In addition to the Equality and Diversity policy, staff are supported by and have access to, various policy and procedure documents such as our Staff Handbook, Anti-Bullying and Harassment, Grievances, Whistleblowing and Pay policies. If necessary, the Discipline Policy and Procedure is also available. These policies can also be accessed by staff on Microsoft Teams. All staff are made aware of new policies and have the opportunity to discuss detail in monthly Team meetings.

All critical information shared to staff, such as an announcement relating to Covid-19 , is also made available in BSL to ensure fair and equal access to information. Managers meet with all staff in supervisions on a monthly basis to check welfare, workload, activity objectives and learning and development. Team meetings are also held monthly to give opportunity for information sharing and transparency across the whole team.

We have developed, designed and delivered bespoke learning and development interventions together with information to support our Health and Wellbeing strategy, all of which is translated into BSL. Using our Learning Management System (LMS) portal, we are able to share e-learning, videos and other accessible communication to all our staff, Deaf and hearing. The content is provided in English, BSL, Audio, subtitles and visual presentations.

We have an internal communication platform (Workplace) which provides all staff opportunity to share information, in English and BSL, for everyone that works at SignHealth.

SignHealth is committed to being anti-racist and we have worked in partnership with external organisations such as Black Deaf UK to set up steering groups to support this work. We are now implementing an Equity, Diversity and Inclusion steering group to broaden this work within SignHealth this year.

It is important to us that all staff are treated fairly and equally, so if any member of staff are found to be in breach of our Equality and Diversity policy, we will take this seriously and the staff member will be subject to disciplinary action. Serious cases of deliberate discrimination may amount to gross misconduct, resulting in dismissal.

SignHealth is committed to adopting a continuous reflective practice approach and monitor the effectiveness of our approaches to ensuring equality of access and opportunity for all staff regularly. Our Cascade HR system enables managers to see at a glance that staff are taking their entitled annual leave, understand sickness levels and to keep track of training requirements and appraisals. Cascade also enables us to run reports to provide us with data according to the subject such as addressing the diversity of the organisation which is checked regularly for monitoring. Monthly supervision sessions provide the opportunity for staff to raise any queries they have in a safe space and discuss with line managers their continuous professional development options.

At SignHealth we understand the importance of intersectionality and the unique lived experience of Deaf people who are, for example, also LGBT and/or part of another cultural community. In our Domestic Abuse service we have worked in partnership with the Home Office to develop a series of short films in BSL on topics such as Forced Marriage, Honour Based Violence and abuse within the LGBT community from a Deaf perspective. These films demonstrate our deep understanding of Deaf people's experience of these issues, which is so often fundamentally different to hearing people's.

"Within the organisation it is great to see such a wealth of diversity and experience. This means I always look forward to coming to work knowing that as a team we are contributing in supporting service user's wellbeing… SignHealth is a very proud organisation to be a member in. The widespread ethos within the organisation is clearly to improve the lives of Deaf people and to remove barriers"

- SignHealth staff member (**link to full story**)

8. Describe how your organisation ensures that all patients are treated fairly irrespective of their age, disability, gender and gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and lived experience, and how you will monitor the effectiveness of your approach to ensuring equality of access, clinical outcomes and experience of the service. *Maximum 2 sides of A4.*

Treating patients and service users fairly and providing equal access to care is absolutely paramount at SignHealth. As an organisation we have 35 years of experience in working with a variety of Deaf people from the Deaf Community across the provision of social care and domestic abuse support as well as our therapy service. We adopt cross-team working approaches and referral processes to ensure that all clients, patients and service users have fair, equal and appropriate access to all services that they need.

All therapists receive regular comprehensive equality and diversity training which includes IAPT for older people, honour based violence, FGM and LGBTQI+ training. Supervision takes place regularly in both 1:1 and group formats where discussions take place around values, identity with a continuous reflection practice approach taken in how we can further adapt to support patients effectively and fairly. This approach is successful, reflected by our excellent recovery and reliable improvement rates, low dropout rate and high satisfactory rates demonstrated within the PEQ.

During assessment we ask patients if they have a preference for the therapist's gender and communication style or if they have any other preferences that we can accommodate such as the best communication platform for their therapy sessions if we are working with them online. We have therapists who identify as LGBTQI+ or who are of Muslim faith and have been successful catering for requests from patients who have requested for these backgrounds and lived-experiences. Our processes also allow for adjustments based on cultural values, age and disability plus dependant commitments when setting tasks for CBT exercises such as being flexible with appointment times and length.

To support the above, our database Iaptus enables us to highlight via patient labels, whether patients are pregnant, have a child under the age of one, if they are transgender, a survivor of domestic or sexual abuse and what their chosen pronouns are so that we can ensure we are offering fully informed support to patients in a manner that is wholly inclusive.

The Deaf community is notably small therefore to enforce fairness and transparency across our service, we also use Iaptus to ensure that there is no risk of one therapist working with or having previously worked with, a patient's family member or partner. As per BABCP and BACP ethical guidelines, therapists do not work with patients that they may know personally in either any current or previous capacity and refer to this in our statement of understanding which covers the risk of meeting patients at Deaf related events.

Our Patient Experience Questionnaire (PEQ) returns meet the benchmark target of 20% and are consistently returning positive responses in relation to how patients feel they were treated by SignHealth staff. During 2020/21, 194 patients completed treatment of which 70 of those returned a PEQ, indicating a 36% return rate.

In 2020/21, more than 97% of patients discharged from our service felt that staff listened to them and felt their concerns were treated seriously at all times or most of the time. Crucially, more than 91% of patients felt that they were both involved in making choices about their treatment and care and received the help that mattered to them at all times, or most of the time.

We are currently working on a BSL version of the PEQs which will enable BSL users to respond in their first language. We also offer options for patients to complete PEQs via hard copy or for a Therapist to translate into BSL in their last session. This allows for fair and equal opportunity for patients to complete PEQs in the manner that the patient feels best suits them.

THE DEAF HEALTH CHARITY SIGNHEALTH

Detailed below is our PEQ return statistics from 2020/21.

	At all times	Most of the time	Sometimes	Rarely	Never	At all or Most of the time
1. Did staff listen to you and treat your concerns seriously?	91.20%	5.90%	1.50%	1.50%	0.00%	97.10%
2. Do you feel that the service has helped you to better understand and address your difficulties?	77.90%	13.20%	4.40%	2.90%	1.50%	91.20%
3. Did you feel involved in making choices about your treatment and care?	79.40%	11.80%	4.40%	1.50%	2.90%	91.20%
4. On reflection, did you get the help that mattered to you?	73.50%	17.60%	2.90%	2.90%	2.90%	91.20%
5. Did you have confidence in your therapist and his / her skills and techniques?	80.90%	11.80%	4.40%	0.00%	2.90%	92.60%

Some examples of written feedback received from our Deaf BSL patients:

"It really helped me in the worst period of my life. I am very grateful to Therapist & the SignHealth service"

" I feel more confident with therapist and trust her 100% she is a wonderful woman to be honest 100%"

"I had a fantastic therapist and I couldn't ask for better than that"

1. Staff Training

• Which accredited IAPT courses have the staff attended and passed?

PWP

[redacted]

- Postgraduate Certificate in Advanced Practice in Psychological Wellbeing, Surrey University November 2020

[redacted]

- Postgraduate Certificate in Improving Access to Psychological Therapies in Primary Care, Liverpool John Moores University 2014.

HIT

[redacted]

- Postgraduate Certificate in Improving Access to Psychological Therapies in Primary Care, Liverpool John Moores University 2013
- Postgraduate Diploma in Cognitive and Behavioural Therapies: High Intensity Training, University of Chester 2018
- IAPT Supervisors course UCLAN, 2015
- Currently working toward BABCP accreditation*

[redacted]

- Postgraduate Certificate in Improving Access to Psychological Therapies in Primary Care, Liverpool John Moores University 2013
- Postgraduate Diploma in Cognitive and Behavioural Therapies: High Intensity Training, University of Chester 2018
- IAPT Supervisors course UCLAN, 2015
- Currently working toward BABCP accreditation*

*There have been issues with gaining suitable CPD that was accessible in BSL during the Pandemic with many organisations including BABCP and BACP not providing BSL interpreters or captions on their webinars. We were informed that it would take time to implement and advised to look at other CBT providers. However, we received the same response from other CBT providers. BABCP have now provided one webinar which is captioned. Hopefully this will lead to more CPD events being accessible.

Management

[redacted] (HIT Team Leader)

- CfD Counsellor training programme, Keele University 2015
- IAPT Couple Therapy for Depression, Tavistock Relationships, 2016
- IAPT Supervisors course UCLAN, 2015

[redacted] (Clinical Lead)

- Clinical Psychology (High % of CBT Components), University of Liverpool 2011
- Postgraduate certificate in CBT for Primary Care, High Intensity IAPT Programme 2012

- EMDR, Michael Paterson, 2016
- IAPT Supervisors Course, Liverpool John Moores University 2011
- IAPT Supervisors course UCLAN, 2015.

• Are all staff trained on IAPT accredited courses for each of the therapies they will offer? If not, where are the shortfalls and what do they intend to do to remedy them?

Yes, our clinical staff are appropriately trained for the therapies they offer.

We currently have no IPT provision which is something we will look at for our HIT Team Leader in the future. We are also committed to increasing our EMDR capacity over the next twelve months enrolling our CBT therapists on the course.

2. ADSMs

• The PHQ and GAD have been translated into BSL. Has this been done for ADSMs? If not, when will it be done?

The translation was a project done in conjunction with SORD (Deaf Research Team) at Manchester University there are no current plans to translate any further measures. Any further projects would require funding.

• Do you currently use ADSMs?

Yes, we mainly use IES/PCL-5, OCI, SPIN and HAI for the clinical presentations our patients are currently presenting with. Our therapists will use whichever ADSM is appropriate for treating each patient and translate this into BSL for their patient.

Our clinical database Iaptus allows patients to complete their questionnaires digitally. However, the majority of our patients require these to be translated into BSL, which is why we have extended sessions times. Not all ADSMs have been translated into BSL. At present we offer options for a written version that clients can fill in before the sessions or for us to relay this into BSL which we do during session times. As a result, our sessions are between 45 minutes to 60 minutes.

Clients can populate an ADSM before a session in either written English or BSL and they are encouraged to do so in order to prioritise session time for therapeutic work whenever possible and appropriate.

3. Process and Outcome measures for the IAPT patients IAPT SignHealth have already treated (either in total or over the last 12 months)

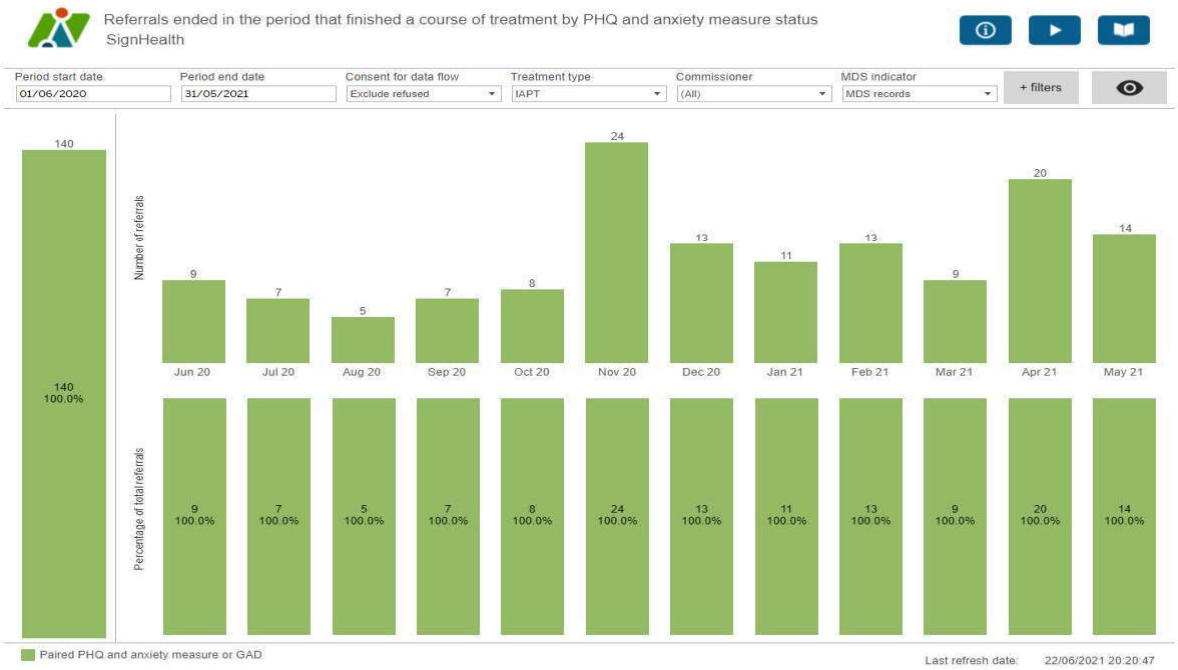
We would like to see the following information:
Period 1 June 2020 – 31 May 2021.

• Total number of patients seen at least twice

140

• For everyone seen at least twice, the paired data completeness and problem descriptor completeness rates

Paired PHQ and GAD 100%



Problem Descriptor – 100%

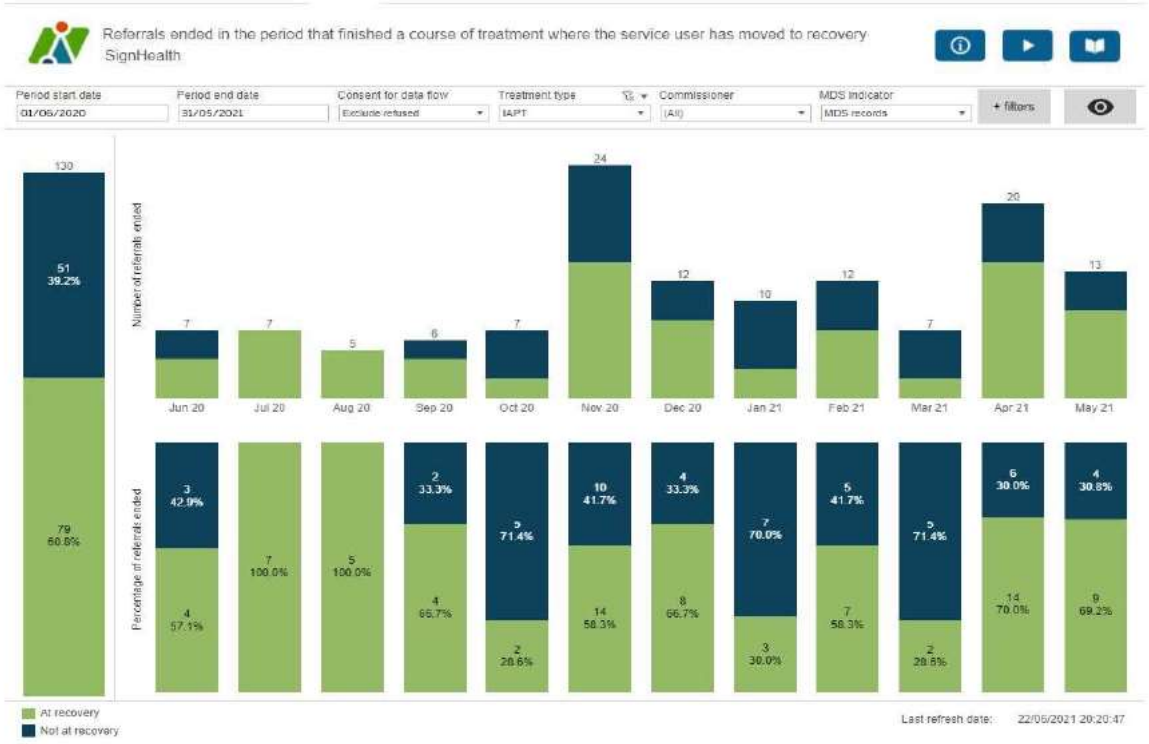
• For the total cohort of people seen at least twice, the proportion who reliably improved and the proportion who reliably deteriorated

Reliable Improvement – 73.6%

Reliable Deterioration – 8.6%

• For the total cohort of people who were seen at least twice and were in caseness at the start of treatment, the proportion who recovered

See chart on next page.



130 at caseness, 79 recovered – 60.8%

Previous three years:

	20/21	19/20	18/19
Recovered	56%	56.4%	58.8%
Reliable Improvement	73.1%	65.5%	72.0%
Deterioration	8.4%	13.1%	7.2%

• The average wait time to start treatment

108 Days to start treatment, on average we waited 114 days to get a funding decision.

• The average number of days between clinical appointments

40 Days between first and second clinical appointment, again funding decisions impact this calculation. Sometimes the first session is approved and we have to reapply for further treatment sessions.

• The average number of sessions (and range) for people who had a course of treatment (i.e. seen at least twice)

The average number of sessions was 9, the range 2 – 21 Sessions.

• **The distribution of problem descriptors**

F321 - Moderate Depressive Episode	7.1%
F400 - Agoraphobia	0.5%
F401 - Social phobias	0.5%
F411 - Generalised Anxiety Disorder	13.0%
F412 - Mixed anxiety and depressive disorder	59.2%
F431 - Post-traumatic stress disorder	16.3%
Other F40-F43 code	3.3%

SignHealth understands that the accuracy of problem descriptor recording, particularly F412, must be improved upon, and we will welcome the opportunity to work with NHS England on this. We have made changes to some of the problem descriptors for our current clients and will be using appropriate labels going forward.

4. National coverage

• **Up to now, there is no coverage in the South West and very little in the East of England. How do SignHealth propose to create some face-to-face therapy provision in those areas to ensure patient choice of delivery is achieved?**

SignHealth are aware of South West NHS services having a Deaf BSL Counsellor working out of Bristol and Somerset Services. This is a key factor in why we have no referrals or arrangements in these areas and have not concentrated on it before.

In the East of England we have a freelance non IAPT counsellor based there who would not work on this contract, but has treated many clients in the area.

To create face-to-face provision throughout the whole of England seems impractical, we cannot provide a therapist in every geographical area currently and we must concentrate on where there is a high volume of Deaf patients. It is important to note that local therapists, in particularly small Deaf communities, will more than likely know the patient; our online offer reduces the possibility of knowing the client significantly.

Our experience of offering sessions online only during the pandemic, and delivering more sessions than ever before, shows us that Deaf people are ready and willing to access therapy remotely. However, we would like to ensure we are engaging all parts of the community. We have a Community Engagement Officer whose role is to increase referrals to all of SignHealth's services, particularly therapy referrals from older Deaf people.

SignHealth will focus the training and recruitment of new trainees in regions where we have limited provision.

5. Vulnerability to service disruption

• **Therapist numbers are small and in any given geographical area, are very small (often just one person).**

How does Sign Health plan to manage if a key person leaves, is off on long term sick, goes on maternity leave etc.

SignHealth has a unique challenge in comparison to Core IAPT hearing services as we do not have the ability to get short term provision from agencies. In our planned recruitment expansion two new posts are both part time so this should give flexibility to scale up capacity at times when needed. We have also planned our group uptake numbers very conservatively, should uptake be successful for group work, we will then increase the number of participants in each group to increase capacity.

SignHealth understands that the recruitment expansion, especially that of new trainee places, is key to minimising service disruption and expanding the BSL IAPT workforce. A partnership approach from SignHealth, NHS England and Health Education England is needed to successfully implement this. The number of compliant IAPT trained staff who have the required BSL skill is extremely low, but we have already identified two qualified PWPs who can be added to the current team.

SignHealth is a unique specialist organisation, 75% of our staff are Deaf BSL users and need to be to deliver their roles successfully. We deliver registered social care services and domestic abuse support services where we are used to the relationship between the service user and the professional being really critical. Therefore, we have a great deal of experience in managing capacity issues caused by staff absence when it occurs. We have a specialist HR team who are used to supporting managers with these issues and we have well established recruitment networks across the Deaf community that we make good use of. Our staff turnover is low, particularly in our therapy team.

At SignHealth we see our staff as the jewel of the organisation and we understand that looking after our employees is key to our success. SignHealth is investing double last year's budget in supporting colleagues to learn and develop their skills; our new e-learning platform in BSL is just one example. We believe in keeping and developing people, not replacing them.

6. Computerised CBT platform

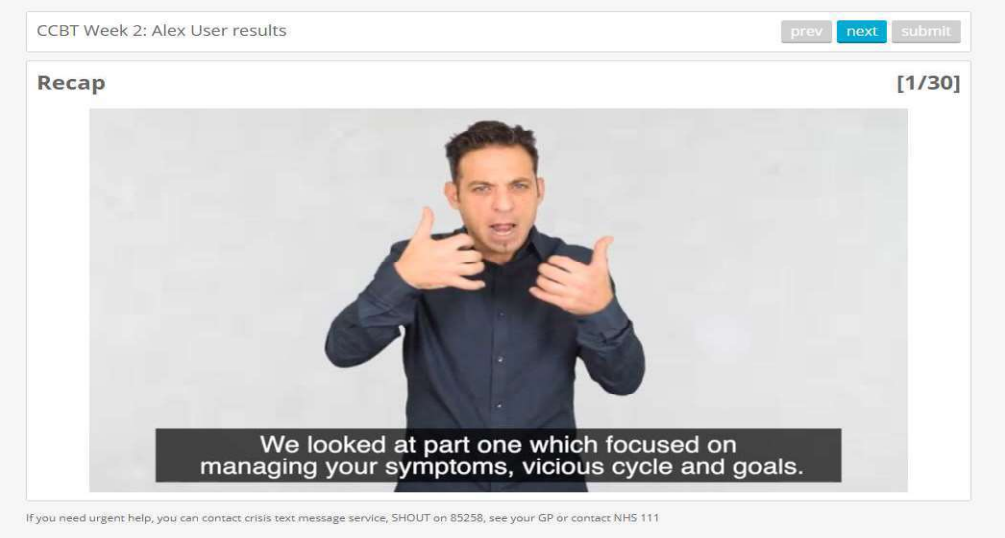
• Can we see the evaluation of the tool from Bradford NHS Trust?

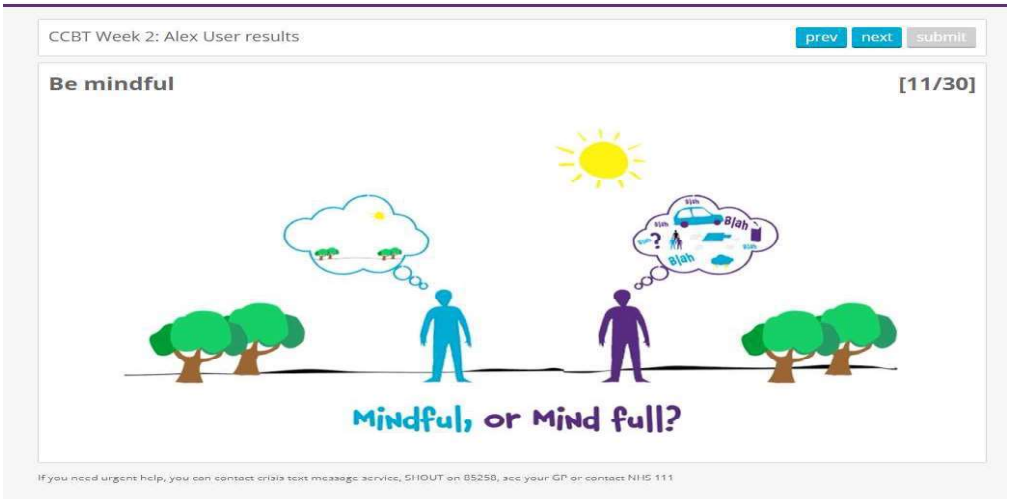
The Principal CBT Therapist has currently checked the Depression content and provided a report with changes we should consider and further content that has been developed will also be sent for feedback. The main reason for doing this was to check that the underlying CBT was evident throughout the course.

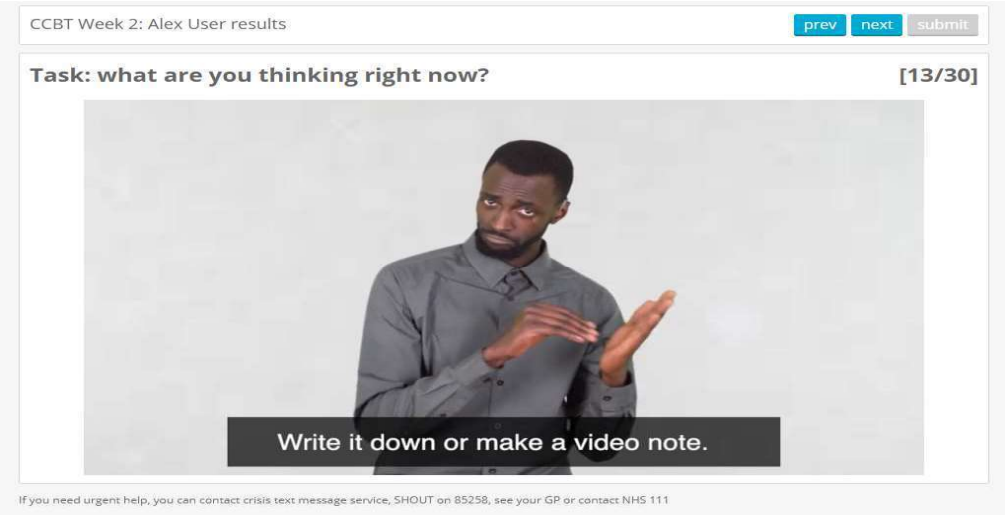
Our cCBT content is produced in BSL, it is subtitled and interactive, patients can upload their own signed videos.

The platform is still in development and has not yet been evaluated through user testing.

The next page shows some screen shots of the content:







• Have they gone through NHSX's DTAC assessment for the tool?

No, we have not gone through this tool since its launch earlier this year. We have contacted our developer and we aim to complete this with their help as this is a new tool that we were not aware of.

7. Advancing equalities in IAPT services

• What is the current breakdown in terms of ethnicity and age of those who are referred to their service, and those who are treated?

Ethnicity	Referral	Treatment
White	51.0%	75.4%
Mixed	2.7%	1.6%
Asian or Asian British	9.6%	14.8%
Black or Black British	2.2%	4.9%
Other Ethnic Groups	0.4%	1.1%
Not Stated/Known/Missing	34.1%	2.2%

Age	Referral	Treatment
< 30	26.7%	27.2%
31 - 45	41.6%	45.1%
46 - 64	26.7%	23.4%
65+	5.1%	4.3%

• Can they expand more on their thinking re. targeted approaches to attract ethnic minorities?

SignHealth is working hard to become an anti-racist organisation, developing anti-racism structures within the organisation. We are committed to supporting and recruiting more people from BAME backgrounds, with the aim to increase the number of people of colour working for and accessing our services. We know how important it is for people to see themselves reflected at all levels of our organisation and we have worked hard to ensure that SignHealth is Deaf-led - we now have a Deaf person as Chair and a majority of Deaf trustees. Our focus is now on ensuring that we have ethnic diversity at all levels of the organisation and we are just in the final stages of recruiting two Deaf people of colour as new trustees onto our Board. Our current Executive Leadership Team of four people includes two people of colour.

SignHealth are working hard to ensure that Black Deaf people are aware of our services, working in partnership with Back Deaf UK to promote awareness and access.

The organisation is on a journey to increase and embrace diversity looking at the intersection of the Deaf community with other protected characteristics, our organisation is Deaf-led at all levels.

Our community engagement officer is a person of colour, who is focusing on engaging with Deaf communities throughout England to raise awareness about SignHealth's services, with a focus on Mental

Health and our Therapies, so they know how to go about making a referral. Her work includes targeting Black Deaf groups as part of our approach to ensure our services reflect diversity.

Delivering a diverse range of therapists is a very big challenge when the community is small, and the number of people who are qualified is also small, but we are absolutely determined to meet that challenge. Recently We have recently recruited a PWP who is a person of colour. We want to discuss with NHS England and Health Education England about encouraging learning and training opportunities for Deaf people of colour to become future IAPT trained therapists; and working with training providers to make the IAPT courses accessible and Black Deaf culturally appropriate.

We will want to engage with other Deaf provider organisations, using our developing anti-racism strategy as an example, to discuss joint workforce recruitment drives to attract and increase the intake of Deaf people of colour to work for us as well as others.

To ensure that we actively include the LGBT+, we are working with Deaf Rainbow UK a specific organisation that helps the LGBT+ Deaf community that was co-founded by one of our colleagues. Our therapists have lived experience of this community, which helps us understand the issues these patients can face. We are also proud to have a prominent [redacted] and we are working with her to develop training for the organisation on Deaf trans people.

Our Domestic Abuse team recently produced a series of short films with the Home Office that included issues crucial to this topic, such as abuse of LGBT+ people in the Deaf community and how honour based violence and FGM issues exist in different cultures within various sub-community groups in the larger Deaf community.

We will focus more on data in the future, examining the demographics of our service users across our service types, working with a diverse range of staff to identify gaps and issues with marketing of services.

8. Workforce

• Can we understand a bit more re. their current workforce in terms of how long they have been working with the organisation?

	Length of Service (Years)
Head of Psychological Therapies & Advocacy Services	3
Clinical Lead	10
HIT Team Lead	6
HIT CBT	9
HIT CBT	9
PWP	8
PWP	<1
Administration Lead	11
Senior Administrator	12
Administrator	2
Administrator	1
Senior Advocate	18

• Why have people left (if applicable)?

The last clinical employee to leave was in early 2018 due to a restructuring of the team, prior to that, only one therapist had left on their own accord since the service began in 2011.

• What plans they have to support growing the BSL workforce within IAPT more widely in the longer term (although unsure we can query this given what Russell was saying yesterday?)

SignHealth would welcome the opportunity to work with NHS England and Health Education England in facilitating IAPT training in BSL. Replicating the course that originally took place at Liverpool John Moores University again would be advantageous to Deaf BSL users. Our Clinical Lead [redacted] has a wealth of experience in assisting Universities and tutors with trainees.

9. 'Step 4'

• Can we have further information on the clinical presentations you are referring to when they mention 'Step 4' patients?

Patients are currently presenting at Step 4 with chronic depression or anxiety, complex PTSD with multiple trauma and some will have the EUPD label attached. Emotional deregulation with maladaptive coping strategies including DSH or substance misuse. Some are referred from local psychology services where they are unable to work with client due to the specific language and cultural needs of a Deaf patient. Some patients are under CMHT and will have a CPN, we also see patients who are stepped down from tertiary services and are in need of psychological therapy.

When a patient is stepped up from Step 3 to Step 4 the episode of care is finished on Iaptus and a new one starts. The new Step 4 episode of care is marked as 'non-iapt' to ensure that data is not sent to NHS Digital or included on any IAPT reporting. SignHealth will continue to source funding for Step 4 patients via IFR's to CCG's, no Step 4 activity will be included in this IAPT contract, and no Step 4 activity has been included in our bid.

10. Costings

• Cost per head currently equates to 2-3 times more per person than a core IAPT service. What is the rationale for this significant difference?

There are a number of reasons:

- Core IAPT services are generally designed for hearing not Deaf people, hence a gap in the need for a specialist service that is linguistically and culturally appropriate
- Delivered by people who are experts by experience (i.e having lived experience as a Deaf person or growing up with Deaf people), as well as being qualified therapists
- A national service requires more travel and therefore less time for sessions – the number of Deaf BSL users are small nationally but are significantly spread out geographically.
- Online fatigue for BSL users so sessions tend to be longer to facilitate breaks or more of these are needed
- Lack of self-help materials in BSL and lower awareness within the community of current topics

This is a very specialist service, providing a service to a very small community, and doing it in a culturally appropriate way. For SignHealth this is not just about communication directly in BSL, it is about Deaf culture. SignHealth can provide a staff team and a service that is linguistically and culturally appropriate; this is really critical and is a very difficult thing to do. We also take into account language deprivation which is often seen in our clients due to lack of mother tongue (90% of all deaf children are born to hearing parents). This is not something that could be done simply via BSL interpreter. Lived experience of Deaf lives and an understanding of the gaps in knowledge due to world and social knowledge commonly seen amongst these clients is crucial.

In providing a national service, our therapeutic caseloads are smaller in comparison to core IAPT services. Our therapists travel many miles per annum delivering our service to the Deaf community which naturally reduces the output levels. Group work has not been implemented to Deaf BSL IAPT patients before, core IAPT services dramatically reduce their cost per head by reducing the amount of one-to-one contacts they do.

Also, a key factor is online fatigue. Our Deaf BSL therapists have to carefully monitor the amount of clinical sessions they do per day via online video. Therapists communicate directly in BSL which means they have to fully focus on the video, they cannot take their eyes away from the screen during that clinical session otherwise the conversation thread is lost. Hearing therapists in core IAPT services can naturally glance away from screens and still follow the conversation.

Preparation time, as well as the therapeutic session itself takes longer. There is no Book on Prescription in BSL and very few self-help materials in BSL. Only at SignHealth are there some self-help materials in BSL but there are less than 20 videos compared to thousands of self-help materials in the wider mainstream. Deaf people often miss out on general conversations undertaken by non-deaf/hearing people who often talk about 'hot/trending' topics from radio programmes or overheard conversation thus leading to a lack of informal education and gain of knowledge. Most television programmes are also not in BSL which makes recognition and self-care of our own mental health more problematic in the early stages. All therapists have to adapt their materials to suit their level of literacy and emotional understanding, and this is done pre and post session. Early sessions are often focused on psychoeducation which is crucial for patients to understand what is happening and why it is happening. We feel this has worked well and have seen low dropout rates, excellent recovery/reliable improvement rates as a result.

The cumulation of the above means our caseloads are smaller so the amount of people we treat each year per therapist is lower in comparison to core IAPT services meaning the cost per head is higher. Providing a national service to Deaf BSL users naturally brings additional costs such as travel, additional room hire, translation and interpretation, keeping a sense of togetherness when based throughout the country.

However, we are very pleased to see NHS England tender for this service having discussed these issues with your colleagues for a number of years, as well as having lobbied and petitioned government ministers and back benchers and campaigned with the Deaf community for a properly funded BSL IAPT service. We have therefore responded to your tender in line with your commercial expectations of minimum numbers of clients within the budget indicated for this service.

If we are awarded this contract we would be pleased to work with NHS England on the information provided above to ensure that there is a consistent set of key messages that adequately explain the cost of this specialist service.

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

N/A

1.0	**Enhanced Health in Care Homes Requirements**

1.1 Primary Care Networks and other providers with which the Provider must cooperate

[ ] PCN (acting through lead practice [ ]/other)
[ ] PCN (acting through lead practice [ ]/other)
[other providers]

1.2 Indicative requirements

By 31 July 2020, agree the care homes for which it has responsibility with the CCG, and have agreed with the PCN and other providers [listed above] a simple plan about how the service will operate.	YES
Work with the PCN and other relevant providers [listed above] to establish, by 30 September 2020, a multidisciplinary team (MDT) to deliver relevant services to the care homes.	YES
Work with the PCN to establish, as soon as is practicable, and by no later than 31 March 2021, protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.	YES
From 30 September 2020, participate in and support 'home rounds' as agreed with the PCN as part of an MDT.	YES/NO
Work with the PCN to establish, by 30 September 2020, arrangements for the MDT to develop and refresh as required a personalised care and support plan with people living in care homes. Through these arrangements, the MDT will: • aim for the plan to be developed and agreed with each new resident within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale); • develop plans with the person and/or their carer; • base plans on the principles and domains of a Comprehensive Geriatric Assessment including assessment of the physical, psychological, functional, social and environmental needs of the person including end of life care needs where appropriate	YES/NO

• draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; • make all reasonable efforts to support delivery of the plan	
From 30 September 2020, work with the PCN to identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows.	YES/NO
From 30 September 2020, work with the PCN to support discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27.	YES/NO

1.3 Specific obligations

[*To include details of care homes to be served*]

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

See Provider Tender response

D. Essential Services (NHS Trusts only)

N/A

G. Other Local Agreements, Policies and Procedures

N/A

J. Transfer of and Discharge from Care Protocols

N/A

K. Safeguarding Policies and Mental Capacity Act Policies

NHS England Safeguarding Policies In addition to complying with local Safeguarding Policies, provider's policies on safeguarding should comply with NHS England's safeguarding policy and must meet the requirements set out in the 'Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework'. Both these documents together with other NHS England safeguarding policies and documents can be found on the NHS England website via the link: https://www.england.nhs.uk/safeguarding/policies-annual-report/