Healthy Minds

Better lives, brighter futures:

Healthy Minds Integrated Peripatetic Mental Health Support Service in Community

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ACTasONE

Transforming our Mental Health Services in Community

Happy Healthy and at Home

Healthy Minds is our strategic and system approach to achieve better lives and improve the support we offer to people with mental health, substance use needs, learning disabilities or are neurodiverse.

As a health and care system, we believe in supporting people across Bradford District and Craven, with the best start in life and – fulfilling our shared purpose to ensure everyone can be 'happy, healthy at home'. This ambition was set out in our Partnership Strategy[i] which was launched in 2022, where we set out our commitment to deliver for our population and our place by meeting people where they are, working with them to access the tools and opportunities to enable them to live longer in good health

Our Purpose

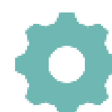
We act as one to keep people happy, healthy at home

Our Population

Supporting the delivery of our priorities and a better experience of health and care

Our Place

Making our district the best place to live, work and study



Our Partnership

Greater value through the best use of our collective resources, minimising duplication and waste

Where we live, study, work and develop relationships is important to ensure good mental and physical health and wellbeing. The coronavirus (COVID-19) pandemic has shone a spotlight on long-standing health inequalities[ii] and the needs of our communities and we know that some communities struggled more than others. Our partnership approach led the way during the pandemic to come together, understand our population needs, build support and better access to care. As a district, we learned what is possible when we *Act as One*[iii] to make a difference for people who need us the most.

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Our Healthy Minds strategy sets our plan to promote, respect and improve the wellbeing of everyone to be active citizens, but also to prioritise our efforts for people with mental health conditions, substance use, neurodivergent needs or living with a learning disability to access care and support.

This strategy sets out three clear priorities to achieve this ambition:

- Promoting better lives,
- Respecting rights and
- Improving support.

We welcome the way our local health and care partnership, spanning NHS, Local Authority, Police, Community, and independent community sector have listened, learned and committed to working to address the mental wellbeing of our people. Through the Mental Health transformation programmes we are in the process of re- designing crisis and community mental health care, making better use of collective resources by bringing together local authorities, NHS services, primary care networks and the voluntary and community sector to deliver proactive, personalised and preventive mental health care. Bradford District and Craven Health and Care Partnership (BDCHP) have ring fenced investment to commission mental health services from local and accessible Voluntary and Community Sector Enterprises aligned with the national Community Mental Health Framework (Sept 2019) and Government White Paper 'Integration and innovation: working together to improve health and social care for all' (Feb 2021).

This commission is available to Bradford district and Craven based VCSE organisations providing mental health services for our communities, in recognition of their vital role in responding to the pandemic , ongoing system pressures and supporting some of the most acutely ill and vulnerable patients. This specification sets out how this service will continue to build on and further deliver the ambitions set by people for our services. As such, we will continue to work with our providers to further shape and transform the service and the system of support.

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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**Healthy Minds Integrated Peripatetic Mental Health Support Service in Community**
Lead System Commissioner	Sasha Bhat, Priority Director for Healthy Minds
Commissioning Manager	Rashmi Sudhir. Head of community mental health
Provider Lead	VCSA
Period	2 Years + 1 contract (subject to ongoing funding)
Date of Review	TBC

1. Population Needs

1.1 National / Local Context

The Mental Health Five Year Forward View (2016) outlines a strategic approach to improving mental health outcomes across the health and care system. There are three main priority areas:

- A 7-day NHS – right care, right time, right quality which include alternatives to admission in non-clinical settings.
- An integrated mental and physical health approach
- Promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens.

The Community Mental Health Framework[iv] describes how the Long Term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks.

Through the adoption of this Framework, people with mental health problems will be enabled to:

- Access mental health care where and when they need it, and be able to move through the system easily, so that people who need intensive input receive it in the appropriate place, rather than face being discharged to no support
- Manage their condition or move towards individualised recovery on their own terms, surrounded by their families, carers and social networks, and supported in their local community
- Contribute to and be participants in the communities that sustain them, to whatever extent is comfortable to them

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This Framework sets out a new approach in which place-based and integrated mental health support, care and treatment are situated and provided in the community. This will be for people with any level of mental health need. It will enable more and higher-quality care to be provided at a local community level (of 30,000 and 50,000 people, the population of a Primary Care Network's geographical footprint) by ensuring that care takes place in the context of people's lives, and supports them to live better within and as part of their communities. It has a strong focus on the needs of people with severe mental health problems, including those who have coexisting physical health problems

There is a wide range of different barriers for our communities accessing mental health care. Lack of knowledge around mental health care, different cultural attitudes or ideas about mental health, and relationships with healthcare practitioners in the local area, institutional attitudes towards minorities, really serve as a barrier for communities accessing mental health access and treatment. However, it has been shown that services based in the community and particularly in the voluntary, community and social enterprise sector (VCSE) are more likely to develop the relationships of trust that promote access and awareness of mental health services for diverse communities. It is also important that health and care systems identify and implement specific measure to address the prevalent inequalities in mental health. Therefore, continuous engagement, collecting and recording local data and intelligence that includes monitoring experiences and outcomes of people from diverse communities, is needed to provide accurate analysis, appropriate service delivery and to inform targeted action for addressing health inequalities.

Policy and guidance

- Healthy Minds Strategy for Bradford District and Craven (2023)[v]
- Connecting people and place for better health and wellbeing - A Joint Health and Wellbeing Strategy for Bradford and Airedale, 2018-2023.
- NHS Long Term Plan (2019) and Major Conditions Strategy (2023)
- The Community Mental Health Framework for Adults and Older Adults (2019)

Local Context

Healthy Minds – promote, respect, improve

Bradford District and Craven is the fifth-largest metropolitan district in England spanning rural and urban areas and representing 25% of the West Yorkshire population. We have a population of 657,579 people including circa 50,000 living in Craven. Younger aged people dominate a large population of Bradford, and the city has the third-highest population percentage for people aged under 16 years in England and there is a rapidly growing older population. A review by the Centre for Mental Health[vi] highlights the impact our demographics, housing, poverty, age, gender and the COVID-19 pandemic has on people with mental health, substance use, neurodivergent needs or living with a learning disability. While we have challenges, the profile of both our population and district, bring with them

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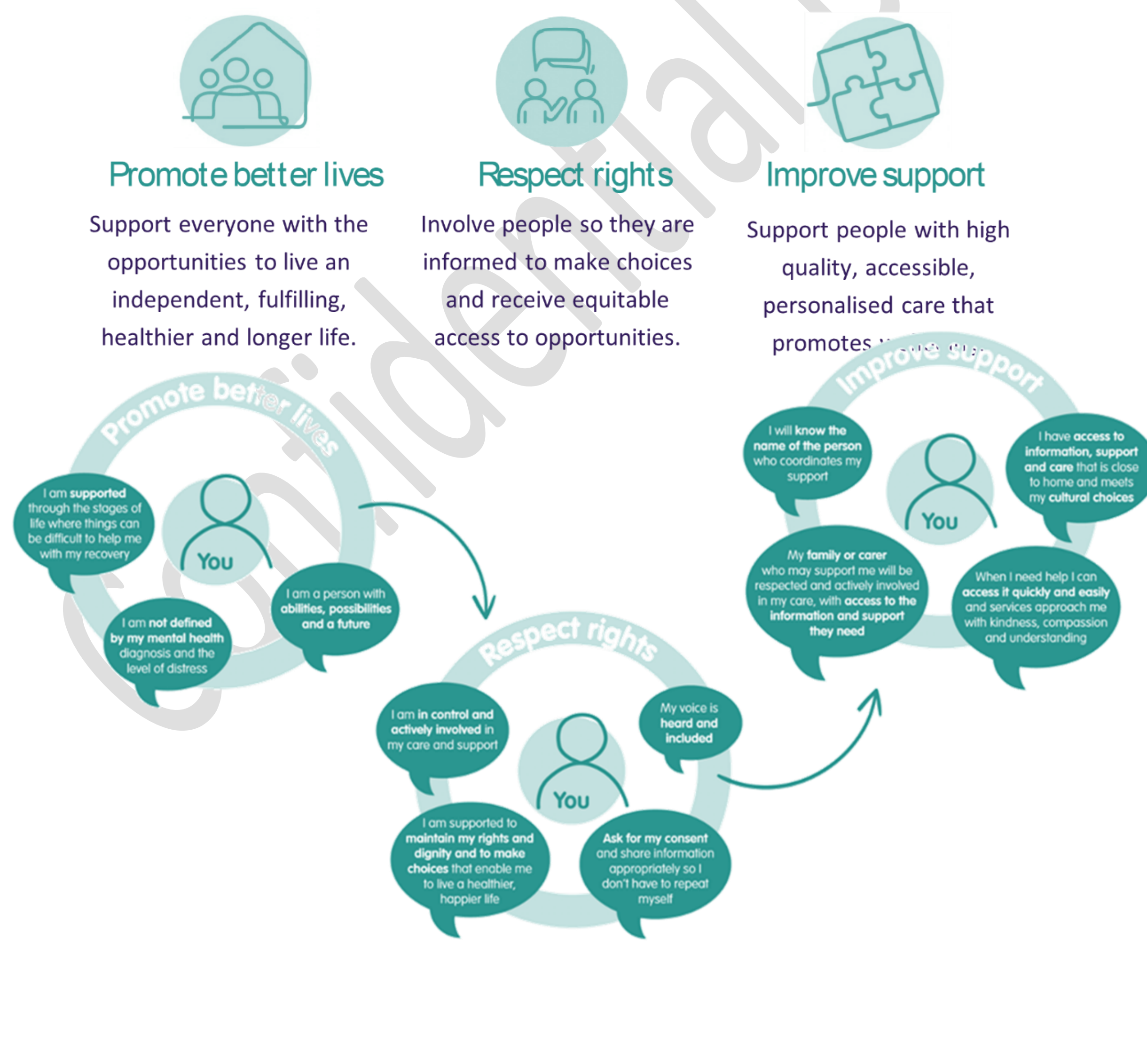
opportunities and assets including diversity, entrepreneurship, resilience, creativity and ambition.

The aim for Bradford District and Craven Health and Care partnership is to create environments and communities that will keep people well across their lifetime; where they are open to speak about emotions without fear of stigma and discrimination. We want to make it acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills and understanding to support their needs. Tackling inequalities is one of the key priorities and we are committed to making sure that equality and diversity is a priority when planning and commissioning local healthcare. The BDDCHP work closely with local communities to understand needs and how best to commission the most appropriate services to meet those needs.

The lived experience of people and carers are at the heart of our Healthy Minds Strategy. We have listened to people, carers and staff sharing their journeys, the challenges and their aspirations for how our services must evolve They told us why these three priorities are important, what this looks like for them in practice and what our overall outcomes should be



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Service User "I" Statements

Promote better lives

1. I am a person with abilities, possibilities, and a future
2. I am not defined by my mental health diagnosis and the level of distress.
3. I am supported through the stages of life where things can be difficult.

Protect rights

4. My voice is heard and included.
5. I am supported to maintain my rights and dignity and to make choices that enable me to live a healthier, happier life.
6. I am in control and actively involved in my care and support.
7. Ask for my consent. Share information appropriately, so I don't have to repeat myself to different people.

Improve access to support

8. I have access to information, support and care that meets and my cultural choices.
9. When I need help, I can access this quickly and easily and services approach me with kindness, compassion and understanding.
10. I will know the name of the person who coordinates my support
11. My family or carer who may support me, will be respected and actively involved in my care with access to information and support they need.

The above Mental Health 'I Statements' have been agreed as the overarching principles that will inform the delivery of our system commissioned mental health services and future service improvement/redesign projects. The statements set out the values and competencies that will be expected from the care and support provided:

Healthy Minds is our strategic and system approach to achieve better lives and improve the support we offer to people with mental health. We want to make it easier for people in Bradford District and Craven to access information, advice, support, and personalised care based on their needs. Through the Mental Health transformation programmes, we are in the process of re-designing crisis and community mental health care, making better use of collective resources by bringing together local authorities, NHS services, primary care networks and the voluntary and community sector to deliver proactive, personalised, and preventive mental health care. We want to create environments and communities that will keep people well across their lifetime; where they are open to speak about emotions without fear of stigma and discrimination. We want to make it acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills and understanding to support their needs. Tackling inequalities is one of the key priorities and we are committed to making sure that equality and diversity is a priority

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when planning and commissioning local healthcare. Healthy Minds partnership work closely with local communities to understand needs and how best to commission the most appropriate services to meet those needs.

This approach may require some reshaping of the existing commissioned services, with an emphasis on raising quality, supporting recovery, and achieving personal as well as service outcomes. This shall be referred to as the 'Transformation Process' and will form part of the on-going contractual arrangements. The service shall work with adults aged 18+ (16+ if they are transitioning from (children's mental health services) who have mental health support needs and/or who suffer from emotional distress. There is a need for the Provider to demonstrate an understanding of the needs of the provision for different age groups and service structure.

Healthy Minds partnership recognises that one of the keys to delivering a safe and effective services in community is by working in a collaborative approach through multi-agency and cross departmental working. The commissioners and the provider/s will work together through the established Healthy Minds Partnership and Mental Health Provider Forum to achieve this in all aspects of service delivery.

This Specification sets out the framework which will contribute to the outcomes that the Healthy Minds partnership wishes to achieve.

2. Outcomes

2.1 NHS Health Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

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2.2 Local outcomes

Working together – our principles and framework

Our Healthy Minds ambition is to make it easier for people in Bradford District and Craven to access information, advice, support and care based on their needs.

To achieve this, we need to move away from siloed services based on thresholds and tiers towards an integrated multiagency, multidisciplinary, place-based service, underpinned by a focus on public health to address inequalities and maintain mental wellbeing through effective community-based prevention and protection strategies.

Through the Mental Health transformation programme, we are in the process of re- designing community mental health care, making better use of collective resources by bringing together local authorities, NHS services, primary care networks and the voluntary and community sector to deliver proactive, personalised and preventive mental health care.

Bradford District and Craven Health and Care Partnership (BD&CHP) have a new ring fenced investment to commission additional mental health services from local and accessible Voluntary and Community Sector Enterprises aligned with the national Community Mental Health Framework (Sept 2019) and Government White Paper 'Integration and innovation: working together to improve health and social care for all' (Feb 2021). This is available to VCSE services providing specialist mental health services in recognition of their vital role in responding to the pandemic , ongoing system pressures and supporting some of the most acutely ill and vulnerable patients.

BD&CHCP have developed a Core Model Framework[vii] (CMF) for Adults and Older Adults in line with the NHS Long Term Plan's vision for a place-based, community mental health model. This enables modernisation of community services to offer whole-person, whole-population health approaches, aligned with the Primary Care Networks (PCN). Co-production will help develop services that combine lived experience with 'traditional' clinical skills. This will facilitate a more person centred service that is focused on the user's needs based on user experience and what is important to them and their general wellbeing. The CMF allows for a shift to a new model of community mental health provision, designed on an asset-based view of communities and integrated working across agencies, rather than a traditional Community Mental Health Team model. People with mental health problems will be supported to live well in their communities, to maximise their individual skills, and to be aware and make use of the resources and assets available to them as they wish. This will help them stay well and enable them to connect with activities that they consider meaningful, which might include work, education and recreation.

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In this CMF, close working between professionals in local communities is intended to eliminate exclusions based on a person's diagnosis or level of complexity and avoid unnecessary repeat assessments and referrals. In the more flexible model envisaged by this framework, care will be centred around an individual's needs and will be stepped up or down based on need and complexity and on the intensity of input and expertise required at a specific time.

The Core Model Framework will be applicable to people irrespective of their diagnosis. This includes but is not limited to those with:

- common mental health problems, such as anxiety or depression
- severe mental illnesses such as psychosis or bipolar disorder
- co-occurring drug or alcohol-use disorders
- eating disorders
- complex mental health difficulties associated with a diagnosis of "personality disorder

Our ambition is to move away from a system that is based on thresholds and tiers to enable people to access information, advice, support and care based on their needs. Working together with people accessing our services, their carers, with staff and stakeholder partners we shared experience and expertise on understanding how we improve the support available. The result is we have adopted, and adapted, the evidence-based model called i-Thrive[viii] to provide a systemic framework for our services to support children, young people, adults and older adults to be happy, healthy at home and have agreed a series of clear guiding principles to deliver and improve our support. Each of the groupings are distinct in terms of the needs and/or choices of the individuals and enable us to ensure we have the right workforce, skill mix and resources required to meet the needs and choice of people. We will underpin this with our focus on public health, addressing inequalities and maintaining mental wellbeing through effective prevention and protection strategies that are community based.

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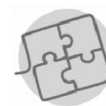
Guiding principles:

Promote better lives

Respect rights



Improve support

Promote better lives	Respect rights	Improve support
Promote hope & better lives	No decision about me without me	No wrong door to services
Happy, healthy, at home	Co-designed	Easy to move between services
Kindness and compassion in our approach	Challenge stigma and be inclusive	Trusted shared assessments
Understanding awareness of trauma	Reduce inequalities	High quality recovery focussed care

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Healthy_Minds_Strategy_v8-final (1).pdf

BDC_Strategy_Narrative_20220301 (2).pd

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3. Service aims and desired outcomes

3.1 Service aims

To develop and deliver locality focused VCSE led 'Healthy Minds Peripatetic Mental Health Service' that supports and is integrated within the Community Mental Health Core Model Framework that will

- Deliver enhanced, integrated social, physical and mental health support in identified localities with flexible 'stepping up' / 'stepping down' of care and is based on intensity of input required and enablement principles.
- Deliver support that is personalised and within a person's community that addresses needs, offers hope and helps someone to live as healthy a life as possible
- Take an asset based approach with an emphasis on self-management and recovery
- Provide integrated models of support configured around the Primary Care Networks
- Develop integrated teams in voluntary and community sector who are confident, skilled and feel supported at work.

Wider aims

- To deliver a person centred service to the specified population , ensuring equity of access and quality of service provision
- To ensure health outcomes and improvements in wellbeing are measured at regular intervals and recorded for submission to national and local datasets
- To support the delivery of the vision and goals of Healthy Minds Strategy
- To be flexible in the delivery of services to ensure the location of services are closer to home and does not prohibit access.

3.2 Service Outcomes

It is expected that through the '**Healthy Minds Peripatetic Mental Health Service'** more people receive intervention at the right place, by the right person in a highly responsive and culturally competent manner.

Purpose

- A joined-up approach working as part of the wide ranging mental health offer to provide continuity and seamless care for patients

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Population

- Increased access to non- clinical mental health support in local communities closer to home.
- Receive coordinated, effective support and care to enable timely access to assessment and advice from the right agency at the right time.
- Reduction in dependence on traditional mental health services by building resilience, support recovery and self-management.
- Increased satisfaction with Healthy Minds and community mental health services
- Increased proportion of people who feel they have recovered from their illness
- An increased range of effective culturally appropriate interventions such as peer support services, counselling psychotherapeutic and pharmacological engagement as well as better access to wider health and wellbeing care

Place

- Increased confidence, skill, response and reflection within our workforce and less stigma
- Utilise effective measurement tools, developing new tools and building the evidence base
- Develop our partners to be a centre of excellence that supports policy, good practice, and innovation in delivering improved and equitable mental health services

Partnership

- Support and develop a strong collaboration and engaged partnership with key stakeholders
- Improve communication, quality and integration of Healthy Minds services.
- Better engagement with our communities that influences our prioritisation of service delivery

4. Service Description

The Service will form a part of an integrated pathway across the voluntary sector, primary and secondary care mental health and social care. It should be based on recovery and social inclusion principles and designed to be accessible and to prevent people falling through gaps between services.. The service will provide additional workforce capacity and interventions supporting the community mental health core model framework.

4.1 Service Summary

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Healthy Minds Peripatetic Mental Health Service in Community will provide

1. A joined-up approach working as part of the wide ranging mental health offer to provide continuity and seamless care for patients
2. An integrated approach with strong links to services and expertise within the voluntary and community sector
3. Provision of a visible and easy to access mental health presence within Communities, GP practices and across PCNs that builds on and utilises already established relationships.
4. Facilitating access and reach between community, primary and secondary care services.
5. Connect system resources and meets needs but does not replicate or duplicate other services. For example : Collaborative working with Social Prescribers, Living Well services and other community wellbeing services
6. Utilises evidence based brief interventions that are part of a coaching and facilitated self-help framework that is forward focused / action orientated, emphasis on psychoeducation, physical and cognitive strategies and self-care .
7. Provide data and outcome measures that are goal based and person reported
8. A commitment to the provision of a responsive and flexible service that can adapt to support individual needs and evolve to meet emerging system needs

4.2 Service Elements

- Support to access, navigate processes and maximise opportunities in areas that facilitate management and/or recovery of their on-going mental health needs.
- Promote and facilitate use of the Healthy Minds tools, services and resources and a clear visible access for wider VCSE support, services, resources and signposting.
- Care navigation support and help to link up all elements of treatment and support available including wider community support, information and advice relating to social factors , wellbeing and wider determinants
- An offer of support that is available to individuals who would not meet clinical thresholds for traditional secondary care services, but typically exceed offers of support targeted at a primary care level.
- An offer of support that is proactive in nature and enables those who typically find it difficult to engage with services/experience barriers to accessing support to do so (where possible)
- Service should provide community representative and culturally competent support based on individual needs
- Option of ongoing 1:1 and/or group support from key workers / peer support workers

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in line with the individual mental health needs identified

- Facilitated self-help, recovery and rehabilitation with therapeutic support for people on waiting lists, or people who have had support from secondary care in the past and want to refresh their self-care management and coping skills
- Continuous service development and improvement and options to meet any identified gaps in relation to provision

The commissioned provider will be a committed partner providing leadership to the new VSCE service, providing challenge within the new service and wider system, and continuously improving services to support the mental health of individuals from local communities. The provider will have strong contract and performance management skills, and the ability to drive transformation and service improvement across the Service in response to local needs and demand for services.

The new service shall work seamlessly with Healthy Minds services to provide access to support. The provider must include a travel budget and reasonable adjustments to support people accessing the service.

The services will be delivered according to the identified primary care network footprint. The provider will develop clear integrated pathways and engagement with mental health services and an active role in embedding multi-disciplinary approaches

The first year of operation will be used as a baseline year to trial, develop and refine the model and understand the demand. This will ensure that the service meets the aims and outcomes specified and allow the further development of acceptance and exclusion criteria and thresholds as well as establishing Interdependence with other services/providers. The service provider will do this by working with local commissioners and relevant stakeholders.

4.3 Delivery Model

The new VCSE provider led service will be divided into 3 lots to cover the 9 PCN population footprints in scope.

- ❖ Lot 1 – To cover the PCN 4, PCN 5, PCN 6 population
- ❖ Lot 2 – To cover the PCN 7 , Affinity PCN, Bradford North West PCN
- ❖ Lot 3 – To cover the WISHH PCN , 5LE PCN , Bingley Bubble PCN

Wave 1 PCN's population footprint **WACA, MODALITY and BD4Plus areas are already commissioned and are not in scope for this particular commissioning round.**

The service model needs to include a team of community mental health practitioners who will support the service delivery. The workforce should include clear roles that will provide additional capacity to the community mental health system. The roles recruited could include Community Connectors, Peer Support workers, Care navigators, Counsellors and Therapists.

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Workforce model needs to be in line with the predicted demand with in core services .The stipulated capacity for any roles will be based on the 70:30 ratio (70 % contact time and 30 % towards admin , training, travel , reporting etc.)

Our knowledge and experience gained from working closely with a number of PCNs across Bradford District and Craven highlights the importance of developing a tailored offer to meet the needs of each PCN in terms of patient needs, demographics and local priorities. The roles will be shaped in consultation with each PCN and be responsive to change and learning as the service develops. The key functions of these roles are to be familiar with the local resources and assets available in the community, vary the support provided, based on needs, and assess a person's ability and motivation to engage with certain community activities that support their mental health needs.

It is envisaged that this service will benefit from utilising a flexible model of delivery that may look slightly different across the range of PCNs. This not only ensures its relevance to specific needs/demographics but also provides an opportunity to ensure maximum learning is achieved during the pilot phase of service delivery. This may therefore include some weekend and evening working, exc. bank holidays. The service will operate at times compatible with the needs of service users, where reasonable. The staff will form part of the integrated mental health teams and where possible co-locate with PCN's, VCS or CMHT's.

Primary areas of service intervention identified through engagement include

- Community mental health (non-clinical)
- Peer Support Provision
- Transition roles (CAMHS – Adults – Older People)
- Culturally Competent Support and Engagement
- Befriending (adults and older people)

Other areas of consideration and connectivity includes working closely with system commissioned specialist services providing

- Housing advice and support
- Financial advice (Welfare / Benefits / Debt)
- Immigration advice
- Transition from Prison
- Carers Support
- Substance Misuse

The service will enable workforce support through contributing towards a mental health learning exchange delivered by the Mental Health Provider Forum and Healthy Mind Summit's to ensure that good practice is shared and the opportunity to learn and explore different

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approaches are proactively encouraged.

4.4 Referrals / Assessment

Referrals to this service will come through variety of channels including:

- Primary Care
- Community Mental Health Teams
- First Response
- Guideline (self-referrals)
- Crisis and Wellbeing Hubs
- Social Care
- VCSE services
- Healthy Mind Services

Specific details of referral pathways and multi-disciplinary approaches will be picked up within the mobilisation meetings.

The Service will have clear communication resources, in line with Healthy Minds, to ensure people are aware of how to access this service. On receipt of the referral, the Provider will assess and if the needs of the person do not fit within the referral criteria, they will return explaining why it has not been accepted with clear and appropriate sign posting and advice. The Service will assess the referral and contact the service user as appropriate.

4.5 Population covered

The service will be available to people of all age who are registered with GP practices in the 9 PCN's specified in delivery model and if not living with the area surrounding the 9 PCN's or if unregistered living within the local authority boundaries of City of Bradford Metropolitan District Council.

The service will accept and work with individuals with dual diagnosis needs providing they have an identified mental health need. Individuals will not be discriminated against in any way.

The service will be compliant with the Equality Act and will make reasonable adjustments as necessary.

Treatment may be refused for any person who does not qualify for NHS treatment under guidelines issued by the Department of Health.

4.5 Any acceptance and exclusion criteria and thresholds

Referrals will only be accepted where the person is known to be under the influence of drugs or alcohol if they are able to be assessed or are not in a heightened state of intoxication that

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forms a risk to access the service.

Referrals will not be accepted if they if they are deemed an immediate risk to themselves or others accessing or working within the service. In these instances, the person shall be diverted as appropriate to the First Response team, Police or A&E.

Where a referral is not accepted, service members will be signposted appropriately.

5. Workforce and Training.

5.1 Staffing profile

The service will be delivered by a mix of qualified practitioners, people with lived experience and volunteers. Service must include some staff who have lived experience as an essential criterion. All staff will be effectively trained to manage risk within the setting. Staffing capacity will be aligned to service needs.

The roles recruited could include Mental Health key workers , Community Connectors, Peer Support workers, Care navigators, Rehabilitation Counsellors and Therapists

5.2 Training, induction and ongoing workforce development

The provider will ensure all staff has relevant experience and skills through careful matching to job descriptions and personal specifications.

The provider will seek staff from specific communities who have appropriate language skills and reflect Bradford's diverse communities and understand cultural and physical barriers such as peer pressure or myths that exist in a community that contribute to people's inability to self-care.

The Provider will ensure all staff access an induction programme and undertake mandatory and other appropriate training prior to seeing service members e.g.

- Information Governance
- Equality and Diversity
- Adult and child safeguarding
- Motivational interviewing
- Lone working and conflict resolution
- Low level mental health conditions including Mental Health First Aid
- Legislative guidance as appropriate including Mental Capacity Act, Care Act etc
- Trauma and autism informed training
- First aid

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- Fire safety
- Infection control

The Service will provide ongoing training and staff updates ensuring staff have the most up to date knowledge about issues and local services such as bereavement, family breakdown, domestic violence, managing medication at home, finance/debt, supported employment, dementia, perinatal health, breastfeeding, weight management and self-care. This will ensure excellent knowledge of local services and the means to access rapidly if required.

The provider will ensure all staff receive regular and appropriate supervision on an individual, peer and group basis.

6. Communications and Engagement

The Service will collaborate with commissioners and partners to undertake communication activity and marketing campaigns to promote the service in line with the Healthy Minds branding. This will include producing materials, information and literature relating to the service. The Service will identify and provide their service information in an accessible format the appropriate languages to the service members who access their service. The providers online and marketing information should clearly detail accessibility information and the language skills offer. The Provider will monitor the impact of engagement and marketing and report marketing and engagement activity at contract review meetings with BDCHPs.

For all the above, the service must support the overall Healthy Minds approach. The service must be listed on the Healthy Minds Service Directory and the service will endeavour to promote and facilitate content, events and information that support Healthy Minds Strategy mission and goals.

In promoting the service – to all audiences – people, services, organisations, external funders, award bodies to name a few – the service will have a clear communication plan to describe the service and partners.

Co Production

The Provider shall be proactive about the participation and involvement of Service Members, family carers and other stakeholders:

- Service Members and carers are consulted on all significant proposals which affect their lives or comfort, and their views are actively taken into account.
- There shall be opportunities and clear evidence of Service member and Carer involvement in processes that influence the management and delivery of the Service. This should be both at a strategic and operational level.
- Service Members and Carers are offered a range of opportunities to give their views, make comments, offer ideas - both individually and in groups - about the Service provided. This will include a regular Service member survey that occurs at least every

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twelve months and

- the service encourages service members, carers and staff to use the Grass Roots system, Friends & Family Test or Care Opinion to feedback experiences of using services.
- Service Members and Carers are encouraged to take part in active decision making about their care and the support they receive.
- Records show that formal or informal consultation has taken place and that proposals have been developed or amended in the light of feedback from Service Members, Carers and other service providers. There is a documented approach to consultation, which makes clear what steps are taken to ensure that consultation occurs and is effective.
- The Provider will send a representative to the relevant Healthy Minds and Mental Health Partnership events and play an active role in system leadership.

7 Financial Envelope

Approximate value of contract over each year will be **£ 850,000** per year. The contract will be for **2 years plus 1 (subject to funding)** The Provider will submit quarterly invoices to the ICB as specified contract. The Dates of invoices will be confirmed during mobilisation period

Total delivery budget allocation is **£780,000** across the 3 lots per years is as below

Lot	Area Coverage	Population Size	Budget £
Lot 1	**To cover PCN4, PCN 5, PCN 6**	**161723**	**275000**
Lot 2	**To cover PCN 7 , Affinity PCN, Bradford North West PCN -**	**174038**	**300000**
Lot 3	**To cover WISH PCN , 5LE PCN , Bingley Bubble PCN**	**117108**	**205000**

Budget to be used towards salary of staff team , recruitment and training costs, IT & phone set up, mileage, expenses & DBS checks for paid employees and volunteers, venue hire and associated costs for provision of group work, specific community based interventions, management charge, overheads, reporting.

8 Monitoring , Evaluation and Reporting

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8.1. Data Metrics

This contract will be hosted by Bradford District Care Trust on behalf of Bradford District Health and Care Partnership. The Provider lead will be responsible for reporting and monitoring information, including outcomes to the ICB. The Provider will ensure subcontracted services report to them in a timely way, to ensure timescales for submission are met in order to submit quarterly monitoring form to ICB to show progress including:

- Service activity levels and outcome
- Significant achievements
- Patient reported outcomes
- Service member feedback and evidence of impact (including ongoing feedback mechanisms such as surveys, feedback box etc.)
- Risks and challenges
- Expenditure to date including any underspend and vacancies
- Benchmarking data
- Capacity and Demand
- Complaints/Compliments
- Incidents (including safeguarding)
- First 4 digits of postcodes.
- Equality and Diversity Metrics
- Integration of services – working in partnership with other organisations
- Staff and third sector experiences
- Service member and family feedback
- Governance and quality reviews including any relevant regulatory body involvement
- Case studies and good practice examples

8.2 National Requirements reported to NHSE

- 2 plus contacts with in 4 weeks
- Implement Goal based outcomes / Patient reported outcome measures (PROMS)
- National Mental health services data set (MHSDS) data flow
- Reporting requirements into quarterly NHS England assurance
- Workforce data

8.3 Local conditions and requirements

1. Healthy Minds sign up – communication, resources and directory.

Providers are expected to sign up to Healthy Minds directory site and maintain their entry up to date on a quarterly basis (note if this does not happen, you may be removed).

We expect all our providers to understand and use the Health and Care Partnership and the Healthy Minds branding and resources as appropriate for Healthy Minds funded initiatives.

All providers are expected to maintain up to date information about their service and how to access (this can be in the form of a leaflet, video or other means) and must be in line with

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our Healthy Minds brand and accessibility standards.

2. Case studies and service member/career feedback - and evidence of using this to improve services with coproduction.

3. Health inequalities - focus on protected characteristics (Equality Act) including ethnicity recording.

4. Representative 70% attendance at Mental health Provider Forum and Healthy Minds partnership board and associated leadership group.

In the first six months, we will expect a full mobilisation of service and monthly highlight reports.

Service monitoring reports will be provided quarterly three weeks after quarter end to the Commissioning team. The service will also provide monitoring information as required by NHS England (NHSE) assurance framework on a quarterly basis. This will be incorporated into the regular quarterly monitoring report for the service.

The Service will submit own data to the national Mental Health Service Data Set (MHSDS).

Contract management meetings will cover issues relating to compliance with the service specification and value for money, which may impact on delivery of the outcomes to be met. The aim will be to identify any risks and agree actions to reduce or eliminate those risks. The focus will be on continuous improvement through a partnership approach.

Quality assurance visits will be carried out if there are concerns about performance or delivery.

8.4 Policies and Procedures

Service Provider is required to have the following policy statements/procedures (these may be additional to any requirements for service data, policies and procedures given in other parts of this specification) and is required to monitor their implementation:

- Complaints Procedure
- Data Protection and information sharing
- Confidentiality
- Learning and Development Policy
- Equality & Diversity Policy
- Quality Assurance
- Recruitment and Staff Selection Procedures
- Managing/responding to violent, aggressive, inappropriate and challenging behaviour (Behaviour Management)
- Safeguarding and Protecting Children Policy and Procedure
- Health and Safety at Work Policy and Service Statement
- Supervision Policy
- Service feedback (e.g., Insight tools, Care Opinion or Friends and Family Test)
- Freedom to Speak or equivalent procedures for staff support.

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The service Provider will maintain the following records which will be made available to the BDCHP upon request:

- Complaints/Compliments book/register
- Individual records relating to work undertaken with service members
- Learning and Development policy and records
- Financial records relating to payments made by the BDCHP
- Quality Assurance audits/review
- Central record of risk management , safeguarding related incidents and causes for concern
- Central record of all DBS checks
- Conflicts of interest register for staff, volunteers and trustees
- Evidence of people's engagement and involvement in service design, evaluation and planning
- Information on service members to include:
  - Name – (for internal use only and not to be shared with commissioners)
  - Date of Birth / Age
  - Postcode
  - Ethnicity
  - Gender/Gender identity
  - Type of Disability
  - Faith/Religion/Spirituality
  - Sexual Orientation
  - Carer or pregnancy

The Service Provider(s) will ensure that all records pursuant to the above are kept securely and comply with all requirements including, but not limited to, legislative requirements and those under this agreement for data protection, confidentiality and access to personal records.

9. Interdependence with other services/providers

The Provider will attend the Mental Health Providers Forum and work with named partners and other services/agencies across the district as identified as appropriate. This will also include involvement in relevant Act as One boards and groups.

The Provider will have the relevant and appropriate representation at the Healthy Minds Partnership Board and associated leadership groups.

The Provider will also scope other relevant groups and structures in the district that are relevant, for e.g., Liaison and Diversion, Living Well Board, Suicide prevention group.
The Provider will ensure that the service is integrated within the broader mental health offer for specified population group, providing a seamless service wherever possible and ensuring arrangements are in place with partners for ongoing support for those that access services wherever this is required.

It is recommended that the Provider is linked with local VCSE infrastructure organisations to

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ensure awareness of development and evolving nature of VCSE services in the district.

10. Applicable Service Standards

10.1 Applicable national standards (e.g. NICE)

This is a specialist mental health support service and all interventions must be evidence-based good practice interventions and, where relevant, approved by registered professional bodies such as NICE, BACP etc.

The Provider must provide evidence for the interventions delivered and the evidence base for that practice. We recognise that new evidence base interventions can be developed and, in such cases, the service must demonstrate the involvement of relevant academic and research bodies and have ethical guidelines and approval.

Providers maintain policies and procedures which incorporate relevant legal requirements and Good Practice guidance:

a. Legislation and Government Guidance will include, but is not limited to;

- Human Rights Act (2000)
- The Health and Care Act (2012)
- The Care Programme Approach (1990 revised 1999)
- Mental Health Act (1983) and Code of Practice
- Health and Safety at Work Act (1974) and all subsequent guidance
- The Equality Act (2010).
- The Care Act (2014)
- The Data Protection Act (2018)
- Children Act (2004) and local Protection Policies
- Carers Recognition and Services Act (1995)
- Community Care (Direct Payments) Act (1996)
- Rehabilitation of Offenders Act (1974)
- The Working Time Regulations (1998)
- Management of Health and Safety at Work Act Regulations (1999)
- Manual Handling Regulations (1992)
- Control of Substances Hazardous to Health (COSHH)
- Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (2013)
- Lifting Operations and Lifting Equipment Regulations (1998)
- Provision and Use of Work Equipment (1999)
- Infection Prevention and control local guidance

b. The Provider has an awareness and understanding of all relevant legislation and good practice guidance relating to Mental Health.

c. All employees are kept abreast of changes in legislation that relate to their job role and are kept informed of evidence-based approaches.

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10.2 Safeguarding responsibilities

As the local health leader, BDCHPs have an obligation to share the safeguarding adults and children message and lead the development of health focused safeguarding initiatives within a wider multiagency approach. All providers of NHS funded services commissioned by the BDCHPs are required to comply with all relevant safeguarding standards.

As a minimum, all providers subject to the national contract will be required to submit an annual self-declaration of assurance against specified safeguarding adults and safeguarding children standards. This must be accompanied by a remedial action plan to address any partially met or un-met standards. The BDCHP may also require additional information in order to monitor compliance against these standards.

The BDCHPs recognise that all providers have a vital role to play in recognising abuse and contributing to the protection of adults and children who are at risk of abuse due to their age, disability or illness. This applies equally whether the risk of abuse comes from, for example, within the service, within other agencies or organisation, from strangers or from family or personal relationships.

Safeguarding is everybody's business. Provider organisations and staff within all commissioned services have a responsibility to help prevent abuse and to act quickly and proportionately to protect people where abuse is suspected.

10.3 Information Governance and Data Collection

The Provider will have completed their Data Security and Protection Toolkit (DSPT) and have an identified Caldecott Guardian in their service(s).

The Provider will collect and record data as agreed with the Commissioner. The Provider will submit their data to the Mental Health Service Data Set (MHSDS) or appropriate data set to monitor performance and must have the mechanisms to do so.

The Provider and service will have the relevant Caldecott guidance and leads in place and be able to demonstrate how their data and use of data adheres to Caldecott principles.

The Provider will support data collection for 'Grass Roots' insight. This will include service member feedback as well as case studies in written and video format. The Provider will work with the Act as One Corporate Function directorate to ensure the service has the relevant systems in place to ensure regular Grass Roots insight is collected and used by the service and mental health leadership team.

The Provider will allow the Commissioner to consult directly with employees and Service Members. The Provider will allow the Commissioners access to the premises, to enable the necessary checks to be undertaken to ascertain that the Services are being provided in accordance with this Service Specification.

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11 Applicable quality requirements and CQUIN goals
Applicable Quality Requirements (See Schedule 4A-C) Not applicable. Applicable CQUIN goals (See Schedule 4D) Not Applicable
12 Location and Provider Premises
The service will be available from locations across Bradford District and Craven as appropriate to serve the population specified . The Provider will source outreach community provision so as to reach the geography and demography of Bradford District and Craven in particular with reference and relevance to the groups mentioned in this specification. This can be mobilised in a staggered manner and in agreement with the Provider will work closely with commissioner and stakeholders to identify the locations for service delivery.

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[i] Act as One - Bradford District and Craven Health and Care Partnership Strategy

[viii] http://implementingthrive.org/about-us/