****

**Greater Manchester Hospital Intervention ‘Navigator’ Pilot**

**Service Specification**

**October 2020**

**Abbreviations, Terminology and Definitions:**

In this document (and associated documents accessed via links), the following abbreviations and terminology are used.

**Abbreviations:**

GM – Greater Manchester

GMCA - Greater Manchester Combined Authority

GMP – Greater Manchester Police

LA – Local Authority

GDPR – General Data Protection Regulation 2018

VCOP – Victim Code of Practice

PCC – Police and Crime Commissioner (in Greater Manchester this office is now replaced by the Deputy Mayors office)

TIIG – Trauma Informed Intelligence Group (Liverpool John Moores University data centre collecting hospital and ambulance data)

**Terminology:**

Commissioner - The grant budget holder (GMCA)

Service – The expected service provided under the terms of this specification

Provider – The successful bidding Service Provider

The EU Directive - The EU Victims Directive establishing minimum standards on the rights, support and protection of victims of crime agreed by the UK and 26 other Member States of the European Union

Navigator – Hospital based intervention worker employed by the Service Provider

**Definitions:**

Victim - A victim of any crime regardless of whether they report to the police or not.

Data Controller - As defined by Article 4(7) and (8) GDPR - is a person who (either alone or jointly in common with other persons) determines the purposes for which, and the manner in which, personal data is to be processed.

Data Processor – As defined in Article 28 GDPR - In relation to personal data, means any person (other than an employee of the data controller) who processes the data on behalf of the data controller.

**Table of Contents**

 **Page**

Abbreviations, Terminology and Definitions …………………………………………….……………………………2

Table of Contents …………………………………………………………………………………………………..…...3

**Section One: Current position**

* 1. Introduction ……………………………………………………………………………………………………4
	2. Victim Code of Practice ………………………………………………………………………..…………….4
	3. The GM Violent Crime Strategy …………………………………………….. ……………………………...5
	4. The GM case for change ………………………………………..…………………………………………...5

**Section Two: Overview of required Service**

2.1 Pilot objectives ...………………………………………………………………………………...……………7

2.2 Core capabilities expected of Provider …………………………………………………..…………………8

**Section Three: Service Requirements**

3.1 Scope …………………………………………………………………………………………………..………8

3.2 General requirements ……………………………………………………………………………….……….9

3.3 Service eligibility …………………………………………………………………………………………….10

3.4 Operating times ……………………………………………………………………………………………...11

3.5 Delivery locations ……………………………………………………………………………………………11

3.6 Case management …...……………………………………………………………………………………..11

3.7 Referral and assessment …...……………………………………………………………………………...11

3.8 Staffing requirements …...…………………………………………………………………………………..12

3.9 Management of service and reporting of management information …...………………………………12

3.10 Service user involvement…...………………………………………………………………………………12

3.11 Equality and accessibility standards …..……………………………………………………………….....13

**Section Four: Mobilisation**

4.1 Timescales ……..…………………………………………………………………………………………….13

4.2 Key mobilization requirements …….……………………………………………………………………...13

4.3 Business Continuity ….……………………………………………………………………………………..14

**Section Five: Key performance indicators, outputs and outcomes**

5.1 Governance ………………………………………………………………………………………………….14

5.2 KPI and outcome requirements ……………………………………………………………………………14

**Section Six: Evaluation**

6.1 Provider support of evaluation..…………………………………….…………………………………………….15

**Appendix 1: Key partners**…………………………………………………………………………………………...16

**Section One – Current position.**

* 1. **Introduction**

Since the devolution of Victim Services funding in 2015 from the Ministry of Justice to the PCC (now Deputy Mayor in GM), GM has developed and improved its offer to all victims of all crime, regardless of whether the crime is reported to the Police or not. A generic service is provided by the current GM commissioned service, Victim Support, with additional bespoke services for certain crime types offered at a GM or LA level.

The government [Serious Violence Strategy (2018)](https://www.gov.uk/government/publications/serious-violence-strategy) highlighted the national need to tackle escalating violent crime, which included expanding hospital intervention programmes to support and divert young people involved in violent crime, and Greater Manchester was subsequently selected as one of the 18 areas across England and Wales to receive additional Home Office funding in 2019 to create Violence Reduction Units.

In order to further improve the offer of support for young victims of violent crime, the GM VRU will now develop a model of hospital youth intervention. A twelve month pilot across three of the ten GM Local Authority areas (Bolton, Salford and Manchester), will focus on providing immediate interventions when young people present at A & E departments (or have been admitted), followed by advocacy to ensure appropriate longer term local support is offered and accessed.

The three areas have been selected based on demand and established partnership support for such a pilot.

The six main desired outcomes:

* Reduce revictimisation / reinjury
* Reduce violent homicide
* Prevent offending
* Reduce attendance at hospital
* Capitalise on existing local support
* Improved life chances for young people

**1.2 Victim Code of Practice**

From November 2015, the UK, along with 26 other European Union Member States, were bound by the obligations of the EU Victims Directive establishing minimum standards on the rights, support and protection of victims of crime. The Directive aims to ensure that a victim of crime, anywhere within the EU, receives a minimum standard of support and protection. The Ministry of Justice also introduced ‘[The Code of Practice for Victims of Crime’](https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime) (revised October 2015). This forms a key part of the wider Government strategy to transform the criminal justice system by putting victims first and making the system more responsive and easier to navigate. The Deputy Mayor and Greater Manchester Police have a shared responsibility and commitment to improve the services and outcomes for victims of crime; to be responsive and accountable to victims, witnesses and communities; and to give victims an effective voice in the wider criminal justice system, not just because of the Directive but because it is right to do so. Young victims of violent crime (many with complex situations) are disproportionately underrepresented in terms of both the offer and uptake of support and this reinforces the need for further improvements to the GM offer.

**1.3 Greater Manchester Strategy**

The [Greater Manchester Serious Violence Action Plan (2020)](https://issuu.com/greatermcr/docs/gm_serious_violence_action_plan) highlights 7 priorities to tackle serious violent crime across GM:

* Support an improved criminal justice response to all forms of serious violence
* Support community and voluntary organisations to deliver activities and interventions in areas of highest need
* Ensure that families and communities that are affected by serious violence are effectively supported through our place-based offer
* Ensure victims of violent crime receive appropriate and timely support
* Create a dedicated Violence Reduction Unit for Greater Manchester
* Work with Community Safety Partnerships and Local Safeguarding Boards to implement a place-based approach to tackling serious violence
* Collaborate with schools, colleges and alternative provision to prevent violence

By embracing a community-led public health approach, the Serious Violence Action Plan aims to set out an ambitious and inclusive programme to reducing violence across Greater Manchester. To aid and coordinate delivery of the plan we have created the Greater Manchester Violence Reduction Unit (VRU), an interdisciplinary team incorporating education, youth justice, public health, probation, police and criminal justice, the voluntary, community and social enterprise (VCSE) sector, victim services and a broader network of organisations and stakeholders. Working closely with academics, health professionals and community leaders, the VRU aims to provide a much richer insight into the problem of violence and how to best target resources to more effectively tackle the issue.

The [Greater Manchester Integrated Health and Justice Strategy (2020](https://democracy.greatermanchester-ca.gov.uk/documents/s5362/GM%20Health%20and%20Justice%20Strategy%202020.pdf)) also aims to address the poor health and inequalities which contribute to the exposure of young and vulnerable people to the criminal justice system, both as victims and offenders.

**1.4 The Greater Manchester case for change**

Academic studies support the notion that many victims will themselves have a propensity to offend. The risk is increased where the victim has been the subject of or exposed to serious violent crime.

Many young victims will often know the offender, due to geographical area, educational setting and gang associations, leading to an even greater risk of retaliation, or carrying a weapon for protection.

Support available for younger victims of serious violent crime is limited.

In a GM audit of violent crime involving victims aged 10-25 (Sept – Dec ’19), only 4 out of 98 were referred to Victim Support. Out of the 4 referred, none took up an offer of support. This 4% referral rate contrasts significantly with an overall referral rate (all reported crime and all age) of 20%. Further academic studies and hospital data show us that only 30 – 40% of serious violent crime affecting 10 – 25 year age group is reported to Police, creating an even bigger void in engagement and support.

In GM, Knife crime almost doubled in the period 2015 to 2018. This is broadly in line with the national trend across the UK.

In the period April 2016 – Feb 2019, the Manchester Royal Infirmary alone recorded 891 knife or sharp object assault injuries. Although overall reductions in knife crime have been achieved in 2019/20, they remain at an unacceptable level, and possession of knives is actually increasing. This funding and activity is not sustainable and future increases can be expected.

Following a steady decline in violent crime recording since the mid-90s, there have been increases in recent years.

Between the year ending June 2016 and year ending June 2019 for Greater Manchester:

* + Overall violence against the person increased by 46%
	+ Violence without injury increased by 49% (this makes up 46% of violence against person)
	+ Violence with injury increased by 26%
	+ Robbery of personal property increased by 54%

As outlined in the 2018 national Serious Violence Strategy, too frequently young and other vulnerable groups of the population are targeted or caught up in serious organised crime For those trapped within the hidden recesses of exploitation, such as ‘county lines’ drug dealing, violence can be a near constant threat or even a reality. It is anticipated that Navigators would frequently come into contact with these victims and, in collaboration with partners, provide an opportunity for the victim to escape the grips of exploitation.

Nationally, in 2017/18 people aged 20-29 accounted for more than 1,900 of the 4,986 admissions to hospital as a result of knife or sharp object assault – an increase of 24% since 2012/13. Admissions involving 10 to 19 year olds increased even more rapidly from 656 to 1,012 – a rise of around 55%.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GM Hospital attendance April – Oct 2019 - knife and sharp/bladed object (Trauma and Injury Intelligence Group - TIIG data)****November 2019 one month snapshot of knife and sharp/bladed object (TIIG data)**

|  |  |
| --- | --- |
|  **Site** | **Number** |
| Manchester Royal Infirmary | 112 |
| Royal Manchester Children’s Hospital | To be provided in future data sets |
| Royal Oldham Hospital | 105 |
| North Manchester General Hospital | 102 |
| Salford Royal | 100 |
| Tameside General Hospital | 73 |
| Royal Bolton Hospital | 71 |
| Wythenshawe Hospital | 69 |
| Fairfield General Hospital | 59 |
| Rochdale Infirmary | 45 |
| Trafford General Hospital | 29 |
| Stepping Hill Hospital | 14 |
| Of the 779 GM A&E assault attendances, 72% were men and 28% women. 37% were aged between 0 and 24 years of age. |

 |
| Whilst evidence of improved life outcomes and reduced financial costs to the wider system is currently limited, positive individual case studies from existing hospital intervention programmes suggest life changing experiences for those with complex backgrounds, and various levels of reductions in attendance at A & E departments. What we do know is that beyond statutory safeguarding within hospitals, a huge number of vulnerable victims will leave the hospital with no support interventions, leading to the possibility of retaliation offending, further victimisation, future offending, Police investigation resource and cost, and further A&E attendance. In many cases, a wider long term cost to the individual and society is incurred, with Criminal Justice interventions / healthcare needs / social care requirements / worklessness all adding up  |

**Section Two – Overview of required Service**

# 2.1 Pilot Objectives (within areas in scope)

 **Primary**

* Reduce individual violence reinjury / victimisation
* Reduce arrest for violence offences (within 10 – 25 age group)
* Reduce instances of violence homicide
* Increase capacity and provision for young victims of violence in Greater Manchester
* Improve identification of, and reduce vulnerability of, young victims of violence, ensuring they receive the right support at the right time
* Ensure that young people receive the support they need to engage or re-engage with services in the community
* Shift to deliver interventions earlier
* Support and enhance safeguarding arrangements within each A&E
* Ensure knowledge and skills are shared across A&E and the partnerships
* Reduce immediate risk to young people by equipping them with risk management strategies and tools supporting them to cope and recover

**Secondary**

* Promote a contextual safeguarding model and improve awareness of safeguarding and vulnerability in the hospitals and wider partnerships
* Provide a more holistic picture of violence in the local areas served by the hospitals
* Change attitudes towards violence
* Identify and reduce high risk behaviour

##  2.2 Core Capabilities expected of the Provider

* Capacity to meet the stated timeframes through having appropriately skilled, competent and resourced staff in place
* Robust experience of delivery of professional, credible and boundaried youth work. Critical to the success of the Service is professionally delivered youth work, provided by intervention workers (Navigators), with the ability to build rapport and trust quickly with vulnerable and often chaotic young people. Navigators will need to be credible to the young people they are working with; able to act as reliable and positive role models, recognising that young victims have often had varying experiences of statutory and voluntary support services. Navigators will need to be trained in the principles of contextual safeguarding, trauma-informed and evidence-based interventions and demonstrate how they will actively maintain professional boundaries.
* In-depth understanding and knowledge of issues relevant to the young people of Greater Manchester and experience of supporting young people who may be facing, or have faced, adverse experiences and are, or may be involved with peer groups caught up in violence, including as potential perpetrators.
* Ability to work at pace in a pressured clinical environment. Bidders will need to demonstrate how their delivery and staffing models can adapt to fit the unique and demanding environment of the hospital Accident and Emergency department and Major Trauma Centres. Navigators are expected to work closely with the safeguarding arrangements that are already in place at the pilot hospitals to complement and enhance their service.
* Ability and extensive experience of reaching into communities and building links with local services. It is extremely unlikely that Navigators will be able to provide ongoing case work to all the young people eligible for the Service and there is a need to build networks, identify suitable existing services and develop referral pathways with these suitable local services. The established VRU, in particular the Victim Champion, will work closely with the Service provider to quickly introduce and develop networks.
* Experience working alongside statutory partners and of how to achieve the best outcomes for young people within these frameworks.
* Experience of conducting dynamic risk assessments and safety planning.
* Demonstrate use of evidence-based interventions. GMCA are not specifying how the Service should engage young people nor what interventions the Service should use. This is down to the Provider and will need to be outlined in the bidders’ tender documentation along with the evidence base that supports their approach and their expected outcomes. The length of time the youth worker engages with a client is likewise not specified, but an indication should be included within the bidders’ tender documentation. Innovation is welcomed and the pilot will allow for flexibility of approaches in order to achieve the best outcomes for young people.

#  Section Three – Service Requirements

##  3.1 Scope

###  GMCA is commissioning a ‘Navigator’ Hospital Intervention Service across three Local Authority / NHS Trust areas - this comprises of [Royal Bolton Hospital](http://www.boltonft.nhs.uk/locations/royal-bolton-hospital/), [Salford Royal Hospital](https://www.srft.nhs.uk/), [Manchester Royal Infirmary](https://mft.nhs.uk/mri/) and [Royal Manchester Children’s Hospital](https://mft.nhs.uk/rmch/). As this is a pilot within an agreed budget, there is not the ability to have a dedicated service at each hospital, and the Service will need to ensure appropriate coverage and visibility across all sites. The average road distance between the three sites (Manchester Royal Infirmary and Manchester Royal Children’s Hospital share the same location) is 9 miles, with an average car travel time of 25 minutes. GMCA appreciate visibility will be based on identified demand and capacity of the Service, but there is an expectation that a robust referral process is established where physical presence of Navigators is not available.

###  It is important to note that all the A&Es serve a population wider than the borough within which they are located. There is therefore an expectation that the Service supports young people attending the A&E regardless of where they live, with appropriate advocacy to ensure they receive ongoing support within their locality.

###  The Service is aimed at vulnerable 10 to 25 year-olds who attend the adult or paediatric A&E departments at the hospitals within the pilot. The Service must work alongside the team in the A&E to proactively identify vulnerable young people and help them to access and engage the support they need to prevent any potential escalation of violence and reduce the risk of repeat victimisation or exploitation.

###  The Service will provide interventions for an appropriate period of time, but is not intended to provide long term support. Linking with statutory partners and / or appropriate community services, the Service will provide advocacy for the young victim to ensure they receive local support as soon as practicable, to help them cope and recover from their experiences in a sustainable community setting.

###  The Service will build on and complement effective partnership working with and between community providers, statutory partners and the hospital.

###  For the purposes of this commissioning process the term ‘Navigator’ or ‘youth work’ does not denote a particular model requiring certain training or qualifications. Bidders will be asked to outline and explain their delivery model, showing how they will utilise different staff, the training they undertake and the level of skills, knowledge and experience that they require of their employees. GMCA reserve the right to review the Navigator job description created by the Provider and nominate a GMCA representative to assist at interview stage.

###  **The Service is not intended to deliver the following elements:**

* Gang exit work
* Medium to long term support and case management work
* Mentoring
* Counselling
* Any form of physical healthcare or health intervention
* Specialist interventions and support where there is a recognised qualification requirement, for instance mental health, neurodevelopment or substance misuse.

###  The above elements are out of the scope of Service and it is important that the Provider is able to identify the circumstances in which another service is better placed to support the young person, and make necessary arrangements for referral.

##  3.2 General Requirements

###  The Provider must ensure that the Service:

* Meets the support needs of young victims of violence
* Acts in the interests of the young victims being supported
* Is confidential (with exception of Safeguarding requirements)
* Is non-discriminatory
* Is available whether or not a crime has been reported to the police
* Understands and implements a gendered approach to service delivery
* Advocates so that victims receive their entitlements and supports responsible authorities in discharging their duties to victims
* Remains flexible and responsive to the needs of the victim

###  GMCA expects the Service to try and engage with all young people (age 10 - 25) who present at A&E or are admitted with injuries that are the result of violence. This would be face to face where possible but may be over the phone if the young person has left the hospital before the Navigator is able to speak to them. Young people attend A&E in large numbers with injuries, illnesses or concerns that do not appear to be linked to violence. However, some of these attendances will be from vulnerable young people who are at risk in the community. It will be down to the professional judgement of the Navigator and the clinical and other staff within the A&E to decide who needs to be referred to, or approached by, Navigators to investigate whether they would benefit from engaging with the Service.

###  The Service is not a replacement for community-based services and should not be duplicating interventions that are already taking place in the local area. The aim is to support vulnerable young people to engage in existing services in their area of residence.

###  Where young people are already well engaged in statutory or community services the role of the Navigator is to help ensure that appropriate information is available to the agencies involved, subject to consent, GDPR and within safeguarding guidelines. Where people are known to statutory or community services but have disengaged or where their package of support is insufficient, then the Service, in consultation with community services, will advocate for the young person to increase the chances that the young person re-engages with a package of care that suits their needs.

###  Some vulnerable young people who attend A&E will not be known to community services or will be completely disengaged from the services that are there to help them. In those circumstances the Navigators will need to maintain contact with the young person with the aim of encouraging them to accept appropriate help and support.

###  The majority of Navigator interventions are expected to be short term. However, it is accepted that in some cases, for a period of time, the only service a young person may engage with will be the Navigator. The aim should always be to try and support that person into longer-term non-hospital-based services.

###  Referrals into community-based services will differ across GM and the Provider will need to make arrangements with each area to ensure that they are contacting the appropriate service in a way that ensures there is a joined-up response to a young person’s needs. Crucially the work should enhance existing safeguarding arrangements. The VRU will act as a constant point of contact to assist the Provider with links into existing services across GM.

##  3.3 Service Eligibility

###  The following eligibility criteria apply to this Service:

* Young person is aged between 10 and 25 years of age
* Young person presents at a hospital in scope of pilot (regardless of area of residence)
* Have been or are suspected as having been the victim of interpersonal violence
* Where a suspected safeguarding issue arises

 Note that although initial engagement with young people subject of domestic violence, sexual violence and / or exploitation would be expected – existing specialist services are already in place and so these support relationships should only exist until the specialist service engages. This does not prevent the Navigator supporting the lead service where appropriate.

###  The Service will also be expected to accept referrals from clinicians, responding to the clinician’s assessment and concerns around vulnerabilities.

##  3.4 Operating Times

###  The Provider will be expected to agree the hours the Navigator team will be available in the hospital with the A&E team. The Provider will need to balance the demands of attendances at the hospital A&Es, including being available for regular hospital safeguarding meetings, with the operating times of statutory and community services they need to link in with. GMCA expect a 7 day a week provision including evenings, and parameters will be agreed between the Provider and GMCA during the mobilisation period.

##  3.5 Delivery Locations

##  The Provider must embed their services in the hospital as a whole and in the A&E department in particular.

###  The Provider will be expected to work closely with services in the community.

###  The Provider must have arrangements in place to contact and where appropriate meet young people outside the hospital setting. The Provider must ensure that it is a safe environment for both the victim and the Navigator and have in place an effective lone-working policy.

##  3.6 Case Management

###  The Provider must be able to provide, maintain and update a secure case management system that meets recognised and appropriate information security management systems standards.

##  3.7 Referral and Assessment

###  The Provider must ensure that the Service:

* Proactively identifies and assesses vulnerable young people who attend A&E
* Utilises the professional judgement of clinicians and others at the A&E to help to identify vulnerable young people
* Puts in place robust referral systems to enable contact with young people who the Navigators have been unable to see at the hospital site
* Maintains contact with community services to ensure smooth referral pathways
* Conducts needs assessments, undertaken by suitably trained members of staff, to identify and record needs and risks
* Refers to suitable support services in accordance with young people’s needs
* Ensures supported, detailed and fully consensual onward referrals (non-consensual where safeguarding allows)
* Supports the hospital safeguarding arrangements
* Records decisions on all actions taken throughout the referral and assessment process

## 3.8 Staffing Requirements

###  GMCA are commissioning a Service based on 4 full time paid Navigators and associated supervision / administration. GMCA accept that an element of the service may be delivered by volunteers, at the discretion of the Provider, but this should be discussed with GMCA.

###  The Provider must ensure that all staff are adequately trained (including Level 3 Safeguarding and Trauma Informed / Adverse Childhood Experience training), receive effective development and clinical supervision to enable them to carry out the role at a high-quality of service delivery, and comply with relevant hospital policies and procedures.

###  All staff, whether paid or unpaid, will be managed within appropriate governance structures, taking account of the need for expert or skilled supervision appropriate to the support needs of staff / volunteers.

###  Adequate and flexible resources must be available to meet demand. The Service must be able to implement a timely response to changes in that demand.

###  All staff and volunteers must have successfully passed an enhanced DBS check prior to working with the Service.

###  All staff accessing patients or records at the hospital will require an honorary contract from the hospital and will need to go through hospital HR processes.

Navigators will be expected to utilise their skills and experience to provide non formal awareness inputs to partner organisations.

###  The Provider must ensure that policies for risk-reporting and whistle-blowing are in place for incidents that arise causing harm or potential harm to young people, staff or volunteers. There is a duty on the Provider to inform GMCA immediately of anything which comes to light which might impact on the Service and / or reputation of partners involved.

###  The Provider shall undertake to facilitate the appropriate continuing professional development and training of staff involved in the delivery of the Service, whether paid or unpaid, to ensure they meet minimum competency standards.

###  The Provider shall ensure that volunteers do not undertake unaccompanied outreach visits.

###  The Provider shall identify a lead staff member for safeguarding for the Service. The Provider shall engage in serious case reviews as required.

##  3.9 Management of the Service and Reporting of Management Information

###  The Provider must have a dedicated Contract Manager who can act as the single point of contact for GMCA from mobilisation and for the duration of the contract to ensure the implementation and delivery of an efficient and effective service. The GMCA single point of contact will be the VRU Victim Champion, who will work closely with the Provider throughout mobilisation and contract period.

###  GMCA will require quarterly performance and management information reports for the Service as specified in the subsequent contract.

##  3.10 Service User Involvement

###  The Provider must actively seek service user input to assist in the identification of service improvement opportunities and to help GMCA understand their experiences, their support needs, and to help shape future victim and witness service provision. All young people should be given an opportunity to feedback about the Service they have received.

###  Complaints procedures shall be made available to victims on request. If the victim would like support in making a complaint, advocacy must be provided. Where the complaint is about the Service, this must be referred immediately to the VRU point of contact to establish the most appropriate independent agency to manage the complaint.

##  3.11 Compliance, Equality and Accessibility Standards

###  The Provider must ensure that no user is excluded on the basis of disability or other protected characteristics, and the Provider must take the need for disabled access, including the needs of those with mental as well as physical disabilities, into account in the delivery of the Service.

###  The Provider shall be required to evidence that reasonable and proportionate adjustments have been made where appropriate to their delivery of the Service.

###  The Provider shall ensure that all web-based content meets Level AA of the [Web Content Accessibility Guidelines](https://www.w3.org/WAI/WCAG2AA-Conformance.html) (WCAG) 2.0 or equivalent.

###  The Provider shall ensure that all web-based content and other materials are compatible with relevant assistive technologies including, but not limited to, screen readers, screen magnifiers and speech recognition software.

###  The Provider shall be expected to observe relevant local policies such as (but not limited to):

* Local Safeguarding Children Board Procedures and Policies
* Local Safeguarding Adults Board Procedures and Policies
* Any information sharing agreements

###  The Provider shall be required to deliver in full compliance with both the [General Data Protection Regulation](https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation) (GDPR) and the Health and Social care [Caldicott Principles](https://www.ukcgc.uk/manual/principles).

 **Section Four –** **Mobilisation**

##  4.1 Timescales

###  GMCA intends to award the contract by mid November 2020 and requires the Provider to be able to mobilise quickly following contract award.

###  The Provider will be expected to work closely with GMCA and partners to ensure the Navigator hospital Service is ready to commence by Feb 2021 at the latest.

###  Bidders will be required to demonstrate their capacity and ability to meet these timescales as part of their tender submissions.

##  4.2 Key Mobilisation Requirements

###  GMCA shall agree with the Provider (within 10 days of contract award), a detailed mobilisation plan, covering all activities that need to be completed before the launch of the Service.

###  During the mobilisation phase the Provider will be expected to:

* Agree information-sharing and data protection protocols with all relevant partners
* Begin networking and service mapping
* Complete an Equalities Impact Assessment for the Service
* Commence recruitment of Navigators
* Develop with GMCA a performance framework
* Put in place honorary contracts for the Service’s staff
* Agree an evaluation plan with the hospitals, GMCA and academic partners
* Create an event and risk log, accessible to GMCA on request, and forming part of the project governance.

###  The Provider shall also be required to work with GMCA to put in place a Memorandum of Understanding with the hospitals, outlining the roles and responsibilities of GMCA, the Provider and the hospitals.

###  GMCA will support the Provider to facilitate effective partnership working with and between providers, statutory partners and agencies involved in this work.

 **4.3 Business Continuity**

The Provider is required to provide a robust Business Continuity Plan that will be effective and dynamic throughout the contract period and ensure flexibility of staff if a workspace or geographical area becomes inoperable or face to face engagement is restricted. This must include reference to compliance with infection control and Covid guidance in hospitals.

#  Section Five - Key Performance Indicators, Outputs and Outcomes

**5.1 Governance**

The strategic governance for this Service falls within the GM VRU Health and Wellbeing Delivery Group.

This Service cuts across a number of strategic themes and so progress / performance and evaluation may be shared (with approval of the Health and Wellbeing Delivery Group), across appropriate departments within GMCA and key partners.

## 5.2 KPI and Outcome Requirements

GMCA understands that a full range of evidenced outcomes and Key Performance Indicators (KPIs) over a 12 month period for this type of project will be challenging. Baseline data needs to be established where possible during the mobilisation period.

###  GMCA, in partnership with Manchester Metropolitan University (Big Data Centre) and Liverpool John Moores University (Trauma Informed Intelligence Group) is considering a performance framework, but welcomes the input of the Provider in establishing an agreed framework.

###  A finalised set of outputs, outcome measures and KPIs will be agreed with the Provider during mobilisation.

###  GMCA reserves the right to amend (with reasonable notice) the agreed KPIs and how they will be measured over the life of the contract, to ensure that they remain fit for purpose and enable GMCA to effectively manage the contract.

**Measures to be considered (but not limited to) include:**

* Number of overall victims in scope who are offered service
* Number who engagement
* Level and period of engagement
* Referral to local support
* Outcomes at specified periods for those engaged (full range of outcomes to be established but will include health / mental wellbeing / education / employment / social engagement / behaviour)
* Revictimisation since intervention
* Involvement in crime as offender since intervention
* Re-presentation / admission at A and E since intervention
* Training to stakeholder staff provided / assisted by Navigators
* Awareness and confidence to report amongst A and E staff
* Awareness of service amongst stakeholders

#  Section Six - Evaluation

##  6.1 Provider Support for Evaluation

GMCA are committed to conducting thorough evaluation and wherever possible, evidence longer term outcomes in order to inform the viability of continuing the Service, and also contribute to the wider research in this field. GMCA accept that some longer term outcome measures will not be achievable within the 12 month pilot period, however GMCA will continue the evaluation beyond the initial pilot timescale, regardless of an extension of Service or not).

###  The Provider is required to actively contribute to and assist with a GMCA led evaluation of the Service across the hospitals involved in this pilot. This will include collecting, processing and sharing data (including exploring how personally identifiable information (PII), as defined under GDPR, could be shared) with GMCA to evidence outputs and outcomes associated with the Service. The evaluation will help to understand the impact of the intervention on those involved, contribute to service delivery and improvement, and inform future conversations around sustainability and funding.

###  GMCA will explore with the Provider the mechanisms for lawful disclosure of personally identifiable information and non-personally identifiable information for the purposes of the evaluation. The Provider will be the data controller under GDPR for the delivery of the Service and GMCA will be the data controller for the purposes of the evaluation. GMCA requires the sharing of any PII and GMCA’s role must be documented in the Provider’s Data Protection Impact Assessment for the Service.

###  The Provider will be expected to develop (or already have in place) a suitable case management system to facilitate the recording of data used for service delivery and evaluation, and to collect and share data that can help evidence the impact of the Service. GMCA will work with the Provider to continue to define key outcomes and measures for the purposes of this evaluation. Data required is likely to include aggregate or anonymised data on service users, alongside individual level or pseudonymised data (to be shared with GMCA via a lawful disclosure). This may include the facilitation of bespoke data collection with service users.

###  Bidders are asked to outline their approach to collecting data for performance-monitoring purposes, and their approach to gathering evidence of outputs and outcomes of their work within their tender submissions. In particular, GMCA are keen to evidence any longer-term impact of the Service on the re-victimisation of young people, reattendance at hospital and post injury offending.

###  Any costs that the Provider believes will be associated with the evaluation process (administrative and technical support, staff time etc.) should be included in their bid.

**Appendix 1**

**Key partners (across each of the three pilot areas)**

* Greater Manchester Combined Authority
* Violence Reduction Unit (and agencies represented within)
* NHS Trusts (Primary / Secondary care)
* Communities
* Youth Justice
* Youth Services
* Children’s Services
* Social Services
* Local Authority Public Service Reform Hubs
* Community Safety Partnerships
* Victim Support
* Greater Manchester Victim Coordinators
* Identified academic partners
* Probation
* Education
* Designated safeguarding leads
* Community and Voluntary sector
* Greater Manchester Police
* North West Ambulance Service
* Greater Manchester Police Custody Interventions team
* Drug and Alcohol Services
* Mental health services
* Specialised GMCA / Local Authority commissioned services (domestic / sexual)