SCHEDULE 4.1

SUPPLIER PROPOSAL

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INDEX

1. Purpose

1.1. The purpose of this Schedule is to set out the Supplier's response to the Authority's requirements, providing detail on how the Supplier will deliver the Services.

1.2. The Supplier shall deliver the Services in accordance with the provisions of this Schedule and any other applicable part of the Agreement, and shall comply with any reasonable requirement of the Authority in this respect notified to it by the Authority from time to time.

1.3. Any statements in this Schedule that the Supplier "will", "shall" or "must" do any thing, or that any thing "will", "shall", or "must" be done (or similar expressions), mean that the Supplier is under an obligation to do that thing, unless expressly provided otherwise in the Agreement.

Part A – Operating Model

2. Operating Model

2.1. The Supplier will ensure transition and mobilisation occurs with minimal disruption by stabilising, maintaining, and improving performance levels.

2.2. The Supplier will ensure that Leadership is active, visible and supportive by providing clear direction both internally and to the widest range of external stakeholders.

2.3. The Supplier will provide Claimant-focused services by:

2.3.1. engaging with representative groups; and

2.3.2. seeking and acting upon feedback where the Supplier believes it appropriate, or by otherwise engaging with the Authority.

2.4. The Supplier will work in partnership with the Authority to innovate and enhance the Claimant journey by applying insight and analytics to improve all end-to-end processes.

2.5. The Supplier will provide a market-leading health and clinical governance structure by focusing on securing a professional clinical workforce delivering the service, and by supporting individual Claimants across the wide range of assessments.

2.6. The Supplier will work stabilise the Service within the first 100 days following the Operational Services Commencement Date, by securing the following:

- Improvements to staff morale;
- Enhanced levels of Claimant engagement and satisfaction;
- Growth in the resource base to meet the Annual Volume Target for Service Delivery Year 1.

<u>Organisational Delivery</u>

2.7. The main Business Support Centres (BSCs) in major urban areas will continue to be supported by the existing enhanced national network of Assessment Centres (ACs). They will continue to operate as central hubs, processing and administering the referrals, performing triage and conducting scrutiny assessments.

2.8. The two Virtual Contact Centres will continue to supplement the BSCs and ACs.

2.9. The Supplier will work with its Sub-contractor EC Harris to undertake an estates review throughout the first six (6) months following the Operational Service Commencement Date to identify and recommend an estate infrastructure solution (which shall then be implemented in accordance with Schedule 15.1 (Estates)).

Planned Innovations

2.10. The Supplier will introduce planned innovations as follows on the dates identified in the table in Annex 3 of Schedule 6.1 (Mobilisation and Resource Plans):

- introduce a new service website from the Operational Service Commencement Date, which will involve a health literacy review and rewrite of web content and key written communications. This will enable Claimants to better engage and understand processes;

- implement a Claimant charter from the Operational Service Commencement Date, to communicate the principles of Claimant service;

- rollout [REDACTED] disability awareness from Service Year 2 by delivering an all-staff training programme to secure additional skills;

- establish a Disability Resource Centre during Q2/2015 in order to provide bespoke, professional training materials for HCPs and (as originally agreed) DMs. Subsequently the Parties agreed that relevant disability resource training material will be provided to DMs via Master-classes as set out in Paragraph 4.27;

- introduce a new questionnaire support team during Q2/2015 in order to increase completion of ESA50/UC50 questionnaires, and provision of FE;

- introduce enhanced Claimant surveys during Q3/2015 in order to facilitate in-depth analysis and segmentation, which will lead to improved satisfaction levels;

- increase HCP FTE in accordance with the resourcing plan in Schedule 6.1 (Mobilisation and Resource Plans) between February 2015 and February 2016;

- increase HCP training resources capacity (including where required with Clinical Standards Leads (CSL's) by 26 FTE. The Supplier will accommodate the training requirements of all new HCPs. The Supplier will achieve this by 30 April 2015. The Supplier will thereafter maintain a level of training resource sufficient to accommodate the training of all new HCPs and for the purposes of Service Delivery Years 4, 5, 6 and 7, this shall be estimated as 21 FTE;

- training classroom capacity within the existing estate to be increased by 100 seats by 31 March 2015;

- provide an Assessment Attendance Taskforce during Q2/2015 to address DNA/loop cases and reduce the number of these cases;

- conduct a health and wellbeing review including long-term sick during Q2/2015. This will aim to reduce sickness rates from [REDACTED] to [REDACTED] by the date which is six (6) months from the Operational Service Commencement Date and [REDACTED] by the end of Service Delivery Year 1. In addition, it will ensure reduced long-term absenteeism and a healthier, more productive workforce by the end of Service Delivery Year 1;

- conduct a HDAS leadership and talent review during Q3/2015 in order to achieve enhanced leadership capability to drive service improvements;

- provide Executive Training during Q4/2015 in order to demonstrate investment in leadership and protect knowledge base;
- establish a training and medical education committee (TMEC) during Q3/2015 in order to improve training and reduce HCP drop-out rate;
- implement a Clinical Quality Improvement Plan during Q3/2015 in order to oversee the safe introduction of OTs and liaison with DWP audit function, and rollout of functional champions;
- introduce MI solution during Q2/2016, which will provide enhanced analytics to drive more consistent operational performance;
- develop the Digital Vision high level business value analysis and high level feasibility (Q1/2017). Business cases subject to request from DWP. Analytics and operational impact analysis to allow business cases to be requested and approved for Digital rollout in the remainder of the Term if requested.

<u>High-level delivery structure</u>

2.11. The Supplier's Business Services Director will work with an enhanced MI and analytics team in order to secure data-driven continuous improvement.

2.12. The Supplier's Programme Director will report directly into the UK General Manager. Reporting lines and Key Personnel are set out in Schedule 9.2.

<u>Distribution of work across supply-chain Sub-contractors and/or directly contracted self-employed HCPs</u>

2.13. The Supplier will directly engage with sessional doctors and manage their availability and skills mix.

2.14. The Supplier will offer sessional doctors an immediate increase in fees of [REDACTED].

2.15. Sessional doctors will continue to be scheduled by the existing national resource management team.

2.16. The Supplier engaged 2 Sub-contractors to focus on London, South and Central England. The 2 Sub-contractors collectively delivered up to 5% of the annualised WCA assessment volume target between them performing only F2F assessments. Supply chain HCPs worked within existing assessment centres. Contracts with these Sub-contractors were terminated on 31st January 2017 in respect of Medacs and 12th March 2016 in respect of Dependability.

2.17. The Supplier's operations will adhere to the MERLIN standard and extend the MAXIMUS approach to supply chain management.

Scheduling and delivery of appropriate assessments by appropriate HCPs, in appropriate locations

2.18. The Supplier will provide Claimants needing to have a F2F assessment with an appointment at a convenient time, date and location based upon information they have provided.

2.19. During Service Delivery Year 1 and Year 2, the Supplier will use the then existing appointment scheduling process, but will introduce a number of improvements, which include:

- Sending Claimants SMS reminders (from Q3/2015) utilising the tactical solution proposed by the Supplier (as specified in 'Implementation Plan for the 'Tactical SMS Solution, November 2015', as included in Controlled Correspondence CHDA COR055, the ("Tactical SMS Solution"));
- Encouraging appointments at times where the service has additional capacity (e.g. evenings and weekends);
- Supporting those Claimants with mental health conditions to engage with the process (e.g. completion of their ESA50/UC50 and attendance at appointments).

2.20. The Supplier will use data analytic tools to manage workflow capacity within the service by moving cases between sites and regions where paper scrutiny

can be undertaken in a timelier manner due to excess capacity at any point in time.

2.21. The Supplier will initiate an ‘intelligent-scheduling’ review to more effectively schedule Claimants with the goal of reducing levels of did not attend (DNA), unable to attend (UTA) and Claimants “looping” through the service.

2.22. Scheduling teams will use the data that is held within the Medical Skills Database to ensure that all work is carried out by suitably skilled HCPs.

2.23. The Supplier’s Clinical Director and clinical quality team will ensure that appropriate assessments are completed by members of multidisciplinary clinical teams.

2.24. Results of audits and case reviews will be analysed and good practice shared throughout the ‘one team’ that includes both the Supplier and, where applicable, its supply chain Sub-contractors, with any areas needing improvement subjected to corrective action.

Claimant Services Processes

2.25. The Supplier will appoint a new role; ‘Head of Claimant Experience’, whose role is to ensure the quality of the Claimant experience is at a high standard.

2.26. The Supplier will ensure that all Claimants are treated with dignity and respect at all stages through the assessment journey. This is in line with the Supplier’s Claimant Charter.

2.27. The Supplier will track levels of complaints, analyse their cause and take corrective actions.

2.28. The Supplier will conduct Claimant demographic analysis and work with disability stakeholders to obtain input on the service design.

Gathering Further Evidence

2.29. The Supplier will use its best endeavours to improve the quantity and quality of FE obtained compared to that obtained by the Exiting Supplier, by obtaining detailed FE from GPs and other practitioners who know the Claimant. This activity will be supported by the questionnaire support team to be established by the Supplier, who will be tasked with collating more FE at the earliest stages of the process.

2.30. The Supplier will introduce a new clinical 'GP engagement strategy' to develop strong relationships with key clinical stakeholders e.g. BMA, GMC, RCN, GP Consortia, and Local Authority Care Services.

2.31. The Supplier will increase the amount of medical evidence collated early in the process and reduce unnecessary downstream F2F assessments.

Delivery of all assessment services

2.32. The Supplier will work with the benefit-specific experts to ensure stability and continuity.

2.33. The Supplier will also use a range of specialist providers for the expert clinical procedures that need to be provided – audiology and HAVS reports.

Approach to and timescales for change

3. Flexibility of Service

3.1. The Supplier will take action on the following four core components to enable the service to meet short, medium and long term fluctuations in demand; resources, estate, digital solutions and process.

Resources

3.2. The Supplier used quality supply chain Sub-contractors (described in Schedule 4.4 (Third Party Contracts) and Paragraph 2.16 of this Schedule) and sessional resources for additional capacity in targeted geographies (initially London, Central and South regions).

3.3. By leveraging BPM, the Supplier will monitor forecasts and apply resources as efficiently as possible to align appropriate resources with the volumes forecasted.

Estate

3.4. The opening of new assessment centres to augment existing accessibility of the estate will improve the Claimant journey by introducing assessment centres in areas of geographic need and enhance the daily throughput capacity of the service driving a reduction in waiting times once the need for a F2F assessment has been identified.

3.5. The Supplier will undertake a review with the Authority on the potential for a more accessible estate approach for Claimants. The review will focus on targeting extended assessment centre opening hours, e.g. 8am to 6.30pm, and weekend working where appropriate and where demand justifies such an approach.

Digital Solutions

3.6. The Supplier's IT Director will work with the Authority to develop detailed plans and business cases for digital solutions

Service Capacity Flexibility

3.7. The Supplier will review the volume targets for Service Delivery Year 2 onward with the Authority in the fourth quarter of Service Delivery Year 1 and discuss with the Authority any resulting re-baselining of the contracted volumes and determine a mutually acceptable change to the targets such that the IBR re-assessments currently on hold could be re-introduced in a planned and achievable flow.

3.8. The Supplier will target attrition and absence rates from the Operational Service Commencement Date. [REDACTED]. In addition, the Supplier will tackle long-term absence within the first 100 days of the service cutover.

3.9. The Supplier has modelled their solution to allow non-doctor HCPs to carry out assessment on an off-LiMA basis (per the recent Authority decision). The Authority shall quality assure and reserve the right to approve the training for such non Doctor HCPs once received from the Supplier. The Authority will not unreasonably withhold or delay such approval.

Healthcare Professional Delivery Performance Expectations

3.10. The Supplier will ensure the delivery performance of HCPs is not compromised while carrying out proposed service re-engineering activities.

3.11. The Supplier will:

- introduce E-learning programmes covering company policy and legal requirements.
- introduce, following Authority business case approval, E-learning (including Claimant service modules) for new entrant training, delivering the dual benefits of reduced training time (as per the business case submitted to the Authority) and accessibility to a wider pool of HCP recruits who can be recruited, trained and productive in reduced timescales;
- develop teams of HCPs at a [REDACTED] line management ratio for RN's, Physiotherapists and Occupational Therapists, at a [REDACTED] line management ratio for Doctors, and [REDACTED] admin / support staff to [REDACTED] service delivery lead, and recruit senior HCPs into the Line Manager roles;
- deploy active monitoring targeted at specialist HCPs engaged in delivering non-ESA cases to ensure that sufficient capacity is maintained at all times; and
- take steps to attract HCPs by developing a remuneration package, CPD, and a collegiate professional environment in order to reduce attrition to [REDACTED] and deliver higher volumes.

Part B – Claimant Journey

4. Claimant Journey

4.1. The Supplier has designed a process and approach for mapping the Citizen Journey™ to help identify and facilitate Claimant interaction with organisations, which can reveal opportunities for improvement and innovation in the Claimants' experience.

Design Rationale

4.2. The Supplier has two overarching principles to their Claimant Experience design:

1) To significantly improve the engagement levels of all Claimants, particularly those with mental health, fluctuating and degenerative conditions; and

2) To improve the experience of Claimants who *do engage*, ensuring that their experience is as positive, personalised and empathetic as possible, one which takes account of all Claimant needs in a consistent manner.

4.3. The Supplier will a) deliver clear communication materials across multiple access channels, b) offer practical help to Claimants (form completion, signposting to further sources of help and advice, reminders, assistance at centres), c) prioritise securing more FE in order to lead to a more informed, holistic assessment and d) train all Claimant facing staff in disability awareness and soft skills.

Meaningful Engagement from the start

4.4. The Supplier will highlight the need for Claimants to provide FE at the earliest stage. The Supplier will help support the Authority to encourage their staff to reinforce these messages.

4.5. The Parties agree that the Authority reserves the right to request that the Parties work towards implementing a solution which will enable the Supplier to telephone all Claimants who have not returned their ESA50/UC50 within 10

days of receipt to remind them to send in the ESA50/UC50 and to offer assistance (particularly to those with mental health conditions) in completing the forms required.

4.6. The Supplier will also signpost Claimants to other sources of help – e.g Citizens Advice Bureau, Mental Health charities and other advocacy groups.

4.7. The Supplier's HDAS Claimant portal will provide additional information and support, with communication tailored to many of the groups they serve.

Provision of Information

4.8. The Supplier will review key documents to ensure they provide clear information and guidance by the Operational Service Commencement Date.

4.9. During December 2015, the Supplier will introduce the Tactical SMS Solution to provide appointment reminders. Subsequently, a business case will be submitted to the Authority by the Supplier for SMS automated Services being the automated SMS services to welcome Claimants to the service, telling them where their referral sits in the process, providing appointment reminders and advising when their case is completed and what to expect next (the "Steady State SMS Solution"). This business case will be submitted by 16 May 2016. Subject to business case approval by the Authority and systems integration, both Parties will agree a date (to be in January 2017) from which the Supplier will introduce the Steady State SMS Solution. In the event that the Steady State SMS Solution is not approved by the Authority, the Tactical SMS Solution shall continue to be delivered by the Supplier until the end of the Term.

Attendance at assessment centres

4.10. The Supplier will minimise the level of non-attendance by introducing a number of initiatives. The key initiative will be the setting up of a joint Assessment Attendance Taskforce. This group will consider action in the following four areas:

4.11. Engagement: The Parties agree that the Authority reserves the right to request that the Parties work towards implementing a solution which will enable the Supplier to make at least three attempts to contact Claimants who have not returned ESA50/UC50s.

4.12. Evidence: the Supplier will record all activity carried out to encourage attendance and make it available to Decision Makers (DMs) in order for an informed judgement to be made on "good cause". The Supplier will work with DMs on repeat 'non-attenders', to take proactive action to complete the process and prevent 'looping'. For example, considering if a home visit is more appropriate.

4.13. Post appointment review: The Supplier will analyse DNA data to establish if there are trends in geography, appointment times, type of disabling condition, age or gender and use this analysis to inform future practice. The Supplier will introduce data analytics to inform intelligent scheduling, ensuring session construction is based on as much evidence of predictable behaviour as possible.

4.14. Clinical expertise: The Supplier will carry out a full programme of 'Disability Confident' training in Service Delivery Year 2 and ensure that Claimant-facing staff treats Claimants appropriately.

Consistency of Claimant experience

4.15. The Supplier will ensure that its supply chain Sub-contractors operate under appropriate SLAs and contractual requirements.

4.16. The Supplier commissioned a full 'Tier 1' supply chain – with assessments being provided by Medacs until 31st January 2017 and Dependability until 12th March 2016 when the Supplier agreements with each were terminated.

4.17. Where used, these Sub-contractors will be fully engaged in the process, and understand the full Service Specification requirements: they will follow the required processes, be subject to relevant SLAs where appropriate, and will use the same recruitment and training materials approved by the Authority.

They are mandated to use the same statistically valid Quality Control measures and will be subjected to rigorous quality audit by the Supplier's in-house team (as well as through the new Assessment Audit process).

4.18. Claimant and Authority feedback relating to supply chain provision will be reviewed and where necessary improvement measures taken.

4.19. The Supplier will share best practice across the supply chain and back into the Supplier's delivery model.

4.20. The Supplier will share best practice across BSCs and ACs.

4.21. Claimants will not perceive any differences between being assessed by an employed or sessional HCP or by any of the HCPs provided by the Supplier's supply chain Sub-contractors.

4.22. In order for Claimants to know what they can expect when doing business with the Supplier, the 'Claimant Charter' will be visible to all Claimants, on the Supplier's website, in written communications and displayed in assessment centres.

<u>Understanding differing health conditions and the impacts on delivering the Claimant journey</u>

4.23. The Supplier's proposals for the service include:

- the role of Functional Champions will be extended to cover fluctuating and degenerative conditions, addictions and sensory impairments. The role of functional champions will be kept under constant review to ensure they remain relevant and valid over the life of the contract as the profile of Claimants may change over time;

- the Supplier will provide specialist support for Claimants with sensory needs through offering large print facilities and Braille copies of documents. The Supplier will ensure all ACs have access to hearing loop facilities and will ensure that its service complies fully with requirements of

the Equality Act 2010. The Supplier will provide interpreter services for people who need sign language support – both at the initial claim stage) and at the AC;

- the Supplier will establish a 'Disability Resource Centre' portal accessible by all staff, which will outline approaches, adjustments and techniques for engaging with people with different health conditions; and

- the Supplier will roll out specialist disability awareness training to over 2000 claimant facing staff by the end of Service Delivery Year 2. The Supplier's partnership with [REDACTED] will ensure the Supplier's rollout of specialist Disability Awareness training to over 2,000 Claimant-facing staff (including HCPs) by the end of Service Delivery Year 2 to ensure that they understand and accommodate any specific requirements individuals have – at all stages of the assessment process.

Accommodating Claimants with mental health issues

4.24. The Parties agree that the Authority reserves the right to request that the Parties work towards implementing a solution which would enable the Supplier to implement reminder calls and texts designed to help all Claimants (including those with mental health conditions) to send back their completed ESA50/UC50s. Calls will be made to ascertain any problems and to offer assistance. The Supplier will also remind Claimants to send in FE – and how to obtain this. If Claimants do not know how to gather this FE, the Supplier will help them to source it.

4.25. The Supplier will extend the current number of Mental Health Champions to 24 to provide greater support to frontline HCPs (both to Supplier staff as well as our supply chain). These champions will be an expert resource for HCPs and for frontline non-clinical staff (receptionists and call centre agents). The champions will also be available to give advice and support to Authority staff so that the Supplier can ensure that there is much greater awareness of challenges faced by this client group across the process.

4.26. From the Operational Service Commencement Date, the Supplier will set up an HDAS Disability Resource Centre accessible by all staff, which specifically provides e-learning modules on a wide spectrum of Mental Health conditions, to include depression, bi-polar, stress / anxiety, Post Traumatic Stress Disorder, eating disorders, schizophrenia and psychosis. The list will be added to over time and as the service evolves.

4.27. Master-classes which will include relevant disability resource centre training material, delivered by functional champions, will be available to DMs, to help educate, problem solve and innovate in order to improve delivery team knowledge and Claimant service experience. Master-classes will be held monthly throughout the term of the Agreement previously agreed to commence October 2016 and now agreed to commence September 2017. They will be recorded as an 'archive of expertise' for access throughout the life of the contract, as well as being made available to DMs.

4.28. The Supplier's CRG will be made up of a cross-section of advocacy groups and the Supplier will ensure representation from the leading mental health charities in order to inform best practice.

4.29. Claimant satisfaction surveys will provide feedback from specific Claimant groups. In Service Delivery Year 1 the Supplier analysed how people with mental health conditions have found their experience and act on these findings as part of the Supplier's approach to Continuous Improvements to the Claimant journey.

<u>Dealing with Claimants with additional requirements and non-clinical</u>

4.30. The Supplier will use a translation service for those Claimants whose first language is not English, or if the Claimant needs a sign language interpreter.

4.31. The Supplier will endeavour to schedule an HCP of the same sex as the Claimant particularly in areas where the culture has many female Claimants who could feel uncomfortable being assessed by a male HCP.

4.32. The Supplier will comply with the requirements of the Welsh Language Act for Claimants who live in Wales.

4.33. The Supplier will provide increased audio tape recording facilities for Claimants who request these at face to face assessments. The Supplier has provisioned for a minimum of 6 units per BSC to be distributed as required to ACs within their region. This service will be provided within a controlled process with a copy of the tape being made available to the Claimant upon request F2F assessments.

4.34. The Supplier will also ensure that when attending assessment locations that the design of the centre takes account of physical and mental conditions by putting in place specially designed chairs, accessible entrances, rooms and waiting areas and simple visual notices to aid understanding.

Handling Claimant and Authority feedback

4.35. The Supplier will carry out a comprehensive review during Service Delivery Year 1 to ensure that feedback loops are fit for purpose – i.e. that they offer the opportunity to provide sufficient information on which to plan Claimant journey improvements.

4.36. The Supplier's Claimant Relations Team will coordinate investigations into issues raised and respond to complaints within contractual timescales and to defined quality standards.

4.37. The Supplier will analyse complaint data and trends will be identified, action plans created and these will include personal performance management programmes, enhanced training and updated communications.

4.38. The Supplier proposes to undertake liaison with national and local representative groups.

4.39. The Supplier will have regular meetings with Authority staff to enable direct feedback to be provided about the service both at a local and regional level.

4.40. The Supplier will also analyse all re-work sent back by DMs and develop corrective action plans.

Part C – Staff Resources

5. Resources to Support Delivery Model

5.1. The Supplier will maintain a capacity planning and resourcing model which will aim to identify the correct level of resources for all elements of the assessment service to deliver the Services in accordance with the Service Levels.

5.2. The Supplier will analyse previous demands, monitor trends and attempt to establish regular joint forecasting with the Authority to aid capacity planning.

5.3. The Supplier will offer all staff clearly defined career paths, a commitment to supporting continuous professional development (CPD) and competitive salaries.

Organisational Design, Management Hierarchy and details of Senior Management Team

5.4. The HDAS Service Delivery team in the UK will be supported in the US by the Supplier's affiliated companies and parent company leadership.

5.5. The Supplier will undertake regular checkpoints and reviews to ensure that delivery is in line with client expectations.

Skills and Experience relevant to each role

5.6. The table below sets out key roles within the Supplier's service delivery structure and the essential skills required for each role:

Key Roles	Essential Skills and Attributes
Leadership Team Member	Excellent communication skills, inspirational leader, visionary, creates an open and inclusive team, provides clear direction and leadership
Senior Manager	Motivational leader, people management skills, professional,

– Clinical	knowledgeable, can communicate with internal and external stakeholders of all levels
Senior Manager – Non Clinical	Motivational leader, people management skills, professional, knowledgeable, can communicate with internal and external stakeholders of all levels
HCP - Trainer	Professional, knowledgeable, clear and concise communicator, at ease with technology, team-player, clinically competent, accurate, personable, confident presenter and facilitator
HCP – Assessor	Professional, knowledgeable, clear and concise communicator, at ease with technology, team-player, clinically competent, accurate, personable
HCP – Auditor	Professional, knowledgeable, clear and concise communicator, excellent attention to detail, approachable, clinically competent, accurate
Middle Manager – Clinical	Lead by example, team worker, motivational, excellent communicator, people management skills
Team Leader	People management skills, decision making, analytical, approachable, inclusive, clinically competent
Admin staff	Diligent, personable, team-worker, approachable, problem solver, flexible, accurate, and at ease with technology
Contact Centre Agents	Professional, knowledgeable, clear and concise verbally, at ease with technology, team-player, effective time management skills
Assessment Centre staff	Personable, approachable, articulate, diligent, accurate, ability to work on their own and using their own initiative, at ease with

	technology, effective time management skills

Summary

5.7. The Supplier will constantly track their assumptions based upon live data and experience and revise the model once it is clear that an assumption has changed over the medium term.

5.8. To aid the forecasting process, the Supplier will also deploy an operations performance monitoring system. This will provide a granular view on historic and current workflow, enabling highly accurate modelling for forecast and capacity planning.

6. Recruit and Retain Multi-Disciplinary Workforce

Planning and capacity management

6.1. The resource management team will ensure available HCP resources are matched with the demand for assessments.

6.2. HCPs will be allocated tasks by local Managers based upon their skills and the level of work required, taking into account all relevant SLAs.

6.3. Employed staff will be allocated tasks in the first instance and then sessional Drs will be used flexibly to supplement resource requirement.

6.4. The task of resource planning will take place daily.

6.5. Local managers will get a daily MI report that indicates which cases require urgent action. Decisions will be taken to reallocate HCPs from less urgent activities to ensure that urgent cases are cleared.

6.6. The Supplier will establish the level of resource required at a regional level, Assessment Centre level and postcode level for those Claimants who need to be seen at home. The Supplier will gather information about the availability of HCPs at specific locations and compare it against the level of work required to be completed. In areas where resource gaps are identified, generation of additional capacity will be considered. Approaches include:

- **Increase resources**: The Supplier will extend the service beyond normal working hours and incentivise the current team to give additional capacity. If increase in demand is deemed to be long term then the Supplier would undertake a geography specific recruitment campaign with its recruitment suppliers.

- **Movement of people**: When the Supplier finds that capacity issues are related to a specific geography, the Supplier will reallocate clinical resource to problem areas and ask HCPs to travel.

- **Movement of work**: When there is capacity in areas with no performance issues, the Supplier will move the work.

6.7. NOT USED.

6.8. The contracts with supply chain Sub-contractors will be based upon them completing a pre-defined volume of assessments within a specific geographical area and the Supplier will set targets for them to ensure that forecast availability is in fact delivered.

6.9. The Supply Chain Manager will monitor performance of the Sub-contractors to ensure that they meet contractual requirements.

Skills requirement planning

6.10. The Supplier will assess the skill sets of all transferring staff and match competencies to roles from the Operational Service Commencement Date.

6.11. The Supplier will undertake a needs analysis within 6 months of the Operational Service Commencement Date, followed by a targeted training programme to ensure any skills gap is narrowed quickly and effectively.

6.12. The skills identified by the Supplier will be reviewed regularly over the life of the contract.

6.13. In order to effectively utilise the skills and experience of existing HCPs, the Supplier will carry out an audit of the Medical Skills Database (MSD), in conjunction with individual HCPs. Identification of skills shortages in any benefit line will, where suitable candidates are identified, result in arranging for existing HCPs being trained to take on the technical assessments required.

6.14. The Supplier's supply chain Sub-contractors will recruit HCPs to the same standard and skill levels as Supplier to ensure that there is standardisation of competence across the service.

6.15. The Supplier will track skill development within their Sub-contractor organisations at an individual, as well as corporate level through the results of their audit activity and feedback process and will record outcomes in MSD.

6.16. The Supplier will carry out a training need analysis to encompass skills development of the HCPs and will share this with the Authority annually.

6.17. The Supplier will measure "Time to Hire" as a KPI for recruitment suppliers.

Incentives to encourage retention

6.18. The Supplier has tailored a reward and incentive programmes and proposes an approach in each of these areas:

- **Pay**: [REDACTED].
- **Accessibility of training**: The Supplier will increase the number of locations from which training is delivered, thus reducing the need for travelling time and for overnight stays.
- **Professional support**: The Supplier will highlight to all HCPs that this is a clinically led business delivering a clinical contract wherein staff are valued, supported and developed in a collegiate and professional work environment, making the transition from traditional healthcare provision smoother.
- **Job perception**: The Supplier will work closely with representative bodies across the multi-disciplinary professions to build professional credibility of the service to promote the career choice of becoming a disability assessor
- **Staff security**: The Supplier will carry out a full safety and security audit of the estate in conjunction with EC Harris. The Supplier will ensure there is transparent communication of the Supplier's and the Authority's stance on zero tolerance to unacceptable claimant behaviour (UCB).
- **Adverse stakeholder reaction**: As approved by the Authority, the Supplier will provide Claimants more information earlier and all information will be

reviewed and modified where possible to make it easier to understand. The Supplier will engage actively with stakeholders to ensure mutual understanding of processes and areas for improvement. The Supplier will work closely with the Authority to ensure there are joined up messages regarding the role the Supplier plays in the decision making process around benefit eligibility and payments.

- **Recognition**: [REDACTED]

6.19. The Supplier will offer London staff a [REDACTED] “London Weighting”.

7. HCP Retaining necessary skills

Approach to Training

7.1. In order to attract and recruit the required numbers of HCPs for Service Delivery Year 1, the Supplier will continue to use the then-current approach to deliver training and professional development from the Operational Service Commencement Date whilst a full review of training materials is undertaken and improvements identified and agreed with the Authority for implementation in Service Delivery Year 1.

7.2. The Supplier will use the Authority's national network of training centres.

7.3. Until 12 September 2015, to enable the effective introduction of their supply chain Sub-Contractors, the Supplier will train their HCPs alongside the Supplier employed HCPs, and the HCPs recruited and employed by Pertemps People Development Group.

7.4. Supply chain trainers will use the same Authority approved training resources and materials to ensure consistency and standardisation. They will be supported by experienced HCP trainers throughout induction so that the quality of their approach and technique meets the Supplier's required standards.

7.5. To ensure that standards are met, the Supplier will evaluate the effectiveness of this approach by setting clear KPIs for supply chain Sub-contractors. These will measure the length of time it takes to get their HCPs to the point of obtaining approval, benchmarking this against standard norms. The Supplier will carry out a fundamental review of all training materials and match these to the requirements of the service – improvements to the format, content and delivery of training will be made in Service Delivery Year 1. The Supplier developed an initial business case by the end of Service Delivery Year 1, which was finalised in Service Delivery Year 3, to move all training guides, materials and content to a virtual learning environment (e-learning): a Massive Open Online course which will enable people to learn effectively using a

blended range of methods such as simulated 3D e-learning, quizzes, self-directed learning and peer to peer learning via discussion forums and which business case is subject to approval by the Authority.

7.6. A summary of the Supplier's training improvements is set out below:

Mobilisation	Appointment/training of additional training staff prior to "go live"
First 100 Days	Training materials amended to reflect Supplier changes (wider Functional Champions, Disability Resource Centre).
	Analysis/revision of the WCA PT training modules to reflect introduction of OTs to the service; the Supplier appointed [REDACTED] as external advisor for this work
	Creation/approval of Training & Medical Education Committee
Day 100 to Month 12	Development/design of new training products/delivery methods
	The Supplier will liaise with the Authority regarding the creation of business cases for the introduction of a virtual online learning environment

7.7. The training and CME training strategy will be owned by the Supplier's new Training & Medical Education Committee (TMEC). This group will comprise internal and external experts in health, disability and government legislation/policy.

7.8. The TMEC will be responsible for defining the training and CME strategy for the service (which will include annual Training Needs Analysis and Training Plans). The TMEC will oversee the production and maintenance of existing training material utilising the inherited expertise from the current supplier. The committee will also be responsible for future training development so that it is

tailored to changing Service and Authority requirements and clinical practice remains evidence based.

Guidance – including production and maintenance

7.9. The Supplier will ensure that each HCP has access to the guides (appropriate to the benefit assessments they carry out). Each guide will be reviewed annually to ensure its' relevance and fitness for purpose so that the guidance material remains up-to-date. The Supplier will agree a programme of review with the Authority during the transition period. The Supplier will house the guides on their intranet knowledge hub to enable easy access.

Assessment of HCP initial competence

7.10. The Supplier will carry out new starter training, supervision and mentorship using the Authority-approved syllabus. All HCPs undergo a clinician-led competency-based interview, which covers their recommended approach on specific and relevant clinical scenarios.

7.11. The Supplier will select practitioners who meet the necessary skills and behaviours required for carrying out functional assessments. Each HCP will then be taken through a quality assurance process which has 4 stages: Stage One – the formal classroom training programme; Stage Two – passing test based upon a Multiple Choice Questionnaire; Stage Three - completion of a supervised real-life assessment; Stage Four - achievement of the quality standards in an unsupervised situation. Stage Four will take place in an AC where the trainee will work closely with a mentor conducting assessments in a supportive live environment. Once they are considered ready for approval 100% of their completed reports will be audited. Prompt constructive feedback will be provided throughout the process so the trainee can achieve the required minimum of at least four grade A and one grade B reports in any sequence of 5 consecutive audits for Authority approval as soon as possible.

7.12. The Supplier's training programme will continually reinforce the importance of softer skills such as empathy, body language and motivational interviewing

techniques, in order to improve the client experience. Throughout this quality management process the Supplier will collect evidence that competency has been achieved and present the evidence to the Authority, requesting approval for the specific benefit assessments. The same approach is applied to any new HCP trained to do paper-based reviews, TI referrals or any of the non-WCA assessments.

7.13. Once an HCP is approved they will enter the national random audit process, where a selection of their work is audited (without their knowledge) and/or subject to case review and results are fed back to them quickly.

7.14. All HCPs will understand that their work is subject to a thorough, fair quality checking regime.

Management of Approval Process, Probationary Period and revocation process

7.15. Prior to seeking HCP approval by the Authority, local CSLs, ACMs, AQALs and CALs will undertake a thorough review of performance to date to ensure breadth and depth of assessment experience and eligibility for approval. The Supplier will gather all necessary evidence to prove that competence to successfully meet the standards for each specific assessment has been achieved. Evidence will include audit and case review result reports, a record of support provided to the HCP, additional training offered, the results of their clinical scenarios from the selection process and full details of their past clinical experience. The Supplier's clinical team leads will work closely with newly approved HCPs to ensure on-going adherence to policy and monitor assessment and report quality.

7.16. If there are reasons to question ongoing competence e.g. level of complaints received or increased levels of DM and peer feedback, the level of case reviews will be increased. In cases where an HCP has been placed on a formal and written performance improvement plan for quality issues, they will be placed back into audit in addition to case reviews. This would be referenced by the Supplier as "Targeted Audit". Once audit results have been

analysed and discussed with individuals, they will be expected to show that improvements have been achieved before audit ceases.

7.17. If issues with competence do not improve following the provision of additional support (mentoring, training, audit and feedback) the Supplier would begin to invoke the revocation process. Each HCP will be subject to a probationary period through our normal performance management appraisal system.

Continuing Professional Development (CPD)

7.18. The Supplier will implement a plan for continuous professional development (CPD for individual HCPs. The Supplier's approach is designed to offer individuals the opportunity to tailor their CPD to their own interests/specialties within the work they are doing, whilst meeting the needs of the Authority. All Personal Development Plans (PDPs) will be constructed in agreement with line managers and HCPs will be required to provide evidence of CPD and an overview of how their actions will lead to achieving the objectives set out in their PDP. HCPs will also receive ongoing feedback and appraisal.

7.19. The Supplier's Continuing Medical Education (CME) activity and CPD programme also ensures compliance with the Doctor Revalidation requirements and upcoming Nurse Revalidation process.

7.20. The Supplier will ensure that as part of the contracting terms/ terms of employment all supply chain Sub-contractors and sessional doctors will conform to the requirements of their regulatory and professional bodies. The Supplier will work closely with them and share their CPD approaches, training and materials where appropriate.

Monitoring and assessment of ongoing competence of HCPs

7.21. The completed work from an approved HCP will be subject to ongoing case review. HCPs will be totally unaware in advance of the cases chosen, to ensure that normal practice is subjected to a thorough check. The result of this review (good or bad) will be fed back to the HCP so that on-going high quality assessments can continue to be delivered.

7.22. Case reviews will also be undertaken on all approved HCPs on a regular basis, the frequency and volume of which will be determined by the Supplier. The Supplier will maintain Case Review documentation that specifies the criteria for determining the level of Case Reviews expected to be completed on each HCP depending on their recent performance and risk of producing poor quality assessments. The Supplier will document the results of each Case Review in a format that indicates whether each Case Review is acceptable or unacceptable along with capturing any types of error made.

7.23. Clinical Standards Leads (CSL), Assessment Centre Managers (ACM), Area Quality Assurance Leads (AQALs) and Clinical Assurance Leads (CAL) will take other opportunities to review HCPs work e.g. while visiting HCPs at assessment centres, when individual HCPs seek additional feedback, and while speaking to DMs about completed reports.

7.24. CSLs, ACMs, AQALs and CALs will also take the opportunity to listen into phone calls, read reports, and observe behaviour, the results of which will be discussed with the individual. Professionally high standards of competence will be acknowledged and rewarded and lower standards will attract supportive improvement actions.

7.25. CSLs, ACMs, AQALs and CALs will also use clinical MI to ensure HCPs are conforming to expected outcomes and this data will be shared with individuals. The positive use of clinical MI is critical in ensuring consistent reports are produced nationally across all benefit streams.

7.26. All managers will receive coaching training and on-going support. HCP line managers will be given skills which will enable constructive feedback to be provided so that recipients can respond in a positive and co-operative way.

Record Keeping and evidence of retention

7.27. Supplier record keeping - and that of their supply chain Sub-contractors - will support clinical and corporate governance processes in ensuring HCPs have and retain all necessary skills, experience and competencies.

7.28. All HR documentation will be retained in line with corporate policy and systems. The Supplier will keep records maintained to the same standard for sessional doctors and supply chain Sub-contractors. All records are subject to the requirements of the Data Protection Act 1998. The Supplier will use the current repository for Medical skills and information, the MSD (medical skills database). The Supplier will use and maintain MSD following completion of an initial audit of each HCP to ensure information is accurate and up to date. The Supplier will make available to the Authority the processes, which they will follow at the required intervals over the life of the contract.

7.29. The Supplier will ensure that evidence is retained in support of actions e.g. audit results, feedback, complaints, appraisals and investigations. These records will be retained securely, available as required by HCPs and team leaders as part of the revalidation process.

Part D – Assessment Quality

8. Assessment Quality

8.1. To meet the Authority's key priority for a stable and de-risked transfer of service, the Supplier will build upon the current clinical quality approach in a measured manner with any changes supported by analysis and justified evidence. All dates below are calculated from the Operational Service Delivery Date.

Identification of quality improvement actions, and ensuring these are undertaken

8.2. The Supplier will make the following improvements in clinical service delivery:

Initiative	Benefit	Timescale
Deliver Clinical Quality Improvement Plan	Consolidated view of all early improvements ensures transparency progress	By Month 6 as part of CIP
Increased number and roles of function champions	24 mental health champions, new champions for addictions, degenerative and fluctuating conditions.	By month 6
Develop and rollout GP engagement strategy	GP practice mapping, messaging to increase provision and quality of Further Evidence	By month 6
Establish External Clinical Governance Board	External panel advises on CQIP and ongoing clinical quality	By Day 100
Introduction of Occupational therapists	Increases available resource pool for service, mitigates risk of resource scarcity	By month 6

Establish Case conferencing process between HCPs and Decision Makers (DMs) 1. Phone conferencing 2. Online pilot/rollout	Improved feedback loops lead to clearer DM decision making and reduced loop cases.	Case Conferencing (Operational service Commencement Date) Pilot Review – completed August 2015 Requirements Review – Q3 Service Year 2 to determine future requirements with the Authority
Rollout Disability Resource Centre for HCPs and DMs 1. Initial rollout 2. Ongoing refresh	Provides online repository of tools and materials to better inform disability awareness	By end of Q2 Service Delivery Year 2 Annual refresh
Clinical leadership and talent review	Shows transferring staff value placed in knowledge and future development opportunities, Reduces leadership attrition	First 100 days
Executive Management Programme	Provides leaders with range of skills needed to transform service and sustain performance	By end Service Delivery Year 1

Walkgrove – e-learning modules for HCPs	Virtual learning environment for all HCP training	End Service Delivery Year 2 Business case
Clinical Knowledge Management System – Utilise the existing LiMA repository while LiMA remains available. In the event LiMA is no longer available, put a business case together for a replacement Clinical Knowledge Management System when requested to do so by the DWP.	Intelligent knowledge store accessible to all HCPs.	CHDA will update the LiMA repository within 2 weeks of being made, or becoming aware of medical advances impacting on the repository. CHDA will provide a business case within 3 months of the request for a business case being made by DWP.
Training and Medical Education Committee	Professional body oversees and assures quality of all training	By month 6

8.2(a) In respect of the Knowledge Management System referenced in the table above, the LiMA Repository will be updated within two weeks of becoming aware of medical advances which impact the repository. To maintain up to date knowledge in medical advances, the Supplier will routinely review 3 sources of “update” source material. These are the McMillan review of new

developments; the BNF in relation to therapeutics; and the regular "what's new in the journals" review from Drs.Net.

8.3. To ensure that clinical quality improvements receive priority, the Supplier will implement a Clinical Quality Improvement Plan (CQIP). This plan will be owned by the Supplier's Clinical Leadership team, with input from their Clinical Governance Board and in co-operation with disability groups and wider stakeholders.

8.4. The Supplier's Clinical Leadership team will also work closely with their Business Services Director to ensure that as they prepare and design future change business cases, they ensure the views of the clinical staff, and the potential impact on clinical training, performance and quality are thoroughly analysed, understood and communicated.

8.5. The continuous improvement plan will include improvements identified through a) a comprehensive quality control and quality audit regime, which will identify improvement opportunities at individual, site and regional levels and b) a greater emphasis on feedback loops with DMs, Claimants and wider stakeholders.

Provision of advice and clarifications to decision makers

8.6. The Supplier will prioritise closer working between HCPs and DMs. The Supplier will ensure DMs can contact their HCPs if they are uncertain about how to interpret information.

8.7. The Supplier's telephone advice line to DMs (across all benefit streams) will provide direct access to experienced HCPs who can answer any question they may have about returned reports or evidence that has been provided by the Claimant.

8.8. The Supplier worked with their Sub-contractor – Clever Together – to run a digital campaign with DMs to generate improvement ideas for the service.

8.9. The Supplier will also provide 300 days of specific training to groups of DMs on topics such as the effects of mental health conditions on daily living activities, fluctuating conditions and how the prognosis of different types of health conditions are recommended.

8.10. The Supplier ran pilot cases to test efficacy and impact of case-conferencing facilities where DMs and HCPs could discuss complex cases.

8.11. The Supplier will introduce condition-specific master classes available to DMs covering a wide range of health conditions. These master classes will be part of a "Disability Resource Centre".

8.12. The Supplier will carry out an evaluation and analysis of the provision of advice to DMs: enhancements will include inviting DMs to provide formal feedback by way of a set questionnaire, inviting DMs into the service to improve understanding and setting a key work objective for Area Managers that they have in place a strong, proactive and constructive relationship with their local DMs.

<u>High quality checking regime, including structure, governance and job-roles</u>

8.13. The clinical quality policies, practices and standards, which the Supplier deploys will equally apply to all the HCPs of its supply chain Sub-contractors.

8.14. The Supplier's senior clinicians will meet regularly with supply chain clinical leads to assess clinical quality performance and to check that clinical support provided is effective. The Supplier's Sub-contractors will provide them with feedback and will share best practice so that all respond positively to the needs of our Claimants.

<u>Clinical Structure</u>

8.15. Clinical Quality within the HDAS service will be overseen by the Supplier's Clinical Director. They will be supported by the Clinical Standards Team and the Clinical Governance Board. The Supplier will inform the Authority of any

planned changes to the Clinical Standards Team and the Clinical Governance Board.

8.16. Clinical structure will include a Clinical Training Lead and a GP Engagement Strategy.

8.17. Additionally the Supplier will bring in [REDACTED] for the first year of the contract to advise on and evaluate the impact of bringing Occupational Therapists into the service.

8.18. The leadership team is responsible for designing, implementing and reviewing all aspects of the Clinical Quality Management system and CQIP and will work closely with the Authority's Medical Directorate.

Monitoring and Audit, including approach to selecting cases and sample sizes

8.19. The Supplier will introduce an audit and case review regime to ensure that the quality standards set by the Authority are achieved, consistently measured and reported upon. In addition, it will ensure that the feedback the Supplier receives as a result of their audit and case review activity delivers ongoing quality and Claimant journey improvements and can be used to support HCPs who need to develop their assessment techniques.

8.20. The Supplier will use the audit and case review expertise (and approval status) that exists within the transferring HCP team and blend this with wider Supplier audit, case review and quality control expertise.

8.21. The Supplier will utilise IT systems provided under the AS IS contract for the random selection of cases for audit. MSRS selects a referral case for audit prior to closure and submission to the Authority. This case is then made available to an approved HCP auditor through a work stack facility on MSRS and LiMA. The auditor completes the audit and provides the relevant HCP with feedback. The auditor carries out an audit to a very thorough set of mandated protocols and checks that the completed assessment includes a wide range of attributes which are both clinically and policy based. A range of results can be achieved indicating that the report is fit for purpose (Grade A),

has minor omissions or errors (Grade B) or would in fact lead the Decision Maker (DM) to make an incorrect decision (Grade C).

8.22. NOT USED.

8.23. If existing HCPs move into assessing in a different benefit stream i.e. if a WCA HCP begins to deliver DLA/AA assessments they will be subject to the regime of audit or case review as set out in Schedule 2.1. Unapproved HCPs must have all of their cases reviewed by the Supplier before any report or advice is provided to the Authority, to ensure the appropriate quality standards are met. Once a HCP is considered by the Supplier to be ready for approval, 100% of their cases will be audited until the HCP achieves the approval criteria. This will be referenced by the Supplier as “Approval Audit”.

8.24. The regime covers:

- Case Review – case reviews shall be undertaken on HCPs at the direction of the Clinical Leadership Team (CLT) in respect of (i) specific assessment errors (ii) less experienced HCPs and (iii) HCPs who require closer scrutiny to consistently produce acceptable reports. Data from completed case reviews shall be reviewed regularly to refine the process and measure improvements. All HCPs conducting assessments are subject to rolling case reviews depending upon their level of risk for producing poor quality. 100% of a high risk HCP’s cases will be reviewed. CHDA will ensure all HCPs regardless of quality are subject to rolling case reviews each Contract Year. A minimum of 5% of all cases will be subject to case review each month.

- Approval Audit – All assessments carried out by a newly recruited HCP must be case reviewed before any advice is sent to the Authority. Where a new entrant HCP is considered by CSLs to be ready for approval, formal approval audit is initiated until the HCP achieves the approval criteria and approval is granted by the Authority, see Part F of Schedule 2.1 for clarity.

- Targeted Audit – target audits shall be performed in cases where an HCP has been placed on a formal and written Performance Improvement Plan for either productivity or quality issues where a record of formal audit is required to finalise personnel related actions. The criteria used to select cases and the volume of auditing should be determined by the Supplier.

8.25. CSLs, ACMs, AQALs and CALs will also take opportunities to monitor the work of HCPs even if this falls outside of the audit and case review process. If interactions are not up to standard, corrective training will be provided. If the standard has been achieved, positive feedback will be given.

8.26. The Supplier will ensure that all audit and case review processes are transparent and that HCPs are aware that they are designed to facilitate reflection, learning and service improvement.

8.27. The sample size of audit and case review the Supplier will carry out is:

Audit / Case Review Type	**Sample Size**
Approval	100% until 5 A grade reports achieved (from 1 March 2015 until the date of signature of Contract Variation 134) 100% until at least 4 A grades and a B grade in any sequence of 5 consecutive audits (from the date of signature of Contract Variation 134)
Case Review	Regular case review pre and post approval to confirm consolidation of skills. Frequency and volume to be determined by the Supplier, as set out in the Case Review Process Guide.
Targeted	Supplier will target any HCPs placed on a formal and written Performance Improvement Plan for quality issues

8.28. The Supplier's clinical team will use clinical management information provided through LiMA and MSRS to monitor the results of the assessment outcomes produced by HCPs – and to check that they fall within mutually agreed "norms".

8.29. CSLs, ACMs, AQALs and CALs will analyse the data on monthly results and will seek to gather additional evidence if certain HCP results warrant close scrutiny.

8.30. The Supplier will also support the new DWP audit process as it begins the new quality checking processes post contract "go live".

Feedback processes and how these influence future quality

8.31. The Supplier will gather a considerable amount of information about how each HCP is performing i.e. audit and case review results, clinical MI outcome, complaints and rework referrals.

8.32. All results will be fed back in a professional, precise and positive manner.

8.33. Auditors, mentors and line managers will all be involved in the feedback process. They will ensure that they have direct contact with individuals who need to alter their approach based upon the evidence gathered. This could take the form of written guidance, a face-to-face session or over the phone. The conversation or guidance will concentrate on the specific areas for improvement and will also include ideas for how their approach can be changed. Feedback on good performance will also be included. It will be a highly interactive process to ensure the HCP feels fully involved. The person giving the feedback will check understanding and also suggest a review period where progress can be checked. The essence of meaningful feedback is to ensure that it is given speedily – any delays can cause frustration on the part of the receiving HCP.

8.34. Feedback (particularly to new entrants) will be prioritised, reflected in annual appraisals and will inform the formulation of annual Personal Development Plans (PDPs).

8.35. The Supplier will also carry out a feedback exercise using information from Claimants, colleagues and the Authority in relation to each HCP as part of appraisal and improvement processes.

8.36. The Supplier will ensure that they use this model to tailor recruitment programmes, training modules and continuous development.

8.37. The impact and introduction of these changes will be overseen by the Clinical Governance Board and will form part of the Clinical Quality Improvement Plan.

8.38. Whilst future personal development will be the responsibility of individuals, line managers will play a key role in ensuring development targets are clearly identified and time is allowed for HCP to undertake the required tasks.

Management information and reporting

8.39. The suite of clinical quality MI produced will be used to evidence SLA compliance, and focus internal continuous improvement activities.

8.40. The results of clinical MI will be brought before the Clinical Governance Board and will be shared monthly with the Authority. The results will also be shared with CSLs, ACMs, AQALs and CALs so that they can manage their teams from an informed position, and shared with HCPs themselves to inform reflective practice and improvement.

8.41. The Supplier will use the results of their quality checking systems, feedback from Claimants (by way of an independent survey of their satisfaction levels and complaints), DM feedback, external stakeholder reactions, and feedback from HCPs (Supplier employees and those from supply chain Sub-contractors). This information will be analysed by individual line managers, the Clinical Training leads and the Head of Claimant Experience so that trends can be identified and informed decisions taken about how the service (and individuals within it) can deliver necessary improvements.

8.42. The Supplier will provide feedback at individual, site and regional level and will also compile an overarching Clinical Quality Improvement Plan to drive changes required across the service.

8.43. The Supplier will work with the Authority to ensure transparency and visibility of these plans and track progress through the Clinical Governance Board.

8.44. NOT USED.

8.45. NOT USED.

8.46. The Supplier will work closely with the Authority to ensure transparency and visibility of these plans and track progress through the Clinical Governance Board. The plans will highlight priority areas for attention, proposed actions for improvement and timescales for improvements to be made. The Supplier will review any changes made so that they can gain a better understanding of the impact of their actions. The Supplier will share the results of feedback and actions they will take with their Claimant Representative Group. The Supplier will also publish details of key initiatives and outcomes of measurable improvements.

Part E – Stakeholder Engagement

9. Stakeholder Engagement

9.1. The Supplier will develop and implement a comprehensive stakeholder management plan.

9.2. The Supplier will agree clear communication protocols with the Authority and across their supply chain Sub-contractors. The Supplier will communicate to relevant external audiences key, tested messages about the delivery of high quality assessments, reduced waiting times and an improved experience for Claimants.

9.3. The Supplier will begin to promote the brand during the mobilisation period and increase activity once the service has gone live.

9.4. The Supplier will use a wide range of platforms to communicate effectively with them, including establishing formal consultation groups, face-to-face meetings, emails, the new supplier website, published materials, and presence at national and local conferences.

9.5. The Supplier will leverage existing strong relationships that they and their Sub-contractors have with key stakeholders: from the Supplier's Programme Director to front line staff, all employees will understand the importance of dealing sensitively with all stakeholders to this service. All relevant staff will be fully media trained.

<u>Communication with GPs</u>

9.6. The Supplier will develop a GP Engagement strategy will establish and maintain interfaces with GPs, CCGs and other clinical stakeholders such as community psychiatric nurses, district nurses and social workers. They will encourage participation in the further evidence gathering process, which is critical in informing a fully detailed assessment and build relationships with key practices

9.7. The Supplier's Clinical Director will hold and build key relationships with GP representative bodies such as the GMC, RCGP and NAPC, and will work closely with the Authority's CMO. To support this activity, the Supplier will establish a GP hotline for enquiries and a dedicated website area for GPs to find answers to Frequently Asked Questions about the service.

Disability Organisations and Claimant Representative Groups

9.8. By the time of service "go live", the Supplier will have established regular formal channels of communication with those who wish to engage constructively with the service. This will be through the creation of a Claimant Representative Group (CRG) and also individually with each organisation. The CRG will be established during mobilisation and will meet during the first month of service Go-live and then at quarterly intervals.

9.9. The Supplier will appoint a wider range of Functional Champions, doubling the current number of mental health champions and expanding to include fluctuating, progressive and musculoskeletal conditions. The Supplier will appoint champions for cardio-respiratory, oncology, musculoskeletal, and neurology, based on an assessment of most common conditions

Media

9.10. The Supplier will operate an in-house 24/7 press office.

Social Media

9.11. The Supplier has developed a bespoke combination of monitoring tools to categorise and prioritise online conversations associated with the delivery of HDAS. This will alert the Supplier and enable them, if necessary, to respond with appropriate messaging.

9.12. The Supplier will appoint a digital media coordinator to work with external advisers to monitor social media issues as they emerge and reinforce positive messages where appropriate.

9.13. Social media monitoring will be undertaken by a monitoring agency which will provide daily and live updates on key posts, a monthly round-up will also be used to identify trends. These will then be flagged with the Supplier's communications team so that issues can be addressed appropriately.

Parliamentarians

9.14. Communication with identified relevant Parliamentarians will be via the Supplier's Programme Director, and Stakeholder team, and written correspondence managed through a dedicated team.

9.15. The Supplier will ensure DWP is regularly updated on activities in this area and will feedback any concerns that are within the remit of the Authority.

External Organisations such as Welfare Rights and Medical Organisations (GMC)

9.16. The Supplier will engage with welfare rights groups on a national and local basis, ensuring that their role is fully understood and how the service will be different from the past.

MPs

9.17. The Supplier will ensure all MP correspondence is replied to urgently, keep records of MPs who have written on behalf of constituents and will seek meetings with MPs who reach a threshold of correspondence to address concerns.

9.18. The Supplier will provide telephone and email hotlines and will encourage MPs to visit HDAS offices in their constituencies.

9.19. MPs across England, Wales and Scotland will be engaged. Appropriate monitoring will take place throughout these administrations and acted upon accordingly.

Part F: Continuous Improvement, Innovation and Transformation

10. Claimant Experience

10.1. The Supplier shall deliver the following:

Innovation	Benefits of Approach	Targeted dates[1]	Technical Dependencies
Transforming the Claimant journey:			
Multi-media content for HDAS website	Extend level of information services for claimants	Approval 03/15 Live 09/15	None
Tactical SMS Solution	Prompting claimants to make contact, return ESA50s	Live 12/15	None
Tactical SMS Solution	Prompting claimants to make contact, return UC50	Date to be agreed between the Parties	None
Implement a call script on the VCC IVR to direct callers to the website FAQs	Extend level of information services for claimants, signpost information resource, reduce avoidable contact	Approval 08/16 Live 09/16	Script changes to existing IVR system
Web chat facility for HDAS website; to	Deliver VCC operating efficiencies and improved	Approval 05/15	None

increase call handling capacity	claimant engagement	Live 12/15	
Steady State SMS Solution	Extend level of information to claimants about their personal position in the process and welcome claimants to the service, what to expect next	Approval 05/16 Live 01/17	Flat file output from Siebel; contract record within MSRS

Use of information technology / digitalisation to improve the claimant journey and / or introduce efficiencies

10.2. The Supplier will improve the Claimant experience in information access via the HDAS web site, deploying content that has been developed using the Supplier's expert health literacy review processes. BJSS will develop user-friendly screen designs to accommodate multiple disability groups, supplemented by easy to follow FAQs, and the inclusion of multi-media.

10.3. For completion of ESA50/UC50 questionnaires, the Supplier proposed an online digital version on 2 June 2016. The Supplier will engage with Disability representative groups to ensure form-filling is less complicated.

10.4. The Supplier will give new HCPs the opportunity to make use of distance learning and overcome objections to residential training.

10.5. NOT USED.