SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	02/GMS/0173
Service	Health and Social Care Co-ordinators – Pan Dorset
Commissioner Lead	NHS Dorset Clinical Commissioning Group
Provider Lead	Dorset Healthcare University NHS Foundation Trust
Period	Financial Year 2015/16
Date of Review	31 March 2016

1. Population Needs

1.1 National/local context and evidence base

The National Context

There are 15 million people in England with one or more long-term conditions (LTCs) and the number of people with multiple LTCs is predicted to rise by a third over the next ten years. The number of older people in England is rising both in absolute terms and as a proportion of the total population. Although many of these older people are in good health, a significant number can be defined as being 'elderly frail' and/ or are living with one or more LTCs.

NHS England describes the need for better joined up and co-ordinated health and social care within the document titled '5 Year Forward View'.

"The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, ***between health and social care****. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases".*

- *Increasingly we need to manage systems – networks of care – not just organisations.*
- *Out-of-hospital care needs to become a much larger part of what the NHS does.*
- *Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.*
- *We should learn much faster from the best examples, not just from within the UK but internationally.*
- *And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money."*

Local Context

Dorset has one of the highest proportions of older people with high impact care needs in the country and the ageing population and the links to LTC and frailty have significant impact on health and social care services. The integration of health and social care is central to responding to the demographic and associated financial challenges.

Under the programme titled 'Better Together' the aim is to bring together Health and Social Care specialists to provide proactive and urgent integrated care.

Evidence and audits show that currently, primary care, community care, mental health teams, secondary care and social care services work independently with little formal co-ordination. Patients are often admitted to secondary care because quick access to health or social care is restricted by availability or criteria.

Dorset recognises the need to co-ordinate services around patients and carers, particularly for those patients who have multiple service providers, in order to prevent admission or facilitate early discharge.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

There are a number of local outcomes for patients and teams which this service will support:

- Integrated Health and Social Care Teams providing a multidisciplinary approach to caring for those patients with complex medical and social conditions.
- Improved health and social care co-ordination across primary, community and secondary services
- Better awareness of local services including the community and voluntary sector
- Patients only having to tell their story once
- Improved patient experience
- Reduction in duplication
- Improved staff satisfaction
- Better Together Strategic Intentions to support; Person-centred, outcome-focused, preventative and co-ordinated care.
- Support initiatives to that enable patients to stay at home and avoid unplanned admissions to Hospital

3. Scope

3.1 Aims and objectives of service

There are a number of objectives as defined within the job description for these posts. Job descriptions will vary locally and will be reviewed as the role develops.

3.2 Service description/care pathway

The job description may differ dependent on individual local operational model and posts may be hosted by a variety of organisations.

The coordinator role is a critical post in supporting the provision of effective integrated case management carried out by members of the integrated team. The post provides the interface between service users, carers, primary care, secondary care, community care, social care and voluntary organisations including Out of Hours Providers (OOH). The role is expected to enhance the provision of pro-active care to support independent living in the community, reduce the need for hospital admission and facilitation of discharge from the acute setting.

The key role of the coordinator will be to assist in the management of vulnerable patients on the at-risk registers for the allocated GP practices in their cluster. They will work with the practice and community staff to identify patients and facilitate referrals and information sharing across agencies (Primary/Community/Hospital Health, Social and Voluntary Care) whilst maintaining an awareness of local services. They will update the service user records and care plans contemporaneously on the practice, community and social care IT systems, using risk-profiling tools to identify patients and monitor progress.

- To work as a key member of the MDT to enable effective integrated health and social care that delivers the '5 features and functions' *(figure 1).*
- Seek to ensure best value from integrated working by implementing efficient procedures that reduce the demands on teams.
- Under guidance from the line manager, take initiative in the organisation and administration of MDT meetings to minimise the demands upon the team.
- Manage agenda items, ensuring all new referrals and cases for discussion are identified and information circulated to team members in advance of the meetings.
- Support the MDT in deploying risk-profiling strategies and tools to identify 'at risk' patients and implement an agreed structured process on how this information will be fed into MDTs.
- Ensure that all patients' Anticipatory Care Plans, diagnostics results and associated correspondence are available at the MDT meetings, liaising with all agencies as appropriate.
- To act as key worker for those people who have been identified by the MDT as 'at risk' of repeated unplanned hospital admissions or long term care e.g. someone who is socially isolated and is frail, whose needs are not at a level that requires the key worker or case manager function to be undertaken by a registered health or social care professional.

(The above point will not be applicable to every Health and Social Care Co-ordinator post due to resource constraints).

- Following MDT meetings update the patient/user of service records and care plans contemporaneously on the practice, community and social care IT systems as agreed at the meeting.

- Assist in devising and getting agreement on multi-agency policies to support the MDT function.

3.3 Population Covered

Supporting the population of Dorset.

3.4 Any acceptance and exclusion criteria.

Please find the attached appended 2015/16 Avoiding Unplanned Admissions Directly Enhanced Service (AUA DES 15/16). This service is designed for those patients who are frail and elderly with long term conditions (and or co-morbidities). (*Append 1)*

3.5 Interdependence with other services/providers

KEY WORKING RELATIONSHIPS – Better Together Sponsorship Board

Royal Bournemouth and Christchurch Hospital Foundation Trust
Dorset County Hospital Foundation Trust
Poole Hospital Foundation Trust
Dorset Healthcare University Foundation Trust
Bournemouth Borough Council
Borough of Poole Council
Dorset County Council
Bournemouth Council for Voluntary Services
Dorset Community Action
Dorset Clinical Commissioning Group (Dorset GP Practices)

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Appendix 1 – Avoid Unplanned Admissions DES 15/16

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

Appendix 2 – Better Together Key Features and Functions. Figure 1

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Quality requirements will be measured through the achievement of the '5 Features and Functions' (appendix 1) however the Health and Social Care Co-ordinator will report on the progress of these features and functions per locality *(see appendix 2 for reporting template)*

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Health and Social Care Co-ordinators base will be locally defined

7. Individual Service User Placement

The Health and Social Care Co-ordinator will have access to appropriate health and social care IT systems with the necessary access as appropriate. All co-ordinators will operate in line with Dorset 'PISA' (Personal Information Sharing Agreement) and Information Sharing Charters in order to ensure that personal information is used in a safe and appropriate manner.

Figure 1 - Key Features & Functions Individual Criteria – What does ACHIEVED look like

	1	2	3	4	5	6	7
Risk Profiling & Case Finding	***A number of resources and methods are used to identify the person (and carer) who is at greatest risk of reaching a crisis and/or at risk of an unplanned hospital admission or care home placement and these are used to create a case list which is reviewed at MDT meetings***						
	SystmOne OR EMIS and electronic frailty index or Q Admissions is used to inform case finding	A methodology/criteria is used to inform case finding	Professional judgement and local intelligence from community staff/volunteers/carers/ others is used to inform case finding	Professional judgement and intelligence from hospital teams is shared with community teams and is used to inform case finding			
Multi-Disciplinary Team Meetings	***MDT meetings are held at least monthly, are effectively administered and managed and are attended/contributed to, by all care providers/care professionals involved with a person's care***						
	Frequency, scope and shape of MDT meeting is agreed and MDT meetings take place on a regular and scheduled basis	All care providers (cross agency – health, social care, voluntary and carer representatives, specialists) involved with a person's care attend or contribute to discussions at MDT meetings	H&SC Co-ordinator works with staff at GP Practices to prepare and administer MDT meetings	Person/carer information is shared at MDT meetings and is used to inform care planning	All inclusive case lists are brought to MDT meetings and staff are encouraged to bring new cases (not on prepared list) to meetings		
Personalised Assessment & Care Planning	***New joint approach towards personalised assessment, care planning and anticipatory care planning is agreed and implemented***						
	Holistic person-centred (person and carer) assessments are carried out, are shared and documentation used supports an integrated care approach	Joint care plans/anticipatory care plans are used to improve outcomes for patients and carers. Documentation used supports an integrated care approach	Care plans/anticipatory care plans are shared with MDT teams and urgent care services. Carer information is included in care plans				
Case Management & Care Co-ordination	***Care provision is better co-ordinated across all care settings improving outcomes for the person and their carer***						
	Role definitions of case manager, H&SC Co-ordinator and key worker are agreed	H&SC Co-ordinators (or staff acting in that role) are deployed to support MDT team meetings / working	The person (and carer) with complex need is identified and is allocated to a case manager at MDT meetings.	The person (and carer) with less complex need is identified and allocated to a key worker at MDT meetings.	Care Co-ordinators are working with the person and their carer and with other care providers to coordinate a person's care across different care settings	Care Co-ordinators (case managers, H&SC co-ordinators, key workers, carers representatives, others) are invited to participate and take an active role in care planning at MDT meetings	Care co-ordination contingency is in place to ensure continuity of care for the person and their carer

Working with Hospitals	***Community and hospital teams work together to join up care pathways, share intelligence and initiate and undertake comprehensive geriatric assessments***						
	Person and carer information and intelligence is shared between hospital staff and MDT's	Comprehensive geriatric assessments and shared care arrangements with hospitals are agreed and implemented	Joint care pathways are developed between community and hospital teams, the person and carer, to improve care transition across different care settings				
Working with Carers	***Carers are recognised for their caring role and supported to deliver that care in a sustained and effective way***						
	Carer's leads are identified in each GP Practice	Carer's leads attend and contribute to MDT meetings	Carers leads support Carers and ensure that they are known to the GP Practice and flagged on clinical and social care IT systems and databases	Carers leads work with social care colleagues and understand the structures, systems and processes, to best represent carers needs in the locality	Carers leads ensure the needs of the carer are considered and reflected in the development of shared and anticipatory care plans		
Enablers	**Development work that will improve and enable delivery of key features and functions**						
	A shared care record (Dorset Care Record) has been developed and is being used by professionals involved with a person's care	Personal information sharing agreements (PISA's) are in place and information is shared between teams, improving outcomes for the person and carer	Staff training is provided (cultural change, new ways of working, systems and tools, integrated care) to support integration of teams and systems	Teams are co-located where possible or alternative working arrangements are in place and are working well to improve co-ordination of care delivery	Integrated care workforce; skills, roles and responsibilities are adapted to deliver a new integrated model of care (workforce recruitment and retention – roles)	Health & Social Care Co-ordinator role is reviewed and adapted as role evolves/matures and funding is secured to maintain role	A universal shared care plan/anticipatory care plan is developed and used cross agency