Schedule 2

SERVICE SPECIFICATION FOR THE PURCHASE OF

SC18024:

COMMUNITY NAVIGATION

This document defines the Community Navigation Service Specification for Kent Residents

To commence on 1st April 2019

Version	Date	Name
V01	17/08/2018	KS
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V09	26/10/2018	KS
V10	05/11/2018	KS
V11	01/05/2019	KS

1 Table of Contents

This specification sets out the requirements for the delivery of the Community Navigation service. All content (including website links) is correct as of 5th November 2018.

Section 1- Introduction

1.1. Introduction

1.1.1. This Service Specification, in conjunction with the Contract Terms and Conditions and other documents which form this Contract, defines the Commissioners' minimum requirements for Service Providers who deliver a Community Navigation service commissioned through this contract. It details the standards and outcomes that must be achieved and describes how these will be evidenced and monitored.

1.1.2. This Service Specification sets out the requirements for the provision of a Community Navigation service which is designed to help older people and Carers make best use of local services and community support to achieve what is most important to them, and so improve their own health, independence and wellbeing.

1.1.3. The contract is split into two distinct Parts:

Part A: Community Navigation *(see Section 4)*

This service will be available to all Kent residents aged over 55 years, regardless of whether or not they are receiving any other services from Adult Social Care. The service will also be available to those under the age of 55 years, who meet the eligibility criteria detailed in this specification (see *clause 4.2.1*)**.**

As of April 2019, Kent County Council are the sole Commissioners of Part A of the contract in East Kent and West Kent. In Dartford, Gravesend & Swanley (DGS) and Swale, this service is being jointly commissioned by the Clinical Commissioning Groups (CCGs) and the Council.

Part B: Community Navigation for Carers *(see Section 5)*

This service will focus on supporting Adult Carers (adults who provide or intend to provide care for another adult (an adult "needing care")).

As of April 2019, Kent County Council and the CCGs in Kent are jointly commissioning Part B of the contract across all four geographic Lots detailed in *clause 3.1.*

Unless stated otherwise *(i.e. Section 4, Section 5, Appendix 3, Appendix 8),* all requirements detailed in this Service Specification, and any references to "Community Navigators", apply to both Part A and Part B.

1.1.4. Community Navigation (for both older adults and Carers) brings together care navigation and social prescribing services which are grant funded by Kent County Council and commissioned by DGS CCG and

Swale CCG (until March 2019), with elements of the current Carers Assessment and Support service contract which is jointly commissioned by KCC and the CCGs. These services involve, for example, guiding people through the health and social care system, providing information and advice, signposting people to services that support their wellbeing, supporting people to maximise their income, connecting people to community resources and carrying out statutory Carers assessments.

Direct support services for Carers (not identified in this specification) will be commissioned separately.

1.1.5. This Specification supports the aim of developing a new outcome-focused care and support model throughout the Contract term to meet the Council's strategic objective that 'Older and vulnerable residents are safe and supported with choices to live independently' *(See Appendix 1 for the supporting outcomes relating to both older people and Carers).*

1.1.6. It is important to ensure that the services delivered through this specification are accessible to all eligible Kent residents *(see clause 1.1.2)*, reflecting their diversity and range of needs and aspirations.

1.1.7. This specification has been produced through engagement with older people and people living with dementia, and Carers, Provider organisations, CCG Commissioners and local care leads, District and Borough Councils, Patient and Public Advisory Group (PPAG), key stakeholders in the community and Kent County Council Commissioners. Kent County Council wishes to thank all those who have contributed to this Service Specification.

1.2. The Engagement Approach

1.2.1. Kent County Council initially undertook an extensive programme of engagement in relation to a Core Offer of support for Older People and People Living with Dementia between January 2017 and August 2017. As part of this a new model of Care Navigation was designed. This engagement has helped to shape the vision, model and outcomes as set out in this specification.

1.2.2. During this period of engagement, Kent County Council spoke with:

- 226 individuals representing 214 community organisations and groups, who participated through 14 engagement workshop events.
- over 200 people aged over 55 in Kent, people living with dementia, and their Carers to understand what was important to them which identified that accessibility to good quality information and advice is vital in supporting people to live independently

1.2.3. The contract model being considered was also subject to a public consultation that ran from 12th June to 23rd July 2017.

1.2.4. Subsequent engagement (held between May-July 2018) has been undertaken with a range of stakeholders including CCG Commissioners and local care leads, Patient and Public Advisory Group (PPAG), district councils and a market engagement event.

1.2.5. This further engagement built on previous work and focused on defining the outcomes of the service, clarifying terms, defining the role, agreeing the scope and timelines for support, and discussing what a future contract might look like – all of which are reflected in this Service Specification.

1.2.6. Through this engagement, the key elements of the Community Navigator role were defined as**:**

Care Navigation:

The Care Navigator role provides a proactive link between different parts of the system; being both a first point of contact for individuals, Carers and health and social care professionals, as well as guiding and co-ordinating the individual's journey through the care system.

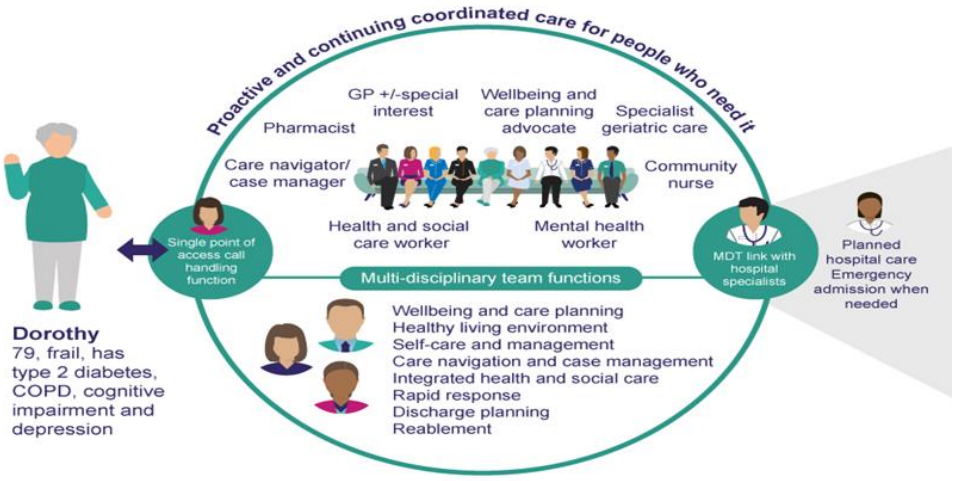
Social Prescribing:

Social prescribing is a way of linking people to sources of support within the community. It provides health and social care professionals with non-medical / non-service focused options (outside of the care system) that can operate alongside existing treatments or care packages to improve health and wellbeing.

1.2.7. Kent County Council wishes to thank those individuals and organisations who took part in the engagement for giving their time and for their valuable contribution.

1.3. Commissioning Intentions

1.3.1. Care navigation has a key role to play in managing demand on health and social care services. It features prominently in the Sustainability and Transformation Plans (STP) and a Care Navigator / Social Prescribing role is seen as a key element of the multidisciplinary team (MDT) approach outlined in the Local Care Model *(see below):*



(Source: Cathy Bellman; Kent and Medway Sustainability and Transformation Partnership)

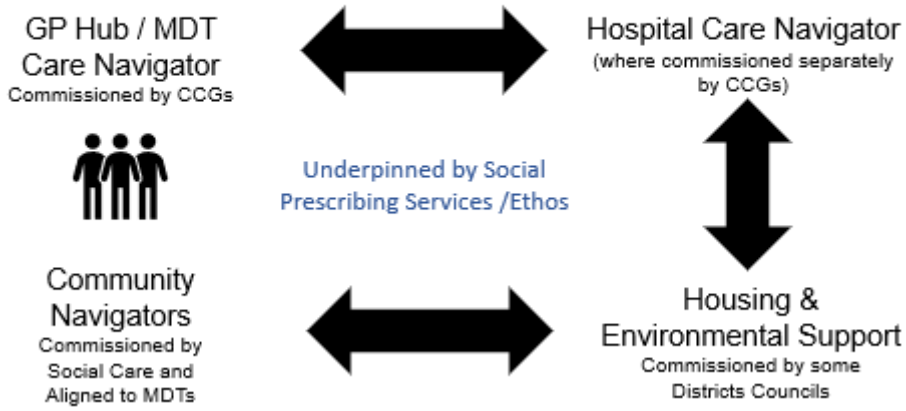
1.3.2. Whilst care navigation is associated with specific roles, the NHS Health Education England Care Navigation Competency Framework highlights:

- that effective navigation is a key element of delivering coordinated, person-centred care and support;
- that navigator roles, job titles and day to day tasks can vary based on local need; and
- the need to move thinking on, focusing on core competencies rather than job roles

1.3.3. Care Navigation is the business of a wide range of people across health and social care. Different roles require different levels of competency, experience and expertise. In developing Care Navigation there needs to be a balance between upskilling the current workforce (whether externally commissioned, part of the Council or the NHS) and commissioning new, specific roles.

1.3.4. In commissioning a Community Navigation service, the intent is to bring together roles currently delivering care navigation and social prescribing services and deliver a more holistic service that is available to all. This specification has been developed to promote innovative solutions to community navigation requirements; solutions which will combine statutory requirements with the broader Kent public service transformation principles, promoting independence and wellbeing.

Proposed Future Model of Community Navigation



(See *Appendix 3* for how the model differs in DGS and Swale CCGs)

1.4. Promoting Integration of Care and Support with Health Services

1.4.1. Improving the way we work with the NHS through integrated commissioning and provision to promote the wellbeing of adults with

care and support needs, including Carers, is vital to delivering the ambition of effective and efficient co-commissioning and delivery. This service must co-operate with any activity to further enhance this and adhere to any developments and enhancements as this develops.

1.5. Sustainability and Transformation Partnership (STP)

1.5.1. The NHS, social care and public health in Kent and Medway are working together to plan how we will transform health and social care services to meet the changing needs of local people.

1.5.2. The Kent and Medway STP are focussed on how best to encourage and support better health and wellbeing, and provide improved and sustainable health and care services, for the population of Kent and Medway.

1.5.3. The vision for the STP local care model is a:

> "…collective commitment of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well. We will help people to understand that hospitals aren't always the best place to receive care. Clinical evidence shows us that many people, particularly frail older people, are often better cared for closer to home. The model will build a vibrant social, voluntary and community sector to support people to look after their health and wellbeing, connect with others, manage their long-term conditions and stay independent."
>
> (The Kent & Medway Sustainability and Transformation Partnership - 'Local Care' Investment Case)

1.5.4. KCC and CCG officers are engaging at both a strategic and operational level, through established networks, to discuss interdependencies and joint working, including the opportunities to further joint commission.

1.5.5. The STP plans are likely to be reviewed on a regular basis, this service must co-operate with any review and adhere to any developments and enhancements as this develops.

http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/Transforming-health-and-social-care-in-Kent-and-Medway-updated-Nov-2016.pdf

Section 2 - Vision and Approach

2.1 The Vision and Approach of the Service

2.1.1. In commissioning a Community Navigation service, the intent is to bring together roles currently delivering care navigation and social prescribing services (for older people and Carers) in order to deliver a more holistic service that is available to all eligible Kent residents.

2.1.2. Community Navigators will work in partnership with those commissioned to fulfil similar roles in health (by both CCGs and Public Health) and district council settings, to both avoid duplication in the support they provide to members of the public, and to promote innovative solutions to community navigation requirements. These solutions will combine statutory requirements with the broader Kent public service transformation principles, promoting independence and wellbeing.

2.2. Service Model

2.2.1. The Community Navigation service is a community resource that aims to improve people's quality of life, health and wellbeing by recognising that this can be affected by a range of social, economic and environmental factors.

2.2.2. The model of the service is to provide a community based care navigation and social prescribing service which is accessible to eligible adults (older people, Carers and adults meeting specific criteria) living in Kent, where there is consistency in delivery across the county.

2.2.3. The contract will provide an opportunity to reduce duplication in the Provider market, align health and social care commissioned roles and create clearer pathways for people. It will be an important step in moving health and social care towards a jointly commissioned model of care navigation and social prescribing.

2.2.4. The service will need to work in partnership with the full range of agencies and groups in the community to support signposting, and aid referrals into non-commissioned services, community based activities/interventions delivered by voluntary sector organisations, SME's, local businesses etc. In doing so the service will address both the inefficient and unnecessary use of health and social care services, and the lack of awareness of existing alternative community based options.

2.2.5. The role must support people to achieve their personal aspirations; participate in their local and wider communities; enhance effective personal support networks; enable individuals to maintain healthy lifestyles; and lead independent and fulfilled lives.

2.2.6. As detailed in *clauses 4.2.10 and 5.2.13*, all Community Navigators will supply basic information regarding what benefits people may be eligible for and assist with completing initial forms where appropriate. Where more in-depth financial advice and support is required people may be referred on to other, more specialist, organisations as appropriate. In this instance, consideration should be given to the level of demand and capacity of specialist Providers.

2.2.7. The service will be demand led and the contract is designed to enable flexibility in response to the changing needs of people and organisations over the lifetime.

2.2.8. **Person-centred**

2.2.8.1. The Person must be central to all decisions regarding the service provided for them. Where appropriate, Community Navigators will also engage with the Person's family, Carer and/or support network to ensure they are best placed to support the Person.

2.2.8.2. The approach will be strength based, focusing on the Person's Personal assets, interests, independence, and social inclusion so that they can be supported to: maintain and improve their wellbeing, become more resilient, and find solutions and support within their community.

2.2.8.3. Community Navigators will work with people to identify areas of interest that are important to them, and signpost them to relevant activities (i.e. activities related to their likes and interests) in their local communities that are not services. For example, art, culture, heritage and physical activities. This may include the provision of direct support to enable people to engage and participate.

2.2.8.4. The Council supports person-centred approaches such as ESTHER and will, through the Design and Learning Centre, support Providers to implement the ESTHER person-centred approach. Further information on the ESTHER model can be found in *Appendix 2* of this specification.

2.2.8.5. The delivery model's person-centred approach must recognise that how this is achieved will vary depending on the needs of the Person. People with more complex and/or multiple needs may require a more structured offer to help and support them. As such the support and interventions offered through this service will need to understand and be responsive to the needs and aspirations of this diverse population.

2.2.8.6. The Provider must be able to demonstrate that the commissioned service is open to all those who meet the eligibility criteria detailed in this specification and as such is able to meet the needs of people with protected characteristics - regardless of their gender identity, ethnicity, disability, religion and beliefs, marital status, or if they are pregnant or on maternity/paternity leave.

2.2.8.7. The role should undertake holistic assessments (e.g. identifying environmental issues in a Person's home, even if only supporting completion of a blue badge application).

2.2.9. **Community Focused**

2.2.9.1. Each Community Navigator must understand the full range of social, health, economic and environmental support available locally and establish excellent knowledge of, and links with, local opportunities and sources of information/support. This will include supporting people to access a range of community activities which allow them to connect with, and contribute to, their local community.

2.2.9.2. Providers should work with their Community Navigators to develop an asset list for their contracted area.

2.2.10. **Promoting Wellbeing**

2.2.10.1. Alongside addressing a Person's identified support needs, the service should also look to promote wellbeing as a concept in order to build resilience and help keep people mentally well.

2.2.10.2. The service should sign post or support people to take part in activities which promote wellbeing such as those identified through the 'Six Ways of Wellbeing' or via 'One You' national resources. This may include being active (e.g. health walks), learning (e.g. reading), taking an active role in their community (e.g. volunteering) or signposting people to local groups or activities.

Information regarding One You Kent can be found at: http://www.kent.gov.uk/social-care-and-health/health/one-you-kent

2.3. Trusted Assessor Element of the Role

2.3.1. All Community Navigators will play a valuable role in supporting people to access equipment and technology that helps them remain independent for longer. This will involve assessing and identifying a Person's adaptation, equipment and assistive technology needs, and arranging for their supply as appropriate.

2.3.2. All Community Navigators are required to complete the KCC approved training courses detailed in *clauses 2.3.3 and 2.3.4* to enable them to fulfil the trusted assessor element of the role. Other training courses are available but are not considered to meet the requirements for this contract as they do not align with the equipment used by KCC. Having a standard course in place also ensures consistency of training and knowledge across the service.

2.3.3. **Training for Community Equipment Assessments**

Any requests for attendance of this training are done via hrlearningdevelopment@mailgb.custhelp.com. This training is delivered over a three day period that includes a comprehensive mentoring assessment to ensure that the delegate meets the competency to assess for equipment.

Any scheduled training sessions provide two ringfenced places for external agencies at a cost of £400.00 with an additional cost of £150.00 for refresher training after 18 months to assess competency and knowledge.

The three day training will provide:

- Relevant policy and legislation
- Functional assessment
- Common conditions and disability
- Assessment for and prescription of free standing equipment as agreed for CEA's
- Assessment for and prescription of minor adaptations as agreed for CEA's
- KCC paperwork
- NRS paperwork
- CTS57 forms

On completion of training, the contact details of all successful candidates are passed to the Community Support mailbox (communitysupport@kent.gov.uk) who circulate the new user forms that

are needed to access the eLearning for iRIS4 which is the system used to place orders for equipment online.

2.3.4. **Training for Assistive Technology (Telecare)**

In order to assess a Person for Telecare, Community Navigators will need to first complete a short eLearning session that provides an overview on how to place orders using the ordering system.

To access this training, Community Navigators will need to email the Learning & Development Team (hrlearningdevelopment@mailgb.custhelp.com) in order to receive a link to the external facing learning platform, Delta.

Once the eLearning has successfully been completed, Community Navigators can contact L & D using the above email address and register to attend a half day classroom based face-to-face training session at a cost of £75.00 per session. This session will provide attendees with an overview of the eligibility criteria and a better understanding of the products available through the service.

An email will be circulated from the Training team at Centra to the Community Support mailbox to advise of contact information of all Community Navigators that have successfully completed the classroom based training. All attendees will then be advised how to register as a new user of the system to commence placing orders for telecare equipment.

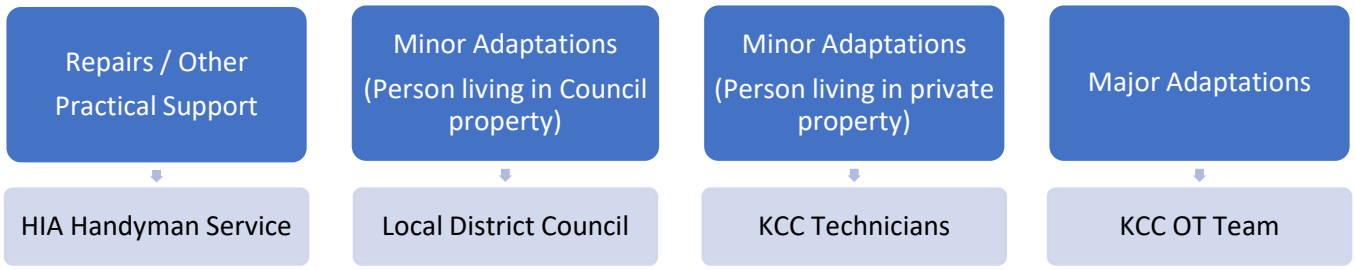
Further refresher training will be available after 18 months to ensure that prescribing staff are fully up to date with equipment and any eligibility/policy changes.

2.3.5. As detailed in the training, Providers must work with KCC to ensure people are only provided with services and/or equipment through this contract where KCC would expect to provide it.

2.3.6. Basic lifeline button alarms are not funded via this service, except in exceptional circumstances for which there is clear criteria detailed in the guidance issued during training. The approval process for such requests is also outlined in the training.

2.3.7. Home adaptations and postural stability classes can play an important role in falls prevention, and as such should be considered by Community Navigators when working with all older people, but particularly when supporting frail adults.

2.3.8. Where Community Navigators identify the following needs within a Person's home they should refer them on to other agencies as shown in the following diagram:



All contact details will be provided during the training.

2.4. Outcome Focused Service

2.4.1. This specification responds to developments in social policy and a shift in focus from service inputs to the outcomes services achieve and as such this specification will focus on the personal, organisational and system outcomes required.

2.4.2. Outcomes can be defined as the intended impact, consequence or result of a service on the lives of both individual people and communities.

2.4.3. Outcome focused services are fundamentally person-centred in approach, recognising that each Person is unique and will have different requirements and levels of needs. They also recognise the need to consider organisational and system outcomes, as mentioned in *clauses 2.8 and 2.9.*

2.4.4. The aim of an outcomes focused Community Navigation service will be to achieve the aspirations, goals and priorities as defined by the Person accessing the service, through support/signposting to a range of interventions and activities. Providers delivering this service will be expected to find innovative solutions to facilitate improved outcomes for people.

2.4.5. KCC and CCG Commissioners have specified below the outcomes which the Providers are to achieve. These outcomes have been co-produced and are what people have told us are important to them.

2.5. Personal Outcomes

2.5.1. Community Navigators are expected to support all people that they work with (under both Part A and Part B of the specification) to achieve their personal outcomes by using an approach which best meets each Person's needs. A range of different responses and approaches will be

required, particularly in relation to the level of need and identified goals/outcomes of older people and people living with dementia.

2.5.2. Further information can be found in *Appendix 5 – Person Profiles*

2.5.3. The Personal outcomes set out below have been identified by the people of Kent as being important to them:

Information and Advice

- I know where to find information and advice and I am confident that this is accurate and easily understood
- The information and advice that I receive is proportionate at the point of contact and I am not left confused with too much or too little information to understand
- I know what is available in my community to ensure I have informed choice
- I am confident that information and advice that I receive is impartial and objective

My Community

- I feel included and connected to the communities of my choice
- I am able to access meaningful social activities

My Support

- I am supported to have a good day
- I am supported to meet my personal goals
- I am appropriately supported to know my 'Rights' in relation to my care and support
- My support is flexible and reliable
- Access to help and support is clear
- I am confident that the services I access are joined up and my information is shared appropriately and safely
- I am confident that staff and volunteers are well trained

My Health and Wellbeing

- I am supported to live safely and independently
- I am able to make informed choices
- I feel listened to and heard
- I am able to maintain Personal relationships
- I feel less lonely and socially isolated
- I feel valued
- I feel equipped to cope in a crisis
- I am supported to manage my long term condition(s)
- I am confident that my needs will be met within an approach which respects my lifestyle choices, beliefs and dignity

2.6. Dementia Specific Personal Outcomes

2.6.1. For the most part, the outcomes for people living with dementia, their Carers and their families are the same as those for someone living without dementia. There are, however, an additional set of specific outcomes that people living with dementia have identified as being important, which include:

- I have access to information, advice and support so that I (and my Carers and/or family) understand the condition and its impacts
- I receive support early in order to prevent crisis
- My Carers have support to understand and learn strategies to manage my challenging or difficult behaviours
- I have access to facilities and activities within local communities that are supportive of people living with dementia

2.6.2. People living with Dementia need to:

- Feel Safe
- Be Involved in the community
- Live where they want to live
- Be as healthy as they can be

2.6.3. Further information can be found in *Appendix 5 – Person Profiles*

2.7. Carer Specific Personal Outcomes

2.7.1. For the most part, the outcomes for Adult Carers are the same as those for someone without caring responsibilities. There are, however, an additional set of specific outcomes that Carers have identified as being important, which include:

- I am supported to live a healthy lifestyle and manage my heath and long-term conditions in order for me to continue my caring role
- My caring role is recognised, and I am appropriately supported in my caring role
- I have support to understand and learn strategies to manage the challenging or difficult behaviours of the Person/people I care for
- Where appropriate, I am involved in decisions made about the Person/people I care for (e.g. where the cared for is someone living with dementia)

2.7.2. Further detail can be found in *Clause 5.5, and* in *Appendix 5 – Person Profiles*

2.8. Organisational Outcomes

2.8.1. The Provider **will** be able to evidence the alignment of their organisational vision and mission into a plan, with set targets and objectives against both the Personal and system outcomes outlined. This should support the Provider in defining its intentions and offer both during the term of the contract and in the future.

2.9. System Outcomes

2.9.1. By working in partnership with Commissioners, the Provider **must** be able to demonstrate how the service specified has contributed to the following:

- Reduction in the number of people entering social care and health services unnecessarily
- Reduction in the level of unmet need at the point of referral to social care or health
- Increased levels and models of mutual/peer support (Part B only)
- Improved outcomes/access to support for people, their families and their Carers as a result of the Community Navigation service delivered by the Provider (including information, advice, signposting and referrals).

2.9.2. Additional system outcomes for Providers delivering Part A of the contract under Lot 3 (DGS) and Lot 4 (Swale) can be found in *Appendix 3.*

Additional system outcomes for Providers delivering Part A of the contract within the South Kent Coast CCG area under Lot 1 (East Kent) can be found in *Appendix 8.*

2.10. Social Value

2.10.1. Kent County Council services have a social purpose and therefore KCC will require that services become smarter at determining social value. This will be through improving the economic, social and environmental wellbeing of Kent. This encourages Commissioners to look beyond the price of a service and consider how to maximise the wider impact and benefits which could be possible with the resources available.

2.10.2. The Commissioning Framework sets out some overarching principles for how we will use social value. The Provider will ensure that they support Kent County Council's Commissioning Framework principles for social value which include:

- **Local Employment**: creation of local employment, volunteering and training opportunities, including employment of individuals with disabilities
- **Buy Kent First**: buying locally where possible to reduce unemployment and raise local skills (within the funding available and whilst minimising risk to KCC)
- **Community development**: development of resilient local community and community support organisations, especially in those areas and communities with the greatest need
- **Good Employer**: support for staff development and welfare within Providers' own organisations and within their supply chain
- **Green and Sustainable**: protecting the environment, minimising waste and energy consumption and using other resources efficiently, within Providers' own organisations and within their supply chain

2.10.3. These themes have been singled out as practical ways to deliver social value outcomes in line with Commissioners' ambitions; however, there may be other priorities which are particularly relevant for your service.

2.11. Communication, Marketing and Engagement

2.11.1. Communication, marketing and engagement regarding the service must be proactive.

2.11.2. The Provider will ensure that the service is publicised to increase public awareness of the support available and how to access it, through (but not limited to):

- GP surgeries
- Local community centres
- Statutory buildings
- Voluntary sector partners
- Word of mouth through community members
- Publication/Awareness of Service

2.11.3. Any public communication messages must consider Easy Read and other accessible forms of communication.

2.11.4. Kent County Council must be informed if a communication message is likely to attract attention of the media, good or bad. The Kent County Council Press Team may need to be involved in the communication or the response.

2.12. Partnership Working

2.12.1. This contract can only be awarded to a legally constituted entity; this can be a single organisation or a legally constituted partnership.

2.12.2. The Council encourages partnership working amongst organisations in the delivery of the Community Navigation service, recognising that some small and medium Providers will not have the footprint to cover the contract's geographic Lots *(see clause 3.2)* in their entirety.

2.12.3. Where Providers group together into partnerships or consortia, the Council will expect the Lead Provider *(see clause 2.13)* to abide by the principles of market stewardship in relation to their supply chain (if applicable).

2.12.4. Where Providers identify organisations that they refer to for specialist information, advice, and support, consideration must be given to the demand and impact created by signposting to these organisations.

2.12.5. If it is the intention of the Provider to signpost to other organisations for benefits maximisation then the Provider must be mindful of the specialist organisation's capacity, and the impact that their referrals are having in terms of increased demand on the service.

2.12.6. The Council wishes to work in partnership with Providers in delivering a high quality comprehensive Community Navigation Service to Kent residents. By signing up to a partnership approach the Council and Service Providers are making a commitment to:

- Have a contract that is flexible enough to reflect changing needs, priorities, strategy, seek continuous improvement through fostering a learning environment and working together, and which has Person and Community Navigator participation at the centre;
- Work towards achieving key outcomes and objectives;
- Communicate openly and honestly with each other clearly and regularly;
- Share relevant information, expertise and plans;
- Avoid duplication wherever possible;
- Monitor the performance of all parties;
- Seek to avoid conflicts but, where they arise, to resolve them quickly at a local level wherever possible
- Improve cross-sector working to ensure integrated, participative working, not only across statutory and voluntary Providers of Services and social care but also with and between Providers outside the social care system. These could include, but are not limited to:
    - Faith groups
    - Minority ethnic community organisations
    - Libraries
    - Employers and employment organisation
    - Colleges
    - A full range of Providers of sports and leisure activities
    - A full range of Providers of arts, culture and heritage activities
    - Informal support groups.

2.13. Lead Provider

2.13.1. Where Providers group together into partnerships or consortia, a Lead Provider will need to be identified.

2.13.2. The Lead Provider will need to collate and analyse the performance information from the partnership or consortia and will be required to monitor the delivery of all outcomes identified within the contract. The Lead Provider will also need to demonstrate their ability to manage the partnership and ensure a proportionate approach to risk management.

2.13.3. The Lead Provider will need to understand and recognise the nature and challenges experienced by the Providers in the partnership or consortia, which may include both small and growing organisations alongside larger and more long-standing organisations.

2.13.4. The Lead Provider must ensure that there is continuity in the partnership or consortia at all times. Any changes to the partnership or consortia, or supplier failure, would need to be formally escalated to Kent County Council (and also to the CCGs in the case of DGS and Swale). Any significant changes must be formally agreed with Commissioners through contract monitoring and formal governance procedures.

2.13.5. Where appropriate, the Lead Provider should have systems for allocation of specific work to Providers within the partnership or consortia. The allocations should ensure that the Person receives services from the Provider that has the correct level of expertise and is best placed to support the Person.

2.13.6. Opportunities for co-location between the Providers within the partnership or consortia and other key community resources should be considered to support the delivery of outcomes *(see clause 2.14).*

2.14. Working Practice and Co-Location Opportunities

2.14.1. Having a strong community presence is key to understanding community dynamics and ensuring that the service has as wide a reach as possible.

2.14.2. All Community Navigators, whether working under Part A or Part B of the contract, will work flexibly and be community based roles (including visiting people in their own homes as appropriate), rather than being office based in the Provider's premises.

2.14.3. The Provider must actively explore opportunities to work with other local Providers and public-sector partners in terms of making the best use of assets, infrastructure, and resources, including shared buildings and utilisation of shared community venues.

2.14.4. Community Navigators (working under Part A of the specification ONLY) will be required to work closely with surgeries who are part of their assigned local GP cluster team and will be required to attend at surgeries

on a regular basis (frequency to be determined during the mobilisation phase of the contract).

2.14.5. Community Navigators (working under Part A of the specification ONLY) will be required to establish good working relationships with their local district council *(see clause 3.1)* and are encouraged to explore the option of basing themselves in the district council offices periodically (frequency to be determined during the mobilisation phase of the contract) to ensure effective sharing of information and maximisation of resources.

2.14.6. Opportunities to co-locate in other available premises in the community that are accessed by members of the public, such as libraries and gateways, should also be explored by all Community Navigators (working under both Part A and Part B of the specification).

2.15. Staff and Volunteers

2.15.1. **Staff Recruitment**

2.15.1.1. Staff must be of good character, assessed through:

- Interview and selection processes
- Seeking and scrutinising references and associated checks prior to employment
- On-going enhanced DBS checks
- Regular supervision.

2.15.1.2. All requirements described below are applicable to all staff, whether employed on a paid or volunteer basis; for the avoidance of doubt, this includes all persons engaged on an ‘as and when’ basis, short term engagements and any external persons you may bring in for the provision of services, events, etc.

This means:

- Employees
- Volunteers
- Work or student placements
- Agency staff – the expectation is that agency staff will not be used to deliver this Contract.

2.15.1.3. It is the Provider’s responsibility to ensure that any individuals recruited meet the legal appointment requirements concerning training, DBS checks and acting independently. Failure to do so will constitute a breach of contract and will be subject to contract sanctions. Further review may result in the withdrawal or suspension of this contract. KCC reserves the right to request access to this information at any time.

2.15.1.4. The Provider will use its best endeavour to replace promptly any staff assigned to this contract who cease their employment for any

reason, and that replacement staff with equivalent skill levels and qualifications are recruited.

2.15.2. **Disclosure and Baring Service (DBS) Checks**

2.15.2.1. The Provider is responsible for ensuring all job applicants (including volunteers, agency staff and work/student placements) granted an interview are asked appropriate questions to ensure they are aware and understand the implications of DBS eligible posts and Rehabilitation of Offenders Act 1974.

2.15.2.2. All staff, volunteers, agency staff and work/student placements engaged in the service must have a completed a clear enhanced DBS disclosure check prior to beginning employment and engagement in the service.

2.15.2.3. Where the Provider is aware that a job applicant has lived overseas within the past 5 years for a period of 6 months or more, a certificate of good conduct or criminal record check from the country of residence should be provided in advance of the job applicant commencing work. Providers must be aware the DBS checking service cannot access criminal records held overseas. A DBS check may not provide a complete view of an applicant's criminal record if they have lived outside the UK. Providers should make sure they have access to all the information available to them to make a safe recruitment decision to safeguard people who access the service.

2.15.2.4. Providers must put in place appropriate protocols for applicants with an unusual address history.

2.15.2.5. The process and procedures the Provider undertakes to check all staff and volunteers must be recorded and retained clearly.

2.15.2.6. The process and procedures the Provider undertakes when using the DBS checking service must be in line with the DBS Code of Practice and the Data Protection Act 1998.

2.15.2.7. Commissioners requires all Providers to have a clear enhanced DBS check for all staff and volunteers engaged in activities with people every 3 years; this must be appropriate to the level of activity delivered.

2.15.3. **Lone Working**

2.15.3.1. Providers are responsible for ensuring that staff and volunteers are safe.

2.15.3.2. Potential risks associated with lone working must be assessed to minimise those risks. Adequate precautions and safe systems of

work should be put in place following a risk assessment so that staff and volunteers are not adversely affected by lone working.

2.15.3.3. All staff should be aware of, and have read, the Provider's lone working policy and procedures.

2.15.4. **Staff Retention**

2.15.4.1. Staff retention has an important benefit as loss of talent and expertise will impact on how effective an organisation is in the long term. Continuous recruitment also adds to the running costs and this can affect delivery and sustainably.

2.15.4.2. The Provider must recognise and develop an effective approach and tool kit for retaining staff.

2.15.4.3. The Provider must put in place a mechanism for gathering and analysing feedback from staff and volunteers and setting action plans. All written documentation regarding these mechanisms must be retained for a minimum of three years.

2.15.4.4. The Provider must ensure there are mechanisms in place to ensure the health and wellbeing of all employees within the organisation. This must be documented through supervision and annual reviews.

2.15.4.5. The Provider must ensure an environment is created to support the retention and investment in employees. This must be documented through supervision and annual reviews.

2.15.5. **Business Continuity**

2.15.5.1. There must be an adequate staffing structure in place which will include contingency measures for both the short and long term absenteeism of members of staff who are involved in providing the service, to ensure continuity of service at the required level throughout the term of the Contract.

2.15.5.2. An established Business Continuity Plan must be in place at the start of the contract. This must detail a methodology, risk assessment, Recovery Strategy, Disaster Recovery Plan and Incident Response Plan.

2.15.6. **Staff Qualifications**

2.15.6.1. Formal qualifications, such as NVQs, are not considered a prerequisite for employment under this contract, instead greater emphasis is placed on relevant equivalent experience that post holders may have, their knowledge of (and links with) the local

community, and their ability to communicate and engage effectively with a diverse range of stakeholders.

2.15.6.2. The Provider must be able to evidence that (at a minimum) all Community Navigators are working at the Enhanced (Silver) competency level across all nine key domains detailed in the Care Navigation Competency Framework.

https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

2.15.6.3. Additional competency domains may be added as needed to meet the specific requirements detailed in this Service Specification (e.g. awareness of issues affecting eligible residents, such as Dementia, Learning Disabilities, Mental Health, Physical Disabilities, Sensory Impairment, caring responsibilities, and medicine optimisation). These will be agreed with the successful Provider(s) during the mobilisation phase.

2.15.6.4. Where Community Navigators are unable to evidence that they are already working at this level, they should be supported to do so within one year of commencement of employment with the Provider, under this contract.

2.15.6.5. After the first year of employment under this contract, as a minimum Community Navigators should be able to demonstrate that they:

- are consistently working at the Enhanced (Silver) competency level
- are working towards meeting the requirements for the Expert (Gold) competency level and are therefore able to work with more complex cases and provide supervision to those working at Silver

2.15.6.6. During the mobilisation phase, contracted Providers will work with Commissioners to agree how best to evidence that the required competency levels are being met. This will feed into *Schedule 14 – Contract Management.*

2.15.6.7. Additional information regarding staff qualification requirements for Lot 3 (DGS) and Lot 4 (Swale) can be found in *Appendix 3*.

Additional information regarding staff qualification requirements for the South Kent Coast CCG area under Lot 1 (East Kent) can be found in Appendix 8.

2.15.7. **Induction and Training**

2.15.7.1. All training and development requirements regarding staff and volunteers are the responsibility of the service Providers, and they

must show that they are complying with the relevant regulations that cover staff competence and training.

2.15.7.2. Providers must ensure that their staff and volunteers have been given, and understand, all guidelines and procedures relating to the service and that staff training specifically includes Mental Health Awareness and the Mental Capacity Act (MCA), Safeguarding, Sensory Awareness, Equality and Diversity, Managing Violence and Aggression, Drug and Alcohol Awareness, Lone Working and all relevant policies and procedures detailed in *clause 7.5.4*, in addition to the training requirements detailed below.

2.15.7.3. It is recommended that all Community Navigators undergo training in motivational interviewing as this will be key to the role.

2.15.7.4. Each new member of staff must undertake a training needs analysis on completion of an induction or a probationary period. This must be incorporated into the staff training and development plan. Full and complete training records for all staff must be maintained and available to KCC for inspection.

2.15.7.5. All Community Navigators will need to complete the ESTHER ambassador e-learning, and for new staff joining the organisation this should form part of their induction. See *Appendix 2* for further information.

2.15.7.6. All Community Navigators will need to attend a Dementia Friends Information Session (lasting 45 minute – 1 hour). Sessions are delivered free of charge by volunteers of the Alzheimer's Society https://www.dementiafriends.org.uk. For new staff joining the organisation this should form part of their induction.

Dementia Friends can undergo further training to be Dementia Friend Champions (who are trained to deliver Dementia Friends Sessions). The Champions Induction is a one-day training programme.
https://www.dementiafriends.org.uk/WEBArticle?page=what-is-a-champion#.W79KJeQUnIU

KCC Commissioners have good links with all the Dementia Friendly Communities across Kent and will support Community Navigators to link in with these groups.

2.15.7.7. Community Navigators must receive adequate IT training to enable them to both complete the required documentation for recording and

monitoring a Person's support, and adhere to the reporting requirements associated with the contract monitoring of the contract.

2.15.7.8. Alongside IT training, Community Navigators must receive training on the documentation used by the Provider, to include data collation (manual & electronic) and using/understanding surveys and questionnaires to support evaluation.

2.15.7.9. The Provider will support staff development, where able, by both facilitating access to appropriate training and offering experiential learning through such things as shadowing. Training for all Community Navigators must therefore include orientation to the localities in which they work, through:

- Visiting local agencies and organisations to increase their knowledge of service provision and facilities, including statutory, voluntary and independent. Examples include:
  - Health promotion services
  - Established community social opportunities
  - Local lunch clubs
  - Day centres and services
  - Carers forums
  - Tea afternoons, etc.
  - Voluntary networks
  - Specialist forums – by increasing cultural awareness
  - Leisure activities – accessible by those with a disability, etc.
  - Specialist interest groups (e.g. Disease specific)
  - Knowledge of private services (care agencies, dog walkers etc.)
  - Housing opportunities – including sheltered housing
- Shadowing health practitioners and working with the MDTs to understand the processes involved at a local level, and also identify how the Community Navigator role can work alongside, and compliment, the navigation roles commissioned to work in health settings (where appropriate).
- Working alongside staff in the District Councils to share knowledge about local services, groups, activities and other resources that Community Navigators may want to signpost people to, but also where referrals can be made to the District Councils for support (e.g. Home Improvement Agency (HIA) services).

2.15.7.10. The Community Navigator will receive professional and personal supervision as per the Provider's staffing policies.

2.15.7.11. Managers and supervisors must receive training in supervision skills and should undertake periodic management training to update their knowledge, skills and competence to manage staff and the service.

2.15.7.12. The need for refresher and updating training will be identified at least annually during staff appraisal and incorporated into the staff development and training programme. For volunteers, refresher and updating training will be identified at least annually during an annual volunteer review process.

2.15.7.13. See *clause 2.3* for specific training requirements related to the Trusted Assessor element of the role.

2.15.7.14. Training on the completion of statutory Carers Assessments will be delivered by the Provider to all those carrying out the Community Navigation for Carers role. In addition to the training detailed in *clause 2.15.7.2*, the Community Navigators for Carers will also be required to complete training around Safeguarding for Children and nominate and maintain a minimum of two people from the organisation, per contractual geographical Lot, to receive training in relation to KCC's client systems. It is noted that only two people from the organisation per geographical Lot can have access to systems at any one time within the boundaries of this specification.

2.15.8. **Staff Supervision**

2.15.8.1. All Staff and volunteers should be actively supported and monitored in their role and receive regular supervision.

2.15.8.2. A full and clear staffing structure with supervision responsibilities must be kept, maintained and available to KCC for inspection.

2.15.8.3. The Provider must ensure regular supervision and team meetings are established and recorded in a written form. All written documentation regarding these meetings must be retained for a minimum of three years.

2.15.8.4. The Provider will be responsible for all actions of its staff/volunteers and will have to demonstrate robust safeguarding policies for all circumstances.

2.15.8.5. All staff must have, as a minimum, an annual appraisal of their overall standard of performance and identification of training and development needs.

2.15.8.6. The Provider will proactively undertake investigations of allegations of misconduct or negligence of any staff member undertaking a role in connection with this Contract and take appropriate action.

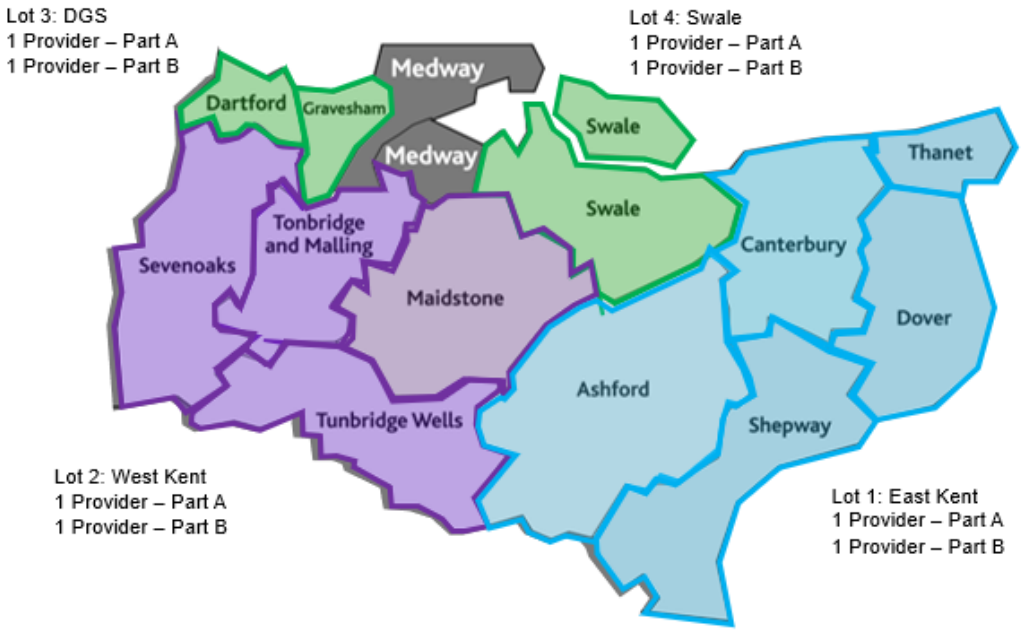
2.15.8.7. A record must be kept of all disciplinary incidents affecting this contract, and relevant information promptly shared with the Commissioners from KCC, and CCGs as appropriate. Commissioners reserve the right to request this information at any time.

2.15.8.8. Commissioners reserve the right to undertake unannounced visits.

Section 3 – Community Navigation Contract Lots

3.1 Contract Lots

3.1.1. The contract will be split into both geographic and service Lots in order to best meet the differing needs and support requirements of the eligible Kent population, as shown below:



3.1.2. Within each geographical area, the contracted Provider(s) will be required to develop clear pathways for people and for referring professionals - working collaboratively where more than one Provider is contracted to deliver the different service Lots (Part A and Part B) in the same area. This will enable the Community Navigators to work more effectively, by focusing on their part of the pathway or client group and referring onto the Provider delivering the other Part of the contract in their area as appropriate (thereby avoiding duplication of roles). The same will be true of specialist services including One You, and district councils for housing related support.

3.1.3. Working collaboratively and taking a holistic approach (under both Part A and Part B), will allow people to be supported within their family unit as appropriate, and where applicable will avoid having different Community Navigators supporting both the Person with care needs and the Adult Carer.

The Providers within each geographical Lot will determine the processes around this collaborative working during the mobilisation phase, but it is anticipated that:

- Where the primary client (the Person who accessed the support first) also has a Carer, the Person with care needs will be

supported by a Lot A Community Navigator and may signpost the Carer to Carers organisations for support as appropriate.

- Where the primary client (the Person who accessed the support first) is an Adult Carer, the Adult Carer will be supported by a Lot B Community Navigator for Carers who may signpost the Person with care needs to specialist organisations for support as appropriate.

- In both instances, the need for further referral may be influenced by the degree to which support for the primary client is able to also address the support needs of others within the family unit.

3.1.4. As detailed in *clause 2.14*, Community Navigators are required to establish good working relationships with their local district council(s) and are encouraged to explore the option of basing themselves in the district council offices periodically to ensure effective sharing of information and maximisation of resources. Doing so will not only support Community Navigators to identify local services, groups, activities, resources etc. that they may want to signpost people to, but also where referrals can be made to the district councils for support (e.g. to the local Home Improvement Agency (HIA) services).

3.1.5. Contracted Providers must work with KCC and CCG Commissioners during the mobilisation phase to establish the operational protocols for how the contract Lots will work in practice in each area of the county *(see Appendix 4 – Contract Mobilisation Plan).*

3.1.6. Community Navigators working under each contract Lot will have a single point of access – one contact number and point of referral.

(In DGSS, referrals made within the MDTs may be passed directly to the linked Community Navigator but will also need to be logged with the Provider. The processes around this will be agreed during the mobilisation phase.)

3.2. Geographic Lots

3.2.1. The contract will be aligned to the CCG boundaries, and services commissioned to support the delivery of Local Care. The service will be commissioned in four separate geographic Lots – East Kent, West Kent, DGS and Swale.

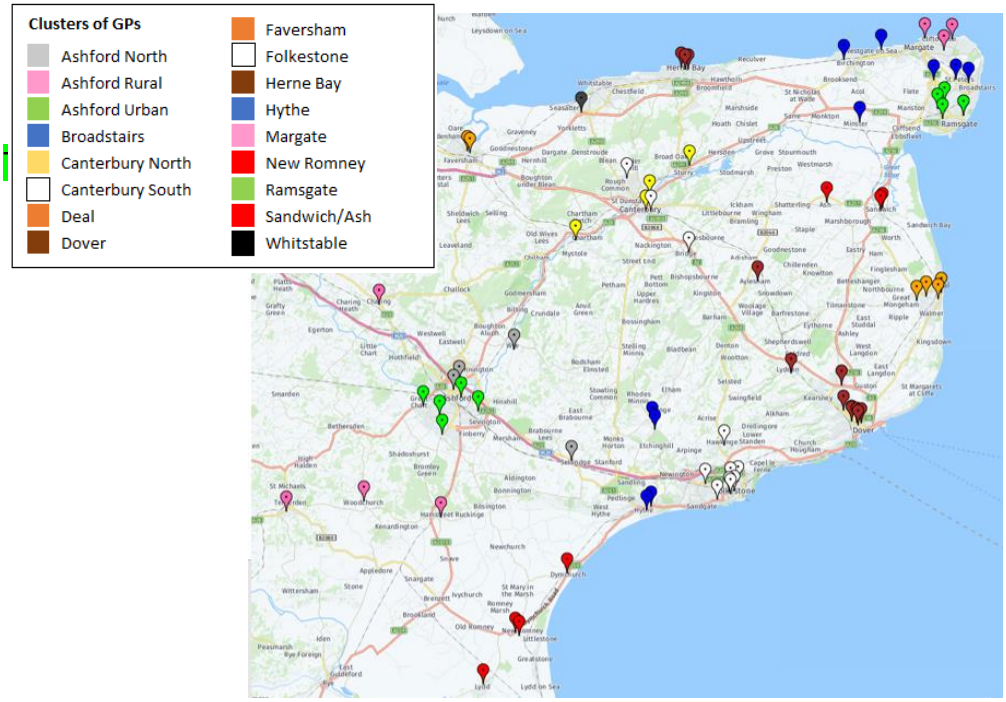
3.2.2. The Community Navigator posts commissioned under Part A of the contract will be aligned to the GP clusters as detailed below.

3.2.3. The Community Navigator for Carers posts commissioned under Part B of the contract will work within the CCG boundaries of the geographic Lots.

How they will be aligned will be agreed with Providers during the mobilisation phase.

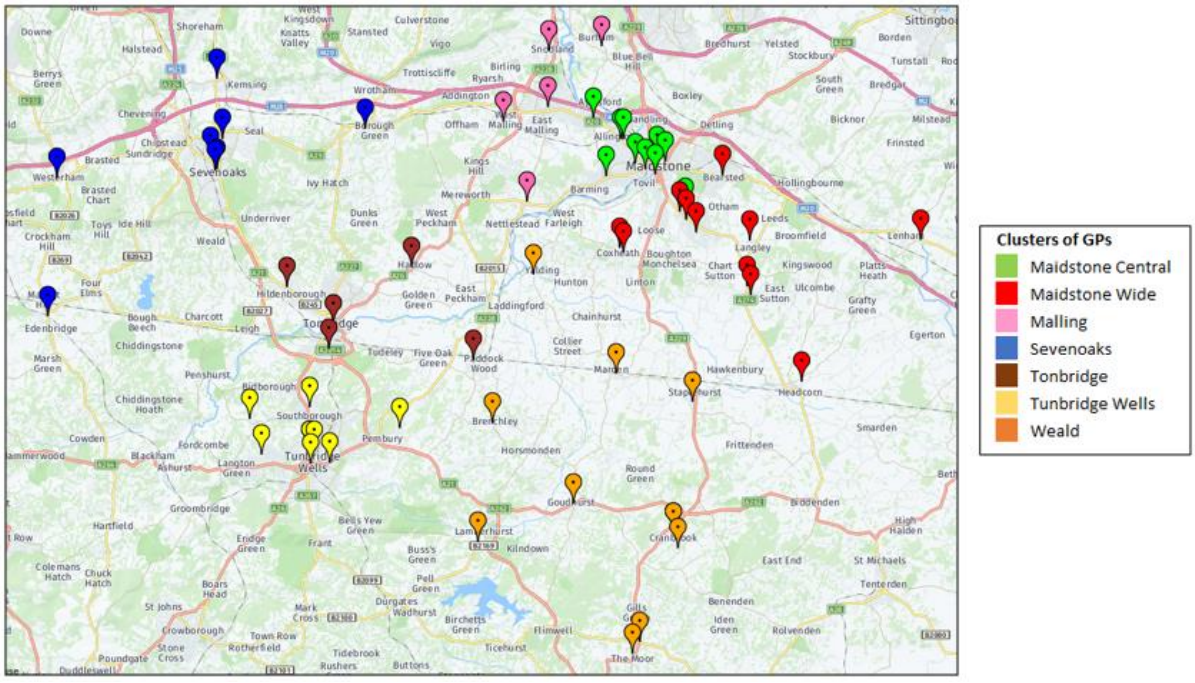
3.2.4. Lot 1: East Kent

The Community Navigator posts will be aligned to the 18 GP clusters in East Kent (three in Ashford CCG, six in Canterbury and Coastal CCG, six in South Kent Coast CCG, and three in Thanet CCG).



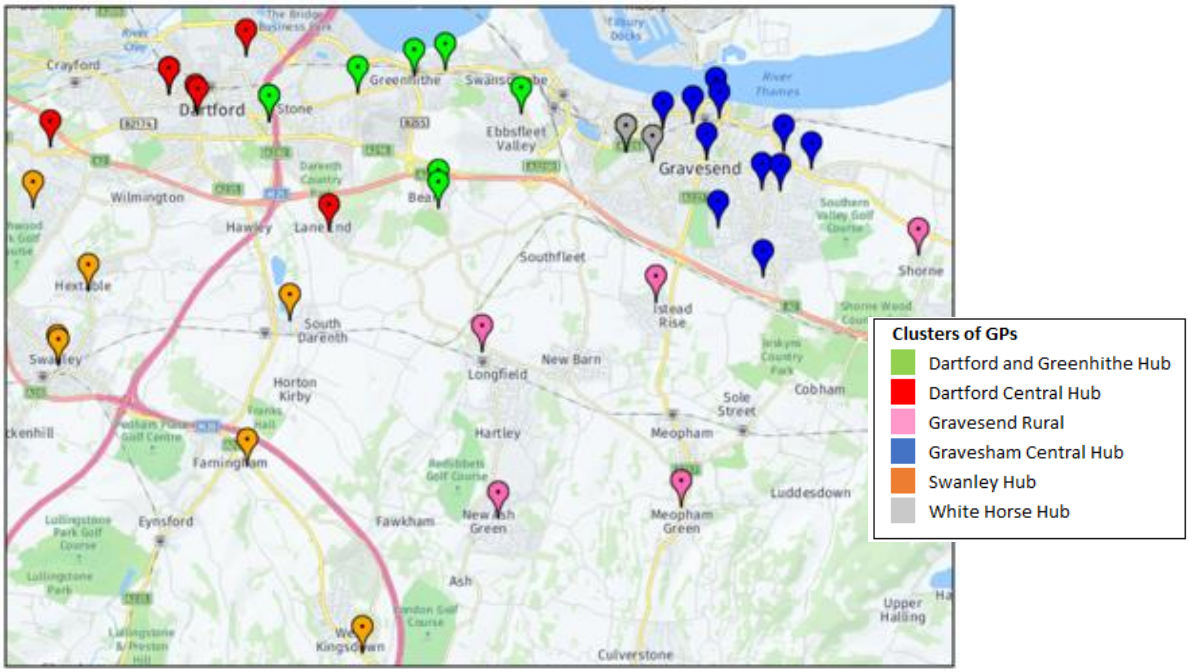
3.2.5. Lot 2: West Kent

The Community Navigator posts will be aligned to the seven GP clusters across the West Kent CCG.



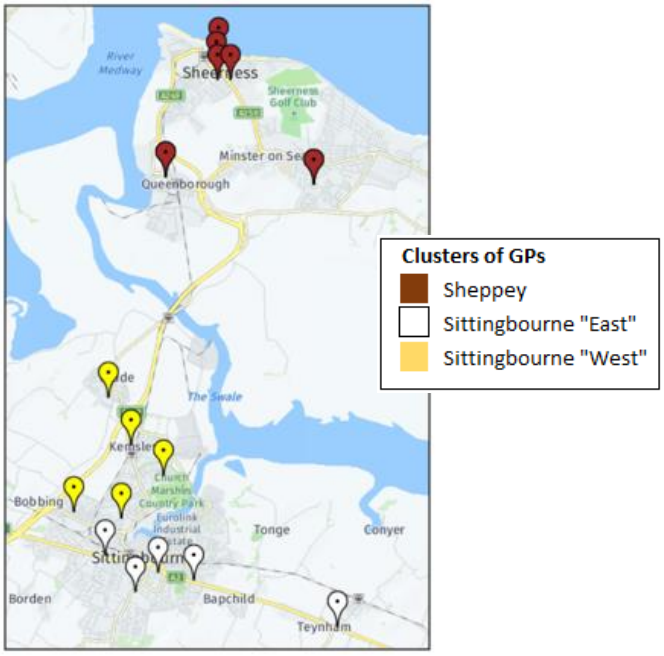
3.2.6. Lot 3: DGS (Dartford, Gravesham and Swanley)

The Community Navigator posts will be aligned to the six GP clusters across the DGS CCG.



3.2.7. Lot 4: Swale

The Community Navigator posts will be aligned to the three GP clusters



3.3. Service Lots

3.3.1. Community Navigation is vital for those people who need support in locating and accessing the appropriate services for themselves and those they care for. In order to ensure people receive the best possible support, each geographic Lot will be subdivided into two Parts – Part A: Community Navigator, and Part B: Community Navigator for Carers. The two Parts may be delivered by the same Provider/consortia, or different ones.

3.3.2. **Part A: Community Navigation**

3.3.2.1. The role will focus on supporting the following groups:

- Older people (over 55 years)
- People with complex issues / frailty (under 55 years)

3.3.2.2. Further information can be found in *Section 4* of this Service Specification.

3.3.3. **Part B: Community Navigation for Carers**

3.3.3.1. The role will focus on supporting Adult Carers (adults who provide or intend to provide care for another adult (an adult "needing care")).

3.3.3.2. Further information can be found in *Section 4* of this Service Specification.

3.3.4. From the Contract Commencement Date, the successful Provider(s) will therefore be commissioned to deliver the Community Navigation service based on the following eight lots:

Lot 1a	-	Community Navigation in East Kent
Lot 1b	-	Community Navigation for Carers in East Kent
Lot 2a	-	Community Navigation in West Kent
Lot 2b	-	Community Navigation for Carers in West Kent
Lot 3a	-	Community Navigation in Dartford, Gravesham and Swanley (DGS)
Lot 3b	-	Community Navigation for Carers in Dartford, Gravesham and Swanley (DGS)
Lot 4a	-	Community Navigation in Swale
Lot 4b	-	Community Navigation for Carers in Swale

3.3.5. The integrated support delivered by Community Navigators will cut across boundaries and they will need to work with agencies within health, social and voluntary sectors.

3.3.6. Social prescribing is at the heart of the Community Navigation role and as such the support given should be holistic and focus on both the Person's needs and interests. The asset mapping carried out by the Provider during the mobilisation phase of the contract will be key to supporting this and should be subject to ongoing review to ensure the Community Navigators under both Parts A and B of the contract are aware of new activities, services, support and resources in their local areas.

Section 4 – Part A: Community Navigation (for older people and people with complex issues / frailty)

4.1. Putting the Service into Context

4.1.1. Kent is home to 1.52 million people, the most populated county in England.

4.1.2. Community navigation is seen to be a key strand in the strategy to reduce demand on health and social care resources, and as such the commissioned service will be available to all those aged over 55 years, regardless of whether or not they are receiving any services from Adult Social Care.

4.1.3. Based on recent population data, the number of older people (55+) in Kent who would be eligible for support from the Community Navigation service is as follows:

CCG	Total Population	Total Population Aged 55+	% of Population Aged 55+
Ashford	**127,250**	38,479	30.2%
C&C	**215,077**	68,319	31.8%
DGS	**258,962**	73,868	28.5%
SKC	**198,365**	75,499	38.1%
Swale	**108,131**	34,481	31.9%
Thanet	**142,587**	50,285	35.3%
West Kent	**478,966**	147,289	30.8%
Total for Kent	**1,529,338**	**488,220**	**31.9%**

(Kent Integrated Data Set April 2017)

4.1.4. Population data looking at the number of people in Kent who are aged 60+ and are affected by income deprivation has also been considered and a summary can be found in *clause 4.5.1.*

4.1.5. An overview of older people profiles can be found in *Appendix 5: Person Profiles.*

4.2. Scope of the Role

4.2.1. The role will focus on supporting older people (over 55 years).

People with complex issues / frailty (under 55 years) are also within scope of this contract, however, this will be by exception and will be at the discretion of the Provider(s) on a case by case basis, dependent on the level of demand and the capacity of the service.

Demand on the contract from those under the age of 55 will be monitored through KPIs during the lifetime of the contract (see *Schedule 14 – Contract Management*) and in line with *clause 4.5.3* the value of the contract (and therefore the number of Community Navigator posts that this funds) may be increased or decreased over time in relation to levels of demand and performance data submitted.

4.2.2. The service will extend beyond signposting by providing support to help people maintain and improve their wellbeing and develop resilience and confidence to help them live as independently as possible. This will include, but is not limited to:

4.2.2.1. Exploring and building social networks for the Person and developing a range of activities which may include Carer support, peer support, befriending, exercise, arts and heritage, creative activities, physical activities and cognitive stimulation opportunities, enabling people to pursue new and old interests and contacts as desired.

4.2.2.2. Supporting people to access their health and social care system (statutory and non-statutory) providing support as needed, working with health and social care teams and other local organisations, to ensure and referrals into the system are made appropriately.

4.2.2.3. Enabling people to identify services within the local community, and where appropriate, facilitate the purchasing of services, to meet their goals, and short and long term needs.

4.2.2.4. Providing initial practical assistance and advice to people, including: entitlements, accessing services and community activities, making referrals, and building confidence through activities such as accompanied visits, initial outings, and form filling.

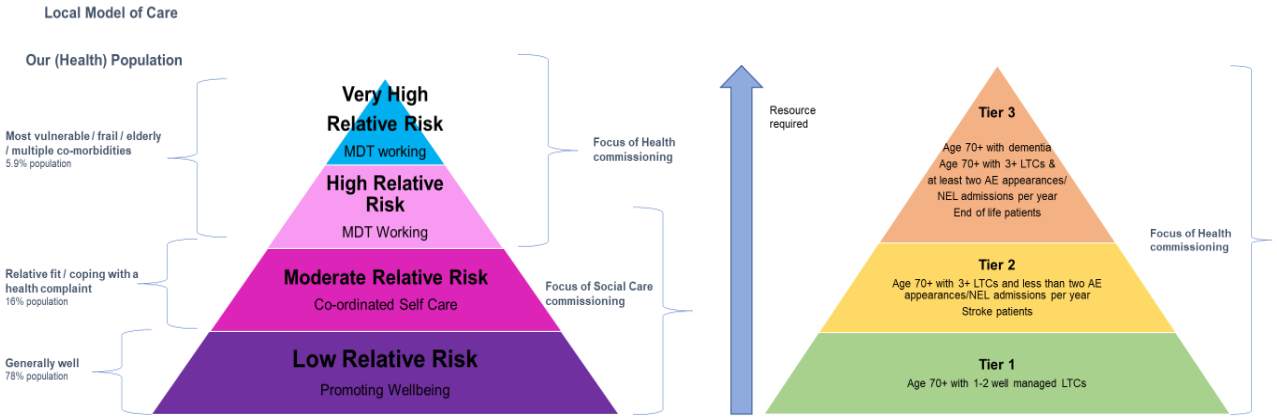
4.2.2.5. Assessing and identifying a Person's adaptation, equipment and assistive technology needs, and arrange for their supply as appropriate *(see clause 2.3).*

4.2.2.6. Making referrals/ provide information to people on local services and opportunities (signposting), and liaising with other specialised community services to ensure appropriate links are made.

4.2.3. The support detailed in *clause 4.2.2* will be available to all eligible Kent residents. This includes individuals receiving respite support, and those currently in short term beds, with the intention to return home. Community Navigators will be required to work with hospital care navigators (which are outside the scope of this contract in all areas except DGS and Swale CCGs), hospital discharge and rapid response teams to ensure the needs of all those requiring support are met.

4.2.4. Where health commission care navigation roles they primarily focus on supporting patients with higher levels of need and complexity, i.e. those that represent the largest resource requirement for health services (Tiers 2-3). Adult Social Care needs to take a broader preventative approach

which is instead focused on diverting people away from social care before their needs escalates to the point of requiring statutory services. The Community Navigators commissioned through this contract will therefore compliment, and work in conjunction with, the CCG commissioned navigation roles which focus on those people who are higher on a frailty index and/or have complex levels of need (with the exception of the DGS & Swale Lots (Lots 3 and 4) – *see Appendix 3,* and the South Kent Coast CCG area of East Kent (Lot 1) – *see Appendix 8*).



(Adapted from Cathy Bellman – Vanguard Model based on Carnell Farall figures)

4.2.5. Where a Community Navigator works alongside a care navigator commissioned by Health, the two will work together to identify which is best placed to support a Person who is considered to be particularly frail or vulnerable *(see clause 4.4).* These pathways will be determined during the mobilisation phase of the contract.

4.2.6. Community Navigators must have an awareness of the specialist services available in their area which support people with dementia, their Carers and their families, so that they can refer them on to services which are able to provide them with specialist information, advice and support to help them understand the condition and its impacts.

This will include raising awareness of, and recommending the use of, the *This is Me* tool when supporting anyone living with, or caring for someone who is living with, dementia.

https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me

4.2.7. Mechanisms used to identify the support people need and the appropriate response in each case will vary depending on the needs of the individual. A signposting only response for people with high level and complex needs may not be appropriate.

4.2.8. The role should not be 'case holding' and is therefore time limited (*see clause 6.5*), however, it is recognised that the support will often need to extend beyond simple signposting.

4.2.9. Vulnerable people are likely to need a greater level of support, particularly at the start of the intervention period. The aim being that the support delivered by the Community Navigator enables people to grow in confidence so that by the end of the intervention period they are able to independently engage in new activities or seek additional support from other agencies. Where appropriate this could include accompanying people on visits, to appointments, or when attending a group/service for the first time.

4.2.10. The Community Navigator will supply basic information on what benefits people may be eligible for and assist with completing initial forms where appropriate. Where more in-depth financial advice and support is required the Community Navigator may refer people on to other, more specialist, organisations as appropriate.

4.2.11. Any elements of *clause 4.2* that differ in any way in DGS and Swale CCG (Lots 3 and 4) are detailed in *Appendix 3.*

Any elements of *clause 4.2* that differ in any way in the South Kent Coast CCG area of East Kent (Lot 1) are detailed in *Appendix 8.*

4.3. Objectives of the Service

4.3.1. The Community Navigator will work with people to identify their needs (signposting or brokering support as appropriate) in order to deliver the following objectives, which support the Personal Outcomes identified in *clause 2.5*:

- People are empowered and supported to achieve their personal goals and address any immediate concerns.
- People are provided with appropriate up-to-date information, advice and guidance.
- People are engaged and supported to plan for the future, including ensuring any ongoing support required is in place.
- People's health, wellbeing and independence is improved, or maintained, as a result of the support received.

4.3.2. Additional objectives that apply when working in DGS and Swale CCG (Lots 3 and 4) are detailed in *Appendix 3.*

Additional objectives that apply when working in the South Kent Coast CCG area of East Kent (Lot 1) are detailed in *Appendix 8.*

4.3.3. The success of the service in meeting the above objectives will be assessed using the Personal Outcomes Recording Questionnaire (see *Appendix 7*). See *clause 6.5.5* for further information.

4.4. Complex Needs / Frailty

4.4.1. People under the age of 55 are eligible for support from Community Navigators if they have complex needs / frailty, however, this will be by exception and will be at the discretion of the Provider(s) on a case by case basis, dependent on the level of demand and the capacity of the service.

4.4.2. People with complex needs are considered to have a range of issues and a combination of layered needs e.g. mental health, communication, physical, sensory, behavioural, medical, cognitive and relationships.

4.4.3. Frailty is a condition of increased vulnerability to major changes in health as a result of seemingly small problems, such as an infection or new medication. It is most common in older age, affecting around 10% of people aged over 65, and develops because as we get older our bodies change and can lose their inbuilt reserves, for example we lose muscle strength. People with frailty are at increased risk of falls, disability, loneliness, hospitalisation and care home admission. These problems can reduce quality of life and are costly for the NHS and social care.

4.4.4. The following PRISMA7 questions should be used alongside the Clinical Frailty Scale to determine a Person's level of frailty. Where Community Navigators have access to the Electronic Frailty Index (eFI) in use in GP practices, this may also be used.

PRISMA7 Questions:

A score of three or more indicates frailty.

1. Are you more than 85 years?
2. Male?
3. In general do you have any health problems that require you to limit your activities?
4. Do you need someone to help you on a regular basis?
5. In general do you have any health problems that require you to stay at home?
6. In case of need can you count on someone close to you?
7. Do you regularly use a stick, walker or wheelchair to get about?

Clinical Frailty Scale:

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

4.5. Community Navigator Posts

4.5.1. Based on a ratio of 1 community navigator per 20,000 population (1:20,000) over 55 years, it is proposed that in order to meet the demand, the Community Navigator posts commissioned by KCC would be distributed across the county as shown in the following table:

CCG	Total Population	Population Aged 55+	% of Total Population Aged 55+	Population Aged 60+ Affected by Income Deprivation	% of Total Population Aged 60+ Affected by Income Deprivation	Number of Community Navigators Required
Ashford	**127,250**	38,479	30.2%	3,958	3.1%	2
Canterbury & Coastal	**215,077**	68,319	31.8%	7,550	3.5%	3
Dartford, Gravesham & Swanley	**258,962**	73,868	28.5%	7,304	2.8%	4
South Kent Coast	**198,365**	75,499	38.1%	9,279	4.7%	4
Swale	**108,131**	34,481	31.9%	4,294	4.0%	2
Thanet	**142,587**	50,285	35.3%	8,307	5.8%	3
West Kent	**478,966**	147,289	30.8%	12,179	2.5%	7
Total for Kent	**1,529,338**	**488,220**	**31.9%**	**52,871**	**3.5%**	**25**

(Source: Kent Integrated Data Set April 2017. Deprivation data taken from 2015 IMD)

4.5.2. Information regarding the CCG funding in place for additional Community Navigator posts in the DGS and Swale CCG areas can be found in *Appendix 3* of this Service Specification; and in the South Kent Coast CCG area of East Kent can be found in *Appendix 8.*

4.5.3. There is flexibility around the model for this contract. Whilst the number of Community Navigators specified above (and in *Appendix 3 and Appendix 8*) has been identified as the perceived requirement at the point of contract award, and it is recognised that Providers may have differing models of how best to maximise the available budget to best meet the needs of the population in the geographical Lot(s) being applied for. The value of the contract (and therefore the number of Community Navigator posts that this funds) may also be increased or decreased during the lifetime of the contract in relation to levels of demand and performance data submitted. See *Schedule 14 – Contract Management* for further information.

Section 5 – Part B: Community Navigation for Carers

5.1. Putting the Service into Context

5.1.1. A Carer is “somebody who provides support or who looks after a family member, partner or friend who needs help because of their age, physical or mental illness, or disability. This would not usually include someone paid or employed to carry out that role, or someone who is a volunteer” (Care Act, 2014).

5.1.2. A Carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support (Carers Trust).

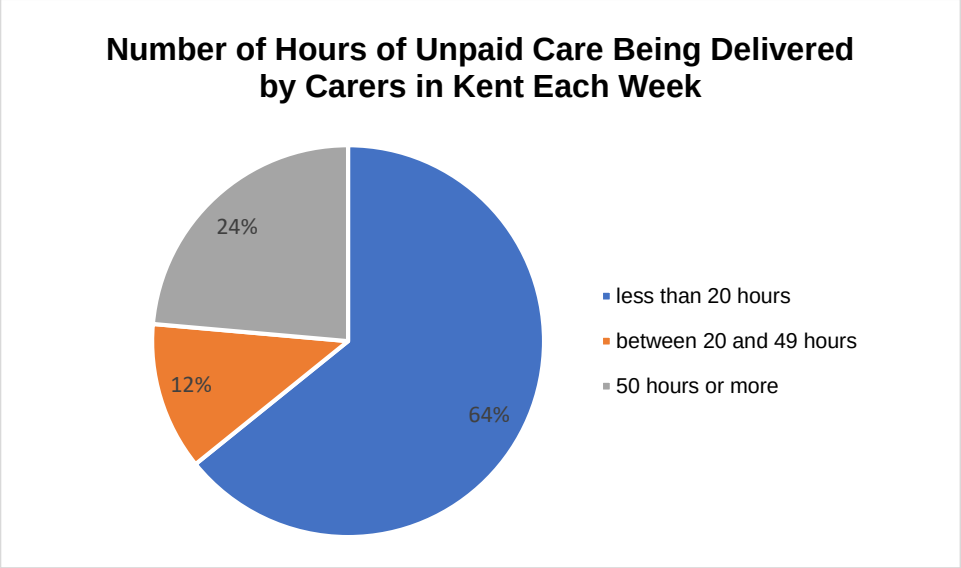
5.1.3. Carers often lead on arranging care provision for the Person they care for, which can include communicating with a range of departments and services. The challenges that Carers face include knowing which service or department to contact, which can be especially difficult when the Person they care for is transitioning through a change in service or they care for people with complex needs.

5.1.4. According to the 2011 Census, 151,777 people, or 10.4% of Kent’s total population, provided unpaid care. This proportion is higher than the regional average of 8.9% and the national average of 10.2%. Of the Kent local authority districts, Thanet has the highest proportion of unpaid Carers with 11.6% or 15,502 residents. Tunbridge Wells has the smallest proportion of unpaid Carers with 9.2% or 10,539 people.

5.1.5. Commissioners will seek to further review and address the differing spatial needs across Kent, and the Provider(s) **must** fully co-operate with any review and the re-focusing of resources in areas of greater need. This service **must** target activity to address any spatial inequalities that currently exist to ensure those in most need are supported.

5.1.6. The provision of unpaid care is a key indicator of care needs and has important implications for the planning and delivery of health and social care services. In Kent, the majority of unpaid Carers (64.2%) provide care for less than 20 hours a week. This proportion is lower than the regional average of 68.1% but slightly higher than the national average of 63.6%.

5.1.7. 23.6% of all unpaid Carers in Kent provide care for 50 or more hours a week. Those aged 50 to 64 provide the highest proportion of unpaid care for both men and women.



5.1.8. Additional intelligence about Carers in Kent includes:

- 9,197 or 6.1% of people who provide unpaid care report bad or very bad health.
- 96.0% of unpaid Carers are from the White ethnic group.
- 56.9% of unpaid Carers are economically active. This proportion is higher than the regional average of 40.8% and the national average of 42.1%.

(Figures from the Kent JSNA update 2013/14 http://www.kpho.org.uk/__data/assets/pdf_file/0016/45160/JSNA-Carers-2013-14.pdf)

5.1.9. An overview of Carer profiles can be found in *Appendix 5: Person Profiles.*

5.2 Prevention and Early Intervention

5.2.1. In accordance with the 'Five Year Forward View' and 'Care Act', this service **must** put an emphasis on prevention, aiming to intervene early to stop escalation of need, preventing crisis and avoiding unnecessary admission to hospital for those individuals and Carers most in need.

5.2.2. Poor and declining health, frailty and mobility have a huge impact on a Carer's life choices, which is acutely felt in those with the heaviest care burden. People will need to be able to participate whilst also feeling safe in the services offered through this specification.

5.2.3. The service **must** identify, review and evaluate Carer's needs and aspirations at the point of referral and throughout their journey with the service.

5.3. Prioritisation of Need

5.3.1. You must provide evidence of how the service will be triaged to prioritise support to those most in need. Where the cared for person is un-befriended the service will provide support for the shortest time possible to allow for transfer to a more appropriate preventative service.

5.3.2. The Carers Diagnostic has highlighted that some demographic groups have a better representation than others, with service provision and clientele being over represented in certain localities in Kent and under-represented in other localities.

5.3.3. KCC and CCG commissioners intend to work with the Provider(s) of this service to introduce both an eligibility (and potential exclusion) criteria to ensure those most in need are able to access this service when they need it.

5.3.4. The Eligibility and Exclusions criteria may include, but not be limited to, the following:

- size of the Burden of Care.
- complementary services Carer/Cared for already in receipt of.
- areas of Deprivation/Hard to Reach Groups.
- whether the Carer lives with the Cared for or not.

5.3.5. Providers will be expected to work with Commissioners to ensure parity of service and access to the service to those Carers most in need, in accordance with any developing eligibility (or exclusion) criteria and across all of Kent's localities and according to funding budgets available. This will be supported by the agreed performance management framework.

5.4. Scope of the Role

5.4.1. The role will focus on supporting Adult Carers as defined below:

The Care Act Section 10:

- *Subsection (3) states: "Carer" means an adult who provides or intends to provide care for another adult.*

- *Subsection (9) states: An adult is not to be regarded as a Carer if the adult provides or intends to provide care under or by virtue of a contract, or as voluntary work.*

"A Carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support" (Carers Trust).

5.4.2. An adult is considered to be someone aged 18 years and over, both with regards to the Carer and the cared for. With regard to the support available to Young Carers, they may be supported to transition over to this service for Adult Carers from the age of 16.

See *clause 5.5.11 - Outcome 9: Improved Support for Young Carers' Transition to Adulthood* for further information.

5.4.3. For the Adult Carer to be eligible for support, the cared for must be a Kent resident. For the purpose of this contract, Kent does not include Medway.

5.4.4. The service will be part of a suite of Carers' services which seek to reduce and prevent Carer breakdown, and will provide support to help Adult Carers maintain and improve their wellbeing, and develop resilience and confidence to help them, and those they care for, live as independently as possible. This will be achieved through the provision of Community Navigation for Carers, Carers Assessments and Support Services.

5.4.5. Many Adult Carers have little contact with services for Carers and are not receiving formal support in their caring role. Improvements in support for Carers will not only contribute to the health and well-being for those with caring responsibilities but will also help the health and social care economy rise to the challenges of our changing local population.

5.4.6. A range of responses may be necessary to support a Carer's physical and mental wellbeing in a flexible and person-centred way in order to promote better integration of health and social care support for the Carer and cared for. As such, the service must meet the needs of a wide range of Carers and acknowledge the differences in the needs of Carers of people with different conditions and issues.

5.4.7. This service is designed to support Adult Carers that meet the criteria contained in this Service Specification by providing appropriate targeted support and/or interventions to:

- access information, advice and guidance; and integrated, personalised services.
- have a life of their own, maintaining social contacts and personal relationships.
- optimise their physical and emotional wellbeing, enjoying separate social and community activities.
- participate in work, leisure activities or education.
- promote and support their financial wellbeing.
- provide support to maintain good health as appropriate.
- have a voice about services for their cared-for Person and for themselves.

5.4.8. Aspects of this service may be delivered to the cared for Person for the benefit of the Carer.

5.4.9. If the Carer needs "replacement care" then the Community Navigator shall send any assessment/review information gained to the cared for's case

manager or care coordinator. If there is no case manager or care coordinator then, with the client's permission, a referral to ARMS (Area Referral Management Service) or services addressing mental health needs shall be made.

5.4.10. Some aspects of this service (Respite provision and Hospital Discharge Service) may only be provided following agreement of both the 'cared for' and the Carer.

5.4.11. Where the cared for person is assessed to lack capacity for this specific decision, then the service should not be provided where they actively object to it or persistently refuse it; if this is in relation to a crisis this must occur as soon as possible to ensure that the service is in the 'best interests' of the cared for person and a further review undertaken to ensure that any ongoing service continues to be in the best interests of the cared for. In these circumstances the Provider will need to evidence that they have signposted / referred to other organisations and groups in the community to meet that Adult Carer's needs, as highlighted in the partnership section of this specification.

5.4.12. National data indicates that the presence of a Carer can greatly reduce admissions to hospital and long term residential or nursing care. Having access to information and support (including regular planned short breaks and access to breaks in a crisis) enables Carers to continue in their caring role, reducing the likelihood of Carer breakdown, whilst also providing them with the opportunity to enjoy a life of their own.

5.4.13. It is important that Carers receive support that is appropriate to their needs and relevant to their caring role, i.e. caring for an individual with a disability, or specific health related condition (including dementia see *clause 5.4.14*). The Provider(s) must therefore ensure that there are defined Carers Support resources with specialist knowledge and/or experience, within the overall service. This may be sub-contracted, by agreement with the Council and/or the CCGs as appropriate, to ensure that these services are provided appropriately.

5.4.14. Community Navigators for Carers must have an awareness of the specialist services available in their area which support people with dementia, their Carers and their families, so that they can refer them on to services which are able to provide them with specialist information, advice and support to help them understand the condition and its impacts for both Carer and cared for.

This will include raising awareness of, and recommending the use of, the *This is Me* tool when supporting anyone living with, or caring for someone who is living with, dementia.

https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me

5.4.15. The Community Navigator will supply basic information on what benefits the Carer, and cared for, may be eligible for and may refer people on to other, more specialist, organisations as appropriate.

5.5. Objectives of the Service

5.5.1. The service will be underpinned by the philosophies of personalisation, flexibility, choice and control. Support should be tailored to meet the Carers and individual's needs, enabling the Carers most in need of this service to maintain a balance between their caring responsibilities and a life outside of caring, whilst enabling the person they support to be a full and equal citizen.

5.5.2. The Community Navigator will work with the Adult Carer to identify their needs (signposting or brokering support as appropriate) in order to deliver the following 11 outcomes and related activities, which support the Carer Specific Personal Outcomes identified in *clause 2.7*:

1. Carers are proactively sought and identified
2. Carers are provided with appropriate up-to-date information, advice and guidance.
3. Carers receive Carers Assessments
4. Carers receive Personal Budgets, which can be met via a one-off payment or a direct payment
5. Carers are engaged and supported to plan for the future
6. Carers feel empowered
7. Carers wellbeing is improved through the provision of emotional support
8. Increased engagement with other sectors
9. Improved support for Young Carers' transition to adulthood
10. Increased knowledge, skills and behaviours for Carers and professionals through training and development opportunities
11. Carers Receive Health Prescribed support when appropriate GP Rapid access and Hospital Discharge Services

Each of these outcomes are described in more detail below, including any specific eligibility criteria, referral routes and locations of activity which may apply:

5.5.3 **Outcome 1: Carers are Proactively Sought and Identified**

Providers will be expected to actively seek and identify Carers, with a special regard given to identifying those:

- new to a caring role at an early stage.
- who have been undertaking a caring role over a period of time and are unknown to statutory services.

The Provider(s) will:

- develop an in-depth understanding of their local Carers population.
- make particular efforts to identify Carers from seldom heard groups, in line with demographic data/expectations, developing the service to respond to their specific needs.
- promote their services to and actively engage with male Carers to help improve service uptake by this group in line with demographic data/expectations developing the service to respond to their specific needs.
- identify Carers at the early stages of caring to enable them to access services that support them to maintain their caring role and prevent crisis situations.
- ensure the service is well marketed including a wide range of marketing materials, media and attendance at health promotion / other public events in local communities.
- encourage all Carers to self-identify and register with their GP as a Carer with a particular focus on Carers experiencing high levels of anxiety and/or depression, including male Carers.
- work towards providing an equitable service across Kent by targeting Carers who have been identified in the Carers Joint Needs Assessment and Carers Strategy review as requiring additional support e.g. younger Carers who are in part-time or full-time employment, Carers living in rural locations, Carers living in more deprived locations where there is greater prevalence of health inequalities, older Carers with higher burdens of care, Carers experiencing high levels of anxiety or depression.
- share information and work in close partnership with the Live Well Kent services to ensure appropriate and/or specialist support can be made available for Carers experiencing high levels of anxiety/depression, or caring for people with common mental illnesses.
- share information and work in close partnership with the Advocacy services to support Carers to have a voice, specifically in reference to those caring for people with common mental illnesses.
- share information and work in close partnership with a range of Providers including those commissioned to provide short term breaks in the home and Providers commissioned to provide Young Carers services.

5.5.4 **Outcome 2: Carers are Provided with Appropriate Up-To-Date Information and Advice in Accordance with Care Act Requirements**

Providers will be expected to provide Adult Carers with appropriate up to date information, advice and signposting in a timely way, in order that they are supported in their caring role.

The Provider(s) will:

- provide Carers with the information they need, in ways that meet their needs and preferences, using a variety of appropriate methods and accessible formats.
- work with Commissioners to ensure that Carers receive timely and accurate information, advice and access to support services.
- work with other Providers and partners to offer and provide coordinated information and advice services which have demonstrable benefits for Carers. This should be developed on a County level, but recognise local needs.
- support Carers to navigate social care systems and access community resources in the right way at the right time.
- develop information and advice in response to local needs which may evolve/change over time.
- record any gaps/unmet need regarding information and advice activity to help inform future commissioning.
- undertake training and keep abreast of innovative solutions in relation to both assistive and communicative technologies to enable them to advise Carers.
- support individuals to understand their housing options and plan for the future.
- support Carers to understand their options, role and responsibilities with regard to the management of third party direct payments on behalf of a service user who lacks capacity.

5.5.5 **Outcome 3: Carers Receive Carers Assessments**

Providers will undertake Carers' Assessments, for those Carers who appear to have a need for support. See *clause 5.5* for additional information.

The Provider(s) will:

- on acceptance of a referral, make an initial contact within 5 working days.
- undertake proportionate, holistic Carers Assessments (including where appropriate self-assessments), working with the Person and any specialist professionals, as necessary, in order to identify levels of need and the outcomes required.
- where a Carer agrees, complete a full Carers Assessment, using the formal Carers Assessment documentation and ensuring identification of the Carer's need(s).
- document the reasons why a Carer has chosen not to have a formal Carers Assessment.
- following a Carers Assessment, work with the Carer to develop their own support plan to meet their assessed needs.
- conduct annual reviews of Carers needs in line with the KCC Policy "Promoting Independence through review" - section B1 - Subsection 1.1 states:
  A light touch review ***should take place within 8 weeks*** *of the commencement of any new service and after sign off of the Plan and*

Personal Budget and a formal review yearly thereafter (or more frequently as required).

- *(the Provider will build on a Carers confidence and resilience, being careful not to create ongoing dependency)*
- input completed Carers Assessments and Reviews into the nominated computer system, within 5 days of conducting the assessment/review.
- identify exceptional circumstances that may lead to a Personal Budget being offered to a Carer in their own right. Where the person with care needs has refused care offered (these cases must be referred back to the appropriate team, within KCC in relation to the cared for individual).
- work with the appropriate KCC teams to facilitate the setting up of Direct Payments/Kent Cards, including collation of information, completion of paperwork and utilisation of the appropriate KCC system, processes and procedures.
- refer to appropriate Short Breaks Services, where a Carer has been assessed as needing a break (this must follow a Carers Assessment and be in accordance with any eligibility/exclusion criteria).
- will document the date of referral to the appropriate Short Breaks Services and the expected outcome for the Carer.

5.5.6 Outcome 4: Carers Receive Personal Budgets, Which Can Be Met Via a One-Off Payment or a Direct Payment

Kent County Council are in a period of transformation and therefore reserve the right to alter the budgetary figures and pathways for authorisation stated below.

The Provider will be expected to approve and administer the Carers Personal budget which can be met by One Off Payments. The Provider can offer a Personal Budget of up to £250 (level to be confirmed) for support to Carers (not replacement care).

The Provider(s) will:

- ensure that Carers, where eligible, are supported to plan how they will best use a Carers One Off Payment to meet their unmet eligible needs and identified outcomes.
- manage the budget specified for the locality and sum of money per Carers personal budget; approving, administering and making payments to Carers in line with any agreed Carers personal budget eligibility criteria.
- ensure that the Carers personal budget will not exceed a maximum value of £250, with up to £150 being authorised by the assessor and between £150 and £250 needing to be authorised by a senior worker within the Provider organisation.
- if the needs of the Carers can only be met by a budget of over £250 the commissioned Carers organisation will email the locality / service manager for approval using the funding request form. The locality service manager / locality team manager must forward the request onto

an Assistant Director if the budget asked for is above £500 for OPPD / mental health services and £400 for Learning Disability services.

- ensure that the Carers personal budget process is administered equitably and meets the unmet eligible needs of Carers in a fair and transparent way, managing expectations and avoiding the creation of any dependency i.e. Carers returning year on year, or multiple Carers of the same 'cared for' person.
- work with KCC to develop and agree further eligibility criteria to ensure the available Carers personal budgets budget is meeting the unmet eligible needs of as many different Carers as possible, including further development of recording mechanisms.
- ensure that payments are fully accounted for in line with KCC approved financial procedures and appropriate receipts and full records retained for inspection.
- return any unspent 'Carers personal budgets' funding to KCC at the end of each financial year; this should include accurate forecasting of spend on a monthly basis and quarterly reporting of actuals and predicted spend to Commissioners.
- enter the payments made to Carers on the nominated KCC system within 5 days of making the payment, following KCC's procedures, guidance and agreed business processes; report any issues/problems with KCC's procedures, guidance and agreed business processes to help inform future commissioning.
- ensure the allocation of Carers personal budgets represents best value so that the unmet eligible needs of all Carers are met appropriately and in the most cost-effective way.

5.5.6.1 **Eligibility (Outcome 4)**

Carer must have had a Carers assessment and have eligible needs.

5.5.6.2 **Referral Route (Outcome 4)**

- Self
- KCC social care teams including the mental health teams KMPT/Community Mental Health Teams
- All Health Professionals and MDTs
- The Voluntary and Community Sector, for example Age UK, Carers Assessment and Support Providers, Adult Carers Short Break and Crisis Response Providers and other relevant organisations.
- Private Organisations, for example but not limited to Home Care Providers

5.5.7 Outcome 5: Carers Are Engaged and Supported to Plan for the Future

Providers will be expected to engage with Carers to plan for the future to enable them to live the life they want, maintain their caring role and be prepared for possible emergency or crisis situations.

The Provider(s) will:

- support Carers to achieve their outcomes; enabling Carers to access a range of information which presents them with options that support them to make an informed choice about how they would like to be supported.
- support Carers to plan how they'd like to live their life and where applicable meet their unmet eligible needs / outcomes by utilising proportionate support planning tools.
- support Carers to plan for emergencies, using various tools, including promoting the Kent Carers Emergency Card and developing their resilience through the development of caring strategies, coping mechanisms and problem-solving skills.
- ensure Carers are able to access Carer Health and Wellbeing Checks to support in identifying various health issues, advising Carers on lifestyle issues and preventing risk of injury within their caring role.
- deliver Carers Health and Wellbeing Checks in partnership with their GP and other Health practitioners, the check should provide time for a Carer to consider, with a support worker, various aspects of health and wellbeing including:
    - Safety and warmth at home
    - Living and caring safely at home
    - Their own health and health care needs
    - Check-ups, vaccinations and screening
    - Work, education and leisure
    - Caring roles and tasks
- support Carers to plan for end of life and any other life transition in order to achieve the best outcomes for them and their cared for Person.

5.5.8 Outcome 6: Carers Feel Empowered

Providers will ensure that Carers feel empowered by having their views and feelings taken into account by others in relation to their care, support and treatment or that of the person they are caring for.

The Provider(s) will:

- support people to develop confidence and skills to enable them to be resilient and empowered to self-advocate.
- ensure where Carers require advocacy they are referred to Kent County Council's Advocacy contract.

- ensure that Carers are treated as 'Expert Partners in Care'.
- utilise support groups to reinforce key messages around Carers' rights and look to manage this in partnership with other organisations wherever possible, to create joined up, seamless provision for the Carer.
- ensure that local 'specific conditions' groups have access to Carers organisations and that the Provider remains an active member of these groups.
- support Carers to access appropriate employment support in order to maintain or enter paid employment linking with Live Well Kent Providers and the services they offer wherever appropriate and with a particular focus on male Carers and common mental illness.

5.5.9 **Outcome 7: Carers' Wellbeing is Improved Through the Provision of Emotional Support**

Providers will deliver emotional support on a one to one and/or a group basis as appropriate.

The Provider(s) will:

- work with KCC and other agencies to ensure that Carers receive timely emotional support which is appropriate and responsive to their emotional needs.
- provide Carers with the emotional support they need in ways that meet their needs and preferences, using a variety of appropriate approaches and methods. This should include telephone support, face to face, home visits, and support/activity groups.
- explore and utilise technology to enable Carers to socially connect with individuals in a similar caring role e.g. Carers interactive forums, online chat groups, Carers UK's online forum https://www.Carersuk.org/forum or the development of a local 'Carers Net' approach developed with and for Carers.
- lead the facilitation of local Carers peer support groups, enabling Carers to meet up on a regular basis across the Provider's area; linking individual Carers with each other to provide support and mentoring for others and build their own resilience; co-developed with the Adult Carers Short Breaks and Crisis Response Providers.
- ensure that groups are accessible to Carers who are working either in full or part-time paid employment. This may require arrangements to ensure that Carers can access short break support to attend groups.
- work in partnership with other relevant KCC and Health commissioned services e.g. Live Well Kent, Advocacy, HealthWatch Kent etc.

5.5.10 **Outcome 8: Increased Engagement with Other Sectors**

Providers will be expected to actively engage with GP surgeries, acute trusts, health and social care teams, private and voluntary sector

Providers, other businesses and employers and the local community to raise awareness of Carers and Carers issues and will use information shared to drive forward strategic thinking, inform future commissioning and enable continuous improvement.

The Provider(s) will:

- raise awareness about the role of Carers and support available to them so professionals can signpost appropriately.
- have a physical or virtual presence at key access points e.g. GPs, acute hospitals and Gateways.
- encourage GPs and other health professionals to identify Carers and encourage them to register as a Carer.
- support Carers to attend and contribute to local decision-making meetings about services, for example the mental health joint commissioning boards where there are reserved places for Carers acting as representatives; Sustainability and Transformation Partnership meetings and other area planning/monitoring groups.
- work collaboratively with Providers who have been commissioned to deliver Adult Carer Short Break and Crisis Response services to ensure the Carer sees a seamless service and effective signposting.
- regularly attend strategic Health and Social Care forums and Provider Forums to raise awareness of the role and needs of Carers.
- actively work with other Providers and partners (including Commissioners) to inform the development & implementation of strategic direction, policy and commissioning decisions.
- proactively work with corporate/private organisations to increase awareness of Carers, the challenges they face and opportunities to better meet their needs, as well as ensuring Carers are supported in employment.
- promote ‘Carers needs’ with local businesses, organisations and retail as above.
- learn from best practice locally, nationally and internationally, using lessons learned and related information to improve the services they deliver.

5.5.11 **Outcome 9: Improved Support for Young Carers’ Transition to Adulthood**

Providers will ensure that Young Carers have a smooth ‘Transitions Pathway’ to support them moving into Adulthood, and that this pathway is periodically reviewed and refined with Young Carers service Providers and other professionals.

Changes in life/home circumstances will trigger the need for specific support and advice e.g. when a young Carer moves from school to further/higher education, to employment or training, or leaves home. Young Carers and their families may need help to plan and access

appropriate financial support, social care, employment and/or education services.

The Transitions Pathway should set a clear process to ensure Young Carers and their families are supported effectively from the age of sixteen years to manage the changes to their caring role when they reach the age of eighteen years (25 years for those with SEND).

The Provider(s) will:

- work in partnership with commissioners, education Providers, Young Carers Providers, other Providers, the Local Children's Partnership Groups, 0-25 Health and Wellbeing board, other appropriate partners and Young Carers to develop a functional Transitions Pathway, policy and procedure for Young Carers.
- work in partnership to enable Young Carers to experience a smooth transfer between Children's and Adult Services.
- support Young Carers to maintain existing support networks and develop new support networks where the need has been identified.
- support Young Carers to plan how they would like to live their life and where applicable meet their assessed needs and outcomes.
- report any issues/gaps identified in the Transitions Pathway to help inform future commissioning.

Where appropriate, and on a case-by-case basis, Providers should consider referring or subcontracting to Providers commissioned specifically to support Young Carers' (aged 16-24) – particularly to ensure continuity of care where support has been provided by the Young Carers' Providers in the past.

5.5.12 Outcome 10: Increased Knowledge, Skills and Behaviours for Carers and Professionals Through Training and Development Opportunities

Providers will be expected to develop and deliver a range of training and development opportunities in partnership with other organisations, targeted at Carers and professionals with the aim of raising awareness and understanding and to enable Carers to maintain their caring role.

The Provider(s) will:

- make arrangements with other Providers and partners to offer and supply Caring with Confidence training, utilising resources available on websites such as http://www.nhs.uk/Carersdirect/Pages/CarersDirectHome.aspx which are shown to have demonstrable benefits for Carers.
- co-ordinate the delivery of specialised and one to one training in response to local needs.

- promote the sharing of Carers' skills and knowledge through Carers peer support groups and develop mutual support networks.
- provide training for health and social care professionals to raise awareness of Carers and their needs.
- signpost, support Carers to access other relevant training e.g. Manual Handling, Lasting Power of Attorney (LPA) training etc.

5.5.13 **Outcome 11: Carers Receive Health Prescribed Support When Appropriate**

Providers will be expected to manage 'Health prescribed support' which aims to build capacity to improve the support available to Carers when their health may be at risk from their caring role. It allows health professionals to refer Carers directly for help and support to enable Carers to stay healthy, both physically and mentally. It will also provide a safety net for those Carers who have not been identified previously.

The Health prescribed support will consist of the following two elements:

5.5.13.1 **Hospital Discharge Service**

Use the ring-fenced funding to develop timely hospital discharge support services delivered to the cared for person where a Carer will have difficulty in coping.

5.5.13.2 **Health prescribed Support**

Use the ring-fenced funding to manage One Off Payments when it is felt the Carers health is at risk.

The Provider(s) will:

- work in partnership with KCC and CCG Commissioners/Stakeholders and other Providers to develop and embed a Carers Health Prescribed support service.
- in line with the agreed eligibility criteria manage the sum of money specified by the CCGs and to administer and make payments for Carers who are considered eligible for a one-off payment usually up to a maximum value as indicated by the relevant CCG (tabled below).
- ensure hospital discharge service works in an integrated way, including with primary care teams as appropriate to the CCG.
- continue to work with CCG Commissioners to refine referral pathways to support hospital discharge services for Carers.
- ensure the hospital discharge support enables effective and timely discharge, which supports the Carer in their caring role:
  - the service is to deliver tasks the Carer would normally perform for the person they care for, this could include personal care and support with daily living, specialist tasks and support with medication.

- the service will support the person post discharge for up to 7 days where the no of support hours required will vary based on needs. 24/7 packages should not be provided on a routine basis.
- the referrals for hospital discharge should normally occur between 8am-8pm 7 days per week.

The Provider will be expected to ensure that Providers they broker support from comply with any regulatory requirements i.e. the Care Quality Commission (CQC) regulations and regulatory activity, if they are being commissioned/brokered to deliver personal care to the cared for.

When the Provider brokers services to be delivered within the Carer's home, Commissioners reserve the right to request that the Provider makes use of the KCC Care and Support in the Home Provider framework.

The service shall be provided free of charge to the Carer and the cared for person and may continue up to a maximum two weeks in duration, during this time appropriate referrals must be made, where necessary and applicable, to enable other support options to be considered.

5.5.13.3 **Eligibility**

Eligibility for health prescribed support

Provide additional support for those Carers whose health and wellbeing is being affected negatively by their caring role and to prevent the development of a crisis situation.

Hospital Discharge service

Support can be provided to Carers for up to (the time period described in the specification) to help them develop confidence to take on or resume their caring role.

The support will be provided by a brokered care package on discharge or no later than 72 hours after discharge and will be part of a wider care package and should not routinely be provided for 24/7 support. It should not be used to replace other services or support, which the cared for has been assessed as requiring.

5.5.13.4 **Service Parameters**

- Discharge is to take place within 1 working day of receipt of the referral where appropriate coordination has taken place.

- Care packages will not be provided for 24/7, except in exceptional circumstances where this should be authorised by a senior manager from Carers Assessment and Support services. An exception report must be submitted and available for review at Contract Management Meetings.

- Night sits will be provided for a maximum of 10 hours per night.

- The hours provided will be measured, this and the cost of care packages should be monitored by the Provider and kept as low as possible.

- Carers support discharge packages should not be routinely used to support end of life situations, particularly to provide night sitting or as part of a continuing health care package.

- Care packages will be provided on discharge or up to 72 hours after discharge.

- When the Provider brokers services to be delivered within the Carer's home, commissioners reserve the right to request that the Provider makes use of the KCC Homecare Provider framework.

- The service should not routinely be used to support planned admissions and, where it is, this should be agreed by a senior manager from the Provider organization.

5.5.13.5 **Referral Route (Outcome 11)**

- All Health Professionals

5.5.13.6 **Recording**

When a referral is accepted the Provider must collect and log the type of intervention delivered to the cared for:

- a sitting service
- a befriending service
- a personal care service (Home Care)
- medical based support
- other – with stated reason

If a referral is refused the Provider must collect and log reasons and outcome, i.e. reason for refusal:

- declined by family and/or the cared for
- any Short Breaks Providers rejection due to insufficient workforce capacity
- inappropriate referrals

- not meeting the eligibility criteria
- Carer signposted to another organisation / group who are better placed to meet needs

The Provider will note overleaf the area/locality variations currently in place in relation to funding and payment limitations. The Provider will work with CCG and KCC Commissioners to review and revise this to deliver greater parity as changes to the local Health and Social Care Economy arise in relation to the Sustainability and Transformation Partnership.

The Provider will monitor actuals monthly and flag any unexpected trends with the CCG and KCC commissioners, the Provider will report actuals to Commissioners on a quarterly basis, as well as forecasting the quarter ahead. Reconciliations will occur at Quarter 3 and forecasting of outturn reported to both CCG and KCC commissioners.

5.5.13.7 **Outcome 11 – Area / Locality Variations**

Health Monies	Health Prescribed Support	Budget (£)	Payment Limitations (£)	Hospital Discharge Service	Budget (£)	Payment Limitations
Ashford	Yes	29,990	800	Yes	69,977	Minimum 85% to cost less than £1000 Maximum 12% to cost between £1000 and £1500 Maximum 3% to cost up to £2000 – Exception report needed.
Canterbury & Coastal	Yes	54,028	800	Yes	126,067	
South Kent Coast	Yes	76,816	800	Yes	115,225	
Thanet	Yes	57,563	400	Yes	86,344	
Swale	No	0	n/a	No	0	
West Kent	Yes	177,171	800	Yes	180,029	
Dartford Gravesham & Swanley	No	0	n/a	No	0	

4.4.14. The success of the service in meeting the above objectives will be assessed using the Personal Outcomes Recording Questionnaire *(see Appendix 7).* See *clause 6.5.5* for further information.

5.6. Carers Assessments

This clause should be read in conjunction with *clause 5.5.5*

5.6.1. Carers Assessments should only be completed when the Community Navigator has already worked with the Adult Carer (signposting or

brokering support as appropriate) and identified that statutory support may be required.

5.6.2. Where Community Navigators identity that statutory support may be needed, Adult Carers are entitled to an assessment regardless of the amount or type of care that they provide, their financial means and/or their own level of support needs. Adult Carers are also entitled to an assessment, regardless of whether or not the adult that they care for has had a community care assessment/needs assessment or if KCC have determined that they are not eligible for support.

5.6.3. In order to ensure continuity of care, where required the same Community Navigator for Carers that has already been working with the Adult Carer will complete the statutory Carers Assessment (rather than handing over to another Community Navigator in the organisation).

This role will not be referred on to another organisation.

5.6.4. Bringing Carers Assessments into scope of the service specified streamlines the support available, meaning the same point of contact (the same Community Navigator for Carers) can be used to develop an Action Plan and identify support mechanisms for Carers once they have completed the assessment.

5.6.5. With a holistic approach being taken under both Part A and Part B, the inclusion of Carers Assessment in the contract enables Carers requiring an assessment to be supported within their family unit (where applicable) without having different professionals support both the Person with care needs and the Adult Carer.

Further information can be found in *clauses 3.1.2 and 3.1.3*.

5.6.6. Whilst the contract is designed to facilitate continuity of support for the Carer by allowing them to be supported by the same Community Navigator throughout the intervention period, the Carer is entitled to request a change in the Community Navigator supporting them at any stage. Such a request should be treated as a complaint *(see clause 6.8)* and documented accordingly.

Where a change of Community Navigator can be facilitated, the Provider must support the Carer in this regard.

5.6.7. Training on the completion of statutory Carers Assessments will be delivered by the Provider to all those carrying out the Community Navigation for Carers role.

5.7. Community Navigator Posts for Carers

5.7.1. No guidance is given around the number of Community Navigator for Carer posts that are required in each CCG area of the county. During the tender process Providers will be asked to detail how they will use the available budget to both deliver against the requirements of this Service

Specification and meet the needs of Carers in the geographic Lot they are applying for. Successful Providers will then work with Commissioners to refine the model during the mobilisation phase.

5.7.2. There is flexibility around the model for this contract and the value of the contract (and therefore the number of Community Navigator for Carers posts that this funds) may be increased or decreased during the lifetime of the contract in relation to levels of demand and performance data submitted. See *Schedule 14 – Contract Management* for further information.

Section 6 – Processes and Pathways

(unless specified otherwise, all processes and pathways apply to both Part A and Part B)

6.1. Service Availability

6.1.1. The service may be offered at flexible times which could take place on evenings and weekends. No additional/enhanced payments will be paid for any part of this contract.

6.1.2. As a minimum it is expected the service will operate broadly from Monday to Friday, flexible within the operating hours of 0800 hours and 1700 hours.

6.1.3. The service is expected to operate for a minimum of 48 weeks per year.

6.1.4. The Provider may close the service during the eight UK recognised annual Bank Holidays and any additional State Bank Holidays which may be announced during the period of the contract (these may not be established or announced at the prior to the commencement of the contract). No additional/enhanced payment will be paid where a Provider choses to operate the service on a Bank Holiday.

6.1.5. Where inclement weather means it is not possible to carry out meetings in person, or visit people in their own homes, the Provider will utilise other means (e.g. telephone) to keep in touch with those accessing the service to ensure that, where possible, each Person continues to benefit from the identified support in the agreed timeframe.

6.2. Referral Pathway

6.2.1. The service will be available to all Kent residents who meet the eligibility criteria detailed in this specification, regardless of whether or not they are receiving any other services from Adult Social Care or Health. This means that referrals for the service can come through a range of routes (including self-referral) and are not limited to referrals from health and social care professionals.

6.2.2. Providers will play an important role in encouraging referrals and ensuring that they are appropriate.

6.2.3. Repeat referrals for a Person (for the same or different support needs) are possible but consideration of the creation of dependency on the Community Navigation service must be assessed by the Provider/Team Leader, as appropriate. Where repeat referrals are identified, the Community Navigator should look to arrange an onwards referral for an

MDT discussion which could avoid premature admission to residential care or inappropriate hospital admission.

6.2.4. All referrals (including self-referrals) will need to be logged as part of the service offer *(see clause 6.3),* with the Provider being responsible for collating all referral information and data from each Community Navigator that they employ. Template forms detailing the information the Provider is required to collate and share with Commissioners as part of the contract management arrangements in place can be found in *Appendix 6* of this specification.

6.2.5. The data collected must be stored and shared safely, and policies and procedures must comply with Data Protection Act 2018 legislation *(see Section 6)* and Information Governance and confidentially requirements as set out in the terms and conditions of the contract.

6.2.6. Unless otherwise stated in *clause 5.4*, the Provider(s) delivering a service to Adult Carers under Part B must formally notify the referrer of the outcome of the referral within 48 hours, whether the service is accepted or refused. If a referral is refused the Provider must collect and log reasons and the outcome, i.e. reason for refusal:

- Declined by family and/or the cared for
- Any Short Breaks Providers rejection due to insufficient workforce capacity
- Inappropriate referrals
- Carer signposted to another organisation / group who are better placed to meet needs
- Other – must be stated

This does not apply to Part A.

6.3. The First Point of Contact

6.3.1. The process for obtaining information about the Person needing support will need to be proportionate to the level of information and support required. For those people who simply require signposting / onward referral to a specific service, and where no further discussion is needed in order to identify how best they should be supported, the short version of the information collection form should be completed at the first point of contact *(see Information Collection Form A in Appendix 6, for where it is identified no further support is needed).*

6.3.2. Where the Community Navigator works with a Person to identify how best their needs can be supported the full information collection form *(see*

Information Collection Form B in Appendix 6, for where it is identified subsequent support is needed) should be completed during the initial contact to document what support and interventions are needed, and demonstrate that:

- appropriate information and advice has been provided to support the Person to make informed choices.
- the Person has been signposted to other services/organisations as appropriate.
- where appropriate, initial plans have been made regarding subsequent/more in depth support that the Community Navigator will provide in order for the Person to meet their desired outcomes (this may include confidence building, accompanied visits, completion of forms etc.)

6.3.3. The information collection forms are designed to make it as easy as possible for Community Navigators to collect the basic information that they need when first looking to support a Person. Having standard template forms ensures that the procedure is consistent across Kent. Additional information, where a Person requires more in depth support and interventions in order to meet their desired outcomes, would be gathered as part of the action planning process *(see clause 6.4).*

6.3.4. In line with NICE guidance, for people who have a diagnosis of dementia the initial assessment of the Person's needs, should be face to face if possible.

https://www.nice.org.uk/guidance/ng97/resources/dementia-assessment-management-and-support-for-people-living-with-dementia-and-their-carers-pdf-1837760199109

6.4. Action Plan

6.4.1. The Community Navigator will work with each Person they support to create an action plan which details the identified needs of the Person, how they are to be supported by the Community Navigator to address the identified needs/meet their identified goals, and in what timeframe this intervention is to be carried out.

6.4.2. The action plan will detail the resources/services/interventions that have been agreed with the Person as potential resolutions to their identified need(s).

6.4.3. A copy of the action plan will be given to the Person, which clearly sets out the information discussed – including the contact details of any

organisations that the Person has been signposted/referred to which offer relevant services and support.

6.4.4. Where appropriate, and with the Person's permission, the Community Navigator may want to share a copy of the action plan with the Person's GP or look to arrange an onwards referral for an MDT discussion (which could avoid premature admission to residential care or inappropriate hospital admission).

6.4.5. If it is identified that the Person needs social care support then the Community Navigator shall, with the Person's permission, either send a copy of the action plan to the Person's case manager or care coordinator; or if there is no case manager or care coordinator already in place then a referral to ARMS (Area Referral Management Service) or services addressing mental health needs shall be made.

6.5. Time Limited Service / Ending Support (Part A only)

6.5.1. *Clause 6.5* (in its entirety) does not relate to Part B of the contract.

6.5.2. Although the service will not be rigidly time limited, the Community Navigator role should not hold caseloads indefinitely and therefore a maximum 12-week intervention period is in place to encourage through put. This should be made clear to the Person needing support, from the first point of contact.

6.5.3. Management of caseload by the Community Navigators, and ensuring the intervention period for each Person is appropriate to the support required (whilst not exceeding 12 weeks), will be essential in meeting the demands on the service and ensuring the required outcomes of the contract are met.

6.5.4. During the intervention period, the Community Navigator will work with the Person to develop and agree a time limited personal action plan. This may involve liaising with relatives, Carers, support networks, health and social care teams, and other agencies as agreed with the Person, to enable them to achieve their goals, and ensure an integrated and personalised approach to care and support.

6.5.5. Whilst a 12-week limit is in place, in the majority of cases the expectation is that the identified objectives of the support will be achieved in a shorter timeframe. However, this specification recognises the importance of working at a person-centred level and delivering a flexible package of support, as there will be occasions where support is required over a longer period (e.g. when supporting a Person to maximise their benefits there is a standstill period in the support between the forms being submitted and a decision being made). In such cases, the total intervention period (excluding any standstill period) should not exceed 12 weeks.

6.5.6. At the end of the 12-week period (if not before), the Community Navigator will complete an exit interview with the Person being supported. At this point case closure will be achieved, either through mutual agreement that the issue has been resolved / outcomes achieved or the Person has been signposted / referred to alternative services.

6.5.7. A Personal Outcomes Recording Questionnaire *(see Appendix 7)* which measures the individual's perception of their own wellbeing must be completed at the start and end of the intervention period (where support entails more than a one off contact/signposting). The information gathered will be used by the Provider to both review the service being delivered and inform the KPI submissions required by KCC Commissioners as part of contract management *(see Schedule 14).*

6.5.8. In exceptional circumstances an extension of the 12-week intervention period can be authorised by the Provider, however, this should be discouraged so as not to create dependency between the Person being supported and the Community Navigator.

6.5.9. People who need ongoing support, having worked with a Community Navigator, should be referred to other services/organisations that are better placed to deliver this type of support. This includes cases where the Community Navigator has concerns regarding the Person's ability to continue working proactively towards resolution through self-management following the end of the intervention period.

6.6. Demand Management

6.6.1. In the majority of cases (excluding the completion of statutory Carers Assessments) signposting/referring to alternative, more specialist, services who may be better placed to support the Person with an identified need can ease the demand on the service.

Signposting = the provision of information on which the Person acts independently
Referring = where the Community Navigator makes contact on behalf of the Person

6.6.2. Excessive demands on the service (including the completion of statutory Carers Assessments) will be managed by:

- collating data to evidence the level of need of those being supported and reflect the capacity of the service in KPI submissions.
- reporting excessive demand to Commissioners, both in terms of the Community Navigation service and the organisations to which it signposts/refers (process to be agreed during the mobilisation phase).
- prioritisation of the referrals undertaken based on knowledge of the Person's vulnerability and the level of risk to the Person.

6.6.3. The Provider must be able to demonstrate to the Council's satisfaction how it manages any volume fluctuations in referrals. This should include the potential impact of both increases and reductions in work allocation, and actions to mitigate these risks.

This will be particularly important with regard to fluctuations in demand linked to winter pressures, as in line with *clauses 4.5.3 and 5.7.2* the value of the contract may be increased or decreased over time in relation to levels of demand on the service.

6.6.4. The Provider's ability to manage demand within the given timeframe is, in many cases, reliant on other services being in place that can support the people that they are looking to navigate through the health and social care systems and/or refer to community based services. The Provider will therefore notify the Commissioners of any gaps in service provision or community activity that may be identified when looking to signpost/refer people on to other organisations for support.

6.7. Communication

In order to ensure that each Person receives a quality service, where their needs are heard and understood, and information is shared, stored and actioned in appropriate ways, we require that:

6.7.1. When communicating with a Person with a disability, you are as inclusive as possible, using appropriate formats, and whenever necessary you make adjustments for the Person.

6.7.2. With all forms of communication, you use the following guidance https://www.gov.uk/government/publications/inclusive-communication/accessible-communication-formats

6.7.3. The Provider has a policy for effective communication between its own staff, volunteers, management committees, directors etc. as well as with other organisations, health and social care professionals, the people receiving a service, and their parents/Carers. This should reflect the organisation's Confidentiality Policy.

6.7.4. There are regular staff meetings with all staff and volunteer groups, where important information is shared, including key information regarding delivery, quality and performance, future developments and changes to the service. As a minimum these meetings should be held monthly. Written records must be maintained at these meetings.

6.7.5. Any concerns regarding the health and social care needs of any individual should be communicated to Kent County Council (email social.services@kent.gov.uk or call 03000 41 61 61).

Any concerns that a Person may be suffering abuse should be reported to Kent County Council's Safeguarding Team as a matter of urgency. http://www.kent.gov.uk/social-care-and-health/report-abuse

Records of correspondence regarding a concern raised (including telephone calls) should be kept on the Person's file, and a copy held centrally by the Provider.

6.7.6. Staff and volunteers are trained to communicate with all people who may access the service, and have a basic awareness of disabilities that may cause communication difficulties (e.g. autism, dementia, sensory impairments or physical disabilities).

6.8. Complaints and Compliments

6.8.1. Providers must ensure an easily understood, well-publicised and accessible *(see clause 5.7.2)* procedure is in place to enable an individual to make a complaint or compliment, and for complaints to be investigated.

6.8.2. The Provider's complaints and compliments policy should also refer to the Ombudsman and KCC's Customer Care department if the complaint requires an alternate signposting route.

6.8.3. All complaints whether they have been formally or informally resolved should be recorded. The record of the complaint / compliment must include:

- The date of the complaint / compliment
- Full details of the actual complaint / compliment
- The date the complaint / compliment was received (if different)
- The date when the complaint / compliment was responded to
- The outcome of the complaint

6.8.4. The Provider will be expected to investigate any complaints or quality issues that arise in a clear and concise way with all evidence clearly documented. Complaints and compliments must be welcomed as an opportunity to continuously improve and develop the service. The Provider must be able to evidence how they ensure learning from complaints improves the quality of the service provided, and how compliments are used to reinforce good practice.

6.8.5. All formal complaints and serous concerns should be provided to KCC within one working day of the complaint being raised with the Provider.

6.9. Invoicing

6.9.1. The value of the contract is as detailed in the Contract Particulars, unless varied during the lifetime of the contract. Any variations will be made in accordance with the Terms and Conditions of this contract and be documented in *Schedule 7 – Change Control* of this contract.

6.9.2. Funding for this block contracted service will be payable in 12 monthly instalments.

6.9.3. Invoices should be submitted quarterly in advance to KCC and/or the commissioning CCG.

6.9.4. Invoices must be submitted via email. Clarification as to which commissioning body the invoices should be sent to, and at which email address, will be given during the mobilisation phase of the contract.

6.9.5. The service shall be provided free of charge to the Person requiring support.

6.10. Exit Strategy

6.10.1. During the mobilisation phase, the Provider must work with KCC and CCG Commissioners in reviewing and adjusting the Protocol for Managing the Exit of a Care and Support in the Home Provider, to ensure its relevance in relation to Community Navigation and to establish the risks inherent in any sudden non-delivery of the service to support business continuity planning.

6.10.2. The Provider must work with KCC and CCG Commissioners to support their understanding of total costs, total overheads and exposure on any given exit strategy, in relation to TUPE and other such matters.

6.10.3. KCC and CCG Commissioners will seek to review this with successful Providers in the first three months of the contract and once agreed, this will form *Schedule 8* of the contract (Exit Arrangements).

6.10.4. In accordance with the break clause detailed in the terms and conditions for this contract, KCC shall have the right to terminate the Contract at any time by giving written notice (of not less than the period specified in the Contract Particulars) to the Provider.

As KCC and the CCGs continue to move towards integration and jointly commissioned services, the Council may look to terminate this contract should an opportunity arise to jointly commission the Community Navigation service at scale with CCGs across Kent.

Section 7 – Compliance and Governance

7.1. Contract Governance

7.1.1. This contract will be managed by KCC (see *Appendix 3* for information on any exceptions that may apply in DGS and Swale CCGs, and *Appendix 8* for information on any exceptions in the South Kent Coast CCG area of East Kent). Roles within KCC are outlined below:

7.1.2. **Strategic Commissioning** is responsible for the commissioning and procurement of this contract. This is the team that Providers should inform of any Regulatory Warning Notices or other actions required by this contract that relate to service delivery and service quality. Providers should email communitysupport@kent.gov.uk with this information. Providers will be informed should this email address change; the commissioner will use the generic email address that the Provider has given. The commissioning team also lead on contract management, arrangement of price uplifts, any contract variations, and the review of outcomes and key performance indicators although KCC reserve the right to utilise a 3rd party representative to manage this (wholly or in part) on our behalf.

7.1.3. **The Safeguarding Team** has the role of safeguarding vulnerable adults and statutory duties regarding adult protection. Providers are expected to work with the Safeguarding Adults Team to address any relevant issues.

7.1.4. **The Complaints Team** has the responsibility of co-ordinating activity and investigation to support complaint resolution.

7.1.5. Data Controller and Data Processor roles which comply fully with GDPR requirements are as detailed in *Schedule 20 Annex 1a/ 1b*.

7.2. Statutory Responsibilities

7.2.1. **The Care Act 2014**

7.2.1.1. The Care Act 2014 is the biggest reform in health and social care for 60 years; the act should make care and support more consistent across the country and puts the wellbeing of Persons at the heart of health and social care services.

7.2.1.2. Through the Care Act, KCC must promote wellbeing when carrying out any of their care and support functions, and must establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for Carers.

7.2.1.3. Under the Care Act 2014 the Council has several statutory duties which include the following:

- Promotion of individuals' wellbeing, which includes:
  - providing information and advice enabling people to make good decisions about their care and support.
  - promoting individuals' wellbeing by providing Services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.

- Duties relating to Carers include:
  - applying the wellbeing principle both to those with care needs and those that care for them
  - prevention – this includes the duty to provide preventative services which reduce Carers need for support
  - provision of assessments based on the appearance of need meaning that the only requirement for a Carers assessment is that the Carer may have need for support now or in the future

7.5.2. **The Equality Act 2010**

7.5.2.1. The Equality Act 2010 makes it unlawful to discriminate (directly or indirectly) against a Person on the basis of a protected characteristic or combination of protected characteristics. Under the Equality Act the public sector have certain duties called the Public Sector Equality Duty (PSED). Under the PSED (section 149) public authorities must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation.
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

7.5.2.2. The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics.
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

7.5.3. **The Mental Capacity Act 2005**

7.5.3.1. The Mental Capacity Act 2005 is the primary legislation for all adult

social care and the five statutory principles should be an integral part of all the work of care Providers.

7.5.4. **Additional legislation and regulations** are listed below however the list should not be regarded as complete or exhaustive but constitutes guidance for Providers. Providers must ensure they remain aware of and comply with all relevant and applicable legislation, this specification and UK law to include the following, as appropriate:

- Care Standards Act 2000;
- Care Act 2014;
- Control of Substances Hazardous to Health Regulations 1989;
- Data Protection Act 2018;
- Disclosure and Baring Service; Employment Rights Act 1996;
- Essential Standards of Quality and Safety March 2010;
- Equality Act 2010;
- Health and Safety at Work etc. Act 1974;
- Health and Social Care Act 2012;
- Health and Social Care Act 2008;
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010;
- Human Rights Act 1998;
- Lifting Operations and Lifting Equipment Regulations 1998;
- Management of Health and Safety at Work Regulations 1992;
- Management at Work Regulations 1992;
- Manual Handling Operations Regulations 1992;
- Mental Capacity Act 2005;
- National Association for the Care and Resettlement of Offenders (NACRO) leaflet;
- National Minimum Wage Act 1998 and Regulations 1999;
- Part V Police Act 1997;
- Personal Protective Equipment Regulations 1992;
- Provision and Use of Workplace Equipment Regulations 1999;
- Public Interest Disclosure Act 1998;
- Public Interest Disclosure Act 1998 (Whistle Blowing);
- Rehabilitation of Offenders Act 1974;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995;
- Working Time Regulations 1998 and 1999;
- Workplace (Health Safety and Welfare) Regulations 1992;

7.3. Reporting – Data Protection and GDPR

7.3.1. In addition to the elements within the wider terms and conditions, KCC and CCG Commissioners are keen to understand the demographics of the individuals receiving, being refused and not accessing the service. This will include identifying any issues or trends which may come to light in relation to particular health needs, geographical anomalies, deprivation and other factors. Providers must therefore report on the contract usage by recording Key Performance Information (KPI) at both a client and

service level. A copy of the KPIs can be found in *Schedule 14* of this contract.

7.3.2. Commissioners will provide the tools needed for reporting on the KPIs and will work with the Provider to refine the process during the first three months of the contract.

7.3.3. The Provider will comply fully with GDPR requirements set out in *Schedule 20 Annex 1a/ 1b.* Where appropriate, this will include working with Commissioners to conduct an initial Data Protection Impact Assessment (DPIA) for the contract, and providing assistance and any necessary information as required when the DPIA is reviewed during the lifetime of the contract.

7.3.4. Data exchange between Providers and Commissioners should involve the minimum necessary personally identifiable information. Where use of Personally identifiable information is considered to be essential each individual item of information should be justified with the aim of reducing identifiability.

7.3.5. Safe transfer of information is an integral part of this process and procedures will be put in place ready for the start of the contract to ensure compliance with best practice. (To be agreed during the mobilisation phase).

7.4. Safeguarding Standards

7.4.1. KCC is fully committed to maintaining safeguarding standards as set out in the Kent and Medway Safeguarding Children's Procedures (Revised April 2018) and the Kent & Medway Multi-agency Safeguarding Adults Policy, Protocols and Guidance (Revised September 2017).

7.4.2. Further information can be found at:

http://www.proceduresonline.com/kentandmedway/

http://www.kent.gov.uk/social-care-and-health/information-for-professionals/adult-protection/adult-protection-forms-and-policies/national-adult-protection-legislation

7.4.3. The Multi-agency Adult Protection Policy, Protocols and Guidance for Kent and Medway document states that 'It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity.'

7.4.4. Providers are required to have policies and procedures which reflect the Kent & Medway Multi-agency Safeguarding Adults Policy. KCC has adopted the principles of Making Safeguarding Personal (MSP). This is a

shift in culture and practice which enhances involvement, choice and control, as well as improving quality of life, wellbeing and safety for the Person being safeguarded.

7.4.5. Providers must maintain the relevant standards to assure safeguarding of vulnerable adults, including DBS checks as applicable for staff (and volunteers) in contact with, or accessing data about, vulnerable adults.

7.4.6. New guidance documents are published periodically, and the Provider shall be required to keep abreast of these and implement where necessary and/or appropriate.

7.5. Protection from Abuse

7.5.1. Abuse and neglect can take many forms and every case should always be considered on its own merit with due consideration given to individual circumstances.

7.5.2. In order to ensure that individuals are protected from abuse we require that all Provider staff, Management Committee members and volunteers are familiar with, and follow, the Kent and Medway Multi-agency Adult Protection Policy, Protocols and Guidance (revised September 2017), and your own policy and procedure on Adult Protection/Safeguarding.

7.5.3. Providers must have robust procedures in place for responding to suspicion or evidence of abuse or neglect to ensure the safety and protection of individuals who access the service. The procedures must reflect local multi-agency policies and procedures, including informing the Care Quality Commission and where appropriate involving the Police. This is in accordance with the Public Interest Disclosure Act 1998 and the Care Act 2014 and Disclosure and Barring Service (DBS).

7.5.4. Providers must ensure that if alleged abuse or neglect occurs whilst the Person is out of the Kent and Medway local authority areas, then the safeguarding policies and protocols of the host local authority where the alleged abuse or neglect took place are followed to make any necessary enquiries.

7.5.5. The Provider's Safeguarding Policy must ensure that all allegations and incidents of abuse are followed up in a prompt, specified timeframe.; and that all details and actions taken are recorded in a dedicated record / file kept specifically for the purpose, as well as on the Personal file of the Individual.

7.5.6. You must also have a Public Interest Disclosure Act 1998 (Whistleblowing) policy which will include procedures under which staff and volunteers can raise, in confidence, any serious concerns that they

may have and do not feel that they can raise in any other way. These can include situations when staff and volunteers believe that:

- a criminal offence has been committed
- someone has failed to comply with a legal obligation
- a miscarriage of justice has occurred
- a Person's health and safety is being endangered
- there are, or may be, financial irregularities

7.5.7. You must have policies in place for staff and volunteers regarding receiving gifts, inheritance and other bequests from individuals who access the service.

7.5.8. You must have policies in place for checking staff and volunteers driving licences directly with the Driver and Vehicle Licensing Agency (DVLA). Training and support should also be in place for staff and volunteers who are involved with driving individuals to community based activities and associated journeys.

7.5.9. Training on the prevention of abuse and self-neglect must be given to all your staff and volunteers within three months of employment commencing and/or engagement in activities with individuals. This must be updated annually.

7.5.10. Any concerns that a Person may be suffering abuse should be reported to Kent County Council's Safeguarding Team as a matter of urgency. http://www.kent.gov.uk/social-care-and-health/report-abuse

The Police should always be alerted (by calling 999) if there are concerns for a Person's immediate safety.

7.6. The Prevent Strategy and Duty

7.6.1. Section 26 of the Counter-Terrorism and Security Act 2015 places a duty on certain authorities to give due regard to, and counter, the threat from terrorism. The Prevent Strategy is part of the overall Counter-Terrorism Strategy.

7.6.2. The Contractor must comply with the requirements and principles in relation to section 26 Counter Terrorism and Security Act 2015 and Prevent to include:

- Having policies and procedures in place that comply with the principles contained in the Government Prevent Strategy, the Prevent Guidance and Channel Guidance.

- In relevant policies and procedures, having a programme to raise awareness of the Government Prevent Strategy among staff, management committee members, directors and volunteers in line with

the Contracting Authorities Prevent Training and Competencies Framework.

- The Council's policies and procedures in relation to the Prevent agenda.

7.7. Reasonable Adjustments

7.7.1. **The Equality Act 2010**

7.7.1.1. The Equality Act makes it unlawful to discriminate (directly or indirectly) against a Person on the basis of a protected characteristic or combination of protected characteristics. Under the Equality Act the public sector have certain duties called the Public Sector Equality Duty (PSED).

7.7.1.2. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages experienced by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- Encouraging people from protected groups to participate in public life, or in other activities where their participation is disproportionately low

7.7.1.3. The Community Navigation service delivered through this specification must make reasonable adjustments to remove barriers which people with a disability or who have multiple challenges experience, to ensure that people receive the same service and level of support, as far as possible, as someone who is not disabled or have support needs. This applies equally to Carers supported under Part B of the contract who may have a disability, or be caring for a Person with a disability, as it does to those supported under Part A of the contract.

7.7.1.4. People (supported under both Part A and Part B) may require information and support in different ways, or require signposting to different services, according to their needs, ability and protected characteristics.

7.7.1.5. This may include access to good quality information and advice materials, for example Easy Read, British Sign language and/or other forms of visual communication where English is not the first language. Providers should also consider working with professional

translators/interpreters when required to support people. In cases where an interpreter is required to enable someone to access statutory support (e.g. when undertaking a Statutory Carers Assessment under Part B of the service specification), then KCC will consider funding the interpretation service on a case by case basis.

7.7.2. **The Accessible Information Standard**

7.7.2.1. The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, people accessing services, Carers and parents, where those needs relate to a Person being d/Deaf or to a disability, impairment, sensory loss. The standard applies to service Providers across the NHS and adult social care system, this means that anyone having direct contact with adult social care service users, their Carers or parents must read and apply this guidance in their everyday practice. This includes partners and voluntary organisations who have delegated responsibilities for elements of the service, such as Carers' Assessments.

7.7.2.2. Commissioned organisations are required to work to the KCC "Accessible Information Standard" policy and guidance.

Section 8 – Performance Monitoring and Management

8.1. Performance Monitoring

8.1.1. Performance monitoring is essential to ensure the effectiveness of the service.

8.1.2. The Service Provider and KCC will review the service through detailed performance monitoring and an effective partnership approach in order to ensure that delivery meets the required standard.

8.1.3. As detailed in the terms and conditions of the contract, both KCC and the Provider may propose variations to the contract specification during the life of the contract. If agreed, the variations will be dealt with according to the process defined in *Schedule 7 – Change Control*.

8.1.4. KCC will use electronic methods for collecting and collating all key performance indicator data, and all Providers will be expected to work with KCC to deliver this effectively and to ensure compatibility with KCC's systems and requirements.

8.1.5. Key Performance Indicator requirements are laid out in *Schedule 14.*

8.1.6. Those receiving the service will be asked to provide feedback via a Personal Outcomes Recording Questionnaire *(see Appendix 7).* The form will measure the Person's/Carer's wellbeing score against a range of outcomes, both at the start and end of the intervention period in order to measure the impact of the service.

8.1.7. Customer satisfaction data collected through KCC's Care Navigation App will also be taken into consideration when reviewing the impact and effectiveness of the service.

8.1.8. Any future additional performance monitoring requirements will be introduced through discussion with Providers and will be informed by the review and development of the service. Where changes are required to the specification you and we will follow the change control procedure laid out in the terms and conditions of this contract.

8.1.9. The Provider will look to develop the service to ensure continuous improvement in the targeting of support to those most in need and most vulnerable in our society.

8.1.10. Whilst there will be a focus on evidencing what services are delivered through the contract, there is also the need to translate this information into a demonstration of value for money and ability to manage demand and reduce costs to the health and social care system. A key part of this will be creating a performance framework that can track an individual from the point of referral through the end point of their journey.

8.2. Contract Reviews

8.2.1. *Schedule 14 – Contract Management* details the requirements of both the Providers and of KCC.

8.2.2. Contract review visits may be either pre-planned or unannounced. KCC reserves the right to undertake a review of the commissioned service at any time and to work with Providers to ensure optimum delivery arrangements.

8.2.3. KCC reserve the right to utilise third-party Auditors in undertaking any performance management elements including contract monitoring, quality assurance and KPI measurement. KCC will develop the roles of various council staff in relation to this contract, its contract management and reviews, therefore a range of KCC representatives may conduct any of the performance management elements. However, any third-party auditors will follow the review arrangements set in *Schedule 14.*

8.2.4. The value of the contract may be increased or decreased during the lifetime of the contract based on the performance data submitted, or to test out different methods of payment, for example, payment related to effective prescribing.

8.3. Quality Assurance Requirements

8.3.1. Service Providers must ensure that a quality management system is in place to guarantee internal control of quality and consistency of practice and be committed to a process of continuous service improvement.

8.3.2. In providing this service you must have in place the following policies and procedures (as a minimum):

- Quality Assurance
- Complaints
- Equalities and Human Rights
- Health and Safety, including Infection Prevention and Control
- Recruitment and Selection
- Induction and Training
- Supervision and Appraisal
- Adult Protection/Safeguarding
- Child Protection/Safeguarding
- Emergency Procedures/Plans
- Serious Incidents
- Lone Working

- General Data Protection Regulations/Information Governance

8.3.3. Providers must ensure compliance with any national applicable quality standards and draw on good practice guidelines, such as the National Institute of Clinical Excellence (NICE) or Public Health England. These include the following:

- Older people: independence and mental wellbeing NICE guideline [NG32]
- Community engagement: improving health and wellbeing and reducing health inequalities NICE guideline [NG44]
- Personalised care and support planning handbook (NHS England and Coalition for Collaborative Care)

8.4. Contract Sanctions

8.4.1. Kent County Council will utilise contract sanctions to denote non-compliance with the contract and specification. There are three types of contract sanctions:

- Poor practice sanctions to express levels of non-compliance with the Service Specification
- Contract compliance sanctions to express levels of non-compliance with the Terms & Conditions
- Safeguarding sanctions where an individual(s) is/are reported to be at risk of harm, abuse or neglect

8.4.2. Each of these contract sanctions have three risk levels starting at Level 1 and escalating up to Levels 2 and 3. A Level 3 flag will prevent the Provider from being offered or accepting referrals from Kent County Council.

8.4.3. Kent County Council will immediately apply a Level 3 Contract Sanction if significant risks to individuals have been identified.

8.4.4. Where contractual non-compliance is evidenced, Kent County Council will work with the Provider to draw up an action plan that addresses areas of concern and articulates the milestones to be achieved. This must be completed within 7 calendar days of the non-compliance being evidenced. The plan will be agreed by Kent County Council and must be delivered by the Provider. Kent County Council will escalate sanctions where Providers fail to meet the plan. It is the Provider's responsibility to evidence that improvements have been made.

8.4.5. Continuous non-compliance of more than three episodes of non-compliance within a 12 month period could lead to the termination of the contract. Kent County Council will be entitled to terminate the contract or

any order without issuing a sanction if Kent County Council finds the Provider to be in serious breach of the contract.

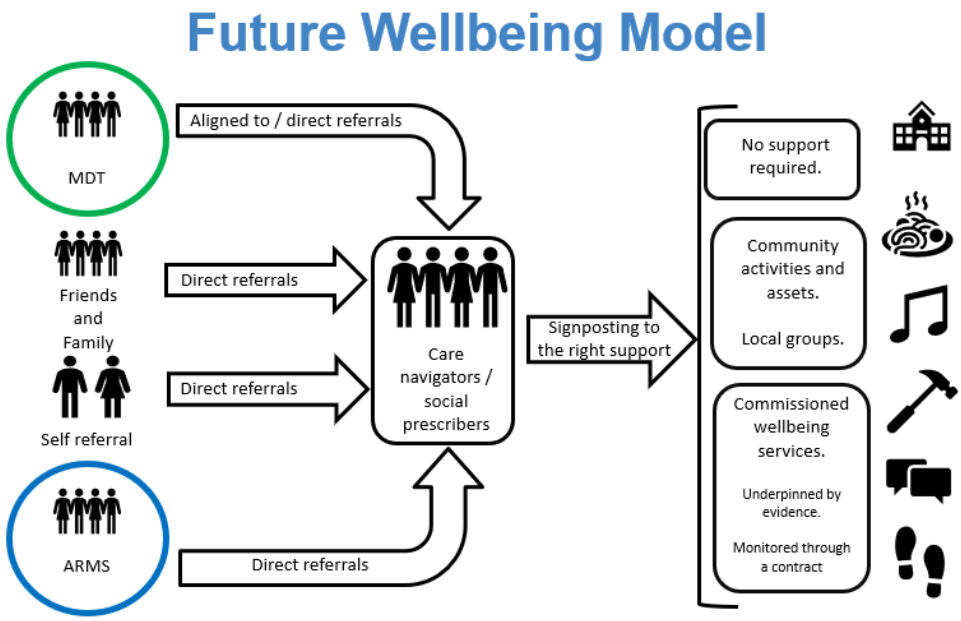
8.4.6. Further information can be found in *Schedule 14 – Contract Management.*

Section 9 – Future Commissioning of Wellbeing Services

9.1. Tracking of Referrals into the Service

9.1.1. The completion of the Information Collection Forms (see *Appendix 6*) for all those who receive support from Community Navigators commissioned through both Parts A and B of this contract will allow Providers and Commissioners to track the referral routes of people into the service.

9.1.2. As detailed in the diagram below, referrals are expected from a variety of sources. There will be a particular emphasis on increasing referrals from MDT (health) and ARMS (social care) teams. Referral source will be monitored using KPI's to determine if this is the case.



9.1.3. KCC's Area Referral Management Service (ARMS) teams will keep a record of all those that they signpost through to the Community Navigation service on KCC's MOSAIC database. In terms of tracking the pathways of those people referred, this will allow Commissioners to:

a) Compare the data from ARMS with the list of those for whom an Information Collection Form has been completed to ascertain whether people are acting on the information that they have been given and making contact with the service.

b) Track future social care contact with those signposted to the Community Navigation service to see whether the support received has successfully kept them out of the Social Care system or if they have come back in and are now receiving other support. If this is the case, then information collected will enable commissioners to determine what support people are coming to Social Care for and establish whether this is support

that could have potentially been sourced differently in the community.

9.1.4. In DGS and Swale CCGs those referred through MDTs will also be tracked through patient records.

9.2. Tracking of Onwards Referrals to Other Services - Measuring Impact and Gap Analysis

9.2.1. As detailed in *clause 6.6*, the Provider's ability to manage demand within the given timeframe is, in many cases, reliant on other services being in place that can support the people that they are looking to navigate through the health and social care systems and/or refer to community based services. The Provider will therefore notify the Commissioners of any gaps in service provision or community activity that may be identified when looking to signpost/refer people on to other organisations for support.

9.2.2. The Provider will also be required to report excessive demand to Commissioners, both in terms of the Community Navigation service and the organisations to which it signposts/refers.

9.2.3. The information gathered regarding gaps and lack of capacity within the market will be used by Commissioners to undertake a more comprehensive assessment phase regarding community based wellbeing services (CBWS) and will help inform the strategic direction for the short and long term.

Many of these services are currently grant funded by KCC and at the time of writing the expectation is that these services will be commissioned through a new contract from January 2020.

9.2.4. In DGS and Swale CCGs, health Commissioners will also use the information to identify interventions that support patient groups in the most appropriate setting within the local health economy. This will be achieved by matching patients to interventions, evaluating the effects, identifying gaps, modelling scenarios, facilitating referrals and monitoring outcomes

9.3. Allocation of Financial Resource

9.3.1. There is flexibility around the model for this contract and the value of the contract may be increased or decreased during the lifetime of the contract in relation to levels of demand and performance data submitted. See *Schedule 14 – Contract Management* for further information.

9.3.2. Customer satisfaction data collected through KCC's Care Navigation App will also be taken into consideration when reviewing the impact and effectiveness of the service, and determining the future level of investment.

Contact Details

Comments or questions should be forwarded to:

Kent County Council
Strategic Commissioning
Strategic and Corporate Services
Sessions House
County Hall
Sandling Road
Maidstone
Kent ME14 1XQ

E-mail: communitysupport@kent.gov.uk

Glossary

When they are used in this Contract, the terms and expressions set out below in the first column have the meanings set out in the second column:

Action Plan	A statement of intent written by the Provider in conjunction with the Person using the service which details the measurable goals and aspirations of the Person that the Provider will support/work with the individual to achieve, and against which progress can be tracked and recorded.
Adult Carer	Care Act, Part 1, section 10, subsection (3): Carer means an adult who provides or intends to provide care for another adult (an adult "needing care")
Adult Protection	Safeguarding vulnerable adults from abuse, harm and exploitation.
ASCH	Adult Social Care and Health (KCC)
Assistive Technology	Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of people with support needs.
Bank Holiday Period	There are eight permanent bank holidays in England which are described as Good Friday, Easter Monday, Christmas Day, Boxing Day, New Year's Day, Early May Bank Holiday, Spring Bank Holiday, August Bank Holiday. On occasions some bank holiday dates can be changed, or other bank holidays can be declared, for example to celebrate special state occasions. When the usual date of a bank holiday falls on a Saturday or Sunday, a 'substitute day' is given, normally the following Monday.
Breach (of contract)	An action in the direct opposition to defined agreed requirements.
Business Continuity Plan	An effective plan of helping business to build resilience against any disaster.
The Care Act	The paper that takes forward the Government's commitments to reform social care legislation and improve the quality of care following the findings of the Francis Inquiry.
Care Navigation	The service fulfilled by the Care Navigator role – providing a proactive link between different parts of the health and social care system; being both a first point of contact for individuals, Carers and health and social care professionals, as well as guiding and co-ordinating a Person's journey through the care system.
Case Management	A targeted, community-based and pro-active approach that assesses people who may have care needs, reviews packages of care and produces co-ordinated care and support plans. Part of KCC Adult Social Care.
Clinical Commissioning Group (CCG)	Created following the Health and Social Care Act in 2012, CCGs replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care

	services for their local area. There are currently 7 CCGs in Kent: Ashford CCG, Canterbury & Coastal CCG, DGS Dartford, Gravesham & Swanley) CCG, South Kent Coast CCG, Swale CCG, Thanet CCG and West Kent CCG.
Commission	The process by which local authorities decide how to spend money to get the best possible outcomes for Persons and communities, based on identified needs.
Commissioner	Members of KCCs' staff who have responsibility for determining what services will be purchased to meet assessed eligible needs.
Community Navigation	A holistic approach that brings together a number of different functions including care navigation tasks, social prescribing tasks, a trusted assessor role and supporting individuals to maximise their benefits.
Complex Needs	A Person with a range of issues and combination of layered needs e.g. mental health, communication, physical, sensory, behavioural, medical, cognitive and relationships.
Confidential Information	All information which has been designated as confidential by You or us in writing or that ought reasonably to be considered as confidential (howsoever it is conveyed and stored), including commercially sensitive information, information which relates to the business, affairs, properties, assets, trading practices, developments, trade secrets, know how, Personnel, customers and suppliers of You and us and all Personal data and sensitive Personal data within the meaning of the DPA, together with all information derived from the above.
Contract	A legally binding agreement between parties to provide goods or services at an agreed price, usually in writing. Contracts must include offer, acceptance, consideration, and be legally enforceable.
Contract Period	The length of the contract (in months) as detailed in the Contract Particulars, which will also state any contract extensions which may be applied.
Co-production:	Where there is active input into service design by the people who refer into and use the service. "Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families, Carers and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change." *The Challenge of Co-production (2009)*
Council	Means Kent County Council (KCC)
Data Protection Impact Assessment (DPIA)	A DPIA is a process designed to help systematically analyse, identify and minimise the data protection risks of a project or plan. It is a key part of the accountability obligations under the GDPR, and when done properly helps both KCC and Providers assess and demonstrate how they comply with all data protection obligations.

Deprivation of Liberty Safeguards (DoLS)	An extension of the Mental Capacity Act (2005) which aims to ensure that the Person in receipt of social and health care are looked after in a way that does not inappropriately restrict their freedom.
Disaster Recovery Plan	A disaster recovery plan is a documented process or set of procedures to recover and protect a business in the event of a disaster, such a plan, ordinarily documented in written form, specifies procedures an organization is to follow in the event of a disaster. It is "a comprehensive statement of consistent actions to be taken before, during and after a disaster".
Disclosure and Barring Service (DBS)	The tool that helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).
Driver Check Code	This is a code the owner of a driving licence can generate with the DVLA directly, to give to an organisation to enable them access to the driver's licence history and check whether there are any endorsements/penalties or disqualifications on a driving licence.
DVLA	Driver and Vehicle Licensing Agency
Easy Read	Easy read uses pictures to support the meaning of text and is primarily used when producing communication materials for those with learning disabilities. Easy read is often also preferred by readers without learning disabilities, as it gives the essential information on a topic without a lot of background information. It can be especially helpful for people who are not fluent in English. Strategic Partners will need consider the needs of their audience in advance – assess which, if any, accessible format versions are likely to be required
European Convention on Human Rights (ECHR)	This is an international treaty to protect human rights and political freedoms in Europe.
Expert Patient Schemes	A self-management programme for people with support needs or are living with long term conditions.
Flexible Package of Support	A package of support for a Person delivered by a Community Navigator should not exceed 12 weeks in total – although it is expected that in many cases the individual's needs will be addressed in a shorter timeframe. In order for this support to be implemented in the most effective, outcomes-based way so that it best supports the Person's individual needs, this timescale can be flexible. This means the 12 weeks of support can take place over a longer period of time if appropriate.
General Data Protection Regulations (GDPR)	The General Data Protection Regulation is a European-wide law that replaces the Data Protection Act 1998 in the UK. It places greater obligations on how organisations handle personal data. It came into effect on 25 May 2018. Further information can be found at https://ico.org.uk/for-

	organisations/guide-to-the-general-data-protection-regulation-gdpr/
Home Improvement Agencies (HIAs)	Based within the District Councils, Home Improvement Agencies support people to live safely in their own homes through access to aids and adaptions which support independence.
Improvement/ Action Plan	A response to raise standards in key areas in service development and delivery within agreed specified timescales.
Information Governance	Information governance (IG) is a framework that brings together all the requirements, standards and best practice that apply to the handling of information within an organisation to ensure compliance with the law, including the Data Protection Act 2018 and Freedom of Information Act 2000 (FOI). The framework is designed to assist with the application of rules concerning confidentiality, privacy, data security, consent, disclosure and access to records.
Intervention Period	The period of time that a Community Navigator is supporting a Person, from the first point of contact through to the point of case closure. The total intervention period (excluding any standstill period) should not exceed 12 weeks *(see clause 5.5).*
KCC	Kent County Council
KCC Area Referral Management Service (KCC - ARMS)	The main access points for people wanting to contact Social Care, Health and Wellbeing about themselves or others. They deal with contacts regarding adults with a physical and/or learning disability, people with sensory needs and older people.
Kent Enablement at Home (KeaH)	KCC's in-house Provider of enablement services.
Key Performance Indicator (KPI)	Criterion that helps to measure service quality and Providers' performance against their contractual obligations.
Lone Workers	Lone workers are defined as individuals who work by themselves, without close or direct supervision, in a wide range of situations, regardless of whether they work in a fixed establishment or are mobile workers away from a fixed base.
Make Every Contact Count (MECC)	Making Every Contact Count (MECC) is about encouraging and empowering people to make healthier lifestyle choices to achieve positive long-term behaviour change. The fundamental idea underpinning the MECC approach is simple. It recognises that staff across health, local authority and voluntary sectors have thousands of contacts every day with individuals from the local population. Staff and volunteers working within these settings are in an ideal position to promote health and healthy lifestyles.
Market Position Statement	A declaration that summarises Commissioners' purchasing intentions which also provides intelligence to Providers (the market) to enable them to plan

	how to respond to the Commissioner's needs.
(Contract) Mobilisation Phase	The development and execution of proposed service provision. The mobilisation phase will run from the date of contract award until the service start date (1st April 2019). The mobilisation plan is fundamental to ensure a smooth transition of current services to the new services. *See Appendix 4.*
MOSAIC	The Council's new database/system that will be phased in to replace SWIFT from January 2019 to hold key information on both the needs and treatment of adults from 26 years who are receiving a social care service, as well as the organisations providing the care.
Multidisciplinary Team (MDT)	A group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for those with complex medical conditions.
Must (must) / Will (will)	To be obliged or required by law.
Ombudsman / Local Government Ombudsman Officer	Officer whose role is to investigate complaints where Persons have been treated unfairly or have received poor service from government departments and other public organisations and NHS in England.
Outcome	Consequence, impact or result of an activity, plan, process or agreed intervention and the comparison with the intended projected result.
Output/s	Outputs are a quantitative summary of an activity. An output tells you an activity has taken place, but it does not tell you what changes as a result.
People / Person	Refers to the users of this service.
Policy	A set of statements which help Person to make sound judgments based on legislation, legal terms and conditions and any regulatory requirements.
Procedure	The method by which a policy is put into practice.
Procurement	The legal and technical process of seeking bids and acquiring goods or services from an external organisation. It is one part of the commissioning cycle. When a good or service is put out to tender, contracts are drawn up and the good or service is 'purchased' or procured.
Provider	The Provider(s)/Organisation(s) commissioned by KCC to deliver the service outlined in this specification.
Response Time	The time taken between a referral being made to the Provider, and the Provider making contact with the individual requiring support.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

Risk	The probability of an unwanted event occurring.
Safeguarding	Describes the multi-agency process of protecting vulnerable adults and children from abuse or neglect and putting systems in place to prevent harm.
Self-care Advice	An umbrella term that includes a range of different situations whereby people are given information on how to better manage conditions or impairments with minimal or no involvement of services.
Service	The Service(s) provided under the terms of this contract.
SMART	Specific, Measurable, Achievable, Relevant and Time-bound goal setting
Social Inclusion	Social inclusion is about involving everyone in society, making sure all have opportunities to work or take part in social activities.
Social Prescribing	Social prescribing is a way of linking people to sources of support within the community. It provides health and social care professionals with non-medical / non-service focused options that can operate alongside existing treatments or care packages to improve health and wellbeing.
Social Value	The Public Services (Social Value) Act 2012 requires commissioning authorities to demonstrate how the service to be procured will "improve the social, environmental and economic wellbeing of the relevant area". The term 'Social Value' aims to describe the additional social, economic and environmental value that can be secured for the community over and above the core contract requirements when a service is procured. Social Value is also a wider term for value beyond the financial element.
Specification	The document that describes the service and the required outcomes.
Staff	Employees and workers who carry out the service for the Provider
Statutory	As required by statute (the law)
Strengths Based Approach	Person led activities that focus on positive outcomes with emphasis on the resources and traits that the Person has.
Supervision	A formal recorded meeting on a one to one basis with the Staff member's line manager to enable administrative KCC; review, discussion of and reflection on the Staff member's work; learning from practice; Personal support; professional development and mediation. Supervision will take place at least quarterly (every three months). Written records of these Supervisions must be kept demonstrating the range, content and outcome of the discussion at each meeting
Supporting People	The act of assisting a Person to complete a task or access the community to remain as independent as possible.
The Kent Partners' Compact	A partnership agreement between the Voluntary & Community Sector (VCS) and the public sector in Kent. It is a jointly agreed framework for mutual working. It expresses the desire of the VCS and the public sector to work together better. It also provides a framework where mutual respect, understanding and fair treatment are the building blocks for true partnership.

	(Link to Kent Partners Compact 2012)
Transformation Agenda	KCC's innovative way of working with its partners with renewed focus on rapid response, prevention, targeted interventions, supporting careers and empowering people.
Trusted Assessor	Carrying out a holistic assessment of need, a Trusted Assessor can help avoid duplication and speed up response times so that people can be discharged from hospital in a safe and timely way - helping them to move from hospital back home or to another setting speedily, effectively and safely.
Wellbeing	'Wellbeing' is a broad concept, and it is described as relating to the following areas in particular: • Personal dignity (including treatment of the individual with respect) • physical and mental health and emotional wellbeing • protection from abuse and neglect • control by the individual over day-to-day life (including over care and support provided and the way it is provided) • participation in work, education, training or recreation • social and economic wellbeing • domestic, family and Personal • suitability of living accommodation • the individual's contribution to society There is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round.
You/your	For the purpose of this specification, the term 'you' and 'your' means the Provider.

Appendix 1: Kent County Council's Strategic Statement 2015-2020

Appendix 2: The ESTHER Model

1. What is the ESTHER Model and who is ESTHER?

1.1. The ESTHER model originates in Sweden, specifically the county of Jonkoping and was developed about 10 years ago. ESTHER was a real person who became unwell with serious heart failure and was admitted to hospital. There were delays in diagnosis, treatment and care planning. Overall the experience that ESTHER had was not good and somehow typical of a lot of patients and service users. The health and social care staff involved in ESTHER's care recognised that there was a different way of doing things that would lead to better outcomes, higher quality care and efficiency.

1.2. In developing this alternative model the patient 'ESTHER' whose experience inspired this new thinking was remembered and the name 'ESTHER' was applied to any patient or service user who might find themselves in a similar situation. In this sense ESTHER can be female or male, old or young; ESTHER is simply a person who needs care and attention from more than one health and care Provider.

1.3. Under the ESTHER model clinicians and care professionals ask, "what is best for ESTHER?" to ensure person-centred care. User involvement is integral to the model, building a network around ESTHER including family, friends and key staff from health and social care.

1.4. Under this model ESTHER has the right to:

- Be involved in his or her own health and social care
- Access to good care in or near their own home
- An individual care plan which is updated regularly
- Equal treatment regardless of where his or her home is situated
- Experience all relevant health and social care Providers as one service

1.5. Further information can be found at:
https://designandlearningcentre.com/overview-of-our-work/ESTHER-model-sweden-kent/

2. Working with the ESTHER Model

2.1. The ESTHER Model in Kent was adopted in 2016 as it was recognise as an excellent way health and social care being able to demonstrate that there is a clear vision and credible strategy to deliver high-quality care and support while promoting a positive culture that is person-centred, open, inclusive and empowering.

2.2. Under the ESTHER model it is recognised that to deliver good care there is a need for all health and social care Providers to collaborate seamlessly across organisational borders. Staff work proactively towards this ensuring that 'ESTHER'

always experiences safety and independence, living as independently as possible and supported by their network.

2.3. Key to developing the quality approach that underpins the ESTHER model are ESTHER Coaches, who are specially trained dedicated members of staff, in a range of job roles and grades. The coaches support the development of other staff across organisational and professional boundaries and create a culture of continuous improvement and sustainable development – always asking “what is best for ESTHER?”

2.4. Another feature is ESTHER cafes, which are open to everyone in health and care services who want to improve life and care for ESTHER. The cafes feature a story or case study told by ESTHER, relaying their experience of recent health and social care services, with a view to identifying what could be done even better and sharing best practice.

3. ESTHER Ambassadors

3.1. An ESTHER Ambassador is someone who promotes ESTHER and raises awareness of the model with those they come into contact with through their work. The training is delivered through a one-hour e-learning package. There is no preparation needed or expected in advance of this training. Upon completion of the training ESTHER Ambassadors are given a badge to wear, it is expected that they wear this.

3.2. An Ambassador e-learning package can be accessed by organisations from April 2019. The ambition is:

- Year 1 – 30% of all staff ambassador trained
- Year 2 – 60% of all staff ambassador trained
- Year 3 – 80% of all staff ambassador trained
- Year 4 – 90% of all staff ambassador trained

4. ESTHER Coaches

4.1. An ESTHER Coach is a person who is trained in quality improvement and coaches their team in this way to make improvements that are of benefit to the experience of those receiving care and to their organisations. Prior to ESTHER Coach training all those identified for the training have to complete the ESTHER Ambassador training. The ESTHER Coach Training is run over a period of 5 months with 4 full day training sessions and one half-day which is the final session for the presentation of their improvement projects. The training focusses on quality improvement, coaching skills and working in partnership with ESTHER.

5. Training Requirements for Community Navigators

5.1. All new staff joining the organisation will need to complete the ESTHER ambassador e-learning as part of their induction. E-learning will be provided free of charge.

5.2. Where Providers choose to train staff as ESTHER coaches there will be a charge of £1,000. The benefits of accessing the coach training will help to demonstrate the person-centered approaches that the Provider is implementing, and that ESTHER is a recognised model of care.

5.3. There is a virtual ESTHER network to provide ongoing support and Providers will have access to the Design and Learning Centre Learning and Development hub for ongoing support and access to ESTHER training and expertise. Providers will also be invited to an annual ESTHER Inspiration Event (free of charge) to understand how the model is progressing and plans for its further development.

Appendix 3: Additional Requirements for Service Lot Part A in DGS and Swale CCGs

This Appendix should be read in conjunction with the main requirements of the Community Navigation contract detailed in this service specification.

The additional requirements do not apply to Service Lot Part B: Community Navigation for Carers.

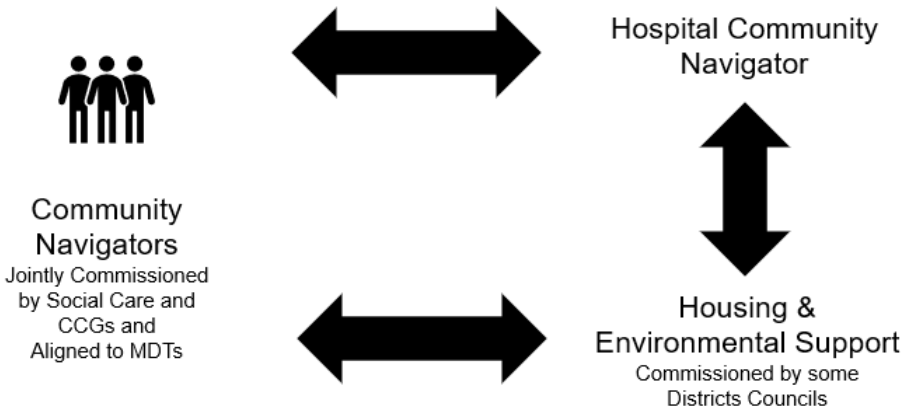
Whilst in East Kent and West Kent, the Community Navigators that KCC is looking to commission through this contract will be expected to work alongside those commissioned separately by health, in DGS and Swale the roles are being jointly commissioned by health and social care. This differing approach means that additional requirements apply in terms of the scope, management and reporting of the contract.

1. Scope of the Role

1.1. In addition to the outline given in *clause 4.*2, the contract will also need to support the agendas of DGS and Swale CCGs by helping to integrate health and social care systems through the mechanism of primary care, and deliver person-centred local care by putting people and their families at the centre. The contract will therefore aim to:

- Improve the health, social and wellbeing outcomes of older people and adults with complex needs/frailty, particularly those at high risk, and maintain or increase their independence
- Reduce demands and make more appropriate use of health and social care services.

Proposed Future Model of Community Navigation



1.2. In DGS and Swale CCGs, the scope of the role will include supporting all younger adults (under the age of 55) who have complex needs / frailty who would benefit from support from a Community Navigator (see *clause 4.3* for further information). In East Kent and West Kent, those under the age of 55 will be supported by exception (see *clause 4.2*).

1.3. Based on the funding arrangements in place at the point of contract award (see section 4 below) it is anticipated that 70% of those supported by this contract will be older people and adults with complex needs/frailty who are at high risk and therefore likely to fall within tiers 2 and 3; 30% are expected to be considered to be a low to moderate level of risk and be referrals for support in the community (including self-referrals and those that come through KCC ARMS). C*lause 4.2.3* of this service specification gives detail regarding these levels of risk. A Key Performance Indicator will be in place for this contract which will monitor this split.

1.4. Additional objectives to those set out in *clause 4.3* are:

- People are supported to avoid the development of health crises which may necessitate A&E attendance and unplanned hospital admissions.

- People are supported to address non clinical needs, and hence to avoid unnecessary GP appointments, and to make more appropriate use of health and social care services

2. Contributing to Multi-Disciplinary Teams

2.1. The CCGs have identified the implementation of Multi-Disciplinary Team (MDT) working and care navigation, to be known as Local Care Teams, as a key priority. Local Care Teams will work at scale of approximately 30,000 – 50,000 population.

General information on Local Care MDT working can be found in the Kent and Medway STP documentation available online.

https://kentandmedway.nhs.uk/stp/

2.2. The aim of the Local Care Teams will be to develop a single integrated team working in partnership with the GP practices, alongside named health and care staff. They will work together for the benefit of the patient with a focus on identifying what is important for the Person, their family and Carers and how the local system can work together to meet those needs, thereby improving the Person's wellbeing. This is described in Kent and Medway STP as the Dorothy model and/or Esther model.

2.3. As a core member of the Local Care Teams in DGS and Swale CCGs, Community Navigators may participate in reviews of the people on the programme, particularly where a Person's needs have escalated. This enables the whole team supporting the Person to develop and/or adapt a shared care/action plan to meet their needs.

2.4. The main work of the Local Care Team will be at the moderate and severe level of need (Tier 2 and 3 in STP definitions) – with proactive case finding utilising tools such as the electronic Frailty Index. In addition, people will be able to self-refer or be directed towards the team's services e.g. by their GP or other members of the team. The role of the Community Navigators in this process will be mainly with Tier 2 patients (moderate level of need) to improve and coordinate self-care, community care and access to better management of chronic long-term conditions – it is expected that as a result of this intervention people will remain healthier for longer and be less likely to move into crisis.

2.5. Weekly meetings will aim to discuss a small number of people who have been proactively identified and/or referred to the Local Care Team.

2.6. In each locality there will be weekly meetings held for one-two hours to discuss and plan for new patients and review patients on the active caseload. The Local Care Team will work closely together across the rest of the week to enable patients to be effectively and proactively managed and supported in the community. Their work will be facilitated by a Local Care MDT Coordinator who will be responsible for organising meetings and attendance, and ensuring that appropriate people are identified for support, agreed actions are followed up, and records are in place.

2.7. The key features of this enhanced and integrated approach will be:

- Greater partnership working across Providers to provide more closely coordinated and integrated support to patients in the community
- A focus on long term conditions, public health and ill-health prevention, with greater interaction between statutory, community and voluntary sector interventions.

3. Collaboration with Other Specialist Roles

3.1. The service will be highly collaborative, and Community Navigators will be required to work closely with other specialist posts in the system who carry out a care navigation function. This includes additional Community Navigators in DGS funded through the Health and Wellbeing Fund (to be known as Community Navigators – Social Prescribing) and other roles focussing on Carers, healthy lifestyles (One You), housing, information and advice, dementia, mental health, end of life, but also any others relevant to the needs of the Person they are supporting. This approach ensures that accessing these services is simple for the Person, maximises the use of resources, and reduces duplication. It is important that the Person is not passed around the system and that

wherever the referral is made the Community Navigator ensures that the correct support is provided by the best and most appropriate service as soon as possible.

3.2. As well as working closely with hospital discharge and rapid response services, it is envisaged that the service will work best where some Community Navigation resource is located within hospital discharge teams. Further consideration will be given to this during the mobilisation phase and will be dependent on the existence of any additional commissioned hospital care navigators.

4. Outcomes

4.1. *Clause 2.9* details that by working in partnership with Commissioners, the Provider must be able to demonstrate how the service specified has contributed to the following:

- Reduction in the number of people entering social care services unnecessarily
- Reduction in the level of unmet need at the point of referral to social care or health
- Improved outcomes/access to support for people and their Carers as a result of the service delivered by the Provider

4.2. Additional outcomes from a Health perspective include:

- Improved health, wellbeing and independence for older people and adults with complex needs/frailty who are most at risk of unplanned hospital admission
- Improved quality of care
- Improved patient experience
- Reduced avoidable emergency hospital admissions
- Reduced or more appropriate use of primary care and other health services

4.3. Meeting these outcomes will be evidenced by the indicative KPIs detailed in *Schedule 14*, and by looking at both the onwards referrals made by the service, and where people who received support from Community Navigators are subsequently found to be in receipt of health and/or social care services.

5. Funding Arrangements

5.1. In addition to the investment from KCC, the DGS and Swale CCGs also intend to fund this contract for a period of 5 years, subject to a review and

break clause at 18 months (30 September 2020), and based on the performance of the contract.

5.2. Should the funding from the CCGs not form part of this contract beyond September 2020, then the number of posts funded by this contract would reduce accordingly. At the point of contract award this is as detailed in *clause 4.5*, however, this is subject to change based on the performance of the contract. Should this situation arise, the Provider(s) will therefore be required to work with KCC Commissioners to determine how the funding can be best utilised to meet the social care needs of those in the DGS and Swale CCG areas.

6. Number of Posts

6.1. With KCC and the CCGs jointly commissioning Part A of the contract in DGS and Swale, the combined budget means that at the point of contract award it is anticipated the total number of posts commissioned would be as below:

CCG Area	Cluster of GPs	Minimum Number of Community Navigator Posts	Number of Team Leader Posts
DGS	Dartford and Greenhithe Hub	2	2
	Dartford Central Hub	2	
	Gravesend Rural Hub	2	
	Gravesham Central Hub	2	
	Swanley Hub	2	
	White Horse Hub	2	
Swale	Sheppey	2	1
	Sittingbourne “East”	2	
	Sittingbourne “West”	2	

6.2. The current Darent Valley Hospital Care Navigator is in scope for this contract and is included in the numbers given in *clause 6.1.* See *clause 3.2* on working with hospital discharge and rapid response teams.

6.3. Two named Community Navigators should be allocated to each locality in the first instance to ensure that the CN can build relationships with GP practices and become part of the MDT. However, there will also need to be flexibility in allocation of staff time across localities in response to variations in locality population profiles and demand, and this will be agreed by Providers and Commissioners during the mobilisation phase and beyond, as required.

6.4. With Providers being asked to manage a team of Community Navigators, who work across both health and social care to support a larger proportion of the population, it is proposed that Team Leader roles are put in place in DGS and Swale. These roles will be funded by the CCGs.

6.5. Providers will be asked to propose the best ways of configuring posts to meet the service specification within the available budget. The final allocation of resource will be agreed by the Provider and Commissioners during the mobilisation phase.

7. Staff Qualifications & Training – Additional Requirement for Team Leaders

7.1. In addition to the requirements detailed in *clause 2.15.6*, the Provider must ensure that the team leader for each CCG area holds a relevant national occupational standard such as NVQ Level 3 or equivalent. Ideally this would be in either Health and Social Care or Information and Guidance.

7.2. Those who do not already hold a relevant standard should be supported to achieve the above qualification as a minimum within 1 year of commencement of employment under this contract.

7.3. The Provider must be able to evidence that all Team Leaders are working at the Expert (Gold) competency level across all nine key domains detailed in the Care Navigation Competency Framework.

https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

7.4. Additional competency domains may be added as needed to meet the specific requirements detailed in this Service Specification. These will be agreed with the successful Provider(s) during the mobilisation phase.

7.5. Where Team Leaders are unable to evidence that they are already working at this level, they should be supported to do so within one year of commencement of employment with the Provider, under this contract.

7.6. During the mobilisation phase, contracted Providers will work with Commissioners to agree how best to evidence that the required competency levels are being met. This will feed into *Schedule 14 – Contract Management.*

7.7. It is anticipated that Team Leaders will be required to carry out supervision of the Community Navigators in their team; have non-clinical case management/oversight of the most complex cases; work closely with MDT coordinators; ensure the service is efficient and duplication of roles

with other services is avoided. The Provider(s) must therefore consider what additional training and support may be needed by Team Leaders**.**

8. Equality and Diversity – Additional Requirements

8.1. Providers will be expected to work with professional translators/interpreters when required to support people, which will be at the providers own cost, unless KCC have agreed to fund as described in *clause 7.7.1.5.*

Appendix 4: Contract Mobilisation Plan for All Lots

Outline of information	Key Objectives/Tasks	Timescales	Key Responsibility
Contract Award	• Contract signed and returned to KCC		
Meet with all those delivering care navigation and social prescribing	• Meetings to be set up for each geographical area of the contract, with commissioners, contracted Providers, District Councils, CCGs, Public Health and all other Providers delivering care navigation and/or social prescribing services. The meetings will be used to agree roles, mobilisation plans and develop a SOP. •		
Current people who access service (applicable if there is going to be a change in Provider)	• Secure consent from people who use the service regarding identifying those who currently attend services delivered by exiting Providers • Develop plans to minimise disruption to people who require support, identify waiting lists • Communicate with people using services with an agreed KCC narrative for a consistent message to service users • Identify the number of people who use services who will transfer to the new service or remain with existing Providers • Agree whether it will be necessary to stop taking referrals to avoid unnecessary transitions (this may depend on TUPE) •		
Workforce	• Work with exiting Providers to determine accurate TUPE information and plans for transfer, this may include consulting with staff		

	• Advertisement of job opportunities if required • Recruitment and induction • Training plan to include requirements, for appropriately qualified, trained and skilled staff • Ensuring staff and volunteers feel supported and are able to continue in their roles, in order to minimise disruption and ensure continuity of support. • Ensure compliance with all legal obligations including appropriate insurances, health and safety and staff qualifications •		
Systems	• Policies and procedures to ensure data protection compliance/Information Governance • Establish the required information and communication systems needed for the service to operate effectively • Ensure existing communication channels are maintained and/or redirected to new channels as appropriate • Implement appropriate policies and procedures • Develop IT and data systems that ensure effective performance reporting which can be completed from the service start date • Transfer of Records and Documents • Websites and other social media •		
Co-location	• Confirm how frequently the Community Navigators will attend one of the		

	practices within their assigned GP cluster. • Confirm how frequently the Community Navigators will base themselves in their local district council office. •		
Marketing and Communications	• Produce marketing plan • Map and link with other community assets and services •		
Mobilisation Start	• Identify the mobilisation leads and responsibilities • Agree how to share information • Managing change effectively to minimise disruption for service users • Communicate and consult with stakeholders to make them aware of the changes and vision for the new service model and co-ordinating communication with KCC • Project managing the mobilisation phase, proactively reporting progress and escalating risks and issues to Commissioners where necessary.		
Finance	• Confirm invoice and payment arrangements •		
Referrals	• Ensure no wrong door approach • Ensure every contact is a positive experience, offer excellent customer service • Map referral pathways • Document referral process and communicate both internally and		

	externally • Identity people currently receiving a service and ensure transition plans in place • Identify waiting list/waiting times • Check capacity and demand • Operational protocols to be agreed within the first 6 months following contract start date •		
Performance Management	• Identify documents and process • Ensure KPIs are understood and that all Community Navigators are capturing and reporting data consistently •		
Contract Start	• Confirm Mobilisation/Transition themes that will continue at contact start and through the first phase of the live contract • Agree Mobilisation/Transition phase completion •		
Other Areas	•		

The Contract Mobilisation Plan will be further added to and refined in coproduction with Providers following contract award.

Appendix 5: Person Profiles

1.1. Older People Profiles

1.1.1. Older people are a diverse section of the population, ranging from relatively healthy, independently living individuals, active and inactive retired, to very frail individuals with multiple long-term conditions, poor physical functioning and cognitive problems, presenting unique challenges.

1.1.2. Many changes occur in later life such as retirement, becoming a Carer, bereavement, or needing care. These changes can have a significant effect on the quality of people's lives. We want more people to successfully manage the major changes that occur in later life.

1.1.3. For older people age increases other risk factors such as cognitive impairment, falls, reduced level of physical activity, co-morbidity, depression, age related diseases, and living in isolation. The services, activities, resources etc. that people are signposted to and supported to access through this contract will therefore need to address these risk factors.

1.1.4. Providers must ensure that the services delivered through this specification are accessible to all older people to reflect diversity and need.

1.1.5. **Older People Living with Dementia**

1.1.5.1. Older people should continue to enjoy hobbies and interests, including people living with dementia, as hobbies and interest may keep a Person with dementia alert and stimulated, so that they maintain an interest in life. Keeping an active social life is key to helping someone with dementia feel happy and motivated.

1.1.5.2. People with the early stages of dementia may enjoy walking, attending gym classes, or meeting up with understanding and supportive friends.

1.1.5.3. People with mid to late stages of dementia may require a more structured, safe and supportive environment in which to enjoy activities and socialise.

1.1.5.4. The stages and progression of dementia will predictably involve cognitive decline, and it is therefore important that the Person with dementia and their Carer are supported to maintain social networks to avoid isolation in the late stages.

1.1.5.5. Dementia is a broad umbrella term used to describe a range of progressive neurological disorders. There are many different types of dementia and some people may present with a combination of types. Regardless of which type is diagnosed, each Person will experience their dementia in their own unique way.

1.1.5.6. People with memory loss often require easy read written information to help them to understand and process information. Engaging in conversation can also sometimes be difficult for people living with dementia.

1.1.6. Older People with a Learning Disability

1.1.6.1. Older people with learning disabilities have the same needs as other older people; to be valued, lead productive and active lives and be treated with dignity and respect.

1.1.6.2. However, as well as experiencing ageism, many older people with learning disabilities experience discrimination because of their learning disability. In addition, they may have reduced social networks because of life experiences.

1.1.6.3. People with learning disabilities are living longer. It is estimated that by 2030, there will be a 30% increase in the number of adults with learning disabilities aged 50+ using social care services. (Published 2014 British Institute of Learning Disabilities (BILD)).

1.1.7. Older People with Autism

1.1.7.1. Autism is an isolating condition which can significantly impair a Person's capacity to form relationships. It is a condition which affects one Person in 100 in the UK, according to figures from the National Autistic Society (NAS).

1.1.7.2. Many people with autism experience heightened sensory sensitivity which can be adversely affected by issues such as noise and lighting. Others may dislike people coming too close and may have atypical communication styles so the struggles with social interaction that can be a part of autism can make this even more of a challenge, potentially leading to loneliness and other problems.

1.1.8. Older People with a Physical Disability

1.1.8.1. Physical disability is usually defined in terms of restrictions in the ability to perform activities of daily living, or the inability to function independently. With increasing age comes increased likelihood of disability, in terms of reduced mobility and declining health.

1.1.9. Older People with Sensory Loss

1.1.9.1. Older People may experience some degree of hearing loss and they may consider themselves as deaf, 'hard of hearing' or having 'acquired hearing loss'. This may be due to age-related damage or other causes (such as noise damage, infection, diseases or injury). This may affect people's capacity to listen and hear in order to participate in conversations.

Different options and environments may need to be offered to support people to join in with social activities.

1.1.9.2. In comparison, people who are born deaf or become deaf at a young age are considered to have 'profound deafness'. They may consider themselves as Deaf (often referred to as Deaf with a capital D), use British Sign Language (BSL) as their first language and identify with the Deaf community.

1.1.9.3. Older people may also experience some degree of sight loss as they get older. This may be age-related, or due to a condition such as cataracts or age-related macular degeneration.

1.1.9.4. People who are registered as blind or partially sighted will have difference experiences and their primary need may focus on their sensory loss.

1.1.10. **Older People from Black and Minority Ethnic Groups and Lesbian, Gay, Bisexual and Transgender Communities.**

1.1.10.1. Increasing diversity means that it is important to address the needs in different communities, for example older people in black and minority ethnic communities, and older people in lesbian, gay, bisexual and transgender communities. It is important to recognise how older people experience discrimination on the basis of their age and other aspects of their identity as well as understand how different backgrounds and life experiences may shape what is important to them.

1.1.11. **Older People Living in Hard to Reach and Deprived Locations**

1.1.11.1. People living in hard to reach locations (such as rural communities, with limited or no transport option) and those living in deprived urban locations will experience additional challenges regarding access to leisure, social, cultural and spiritual activities in their local and wider community. They may also find it harder to access information and advice about the support and community facilities available. There is a link between low social economic status and loneliness.

1.1.12. **Older People Who Are Housebound**

1.1.12.1. In addition to people who live in hard to reach locations, some older people may be unable to leave their homes because of illness and injury, or even due to limited access to and from their properties. These people may experience additional social isolation and difficulty in accessing information, advice and support.

1.1.13. **Older People and Falls**

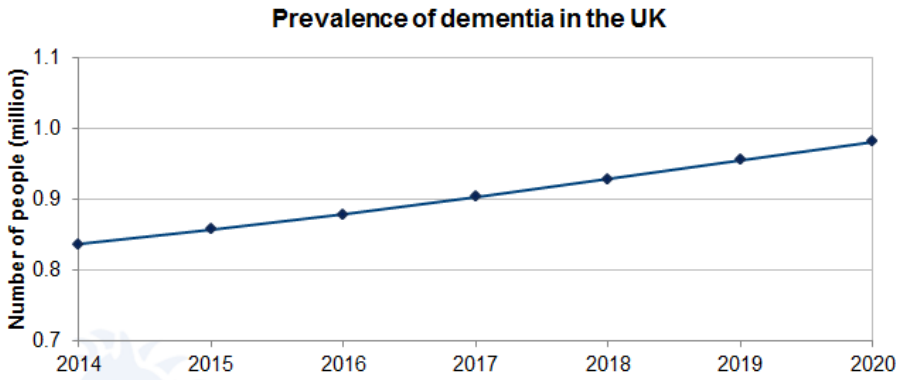
1.1.13.1. Many falls, especially amongst the older population, can be prevented if at risk individuals are identified from the first fall, and interventions put in

place to prevent a second fall. The National Service Framework for Older People (NSF), Chapter 6 "Falls" (2001), highlighted the success and importance of reducing the number of falls that resulted in serious injury by having interventions that target multiple risk factors for individuals such as balance, gait or mobility problems (intrinsic) which can include Postural Stability Services.

2.1. Dementia Profile in the UK

2.1.1. Dementia is an umbrella term used to describe a range of progressive neurological disorders, the symptoms of which include loss of memory, intellect, rationality, social skills and normal emotional reactions.

2.1.2. Dementia currently affects more than 900,000 people nationally and this number is predicted to rise as the UK's population continues to age and grow.



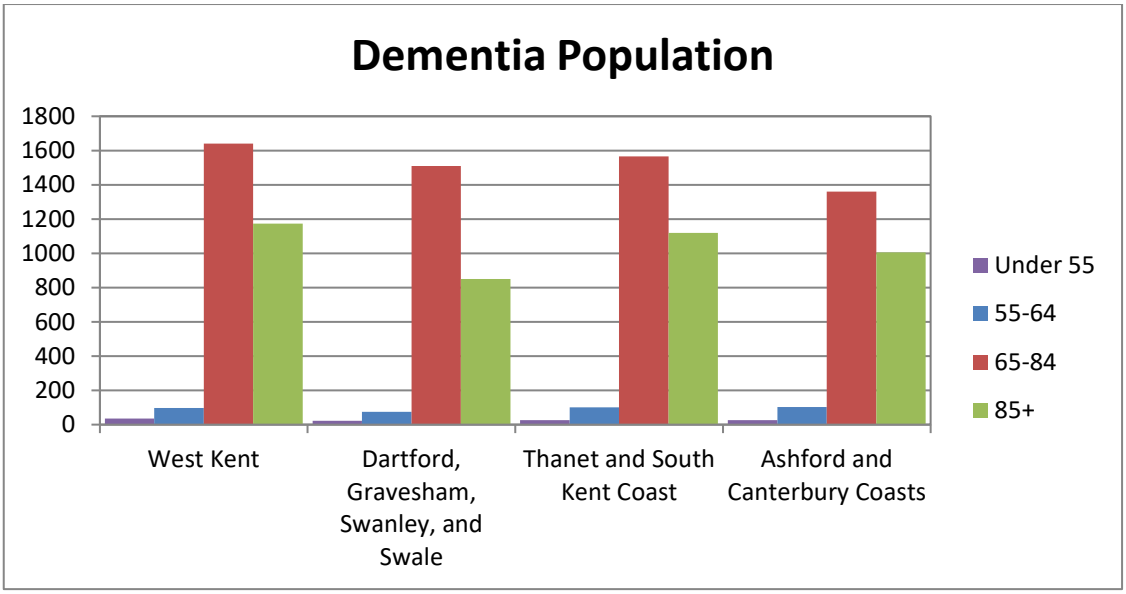
- The **Prime Minister's challenge on dementia 2020** targeted making England: *"the best country in the world for dementia care and support and for people with dementia, their carers and families to live".*

Source: Alzheimer's Research UK, Dementia Statistics Hub

2.1.3. Whilst more prevalent in older age, around 5% of those with a dementia diagnosis have young onset dementia, which it affects people of working age, usually between 30 and 65 years old.

2.2. Dementia in Kent

Kent Dementia Population 55+ as of 31st April 2017					
CCG Area	Under 55	55-64	65-84	85+	Total
West Kent	35	98	1640	1174	2947
Dartford, Gravesham, Swanley, and Swale	22	75	1509	851	2457
Thanet and South Kent Coast	26	101	1565	1119	2811
Ashford and Canterbury & Coastal	26	103	1360	1005	2494
Total	109	377	6074	4149	10709



(Kent Integrated Data Set April 2017)

2.2.1. Of the 12,719 people diagnosed with dementia in Kent, 2,787 received support from Kent County Council in the form of services such as home care and residential and nursing care (figures correct as of April 2017). This number includes people who have a Direct Payment to access dementia day care. There will also be an unquantified number of people who receive services directly from the voluntary and community sector Providers in Kent.

2.2.2. The number of people that have undiagnosed dementia, who receive support from both Kent County Council and from the voluntary and community sector in Kent, is unquantified.

3.1. Carers Profiles

3.1.1. Carers hold families together, enabling loved ones to get the most out of life and making an enormous contribution to society. Many people don't think of themselves as 'Carers'. They see themselves simply as a husband, wife, partner, father, mother, son, daughter or friend looking after someone they love, who needs support. Caring comes in all shapes and sizes and different challenges present themselves depending on the individual in need of their support, the Carer and their needs.

3.1.2. A Carer helps someone cope with day-to-day living. Depending on their condition, the Person they care for might require more help on some days than others. All circumstances are different, but a Carer might help with any of the following:

- Personal care: washing, dressing, taking medication
- household tasks: shopping, cleaning, cooking, laundry
- financial matters: dealing with bills, writing letters
- supervision: watching over someone who can't be left alone
- travel assistance: getting out and about, going to appointments

- emotional support: friendship, listening and advice.

https://www.which.co.uk/elderly-care/for-Carers/being-a-Carer/422457-what-is-a-Carer

3.1.3. Parity of Access for Those Carers Most in Need

3.1.3.1. People living in hard to reach locations such as rural communities, with limited or no transport options, and those people living in deprived communities will experience additional challenges regarding access to working, leisure, social, cultural and spiritual activities in their local and wider community. They may also find it harder to access information and advice about the support and community facilities available to support them in their caring role.

3.1.3.2. There is a link between low social economic status and loneliness. Loneliness can affect people of all ages but being lonely can also become a serious problem when it becomes a chronic day to-day reality which, over time, can grind people down. This can affect their health and wellbeing, and damage people's ability to connect with others.

3.1.3.3. In addition to people who live in hard to reach locations, some people may be unable to leave their homes because of illness and injury, or even due to limited access to and from their properties. These people may experience additional social isolation and access to information advice and support.

3.1.3.4. This service must work towards delivering parity of access for all Carers, regardless of their situation.

3.1.4. Carers with Sensory Loss

3.1.4.1. People may experience some degree of hearing loss and they may consider themselves as deaf, 'hard of hearing' or having 'acquired hearing loss'. This may be due to age-related damage or other causes (such as noise damage, infection, disease or injury). This may affect people's capacity to listen and hear in order to participate in conversations.

3.1.4.2. In comparison, people who are born deaf or become deaf at a young age are considered to have 'profound deafness'. They may consider themselves as Deaf (often referred to as Deaf with a capital D), use British Sign Language (BSL) as their first language and identify with the Deaf community.

3.1.4.3. People may also experience some degree of sight loss as they get older. This may be age-related, or due to a condition such as cataracts or age-related macular degeneration.

3.1.4.4. This service **must** both consider different options and environments needed to support people in the delivery of their service **and** promote consideration of Carers sensory needs to the broader public and private social care sector as well as employers and businesses in general, in collaboration with other Providers i.e. Carers Assessment and Support Organisations, Kent Association for the Blind and Hi Kent.

3.1.5. Carers from Protected Characteristic Communities

3.1.5.1. This service **must** work towards delivering improved parity of access to those in most need in their community whether that be a geographical community or in relation to their protected characteristics.

3.1.5.2. It is important to recognise that people may experience discrimination on the basis of their protected characteristics and other aspects of their identity as well as understanding how different backgrounds and life experiences may shape what is important to people. The Provider **must** ensure the delivery of this service is person centred and actively promotes consideration of Carers' needs to the broader public and private health and social care sector as well as employers and businesses in general, in collaboration with other Providers.

Appendix 6: Information Collection Forms

Information Collection Form A for Community Navigation Services

To be completed at the first point of contact where it is identified no further support is needed

Details of Person Supported/Signposted			
Name		**Date of Birth** (dd/mm/yyyy)	
Full Address			
Postcode		**Telephone Number**	

Details of the Support Needed	
Enter the reason for which support is needed	Please Select
Organisation(s) Person signposted on to	
Organisation(s) Person referred on to and supported to access	

Details of the Referral (if not a self-referral)			
Referral Source	Please Select	**Date of Referral** (dd/mm/yyyy)	

Details of Community Navigator			
Name of Community Navigator		**Date Form Completed** (dd/mm/yyyy)	

A digital or hard copy form may be used to gather the required information. Information Collection Form A will be further refined in coproduction with Providers during the mobilisation phase.

Information Collection Form B for Community Navigation Services

To be completed at the first point of contact <u>where it is identified subsequent support is needed</u>

Details of Person Requiring Support							
Name				**Date of Birth** (dd/mm/yyyy)			
Full Address (including Postcode)							
Email Address							
NHS number (where known)				**Telephone Number**			
Ethnic Origin	Please Select			**Religion or Belief**	Please Select		
Gender	Please Select			**Sexual Orientation**	Please Select		
Marital Status	Please Select			**Does this Person live alone?**	Please Select		
Primary Disability	Please Select			**Does this Person have caring responsibilities?**	Please Select		
Does this Person have Dementia? (Diagnosed or suspected)	Please Select			**If yes, are there concerns around the management of dementia?**	Please Select		
Does this Person have any known medical conditions?	Anaemia ☐	Cardiac ☐	Epilepsy ☐	Kidney Disease ☐			
	Asthma ☐	COPD ☐	Hip / Knee ☐	Stroke ☐			
	Cancer ☐	Diabetes ☐	Hypertension ☐	Other (see below) ☐			
Where other medical conditions are disclosed, please give detail				**Does this Person smoke?**	Please Select		

Details of the Support Needed	
Enter the primary reason for which support is being requested	Please Select
Enter the secondary reason for which support is being requested	Please Select

Additional information provided	
Details of Additional Support Agreed	
Organisation(s) Person signposted on to	
Organisation(s) Person referred on to and supported to access	

Details of Person Making the Referral (if not a self-referral)			
Referral Source	Please Select	**Date of Referral** (dd/mm/yyyy)	Click or tap to enter a date.
Name of Referrer		**Telephone Number**	
Name and Address of Organisation (if professional)			
Address (if non-professional)			
Email Address			

Details of Community Navigator			
Name of Community Navigator		**Date Form Completed** (dd/mm/yyyy)	Click or tap to enter a date.

A digital or hard copy form may be used to gather the required information. Information Collection Form B will be further refined in coproduction with Providers during the mobilisation phase.

Total Initial Score:	
Total Final Score:	

Appendix 7:
Personal Outcomes Recording Questionnaire

Name:		**Date of Initial Score:**	
Telephone Number:		**Date of Final Score:**	

Below are some statements about feelings and thoughts. When responding, please use the following scoring key and choose the answer that best describes how you are feeling:

1 - None of the time 2 – Rarely 3 - Some of the time 4 - Often 5 – All of the time

1 - Access to Information and Advice	**Initial Score**	**Final Score**
I know where to find information and advice that I am confident is accurate and I can easily understand.		
2 - Choice and Independence	**Initial Score**	**Final Score**
I feel independent and confident that I am able to make informed choices.		
3 - Where I Live	**Initial Score**	**Final Score**
I am supported to live safely and independently.		
4 - My Wider Community	**Initial Score**	**Final Score**
I feel included and connected to the communities of my choice.		
5 - Social Inclusion	**Initial Score**	**Final Score**
I am able to access meaningful social activities.		
6 - Managing my Money	**Initial Score**	**Final Score**
I am able to understand and manage my finances, and to apply for benefits related to my needs (including knowing how to access advisory services to support me with my finances if needed).		
7 - My Health and Wellbeing	**Initial Score**	**Final Score**
I have been feeling optimistic about the future.		

I've been feeling useful.		
I've been feeling relaxed.		
I've been dealing with problems well.		
I've been thinking clearly.		
I've been feeling close to other people.		
I've been able to make my mind up about things.		

For question 8 please use the following scoring key when responding:

1 - strongly disagree 2 – disagree 3 – not sure 4 - agree 5 – strongly agree

8 – The Community Navigator's Support	**Initial Score**	**Final Score**
I am optimistic that the Community Navigator will be able to help me.		n/a
The support I received from the Community Navigator helped me to achieve my personal goals.	n/a	

9 – Your Experience (to be completed at the end of the support)
Support Received (e.g. referrals to other services/organisations, community equipment, accompanied visits)
What was good about your experience?
What could have made it better?

10 – How likely are you to recommend the Community Navigator service to friends and family if they needed similar support?					
Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know

A digital or hard copy form may be used to gather the required information. The Personal Outcomes Recording Questionnaire will be further refined in coproduction with Providers during the mobilisation phase.

Appendix 8: Additional Requirements for Service Lot Part A in South Kent Coast CCG

This Appendix should be read in conjunction with the main requirements of the Community Navigation contract detailed in this service specification.

The additional requirements apply only to Service Lot Part A: Community Navigation in South Kent Coast CCG. They do not apply to Service Lot Part B: Community Navigation for Carers, or to Service Lot Part A: Community Navigation in the other CCG areas that make up the East Kent geographical Lot.

The Community Navigators that KCC is looking to commission through this contract will be expected to work alongside those commissioned separately by health.

In South Kent Coast the roles are being jointly commissioned by health and social care. This differing approach means that additional requirements apply in terms of the scope, management and reporting of the contract.

1. Scope of the Role

1.1. In addition to the outline given in *clause 4.*2, the contract will also need to support the agenda of South Kent Coast CCG by helping to integrate health and social care systems through the mechanism of primary care, and deliver person-centred local care by putting people and their families at the centre. The contract will therefore aim to:

- Improve the health, social and wellbeing outcomes of older people and adults with complex needs/frailty, particularly those at high risk, and maintain or increase their independence
- Reduce demands and make more appropriate use of health and social care services.

1.2. In South Kent Coast CCG, the scope of the role will include supporting all younger adults (under the age of 55) who have complex needs / frailty who would benefit from support from a Community Navigator (see *clause 4.3* for further information). In the remainder of East Kent, and West Kent, those under the age of 55 will be supported by exception (see *clause 4.2*).

1.3. Based on the funding arrangements in place at the point of contract award (see section 4 below) it is anticipated that 70% of those supported by this contract will be older people and adults with complex needs/frailty who are at high risk and therefore likely to fall within tiers 2 and 3; 30% are expected to be considered to be a low to moderate level of risk and be referrals for support in the community (including self-referrals and those

that come through KCC ARMS). C*lause 4.2.3* of this service specification gives detail regarding these levels of risk. A Key Performance Indicator will be in place for this contract which will monitor this split.

1.4. Additional objectives to those set out in *clause 4.3* are:

- People are supported to avoid the development of health crises which may necessitate A&E attendance and unplanned hospital admissions.
- People are supported to address non clinical needs, and hence to avoid unnecessary GP appointments, and to make more appropriate use of health and social care services

2. Contributing to Multi-Disciplinary Teams

2.1. South Kent Coast CCG has identified the development of integrated case management delivered through Multi-Disciplinary Team (MDT) working as a priority. Community Navigators support MDT working. Collectively professionals from various services will work together within Primary Care Networks (i.e groups of practices) at scale of approximately 30,000 – 50,000 population.

General information on Local Care MDT working can be found in the Kent and Medway STP documentation available online.

https://kentandmedway.nhs.uk/stp/

2.2. The future model of care delivered through Primary Care Networks will be to develop a single integrated team working in partnership with the GP practices, alongside named health and care staff. They will work together for the benefit of the patient with a focus on identifying what is important for the Person, their family and Carers and how the local system can work together to meet those needs, thereby improving the Person's wellbeing. This is described in Kent and Medway STP as the Dorothy model and/or Esther model.

2.3. As a core member of the Primary Care Networks in South Kent Coast CCG, Community Navigators may participate in reviews of the people on the programme, particularly where a Person's needs have escalated. This enables the whole team supporting the Person to develop and/or adapt a shared care/action plan to meet their needs.

2.4. Through MDT working, Primary Care Networks will work to support patients at the moderate and severe level of need (Tier 2 and 3 in STP definitions) – with proactive case finding utilising tools such as the electronic Frailty Index. In addition, people will be able to self-refer or be directed towards the team's services e.g. by their GP or other members of the team. The role of the Community Navigators in this process will be

mainly with Tier 2 patients (moderate level of need) to improve and coordinate self-care, community care and access to better management of chronic long-term conditions – it is expected that as a result of this intervention people will remain healthier for longer and be less likely to move into crisis. In addition Community Navigators will work with the most vulnerable patients to support access to further services and benefits were appropriate.

2.5. Routinely scheduled meetings will aim to discuss a small number of people who have been proactively identified and/or referred to the Primary Care Network MDT.

2.6. In each Primary Care Network there will be routinely scheduled meetings held for one-two hours to discuss and plan for new patients and review patients on the active caseload. There is an expectation that services will work closely together across the rest of the week to enable patients to be effectively and proactively managed and supported in the community. Their work will be facilitated by a Primary Care Network MDT Coordinator who will be responsible for organising meetings and attendance, and ensuring that appropriate people are identified for support, agreed actions are followed up, and records are in place.

2.7. The key features of this enhanced and integrated approach will be:

- Greater partnership working across Providers to provide more closely coordinated and integrated support to patients in the community
- A focus on long term conditions, public health and ill-health prevention, with greater interaction between statutory, community and voluntary sector interventions.

3. Collaboration with Other Specialist Roles

3.1. The service will be highly collaborative, and Community Navigators will be required to work closely with other specialist posts in the system who carry out a care navigation function. This will include other roles focussing on Carers, healthy lifestyles (One You), housing, information and advice, dementia, mental health, end of life, but also any others relevant to the needs of the Person they are supporting. This approach ensures that accessing these services is simple for the Person, maximises the use of resources, and reduces duplication. It is important that the Person is not passed around the system and that wherever the referral is made the Community Navigator ensures that the correct support is provided by the best and most appropriate service as soon as possible.

3.2. As well as working closely with hospital discharge and rapid response services, it is envisaged that the service will work best where some Community Navigation resource is located within hospital discharge teams. Further consideration will be given to this during the mobilisation

phase and will be dependent on the existence of any additional commissioned hospital care navigators.

4. Outcomes

4.1. *Clause 2.9* details that by working in partnership with Commissioners, the Provider must be able to demonstrate how the service specified has contributed to the following:

- Reduction in the number of people entering social care services unnecessarily
- Reduction in the level of unmet need at the point of referral to social care or health
- Improved outcomes/access to support for people and their Carers as a result of the service delivered by the Provider

4.2. Additional outcomes from a Health perspective include:

- Improved health, wellbeing and independence for older people and adults with complex needs/frailty who are most at risk of unplanned hospital admission
- Improved quality of care
- Improved patient experience
- Reduced avoidable emergency hospital admissions
- Reduced or more appropriate use of primary care and other health services

4.3. Meeting these outcomes will be evidenced by the indicative KPIs detailed in *Schedule 14*, and by looking at both the onwards referrals made by the service, and where people who received support from Community Navigators are subsequently found to be in receipt of health and/or social care services.

5. Contract Management and Reporting

6. Funding Arrangements

6.1. In addition to the investment from KCC, South Kent Coast CCG also intends to fund this contract for a period of 5 years, subject to a review

and break clause at 18 months (30 September 2020), and based on the performance of the contract.

6.2. Should the funding from South Kent Coast CCG not form part of this contract beyond September 2020, then the number of posts funded by this contract would reduce accordingly. At the point of contract award this is as detailed in *clause 4.5*, however, this is subject to change based on the performance of the contract. Should this situation arise, the Provider(s) will therefore be required to work with KCC Commissioners to determine how the funding can be best utilised to meet the social care needs of those in South Kent Coast CCG.

7. Number of Posts

7.1. South Kent Coast CCG's contribution to the Community Navigation Service (Part A) of the contract in South Kent Coast accounts for:

8.3 x FTE (35 hrs), likely to include

- a Snr Community Navigator Lead
- a Triage Community Navigator

7.2. Named Community Navigators should be allocated to each identified group of practices within Primary Care Networks in the first instance to ensure that the Community Navigator can build relationships with GP practices and become part of the MDT. However, there will also need to be flexibility in allocation of staff time across Primary Care Networks in response to variations in locality population profiles and demand, and this will be agreed by Providers and Commissioners during the mobilisation phase and beyond, as required.

7.3. Providers will be asked to propose the best ways of configuring posts to meet the service specification within the available budget. The final allocation of resource will be agreed by the Provider and Commissioners during the mobilisation phase.

8. Staff Qualifications & Training – Additional Requirement for Team Leaders

8.1. In addition to the requirements detailed in *clause 2.15.6*, the Provider must ensure that the team leader for each CCG area holds a relevant national occupational standard such as NVQ Level 3 or equivalent. Ideally this would be in either Health and Social Care or Information and Guidance.

8.2. Those who do not already hold a relevant standard should be supported to achieve the above qualification as a minimum within 1 year of commencement of employment under this contract.

8.3. The Provider must be able to evidence that all Team Leaders are working at the Expert (Gold) competency level across all nine key domains detailed in the Care Navigation Competency Framework.

https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

8.4. Additional competency domains may be added as needed to meet the specific requirements detailed in this Service Specification. These will be agreed with the successful Provider(s) during the mobilisation phase.

8.5. Where Team Leaders are unable to evidence that they are already working at this level, they should be supported to do so within one year of commencement of employment with the Provider, under this contract.

8.6. During the mobilisation phase, contracted Providers will work with Commissioners to agree how best to evidence that the required competency levels are being met. This will feed into *Schedule 14 – Contract Management.*

8.7. It is anticipated that Team Leaders will be required to carry out supervision of the Community Navigators in their team; have non-clinical case management/oversight of the most complex cases; work closely with MDT coordinators; ensure the service is efficient and duplication of roles with other services is avoided. The Provider(s) must therefore consider what additional training and support may be needed by Team Leaders**.**

9. Equality and Diversity – Additional Requirements

9.1. Providers will be expected to work with professional translators/interpreters when required to support people, which will be at the providers own cost, unless KCC have agreed to fund as described in *clause 7.7.1.5.*