CR~~

Ref	Operational Standards	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Application
	~~and hospital of the Service User's choice*~~					
	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 from psychiatric in-patient care*	Operating standard of 95%	Review of Service Quality Performance Reports	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

In respect of those Operational Standards shown in ***bold italics***, the provisions of SC36.37A apply.

* as further described in *Joint Technical Definitions for Performance and Activity 2017/18-2018/19,* available at: https://www.england.nhs.uk/wp-content/uploads/2015/12/joint-technical-definitions-performance-activity.pdf

** (The Co-ordinating Commissioner has discretion to vary the consequence of breach, in agreement with the Provider, where it is appropriate to do so to take account of the operation of a nationally-approved pilot project.)

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

NB Shaded standards are Not Applicable to this contract

The Prime Provider shall be responsible for ensuring that all services (including those sub-contracted) are delivering efficiently and effectively against stated quality standards. Where elements of services are sub-contracted, or make contributions towards their delivery, to others, the Prime Provider retains overall responsibility for delivery of the services and for the performance of all of the obligations on its part under the contract.

	National Quality Requirement	**Threshold (2017/18)**	**Method of Measurement (2017/18)**	**Consequence of breach**	**Timing of application of consequence**	**Application**
E.A.S.4	Zero tolerance methicillin-resistant *Staphylococcus aureus**	>0	Review of Service Quality Performance Reports	£10,000 in respect of each incidence in the relevant month	Monthly	A
E.A.S.5	Minimise rates of Clostridium difficile*	See Schedule 4F	Review of Service Quality Performance Reports	As set out in Schedule 4G, in accordance with applicable Guidance	Annual	A
E.B.S.4	***Zero tolerance RTT waits over 52 weeks for incomplete pathways****	***>0***	***Review of Service Quality Performance Reports***	***£5,000 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***~~	~~***Review of Service Quality Performance Reports***~~	~~***£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***~~	~~***Review of Service Quality Performance Reports***~~	~~***£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***~~

~~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~~	~~Review of Service Quality Performance Reports~~	~~£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~~	~~Review of Service Quality Performance Reports~~	~~£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~~	~~Trolley waits in A&E not longer than 12 hours*~~	~~>0~~	~~Review of Service Quality Performance Reports~~	~~£1,000 per incidence in the relevant month~~	~~Monthly~~	~~A+E~~
E.B.S.6						
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	95%	Review of Service Quality Performance Reports	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	A
	Duty of candour	Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident in accordance with Regulation 20 of the 2014 Regulations	Review of Service Quality Performance Reports	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	Monthly	All
	~~Completion of a valid NHS Number field in mental health and acute~~	~~99%~~	~~Review of Service Quality Performance Reports~~	~~Where the number of breaches in the month exceeds the tolerance~~	~~Monthly~~	~~A MH MHSS~~

	~~commissioning data sets submitted via SUS, as defined in Contract Technical Guidance~~			~~permitted by the threshold, £10 in respect of each excess breach above that threshold~~		
	~~Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance~~	~~95%~~	~~Review of Service Quality Performance Reports~~	~~Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold~~	~~Monthly~~	~~A&E~~
	**Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Operating standard of 90%	Review of Service Quality Performance Reports	Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold	Monthly	MH MHSS
	**Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	Operating standard of 90%	Review of Service Quality Performance Reports	Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold	Monthly	MH MHSS
E.H.4	**Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	Operating standard of 50%	Review of Service Quality Performance Reports	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	MH MHSS
E.H.1	**Improving Access to Psychological Therapies (IAPT) programmes: the	Operating standard of 75%	Review of Service Quality Performance Reports	Issue of Contract Performance Notice and subsequent process in	Quarterly	MH MHSS

	percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral			accordance with GC9		
E.H.2	**Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	Operating standard of 95%	Review of Service Quality Performance Reports	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	MH MHSS
	~~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 and young adults) across all tumour sites~~	~~Failure to produce a robust implementation plan, by 30 June 2016, to achieve full implementation as described under Service Specification B15/S/a Cancer: Chemotherapy (Adult) by 31 March 2017~~	~~Review of Service Quality Performance Reports~~	~~5% of the Actual Monthly Value for the Services provided under Service Specification B15/S/a (Cancer: Chemotherapy (Adult) per month, until a robust implementation plan is produced~~	~~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 produce a robust implementation plan, by 30 September 2016 to achieve full implementation as described under Service Specification B15/S/b Cancer:~~	~~Review of Service Quality Performance Reports~~	~~5% of the Actual Monthly Value for the Services provided under Service Specification B15/S/b Cancer: Chemotherapy (Children, Teenagers and Young Adults) per month, until a robust implementation plan is produced~~	~~Monthly~~	~~Where both Specialised Services and Cancer apply~~

		~~Chemotherapy (Children, Teenagers and Young Adults) by 30 September 2017~~				

National Quality – Social Care

	National Quality Requirement	**Threshold (2017/18)**	**Method of Measurement (2017/18)**	**Consequence of breach**	**Timing of application of consequence**	**Application**
ASCOF Domain 1	Enhancing quality of life for people with care and support needs	**19 (Not a %, maximum score possible is 24)**	1A Social care-related quality of life	Performance management action plan monitoring	**Annual adult social care survey**	
		78%	1B Proportion of people who use services who have control over their daily life	Performance management action plan monitoring	**Annual adult social care survey**	
		90%	1 C (1) Proportion of people using social care who receive self-directed support	Performance management action plan monitoring	**From SALT submission**	**Monthly**
		35%	1 C (2) Proportion of people using social care who receive direct payments	Performance management action plan monitoring	**From SALT submission**	**Monthly**
		90%	1 C (1a) Proportion of people using social care receiving self-directed support	Performance management action plan monitoring	**From SALT submission**	**Monthly**

		100%	1 C (1b) Proportion of carers receiving self-directed support	Performance management action plan monitoring	**From SALT submission**	**Monthly**
		35%	1 C (2a) Proportion of people using social care receiving direct payments	Performance management action plan monitoring	**From SALT submission**	**Monthly**
		100%	1 C (2b) Proportion of carers receiving direct payments for support direct to carer	Performance management action plan monitoring	**From SALT submission**	**Monthly**
		8 (Not a %, maximum score possible is 12)	1 D Carer-reported quality of life	Performance management action plan monitoring	**Biennial carers survey**	
		10%	1 E Proportion of adults with a learning disability in paid employment	Performance management action plan monitoring	**SALT submission**	**Monthly**
		15%	1 F Proportion of adults in contact with secondary mental health services in paid employment	Performance management action plan monitoring		**Monthly**
		70%	1 G Proportion of adults with a learning disability who live in their own home or with their family	Performance management action plan monitoring	**SALT submission**	**Monthly**
		70%	1 H Proportion of adults in contact with secondary mental health services who live independently, with or without support	Performance management action plan monitoring		**Monthly**

		47%	1 I (1) Proportion of people who use services who reported that they have as much social contact as they would like	Performance management action plan monitoring	**Annual adult social care survey**	
		48%	1 I (2) Proportion of carers who reported that they have as much social contact as they would like	Performance management action plan monitoring	**Biennial carers survey**	
ASCOF Domain 2	Delaying and reducing the needs for care and support	**10**	2 A (1) Permanent admissions to residential and nursing care homes for younger adults (per 100,000 population)	Performance management action plan monitoring	**SALT submission**	**Monthly**
		685	2 A (2) Permanent admissions to residential and nursing care homes for older adults (per 100,000 population)	Performance management action plan monitoring	**SALT submission**	**Monthly**
		10	2 A (1) 2015-16 Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population	Performance management action plan monitoring	**SALT submission**	**Monthly**

		685	2 A (2) 2015-16 Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Performance management action plan monitoring	**SALT submission**	**Monthly**
		85%	2 B (1) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) (%)	Performance management action plan monitoring	**SALT submission**	**Monthly**
		5%	2 B (2) Proportion of older people (65 and over) who were offered reablement services following discharge from hospital (%)	Performance management action plan monitoring	**SALT submission**	**Monthly**
		10	2 C (1) Delayed transfers of care from hospital (per 100,000 population)	Performance management action plan monitoring		**Monthly**
		5	2 C (2) Delayed transfers of care from hospital, and those which are attributable to adult social care (per 100,000 population)	Performance management action plan monitoring		**Monthly**

		75%	2 D Proportion of those that received short-term service during the year where sequel was either no ongoing support or support of a lower level (%)	Performance management action plan monitoring	**SALT submission**	**Monthly**
ASCOF Domain 3	Ensuring that people have a positive experience of care and support	**67%**	3 A Overall satisfaction of people who use services with their care and support (%)	Performance management action plan monitoring	**Annual adult social care survey**	
		46%	3 B Overall satisfaction of carers with social services (%)	Performance management action plan monitoring	**Biennial carers survey**	
		75%	3 C Proportion of carers who report that they have been included or consulted in discussion about the person they care for (%)	Performance management action plan monitoring	**Biennial carers survey**	
			3 D Proportion of people who use services and carers who find it easy to find information about services (%)	Performance management action plan monitoring	**Social care and carers surveys**	
		77%	3 D (1) Proportion of people who use services who find it easy to find information about services (%)	Performance management action plan monitoring	**Annual adult social care survey**	

		75%	3 D (2) Proportion of carers who find it easy to find information about services (%)	Performance management action plan monitoring	**Biennial carers survey**	
ASCOF Domain 4	Safeguarding people whose circumstances make them vulnerable and protecting them from avoidable harm	**72%**	4 A Proportion of people who use services who feel safe (%)		**Annual adult social care survey**	
		85%	4 B Proportion of people who use services who say that those services have made them feel safe and secure (%)		**Annual adult social care survey**	

In respect of the National Quality Requirements shown in ***bold italics*** the provisions of SC36.37A apply.

*****(as further described in *Technical Guidance for Commissioners,* available at https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/)

** Reporting in respect of Mental Health will only become applicable once it falls within the remit of the Prime Provider

In respect of the National Quality Requirements shown in ***bold italics*** the provisions of SC36.37A apply.

***** as further described in *Joint Technical Definitions for Performance and Activity 2017/18-2018/19,* available at: https://www.england.nhs.uk/wp-content/uploads/2015/12/joint-technical-definitions-performance-activity.pdf

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Outcomes Based Commissioning

In Bath and North East Somerset, local authority and CCG commissioners are planning to use an Outcome Based Accountability (OBA) approach to plan and measure the performance of community health and social care services This is a disciplined and practical framework for improving outcomes for whole populations, and also for measuring the performance of services which focuses on outcomes that the services are intended to achieve.

The system incentivises interventions that add most value for individuals, shifting resources to community services, a focus on keeping people healthy and in their own homes, and co-ordinated care and support across settings and regions. It also encourages a focus on the experience of people using the services, and achieving the outcomes that matter to them through more integrated and person-centred services.

The advantage of this approach is that it uses a clear and common language, which will help us work together as commissioners and providers on improving outcomes. A Copy of the OBA framework can be found in Schedule 6B – Appendix 2

Other Quality Requirements

This schedule sets out current arrangements and it is expected that the Provider will work with Commissioners to further develop criteria to ensure requirements sufficiently covered.

All quarterly reports including Adult and Children's Safeguarding are due as follows:

Reporting Period		Report received by Commissioners by	Due Date for contract meeting
Quarter 1	April - June	1st week of August	August 2017
Quarter 2	July - September	1st week of November	November 2017
Quarter 3	October - December	1st week of February	February 2018
Quarter 4	January - March	1st week of May	May 2018

All papers to be sent to the DSCRO box in time for the contract meeting– CSCSU.dscro-box@nhs.net and providing there is no patient / service user identifiable information please also copy to the named Quality Lead at BaNES CCG and the Quality Lead at the Local Authority all identifiable information needs to be sent through to Safeguarding.adults@bathnes.gcsx.gov.uk
Note there may be some exceptions to the above however where these occur it is set out in the table.

For adults and Children's Safeguarding Annual reporting requirements are set out below: :

All Providers

Reporting Period		
Annual Report	April – March	1st week of August
Annual Audit	April – March	1st week of August

Domain 1: Preventing people from dying prematurely			
Quality Requirement	**Threshold**	**Method of Measurement**	**Consequence of breach**
Infection, prevention and control Patients will have reduced risks of infection. This will be achieved by the Provider demonstrating effective infection prevention and control practices.	No penalty applied unless the in-year cumulative target is reached. If there is a breach of cumulative monthly limits the provider will be requested to provide a reduction plan and attend a monthly teleconference until commissioners have adequate assurance.	Monthly infection, prevention and control monitoring information via the quarterly Quality Performance Scorecard to include: • MRSA Bacteremia • Clostridium Difficile • MSSA (Norovirus- reported as bed days lost • Carbapenemase Producing Enterobacteriaceae – By exception • TB – By exception • Ebola – By exception • Results of audits e.g. hand hygiene 6 month and End of Year DIPC Reports to include information on: • Evidence of completed actions, lessons learnt and embedding organisation learning • Providers are expected to demonstrate involvement in post infection reviews as necessary • The Annual Infection, control and prevention Report to include all information from Q reports plus	Subject to General Condition 9.4 (*Contract M anagement)*

	MRSA Bacteremia Target for 2016-17 = 0 C-Diff Target for 2016-17 = 4.	assurance that the provider complies with the criterion set out in the health and social care act 2008. • Provider to report via monthly quality scorecard. RCA on all deaths attributed to C Difficle part 1 or 2 on the death certificate. • The provider will comply with Schedule 4 Part G Clostridium Difficile.	
Reducing Antimicrobial resistance **Compliance with PHE Start Smart (2013) and Focus Antimicrobial Stewardship Toolkit for English Hospitals (latest edition to be used).**	Not applicable	https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus Linking to NPSA alert, a working group will be set up to continue to utilize the tools available. Report activities in place against all guidance categories, providing evidence of activity (for example number of meetings held, membership, guidelines used, audits done, E&T provided) Report 6 monthly. Currently these include: • Evidence of reducing antimicrobial resistance within the medicines management work programme • Evidence-based antimicrobial prescribing guidelines • Quality Assurance Measures/Audits • Education and Training	Subject to General Condition 9.4 (Contract Management)
Optimising the use of Medicines TDA Planning Guidance extract Context: All Providers should have a proactive approach to optimising the use of medicines to support high quality care.	Not applicable	The Provider has a named Executive Director with Provider-wide responsibility for medicines optimisation. There is a medicines optimisation strategy to deliver better patient outcomes based on the Royal Pharmaceutical Society “Standards for Hospital Pharmacy” and NICE clinical guideline for medicines optimisation. The Provider has a development plan informed by completion of tools such as the NTDA medicines optimisation framework. 6 monthly formulary compliance to be monitored by Medicines Management Group as part of the medicines	Subject to General Condition 9.4 (*Contract Management)*

		optimisation strategy (report to be provided to CQRM). Report on progress on a 6 monthly basis. Examples of audits in six monthly reports.	
Deteriorating patients will be effectively managed by the provider The Provider will do this by providing evidence use of the national Patient Early Warning system or alternative and use this throughout the patient episode of care	95% of inpatients 16 and above (exception in pregnancy) should have evidence of use of the NEWS within 1 hour of admission and evidence that actions are taken as required to prevent avoidable deterioration in the patient's condition.	• The provider will carry out an audit on an agreed number of 20 patients at least twice in the year (September and January) • Physiological observations should be recorded at the time of admission or initial assessment • NEWS should be monitored at least every four hours after admission to hospital unless a decision is made and documented at a senior level to decrease the frequency of to for an individual patient. We would like to work with the commissioner to develop sensitive and selective approach to this requirement based on clinical expertise. • Any patient whose NEWS score triggers action should be screened for sepsis and delirium. • Annual report to include training, compliance, audit results and evidence of learning.	Subject to General Condition 9.4 (Contract Management).
Sepsis Early recognition and management		Provider to ensure a continued focus on the early recognition and management of sepsis (adults only). To ensure: • Established local protocol in place defining which patients require screening, the screening tool, Early Warning Score (EWS) and Sepsis Six Pathway • Screening of all patients for whom sepsis screening is appropriate as per agreed pathway, • 95% of patients admitted to community inpatient facilities will be screened for sepsis on admission • 100% of patients identified as having sepsis referred from inpatient settings to acute hospitals as per agreed internal pathway. • Adherence to best practice contained within the NICE Guidance: Sepsis: the recognition, diagnosis and management of severe sepsis (due for publication July 2016) (if applicable to Community Providers) • Evidence of local sepsis protocol (and regular review of this)	Subject to General Condition 9.4 (Contract Management).

		• Evidence of audit activity pertaining to patients who met local protocol criteria and required sepsis screening • Evidence of measures undertaken to ensure adherence to NICE Guidance. • Six monthly reporting to Commissioners incorporated into the Infection Control DIPC Report.	
Nutrition and hydration All patients have access to adequate nutritional and hydration.	90% of all inpatients screened within 24 hours of admission to hospital.	• As per national guidance the provider will develop a food and drink strategy in accordance with the Hospital Food Standards SC19 in NHS Contract. This must be presented to commissioners by the end of Q3. • Monthly report of % of inpatients screened within 24 hours of admission to hospital – add measures for community from Q2 via Quality Performance Scorecard. • Annual report of % of staff trained to use a validated nutritional screening tool.eg Malnutrition Universal Screening Tool (MUST) • Annual audit 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 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. Monthly reporting on scorecard on school nursing contacts available for height and weight, (including weight under and over) and weight advice.	Subject to General Condition 9.4 (Contract Management).
Making every contact count (MECC) April 2016 The implementation of the approach should encompass the following core	N/A	Provider to agree implementation plan with Commissioners including trajectories, in line with published guidance by end of Q2. Annual report including evidence of actions taken and outcomes using the MECC evaluation tool.	Subject to General Condition 9 (Contract Management)

components: • Organizational readiness: provision of leadership, support for lifestyle improvement for staff and service users • Staff readiness: engaging staff with implementation and embedding within practice, building expertise of service delivery, staff should be competent and confident to support service users when opportunities arise • Enabling and empowering service users/carers: support to engage with and/or ask about health and wellbeing choices and accessibility to use information to support opportunities for self care			

To embed MECC into relevant policies and procedures: • Organizational vision and strategy • Corporate plans and strategies • Patient and public involvement plans HR process – job descriptions, appraisal process, recruitment and retention process, staff surveys			
Care Programmed Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	Operating standard of 95%	Review of quarterly Service Quality Performance Reports	Where the number of breaches in the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each excess breach above that threshold (Trust level)

Domain 2: Enhancing quality of life for people with long term conditions			
Quality Requirement	**Threshold**	**Method of Measurement**	**Consequence of breach**

NICE Guidance Patients will access care and treatment that has been recommended by NICE guidance. The provider will assure the commissioner that appropriate processes and mechanism are in place to implement NICE guidance and stop using guidance.	The Provider will assess all guidance within 3 months for relevance and action plans will be developed to address areas of non-compliance. Any non-compliance or partial compliance to be agreed with commissioner.	• Quarterly report on the implementation of NICE to include any exceptions to implementation and flag any on the providers risk registers. If business cases have been presented then these must be listed for information. • The provider must complete 3 audits of NICE Guidance per year. The commissioners would like the provider to focus on the following audits (provider to agree any variation with the Commissioners in Q1) • Diabetes quality standard 6 and to specifically audit standard 13 and 15 for Type Diabetes, Continence Quality standards, • The audits are to be provided to the commissioners by the end of Q3. • The provider will agree compliance with the CCG Policy Statement on NICE Guidance and agree to its requirements	Subject to General Condition 9.4 (Contract Management).
Quality Premium 2016/17 Provider to work collaboratively with the Commissioner to deliver Quality Premium for 16/17.	Not applicable	• Quarterly assurance report to be submitted with regards to activities undertaken to support the Commissioner in pursuit of Quality Premium(s) as required.	
Ensure that all children (15+) who are Continuing Care or patients of Lifetime have a Hospital Passport**,** which will have a concise summary on the front page. Then work with parents to make sure they have ownership of the document.	100% of appropriate children.	6 month reporting via Quality Scorecard to Clinical Quality Review Group.	Subject to General Condition 9.4 (Contract Management).
Care Programme Approach (CPA)	95% of CPAs should have a record of the mental health worker who is responsible for their care	Numerator: Number of patients with a record of mental health worker responsible for care Denominator: Number of patients on CPA Monthly	Subject to General Condition 9 (Contract Management)

CPA Review % of those on CPA reviewed	95%	Review of monthly report	Subject to General Condition 9 (Contract Management)
% Annual review for non-CPA service users	95%	Review of monthly report	Subject to General Condition 9 (Contract Management)
Assessment of Risk % of all patients on CPA to have a documented risk assessment	95% of all patients have a documented risk assessment	Numerator: Number of patients with documented risk assessment Denominator: Number of patients on CPA Review of monthly report	Subject to General Condition 9 (Contract Management)
% of all patients who have a Crisis and Contingency Plan	95% of service users have a plan	Numerator: Number of patients with documented crisis contingency plan Review of monthly report	Subject to General Condition 9 (Contract Management)
Mental Health Services Provider to demonstrate patient's recovery outcomes as a result of validated recovery measurement tools.	Receipt of report	Multi-lateral contract - Provider/Commissioners to agree universal recovery measures most appropriate for each condition/service by end Q1. Bi-annual report in September and January	Subject to General Condition 9 (Contract Management)

Domain 3: Helping people to recover from episodes of ill health or following injury			
Quality Requirement	**Threshold**	**Method of Measurement**	**Consequence of breach**
Stroke Patients Ensure the Early Supported Discharge Team is ready and has the capacity to maintain at least 50% of patients who meet the criteria for ESD out of the RUH within 7 days.	50%	Monthly reporting via Quality Scorecard to Clinical Quality Review Group.	Subject to General Condition 9.4 (Contract Management).
Maintain Saturday and Sunday discharge rate to 2012-13 outturn CQUIN 12-13	2012-13 weekend discharge rate.	Monthly reporting via Quality Scorecard to Clinical Quality Review Group.	Subject to General Condition 9.4 (Contract Management).
To maintain length of stay for patients who have had a stroke or fractured neck of femur to 2012-13 outturn CQUIN 12-13	2012-13 LOS for patients who have had stroke or fractured neck of femur.	Monthly reporting via Quality Scorecard to Clinical Quality Review Group.	Subject to General Condition 9.4 (Contract Management).
To ensure patients with dementia receive appropriate care for basic health needs	95% All inpatients with dementia will receive a physical health assessment and be screened using the MUST nutrition screening tool on admission with appropriate care planned in accordance with identified risk and carer involvement where appropriate	Quarterly audit of random 10% records Quarterly update and bi annual audit	Subject to General Condition 9 (Contract Management)
*Implementation of national standards on reducing underlying levels of usage of anti-psychotics for people with dementia, to ensure	100% for those with a diagnosis of dementia who are prescribed anti-psychotics receiving an annual	Providers will ensure that anti-psychotic prescribing is regularly reviewed , ensuring that prescribing only happens in line with (1) 'Call to action' and the Royal college of Psychiatrists guidance (2) patient best practice as defined by	Subject to General Condition 9 (Contract Management)

appropriate prescribing and better clinical care.	review as a minimum	standards from national users groups such as those for Alzheimer's and dementia who are part of the national work with DH The trust will work in line with national policies to reduce the inappropriate prescribing of antipsychotics.	

Domain 4: Ensuring that people have a positive experience of care			
Quality Requirement	**Threshold**	**Method of Measurement**	**Consequence of breach**
Discharge: The Provider will meet all expected standards for discharge and transfer of patients Provider to complete audits of Discharge Summaries based on the standards set out in in the transfer/ discharge schedule of the contract K.	Continuous improvements of audit results with minimum threshold of: a) 95% compliance of data completeness b) 95% data timeliness received within 24 hours	The Provider will complete audits of Discharge Summaries based on the standards set out in in the transfer/ discharge schedule of the contract K.(Sample is a minimum of 50 records).	If the 95% threshold is not met at the biannual audits in Q2 and Q4 with regards data timeliness (point b) a contract query will be issued to the Trust in line with General Condition 9.4 (Contract Management).
Clinical Audit: The Provider will have processes for clinical audit and will demonstrate implementation of actions arising from the audit (including audits as detailed by the Clinical Networks and the Clinical Outcome audit requirements as set out in this Schedule).	Annual Clinical audit process and plan in place. Contribute at least the minimum data set for national audits.	• The Provider will undertake 1 audit of Commissioner choice, the Commissioner will inform which audit it will be at the end of quarter 3. • Annual Audit Report at end of Q4, to include examples of learning that has taken place following the clinical audits, and examples of changes implemented as a result. • Sample of (numbers TBC in Q1)4Audit methodology to be agreed with the provider and Commissioner in Q1.	Subject to General Condition 9.4 (Contract Management).

The Commissioner welcomes audits in relation to the CCG/ Councils strategic goals.			
Case file audit: The provider will have processes in place to support the Commissioner to undertake care case file audits for health and social care. The audits will consider quality of practice on cases.	Minimum 10% for social cases file audit. Minimum of 20% for CHC complex and fast track.	• The provider will ensure that records are kept up to date and will make staff available to facilitate the commissioner's requirement to undertake a 10% case file audit. This may include talking directory with staff. The audit will either be generic or themed • Annual audit report at end of Q4 to include examples of learning that has taken place following the audits, and examples of changes implemented as a result. • The 10% and 20% audit will be on cases which required a Care Act or CHC assessment (service user and carer) below the threshold for single panel submissions. • A 10% audit of cases which came to single panel or equivalent.	

Domain 4: Ensuring that people have a positive experience of care			
Quality Requirement	**Threshold**	**Method of Measurement**	**Consequence of breach**
Case File Audits (service users and carers records. (commissioner led)	10% Audit	• The provider is required to respond to the recommendations within the report within 1 month of receipt of the audit report	

Delivering Same Sex Accommodation and facilities. Inpatients will have their dignity respected at all times Men and women should not normally have to share sleeping accommodation or toilet facilities. Irrespective of where patients are, staff should always take the utmost care to respect their privacy and dignity. In addition patients should not need to pass through opposite sex accommodation or toilet and washing facilitates to access their own Privacy and Dignity The elimination of mixed sex accommodation Good Practice Guidance and Self-Assessment Checklist	100% compliance of delivery against agreed DSSA plan. Zero non- clinically justified mixed sex occurrence of sleeping accommodation.	• Report by exception monthly the total number of mixed sex occurrences in line with National policy for sleeping accommodation and Provider & Commissioner agreed clinical justifications framework. • Report by exception Monthly the Number of non-clinically justified mixed sex occurrences of sleeping accommodation (e.g. breaches). • The Commissioner reserves the right to review a reasonable proportion of reported clinically justified mixed sex occurrences in year. • The provider will confirm any bathroom breaches, where they occur distinct from sleeping accommodation breaches, to the commissioner on an exceptions basis and in line with DH Guidance.	The provider and commissioners to agree the clinical justification framework. The Co-ordinating Commissioner may, at its discretion, recover the sum of £250 per patient per breach per day of non-clinically justified sleeping accommodation.
PLACE Annual PLACE (patient led assessment of care environment) score or equivalent. This is applicable to hospitals, hospices, day treatment centres providing NHS Funded care See NHS England Website for assessment forms and supporting guidance.	Not applicable	Annual Report to be provided to the commissioner in the Quarter following the assessment with any relevant planned actions	Subject to General Condition 9.4 (Contract Management).

Patient/ service user Experience The Provider will implement a range of quantitative, qualitative methodologies to capture, understand, improve and measure patient/ service user experience. This will meet the diversity of the population including those with special communication needs.	Evidence of using consistent and effective patient/ service user experience monitoring to improve and design services.	The Provider will report on patient/ service user experience on a quarterly basis to include • Friends and Family Test, including improvement examples of 'you said, we did' • 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 as per Assurance of Good complaints handling for acute and Community Care – A toolkit for Commissioners • service improvements • A minimum of four patient/ service user stories which have resulted in a change to service delivery or quality to be shared with the Commissioner. Evidence of how patient/ service user forums fed into the board and inform decision making e.g. quality impact assessments. These stories will relate to service provided by the Prime. All other services will be required to provide a minimum of 1 patient/ service user story per year. • Case examples to illustrate good practice identified in line with the national key areas where patients report higher poorer experiences (NHS Toolkit) • Reports from patient/ service user focus groups if relevant • Evidence of engagement with people with LD, sensory or physical disability • Evidence of engagement with Children and Young People • Report on environmental audits such as 'You're Welcome' DoH, 2011 for children and young people. • Executive walkabouts • Links to health watch Evidence of how the carers survey results feed into service improvements / changes • Evidence of how the adult social care survey results feed into service improvements / changes • Evidence of how learning from complaints feeds into	Subject to General Condition 9.4 (Contract Management).

		service improvements / change The provider will meet the requirements of schedule 6 part E - Surveys and report these to the quality group as stated. For Q4 the Report will be an Annual Report and can also include executive walkabouts, and any other patient/ service user and carer feedback. In Q1 the provider will share their Service User Engagement Strategy with the commissioner The provider will publish the results of local patient surveys.	
Complaints Patients / Service users will have their complaint dealt with as quickly and sensitively as possible The Provider will comply with NHS complaints Section 17 and18 of the Local Authority social Services & National. Health Services Complaints (England) Regulations 2009 and will implement any new standards. The NHS and Local Authority are as outlined in page 3 the 'responsible body'	The Provider will comply with its complaints policy and shall ensure that it is fully compliant with National Standards and guidance.	• Quarterly number of complaints/PALS enquiries by category, themes, outcome and the number referred onto Ombudsman and quarterly number upheld by Ombudsman. The report will include evidence of service improvement as a result of complaints and feedback. • Acknowledgement of complaints within 3 working days and resolution within the agreed deadline with the complainant. • Timescale agreed with complainant falls below 90% (unless previously agreed with commissioner to accommodate service issues). • Annual satisfaction survey of users of the complaints process (in annual customer care report). • As outlined in the Francis Report, commissioners should be able to access all complaints information as and when the complaints are made and should receive complaints and their outcome on as near to real time basis as possible. • The Commissioners will liaise with the provider to agree process for complaints review this will be carried out on an annual basis. • Evidence of implemented accessible complaints policy	Subject to General Condition 9.4 (Contract Management).

Complaints (Local Authority) . The Provider will comply with National Health Services Complaints (England) Regulations 2009 and with the local arrangement with the Local Authority on complaints in relation to delegated statutory functions for adult care.	The Provider will comply with its complaints policy and shall ensure that it is fully compliant with National good practice guidance. The Provider will also comply with the local arrangement. Number of complaints not responded to within 30 working days	The Provider will comply with the local arrangement as per the Complaints Assurance Framework Provider to work with commissioners and to respond to Commissioner requests for a complaint investigation within 30 working days. Responses for commissioner-led complaints to be sent to the commissioner rather than directly to the complainant.	
Improving Outcomes for people with Learning Difficulties CQUIN 12-13	Not applicable.	To continue to develop Health Action Plans for people with LD who have had a Health Check and a Well Persons Check for those who have not had a Health Check and to continue monitoring outcomes from the action plans. Quarterly reporting to the LD Commissioner.	Subject to General Condition 9.4 (Contract Management).
Maintaining the timeliness and quality of the CHC/FNC assessment	1. All application for NHS funded continuing healthcare to be fully completed and submitted within 28 days of initial checklist 2. All reviews for CHC are carried out at agreed timescales. All reviews for funded nursing care are carried out at agreed	Monthly via quality scorecard.	Subject to General Condition 9.4 (Contract Management).

	timescales.		
Maintain the timeliness and quality of Care Act assessments	90%	Monthly via quality scorecard	
Maintain the timeliness and quality of Care Package delivery	95%	Monthly via quality scorecard	
Maintain the timeliness of reviews	80%	Monthly via quality scorecard	
Productive Tools Application of NHS Institute Productive tools to identify opportunities for maximising quality and efficiency of experience		1. Continue to deliver the foundation modules of the NHS Institute Productive tools for the ward: • Well organised working environment • Knowing how we are doing • Patient status at a glance. 2. Quarterly progress reports against the three foundation modules in the programme • Annual report to evidence successful maintenance of the three Foundation Modules	
Workforce The provider will demonstrate that it has a healthy, caring and competent workforce. Provider to take forward the national guidance How to Ensure the Right People, with the Right Skills, Are in the Right Place at the Right Time: guidance on developing social care workforce; ensuring social care leadership is in place and ensuring the Principal Social Worker leads in accordance with the Care Act guidance and national body. Ensure HCPC	Not applicable for health as provider will set own thresholds. Social care staff are legally literate and deliver requirements of Care Act, Children and Families Act, MCA, MHA and HRA (this is not an exhaustive list	• The provider will report on a Q basis against the following indicators • Have staff recruitment and retention strategies in place, (effectiveness to be regularly reviewed) • Have systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning • Staff sickness absence against provider target (specify target). • Vacancy Rates for social care/ nursing staff/ number of open posts at the end of the quarter. • Vacancy Rates for medical staff/ number of open posts at the end of the quarter. • Vacancy Rates for other relevant professional staff/ number of open posts at the end of the quarter. • Feedback from annual staff survey • % of new front line staff having had DBS • Percentage of agency staff (agency spend as a percentage of total pay bill)	Subject to General Condition 9.4 (Contract Management).

standards are monitored and achieved Ensuring adequate numbers of nursing staff for each ward and department for all shifts across 7 days		• Mandatory Education and Training: reporting of the % of mandatory training completed • Annual training and learning report for statutory prime functions (Social care, CHC, children's health) • The report will include details of the details of the different types of training / learning and professional development social and health care staff undertaking statutory functions. Details on supervision and management oversight of practice. Any audits undertaken in year; details from annual staff satisfaction survey. In addition the report will include performance against the LSCB and LSAB training requirements and any additions included in the safeguarding schedules. • Disciplinary/fitness to practice issues: reporting of the number of staff under a formal performance management process • Professional registration: reporting of the number of staff who have failed to maintain registration. • PDP's, appraisals and KSF: reporting the % of staff who have a PDP and received an appraisal. • Induction attendance rates (as percentage of new starters). • Staff FFT results and action plan (unless this is included in another report). • The provider to share Whistle Blowing policy and anonymised summary of any concerns raised. • All reports to be split report by staff who work with under 18 and staff working with over 18 (*request from children's commissioners*) or to provide a children's services sub section report if more appropriate for the provider • Confirmation provided that all new starters' pre-employment checks were completed in accordance with NHS guidelines. Audit on request by commissioner as appropriate. • Staffing numbers to be reported as recommended by Francis, recommendation no 205, as applied to a mental health inpatient setting. The Provider will ensure that each patient has a named nurse on each	

		shift. • Once level has been agreed, each ward and department will publish and publically display their staffing levels of qualified and unqualified staff • Summary report of activities/ policies that positively promote the health of staff.	
Governance Assurance		The provider will meet the governance arrangements for the Prime as agreed with the Commissioners. The provider will agree a governance framework (to include clinical, professional, supervisory, corporate, information, research) with the Commissioners each year at end of Q3 for the following contractual year.	
To increase awareness of carers of people who use mental health services, to build relationships with them and to offer information and support.	95% of service users are asked if they have a carer, or person they rely on for support. Carers are offered a carers assessment	All service users to be asked if they have an identified carer and for this to be recorded on their electronic record. All carers to be referred for assessment in line with Triangle of Care approach. Triangle of care self-assessments and action plans to be shared with Commissioners locally. • Via quality sub group/CQPM and locality meetings	Subject to General Condition 9 (Contract Management)
NHS Constitution Demonstrate that the provider meet the public pledges in the NHS Constitution.	Not applicable	• Provide annual report on previous year to the Commissioner by the end of Quarter 1.	Subject to General Condition 9.4 (Contract Management).

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Quality Requirement	**Threshold**	**Method of Measurement**	**Consequence of breach**
End of life care The provider will have robust processes in place as per NICE Guidance (NG31) to meet the needs of patients at the end of life.	Not applicable	Six monthly reporting to the Commissioner to include measurable outcomes relating to: • Quality of End of Life Care • Care in the last days and hours • Choice • Advance directives • Involvement of Carers	Subject to General Condition 9.4 (*Contract Management)*
Learning from Incidents The provider will have a process for reporting, managing and learning from all patient safety incidents and have clear systems are in place to ensure all untoward clinical incidents/near misses/ riddor incidents are reported and acted upon appropriately. The report must specifically include falls, medication errors. **Blood transfusions** Provider to report on Transfusion Hazards including, Serious Hazards of Transfusion (SHOT) reporting, blood transfusions, number and complications.	The Provider will actively demonstrate that there is a learning culture	The Provider will submit a quarterly incident report in Q1, Q2 and Q3. This will cover incidents by numbers/ themes/ actions taken as a result of the incidents. Provider will also provide monthly: • Number of Medication errors – with harm • Number of Medication errors – No harm In Q4, the Provider will submit an annual incident report. All clinical, non-clinical and near-miss incidents relating to the transfusion process, including collection, delivery and receipt of the blood must be reported via the incident system. Reporting will be included in the quarterly incident reports.	Subject to General Condition 9.4 (Contract Management).
Quality Accounts Provider to show progress in improving the quality of care in the quality priorities as agreed with the commissioner for the year.	Not applicable	Quality priorities for 2017/18 to be agreed with commissioner before publication of Quality account in 2016-17. Provider to submit 6 monthly update of progress against the quality priorities at Q2 and Q4.	Subject to General Condition 9.4 (Contract Management).
Deaths	Not applicable	Report overall figures monthly on Quality	Subject to General Condition 9.4 (Contract

The provider will report on any unexpected deaths of patients/ service users during an open episode of care.		scorecard to provide evidence that the Provider Board receive information on deaths on a regular basis including thematic review if applicable 6 month report on outcomes of inquests involving the provider and detail any actions required as a result.	Management).
VTE Reduction in number of patients who have a VTE whilst an inpatient.	95% to be assessed for VTE. 100% to receive appropriate prophylaxis. 0 of patients develop a Hospital Acquired Thrombosis (HAT) during or post admission	% of patients assessed for VTE to be reported monthly on Quality Scorecard. % of those assessed for VTE who receive appropriate prophylaxis to be reported on monthly quality scorecard. All patients who have a VTE will have an investigation carried out preferably using root cause analysis methodology and the learning from this will be shared with the commissioner. Appropriate RCA to be completed for all patients who develop a Hospital Acquired Thrombosis (HAT) during or post admission. Bi-annual report to be submitted which includes review of themes arising from RCAs.	Subject to General Condition 9.4 (Contract Management).
Clinical Responsibility Implement *Guidance for taking responsibility: Accountable clinicians and informed patients*. (Academy of Medical Royal Colleges')	Not applicable	The provider will embed the practice of clear clinical responsibility with a named director responsible for a patients care.	Subject to General Condition 9.4 (*Contract Management)*
Hospital & Community Acquired Pressure Ulcers The provider will implement best practice to continue to work to reduce the number and severity of hospital and community acquired pressure ulcers.	Monitor, report and reduce overall number of all pressure ulcers (grade category 2 and above) acquired by patients whilst in NHS care.	• Monthly reporting on the quality scorecard of the numbers of hospital and community acquired pressure ulcers grade 2, 3 and 4. • Report all category 3 and 4 pressure ulcers on Steis and endeavour to complete RCA's jointly with other providers. • Actively engage with the commissioner led community-wide pressure ulcer work stream and implement agreed best practice as agreed. • Provider to agree a provider action plan for the reduction of pressure ulcers with the commissioners by the end of Quarter 1.	Subject to General Condition 9.4 (Contract Management).

		• Provider must work with other providers on joint RCA's where possible. • Submit an Annual report.	
Health and Safety The provider will have up to date and effective health and Safety measures in place To provide Copy Annual Health and Safety report.	All providers will maintain compliance with national health and safety requirements.	The provider will supply the commissioners with an up to date health and safety report if requested.	Subject to General Condition 9.4 (Contract Management).
Information Governance The Provider will comply with the information Governance Toolkit standards in the self-assessment The Provider will update the information governance toolkit each year.	The Provider will demonstrate compliance at Level 2 and the requirements set out in Schedule 8.	The Provider will submit to the information governance toolkit on line by 31 March each year. Where partial or non-compliance is revealed, organisations must take appropriate measures (e.g. assign responsibility, put in place policies, procedures, process and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements. The provider will report information breaches to the Commissioner as they occur and will produce an Annual Report setting out activity on breaches and 'near misses' action taken and monitoring The Provider will report the number of Caldicott advice requests made and incidents where the Guardian has been involved and the advice given on an annual basis and as part of their Annual Report but as they occur in relation to delivery of statutory functions	Subject to General Condition 9.4 (Contract Management).

Research Governance The provider will comply with research governance principles and practice Annual Research Governance Plan.	Not applicable	The provider will report on research activity within the Trust Quality Account each year as per Quality Account Toolkit 2010/11.	Subject to General Condition 9.4 (Contract Management).
Falls The provider will demonstrate reduction in the number and severity of patient falls;	Reduction in the number and severity of patient falls, using NICE guidance 'Falls in older people: assessing risk and prevention' 95% of all admissions to Community Hospitals to have a falls risk assessment within 24 hours of admission/ transfer	• The provider will demonstrate adherence to the NICE Falls guidance. • Quarterly report showing number and severity of falls within the Adverse Event Report • 6 monthly audit falls audit in Community Hospitals as per requirement to demonstrate 95% of admissions have a falls risk assessment within 24 hours. The provider will engage with the Commissioner led falls management work-stream and implement agreed b**e**st practice/pathway re-design. • Quarterly Quality Scorecard to show monthly data on: • No. of inpatient falls in Community Hospitals • Falls in Community Hospitals/1,000 bed days • Safety thermometer: No. of falls which caused harm	Subject to General Condition 9.4 (Contract Management).
Harm Free Care The NHS Safety Thermometer allows frontline teams to measure how safe their services are and to deliver improvement locally	To collect data on 3 elements of the NHS Safety Thermometer & to maintain the same level of harm as 2013/14: 1. pressure ulcers, 2. falls and urinary tract infection in	1. The provider will submit data onto the national safety thermometer one day each month and maintain the same levels of harm • Quarterly report showing number and types of harm	Subject to General Condition 9.4 (Contract Management).

	patients with a catheter		
Serious Incidents The Provider will comply with the Serious Incidents Requiring Investigation (SIRI) reporting policies and procedures as per Schedule 6d. Where a provider identifies a possible SIRI from another health care provider they will collaborate to determine if it is a SIRI, who will report it and will also inform the commissioner. The Provider will report directly to the commissioner when a service user goes missing. The Provider will report directly to the commissioner any incident which presents a reputational risk to the commissioner in terms of delivering statutory duties	100% compliance with reporting SIRI within required timescales to STEIS as set out in schedule 6d of this contract. Reputational risks will be reported within 1 working day	The provider will report serious incidents to the commissioner(s) in accordance with the timescales and procedure detailed in Schedule 6 Part D, Appendix B. • Initial investigation report to be submitted and loaded on STEIS within 72 hours of the event including actions taken to inform patients and/ or their families and meet Duty of Candour requirements.. • Investigation completed with final report (RCA) reported to Commissioner within 60 days (as per registration guidance and NHS England Serious Incident Framework March 2015). • Monthly submission of number of SIRI's including nil returns (to tally with those reported via STEIS) via Quality Scorecard. Numbers reported within 2 working days and numbers breaching RCA deadline. • The provider will monitor implementation of action plans including effectiveness of changes implemented following an investigation which the Commissioner will monitor through monthly quality meetings. • Quarterly and Annual reports to include numbers and themes of incidents, changes to practice and how sharing of learning has occurred. • Report SIRIs to external organisations as detailed in Schedule 6 Part D, Appendix E. • Ensure GPs are aware of any SIRIs that involve their patients. • Consultants' communications with GPs for all SIRIs regarding their patients.	Subject to General Condition 9.4 (Contract Management).
Safeguarding Children All providers working with children, young adults, adults and their families (including	The organisation works within the legislative framework for Safeguarding children	All providers are expected to comply with the standards and Key performance indicators set out in schedule 2 The Services, part K Safeguarding.	As per clauses 24, 47, 49 & 55 of section E in their entirety.

adult services who work with parents will demonstrate that they have appropriate provision and processes in place to comply with safeguarding children's legislation and practice).	(Children Act 1989, 2004: Section 11 and Working Together 2015).		
Safeguarding Adults All providers working with adults and their families will demonstrate that they have appropriate provision and processes in place to comply with safeguarding adults practice.	Care Act 2014 and associated guidance; NHS, ADASS, SCIE and LGA good practice guidance	All providers are expected to comply with the standards and Key performance indicators set out in Schedule 2 The Services, part K Safeguarding.	As per clauses 24, 47, 49 & 55 of section E in their entirety.
Patients with a Learning Disability People with learning disabilities and/or autistic spectrum conditions (ASC) will be able to access mainstream services	Reasonable adjustments are made to services to allow access to mainstream mental health and other services. The Provider will fully implement the Accessible information Standard by 31 July	• Annual report against standards set out in 'Valuing People Now' and 'Health Care for All'. • Review and improve flagging system and pathways. • Promote use of passports • Training needs analysis for all staff • Protocols in place to provide support for carers • Process in place to actively seek feedback from people with learning disabilities and their family/carers • annual audit of practices for patients with learning disabilities • quarterly example of a case where care was not delivered as planned and led to organisational service improvement for patients with an LD The 'Information Standards Notice' which is the formal document which tells organisations that they must follow the standard is published on the Health and Social Care Information Centre website at www.hscic.gov.uk/isce/publication/scci1605	Subject to General Condition 9.4 (Contract Management).

	2016 (Health and Social Care Act 2012)	The provider will undertake a baseline assessment of the requirements of the standard and provide an action plan by the end of Q1 2016	
LD – prescribing (as NHSE letter 2015) Aim to reduce inappropriate prescribing of antipsychotic and anti-depressant medication to patients with a known LD condition in line with Nice guidance	Subject to baseline, thres to be Agreed by Provider/ Commissioners by end Q2	Audit report to include: • baseline current antipsychotic and antidepressant prescribing for known LD patients benchmark against national data for prescribing • policy and procedure documents including communication with patients and carers/families • audit plan • training plan	Subject to General Condition 9 (Contract Management)
Safety Alerts The provider will have processes for assessing, and implementing (where appropriate), alerts received via the CAS system.	Not applicable.	The provider will report any exceptions to the implementation of CAS alerts on a quarterly basis.	Subject to General Condition 9.4 (Contract Management). Annual risk management report due Q4.
Provider to ensure a system-wide approach to foster a positive patient/ service user 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	N/A	Evidence of a system-wide approach to fostering a positive patient safety culture Evidence of senior leadership commitment to safety Outcome of safety surveys and improvement measures taken 6 monthly	Subject to General Condition 9 (Contract Management)

culture: using tools such as climate surveys to monitor the attitudes of staff to safety issues and identify areas for development • Executive and clinical leaders commitment to developing a positive safety culture			
Risk management The provider must have a corporate risk reporting system that includes clinical and social care risk assessment and risk register reporting.	Not applicable.	All Clinical and social care risks (12 or above) to be reported on a quarterly basis to the quality meeting with actions planned to mitigate the risks and progress against the actions Annual risk management report due Q1 (17/18) for covering previous year (16/17).	Subject to General Condition 9.4 (Contract Management).
CQC Full and continuing registration with the Care Quality Commission for all services providing a regulated activity and advise commissioners of any external CQC quality visits or regulatory inspections to registered services. To report any exceptions in performance on the CQC Intelligence Monitoring profile or equivalent system for CQC	To be fully compliant with all CQC regulations. Not applicable	Report within 2 working days any breach of registration or any conditions imposed by CQC. To advise commissioners of CQC visits within 2 days and make available feedback and remedial action. A copy of all external CQC reports including associated action plans to be provided to commissioner once submitted to CQC. Exception reporting To provide an explanation of those indicators reported as being at 'risk' or 'elevated risk and, where appropriate, an improvement plan for those indicators.	Subject to General Condition 9.4 (Contract Management).

Equality and Diversity The provider should ensure they comply with the Equality Act 2010 and the Public Sector Equality Duty and show how they are using the NHS Equality Delivery Systems framework to achieve this.	The provider shall take all reasonable steps to ensure the observance of this clause by all members of the parties' personnel and by all providers and subcontractors of the parties.	The Provider will complete the Self-Assessment using Equality Delivery Systems (EDS) by the end of Quarter 2 and provide an Annual Report at the end of Quarter 3 with any outstanding actions. The Provider will publish an Annual Report on the Trust website by the 31 January each year.	Subject to General Condition 9.4 (Contract Management).
National reports Ensure that relevant recommendations from national reports published previously and within the contract year are acknowledged and acted upon. For example, Francis reports, Berwick Winterbourne view.	Not applicable.	The Provider will review any National Guidance and provide any Action Plans arising from the review as requested by the Commissioner.	General Condition 9.4 (*Contract Management*).
Catheter Care The provider will implement best practice to reduce the number of urinary catheters and associated urinary tract infections through implementation of the urinary catheter care bunds ref NHS SW Patient Safety Programme.	Report quarterly on CAUTI prevalence.	Quarterly report outlining data collected showing numbers in situ, compliance with catheter care bundle (insertion and ongoing care), and number of catheter associated urinary tract infections.	Subject to General Condition 9.4 (Contract Management).
Edmonton Frailty score The proportion of patients aged 75 and over, to whom the Edmonton frailty score is applied to following referral to inpatient and 'Active Aging' services. The proportion of those having been identified who are appropriately assessed and the number referred to specialist services where	Provider to use the Edmonton frailty scale in the assessment of 90% of new referrals to the actively aging service and admissions to inpatient units.	The Provider will give assurance of the application of the Edmonton frailty scale for 90% or more of assessments of service users within inpatient units and the 'Active Aging' service. Report on a Quarterly basis.	Subject to General Condition 9.4 (Contract Management).

indicated.			
Quality Assurance Visits	The provider will facilitate commissioners plan for quality assurance visits in accordance with Commissioner Quality Visit policy	Draft Reports to be provided by commissioners to the provider within 4 weeks of the visit. Commissioner(s) will carry out a schedule of announced visits equating to approximately 1 per quarter. Additional visits may occur in response to emerging concerns or additional information.	Subject to General Condition 9.4 (Contract Management
To understand the level of harm and negligence attributed to the organisation.	The Commissioner will have assurance that learning takes place as a result of a claim.	Bi-Annually; Provide a report on related claims and associated learning 6 monthly.	Subject to General Condition 9.4 (Contract Management
Case management Effective case management improves experiences of users and carers, supports better care outcomes, reducing the use of hospital-based services, and enabling a more cost-effective approach to care**.** Complex-care patients are defined as those people who are managing multiple chronic diseases, taking several medications, may have limited social supports or suffer from dementia, mental illness or addiction		Reporting agreements to be agreed between the commissioners and the Provider by the end of Q2 and may include • effective processes for identification of complex patients numbers of complex patients identified • number of complex patients assigned a case manager • clear, measureable outcomes identified for patients being case-managed • number of and reasons for admissions into acute care of those being case managed • clear role description for case managers • appropriate caseloads to ensure patients are receiving optimum care • number of patients for whom district nursing care has been withdrawn; to include rationale for decision to withdraw care	Subject to General Condition 9.4 (Contract Management).

WRES- The provider must implement the National Workforce Race Equality Standard (WRES).	The provider shall be fully compliant with requirements of the WRES.	The provider must implement the National Workforce Race Equality Standard using the 9 metrics published. The provider will publish an Annual Report showing progress on the implementation of the WRES against the 9 metrics. The report should include an action plan showing progress on all poor performing metrics.	Subject to General Condition 9.4 (Contract Management).
To share with commissioners the measures in place to signal any deterioration in quality related to a cost improvement plan	All early warning triggers indicating a deterioration in quality related to a cost improvement plan are alerted to the commissioner	Monthly Exception report Ad hoc presentation of quality impact assessments of CIPs as required in advance of implementation of CIP	Subject to General Condition 9 (Contract Management)
Third party provider assurance (including out of area and sub contracted placements)	As per provider Assurance Compliance process	Bi annual report and issues by exception	Subject to General Condition 9 (Contract Management)

*** Reporting in respect of Mental Health will only become applicable once it falls within the remit of the Prime Provider**

Working towards Public Health Quality Standards for CCG / LA contracts

Aim:

- to increase awareness and activity which contributes to Public Health across all commissioned organisations
- to incorporate Public Health quality standards into Local Authority and CCG contracts
- to ensure that Public Health standards are considered in the procurement processes for Local Authority and CCG contracts

Objectives ;

1. to develop a single Public Health quality statement which can be included in all contracts

2. to develop a list of relevant Public Health quality standards for providers to use as a self-assessment checklist

3. to provide a template for providers to use to develop an annual public health plan

4. to produce question/s to include in procurement processes

1. Quality statement

We expect providers/ each organisation to provide an annual plan which sets out how they will: promote health and wellbeing in staff and clients, create a healthy environment to visit or work in and to ensure services are based on Public Health intelligence and evidence.

The checklist below provides a list of quality standards which providers can use to self-assess and to identify areas for action.

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

The CQUINs that are applied to this Contract will be the national CQUINs relevant to this Contract. By 30 April 2017, the parties will agree the indicators and milestones for each CQUIN.

SCHEDULE 4 – QUALITY REQUIREMENTS

E. Local Incentive Scheme

Not Applicable

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 SC36.47 (*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 SC36.47 (*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

Not used

Documents supplied by Commissioners

Not used

SCHEDULE 5 - GOVERNANCE

B.1 Provider's Mandatory Material Sub-Contractors

Not Applicable

SCHEDULE 5 - GOVERNANCE

B.2 Provider's Permitted Material Sub-Contractors

Permitted Material Sub-Contractor **[Name]** **[Registered Office]** **[Company number]**	**Service Description**
Age UK Age UK B&NES, 18 Kingsmead Square, Bath BA1 2AE Registered charity number 1110455 | Company number 5367286	Community Opportunities for Older People Who are Living with Dementia in B&NES Home From Hospital/Home Response Service (SD27, 52)
Alzheimer's Society 43-44 Crutched Friars, London, England, EC3N 2AE Charity No. 296645 Registered No. 2115499	Community Opportunities for Older People Who are Living with Dementia in B&NES (SD18, SD52)
Bath ethnic minority senior citizens association (BEMSCA) Fairfield House, 2 Kelston Road, Bath, BA1 3QJ	Day Services (SD52)
Bath Mind Bath Mind 13 Abbey Church Yard Bath BA1 1LY Charity No 1069403	Community Based Mental Health Pathway Wellness Service Housing Related Support Homelessness Prevention Services for Adults 18 and over Mental Health Wellbeing and Recovery Service (SD14, 28)
Carers Centre Registered office: I Riverside Cottages, Radstock BA3 3PS. Registered number: 3289938 Charity Registration Number: 1060080	Adult's Carers Centre provision (SD2) Dementia Challenge (SD28)
Clean Slate Training and Employment Limited 3 Monmouth Place, Bath, BA1 2AT	Worklessness (SD52)
Creativity Works For Everyone	Community Based Mental Health Pathway

Leigh House, 1 Wells Road, Radstock, Somerset, BA3 3RN Registered Charity No. 1075812 Company No. 3768255	Wellness Service (SD14)
Curo The Maltings River Place Lower Bristol Road Bath BA2 1EP The Curo Group incorporates: Two companies registered in England and Wales: Curo Group (Albion) Limited (Co. No. 4302179, HCA No. LH4336) and Curo Enterprise Limited (Co. No. 08103621). Two charitable registered societies: Curo Places Limited (FCA No. 7091, HCA No. LH4209) and Curo Choice Limited (FCA No. 24208R).	Extra Housing Services Home Responsive Services Housing Related Support Homelessness Prevention Services for Adults 18 and over (Lead subcontractor) Housing Related Support – Positive accommodation and support pathway for younger people Independent Living Service Extra Care Housing Services- Stepdown Beds Extra Care Housing Services- Stepdown Beds Homelessness & Housing Support - Temporary Accommodation Young Parents service Pathway Mediation Service Bath Foyer Independent Living Service - including Older People Independent Living Service – sheltered services and rural dementia service Wellbeing House (SD25,SD28, SD29, SD30)
deafPLUS, National Office, Trinity Centre, Key Close, Whitechapel, London, E1 4HG	Sensory Equipment (SD52)
Developing Health and Independence (DHI) 15/16 Milsom Street, Bath BA1 1DE Company No: 3830311 Charity No: 1078154	Substance Misuse Wellness Service Direct payments and personal budget support Housing Related Support Homelessness Prevention Services for Adults 18 and over Housing Related Support – Positive accommodation and support pathway for younger people Part of the pathway of delivery for Community Mental Health Pathway

	(SD23,28,50,52)
Dorothy House Foundation Winsley, Bradford-On-Avon, Wiltshire, BA15 2LE	Part fund to hospice (SD24)
Freeways Leigh Court Centre Pill Road, Abbots Leigh, Bristol, BS8 3RA	Learning Disability (SD43,28)
Guinness Care 30 Brock Street, London NW1 3FG	Housing Related Support Homelessness Prevention Services for Adults 18 and over (SD25)
Julian House 55 New King St, Bath, BA1 2BN Registered No. 19305R	Community Based Mental Health Pathway Housing Related Support Homelessness Prevention Services for Adults 18 and over
Keyring Unit 21 St Olav's Court, City Business Centre, Lower Road, London SE16 2XB	Learning disability (floating support) SD43/28
Knightstone Housing Association Weston Gateway Business Park, Filers Way, Weston super Mare, BS24 7JP	Extra Care Support (SD25)
Methodist Homes Housing Association [Details]	Extra Care Housing Support
Quartet Royal Oak House, Royal Oak Avenue, Bristol, BS1 4GB	Grant Agency (SD52)
Research Institute for Care of the Elderly (RICE) *The RICE Centre, Royal United Hospital, Combe Park, Bath, BA1 3NG* Registered Charity No. 1042559	Research Institute for Care of the Elderly (SD52)
National Schizophrenia Fellowship t/a Rethink Mental Illness 89 Albert Embankment, London, SE1 7TP	Floating Support (SD28)
Royal United Hospitals Bath NHS Foundation Trust	SD32

Combe Park, Avon BA1 3NG	
Second Step 9 Brunswick Square Bristol BS2 8PE	Community Based Mental Health Pathway Wellness Service (SD28)
Solon 1 Newfoundland Court, St Paul Street, Bristol. BS2 8AN	Supported Living (SD28)
Soundwell Music Therapies Trust registered charity number 1093992 whose registered office is at PO Box 3313, Bristol BS5 5GJ	Music Therapy services (SD14)
SPA (Peggy Dodd) Bath Brierley House Summer Lane, Combe Down, Bath, BA2 5JX	Day Services (SD18)
Stroke Association Stroke Association House, 240 City Road, London EC1V 2PR (No 61274). Registered	Specialist Neurology and Stroke Service (Adults) (Community Stroke Co-ordinator and Communication Support Service) (SD48)
St Mungos Registered Charity No 1149085, Company No 8225808, Housing Association No LH0279 Registered Charity No 1149085, Company No 8225808, Housing Association No LH0279	Community Based Mental Health Pathway Mental Health and Recovery Service Wellness Service (SD14,52)
Home Group Stonham Home Group First Floor, High Point, Thomas Street Taunton TA2 6HB	Accommodation Based Service
(South West Action for Learning and Living Our Way) The Old Engine House, Old Pit Road, Midsomer Norton, Radstock, BA3 4BQ	Learning disability and training for independent living (SD43)
Volunteers Centre Volunteer Centre, Bath Central Library, 19 The Podium, Northgate Street, Bath, BA1 5AN	Wellness Service – Lifestyle and Wellbeing Support (SD52)

Charity Number 1042007 Company Number 2948107	
Virgin Care Provider Services Limited Lynton House, 7-12 Tavistock Square, London, WC1H 9LT	Non-clinical services
WECIL Limited Link House, Britton Gardens, Kingswood BS15 1TE	Direct Payment provider
We Care and Repair Limited 5 Hide Market, Waterloo road, St Philips, Bristol, BS2 0BH	HIA (SD16)

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Commissioner	Identified role
NHS Bath and North East Somerset CCG and Bath and North East Somerset Council – the Commissioner	Prepare the Commissioning Contract for signature by Provider and Commissioner.
	Administer the Commissioning Contract for the duration of the contract including in year variations
	Provide a focal point for leadership of commissioning and contracting with the Provider of the Commissioning Contract
	Negotiate the contract terms, schedules and conditions of the Commissioning Contract with the Provider
	Test the activity and financial information received from the Provider with regard to the Commissioning Contract
	Monitor Provider performance against the quality standards within the Commissioning Contract.
	Monitor Provider performance against an agreed Outcomes Based Accountability performance framework
	Challenge the Provider where performance falls below acceptable standards, and if no satisfactory response is received, take appropriate contractual action
	Administer the dispute resolution process on behalf of both the Commissioner and Provider if/when required
	Manage the development of patient pathways and agreement of patient and service user pathways with the Provider with regards to the Commissioning Contract including referral and discharge protocols.
	Agree the activity and financial plans with the Provider in accordance with the principles and timescales set out within this contract
	Directly receive contract monitoring information from the Provider, and be responsible for the review of this information and payment of its invoices directly to the Provider.
	Monitor Patient and Service user Experience and the clinical effectiveness of service delivery

The Commissioner remains responsible for the following:

- performing and excising its statutory duties and functions
- making decisions for committing commissioning resources
- liabilities as a result of the exercise of its functions

SCHEDULE 5C1
Commissioner Roles (document 1 of 2)

NHS Standard
Contract schedule 5C

SCHEDULE 5C1
Commissioner Roles (document 2 of 2)

This document contains scenario's to evidence the principles listed in the excel spreadsheet within Schedule 5C1

Scenarios – commissioning responsibilities and actions
The following sets out in general terms the actions and responsibilities that sit with the council / CCG and Virgin Care in relation to the sub-contracted services.

1. Service performing well – no concerns
A service consistently meets or exceeds its targets in service delivery. Feedback from service users is consistently positive, and there are no concerns re: safeguarding, quality or capacity within the service.
Virgin Care:

- Contract management ;
    - Setting monitoring meetings, setting monitoring expectations (i.e. what data they require from the provider, what frequency, what format), agreeing representatives from both sides, checking provider data quality, agreeing tolerances, signing off monitoring.
- Reporting to commissioner:
    - Developing reports to agreed format, content and timeframe.
- Service overview:
    - Continue to ensure service fits in with the overall strategic picture within B&NES.
    - Continue to ensure the service is fit for purpose and is meeting identified needs while also building local and individual capacity.

Council / CCG:

- Contract oversight – agreeing format, frequency and content of dashboard, to include safeguarding and service user / peer feedback. Sign off high level monitoring, have direct access to full detailed monitoring on request.
- Set and agree tolerances for performance.
- Continue to ensure funds available for the service as agreed with Virgin Care.
- Horizon scan to ensure the service(s) continue to fit with the regional and national direction of travel.

2. Service performing poorly – improvement needed
Through regular monitoring meetings and service user feedback, it is found that a service is performing poorly in one or more areas (including but not limited to capacity / volume, budget, timescales, scope, outcomes, service user feedback) but it is felt that improvements can be made (agreement on what constitutes poor performance will need to be reached between the council / CCG and Virgin Care, and with their subcontractors). Poor performance could also be identified by the council / CCG commissioners through feedback from complaints, safeguarding reviews, deep dives, wholescale reviews etc. This would then be passed to Virgin Care to note / act upon as agreed.

Virgin care investigate and analyse the poor performance, including requesting additional monitoring information, data and service user feedback if required to obtain a full picture of which part(s) of the service is performing poorly and why, and what has contributed / led to it. In the first instance, Virgin Care follows its quality / service improvement protocols to support the provider to improve.

Virgin notifies the council / CCG commissioners of the poor performance and its mitigating actions as the Prime (report to be to an agreed template).

Should the poor performance continue, Virgin requests further supporting data / feedback as is felt necessary then prepares a report for council / CCG commissioners of the service, the performance issues and the actions Virgin and the sub-contractor have taken to improve the performance. This report includes reference to the

context of the service and why it is deemed that improvements can be made rather than the service being decommissioned. The report is to a standard template, as agreed with the council / CCG commissioners.

Should this issue of poor performance arise in year 1, Virgin and council / CCG commissioners then jointly agree on an improvement plan for the service. In years 2 and 3, council / CCG commissioners agree a tolerance / risk level within which Virgin can develop improvement plans without immediate reference to the commissioners. The tolerance / risk could include financial (i.e. the value of the contract for the service), its importance within the local health and care economy, the number of people using the service, the level of needs of the people using the service and the presence (or not) of other similar services in the area.

Once the improvement plan has been agreed with commissioners, Virgin discuss and agree the improvement plan with the sub-contractor and support the provider to implement the plan. Virgin monitor the implementation of the plan, and report back at agreed intervals to the council / CCG commissioners.

If the improvement plan succeeds, Virgin reports this back to the council / CCG commissioners and then continues to follow its regular contract management role.

If the improvement plan does not succeed, Virgin follows its contract management policies with the provider and informs the commissioner. If the service continues to perform poorly, and after all mitigating actions have been undertaken and support provided to the sub-contractor, Virgin Care may decide to follow its decommissioning protocols, with the agreement of the council / CCG commissioner.

3. Service over-performing – tolerance exceeded

Through regular monitoring meetings and service user feedback, it is found that a service is performing over and above one or more agreed tolerances (e.g. capacity / volume, budget, timescales, scope, outcomes, service user feedback).

Virgin care investigate and analyse the over-performance, including requesting additional monitoring information, data and service user feedback if required to obtain a full picture of which part(s) of the service are over-performing and why, and what has contributed / led to it.

In the first instance, if the over-performance is having an overall negative impact on service users, the service itself, budgets, other services or the broader health and care economy in B&NES, Virgin Care follows its quality / service improvement protocols to support the provider to return to within the agreed tolerance. If the over-performance is having an overall positive impact, Virgin reviews this to assure itself that it is an overall positive impact, and applies any learning from this to other relevant services it may be commissioning.

In all cases, Virgin notifies the council / CCG commissioners of the over-performance, its mitigating actions as the Prime and any learning (report to be to an agreed template).

Should the over-performance continue to have a negative overall impact, Virgin requests further supporting data / feedback as is deems necessary then prepares a report for council / CCG commissioners of the service, the performance issues and the actions Virgin and the sub-contractor have taken to return the service to within tolerance. This report includes reference to the context of the service and why it is deemed that improvements can be made rather than the service being decommissioned. The report is to a standard template, as agreed with the council / CCG commissioners.

Should over-performance with a negative impact arise in year 1, Virgin and council / CCG commissioners then jointly agree on an improvement plan for the service. In years 2 and 3, council / CCG commissioners agree a tolerance / risk level within which Virgin can develop improvement plans without immediate reference to the commissioners. The tolerance / risk could include but is not limited to financial (i.e. the value of the contract for the service), its importance within the local health and care economy, the number of people using the service, the level of needs of the people using the service and the presence (or not) of other similar services in the area.

Once the improvement plan has been agreed with commissioners, Virgin discuss and agree the improvement plan with the sub-contractor and support the provider to implement the plan. Virgin monitor the implementation of the plan, and report back at agreed intervals to the council / CCG commissioners.

If the improvement plan succeeds, Virgin reports this back to the council / CCG commissioners and then continues to follow its regular contract management role.

If the improvement plan does not succeed, Virgin follows its contract management policies with the provider and informs the commissioner. If the service continues to perform poorly, and after all mitigating actions have been undertaken and support provided to the sub-contractor, Virgin Care may decide to follow its decommissioning protocols, with the agreement of the council / CCG commissioner.

4. Virgin want to make a radical change / redesign

Through regular contract monitoring and management, Virgin develop a picture of provision, needs, assets, gaps and wellbeing within a particular locality / group / service area.

Virgin analyse this particular locality / group / service and conclude that the needs within this particular locality / group / service could be better met (or the assets better complimented) by redesigning the support that is currently provided via one or some of the services it is commissioning.

Virgin develops a PID outlining its proposals (to a format agreed by the council / CCG) and how they align to the agreed transformation plan(s), and presents it to council / CCG commissioners.

The council / CCG commissioners work to an agreed deadline (e.g. 28 days or similar) to analyse and approve / reject the proposal (governance needs to be agreed). The panel reviewing the proposals must include community champions. The requirements the commissioners look for in order to approve a proposal are clearly set out so that Virgin can present information as simply and clearly as possible. Council / CCG commissioners to develop these requirements and a template for proposals.

Assuming the council / CCG commissioners decide to move forward with the proposals, a full business case and project plan is drawn up by Virgin Care. These must reference how the project will support the agreed transformation plan(s).

The council / CCG commissioners will need to have a process in place which will allow them to be able to agree to any staffing requests the project plan may contain (e.g. commissioning / procurement, Finance, communications etc.). The identified project team must include meaningful roles for community champions and the VCSE.

Virgin Care lead on the implementation of the plan, with support from the council / CCG as agreed following the approval of the business case and project plan. The council / CCG commissioners monitor the implementation of the business plan, and ensure communications are consistent and accessible between themselves, Virgin Care and the sub-contractors. A clear communications plan is developed and implemented by Virgin Care, with council and CCG input as required.

Virgin Care's role in implementing the plan will include, analysing local and national datasets, reviewing the MPS and ensuring the plan aligns, bringing all the required parties together to implement the plan, running consultation events, meeting with existing and potential service users and working with relevant professionals to implement the plan.

The council / CCG commissioner's role in implementing the plan will include agreeing timescales for approval / refusal of PIDs. Making staff available and committing their proportion of time to the project.

The embedded document below describes the roles and responsibilities of the council / CCG commissioners and the provider in relation to the commissioning roles.

Roles and responsibilities

8. SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Principles relating to reporting requirements have been redacted
FOIA exemptions: Section 43 (2) andSection 2

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
1. As specified in the list of omnibus, secure electronic file transfer data collections and BAAS schedule of approved collections published on the HSCIC website to be found at http://www.hscic.gov.uk/article/5073/Central-Register-of-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		
2. Patient Reported Outcome Measures (PROMS) http://www.hscic.gov.uk/proms	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	Where applicable
National Requirements Reported Locally				
1. 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 SC36.31)	Monthly to FIG	NHS standard format as per Appendix 3 detailed in C02 and C03 in local reporting requirements.and / or as agreed locally.	By no later than the First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable	
2. 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	Monthly / Quarterly	As detailed in Schedule 4 section A, B, C. Service performance scorecards As detailed in service	Within 15 ~~Operational~~ working Days of the end of the month to which it relates. Filename format: PPPPP_CCG_QUALITY	

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
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 (*Venous Thromboembolism*) e. report on performance against the HCAI Reduction Plan		level reporting appendix including in year developments inline with service transition / transformation. Appendix 1 or local agreement	_YYYYMMDD_P00_V01 See note 4 regarding file formats See reporting principles above for agreement during transition period Submit via CSU and or Council as per service level reporting appendix.	
3. 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	As detailed in Schedule 4 E	As detailed in Schedule 4 E.	As per local agreement or Schedule4 E. Filename format: PPPPP_CCG_CQUIN00_YYMMDD_P00_V01_CS00N03 See note 4 regarding file formats	
4. 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.	According to published NHS Safety Thermometer reporting timeframes	According to published NHS Safety Thermometer reporting routes	According to published NHS Safety Thermometer reporting routes	
5. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	As detailed in Schedule 4.	Format to be agreed.	First Reconciliation Date for the month to which it relates. Filename format: PPPPP_CCG_COMPLAI	

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
				_YYMMDD_P00_V01_CS00N05 See note 4 regarding file formats	
6.	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 First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable. Filename format: PPPPP_CCG_SDIP000_YYMMDD_P00_V01_CS00N06 See note 4 regarding file formats	
7.	Summary report of all incidents requiring reporting	As detailed in Schedule 6C	As detailed in Schedule 6 C	As detailed in Schedule 6 C Filename format: PPPPP_CCG_INCIDEN_YYMMDD_P00_V01_CS00N08 See note 4 regarding file formats	
8.	Data Quality Improvement Plan: report of progress against milestones	In accordance with relevant DQIP	In accordance with relevant DQIP	In accordance with relevant DQIP First Reconciliation Date for the month to which it relates	

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
			Filename format: PPPPP_CCG_DQIP000_YYMMDD_P00_V01_CS00N09 See note 4 regarding file formats	
9. 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 http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/documents/isb-1594/amd-31-2012/index_html	Monthly	As set out in relevant Guidance Appendix 2	As set out in relevant Guidance Filename format: PPPPP_CCG_VIOLENC_000_YYMMDD_P00_V01_CS00N10 See note 4 regarding file formats	
10. 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 by the Co-ordinating Commissioner from time to time)	As set out in relevant Guidance	As set out in relevant Guidance	
11. Report on compliance with National Workforce Race Equality Standard	Annually	To be agreed	1st July 2016 as set out in NHS England technical Guidance: http://www.england.nhs.uk/wp-content/uploads/2015/04/wres-technical-guidance-2015.pdf Filename format: PPPPP_CCG_WRKFOR	

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
				C_YYYYMMDD_P00_V01_CS00N12 *See note 4 regarding filename formats*	
12.	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/s-reporting	Specialised Services where applicable

Local Requirements Reported Locally					
	Reporting period	**Format of report**	**Timing and method for delivery of report**	**Application**	
C01 Community Services Data Sets – interim flow while CIDS 2.7 and CYPHS are being developed until data quality assured and data flows nationally.	Frequency of reporting: Monthly (cumulative data to be provided)	CSV file See appendix 10	15th WKD or by no later than the First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable / whichever is first File format: CSV file Filename format: PPPPP_C01_CIDS000_yyyymmdd_OTHERINFO_P00_V01 See note 4 for filename format details.		
C02	*Frequency of*	Format as per	First Reconciliation Date		

Aggregate Contract Monitoring Report (ACM - locally known as SLAM)	*reporting:* Monthly *Period of data contained in return:* The total activity and associated costs (if applicable) contained within the ACM/Report for any particular month MUST tie-back to the invoices raised in reference to the same period. Any monthly resubmission of data must be accompanied by a reissued monthly ACM dataset to be used on a bulk-replacement basis." The submission of ACM is tied in to that of the timetable within Schedule 6 of the NHS Standard Contract to ensure that ACM submissions can be reconciled with both SUS Commissioning Data Set (CDS) submissions and	specified minimum dataset: Report to be based on data submitted to SUS and any Non-SUS related items in the activity schedule. Revised template reflects national Aggregate Contract Monitoring template (ACM). POD list as agreed between Commissioner and Provider See Appendix 3: C02	for the month to which it relates, consistent with data submitted to SUS, where applicable. CSV (tab delimited)file Filename format: PPPPP_CCG_SLAMAGG_YYYYMMDD_P00_V01_CS00A02 *See note 4 regarding filename formats*		

	any other patient-level datasets that support the aggregate figures in the ACM. Providers must use a consistent method of completion to populate the ACM with data for each ACM submission. This will be one of two formats: • Individual months • Twelve months every month No other completion method (e.g. current month only or cumulative year to date) is permitted. Amendments to previous months to be related to hard close process. Customer / CSU contract lead to agree.				
C03 Contract Monitoring Datasets (Detailed ACM - locally known SLAM backing data)	*Frequency of reporting:* Monthly	Patient level dataset for all items included in the C2 – Aggregate Contract	First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS,		

	Period of data contained in return: Report to include all data from April to latest reported month with values at the Post-Reconciliation Inclusion Date for all months except current month. Amendments to previous months to be related to hard close process. Customer / CSU contract lead to agree.	Monitoring Report, SUS and non-SUS. Format as per specified minimum dataset: Aggregate Contract Monitoring Report (C02) and this dataset must reconcile. If historically you have provided a summary tab of activity volume and associated costs (if applicable) please feel free to continue to supply this report. See Appendix 3	where applicable. CSV (tab delimited)file Filename format: PPPPP_CCG_SLAMPLD_YYYYMMDD_P00_V01_CS00A03 *See note 4 regarding filename formats*		
C04 Community Services Data set supporting reconciliation and business rules Provision of commissioning rules to reconcile Community Service Data set to identify : 1. Services Commissioned 2. Services commissioned on a basis other than total contacts e.g. per first contact; finished episodes etc. This applies to all Adult Community and Children	Statement of methodology in use by the provider to reconcile patient level minimum data set to Community Services Contract Activity report	Statement of methodology in use by the provider to reconcile patient level minimum data set to Community Services Contract Activity report	Methodology to be presented at first Finance and Information Group (FIG) or equivalent contract meeting and updates to be presented as occur.		
C05 Delayed Transfers of Care Reporting: 1) national format for local submission ONLY	Monthly	Required fields and format as per template (Appendix 4):	By the end of each Monday (for previous Thursday snapshot) CSV (tab delimited)file		

			/ xlsb Filename format: PPPPP_CCG_DTOCAGG_YYYYMMDD_P00_V01_CS00A15 See note 4 regarding file formats		
C06 Delayed Transfers of Care Reporting With additional local coding: 2) national format data plus new local data fields– we are operating a local version of what we expect to become a national pilot 3) BANES operational breach reports as collated by hospital social workers on agreed template including national and local data fields for all Banes breaches in hospital beds	Weekly	Format - for local agreement For 2) as Appendix 4 plus service code and action code as defined in appendix 11 For 3) See appendix 11 - separate spreadsheet template including coding info. Schedule 6a appendix BANES DToC Recording *dd.mm.yy*.xls	By the end of each Monday (for previous Thursday snapshot) 2) CSV (tab delimited)file / xlsb Filename format: PPPPP_CCG_DTOCLOC_YYYYMMDD_P00_V01_CS00A30 3) Excel Filename format: PPPPP_CCG_DTOCPLD_YYYYMMDD_P00_V01_CS00A31 See note 4 regarding file formats		
C07 Operational delays: BANES operational reports for non-bedded delays as collated by community teams including district nursing and reablement teams in similar format to bedded DToc reports	Monthly	Format – for local agreement See appendix 13- bridging the gap scorecard. Days and people to tie in to DTOC methodology.	Within 15 working Days of the end of the month to which it relates.		
C09 Operational Care delays – daily report	Daily	For local agreement Current format	Filename format: tba		

		appendix 12 separate: schedule 6a appendix 12 – Daily collection for commissioners			
C10 Daily Urgent Scorecard	Daily by 10.00am	TEMPORARILY NOT REQUIRED UNTIL REQUESTED. 10.00am each working day with back-population for any weekend & Bank Holiday data. Required fields and format as per template (Appendix 9). Format may be reviewed and changed in-year	PPPPP_CCG_UCDADD0_YYYYMMDD_P00_V01_CS00L51 See note 4 regarding file formats		
C12 Audiology Patient Level – interim feed until all data provided in ACM C02 and C03.	Monthly	As per appendix 8 subject to change in year. Patient level for all Audiology contacts – to support cost per case contract monitoring.	PPPPP_CCG_AUDIO00_YYYYMMDD_P00_V01 _CS00L59 See note 4 regarding file formats		
C13 Improving Value / QIPP feeds Hip & Knee (Osteoarthritis) OA Pathway	Monthly	Appendix 5	15th WKD File format: CSV file Filename format: PPPPP_CCG_HIPKNEE_YYYYMMDD_P00_V01_CS00L62 See note 4 for filename		

			format details.		
C14 Domiciliary Care Allocation system Reporting	Monthly	Report of DCAS system activity / performance for clients and provider performance. Format for local agreement	Within 5 Operational Days of the end of the month to which it relates. Filename format: PPPPP_CCG_DOMALLO_YYYY_MMDD_P00_V01_CS00L70 *See note 4 regarding file formats*		
C15 SALT reporting interim indicative reports	Quarterly	SALT submission format with additional raw data rows for any calculated cells. http://content.digital.nhs.uk/socialcarecollections2017	Within 15 days of period end. Excel Filename format: PPPPP_CCG_SALT000_YYYY_MMDD_P00_V01_CS00L71 *See note 4 for filename format details.* Submit to Council and CSU		
C16 Adult Safeguarding reporting to support SAC statutory return.	Monthly	Tbc SAC http://content.digital.nhs.uk/socialcarecollections2017	Within 15 days of period end. Excel Filename format:		
C17 Continuing Healthcare		National template	Within 15 days of period		

Data to support NHSE quarterly submission. .	Quarterly	and guidance for 2017/18 are in separate supporting info.	end. Excel		
C18 Outpatient Referral Data		Dataset of all types of referrals by source of referral, as per specified minimum patient level dataset: Appendix 6	First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable. CSV Filename format: PPPPP_CCG_OPREF00_YYYYMMDD_P00_V01_CS00A01 *See note 4 regarding filename formats*		
C19 Carer's Centre Register A list of Carers used directly by the Council.	Monthly	As per service specification SD2 – extracted into Appendix 15 below.	Format and name tbc – as now – no change requested For Secure transfer by The Carer's Centre directly to B&NES Council using GlobalSCAPE.		

Notes

Note	All contracted data and information returns from the Provider to be sent as an attachment or via the HSCIC SFT-	

1	On or before due date for the following CCGs to the email address in the table below. : - All other associate CCGs will have different email addresses; please report separately and directly to those contacts. Please use the filename as a subject line for every message. Please add the details below to each schedule item you email to enable us to contact you if needed.	

Organisation Code (of Sender)	
Organisation Name (of Sender)	
Name of Sender	
Email address of Sender	
Recipient Team\Name (at CSU)	
File Name	
Data Description	
Data contains PCD (Y/N)	
Data contains Sensitive data (Y/N)	

Financial Month of data Submission	
Financial Year of data Submission (15/16)	
Data Format (e.g. csv, xlsx, Access)	
File Password protected? (Y/N) (*please send password in a separate email*)	
Data has previously been submitted? (Y/N) *(e.g. Is this an update or revision of current data?)*	
Comments	

ODS CCG Name	CCG ODS	DSCRO email	NCA / CEfF Email
NHS Aylesbury Vale CCG	10Y	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS Bath and North East Somerset CCG	11E	CSCSU.dscro-box@nhs.net	CSCSU.ceff-west@nhs.net
NHS Bedford	06F	CSCSU.dscro-bedford@nhs.net	
NHS Bracknell and Ascot CCG	10G	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS Brighton & Hove CCG	09D	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Bristol CCG	11H	dscswcs.info@nhs.net	dscswcs.NCA-BCCG@NHS.net
NHS Chiltern CCG	10H	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS Coastal West Sussex CCG	09G	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Crawley CCG	09H	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Dorset CCG	11J	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS East Surrey CCG	09L	SCWCSU.SySxDMIC@nhs.net	
NHS Eastbourne, Hailsham & Seaford CCG	09F	SCWCSU.SySxDMIC@nhs.net	
NHS Fareham & Gosport CCG	10K	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Gloucestershire CCG	11M	CSCSU.dscro-box@nhs.net	GLCCG.Glos-ceff@nhs.net
NHS Hastings & Rother CCG	09P	SCWCSU.SySxDMIC@nhs.net	
NHS High Weald & Lewes Ravens CCG	99K	SCWCSU.SySxDMIC@nhs.net	
NHS Horsham & Mid Sussex CCG	09X	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Isle of Wight CCG	10L	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Newbury and District CCG	10M	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS North and West Reading CCG	10N	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS North East Hampshire & Farnham CCG	99M	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS North Hampshire CCG	10J	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS North Somerset CCG	11T	dscswcs.info@nhs.net	dscswcs.NCA-NSCCG@nhs.net
NHS Oxfordshire CCG	10Q	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS Portsmouth CCG	10R	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Slough CCG	10T	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS Somerset CCG	11X	SCWCSU.DMIC@nhs.net	dscswcs.bnssgcontracts@nhs.net
NHS South Eastern Hampshire CCG	10V	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS South Gloucestershire CCG	12A	dscswcs.info@nhs.net	dscswcs.NCA-SGCCG@NHS.net
NHS South Reading CCG	10W	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS Southampton City CCG	10X	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Surrey Heath CCG	10C	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Swindon CCG	12D	CSCSU.dscro-swindon@nhs.net	
NHS West Hampshire CCG	11A	SCWCSU.DMIC@nhs.net	southcsu.ncainvoices@nhs.net
NHS Wiltshire CCG	99N	CSCSU.dscro-box@nhs.net	WCCG.safehaven@nhs.net
NHS Windsor, Ascot and Maidenhead CCG	11C	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net
NHS Wokingham CCG	11D	CSCSU.dscro-box@nhs.net	CSCSU.ceff-east@nhs.net

Note 2	All file format templates for monitoring are included as appendices all reporting to be provided according to these specifications.
Note 3	Both parties will process contract account reconciliations in line with the timetable in Reconciliation Scheduled. The list of contract Reconciliations can vary in-year. Timetable to be added when released nationally.

Contract Reconciliation Timetable 2017/2018

National Deadlines
Local Commissioner Deadlines
Local Provider Deadlines

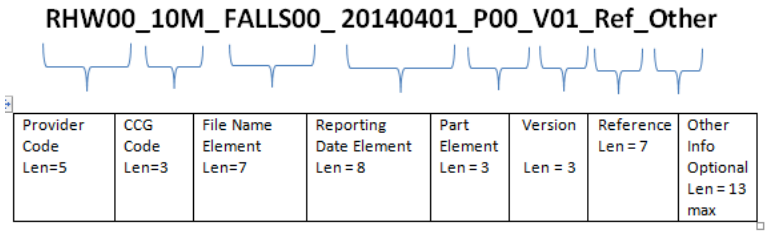
NHS
South, Central and West Commissioning Support Unit

				All to be raised and closed by Post Reconciliation date SC 36.29 Details below are local definition of the timetables unless details in the further information						SC36.30, SC36.30,SC36.32.SC36.35, SC36.36,SC36.45, SC36.45 No later than 20 Operational Days all outstanding issues closed from final reconciliation account date		
Month	**First Reconciliation Inclusion Date (SUSsubmission date)**	**First Reconciliation Date (SUS publication date)**	**Provider Reconciliation account reports deadline**	**Commissioner will send out Contract Account Reconciliations**	**Response from Provider to Contract Account Reconciliations**	**Monthly Reconciliation Process close down**	**Post Reconciliation Inclusion Date**	**Provider issues final Reconciliation Account**	**Post Reconciliation Date (SUS publication date)**	**Commissioner will send out Contract Account Reconciliations**	**Response from Provider to Contract Account Reconciliations**	**Reconciliation Close Down for final account final 20 working day**
Apr-17	19-May-17 Fri	30-May-17 Tue	19-May-17 Fri	09-Jun-17 Fri	16-Jun-17 Fri	19-Jun-17 Mon	19-Jun-17 Mon	26-Jun-17 Mon	27-Jun-17 Tue	03-Jul-17 Mon	17-Jul-17 Mon	31-Jul-17 Mon
May-17	19-Jun-17 Mon	27-Jun-17 Tue	19-Jun-17 Mon	07-Jul-17 Fri	14-Jul-17 Fri	18-Jul-17 Tue	19-Jul-17 Wed	26-Jul-17 Wed	27-Jul-17 Thu	02-Aug-17 Wed	16-Aug-17 Wed	31-Aug-17 Thu
Jun-17	19-Jul-17 Wed	27-Jul-17 Thu	19-Jul-17 Wed	08-Aug-17 Tue	15-Aug-17 Tue	16-Aug-17 Wed	17-Aug-17 Thu	24-Aug-17 Thu	25-Aug-17 Fri	01-Sep-17 Fri	15-Sep-17 Fri	29-Sep-17 Fri
Jul-17	17-Aug-17 Thu	25-Aug-17 Fri	17-Aug-17 Thu	07-Sep-17 Thu	14-Sep-17 Thu	18-Sep-17 Mon	19-Sep-17 Tue	26-Sep-17 Tue	27-Sep-17 Wed	03-Oct-17 Tue	17-Oct-17 Tue	31-Oct-17 Tue
Aug-17	19-Sep-17 Tue	27-Sep-17 Wed	19-Sep-17 Tue	09-Oct-17 Mon	16-Oct-17 Mon	17-Oct-17 Tue	18-Oct-17 Wed	25-Oct-17 Wed	26-Oct-17 Thu	01-Nov-17 Wed	15-Nov-17 Wed	29-Nov-17 Wed
Sep-17	18-Oct-17 Wed	26-Oct-17 Thu	18-Oct-17 Wed	07-Nov-17 Tue	14-Nov-17 Tue	16-Nov-17 Thu	17-Nov-17 Fri	24-Nov-17 Fri	27-Nov-17 Mon	01-Dec-17 Fri	15-Dec-17 Fri	03-Jan-18 Wed
Oct-17	17-Nov-17 Fri	27-Nov-17 Mon	17-Nov-17 Fri	07-Dec-17 Thu	14-Dec-17 Thu	18-Dec-17 Mon	18-Dec-17 Mon	27-Dec-17 Wed	28-Dec-17 Thu	04-Jan-18 Thu	18-Jan-18 Thu	01-Feb-18 Thu
Nov-17	18-Dec-17 Mon	28-Dec-17 Thu	18-Dec-17 Mon	10-Jan-18 Wed	17-Jan-18 Wed	17-Jan-18 Wed	18-Jan-18 Thu	25-Jan-18 Thu	26-Jan-18 Fri	01-Feb-18 Thu	15-Feb-18 Thu	01-Mar-18 Thu
Dec-17	18-Jan-18 Thu	26-Jan-18 Fri	18-Jan-18 Thu	07-Feb-18 Wed	14-Feb-18 Wed	16-Feb-18 Fri	19-Feb-18 Mon	26-Feb-18 Mon	27-Feb-18 Tue	05-Mar-18 Mon	19-Mar-18 Mon	04-Apr-18 Wed
Jan-18	19-Feb-18 Mon	27-Feb-18 Tue	19-Feb-18 Mon	09-Mar-18 Fri	16-Mar-18 Fri	19-Mar-18 Mon	19-Mar-18 Mon	26-Mar-18 Mon	27-Mar-18 Tue	04-Apr-18 Wed	18-Apr-18 Wed	02-May-18 Wed
Feb-18	19-Mar-18 Mon	27-Mar-18 Tue	19-Mar-18 Mon	10-Apr-18 Tue	17-Apr-18 Tue	18-Apr-18 Wed	19-Apr-18 Thu	26-Apr-18 Thu	27-Apr-18 Fri	03-May-18 Thu	18-May-18 Fri	04-Jun-18 Mon
Mar-18	19-Apr-18 Thu	27-Apr-18 Fri	19-Apr-18 Thu	10-May-18 Thu	17-May-18 Thu	21-May-18 Mon	21-May-18 Mon	29-May-18 Tue	30-May-18 Wed	05-Jun-18 Tue	19-Jun-18 Tue	03-Jul-18 Tue
Further Information	Deadline for submitting data to SUS (5pm). Inclusion date meets the 15WKD deadline generally		National 15th WKD Inlcusion date for SUS EACV 36.28, SUS Non EACV 36.35 National 20th WKD for Non SUS EACV 36.31, Non SUS Non EACV 36.36	SC 36.29., SUS or non SUS First Reconciliation Date or invoice Local Target 14 working days from First Reconcilation Inclusion Date	Local Target 5 WKD from receipt of queries	Final Responses to resolve and agree changes for reconciliation to be closed and any resubmission or SUS and final reconciliation account Local suggestion 2 working days from response	If monthly close down not applicable, any outstanding issue to be resolved by this date. SUS rescubmission date	SC36.30 5 WKD of Final reconciliation date		SC 36.45 5 working days and pays uncontensted amounts	Local 10 days response	SC36.45 Total over 20 WKD to resolve any outstanding issues. Outstanding referred to dispute resolution

Note 4

File Naming Convention

All filename formats to be provided according to the above specifications. Details for format below.



Part 1 – PPPPP

- National Provider Code five characters. NHS Acute provider's three character code and two trailing 00s e.g. PPP00.
- Virgin in this contract to use ODS + 00, not site code

Part 2 – CCG Code

- As per defined in ODS (alpha-numeric three characters).
- Where multiple CCGs are being submitted in one file, please use the lead CCG code.

Part 3 – File Name

- As defined in the Schedule (alpha – numeric 7 characters). Pad out with trailing zeros to make the element length add up to the correct seven number of characters.

Part 4 – Reporting Date

- For monthly reports = Use first of month that relates to the data e.g. _20140401_ for M01 data even if sent in May
- For weekly report = Date of the Week first date, or snapshot date
- For Daily report = Date

Part 5 – Part

- If data captured in one file end with 00 i.e. 'P00'

Part 6 – Version

- Starting with V01

Part 7 – Reference

- As defined in the Schedule (i.e. alpha – numeric 3 characters to align with type of requirement), see below:

- Contract Category, as specified in the contract document detailed below.

All Services	All
Accident and Emergency Services	A+E
Acute Services	A
Ambulance Services	AM
Cancer Services	CR
Continuing Healthcare Services	CHC
Pharmacy Delivered Community Services	Ph
Community Services	CS
Diagnostic, Screening and/or Pathology Services	D
End of Life Care Services	ELC
Mental Health and Learning Disability Services	MH
Mental Health and Learning Disability Secure Services	MHSS
NHS 111 Services	111
Patient Transport Services	PT
Radiotherapy Services	R
Surgical Services in Community Setting	S
Urgent care/Walk-in Centre Services/Minor Injuries Unit	U

- Flow type identifier. To support identification of the data for customers.

  N-National
  A – All requirements which have been reviewed and aligned CSU – wide.
  R – Regional requirements which are part of the old CSU areas to support any initiatives set up in the geography.
  L – Local requirements which would be specific to the contract / CCG requirement very local flows

Part 8 – Other

- This is an optional field you can add additional elements to support use and identification.
  - Example would be to add additional to support identification of the file for specific use.

Note 5	To follow	

Appendix 1

N2 Quality Report

Key Performance Report

Qualifying criteria
Performance Report details

Feeder file specification	
File format	Comma-separated variable-length fields/ Tab Delimited/XLSB ; column headers in 1st row.
File name	PPPPP_CCG_QUALITY_YYYYMMDD_P00_V01_--00N--_OTHER See Note 4 on Information Schedule for file format detail
Extract frequency	Withing 15 Operational Days of the end of the month to which it relates
Delivery mechanism	To be sent to email address as identified in Note 1 on the Information Schedule

Seq	Data item	Detail	Data Format	max length
1	KPICode	Code of Indicator report	an	10
2	Source	Source of data	an	30
3	Year	Year of data	YYYY	
4	Period of Report	Month of the report	MM	
5	ORGANISATION CODE (CODE OF COMMISSIONER)	National ODS code - see HSCIC website for list of valid codes. This should should be derived with reference to the published commissioner assignment method (hierarchy).	an	5
6	ORGANISATION CODE (CODE OF PROVIDER)	National ODS code - see HSCIC website for list of valid codes.	an	6
7	Service	Name of service	an	20
8	Site	Site for provider	an	20
9	Month	Month of data	MM	
10	Target (Current Month)	National or local target for the indicator number or percentage	n	6
11	Numerator (Current Month)	Number or percentage	n	12
12	Denominator (Current Month)	Number or blank	n	12
13	Target (YTD)	National or local target for the indicator number or percentage	n	6
14	Numerator (YTD)	Number or percentage	n	12
15	Denominator (YTD)	Number or blank	n	12
16	Target (year end)	National or local target for the indicator number or percentage	n	6
17	Numerator(year end)	Number or percentage	n	12
18	Denominator (year end)	Number or blank	n	12
19	User Field 1	Leave blank unless local agreement for content	an	150
20	User Field 2	Leave blank unless local agreement for content	an	150
21	User Field 3	Leave blank unless local agreement for content	an	150
22	User Field 4	Leave blank unless local agreement for content	an	150
23	User Field 5	Leave blank unless local agreement for content	an	150

Appendix 2

N10 Violence MDS Specification

NHS
South, Central and West
Commissioning Support Unit

Specification

Information Sharing to Tackle Violence Minimum Data Set

Version	Date	Author	Details
V1	01/02/2016	Sarah Gibbs	Alignment to the national

Requirements and Rationale
The purpose of the Information Sharing to Tackle Violence Minimum Data Set is to enable the collection of anonymised information on those PATIENTS presenting at Accident and Emergency Departments for treatment as a result of a violent assault. This information is to be shared with Community Safety Partnerships (formerly known as Crime and Disorder Reduction Partnerships in England) to reduce community violence. The requirement for ACCIDENT AND EMERGENCY DEPARTMENT TYPE '01' to collect the Information Sharing to Tackle Violence Minimum Data Set is considered mandatory. The requirement for ACCIDENT AND EMERGENCY DEPARTMENT TYPE '02', '03' and '04' to collect the Information Sharing to Tackle Violence Minimum Data Set is considered optional. The frequency of reporting the Information Sharing to Tackle Violence Minimum Data Set should be determined locally, but must be at least monthly. Submission Information: The Information Sharing to Tackle Violence Minimum Data Set is submitted to a Community Safety Partnership using the Information Sharing to Tackle Violence XML Schema. http://www.isb.nhs.uk/documents/isb-1594/amd-31-2012/index_html#Information

Information Sharing to Tackle Violence Minimum Data Set

Qualifying criteria
Information for sharing minimum data set.

Feeder file specification	
File format	Comma-separated variable-length fields/ Tab Delimited/XLSB ; column headers in 1st row.
File name	PPPPP_CCG_VIOLENC_YYYYMMDD_P00_V01_-00N10_OTHER See Note 4 on Information Schedule for file format detail
Extract frequency	First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable.
Delivery mechanism	To be sent to email address as identified in Note 1 on the Information Schedule

Seq	Data item	Detail	format	max length
1	REPORTING PERIOD START DATE	Date of the start of the reporting period	CCYY-MM-DD	10
2	REPORTING PERIOD END DATE	Date of the end of the reporting period	CCYY-MM-DD	10
3	SITE CODE (OF TREATMENT)	ODS code of the A&E department, hospital or trust	an	9
4	ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	Date and time that the patient attended (i.e. arrived at) A&E department	YYYY-MM-DDThh:mm:ss	19
5	ASSAULT DATE AND TIME	Date and time that violent incident occurred	YYYY-MM-DDThh:mm:ss	19
6	ASSAULT METHOD	Details of the primary method of assault including whether a weapon or body part was used, and if so, what. One selected from the following: 01 Fist 02 Feet 03 Head 04 Other (specify) 05 Combination of body parts 06 Pushed 07 Glass 08 Bottle 09 Knife 10 Other bladed or sharp object (specify) 11 Any blunt object (specify) 12 Firearm 13 Explosive 14 Other weapon (specify) 15 Patient asked but does not know / refuses to say 16 Unknown (patient unconscious / dead)	an	2
7	ASSAULT METHOD OTHER DESCRIPTION	Free text description of the weapon(s) if 04, 10, 11 or 14 is selected for ASSAUL	an	25
8	ASSAULT LOCATION TYPE	Type of location where the violent incident took place One selected from the following: 01 Home or private address 02 Other location (specify)	an	2
9	ASSAULT LOCATION DESCRIPTION	Free text description of the type of location the incident took place if 02 is selected for ASSAULT LOCATION DESCRIPTION	an	255
10	User Field 1	Leave blank unless local agreement for content	an	150
11	User Field 2	Leave blank unless local agreement for content	an	150
12	User Field 3	Leave blank unless local agreement for content	an	150
13	User Field 4	Leave blank unless local agreement for content	an	150
14	User Field 5	Leave blank unless local agreement for content	an	150

* Please note the cut off date to run the report would be the last day of the month.

Appendix 3

C02 Community Contract Schedule Report Specification

Aggregate Contract Monitoring (ACM) Template

Qualifying criteria
Provides aggregate contract monitoring report against plan This ACM is required to be submitted on a monthly basis to the DSCRO/CSU/other organisation as nominated by each commissioning function in line with the dates documented in the data submission timetable within Schedule 6 of the NHS Standard Contract. The total financial value contained within the ACM for any particular month MUST tie-back to the invoices raised in reference to the same period. Any monthly resubmission of data must be accompanied by a reissued monthly ACM dataset to be used on a bulk-replacement basis. Resubmission of patient-level data must also be accompanied by a resubmission of this aggregate template. Failure to meet this requirement and its associated timescale could result in an Information Breach pursuant to the Service Conditions contained within the NHS Standard Contract 2016/17.

Feeder file specification		
File format		Comma-separated variable-length fields/ Tab Delimited/XLSB ; column headers in 1st row.
File name		PPPPP_CCG_SLAMAGG_YYYYMMDD_P00_V01_-000A0-_OTHER See Note 4 on Information Schedule for file format detail
Extract frequency		First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable.
Delivery mechanism		To be sent to email address as identified in note 1

Seq	Field Name	Notes	Data Format	max length
1	Month	Month in which the activity occurred (1 = Apr, 2 = May...12 = Mar). Month should be set to zero if the ACM is being used as a Price Activity Matrix (PAM)	n	2
2	Year	Financial year in which the activity occurred (15/16 = 2015/16, 16/17 = 2016/17...)	an	5
3	File Date	Date and time that will be used to ascertain the latest version of the ACM.	DD/MM/YYYY hh:mm	

4	ORGANISATION CODE (CODE OF PROVIDER)	National ODS code - see HSCIC website for list of valid codes. This should should be derived with reference to the published commissioner assignment method (hierarchy).	an	6
5	Organisation Code (Responsible CCG)	National ODS code - see HSCIC website for list of valid codes. This should should be derived with reference to the published commissioner assignment method (hierarchy).	an	5
6	ORGANISATION CODE (CODE OF COMMISSIONER)	National ODS code - see HSCIC website for list of valid codes. This should should be derived with reference to the published commissioner assignment method (hierarchy).	an	5
7	ACTIVITY TREATMENT FUNCTION CODE	National 3-figure ODS code - see HSCIC website for list of valid codes (999 if not applicable)	an	3
8	LOCAL SUB-SPECIALTY CODE	Local 8-figure code - see HSCIC website for guidance.	an	8
9	NHS England Commissioned Service Category	See list of valid NHS England Commissioned Service Category codes.	an	2
10	Service Code	See list of valid Specialised Service codes.	an	8
11	Healthcare Resource Group	HRG code containing respective top-up suffix where applicable e.g. AA18Z/8 or QZ15B/BP25.	an	50
12	National Point Of Delivery	See list of valid National Point of Delivery (POD) codes - see separate sheet	an	10
13	Local Point Of Delivery	This field MUST be mapped to the National Point of Delivery (see above)	an	10
14	Local Point Of Delivery Description	This field MUST be mapped to the National Point of Delivery (see above)	an	50
15	Further Detail Code	Free text similar to an Ad-Hoc Description field. This field must be completed where the National Point Of Delivery is indicated as requiring more detail. Where further detail needs to captured in structured data, this should be in the format DESCRIPTION|MEASURE.	an	10

16	Further Detail Description		an	100
17	National Tariff	National tariff flag (Y=national tariff, N=locally-agreed tariff)	an	1
18	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	National ODS code - see HSCIC website for list of valid codes. This should should be derived with reference to the published commissioner assignment method (hierarchy).	an	6
19	Activity Plan	The planned activity for the period	n	10
20	Price Plan	The planned full value for the period (base + MFF)	n	
21	MFF Plan	The planned MFF value for the period	n	
22	Activity Actual	The actual activity for the period	n	10
23	Price Actual	The actual full value for the period (base + MFF)	n	
24	MFF Actual	The actual MFF value for the period	n	
25	Service number	service description code	an	50
26	Service Description	service description name	an	150
27	Sub-Service Code	Sub (lower) service level code	an	50
28	Sub-Service Description	Sub (lower) service level name	an	150
29	Provider Type Code	Code to represent if the service provider is: Prime, Collaborative or subcontracted	an	50
30	Provider Type Description	Name to represent if the service provider is: Prime, Collaborative or subcontracted	an	150
31	SBU Code	code for Service business unit code - groups of aligned services	an	50
32	SBU Description	name for Service business unit code - groups of aligned services	an	150
33	Provider codes	code of Provider of service -	an	50
34	Provider description	name fof provider of service	an	150
35	Data Source	Data source - where data is submitted nationally / stored	an	50

36	Level of Data	Data detail level	an	150
37	Commissioner / funding Codes	Code for commissioner who is funding service	an	50
38	Commissioner / funding Description	name for commissioner who is funding service	an	150
39	Referral Plan	The planned referrals for the period (as per IAP)	n	10
40	Referrals Actual	The actual referrals for the period (as per IAP)	n	10
41	Service number	Agreed tolerance of actual to plan	n	10

More detail can be found in spreadsheet provided as additional information
Please note - subject to change by NHSE, template to be updated to reflect

C03 Community Care PLD

Patient Level Data to support Aggregate Contract Monitoring (ACM) Template

Qualifying criteria
Community Care Services PLD file.

Feeder file specification	
File format	Comma-separated variable-length fields/ Tab Delimited/XLSB ; column headers in 1st row.
File name	PPPPP_CCG_SLAMPLD_20170401_ P00_V01_CS00A03 See Note 4 on Information Schedule for file format detail
Extract frequency	First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable.
Delivery mechanism	To be sent to email address as identified in note 1

ID	Data Item Name / NHS	Data Item Description	Format	Physical Data Type

	Data Dictionary Name			
1	LOCAL PATIENT IDENTIFIER	This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.	max an10	varchar(10)
2	ORGANISATION CODE (CODE OF PROVIDER)	The ORGANISATION CODE of the ORGANISATION acting as a Health Care Provider.	max an12	varchar(12)
3	ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	The ORGANISATION CODE of the ORGANISATION responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group.	max an12	varchar(12)
4	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	The ORGANISATION CODE derived from the PATIENT's POSTCODE OF USUAL ADDRESS	max an12	varchar(12)
5	NHS NUMBER	A number used to identify a PATIENT uniquely within the NHS in England and Wales	n10	integer
8	POSTCODE OF USUAL ADDRESS	The POSTCODE of the ADDRESS nominated by the PATIENT with ADDRESS ASSOCIATION TYPE 'Main Permanent Residence' or 'Other Permanent Residence'	max an8	varchar(8)
9	PERSON STATED GENDER CODE	PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.	an1	char(1)

10	ETHNIC CATEGORY	The ethnicity of a PERSON, as specified by the PERSON.	an2	char(2)
11	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	The ORGANISATION CODE of the GP Practice that the PATIENT is registered with.	an6	char(6)
12	ORGANISATION CODE (CODE OF COMMISSIONER)	The ORGANISATION CODE of the ORGANISATION commissioning health care.	max an12	varchar(12)
13	CARE CONTACT IDENTIFIER (ACTIVITY IDENTIFIER)	The CARE CONTACT IDENTIFIER is used to uniquely identify the CARE CONTACT within the Health Care Provider. It would normally be automatically generated by the local system upon recording a new Care Contact, although could be manually assigned.	max an20	varchar(20)
14	CARE CONTACT DATE (ACTIVITY DATE)	The relevant activity date will vary from dataset and the CDS ACTIVITY DATE, or specific dataflow guidance, should be used. Broadly speaking, the relevant activity date is: Community: Care Contact Date	an10 CCYY-MM-DD	date
16	WITHHELD IDENTITY REASON	Allows suppliers of records to indicate to recipients of the record that the record has been purposely anonymised for a valid reason.	an2	char(2)
17	Age at Care Contact Date (Age at Activity Date)	The number of completed years between the person birth date of the patient and the activity date.	n3	integer

19	ACP DECIDING RIGHTS STATUS	The status of the Advance Care Planning deciding rights.	n2	char(2)
20	AFTERCARE DATE	The DATE on which a first aftercare appointment is scheduled for.	CCYY-MM-DD	an10
21	ANY INCIDENT REPORTS DURING ADMISSION	Any incident reports during admission identifies where there has been an incident report during ADMISSION.	an2	char(2)
22	CARE PLAN STATUS	Care plan status demonstrates if a care plan has been agreed or not.	an2	char(2)
23	ANNUAL REVIEW DATE	The YEAR, MONTH and DATE of an annual review, if appropriate	CCYY-MM-DD	an5
25	DECIDED TO ADMIT DATE	DECIDED TO ADMIT DATE may be the same as the date of admission. Alternatively, a decision may be made to admit at a future date.	CCYY-MM-DD	an10
26	DISCHARGE DESTINATION	The destination of a PATIENT on completion of a Hospital Provider Spell, or a not that the PATIENT died or was a still birth.	an2	char(2)

27	SERVICE DISCHARGE TIME	Service Discharge time is the time a PATIENT was discharged from a SERVICE. This would occur once all the services or teams (for example as part of a multidisciplinary team) have finished treating a patient under a specific referral.	HH:MM:SS	an8
28	FOLLOW-UP APPOINTMENT DATE	The date of a follow-up appointment, if appropriate	CCYY-MM-DD	an10
29	REFERRING GENERAL PRACTITIONER CODE	The GENERAL MEDICAL PRACTITIONER PPD CODE to identify the GP responsible for referring the PATIENT to the service.	an8	char(8)
31	ACTIVITY LOCATION TYPE CODE (PREFERRED)	The type of LOCATION for an ACTIVITY: where PATIENTS are seen, where SERVICES are provided or from which requests for SERVICES are sent.	an3	char(3)
32	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE	The RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION of a PERSON, as specified by a PERSON.	an4	char(4)
33	REFERRAL REJECTION TIME	The time the Referral Request to a Health Care Provider's Service was rejected by the Health Care Provider's Service. The overarching referral may remain open if another service or team involved in the same referral is still actively treating the patient.	HH:MM:SS	an8
34	OUTCOME OF ATTENDANCE	This records the outcome of an Out-Patient Attendance Consultation.	n1	char(1)

35	Service number	service description code	an	50
36	Service Description	service description name	an	150
37	Sub-Service Code	Sub (lower) service level code	an	50
38	Sub-Service Description	Sub (lower) service level name	an	150
39	Provider Type Code	Code to represent if the service provider is: Prime, Collaborative or subcontracted	an	50
40	Provider Type Description	Name to represent if the service provider is: Prime, Collaborative or subcontracted	an	150
41	SBU Code	code for Service business unit code - groups of aligned services	an	50

42	SBU Description	name for Service business unit code - groups of aligned services	an	150
43	Provider codes	code of Provider of service -	an	50
44	Provider description	name fof provider of service	an	150
45	Data Source	Data source - where data is submitted nationally / stored	an	50
46	Level of Data	Data detail level	an	150
47	Commissioner / funding Codes	Code for commissioner who is funding service	an	50
48	Commissioner / funding Description	name for commissioner who is funding service	an	150

49	Referral Plan	The planned referrals for the period (as per IAP)	n	10
50	Referrals Actual	The actual referrals for the period (as per IAP)	n	10
51	tolerance	Agreed tolerance of actual to plan	n	10
53	Discharge Date		CCYY-MM-DD	an10
54	Referral Date		CCYY-MM-DD	an10

More detail can be found in spreadsheet provided as additional information

Appendix 4

C05 Delayed Transfer of Care Specification

Specification

Delayed Transfers of Care

Version	Date	Author	Details
V1	01/02/2016	Sarah Gibbs	Review of requirements supporting national criteria
			Aligned to Data Dictionary Standards in flow groups and definitions
	14/07/2016	Cecile Coignet	Based on the CSU Draft PLD and Aggregate DTOC Templates 2016-17 v0.1
	22/09/2016	Veronika Sas	Deleted Local codes from 'DToC Aggregate' tab
			File name has been changed both 'DToCAGG
	26/09/2016	Veronika Sas	'National Sitrep Codes' tab has been changed.
	26/09/2016	Veronika Sas	The 'Responsibility' tab has been changed.

Requirements and Rationale
Definition of a Delayed Transfer 3.1 A SitRep delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when: a. A clinical decision has been made that patient is ready for transfer AND b. A multi-disciplinary team decision has been made that patient is ready for transfer AND c. The patient is safe to discharge/transfer.

Delayed Transfer of Care Aggregate

Qualifying criteria
Patient whose discharge is delayed as at weekly snapshot (Thursday midnight)
This return will be required to completed at Trust Level

Feeder file specification	
File format	Comma-separated variable-length fields/ Tab Delimited/XLSB ; column headers in 1st row.
File name	PPPPP_CCG_DTOCAGG_YYYYMMDD_P00_V01_--00A1-_OTHER.csv See Note 4 on Information Schedule for file format detail
Extract frequency	Weekly snapshot to be sent **no later than Monday 4pm** (for snapshot previous Thursday)
Delivery mechanism	To be sent to email address as identified in Note 1

Seq	Data item	Detail	Data Format	max length
1	**ORGANISATION CODE (CODE OF PROVIDER)**	**National ODS code - see HSCIC website for list of valid codes.**	**an**	**6**
2	Provider Org Name		**an**	**50**
3	Local Authority Code		**an**	**5**
4	Local Authority Name		**an**	**50**
5	CCG Code	**National ODS code - see HSCIC website for list of valid codes.**	**an**	**5**
6	CCG Name		**an**	**50**
7	Acute Or Non Acute Description		**an**	**20**
8	Reason For Delay	**National reason for delay. See National Sitrep code sheet - Must be exactly as per the National Sit rep codes tab, column A in both content and format - deviation disables the automated data load process!**	**an**	**4**
9	NHS A SUM	number of patients delayed	**n**	**6**
10	NHS B SUM	number of days delayed	n	6
11	Social Care A SUM	number of patients delayed	**n**	**6**
12	Social Care B SUM	number of days delayed	**n**	**6**
13	Both A SUM	number of patients delayed	n	6
14	Both B SUM	number of days delayed	**n**	**6**

Note	Data Items in yellow are items not collected in the UNIFY submission

National Code	Nat_Code_Desc_Long	Nat_Code_Desc_Short
A	Awaiting completion of assessment	A_COMPLETION_ASSESSMENT
B	Awaiting public funding	B_PUBLIC_FUNDING
C	Awaiting further non-acute (including community and mental health) NHS care (including intermediate care rehabilitation services etc)	C_FURTHER_NON_ACUTE_NHS
Di	Awaiting residential home placement or availability	DI_RESIDENTIAL_HOME
Dii	Awaiting nursing home placement or availability	DII_NURSING_HOME
E	Awaiting care package in own home	E_CARE_PACKAGE_IN_HOME
F	Awaiting community equipment and adaptations	F_COMMUNITY_EQUIP_ADAPT
G	Patient or Family choice	G_PATIENT_FAMILY_CHOICE
H	Disputes	H_DISPUTES
I	Housing – patients not covered by NHS and Community Care Act	I_HOUSING

Appendix 5

C13 Hip and Knee Pathway Specification

Template below

Field Name	Data example
Urgency	OA Pathway
Discharge Location	Discharge-Self Management
Date Discharge	04/04/2016
NHS Number	
Date Referral	16/12/2015
Date Referral Month Description Short	Dec
Source	General Practise
Service Offered	Physiotherapy
Primary Reason	Assessment
Secondary Reason 2	
Secondary Reason 3	
Secondary Reason 4	
GP Referral	1
Outcome	Accepted
GP National Practice Code	L81122
Registered GMS Practice	St. Mary's Surgery
CCG	11E
Contact Location	Paulton Memorial Hospital
Stay In Service Length Days	110
Stay In Service Length Months	4
Unit	Sirona Physiotherapy Outpatients

Appendix 6

C18 Referral Specification

Template to follow

Specification

Referrals

Version	Date	Author	Details
V1	01/02/2016	Sarah Gibbs	Review the data flows for national aligment FOP, Ereferrals, OP
	18/10/2016	Sarah Gibbs	Updated wording to remove the word Outpatient

Requirements and Rationale
Referrals are based on a monthly snapshot and a year to date file should be sent each month to capture any additional referrals or changes in the data file.

Referrals

Qualifying criteria	
GP referrals and Other Referrals into the system	
All referrals received by the trust.	
OR	Other exclusion are for referrals received and cancelled or non accepted due to: GP, Hospital or Patient Request , Hospital Refusal , Medical Advice Ref to Other Provider
	Patient gone private

Feeder file specification	
File format	Comma-separated variable-length fields/ Tab Delimited/XLSB ; column headers in 1st row.
File name	PPPPP_CCG_OPREF00_YYYYMMDD_P00_V01_-000A--_OTHER See note 4 on Information Schedule regarding file name formats
Extract frequency	First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable.
Delivery mechanism	To be sent to email address as identified in Note 1 of Information Schedule

Seq	Data item	Detail	format	max length
1	ORGANISATION CODE (CODE OF PROVIDER)	National ODS code - see HSCIC website for list of valid codes.	an	6
2	ORGANISATION CODE (CODE OF COMMISSIONER)	National ODS code - see HSCIC website for list of valid codes. This should should be derived with reference to the published commissioner assignment method (hierarchy).	an	5
3	Date Letter Received / Date of Referral	Date referral received by department. UBRN Converted date	yyyy-mm-dd hh:mm:ss	
4	Hospital Spell Number/local number		an	20
5	Local patient number	Local PAS ID	an	12
6	NHS number		an	10
7	Age	Age at date of referral to one decimal place	an	3
8	Post code		an	8
9	Gender *	1 male 2 female	n	1
10	Event Category	As defined in the E referral system 1 Request 2 Referral Letter 3 Appointment 4 Miscellaneous 5 Additional requirements 0 Advice	an	1
11	Service Type Requested	As defined in the data dictionary service type requested.	an	2
12	General Medical Practice Code	National ODS code - see HSCIC website for list of valid codes.	an	6
13	Referring GP practice code	National ODS code - see HSCIC website for list of valid codes.	an	6
14	Referring GP code	National ODS code - see HSCIC website for list of valid codes.	an	8
15	Registered GP code	National ODS code - see HSCIC website for list of valid codes.	an	8
16	Source Of Referral Code	See source of referral table (national codes) as defined in the Data Dictionary	n	2
17	Priority Description	Code: 1 Routine; 2 Urgent; 3 Two Week Wait	n	1
18	Appointment Type	Planned Care, Diagnostics and Outpatient, Unscheduled Care, Community, Other to match e - referral	an	150
19	Consultant Code	National ODS code - see HSCIC website for list of valid codes.	an	8
20	Referring Specialty - specialty to which the GP or other referred the patient into, this may be different to the actual specialty the referral is received by	National Treatment Function Code as defined in Data Dictionary and E - referrals	n	3
21	MainSpecialty Code	National 3-figure ODS code - see HSCIC website for list of valid codes (999 if not applicable)	an	3
22	Treatment Function Code Specialty	National 3-figure ODS code - see HSCIC website for list of valid codes (999 if not applicable)	an	3
23	C&B	Y/N (Referral; via Choose and Book) This will be used to measure C&B Utilisation	an	1
24	Unique Booking reference Number / Patient Pathway ID (whichever applicable)	When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be	an	20

Appendix 8

C12 – Audiology Patient Level

See below.

Field name	**example**
NHS Number	
Referral Date	26/08/2016
Local Patient ID	31029
Date of Birth	
Contact Date	11/11/2016
Contact Code	Binaural Mould Fit Complete (2)
Contact detail	Binaural Mould Fit Complete (2)
Tariff code	6
Tariff detail	audiology device fitting
Location Type code	2
Location Type detail	CLINIC
Responsible GP Practice (National Code)	L81123
Responsible GP Practice Detail	xxx Surgery
Contact Type Code	1
Contact Type Detail	First
Contact Medium Code	1
Contact Medium Detail	Face to Face
Service code	123
Service Detail	Adult Audiology
Consultant Type code	2
Consultant Type detail	Non Consultant Led

Responsible CCG code	11E
Responsible CCG description	Bath & North East Somerset CCG
Attended type code	1
Attended type detail	Attended
Administrative Category Code	2
Administrative Category detail	NHS

Appendix 9

C10 Daily Urgent Scorecard

6 data items provided daily in excel spreadsheet one row per day

Activity Date	C22. Daily occupancy level (SIRONA)	C25. Number of open beds (SIRONA)	F15. Daily community DTOCS - (Sirona/NHS) - SIRONA	F16. Daily community DTOCS - (Sirona/Social Services) - SIRONA	C42. Reablement beds available - SIRONA	C43. % Reablement bed occupancy - SIRONA

See also appendix 12

Appendix 10

C01 Community Services flat file – interim for CIDS

1 record per contact format as below.

Field Name	**Data example**
Contact ID	50797483
Employment Status	
Ethnic Category	White - ethnic group
Preferred Communication Language	
LOCAL PATIENT IDENTIFIER	39498117
NHS Number	[TO BE REMOVED BY CSU]
Organisation Code Residence Responsibility	11E
Person Birth Date	[TO BE REMOVED BY CSU]

Person Gender Current	F
Postcode Of Usual Address	[TO BE REMOVED BY CSU]
GP National Practice Code	L81644
GP Code	
Organisation Code of Commissioner	11E
Financial Month of Referral	1
Primary Reason For Referral	UTI - N39.0
Priority Type	Normal
Referral Closure Date	
Referral Closure Reason	
Referral Request Received Date	15/04/2016
Service Request Identifier	50797483
Service Type Referred To	Sirona Reablement Service
Source Of Referral	Royal United Hospital
Other Reason for Referral	UTI - N39.0
Activity Location Type	Home of Patient
Care Contact Date	22/04/2016
Care Contact Time	18:40:00
Care Contact Type	FollowUp
Clinical Duration of Care Contact	25
Consultation Method Used	Face to face
Financial Month of Contact	1
Organisation Code of Provider	NLX00
Caseload Name Provider	Reablement

Appendix 11

C06 Delayed transfers of Care – local format data

A template is in place locally collecting:

Template columns	Example
Health Care Area (drop down list)	Acute - Hospitals
Provider (drop down list)	RUH
DToC Date	2.2.17
Patient Initials	
NHS Number	
Date Admitted	21-Nov-16
Date Ready for Transfer (RFT)	
Core NHSE Code (drop down list)	B. Awaiting public funding
Service Code (drop down list)	B1. Social Care
Action Code (drop down list)	Bb. Awaiting funding decision for placement.
Number of days delayed	8
Reason for Delay Comments (please give brief description why patient is delayed)	Funding decision re a residential placement at The Orangery deferred pending exploration of the cost of nursing vacancies in other homes.
Actions taken this week to expediate	
Attributable to NHS, Social Care or Both	Social Care
Service responsible for transfer	
DToC Code (Official DToC)	D (means yes)
CCG code (drop down list)	11E - Banes

drop down for health care areas:

Health Care Areas
Acute - Hospitals
Community - Hospitals
Other Community - Teams

Other drop downs:

Core NHSE Code	Service Code	Action Code	DToC Code (Official DToC)	Area Code (CCG code)
A. Awaiting completion of assessment	A1. Social Care	Aa. Awaiting therapy assessment	D	i.e. 11e
	A2. Continuing Health Care (CHC)	Ab. Awaiting completion of CM7		
	A3. Mental Health	Ac. CM7 Received/assessment in progress but no care plan agreed		
		Ad. Awaiting mental health assessment		
		Ae. Awaiting CMHT allocation/assessment		
B. Awaiting public funding	B1. Social Care	Ba. Awaiting funding decision for domiciliary care package.		
	B2. Continuing Health Care (CHC)	Bb. Awaiting funding decision for placement.		
	B3. Mental Health	Bc. Awaiting funding decision for Domiciliary Care package - CMHT		
		Bd. Awaiting funding decision for placement - CMHT		
C. Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	C1. Community Hospital (Bedded Care)	Ca. Waiting health care services to be implemented in the community (reablement/Continuing Health Care)		
	C2. Community Team (Non bedded Care)	Cb. Nursing home of patients choice accepted patient but no bed available yet - NHS funded care (Continuing Health Care)		
	C3. Mental Health Capacity	Cc. Waiting transfer to Community Hospital		
		Cd. Waiting transfer to other hospital (i.e. RNHRD)		
		Ce. Waiting CHC series/placement to be implemented		
D.i) Awaiting residential home placement or availability	Di1. Social Care	Dia. Assessment completed, care plan agreed family looking for Residential Home.		
	Di2. Continuing Health Care (CHC)	Dib. Awaiting Residential home to assess.		
	Di3. Mental Health	Dic. Funding has been agreed by the Local Authority (public funding) but there is no bed available at the chosen residential home (relates to the choice directive)		
	Di4. Self-Funding	Did. Assessment completed, care plan agreed family looking for Residential Home - CMHT		
		Die. No availability within agreed rates		
D.ii) Awaiting nursing home placement or availability	Dii1. Social Care	Diia. Assessment completed, care plan agreed family looking for Nursing Home.		
	Dii2. Continuing Health Care (CHC)	Diib. Awaiting Nursing Home to assess.		
	Dii3. Mental Health	Diic. Funding has been agreed by the Local Authority (public funding) but there is no bed available at the chosen Nursing Home (relates to the choice directive)		
	Dii4. Self-Funding	Diid. Assessment completed, care plan agreed family looking for Nursing Home - CMHT		
		Diie. No availability within agreed rates		
E. Awaiting care package in own home	E1. Social Care (Dom Care)	Ea. Waiting social services funded domiciliary care (home care)		
	E2. Continuing Health Care (CHC)	Eb. Waiting privately funded domiciliary package.		
	E3. Mental Health	Ec. Waiting CMHT funded domiciliary care package		
	E4. Self-funding	Ed. Waiting reablement (social Care)		
		Ee. Delayed due to patient or family choice		
F. Awaiting community equipment and adaptations	F1. Social Care (Dom Care)	Fa. Awaiting needs assessment		
	F2. Continuing Health Care (CHC)	Fb. Awaiting equipment order		
	F3. Mental Health	Fc. Awaiting funding		
	F4. Self-funding	Fd. Awaiting fitting/supply		
G. Patient or Family choice	G1. Social Care (Placement)	Ga. No top up funding available		
	G2. Continuing Health Care (CHC)	Gb. No availability in local area (Local to family's area of choice)		
	G3. Mental Health	Gc. Alternative temporary offer made, family declined		
	G4. Self-funding	Gd. More than 2 appropriate offers made, family declined		
H. Disputes				
I. Housing – patients not covered by Care Act				

Appendix 12

C09 Operational care delays – daily report

Bridging the Gap

16.01.2017

BaNES Daily Position	Today's clients
Days lost to POC	80
Days lost to Placement	0
Total	80

Days lost

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Reablement	228	331	394	363	327	421
District Nursing	61	132	66	41	44	23
Hospitals	404	325	270	272	431	417
Stroke ESD	63	33	3	4	6	0
Total	756	821	733	680	808	861

Capacity

Number of outstanding requests for Dom Care Providers	Number of hours	*C22. Daily occupancy level (SIRONA)*	*C25. Number of open beds (SIRONA)*	*F15. Daily community DTOCS - (Sirona/NHS) - SIRONA*	*F16. Daily community DTOCS - (Sirona/Social Services) - SIRONA*	*C42. Reablement beds available - SIRONA*	*C43. Reablement bed occupancy - SIRONA*
14	168.75	1.00000	59	0	7	17	1

Data for Commissioners Urgent Care Scorecard

16-Jan-17

Measure		Detail	Sulis	Paulton	CRC Beds	ORCP Beds	Totals
D2A Pathway 2		Number patients transferred from acute hospital in last 24 hours	0	0	0	0	0
		Number expected discharges today	2	3	0	0	5
		Number patients admitted from the community in last 24 hours	0	0	0	0	0
		Number vacant beds available for admission now	0	0	0	0	0
		Number of these beds already allocated	0	0	0	0	0
		Number of beds available for Females	2	2	0	0	4
		Number of beds available for Males	0	1	0	0	1
Reablement, CNSS & IMPACT			Bath	Keynsham	MSN	IMPACT	ESD	Totals
Admission Avoidance	*Locality team clinician in charge*	Number Admissions prevented in last 24 hours	0	1	0	0	0	1
		Number Admission referrals declined in last 24 hours	0	0	0	0	0	0
		Number Admission Avoidance spaces available today	2	0	1	0	0	3
		Total number Admission Avoidance referrals on caseload	16	14	17	0	0	47
		How many of these are not allocated for today?	0	0	0	0	0	0
Planned	*Locality team clinician in charge*	Number Planned referrals received in last 24 hours	0	0	0			0
		Number Planned referrals awaiting assessment	27	10	14			51
		Number Planned referrals overdue assessments(over 6 weeks)	0	3	6			9
		Longest wait for planned assessment	0	26	63			89
		Total number Planned referrals on caseload	155	47	75			277
D2A Pathway 1	*Locality team clinician in charge*	Number D2A referrals seen in last 24 hours	0	0	0			0
		Number D2A spaces available today	0	1	1			2
		How many of these have already been allocated?	0	1	0			1
		Is there support for Reablement Visits?	Yes	No	Yes			No
		How many on D2A Caseload?	23	11	13			47
Acute Hospital Discharge	*Locality team clinician in charge*	Number referrals taken in last 24 hours				0	1	1
		Number spaces available today				0	0	0
		How many of these have already been allocated?				0	1	1
		Number of Patients waiting for service				0	1	1
		Staffing Status	#N/A	#N/A	Amber	0	green	

Appendix 13

C07 Delayed operational care delays – monthly scorecard local format data

B&NES Adult Services Scorecard

Provision of care to bridge gap between discharge from service to domiciliary package start

		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	15/16	16/17
Reablement															
Bath	days	140	210	135	174	85	134	104	132	119	98	111	134	61	121
	visits	173	479	225	274	143	267	233	363	323	290	208	236	107	260
Keynsham	days	200	80	129	204	103	157	174	113	111	110	62	25	98	118
	visits	283	136	305	360	262	286	343	140	222	312	170	41	137	237
Midsomer Norton	days	54	73	63	43	4	81	67	42	63	154	162	83	43	78
	visits	47	84	179	63	5	167	172	97	154	312	361	236	93	174
Total	**days**	**394**	**363**	**327**	**421**	**192**	**372**	**345**	**287**	**293**	**362**	**335**	**242**	**202**	**317**
	visits	**503**	**699**	**709**	**697**	**410**	**720**	**748**	**600**	**699**	**914**	**739**	**513**	**337**	**671**
District Nursing															
Bath	days	11	5	15	0	0	7	0	6	31	99	39	18	18	22
	visits	14	9	13	0	0	8	0	6	31	106	39	18	21	23
NES	days	11	0	0	2	7	0	24	17	34	48	36	39	11	23
	visits	22	0	0	2	12	0	15	20	36	51	37	42	20	24
Twilight	days	44	36	29	21	20	2	18	17	6	29	23	21	36	17
	visits	4	1	0	0	0	0	0	18	7	31	24	21	22	11
Total	**days**	**66**	**41**	**44**	**23**	**27**	**9**	**42**	**40**	**71**	**176**	**98**	**78**	**64**	**63**
	visits	**40**	**10**	**13**	**2**	**12**	**8**	**15**	**44**	**74**	**188**	**100**	**81**	**59**	**58**
Hospitals															
St. Martin's	days	110	138	191	165	64	70	100	62	148	286	93	133	139	125
Paulton	days	160	134	240	252	150	147	149	214	212	193	115	176	112	179
Total	**days**	**270**	**272**	**431**	**417**	**214**	**217**	**249**	**276**	**360**	**479**	**208**	**309**	**251**	**303**
Specialist Services															
CHC/FNC	days													92	
	visits													97	
Community Neuro & Stroke	days	3	4	6	0	0	1	0	0	2	1	2	1	25	1
	visits	9	6	22	0	0	1	0	0	2	2	4	2	48	1
Total	**days**	**3**	**4**	**6**			**1**			**2**	**1**	**2**	**1**	**43**	**1**
	visits	**9**	**6**	**22**			**1**			**2**	**2**	**4**	**2**	**67**	**1**
Overall															
Total	**days**	**733**	**680**	**808**	**861**	**433**	**599**	**636**	**603**	**726**	**1,018**	**643**	**630**	**577**	**683**
	visits	**552**	**715**	**744**	**699**	**422**	**729**	**763**	**644**	**775**	**1,104**	**843**	**596**	**457**	**731**

Appendix 15

C19 Carer's Register

Description of requirement below should tie into the Carer's Centre Service Specification section 5.1.8 Develop and Maintain a Carer's Register.

To maintain on behalf of the Council and the Clinical Commissioning Group a Carer's Register. This register will contain carer's contact details, their date of birth, their relationship to the person cared for and the cared for person's service user group.

The register is to be reviewed and updated regularly and details relating to carers who no-longer have caring responsibilities must be removed within six months of their caring role coming to an end.

The register should clearly reflect the number of carers who have received information, advice or a service from or through the Carer's Support Service, and identify the type/types of service provided.

The register is intended to ensure that carer's receive accurate up to date information on services and support available and will be used to ensure that carers have a voice in the way future services are planned, developed and commissioned.

The register will provide a clear profile of local carers and will be linked to a record of support provided to the carer and outcomes achieved. This information will be used to inform future commissioning decisions and will therefore need to be made accessible to commissioners.

The provider will support Carers to develop contingency plans and emergency plans using agreed processes and forms.

Data collected at initial assessment is to include:

Gender of the Carer

Ethnicity of the Carer

Age group of the Carer

Disability of the Carer

Postcode of the Carer and the person cared for.

Service user group of those accessing services – Old people, physical and sensory impairment, learning disability, mental health, alcohol and substance misuse, children with disabilities, other (specify other).

Outcomes to be achieved.

Appendix 16 (Included within Annexe A)

NHS Standard Contract Schedule 6A and B reporting appendix

NHS Standard Contract Schedule 6A

Appendix 17 (included within Annexe A)

NHS Standard contract schedule 6a v0.8 supporting info

NHS Standard contract schedule 6a

* In completing this section, the Parties should, where applicable, consider the change requirements for local commissioning patient-level data flows which will need to be implemented from when the new national Data Services for Commissioners technical solution becomes operational. These change requirements will be published within the *Data Services for Commissioners Resources* website: https://www.england.nhs.uk/ourwork/tsd/data-services/

** As set out in SC13.7, the first annual report on the Provider's progress in implementing the Workforce Disability Equality Standard must be supplied by 31 March 2019.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

Redacted
FOIA exemptions: Section 43 (1), Section 43 (2) andSection 2

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) Reportable Patient Safety Incidents & (3) Other Patient Safety Incidents

SERIOUS INCIDENTS

1 **General**

1.1 The revised Serious Incident Framework published by NHS England in March 2015 builds on and replaces the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation issued by the National Patient Safety Agency (NPSA, March 2010) and NHS England's Serious Incident Framework (March 2013). It also replaces and the NPSA Independent investigation of serious patient safety incidents in mental health services, Good Practice Guide (2008). The Department of Health is currently reviewing its 2005 guidance 'Independent investigation of adverse events in mental health services' and further guidance may be provided in relation to issues associated with Article 2 of the European Convention on Human Rights – the right to life. Until the 2005 guidance is replaced, it should be read in conjunction with the Framework which can be found at the link below.

http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

1.2 Lapses in patient safety represent a deficiency in the provision of quality healthcare and have a direct correlation to occurrences of patient harm. The majority of these lapses are preventable.

1.3 The Provider is required to provide patients with healthcare that is safe, timely, beneficial, patient centred, equitable, efficient and delivered in accordance with national standards and the terms of this Agreement. Upon the occurrence of a Serious Incident Requiring Investigation (SIRI) the Provider will be required to comply with the provisions of this schedule. In the event that the Provider fails to comply and is in breach of one or more of the provisions set out below, the Commissioning Organisation (on behalf of any Associate Commissioner(s)) shall apply the relevant provisions laid out in the Service Conditions and General Conditions 9 as it sees fit. The Provider shall comply with all national guidance and best practice on the management and reporting of Serious Incidents, in association with the Care Quality Commission (CQC) registration requirements and in accordance with, but not limited to the following, as amended from time to time:

- Serious Incident Framework March 2015;
- Never Events detailed under schedule 4 part D;
- NHS Being Open guidance and NHS contractual Duty of Candour;
- Checklist Guidance for Reporting Managing and Investigating Information Governance Serious Incidents Requiring Investigation;
- Clinical governance and adult safeguarding: an integrated process;
- The South of England Pressure Ulcer Framework 2012.

Remedial steps shall promptly be taken to prevent reoccurrence. A subsequent audit or review will be undertaken by the Provider to evaluate the effectiveness of the remedial steps undertaken, on an exception basis, as agreed between the Commissioner and Provider to provide assurance on action plans.

1.4 In order to improve the quality of services being delivered to all patients, the Parties shall work towards the development of robust measures for quality improvement; disseminate information and exchange knowledge and ideas as appropriate.

1.5 The Parties acknowledge and agree that reliable and timely data (see Appendix B) relating to the occurrence of Serious Incidents and Patient Safety Incidents and Never Events is critical to understanding the way in which such incidents occur and changing processes of care (as appropriate) so as to reduce occurrences.

1.5 The Provider shall therefore be responsible for the prevention of Serious Incidents and Patient Safety Incidents and ensuring that the risk of harm to Patients is reduced to as a low a level as is practicable. As part of this process, the Provider is required to comply with the guidelines set out in the National Framework. The Lead Commissioner (Commissioner with main responsibility for managing the Serious Incident process) shall monitor the Provider so as to enforce compliance against the National Framework.

1.6 In addition to quantifying the data (i.e. reporting on the numbers of incidents), the Provider shall ensure that the reporting system is designed (using recognised tools and techniques (e.g. RCA)) to provide outcomes, recommendations and actions so as to improve the effectiveness, efficiency and quality of their services. The provider will monitor the implementation of action plans, including the effectiveness of any changes implemented following an investigation, which will be monitored through contract or quality meetings. The provider will have systems in place for the Board of Directors to receive regular briefings on the detail of significant events, trends and other analysis of Serious Incidents, including those open beyond deadlines.

1.7 The Lead Commissioner, at its discretion, shall support the Provider, where it is reasonably able to do so, in complying with the obligations detailed within the National Framework. Such support shall not create any obligation on the Commissioner and the responsibility for the provision of good quality healthcare remains the sole responsibility of the Provider.

1.8 The Provider should immediately inform patients and/or their families that a serious incident has occurred, according to the principles of the Duty of Candour Framework, including offering appropriate support to patients/their families and the staff involved who may also be affected by the incident. Confirmation that this has happened should be documented on STEIS within 3 days of the incident being identified.

2 Commissioners' Requirements

2.1 The Provider shall notify the Lead Commissioner within two working days of the identification of any Serious Incident directly or indirectly affecting patients. The Provider shall use its discretion whether the incident merits informing the on call Director of the Commissioning organisation out of hours depending on the circumstances of the Serious Incident. The Provider shall comply with the arrangements for reporting and investigating incidents as set out in its internal policy and any national, county or Local Authority framework, recommendations, codes of practice or legalisation (as amended from time to time) to include, but without limitation from: The Department of Health, NHS England, Care Quality Commission, Information Commissioner's Office, Health & Safety Executive.

2.2 The Provider shall comply with the guidelines set out in the Serious Incidents Framework, Part Three: The Serious Incident Management Process (page 31). The Provider will report to the Commissioner without delay and no later than 2 working days after the incident is identified see Appendix A).

Reporting a serious incident must be done by recording the incident on STEIS and the Provider should comply with the National Framework (link below).

http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

2.3 The decision to commission an independent investigation can be made at any stage of the incident management process, depending on the nature and circumstances of the incident.

For provider-focused independent investigations, it is the Commissioner of the care within which the serious incident occurred who should make the final decision on the type of investigation required. Commissioners may wait until they have received the Provider's internal report (which should be completed within 60 days, in line with section three of the Framework) before making the decision as to whether or not to commission an independent investigation.

3 Never events

3.1 The Provider will comply with the never event guidance at detailed in the link below.

http://www.england.nhs.uk/ourwork/patientsafety/never-events/

4 Partnership working

4.1 Please refer to pages 24 – 25 of the National Framework on the Involvement of Multiple Commissioners and the Involvement of Multiple Providers. The RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model will be adopted as per the national framework. Where BaNES CCG is the lead commissioner for the contract, the CCG will assume the Lead Commissioner role for the serious incidents and oversee the response to each Serious Incident.

5 Dissemination of learning

5.1 In broad terms, Serious Incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

5.2 The definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using the description below. Inevitably, there will be borderline cases that rely on the judgement of the people involved (see section 1.1 of the National Framework).

6 Definition of Serious Incidents

6.1 Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death of one or more people. This includes
      - Suicide/ self-inflicted death; and

      - Homicide by a person in receipt of mental health care within the recent past (see Appendix 1 of the National Framework);

    - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
      - The death of the service user; or

      - Serious harm;

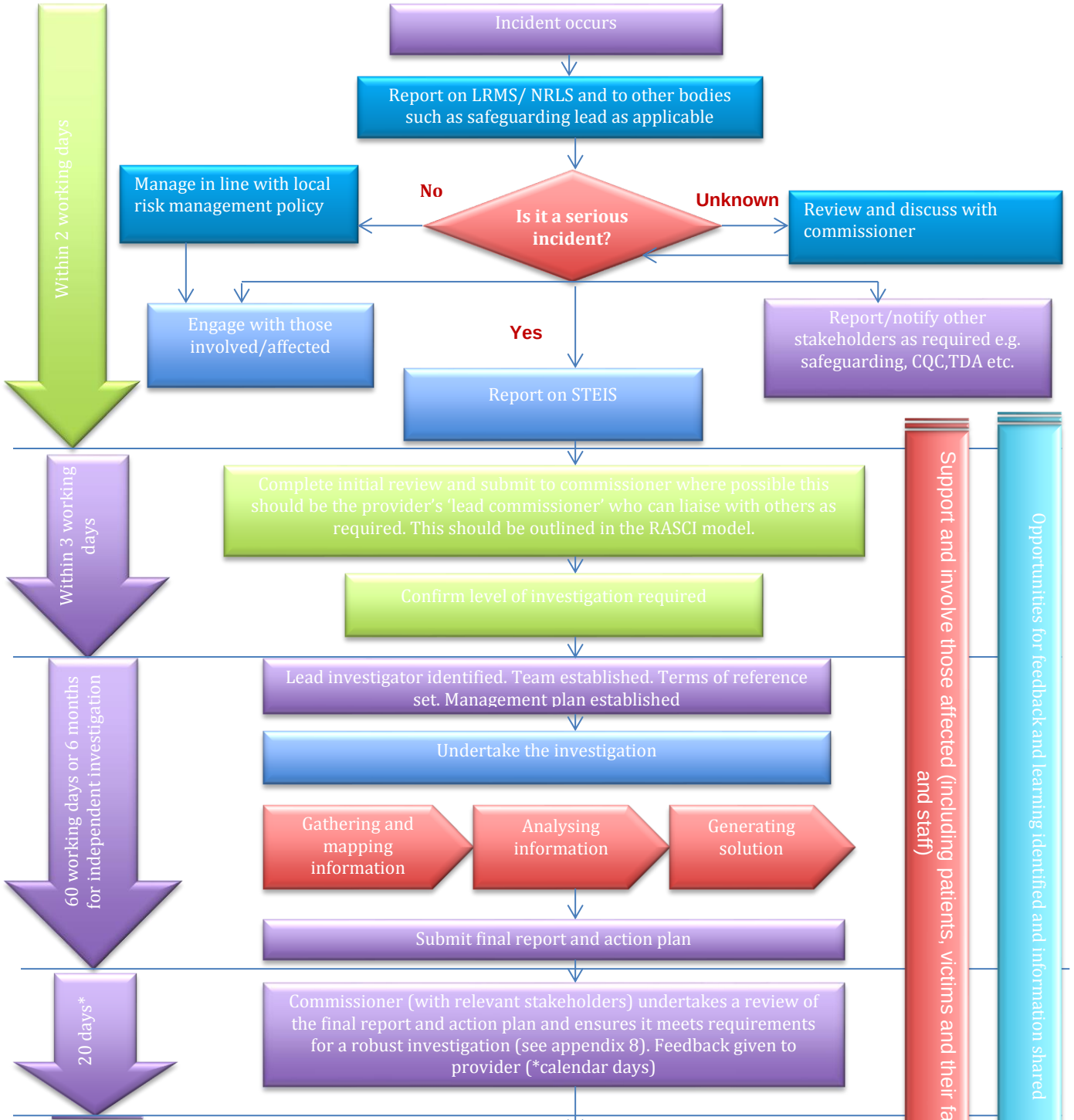
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
      - Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or

      - Where abuse occurred during the provision of NHS-funded care.

  This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 of the National Framework for further information).

- A Never Event - all Never Events are defined as Serious Incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information;
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (see Appendix 2 of the National Framework for further information);
    - Property damage;
    - Security breach/concern;
    - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
    - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
    - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
    - Activation of Major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

APPENDIX A: OVERVIEW OF THE SERIOUS INCIDENT MANAGEMENT PROCESS


Incident occurs
Report on LRMS/ NRLS and to other bodies such as safeguarding lead as applicable
Is it a serious incident?
No
Unknown
Manage in line with local risk management policy
Review and discuss with commissioner
Yes
Engage with those involved/affected
Report/notify other stakeholders as required e.g. safeguarding, CQC,TDA etc.
Report on STEIS
Within 2 working days
Within 3 working days
Complete initial review and submit to commissioner where possible this should be the provider's 'lead commissioner' who can liaise with others as required. This should be outlined in the RASCI model.
Confirm level of investigation required
60 working days or 6 months for independent investigation
Lead investigator identified. Team established. Terms of reference set. Management plan established
Undertake the investigation
Gathering and mapping information
Analysing information
Generating solution
Submit final report and action plan
20 days*
Commissioner (with relevant stakeholders) undertakes a review of the final report and action plan and ensures it meets requirements for a robust investigation (see appendix 8). Feedback given to provider (*calendar days)
Support and involve those affected (including patients, victims and their fa
and staff)
Opportunities for feedback and learning identified and information shared

See Part Three (p. 31) of the National Framework http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

APPENDIX B:

RESPONSIBILTIES AND TIMESCALES

Event/Action	Timescale	Further Information/ Guidance	Responsibility
Serious Incident identified - Report to commissioner of service or lead commissioner (as agreed)	As soon as possible and within 2 working days of the incident being identified. Or Immediately where: - The provider or commissioner Major Incident Policy is invoked - There is (or is likely to be) significant public concern and/or media interest - Incident will be of significance to the police.	Report via STEIS (or if no access to STEIS, via the serious incident reporting form agreed with the commissioner, sent via e-mail to agreed e-mail address) Where immediate notification is required, this must be also by telephone (including use of On-Call system Out of Hours) If there is any doubt about whether an incident is serious or not, the principle is to report it as it can be downgraded later if necessary	Provider where incident occurred

If provider has no STEIS access, input details of incident from report form from provider onto STEIS	On receipt of form from provider.		Commissioner
Comply with any further reporting and liaison requirements with regulators and other agencies	Within 2 working days of the incident being identified.	See appendix 2 of the Framework.	Provider where incident occurred
Carry out an initial review of the incident and update STEIS within 72 hours (submission of a separate report is not required)	Within 3 working days of the incident being identified.	This will inform the level of investigation required.	Provider where incident occurred
Document on STEIS what actions have been taken to meet Duty of Candour requirements	Within 3 working days of the incident being identified.	Include steps taken to involve and support those affected (patients, victims, families, staff)	Provider where incident occurred
Submission of final investigation report and action plan.	60 working days (Internal investigations)	A formal request to suspend an investigation or extend timeframes may be made – this would only	Provider

	6 months (Independent investigations)	be granted in exceptional circumstances (see Framework section 4.5.1)	Investigation Lead (+ provider for action plan)
Quality assurance + feedback to the provider	20 calendar days from submission of the investigation report and action plan	Need assurance that the report fulfils the required standard for robust investigation and action plan.	Commissioner
Closure	Once there is assurance that there has been a robust investigation and the actions taken or planned address any recommendations and, if actions remain open, there is a robust arrangement for regular review.		Commissioner

APPENDIX C:

Commissioner Standard for Serious Incidents

The Commissioner will require the following information to be included in the reporting of the Serious Incident:

1. Initial Management Report

1.1 For all Serious Incidents (SIs) and Never Events, the provider will submit an Initial Management Report (IMR) within 72 working hours of the incident being reported onto STEIS. The 72 hour update may be provided by submission onto STEIS or via secure e-mail. Arrangements for this will be agreed between the commissioner and the provider. This will confirm whether a serious incident has occurred and immediate action taken (including where other organisations / partners have been informed).

1.2 The 72 Hour STEIS update will include the following:

Person details

- Gender
- Age
- GP practice post code – for acute, community and MH providers, this is to identify the person's lead commissioner location and is required for the reporting of SI's to each CCG
- For individuals resident in nursing homes - the GP practice post code is related to the home and may be irrelevant to the commissioner who may be out of county.
- Date of admission or commencement of NHS services relevant to the SI
- Date of Death (if applicable)

Incident details

- STEIS number
- Provider local identifier number e.g. adverse event form number
- Date of incident
- Location (area)
- Service/Specialty/ Directorate or Division
- What occurred (why this is an Serious Incident)
- Description of what happened, including brief account of events leading up to the incident
- Immediate action taken to ensure organisation-wide patient safety

Action Plan

- Initial review panel findings and plan
- Any media concerns and verification of contact with provider communication team if this is the case
- Confirmation of notification of relevant organisations e.g. Local Information Governance Lead and NHS England if applicable
- Confirmation of adherence to the Duty of Candour Framework

2. Final RCA investigation report

2.1 The Provider is encouraged to use the report writing templates provided in the National Framework.

2.2 The commissioner may, by agreement, accept an executive summary report, provided a full RCA, recommendations and action plan is included.

2.3 The Lead Commissioner requires the following areas as a minimum in any final Serious Incident Report:

- Terms of Reference
- Background
- Chronological Narrative
- Key Care and Service Delivery Problems
- Key Contributory Factors
- Root Cause/Causal Factors
- Good Practice
- Recommendations and Action Plan
- Sharing and Disseminating Lessons Learned
- Action Plan

2.4 *For Domestic homicide reviews*: see Appendix 4, of the National Framework.

2.5 *For Investigation of homicide by those in receipt on mental health care:* see Appendix 1 of the National Framework.

2.6 *Secure transfer of information:* The provider must ensure that any reports or documents related to the serious incident investigation are sent using secure NHS.net mail.

APPENDIX D:

REPORTING REQUIREMENTS TO COMMISSIONER

Ref	Requirement	Threshold	Reporting Requirements	Consequence of breach
SI-01	Numbers of SIs reported in previous month	Monthly reporting on Quality Scorecard to CQRM	*Monthly submission via Quality Scorecard:* 1. Total number of SIs 2. Numbers of: ▪ Pressure ulcers grade 3 ▪ Pressure ulcers grade 4 3. PE/VTEs that result in death 4. High harm falls 5. Unexpected deaths 6. Safeguarding concerns 7. Numbers reported within 2 working days 8.	GC9
SI-02	Summary of SIs &	Report received by	*By exception & within 72 hours of the event report*	GC9

	Never Events	exception: Within 72 hours of all SIs or Never Events.	▪ Summary of event ▪ Immediate actions taken ▪ Process for investigation (including terms of reference if available) ▪ Press release, if available/applicable ▪ Providers will ensure that any serious incident related to safeguarding children and adults is reported to the CCG and the process for this will be set out in their safeguarding adult and children policies.	
SI-03	Trend analysis of Sis	Quarterly narrative report to CQRM as per reporting schedule	*Quarterly and Annual Report to include:* ▪ Total numbers of SIs by type ▪ Analysis of: ➢ SI trends ➢ Types, locations, service ➢ Recurring root/contributory causes ➢ Changes to practice over previous quarter/half year/year ▪ narrative to highlight actions taken to address any identified organisational or service trends ▪ Narrative to demonstrate how sharing and learning across the organisation has occurred.	GC9
SI-04			*with:* ▪	GC9

APPENDIX E:

EXTERNAL REPORTING

Incident type	**Organisation receiving reports**	**Information reported**
Central Alerting System (CAS)	Department of Health	Details of actions taken to address issues relating through alert
Communicable disease outbreaks and other public health issues	Public Heath England	Infection control and other public health incidents with details of spread of disease, contact etc.
Data losses and Caldicott contraventions	Information Commissioner	Description of contravention e/g/ patient details disclosed inappropriately.
Death certification: The doctor cannot complete a death certificate if the death occurred: ▪ during an operation ▪ due to industrial disease ▪ due to unnatural, violent or other	HM Coroner	Details about patient and full circumstances of death

suspicious circumstances		
Environment related incidents e.g. waste disposal	Environment Agency	Information on incidents e.g. type of waste and hazards
Foundation Trust	Monitor	Details of incident including initial findings, final investigation report and outcome
Fire or estate related incidents	NHS Property Services	Details of fire incident Injuries/death cause Type/quantity loss
Insurance claims and incidents	NHS Litigation Authority (NHSLA)	Details and cost of loss/claim
Medical device related incidents	MHRA	Comprehensive details related to devices involved in incident including manufacture date, expiry date.
Medicine/blood related incidents	Medicines and Healthcare Products Regulatory Agency (MHRA)	Comprehensive details of incidents related to adverse drugs reactions. From 8 November 2005 it is mandatory to report a serious adverse event or reaction related to blood or blood components to the MHRA.
Mental Health Act: incident involving a patient detained under the MHA	Care Quality Commission	Details of the individual, type of section, occurrence
National Confidential Enquiries	Confidential Enquiry panels	E.g. for National Confidential Enquiry into Peri-operative deaths (NCEPOD) – details of death
Patient safety incidents	BaNES CCG, who will then report to NHS England	All patient safety incidents including near-miss events.
Post mortem related incidents	Human Tissue Authority (HTA)	All serious incidents that occur at establishments in the post mortem sector holding an HTA license.
Radiation related incidents	▪ Environment Agency ▪ HSE ▪ Care Quality Commission (CQC)	All incident information. Quantity/type of radioactivity to comply with Ionising Radiation Medical Exposure Regulation (IRMER)
Residential/Nursing Care incident involving individual in a registered care home with or without nursing	Care Quality Commission	Details of individual, occurrence
RIDDOR incidents	Health & Safety Executive (HSE)	Injuries from work based accidents. Details of incident and persons involved.

Safeguarding adults: Neglect, harm or abuse of an adult at risk	Local Authority: Local Safeguarding Adults Board	Details of incident
Safeguarding children / child protection	Local Authority: Local Safeguarding Children Board	Details of child protection related incident
Screening incidents: ▪ Diabetic retinopathy ▪ Abdominal Aortic Aneurysm ▪ Foetal Anomaly ▪ Infectious diseases in pregnancy ▪ Sickle Cell & Thalassemia ▪ Newborn Blood Spot ▪ Newborn Hearing ▪ Newborn & Infant Physical Examination	▪ Regional Director of Public Health ▪ Regional Quality Assurance Lead for the relevant programme ▪ Director of the relevant national screening programme ▪ Director of UK National Screening Committee	All incident information Comprehensive report with RCA and learning
Serious Adverse Blood Reactions and Events (SABRE)	MHRA	Details of incident including initial findings
Incident involving a patient detailed under the Mental Health Act	Mental Health Act Commission	Details of the individual, type of section, occurrence
Incident involving individual in a registered residential care home	Care Quality Commission	Details of individual, occurrence

Monitor:
Please note that some external reporting requirements are dependent on set criteria, e.g. data loss and requirements to report to ICO. Reporting is required when meeting these criteria.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Service Development and Improvement Plans

Redacted
FOIA exemptions: Section 43 (1), Section 43 (2) andSection 2

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

Type of Survey	Threshold	Method of reporting and Publication	Consequence of Breach
Provider to choose to undertake two surveys per annum from the following list (one survey must relate to Patients and one to Carers) • Diabetes • MSK • Older People • Dementia • Learning Disability • Mental Health	Not applicable	Survey Report to be provided to Commissioners by end of Q3	General condition 9.4 (Contract Management)
Provider to undertake a patient survey on self-management of LTCs	To provide baselines results from an initial survey	Provider to agree with Commissioner by end of Q1	General Condition 9.4 (Contract Management
The provider should also take part in all relevant national surveys, including, but not limited too; • Stroke Monitoring of patient care (through SSNAP) • In-patient diabetes audit/experience survey (If applicable to services provided by the Provider)	Demonstrate improvements on previous year's survey findings	Annually From the second contract year onwards, the provider will report findings on all national survey findings with any associated actions plans and progress against the plans to commissioners	General Condition 9.4 (Contract Management)
Support Local Authority to deliver Adult Social Care and Carers Surveys		Annual	General Condition 9.4 (Contract Management)

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Local Information Governance requirements

1. Council Records

1.1. The Council and the Provider agree that the Council will retain custody, control, ownership and management of all Existing (Dormant) Social Care Records.

1.2. All Existing (Active) Social Care Records and Provider Social Care Records are to be managed by the Provider for the purposes of fulfilling its obligations under the Contract but the ownership and control shall remain with the Council.

1.3. Unless and until the Council and the Provider agree otherwise in writing, it is agreed that:

1.3.1. the Provider shall be responsible for the safe custody and storage of

(i) the Provider Social Care Records during any period(s) that they are being used by the Provider for the purposes of providing the Services in accordance with the Community Services Contract and

(ii) the Existing (Active) Social Care Records and the relevant provisions of this Clause 1 will apply; and

(iii) the Provider Social Care Records during any period(s) that they are considered closed or otherwise dormant during the duration of this contract

1.3.2. the Council shall be responsible for the safe custody, and storage of the Existing (Dormant) Social Care Records.

1.4. The Council and the Provider shall agree, enter into and maintain an information sharing protocol ("Information Sharing Protocol") setting out the terms on which data relevant to the provision of the Services will be shared by the Provider with the Commissioners and any third parties. The Parties agree that this protocol will be agreed as soon as reasonably practicable after the Expected Service Commencement Date.

1.5. In addition and without prejudice to its other obligations, the Provider agrees to create, maintain, store and retain the records referred to in Clause 1.3.1 in accordance with the Law (as updated from time to time). The Provider also agrees to comply with the Records Management Standard: BSI 15489 (or equivalent) insofar as it applies to business and corporate (non-care) records..

1.6. The Provider agrees to provide the Council with full details of all arrangements made for the storage and retention of the records referred to in Clause 1.3.1. In the event that the Council, acting reasonably, is not satisfied with the suitability of such arrangements (including but not limited to compliance with Clause 1.5) it shall notify the Provider and provide details of the steps that need to be taken to remedy the situation.If, having co-operated with the Provider and given the Provider a reasonable period within which to take such identified and/or agreed remedial steps (as applicable), the Council remains unsatisfied (acting reasonably), it shall have the right to require the Provider to return all such records to the Council subject to the Council agreeing to make those records available to the Provider where necessary for the proper provision of the Services in accordance with the Community Services Contract. This Clause is without prejudice to the remedies available to the Council for breach, by the Provider, of its obligations within the Contract.

1.7. In addition and without prejudice to any other Clause of the Contract, the Provider shall:

1.7.1. allow the Council access to inspect and take copies of any or all of the records referred to in Clause 1.3.1 at all reasonable times on reasonable notice where access to, or the copying of, such documents is necessary or incidental to the efficient discharge by the Council of its

functions, powers and/or duties; and

1.7.2. in relation to the records referred to in Clause 1.3.1 and their content, at all times comply with its obligations under the Contract.

1.8. In accordance with and subject to the Information Sharing Protocol, the Council will ensure that the Provider is given such access to inspect and/or take copies of any or all of the records referred to in Clause 1.1 and 1.3.2 as is reasonably necessary for the purpose of enabling the Provider to properly provide the Services in accordance with Community Services Contract at all reasonable times on reasonable notice.

1.9. Upon expiry or termination of the Community Services Contract whether in whole or in part, it is agreed that custody, management and control of all those records referred to in Clause 1.3.1 that are relevant to the provision of the Terminated Services shall immediately transfer to the Council and/or a third party nominated by the Council and Clause 1.13 shall apply. The transfer of records in accordance with Clause 1.3.1 shall be undertaken in a secure manner, in accordance with Safe Transfer Principles and as agreed with the Council. All costs incurred in securely transferring such records shall be the responsibility of the Provider. The Parties will agree practical arrangements enabling custody of such records to be transferred to the Council and/or third party immediately upon termination or as soon as reasonably practicable thereafter. During any interim period, the Provider agrees to continue to permit the Council and any third party authorised by the Council to have access to or copies of such records. The Provider's obligations pursuant to Clauses 1.3.1, 1.5, 1.6 and 1.7 shall cease to apply in respect of any records transferred to the Council and/or third party in accordance with this Clause 1.9

1.10. Subject to any limitations in Law, where the Provider:

1.10.1. has transferred records to the Council, the Council shall:

1.10.1.1. where some Services only have been terminated, allow the Provider access for the duration of the Community Services Contract to inspect or take copies of any or all of the transferred records at all reasonable times on reasonable notice by the Provider where such inspection or copying is required for the purposes of providing Services other than the Terminated Services;

1.10.1.2. where the Community Services Contract has been terminated in whole or has expired, allow the Provider access on reasonable notice to the transferred records, if the Provider has demonstrated to the reasonable satisfaction of the Council that it requires such access (including in the case of a dispute between the Provider and the Council); or

1.10.2. has transferred records to a third party, the Council shall procure that such third party shall:

1.10.2.1. where some Services only have been terminated, allow the Provider access for the duration of the Community Services Contract allow the Provider access to inspect or take copies of any or all of the transferred records at all reasonable times on reasonable notice of the Provider where such inspection or copying is required for the purposes of providing Services other than the Terminated Services;

1.10.2.2. where the Community Services Contract has been terminated in whole or has expired, allow the Provider access on reasonable notice to the transferred records, if the Provider has demonstrated to the reasonable satisfaction of the Council that it requires such access (including in the case of a dispute between the Provider and the Council).

2. Integrated Records

2.1. The Parties agree that, in due course, the intention is for the Provider to develop and use an integrated health and social care record system. Each Commissioner shall co-operate with the Provider, but only in so far as such co-operation is reasonable and does not require the

Commissioners to incur any cost or other liability to third parties, with a view to assisting the Provider to implement such integrated health and social care record system. Where an integrated system is developed, the Provider must ensure that it is compliant not only with all relevant Law but also with the records management requirements of both the CCG and the Council.

2.2. In the event that, due to the integration of CCG Services and Council Services, the Provider (acting reasonably) is not able to identify any individual record as being solely a Health Record or solely a Social Care Record, such record shall be treated as a Social Care Record for the purposes of this Clause

3. Data Breaches

3.1. The Provider will have agreed Incident Management and reporting procedures.

3.2. All data breaches or security incidents regarding the Commissioner's data will be notified to the Commissioner as soon as practicable after becoming aware of the breach and no later than within the 24 hour limit started with the IG Toolkit SIRI process, and the Provider will keep the Commissioner informed of any investigation.

3.3. The Provider will also fully co-operate with the Commissioner in relation to any questions or investigations it carries out into the breach.

3.4. The Provider shall promptly notify the Commissioner of any regulatory action taken by the Information Commissioner's Office in relation to the services and data relating to the services.

3.5. The Provider will have a suitably qualified Senior Information Risk Officer (SIRO), Caldicott Guardian and Information Governance Manager.

4. Legislation

The Provider shall comply with all relevant legislation. This will include:

- The Data Protection Act 1998
- Caldicott guidelines
- Freedom of information Act 2000
- Health and Social Care Act 2012
- Care Act 2014
- Common law duty of Confidentiality
- General Data Protection Regulations 2016

5. IG Toolkit and Procedures

5.1. The Provider will supply any Data Controller with information requested for completion of their IG Toolkit. This shall be collated by the IG manager of either Bath and North East Somerset CCG or Bath and North East Somerset Council to avoid the Provider receiving a large number of requests.

5.2. The Provider shall complete the IG toolkit and be compliant to at least level2 on all requirements

5.3. The Provider shall have a suite of policies, procedures and plans which will cover all of their processes. This will include:

- Information Governance Framework
- Information Governance policy
- Information Security policy
- Business Continuity plan
- Records Management policy
- Data Protection Policy
- Freedom of Information Policy

- Data Transfer policy

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

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

5.6. The Provider will assist the Commissioner with all actions regarding IG incidents.

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

5.8. All Information Assets shall be protected by appropriate technical measures which shall be kept up to date.

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

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

5.11. The Provider will ensure that patients/service users are informed of any processing and changes to processing that occur. The Provider will ensure that patients/service users are able to opt out of sharing where appropriate.

5.12. Audit trails will be available on all systems.

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 on or before the Transfer Date, apply for a Direction Letter 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 Without prejudice to Schedule 1 Part A (Conditions Precedent) and General Condition 4.1 (Transition Period), the Provider must supply to the Co-ordinating Commissioner in advance of the Transfer Date proof of a successfully submitted application.

2.1.3 The Provider (or its Sub-Contractor if relevant) will comply with the terms of the Direction Letter (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.

2.1.4 Where any member of Staff omitted from the Direction Letter supplied in accordance with paragraph 2.1.2 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.

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 before the Transfer Date.

2.3 Transfer Option

As soon as reasonably practicable and in any event no later than 20 Operational Days 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.

2.4 Calculation of Transfer Amount

2.4.1 The Commissioners will use reasonable endeavours to procure that 20 Operational Days after the Transfer Option Deadline, the Transfer Amount is calculated by the former provider's Actuary1 on the following basis and notified to the Provider along with any appropriate underlying methodology.

- 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 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 principles2 under which the former provider's Broadly Comparable scheme received a bulk transfer payment from the NHS Pension Scheme (together with any shortfall payment)3, 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

1 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 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.

3 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.

4 terms from the NHS Pension Scheme set by the Department of Health from time to time.

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

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 if relevant, the issue of a contracting-out certificate in respect of the Provider's (or any Sub-Contractor's) Broadly Comparable scheme which covers the employment of the Eligible Employees; and

2.5.4 the calculation of the Transfer Amount in accordance with Paragraph 2.4 (Calculation of Transfer Amount); and

2.5.5 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),5 by the trustees or managers of the Provider's (or Sub-Contractor's) Broadly Comparable scheme (or NHS

4 Commissioners should obtain a signed note from the NHS Pension Scheme Actuary during the procurement specifying the bulk transfer terms that apply.

5 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.

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(s) and Right of Set-Off

4.1 If the Co-ordinating Commissioner is entitled to terminate this Contract under General Condition 17.7.14 (Termination: Provider Default), the Co-ordinating Commissioner may in its sole discretion instead of exercising its right under General Condition 17.7.14 (Termination: Provider Default) permit the 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 General Condition 17.7.14 (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); 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 General Condition 17.7.14 (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.

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, the Sub-Contractor also secures a Direction Letter 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 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 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 General Condition 29 (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 Relevant to Pension Schedule

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 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
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 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: (i) accrued rights in the NHS Pension Scheme; or (ii) 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 months6 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

6 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.

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