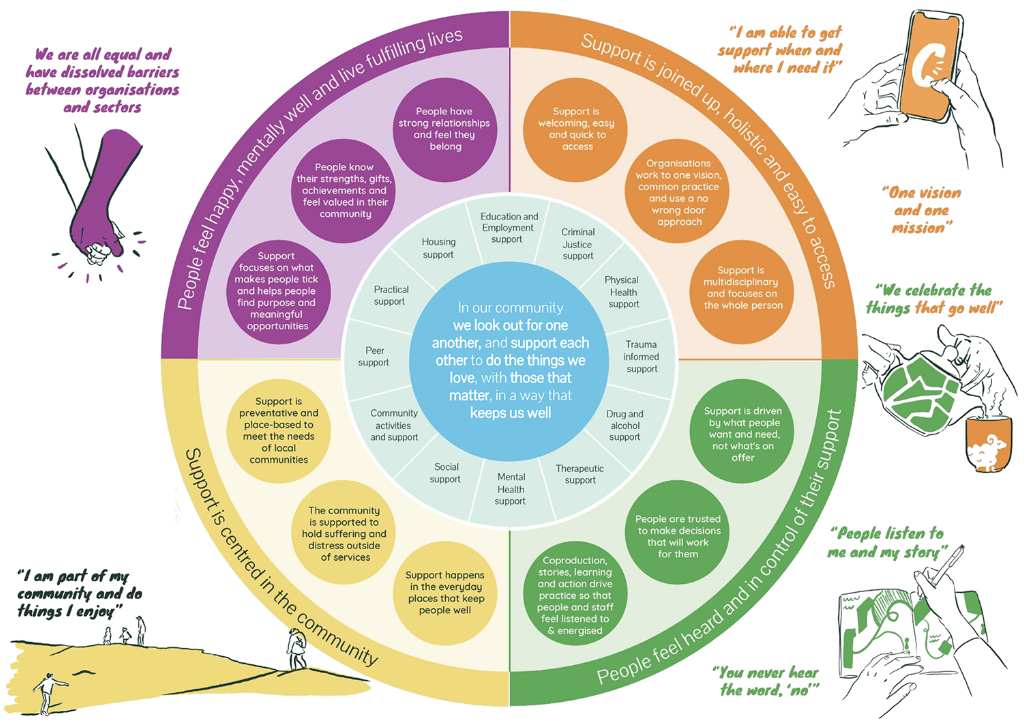
# DERBY CITY PEER SUPPORT AND RECOVERY SERVICE

# SECTION 3 - SPECIFICATION

## 3.1 BACKGROUND TO COMMUNITY MENTAL HEALTH IN DERBY

The vision for community mental health support and services in Derby that every person in Derby City should get the mental health support they need, when and where they need, to do the things we love, with those who matter, in a way that keeps people well – this means that:



We are working to achieve vision through a whole system approach to community mental health called [Derby Wellbeing](https://livingwellderbyshire.org.uk/localities/derby-wellbeing), bringing together partners from Derby City Council, health, other public sector and statutory organisations, voluntary and community sector organisations, people with lived experience and others with the aim of transforming how people access, experience and achieve their outcomes from community mental health services. Co-production is key to this approach, so that the voice and experiences of people with lived experience of poor mental health is central to what is delivered.

Derby Wellbeing is part of the wider Derby and Derbyshire Living Well programme that is aiming to deliver person-centred transformation of community mental health approaches and services. It is a multi-agency programme led by Joined Up Care Derbyshire and includes a System “Collaborative” group of statutory, voluntary and community sector partners.

## 3.2 INTRODUCTION AND CONTEXT FOR THE SERVICE

As part of the Derby Wellbeing programme, Derby City Council (DCC) and the Derby and Derbyshire Integrated Care Board (ICB) (formerly the Clinical Commissioning Group, CCG) are working together to fund support that promotes stability and recovery for those affected by mental health issues.

DCC and the ICB wish to appoint a Service Provider to provide and deliver this service. Collaborative bids are encouraged.

The contract management role will be performed by the ICB or any successive body and this includes payment to the Service Provider.

The Service required is a flexible, inclusive, community-based support service for people with mental health needs to provide peer support and recovery. This Service will help people to improve and maintain their mental health with an emphasis on recovery, self-management, independence and overall wellbeing. It is envisaged that there will be a range of support activities that will deliver these outcomes for people on an individual and group basis.

The purpose of the support Service is to ensure that local people with mental health needs have access to good quality support to promote learning; self-help; social inclusion; recovery; resilience, stability and maintenance.

The Service has four core elements:

* Peer support by volunteers and development of self-help groups
* Recovery education
* Goal-setting and individualised recovery support
* Bridge-building and developing community partnerships

## 3.3 THE CURRENT SERVICE

The current support service is provided by Richmond Fellowship and is known as Derby City Life Links. There are over 150 people accessing the Service support groups and one to one support at any given point, with more in contact with the advice line. This varies from people in frequent contact (once per week or more) and those who receive support from time to time as needed, or initial support with little required follow up.

There are potential TUPE implications the current Service Providers' Personnel details are provided in [xx]

## 3.4 AIMS AND OBJECTIVES

The key aim and objectives of the Mental Health Peer Support and Recovery Support Service have been developed based on national guidance and local engagement with people with lived experience and partner organisations.

***The overall aim is to enable people to improve and maintain their mental wellbeing and recover from mental illness.***

The Service Provider will be a partner in the Derby Wellbeing programme, collaborating with statutory, voluntary, community and other Joined Up Care Derbyshire system partners, including as a member of the Derby Collaborative.

The ***key objectives*** include but are not limited to, the following:

* To provide community-based recovery support through one-to-one and group sessions to help people to improve and maintain their mental health with an emphasis on recovery, self-management, independence and overall wellbeing.
* To develop, promote and help sustain volunteer peer support and self-help in a range of delivery methods, with accompanied support for people to enable them to provide support to their peers, find friendships and reconnect with communities in a meaningful and safe way. This includes working collaboratively with wider Derby Wellbeing paid and voluntary peer support workers.
* To co-produce/co-design a recovery education programme working with people with lived experience (to align with and compliment other local developments) including, for example, a range of self-management, learning, and development opportunities based on local need and for interventions to be evaluated to support future planning.
* To support people, where possible, to access universal services or non-specialist health and social care service provision, and informal/community support recognising the need for social inclusion and an ‘ordinary life’. Barriers to accessing community provision will be addressed and worked through based on people’ goals and needs. This includes supporting improved access to opportunities to improve physical health.
* To support the smooth transition of younger people into this Service by working in partnership with organisations that may be supporting young people approaching 18, so that young people’s needs are understood, taken into account and addressed.
* To provide support to people by recognising the direct and indirect impact of Covid-19 on mental health and wellbeing.
* Reduce or delay eligible support needs and demands across other Derby Wellbeing partners including on statutory mental health and social care services, and voluntary and community partners including through the system Collaborative
* To support people to consider their physical health goals, in particular recognising the substantial health inequalities and premature mortality for people with a severe mental illness. Providing information and signposting to enable people to meet these goals, through peer support or a variety of statutory, voluntary and community sector provision.
* Provide follow up support and interventions to people accessing Crisis Alternatives provision, where needed; for example Safe Havens, Crisis Cafes and the Mental Health Helpline and Support Service

In working towards these objectives, the Service Provider will:

* Work as part of the Derby Wellbeing system approach, establishing strong local partnerships with the range of organisations (including social care professionals, Local Area Coordinators, Public Health, education providers, health professionals and providers including GPs, Care Coordinators, secondary mental health Derby Wellbeing teams , Derbyshire Healthcare Foundation Trust services and IAPT services) to raise awareness of the service, understand and respond to needs with the County Council, ICB, providers, people with lived experience and other stakeholders. Collaborative work will be critical to the success of the service including to help people to find community support; identify and communicate signs of deterioration and facilitate access to support in a crisis.
* Ensure equitable access, reduce stigma and promote social inclusion by maximising access (places where people are comfortable and can physically access) to a range of local community buildings, resources and activities.
* Provide a support function that maximises social inclusion across seven days per week based on local needs, with appropriate opportunities in line with demand during evenings and weekends.
* Ensure inclusivity, collaborating with community partners, so that local people have equitable access to local support, recognising and supporting system understanding the diverse needs of residents in Derby identifying and overcoming gaps and barriers to access. This includes the diverse range of ethnicities, sexual orientation, gender and gender identities of people and communities within the city, people with learning disabilities and autistic people, and the high proportion of people with a hearing impairment and other sensory impairments.
* Provide support to people who may also have wider needs alongside their mental health condition such as autism, learning difficulties, physical disabilities and sensory impairments where the service can provide support to meet their goals.
* Ensure the service supports adults of all ages including younger and older adults.
* Help people to access specialist services where needed, including drug and alcohol services, debt advice, housing advice, benefits advice, advocacy and employment services
* Establish mechanisms for and ensure ongoing involvement and engagement of those with personal experience of mental health problems in the design, development, delivery, and evaluation of the service and wider Derby Wellbeing system – including the development of voluntary and paid roles within the service and progression to system partners.
* Enable people to access volunteering opportunities and support to gain employment or get back into work, working collaboratively with partner programmes including IPS (individual placement and support service) and Work Your Way.

The following are a summary of priorities that local people with mental health needs and other partners have told us are key for the Service:

* Focusing on the assets of the person and what would make life easier for them.
* Developing .and maintaining a person’s strengths, independence & building resilience.
* Having a safe and welcome place and familiar environment to access support.
* Having good access to community resources and provision with increased social inclusion.
* Ensuring easy access – preferably a central location, on a bus route and good access for people with physical disabilities.
* Access to support during the evening and weekends.
* Having access to activities to support relaxation, self-esteem, making friends and creative expression – being innovative, creative and open to therapeutic options such as art and creative writing.
* Having access to telephone and online support.
* Groups and courses focusing on recovery and helping increase confidence in managing mental health.
* Improving personal outcomes and furthering or achieving individual goals.
* Increased ability to support others with mental health needs through peer support and ensure that support is available for peer supporters to do this effectively and safely.
* Increasing carer confidence in supporting people affected by mental health
* Carers receiving preventative input to support their wellbeing.

Some of the underlying principles that people with lived experience expressed include:

* Being communicated with in a way that people can understand and being understood by other people
* Being actively listened to, heard and respected
* Feeling needed, valued, hopeful and are able to support others Co-production so that delivery is in partnership with those with lived experience
* Good communication and joint working between agencies to ensure that if needs changed there was a positive and quick response
* Joined up working ethos; working with partners as part of the Derby Wellbeing system to support safety and trust
* Reducing the stigma of mental health
* Not customers or clients; we are individuals, people, human beings, who should all be looked at holistically and given hope and opportunity.
* Having an age-less service
* Enabling people to develop resilience to maintain and improve their mental health, recognising that for some people stability will be the goal
* Having confidence that support is there if needs increase or mental health deteriorate
* Staff to have necessary training, skills and empathy, including being able to recognise and support needs of people with complex and sometimes challenging needs
* Encourage and support positive risk and helping people to develop responsibility for their own choices
* Support to navigate a complex care and support system
* Include carers where possible, so they can support the recovery and resilience of the person and for carers to connect to their own support
* Delivery (of recovery education) to be within a non-clinical setting, i.e. people are students

## 3.5 INCLUSION CRITERIA

The people who will be able to receive this service:

* Are Derby residents\*
* Are over 18 (although as above, there is an expectation that the Service will work in partnership to support younger people in transition to adult services).
* Have a presenting mental health need. There is no requirement to have a formal diagnosis to access this Service (people may instead present clear signs and symptoms of poor mental health and identify themselves as requiring support)
* Are carers/family members of those who have a mental health need
* People may also have other needs in addition to their mental health needs, such as autism, a learning disability, physical disability or sensory impairment. Access and promotion of services must take account of these needs and reasonable adjustments should be made to ensure that people with a range of other needs are able to benefit from support.

*\* People who may be accessing other Derby health and social care services temporarily but are otherwise not a Derby resident may access this service, for example if a person is temporarily in Derby following a hospital admission. The Service Provider will need to record and report on who is using the Service who is not ordinarily a Derby resident.*

The access criteria are broad to be as inclusive as possible, however it should be made clear that the Service exists to support people’s mental health needs and is therefore not expected to meet all of a person’s needs.

All people must have an individual support and recovery plan in place detailing how the Service will support them to achieve the outcomes offered. The primary reason for this is to identify and agree therapeutic support, however this will also identify occasions where the person’s needs cannot be met by the Service Provider and also to identify where the person can or will benefit from wider support. Cases whereby the Service Provider feels they cannot meet the needs of a person will be recorded and reported to the Council and ICB on a quarterly basis for wider discussion. The Service Provider, and Council and ICB will have regular discussions about any necessary prioritisation as a result of short- or long-term high demand for the service. See also section [xx.xx] below.

## 3.6 EXCLUSION CRITERIA

The following groups are excluded from this Service:

* People living in the Derbyshire County Council and other local authority areas.
* People who do not have a mental health need that can be met by the Peer Support and Recovery Service (e.g. a person who is frail, elderly with physical health rather than mental health needs).
* People who are aged 17 and under (although people in transition from children to adult services will be supported as above).
* People with personal care needs unless they are supported by a personal carer who will fully meet those needs during all service activity.

## 3.7 CORE ELEMENTS OF SERVICE

People receiving this Service are expected to receive:

* An assessment of their needs (in relation to the Service support available) made in conjunction with themselves, and, if it is their choice, their Carer and/or family. This assessment will take into account information from Derby Wellbeing system partners such as health and social care workers and other referring bodies
* A personalised recovery and maintenance plan articulating their assets, strengths, and individual goals and aspirations, clarifying how the Service can support them and identifying other forms of support
* Support to achieve or further their personal goals by accessing one-to-one support; group support; support both within the service and outside of the service
* A review of their needs and goals at appropriate intervals, and in proportion to their support needs and wellness
* Good communication about what is on offer that may meet their needs both within and outside of the service
* Support to access support outside of the Service, particularly where barriers to accessing universal or non-specialist provision have been identified
* Opportunities to gain a good understanding of their mental health needs and how to manage them through access to recovery education
* Opportunities to be involved in the delivery of recovery education
* Opportunities to support others through peer support and self-help, including any confidence building or learning support needed to achieve this meaningfully and safely
* A clear understanding of what steps would be taken by whom if a person’s mental health deteriorated – for example self-management plan, or facilitating reassessment and referral to statutory partnership organisations
* Opportunities to get involved in the design, delivery, and evaluation of the Service available on a personal and strategic basis.

The Service should minimise the level of information that needs to be collected from people, by taking a flexible approach to assessment. **With the permission of the person concerned**, information will be gathered from professionals who refer them to the Service and shared in order to provide an appropriate and safe approach to goal setting. As part of the approach to joint working, appropriate information sharing agreements should be in place to facilitate this.

The role of this Service in relation to carers is anticipated to be to help identify carers and signpost them to support and to work with and support carers where this is identified as being beneficial for the person’s their recovery. For example, it may be entirely appropriate for a carer to support the person to take part in recovery education sessions or to attend a therapeutic or peer support group if it would be mutually beneficial. Where the carer has support needs in their own right, the Service Provider will work alongside local carer support organisations with a view to making introductions and supporting access to these Services. The Service Provider will however consider how carers' needs could be met as part of a peer support model within the Service, being mindful of the need to avoid duplicating other resources within the City.

The four core elements of the Service are:

* Volunteer peer support and development of self-help groups
* Recovery education
* Goal-setting and individualised recovery support
* Bridge-building and developing community partnerships

These aspects of provision are seen as intrinsically linked but are defined separately as below to support clarity.

**3.7.1 Volunteer Peer Support and development of self-help groups**

The expectation is that a significant proportion of the support available will be delivered by and in partnership with, experts by experience, people using the service, and volunteers. It is anticipated that the Service Provider will need to develop and provide appropriate infrastructure to be able to make this happen. There will be a need to offer support and learning opportunities to those people involved in delivery of peer support and ensure that safe working arrangements are in place to communicate any concerns or incidents.

Volunteer peer support could be both formal and informal, based on local needs. Wherever possible volunteer peer support should exist within the context of ‘natural’ communities and support networks i.e. by utilizing support within a person’s geographical community, or by building on their current support networks. Volunteer peer support should follow the same principle as other aspects of the Service, in the sense that wherever possible people should be encouraged to access ‘non-specialist’ and ‘natural’ peer support whilst recognizing that people may need support to overcome barriers and transition to universal provision and friendships outside of support services.

For this element of the service, the Service Provider will:

* Work collaboratively with the Derby Wellbeing programme and partners including health, voluntary and community, infrastructure organisations, local area coordinators, social prescribers and others to coordinate support for the development and sustainability of peer support insider and outside of the service including system experts by experience and volunteer and paid peer support.
* Provide a range of support to existing peer support and help groups, ensuring peer supporters are involved, listened to, feel and be supported
* Enable and grow volunteer peer support and self-help groups that provide safe spaces for people to meet in their local community. This will include support to find appropriate venues which are easily accessible and free (or at a low cost), help and encouragement to get the group up and running, start-up resources (if required) and acting as an on-going point of contact of support for the group.
* Ensure that the distribution of groups take into account other local opportunities available to people to ensure there are no gaps or duplication. This will be through working closely with Local Area Coordinators, Talking Points, Community Action Derby (CAD) to understand any gaps in Services and respond to local need without duplicating Services.
* Ensure self-help and volunteer peer support groups are able to cover a flexible timetable based on the needs of the people involved (i.e. opportunities to meet in the evening and at weekends if this is what is identified as useful by people).
* Keep in regular contact with and regularly evaluate and offer support to all volunteer peer support activity through participant feedback to ensure they are viable, operating effectively and to demonstrate that overall service objectives are achieved.
* Be responsible for all set up costs which will come from the funding provided. No additional funding is available for this element of costs. People who use groups and activities may be asked to make a small contribution to activity or refreshment costs. The Service Provider must ensure that any charge is:
* affordable and does not act as a barrier to accessing support activities
* appropriate to the activity and discussed with people as part of developing programmes e.g. healthy eating, cooking on a budget.
* Where possible and appropriate, encourage groups to become self-sustaining and independent from the Service Provider, though possibly with support from other the voluntary and community sector infrastructure organisations and/or others.
* Ensure that this element of the Service provides equity of access to all people, being mindful of people with distinct physical, cultural, religious or sensory needs for example the deaf community.

**3.7.2 Recovery education**

The Service Provider will work collaboratively with Derby Wellbeing partners to consider local needs, and co-design a programme of learning opportunities designed to support people to learn about their mental health conditions. The Service Provider is not expected to be the sole party delivering recovery education but is expected instead to contribute and link into local development and delivery. Development of the recovery education offer will involve close collaboration with adult education and Derby Wellbeing partners including health, social care, other community organisations and mental health service providers in order to meet the needs of people in Derby City, complementing but avoiding duplication of other/existing learning opportunities.

Recovery education will offer opportunities for shared decision making, self-management, adult learning, co- production and community participation. Based on the recovery framework CHIME, the range of courses should offer people:

* Connectiveness
* Hope
* Identity
* Resilience
* Meaningful opportunities
* Empowerment.

The focus is an educational approach and learning opportunity not therapy.

Educational recovery courses will focus on enabling leaners to gain knowledge and understanding of coping strategies and skills, building on strengths and enabling people to work towards their own goals. The programme will support learners to develop awareness, confidence, and coping mechanisms and will act as an introduction to activities that are designed to promote relaxation and personal growth. Learners will feel more able to manage their condition, and more confident in achieving their individual goals for independence, resilience, stability and recovery.

There is an expectation that core aspects of this element will be co-developed and co-delivered with experts by experience, and that opportunities to deliver recovery education will be clearly communicated to local people. There will need to be learning from Covid including the opportunity to offer courses in a range of settings including classroom, fact-to-face and online. The Service Provider will need to work alongside community partners to ensure that social inclusion and accessibility is paramount. The Service Provider will consider offering delivery opportunities on a voluntary and paid basis commensurate with expectations.

The Service Provider will ensure that learning opportunities are in line with local needs, avoid duplication, and are delivered in a way that promotes equity of access for all citizens and, as above, responds to distinct physical, cultural, religious or sensory needs as appropriate.

Recovery education interventions are anticipated to be short-term in nature, with the expectation being that person will engage in the programme and be supported to access peer support or community provision thereafter if that is their wish.

The Service Provider will use appropriate and accessible venues to deliver these learning opportunities from and will consider local feedback about utilising community (non-clinical) venues to do so. The Council and ICB will not be funding transport for people to attend Service provision and the Service Provider will need to assess how the Service is accessible to all people who will potentially use the Service.

The hours of delivery are expected to be based on the needs of people using or potentially benefiting from the learning opportunities.

**3.7.3 Goal-setting and individualised recovery support**

On introduction to the service the individual and Service Provider will discuss and agree how the service can support their goals for recovery. An asset-based discussion will need to take place, taking into account the person’s strengths, existing networks and aspirations. An individual recovery support plan will be developed which describes how the service can support the individual to maintain stability and attain recovery. This will need to link and align with (but not duplicate) the Derby Wellbeing partner model including individual plans.

The Service Provider will work together, alongside a carer if appropriate, to identify what support the person needs within and outside of the Service – this may be a blend of individual and group support. The Service offered will be led by the person’s support needs and is expected to be dynamic given the changing needs of the person.

The overall aim as discussed elsewhere is to maximise the person’s independence and wellbeing by ensuring they have the support to meet their recovery or maintenance goals. The individual support and recovery plans will be reviewed at appropriate intervals proportionate to the person’s involvement with the Service and their degree of wellness. Progress made against recovery goals will be recorded and shared with the Council and ICB on an aggregate level on at least an annual basis. See also 3.6 above for what people accessing the Service should expect in terms of support.

**3.7.4 Bridge-building and developing system and community partnerships**

A key goal of this Service is to ensure that people have good access to universal and non-specialist support that may improve their mental health and independence in a non-stigmatising way. In order to achieve this, the Service Provider will need to develop excellent working relationships with a broad range of statutory and non-statutory partners. For example, the Service Provider will want to make close links with local organisations supporting volunteers, in recognition of the important role that volunteering can have on a person’s wellbeing.

The Service Provider will need to ensure that as much as possible people are benefiting from the full range of universal services and community support options available, helping them to live as independently as possible. Any barriers to accessing universal or community provision will be explored with the person in the context of the individual recovery and support plan. The Service Provider will record support accessed by people, to create an overall picture of access to universal and specialist support.

The Service will function as part of the Joined Up Care Derbyshire system approach to supporting people with mental health needs and as such will work alongside a broad range of system partners, in particular as part of Derby Wellbeing network and collaborative groups. This will ensure the offer is integrated and complements related system provision such as the range of services being developed as part of the Mental Health Urgent Care Programme. important

## 3.8 SERVICE DELIVERY ARRANGEMENTS

**3.8 .1 Telephone and Online Support**

The Service Provider will develop telephone and online (including video) support as a vital way to respond to people’s needs and promote their independence. These proposals will include hours of operation; Personnel and supervision; safe working policies; training and support; escalation policies and support; assessment etc. The telephone and online support offer will incorporate the following elements:

**3.8.1.1 Targeted intervention (delivered by paid operational Personnel)**

The targeted element will be made available to those who are unable to attend face to face support for a variety of reasons (e.g., due to their mental health condition; lack of transport; childcare or other caring responsibilities) and will be expected to offer a similar level of support to that delivered within communities (where appropriate). This will be essential in ensuring the widest possible reach of this Service and in removing barriers to people accessing support. The offer will follow the same step-up/step-down approach as in the wider model with length of targeted support related to a person’s needs.

The Service Provider will need to determine how to work with incoming calls, as the targeted telephone support offer will deliver an accessible source of support (equivalent to a drop-in function) and an element of early intervention and timely information provision and signposting to community and universal support and activities, and specialist interventions.

**3.8.1.2 Peer support (delivered by volunteers)**

People will have access to opportunities to receive and provide volunteer peer support, including telephone support as part of this Service. The Service Provider will be expected to develop a response to the needs of people who are unable to attend peer support groups in their local community for a variety of reasons (e.g. due to their mental health condition; lack of transport; childcare or other caring responsibilities), for example telephone contact with volunteer 'Experts by Experience' as a one-off or time limited basis according to needs.

To ensure safe delivery of the Service, volunteer peer supporters delivering this element will need training in relation to safeguarding and confidentiality etc; have access to regular supervision and access to immediate professional support as a way of escalating issues that may arise during a peer support telephone call.

This element of the Service will deal with appropriately risk-assessed and scheduled outgoing calls only. It will not offer a crisis helpline or receive incoming unplanned calls.

The telephone support service will need to be delivered in an effective and efficient way.

**3.8.2 Service availability and referrals**

The Service will be delivered in a way that meets the needs of people with mental ill health. Consideration should be given to timing and flexibility of Service provision so that it provides ease of access for working people with mental ill health and their carers. It is expected that the Service will develop flexible working arrangements which include evening and weekend working, based on local needs.

The Service Provider will ensure the service is available by all modern methods of communication but must include a local 01 prefix landline number and minicom access in addition to any other advertised phone number.

The Service Provider will have arrangements in place to ensure continuity of Service, for example, during annual leave and Personnel illness.

The Service Provider will have a clear policy in place detailing how to respond to people who may be abusive or threatening towards any member of Personnel or other people. This will include an option to exclude the person from the service at the discretion of the Service Providers Service Manager.

There are no fixed hours of delivery as the expectation is that the service will meet the needs of people across seven days of the week, in accordance with expressed local needs.

The Service Provider will be expected to accept referrals Monday to Friday and have an answerphone facility where Personnel are not available to take calls.

The Service Provider should ensure that people have good information about what support is available during evenings and weekends and develop volunteer peer support networks and good access to community provision so that support is available outside of office hours.

The Service Provider will develop an appropriate and easily accessible referral policy and protocol, including to capture essential demographic data to contribute to the monitoring of the Service.

The Service Provider should provide an initial response to all referrals within three working days.

The Service Provider will see people within seven working days[[1]](#footnote-1) from the time of the referral.

It is expected that the Service Provider will operate a triage system whereby referrals are prioritised according to need. The Service Provider will agree details of triage and prioritisation arrangements with the Council and ICB.

Referral will be by an open referral system (with consent of the person being referred). The Council and ICB would expect to see referrals from people directly (i.e. self-referrals) as well as professionals across Health and Social Care including but not limited to GPs, Occupational Therapists, Community Psychiatric Nurses, Social Workers, Enablement workers, the Radbourne and Hartington Units (DHcFT’s main inpatient service for Derbyshire residents with acute mental health needs), EMAS, 111, Police, Probation and other voluntary sector organisations.

The Service Provider may refuse a referral if:

* the risk assessment process identifies an unmanageable risk
* the person refuses to work with the Service Provider
* the person does not meet the criteria for the service
* a person’s needs cannot be met by the Service or are not eligible. In such cases they will be referred/signposted to other appropriate services or support by mechanisms to be developed and agreed with other Service Providers.

The Service Provider is expected to make efforts to contact and engage the person, recognising that this can be challenging for people with poor mental health. Where the Service Provider is having problems engaging a person who has been referred by a partner organisation they should talk to and work with the referrer to look try to engage the person before rejecting the referral.

Refusals will need to be recorded by the Service Provider including reasons why the person could not be supported and discussed with the Council and ICB as part of performance reporting requirements. The Service Provider will also record and report on what signposting and support is offered to those people who are not deemed to be eligible for the Service. We anticipate that a collaborative approach to understanding the needs of people who are not deemed suitable for this Service will be important to inform the wider partnership and support the development of a strategic approach to mental health.

## 3.9 PROMOTION OF THE SERVICE

The Service will initially be known as the Derby City Recovery and Peer Support Service; however, the Service Provider may wish to engage with local people to agree an appropriate and non-stigmatising service name, with final approval from the Council and ICB. Any promotional or information resources must be approved by the Council and ICB to ensure consistency and local branding on all documentation.

The Service Provider will:

* Deliver and keep updated an easily accessible, unique webpage that is clearly branded as the Derby Recovery and Peer Support Service (or alternative working title as above). The site will clearly detail referral processes, complaints procedures, and signposting to other sources of support. The content management for the website will need to be responsive to the dynamic nature of self-help and peer support groups associated with the service and their plans for activities etc. The site must be accessible, easy to use from an individual and carer perspective, share and promote good practice and link to appropriate online community resources.
* Successfully promote itself in order to become a key part of the Derby Wellbeing mental health system in Derby including as part of the Derby City Collaborative. It will become an effective, well used resource for the local population, creating strong links with statutory and non-statutory partner organisations including health and social care professionals and other system partners to ensure referrals are encouraged and received from a wide variety of sources including heard to reach groups such as people from ethnic minority communities; people with physical, hearing and visual impairments; people with learning disabilities, autistic people and LGBTQI+ people.
* Offer taster sessions and open days, considering innovative uses of printed/ social media, as well as participation in key national awareness raising events such as World Mental Health Day. The Service Provider will make the Council and ICB aware of marketing and social media communications and the Council and ICB reserve the right to amend or require the communications to be amended or stopped. The Council and ICB will own the Intellectual property rights to any materials produced.
* Build a network within the local community including community leaders, Local Area Coordinators, local GP practices, social prescribers, hospitals, pharmacies, community and voluntary groups, and local businesses where appropriate.
* Consider the use of SMS text services, emails social media, promotional and online help and chat tools to keep people informed of short-term changes to activities and as a simple reminder tool.

## 3.10 MOBILISATION AND TRANSITION TO NEW SERVICE DELIVERY MODEL

The Service should be especially flexible and responsive during the transition from current service provision to the new arrangements. This will be jointly scoped out with the Council, ICB, other key system partners, current Service Provider and the successful Service Provider at the pre-contract stage.

There will be no service overlap between the existing and forthcoming Service i.e. the old Service will end and the new Service will start the next day.

The Service Provider will be expected to support transition and continuity of peer and other support from the current service and develop effective communications and relationships with groups, volunteers, partners and communities.

The Service Provider will be expected to develop information sharing agreements with key partners within this transition period.

The Service Provider will need to work alongside statutory partners to clarify working relationships and protocols to ensure people can access or re-access services when required.

The Council and ICB recognise that the Service will take time to embed, and the monitoring and performance requirements will have more flexibility within the first six months.

## 3.11 SERVICE DELIVERY LOCATION & ACCOMMODATION

It will be a requirement of the Service to ensure that the support available is accessible to all citizens within Derby City, specifically with regards to their geography as well as protected characteristics. The expectation is that there will be a small, central Derby ‘hub’ to act as an operational base for the service, with a network of community-based locations being utilised to ensure that inclusion and community integration is at the heart of delivery. The Service Provider will be expected to produce evidence that the service is actively providing community solutions in line with the social inclusion traffic light tool.

The Service Provider will meet the costs required to cover accommodation as well as associated accommodation costs such as office hardware, telephones and business support costs within the overall budget.

The expectation is that the Service Provider will have an office base within Derby, which also doubles as the ‘hub’ described above to ensure that people find the Service easy to access. Whilst other models may be considered, the key priority is that there is strong access and flexible delivery within and across Derby.

It is an expectation that the Service Provider will embrace elements of modern methods of working, e.g. remote access, working from home and hot-desking to ensure the Service is as flexible, effective and efficient as possible.

The Service Provider will be responsible for the management of health and safety, risk management and for ensuring adequate arrangements are in place. In particular the Service Provider must ensure that third party premises are appropriate for activities and hold appropriate public liability insurance cover.

The Service Provider will ensure that office accommodation and any other base(s) where Personnel or volunteers are working will have arrangements for safe and secure storage of case records and confidential files.

**Accommodation and Funding**

The Council expects that the maximum of costs on central accommodation (rent) is 7.5% of total annual expenditure. Service providers will need to justify why they believe their costs in this area need to be higher, as it would seem contrary to our community focussed model if more than this amount was spent on this element.

## 3.12 PARTNERSHIP WORKING

There is an expectation that the Service will work collaboratively with key community partners within the Derby Wellbeing programme to ensure inclusive access to, experience of and outcomes from the peer support and recovery, and other community mental health services in the City, in particular:

* Work with Local Area Coordinators and the Community Hub to understand local community support networks and identify where closer working would break down barriers and support people with social inclusion.
* Understand and work with the Council’s Talking Points to consider opportunities for mutual support and facilitate introductions for wider support.
* Work alongside local carer support organisations to ensure that support and activities compliment and do not duplicate.
* Understand what voluntary, community and faith sector organisations exist locally with support from the Community Action Derby (CAD), with a view to building bridges and expanding social networks.
* Develop relationships with a broad range of universal/non-specialist support providers such as activity, sport and leisure facilities, education providers, welfare support providers with the purpose of ensuring a person’s goals around social inclusion and personal development are met.
* Develop relationships with organisations offering support with volunteering opportunities and employment support.
* Develop working relationships with primary care; our strategic ambition is to develop mental health support at primary care level and we expect this service to ensure that GP surgeries are aware of how to access it, what if offers, and promote a simple means of accessing it with minimum paperwork.
* Develop working relationships with health and social care partners including adult social care teams, Care Coordinators, Community Psychiatric Nurses, and Occupational Therapists to agree how people will be supported should their needs change. It is expected that formal arrangements will be made with Derbyshire Healthcare Foundation Trust (DHcFT) regarding access to occupational therapy support, assessment and advice.
* The Service will promote itself to other providers and organisations that are likely to encounter people requiring support for their mental health.

Other key partners include:

* + Secondary MH services - Derbyshire Healthcare Foundation Trust
  + CAMHS
  + IAPT Services
  + Statutory and non-statutory Advocacy Services
  + Community Action Derby (VCS infrastructure organisations including in Derby Wellbeing)
  + Voluntary and community organisations including mental health organisations, ethnic community organisations and faith groups
  + Mental Health Together - Derby Mental Health Forum
  + Priority Families Programme
  + Substance misuse services
  + Domestic abuse services
  + Probation services
  + Employment services and mainstream employment and benefits services including Job Centre, Benefits Agency
  + Welfare Rights Services including Citizens Advice and DHA
  + Housing support providers and housing agencies including Derby Homes
  + Services which support homeless, vulnerable or isolated people
  + Derby Adult Learning Service (DALS)
  + Local colleges, education/training agencies,
  + Public health lifestyle services e.g. exercise, healthy hating, stop smoking

Referral pathways will need to enable people to transition flexibly, respecting the fact that people’s needs will fluctuate during their recovery journey. The Service Provider will make proactive referrals to partners’ services when appropriate and will accept referrals from these services as and when required.

The Council and ICB are committed to working with other commissioners and partners to ensure that this Service delivers good outcomes for people accessing it. This may include for example supporting the development of referral pathways from statutory agencies or facilitating communication between support providers with shared aims.

## 3.13 PERSONAL BUDGETS AND PERSONAL HEALTH BUDGETS

Where a person with a Personal Budget or Personal Health Budget wishes to purchase additional support from the Service Provider(over and above that identified in their individual recovery plan) then this could allowable as long as:

* The support to be purchased is clearly distinct from the support offered by the Recovery and Peer Support Service and is separately recorded and monitored and reported on to the Council and ICB.
* The Service Provider is appropriately registered with local and national bodies to deliver an additional service for Person with Personal Budgets or Personal Health Budgets.

Over time this could bring in additional income and business development opportunities for the Service Provider and may offer people choice and control. The Service Provider will need to clarify what support is proposed and have clear communication plans in place to support the person understanding and decision-making. The Council and ICB will be mindful of the potential for double funding as a result of this arrangement and would therefore need to have an on-going understanding of the use of Personal Budgets or Personal Health Budgets alongside the Service. For example, the Council and ICB will require information as to how any additional services are marketed and be clear on the distinction between these and the core Service as described within this specification.

## 3.14 REQUIRED OUTCOMES

The Service Provider will use appropriate recovery tools to measure achievement of individual outcomes, which will be agreed with the Council and ICB prior to the commencement of the Service. This data will be able to be aggregated to a service level to measure the overall impact of the Service and to measure Personnel performance targets. Data will be provided in quarterly and annual reports as well as for ad-hoc requests by the Council and ICB.

The Service Provider will agree a method of outcomes monitoring for volunteer peer support groups with the Council and ICB prior to commencement of the Service. Data collection will be proportionate for this element of the Service and may include an annual survey of people using the peer support groups. All monitoring data will be available as a raw data set on request and aggregated to a service level for the purpose of performance reports.

The Service Provider will work with people with lived experience to develop outcomes for people using the service and carers, which it will agree with the Council and ICB [within 3 months of commencement of the service]. This can be based on the examples below which were developed for the previous service:

|  |  |
| --- | --- |
| As a result of accessing support from this Service\* …. | |
| **Outcomes for people using the service\*\*** | I feel more able to manage and maintain my mental health condition |
| I feel more knowledgeable about my condition and have improved coping skills |
| I feel that the service responds to my needs quickly enough when I need or ask for help |
| I feel that the support available is provided at times and days that suit me |
| I feel that the support is delivered in a way that makes me feel safe and comfortable, such as a good choice of venues |
| I feel more able to sort out any problems relating to accessing other services or support (such as housing support/ benefits etc) |
| I feel I am able to access peer support/ support available from other people with mental health needs |
| I feel that I have more structure and positive things to do |
| I feel that I have been given opportunities to volunteer and/or support other people |
| I feel that I have been supported to work towards or achieve my goals around access to employment, volunteering, education or training |
| I feel that I have opportunities to be involved in how the service is designed and provided |
| I feel that my ideas and feedback will be listened to and considered |
| I feel less socially isolated |
| I feel more involved in my community |
| I feel that my physical health has improved |
| I feel that my mental health has either a) improved or b) stabilised |
| I feel more able to live independently in the community |
| I feel more confident that my support needs would be met if my mental health worsened |
| I feel satisfied with the support I have received from this service |

The Service Provider will work to achieve and evidence these outcomes on a self-reporting basis. The Service Provider is expected to capture information from people using the service at timely intervals to evidence these outcomes, and evidence that 75% of people agree with the agreed outcome statements.

The Service Provider will be expected to work towards the following Key Performance Indicators in Year 1 of Service delivery. Evidence and evaluation should include qualitative and quantitative sources of information. Key Performance Indicators will be reviewed on an annual basis.

**Performance Requirements for Year 1**

| **Performance Requirements** | **Method of Measurement** | **Frequency of Monitoring** |
| --- | --- | --- |
| Evidence that the Service is developing and working to a recovery focussed approach | Development of database/ system reflecting progress against individual goals, being able to aggregate this to a reflect outcomes achieved across all elements of service delivery | Monthly for the first six months; Quarterly thereafter |
| Evidence that the Service is supporting people in a positive way in line with the outcomes statements as above | People and carers self-reporting as above; evidence that at least 75% of people agree with the outcomes statements as a result of the support received | At least annually |
| Maintaining current and developing positive new working relationships with stakeholders, identifying when people may need access to clinical or therapeutic interventions, or support from a partnership organisation around a linked issue such as housing; drug and alcohol support; benefits etc. | Information sharing agreements in place; working relationships clarified and any Service Provider to Service Provider protocols in place; evidence through case studies/ people’s feedback; other measures to be agreed with the Council and ICB | Monthly for the first six months; Quarterly thereafter |
| Evidence of information sharing agreements being in place with key partner organisations to support assessment and safety | Information Sharing Agreements in place | To be demonstrated within contract initiation period |
| Development of unique website reflecting the key information needed by people who may benefit from the Service | Website operational albeit in basic form initially | To be demonstrated within contract initiation period |
| Evidence of geographical spread/ equity of access for all elements of the Service | Evidence gathered through:   * Clear spread of activity across city * Variety of activities developed based on local demand * targeted promotion materials produced that reflect diverse needs within city * access data to ensure support is reaching all demographics, including protected characteristics and people transitioning to adulthood | Monthly for the first six months; Quarterly thereafter |
| Evidence of developing peer supporters through each element of the Service | Outcomes tools; training records; recruitment of peer supporters; case studies; reporting of numbers of people supporting and being supported; increase to be noted year on year regarding reach of Peer Support element | Monthly for the first six months; Quarterly thereafter |
| Evidence of increased number of people being supported to move on to community/ non-specialist provision having achieved their personal recovery goals. | Outcomes data; monitoring data; demonstration against social inclusion traffic light monitoring; case studies and people’s feedback | Quarterly |
| Numbers of people being supported within distinct activities of the service: Peer Support (as a recipient and as a supporter); Recovery Education; individualised recovery and support and others as suits the Service delivery | Numbers of people accessing which areas of support | Monthly for the first six months; Quarterly thereafter |
| Numbers of people supported to access training; education; volunteering and employment as a result of the service | Numbers of people supported to achieve or further their goals in these areas; year on year increase in the number of people being supported to attain training; volunteering; and paid employment within and outside of the Service | Monthly for the first six months; Quarterly thereafter |
| Referral information to detail where the referrals are coming from | Numbers of people being referred by whom | Monthly for the first six months; Quarterly thereafter |
| Recovery Education development | Evidence of partnership working to determine priorities and scope out existing activities,  Evidence of developing programme in place,  Numbers of people supported to access recovery education  Positive feedback received from people regarding their learning experience and outcomes | Monthly for first six months and quarterly thereafter |
| Demonstration that the service is supporting wider aims to reduce the impact on statutory service provision | Individual feedback/ case studies/ impact analysis demonstrates a general trend towards a reduction in usage of statutory health and social care services as a result of the service; other measures to be agreed by the Council and ICB.  The Council and ICB will work with the Service Provider to identify ways that we can use local data and information to achieve this measure. | Monthly for the first six months; Quarterly thereafter |
| People who may be accessing other Derby health and social care services temporarily, but are otherwise not a Derby resident may access this service - for example if a person is temporarily in Derby following a hospital admission. The Service Provider will need to record and report on who is using the Service who is not ordinarily a Derby resident | Numbers of people using the Service who are not a City of Derby resident. | Quarterly |
| Evidence of contributions to, engagement and effective collaborative working within the Derby Wellbeing system | Examples and feedback from system partners | Quarterly |

## 3.15 SAFEGUARDING

Both the Council and the Service Provider must follow laid-down national and local safeguarding procedures as part of the process of managing and preventing serious concerns. These safeguarding procedures relate both to adults and any children that may visit the Service as part of the wider involvement of the community.

The Service Provider will be fully compliant with the protocols for Safeguarding Adults and Safeguarding Children set out by the Council on our website:

* <http://www.derby.gov.uk/health-and-social-care/safeguarding-adults-at-risk/safeguarding-vulnerable-adults>
* <https://www.derbysab.org.uk/>
* <https://www.derby.gov.uk/health-and-social-care/safeguarding-children/>
* <https://www.ddscp.org.uk/>

The Service Provider will need to demonstrate understanding and compliance of Derby Adults and Children’s Safeguarding policies and procedures. This will include demonstration of training for all Personnel and appropriate training being delivered to volunteers that is proportionate to their role.

The Service Provider will have a named officer will act as the lead safeguarding officer who will be responsible for reporting to the Council all concerns raised in connection with the protection of vulnerable adults at Stage One of the Safeguarding Adult Protection Policy and Procedures and inform the Council in writing who that person is. The Service Provider will notify the Council of any changes to this member of Personnel.

The Service Provider will ensure all its Personnel are aware that they are individually responsible for compliance with the Safeguarding Adult Protection Policy and that they know all the internal and external processes for reporting all concerns in connection with the protection of vulnerable adults and children where appropriate.

Personnel should be told in writing that they can report concerns through the nominated member of Personnel, or if they would prefer to, through the Council as set out in the Council’s Safeguarding Adult Protection Policy and Procedures.

Staff training needs in relation to safeguarding will be continually evaluated with all staff receiving appropriate training, The Service Provider will be able to access the Council’s training relating to appropriate Safeguarding courses.

The Service Provider is expected to have a clear statement outlining the service’s responsibilities towards people using the service available for all staff,

The Service Provider will demonstrate senior management commitment to the importance of safeguarding and promoting the welfare of people using the service.

## 3.16 SERVICE PROVIDERS' PERSONNEL

A number of the present post holders may have TUPE rights as the Service being tendered is largely similar to their current duties. Details of their employment contracts are included in [xx.xx]

The Service Provider will supply sufficient suitably experienced and skilled Personnel and demonstrate a robust, safe, values-based approach to recruitment, which includes employment checks (references, right to work checks etc.).

Personnel must have undertaken or are willing to undertake specialist training and professional development to effectively provide and manage the Service as described in this Service Specification.

The Service Provider may also wish to consider providing opportunities for less experienced Personnel who may have life experiences, skills or knowledge which will bring value to the Service.

The Service Provider will ensure their Personnel are competent, appropriately skilled, supervised and supported on an on-going basis to maintain the overall quality of the Service.

The Service Provider will ensure that all Personnel will have undergone the necessary clearance checks, including enhanced DBS checks, updated every three years and meet the necessary requirements before being appointed, when required. They will also undergo any other relevant checks required under future legislation. Documentary evidence of this may be requested by the Council and ICB.

The Service Provider will need to consider the appropriateness of DBS checks for volunteers based on role descriptions and level of contact with people.

The Service Provider will employ Personnel who have an awareness and experience of supporting people who have experienced mental ill health. This must include both common mental disorders such as anxiety and depression, as well as severe mental illnesses such as schizophrenia and psychoses.

The Service Provider will also employ Personnel who are able to work with a range of a person’s needs including communication; sensory; learning disability; autism and Asperger’s.

Effective leadership of Services is key to the successful implementation of our desired approach, particularly in fostering a positive approach to recovery and maintaining stability and wellbeing amongst Personnel. The Personnel profile of the Service must reflect the aspirations of a recovery approach and that of an inclusive service. This will require an appropriate skill mix.

It is expected that in addition to a core Personnel team funded through this contract, the Service should also draw from, and utilise the skills of, the local community including experts by experience in a paid and voluntary capacity. It is anticipated that volunteers should be a significant part of the service and that good opportunities are provided to support progression into paid work within or outside of the Service.

The Service Provider will ensure that their organisation has Personnel who are able to facilitate and support volunteer peer supporters and have expertise in developing and maximising social capital and enabling community-led activities and initiatives.

## 3.17 PERSONNEL SUPERVISION, APPRAISAL, RETENTION, TRAINING & DEVELOPMENT

The Service Provider will be required to have the following systems in place:

* A system for a comprehensive induction process including service specific training and equal opportunities training for all Personnel.
* A health and safety policy and training plan inclusive of all areas deemed necessary to work safely within different settings.
* Risk management policy and procedures.
* The Service Provider will ensure that all operational Personnel have received adequate training in Safeguarding and fully understand and comply with the Derby City Adults and Children’s Safeguarding policy and procedures.
* The Service Provider will ensure that all operational Personnel have access to case management and professional supervision and support on at least a monthly basis to ensure quality and consistency of Service.
* Each member of Personnel will have a personal and professional development plan/portfolio that is assessed, implemented and evaluated on an annual basis. Documentary evidence of this may be requested by the Council and ICB.
* The Service Provider will allow Personnel to have the opportunity to attend appropriate further training.
* The Service Provider will consider what support, supervision; training and progression opportunities are proportionate to volunteers and experience by experience within the service and demonstrate evidence of their organisational policy with regards to this.
* The Council’s own Workforce Learning and Development training courses are available to the Service Providers’ Personnel, as a partner agency working with the Council and can be found at <http://www.derby.gov.uk/health-and-social-care/your-life-your-choice/support-from-adult-social-care/training-courses/>
* The Service Provider will report on their practices around Personnel training and appraisal as part of the contract monitoring process.
* The Service Provider will have retention offer to attract and retain Personnel.

## 3.18 SERVICE VALUES, PRINCIPLES AND ETHOS

The Service will work in line with the values and principles underpinning personalisation, recovery and an asset-based approach to care and support as well as those which have been specifically highlighted by local stakeholders in section [xx.xx] above.

All Service Provider is expected to be an active partner in [Derby Wellbeing](https://livingwellderbyshire.org.uk/localities/derby-wellbeing) and the over-arching [Living Well Derbyshire](https://livingwellderbyshire.org.uk/) programme. This includes signing up and adhering to the values, principles and behaviours of the partnership, working to support the changes The Service Provider must sign-up to the Living Well Alliance and Derby Wellbeing Collaborative.

The Service will:

* be responsive and flexible enough to reflect changing needs and priorities.
* have systems in place to ensure continual improvement.
* be delivered effectively and efficiently.

The Service Provider will be required to show evidence of taking account of a person’s views about the Service, particularly in respect of accessibility and impact. The Service Provider will detail and agree with the Council and ICB how they intend to collect and analyse this feedback and use it to monitor and improve the Service. The Service will have policies and procedures in place for making and maintaining records of engagement with people. The policies and procedures will be expected to detail standards for recording personal information, internal audit and quality monitoring, storage, cataloguing, archiving and destruction.

## 3.19 MANAGEMENT, MONITORING AND FEEDBACK

The Service Provider will provide quarterly monitoring and management information, an annual report and other information on request. See section [xx.xx] **Required Outcomes** for details of the minimum requirements.

It is also expected that the Service Provider will use all monitoring data and feedback to review service performance and make adjustments and improvements to the service in light of findings.

The Service Provider will have an easily accessible complaints procedure and make this known to all stakeholders and users of the service. The Service Provider will analyse the themes presenting within any complaints or compliments received and report these to the Council and ICB on a quarterly basis, including detailing what actions have been taken by whom and when. Findings of complaints will be reviewed and reported on in line with the Service Provider’s own complaints policy, and service adjustments made where necessary.

The Service Provider shall provide suggestions and feedback to the Council and ICB on how the service could be improved, in line with the principles of personalisation and greater choice and control for people and carers. The Service Provider’s constructive feedback on how the local support offer could be improved outside of the Service would also be welcomed and is expected to form part of the on-going dialogue between Service Provider and Council/ICB in the spirit of joint working.

All statistical data will be recorded onto a computerised database, using standard categorisation of issues. Monitoring data and raw data will be made available to regulatory bodies and the Council and ICB on request and will be regularly provided at contract monitoring meetings.

The Service Provider is required to keep comprehensive records of people’s contacts which will enable both quantitative and qualitative analysis.

The Service Provider will record and report on unmet needs to support commissioning and service development locally for the Council and ICB as well as Derby Wellbeing system partners.

## 3.20 INFORMATION SHARING AND DATA PROTECTION

People have a general right to independence, choice and self-determination including control over information about themselves. In the context of adult safeguarding these rights can be overridden in certain circumstances.

Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without informed consent. The Service Provider and any associated organisations will sign up to Information Sharing Agreements as part of the pre-contract/ contract initiation period.

The law does not prevent the sharing of sensitive, personal information within organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified.

With the consent of the person, the Service Provider can share appropriate information with the referrer, the person’s GP and other organisations the person is involved with.

The Service Provider and its Personnel must comply with Data Protection Act 2018, UK GDPR 2021, any future ‘applicable UK data protection legislation’ and Article 8 of the Human Rights Act (the right to privacy) and any subsequent legislation that is applicable during the course of the Agreement.

As a minimum this means:

* People are informed of how their personal data will be processed.
* Personnel will not share information about people outside of the workplace.
* Records will be accurate and kept up to date.
* People will have a right to access to information held about them.
* Personal data will be kept secure at all times.
* Any disclosure of personal information must be done securely.
* Personal data will not be collected that is not required for the provision of the service.

The Service Provider shall have a Data Protection Policy that governs conduct of Personnel and how personal data is kept secure.

The Service Provider must ensure that the Personnel who provide this Service are aware of their responsibilities under the Data Protection Act 2018, UK GDPR 2021 and any future ‘applicable UK data protection legislation’. The Service Provider will ensure that new Personnel receive training with regard to this as part of their induction and regular refresher training at least every two years.

The Service Provider must therefore ensure signed confidentiality agreements are in place for all members of Personnel working on the contract.

The Service Provider will ensure appropriate security procedures are followed to protect the personally identifiable information belonging to people when making referrals or communicating on their behalf.

The Service Provider will provide the required information for the Council to complete a Data Privacy Impact Assessment. The Service Provider should note that this may change the draft Information Processing/Sharing Agreement in Schedule XX

**Location of Personal Data Storage/Back-up**

The Service Provider is to ensure that any personal data processed under this contract shall not be processed outside of the UK. If requested the Council may consider alternatives to this as long as significant security requirements are met, which may mean a change of terms and conditions the Service Provider has with any third-party storage solution provider. The Council is under no obligation to consider a request to store this personal data outside of the UK. Any additional costs the Service Provider incurs to meet these requirements shall be entirely met by the Service Provider.

The Service Provider is required to understand where the personal data is 'stored' especially if using 'cloud services'.

The Service Provider will engage and respond to any request from the Council concerning the location of stored personal data, with proof if requested, at no extra cost to the Council.

## 3.21 SOCIAL / ADDITIONAL VALUE

Social value expectations are embedded within this Service Specification and will be implicit in individual User outcomes. The Service Provider will also be expected to consider how best to maximise additional social value for the area of Derby and its residents through the mechanisms below:

Wellbeing for Children and Young People:

* Advice and Information Sessions/Workshops in various settings ie education establishments/sports clubs etc.

Employment Opportunities:

* New roles created in Derby and Derby residents interviewed.
* New Skills/Training for Adults and Young People
* Interview workshops/Experience
* CV Workshops
* Training/Retraining

Other possible additional benefits

* considering how you can generate value to the local supply chain
* considering seeking external funding as appropriate to further the aims and objectives of the service.
* considering how you can minimise the environmental impact to the local community when delivering these services.
* Considering other ways that the contract can offer additional value in the delivery of the contract

The Service Provider will be required to record and report on additional value to the Council through contract management.

## 3.22 IR35 (INTERMEDIARIES LEGISLATION) AMENDMENT FOR OFF-PAYROLL WORKING IN THE PUBLIC SECTOR

The law now requires public sector bodies to decide the employment status of persons they engage to provide Services, or predominantly Services, through an intermediary such as a personal service company or agency. The Council will decide the employment status prior to engagement using HM Revenue and Customs employment status tool, which can be found here -

<https://www.tax.service.gov.uk/check-employment-status-for-tax/setup>

If the Council decides the engagement is ‘employment’ Tax and Employees National Insurance will be deducted from the Service Providers invoice under PAYE.

The Council believes that IR35 is not applicable to this requirement. However, if it becomes apparent that there needs to be a review of the employment status of this requirement, then the Service Providers shall co-operate with and assist the Council in reaching a decision if IR35 is applicable, which shall rest with the Council.

## 3.23 EQUALITIES, DIVERSITY AND INCLUSION

The Council is committed to advancing equality of opportunity and providing fair access and treatment in employment and when delivering services. We will work to deliver our commitments by tackling inequality arising out of age; disability; gender re-assignment; marital status and civil partnership; pregnancy and maternity; race; religion and belief including non-belief; sex or gender; sexual orientation; and other forms of disadvantage such as rural deprivation and isolation. Our policy applies to every Councillor, manager and employee of the Council and any other person or organisation employed by the Council to work or to deliver services on its behalf, including those employed through contractual, commissioning or grant-aided arrangements.

It is the responsibility of the Service Provider to actively meet the requirements of the Equality Act 2010 and Derby City Council responsibilities under the Public Sector Equality Duty (the Duty) by paying due regard to:

* eliminating discrimination, harassment, and victimisation and any other conduct that is prohibited by the Equality Act
* advance equality of opportunity
* foster good relations between people who share a relevant protected characteristic and those who don’t.

Having due regard means the Service Provider needs to:

* remove or minimise disadvantages suffered by people due to their protected characteristics:
* take steps to meet the needs of people with certain protected characteristics where these are different to the needs of other people
* encourage people with certain characteristics to participate in public life or in other activities where the participation is disproportionately low.

The Council and ICB also expects the Service Provider to:

* capture effective data collection on Personnel and people using the service and analyse these statistics
* produce equality impact assessments on policies, procedures and services that may have an impact on people or the service as a whole
* provide one or more equality objectives at least every four years

The Duty and this Specification requires the Service Provider take into account disabled people’s impairments, when making decisions about policies and services, as the law recognises that disabled’s people’s needs may be different from the needs of non-disabled people. This might mean making reasonable adjustments or treating disabled people better than non-disabled people to meet their needs.

All Personnel employed by the Service Provider will recognise and respect the religious, cultural and social backgrounds of people in accordance with legislation and local and national good practice.

The Service Provider will ensure that it has access to appropriate translation services/resources to enable equity of access and understanding.

## 3.24 SERVICE CONTINUITY AND RISK MANAGEMENT

The Service Provider will need to have a service continuity plan in case of risks to the continued delivery and expected performance of the Service, e.g. emergencies, disaster recovery, insolvency, staffing issues. The service continuity plan shall refer to all elements required to perform the Service Specification and as a minimum cover when the plan will be triggered, approach and obligations liaising with the Council, ICB and other partners, data security, monitoring and management of financial risks to the service, maintaining sufficient staffing levels with clear roles and responsibilities, Service accommodation, maintain supply chain, Service catch-up and return to normal

The Service Provider should have scenario planning for known issues and identified risk, have a clear process of contingency plan review and update.

The plan should demonstrate an understanding that, at all times, the priority shall be the care, support and safety of the people receiving a service from the Service Provider

The Service Provider shall upon the Council's request provide the service continuity plan and any other risk management strategies documents relating to the performance of this Service, at an agreed interval as part of the framework/contract initiation period.

The Service Provider shall review the service continuity plan on an annual basis during the term of the contract, to ensure it is addressing all know issues and risks.

## 3.25 LOTS

The opportunity has not been broken down into lots as it is felt that to do so would undermine the Service Provider’s ability to gain a holistic view of people’s needs across the City and to monitor and meet the needs of people effectively. Partnerships and collaborative or joint working between different organisations for aspects of the Service (e.g. within harder to reach communities) will be considered to be advantageous, recognising the many advantages of bringing together different expertise and experiences.

## 3.26 INSURANCE

The Service Provider will have the following insurances in place during the performance of the contract:

* Employer's liability insurance in accordance with any legal requirement for the time being in force in relation to any one claim or series of claims
* Public Liability Insurance - £5m for each and every event

## 3.27 PAYMENTS AND FUNDING

Payments will be made by the ICB, [in advance?], on a quarterly basis.

Invoices are to be sent to the ICB on a quarterly basis in advance. No payments will be made without a valid invoice.

For the period from the Commencement Date to the [xx] any annual cost will be pro-rata the number of months from the Commencement Date. For example, if the Contract starts on the 1 June 2023 and the annual charge is £240,000, only 9 months’ worth of charges shall be paid, i.e. £180.000.

## 3.28 EXIT STRATEGY

Towards the end of the Agreement where there is no extension to the Initial Term or a new Agreement is let with another organisation the Service Provider will assist as appropriate, and in a reasonable, positive and timely manner that offers maximum support and positive outcomes for people using the service.

The Service Provider will work alongside alternative Service Providers and support transfer arrangements to future Service Providers. The Service Provider will ensure that any transfer arrangements are conducted in a manner which is focussed on the wellbeing on the users of the services and are supported by appropriate information sharing or other agreements/protocols.

1. Working day is defined as Monday to Friday excluding Bank Holidays [↑](#footnote-ref-1)