

## SCHEDULE 2 – THE SERVICES

### A. Service Specification

<b>Service Specification No.</b>	11J/0235
<b>Service</b>	Non-Clinical Health Coaching and Social Prescription in Primary Care for People with Long Term Conditions and Carers
<b>Commissioner Lead</b>	Primary and Community Care Directorate
<b>Provider Lead</b>	
<b>Period</b>	1 April 2019 – 31 March 2022
<b>Date of Review</b>	April 2021

#### 1. Population Needs

##### 1.1 National/local context and evidence base

Local people have told us that they want services that are joined up, offer choice and are provided by staff who listen to their needs and support them to make positive changes to improve their health and wellbeing.

In 2013, NHS organisations within Dorset commissioned The Market Research Group (MRG) at Bournemouth University to undertake a survey of local residents and users of NHS services within Dorset on their behalf; The Big Ask.

The Big Ask reached over 6,000 local people. Many people were unaware of alternative services to support them, and said that more personal and face-to-face services locally were important to them. Having a choice of options of support or services was also important to many people. Primary care is the main source of information for people (81%) about other services available to them.

This echoes the statement made in the National Voices 'I' statements for person-centred coordinated care; *"I am supported to understand my choices and to set and achieve my goals"*.

*"Taken together, my care and support help me live the life I want to the best of my ability"*

*"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."*

It is well recognised that Primary Care services are under increasing pressure with rising demand, particularly from an ageing population. GP surgeries are facing an increase in the number of patients attending, many with increasingly complex social as well as health needs. It has been estimated that 20% of appointments in Primary Care are for non-medical reasons (Citizens Advice, 2016). In reality GP's and the Primary/Community Care Team are not necessarily equipped to handle all the social, emotional and practical needs they present; these can often be better met from a range of voluntary and community services and support available, as well as some statutory services such as those provided by councils and housing associations.

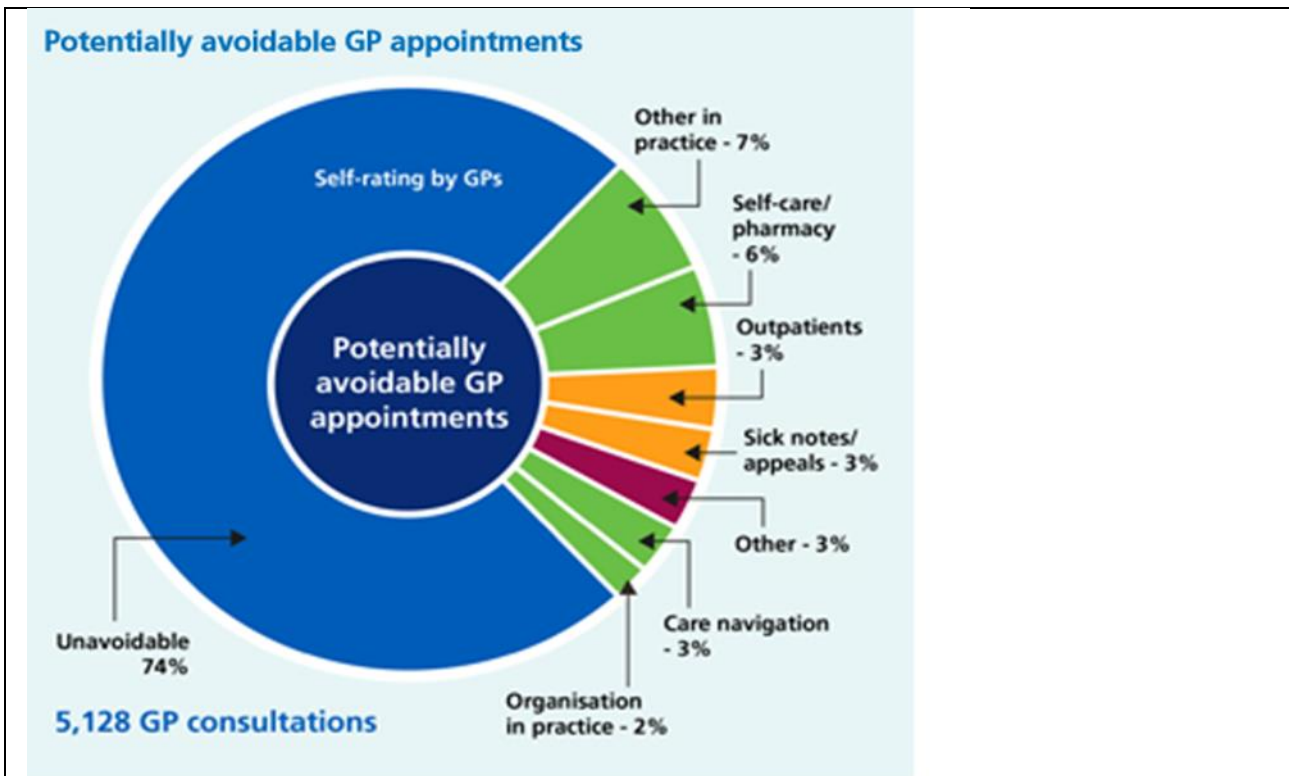


Fig. 1 GP Consultations Breakdown (GP Forward View)

The healthcare system in Dorset faces several challenges in providing the best quality of care, these challenges include, but are not limited to:

- Peoples changing health needs – people are living for longer with complex and long-term health conditions and our services must reflect this changing health need
- Avoidable variations in the quality of care currently provided – this includes not meeting national quality standards within acute hospitals and a failure to meet needs in the community leading to people seeking care from responsive, emergency services
- Treatments are becoming increasingly specialised and access to them requires specialist staff based at larger centres
- Currently the healthcare service is clinically unsustainable due to an increasing demand for services and insufficient provision within the community
- We do not always have staff with the right skills where we need them, partly due to national and local shortages of staff with specialist skill
- Dorset’s healthcare system now spends more money than it receives.  
*Dorset Clinical Services Review – Decision Making Business Case (Sept 2017)*

Within Dorset, the Clinical Services Review (CSR) and Dorset Sustainability and Transformation Plan (STP) has identified that the empowerment of patients to manage their own health and wellbeing throughout their pathway of care, is a key priority. This is the main driver for this specification; Non-Clinical Health Coaching and Social Prescription in Primary Care which will be commissioned around outcomes for people with long term conditions (LTC’s) and carers.

It will enable a new way of working to be embedded within Dorset, drawing on core skills developed for the health and care workforce alongside that of Primary Care Home developments and The GP Forward View (2016) which identifies support for Personalised Care and Support Planning (PCSP) via Self-Management, Social Prescribing and Active Signposting as three of the 10 High Impact Actions, to release time for care.

The Care Act 2014 in England emphasised the need to work alongside individuals, families, carers and communities to help people stay strong and to build more welcoming, inclusive supportive communities, instead of relying on services. (People, Places, Possibilities 2015). The main principle being to promote health and wellbeing.

In addition, the NHS England Five Year Forward View supports local models of social prescribing to enable GPs to access practical, community-based support for their patients, including access to advice on employment, housing and debt. This is reflected in the Dorset Primary Care Locality Transformation Plans.

In March 2017, NHS England published Next Steps on the Five Year Forward View, this restated the importance of personalised care in meeting the triple aim of improved health and wellbeing, better care and greater value for the public pound.

Alongside this, it is well documented that an individual with a long term condition/s requires the information and skills to be able to thrive not just survive, therefore every contact with a health and social care professional is important in enabling an individual to live well with their LTC – Making Every Contact Count (MECC). However, 60% of people are unknown to health and social care when at crisis point; it is therefore paramount that patients are identified for Personalised Care and Support Planning at an earlier stage in their care pathway to help build resilience at an individual, family and community level.

Furthermore;

- 70% of NHS budget goes towards supporting people with LTC's
- 35-40% of people living with LTC's have low knowledge, skills and confidence to manage their health and wellbeing;
- 40% say they would like to be more involved in understanding/managing their health, care and wellbeing
- Of the 8,760 hours in a year, a patient with a LTC will spend on average 4 hours with a clinician – let's support people to maximise the time they spend managing their own health and care. (Personalised Care Directorate, NHSE)
- The 2011 Census showed a total of 82,859 carers Dorset-wide, of this 17,325 were in Bournemouth, 16,212 in Poole, 49,322 in Dorset

A wide range of voluntary, community and social enterprise (VCSE) services have been successfully commissioned within Dorset to provide Social Prescription, Voluntary Sector Navigation and Non-Clinical Health Coaching over the past six years. It is now timely to bring this service offer together.

Representatives from these organisations and the wider stakeholder group held five task and finish group meetings from October 2017 – March 2018. The meetings were co-chaired by a GP with special interest in self-management approaches to care and a person with lived experience. The following work streams were discussed and informed by local and national Best Practice;

- A review of the current services in Dorset and open discussion on how to incorporate the new model within the local and national context
- A review of the national Self-Care New Models and agreement on the core elements and outcomes of a new service for Dorset
- Discussion and agreement on the outcome measures/key performance indicators (KPIs) to be used
- Information Technology - joining up and accessing data (Dorset Care Record and SystemOne)
- Workforce modelling including skills and competencies
- Agreement of the financial envelope and the services that this covers
- Patient and referral pathway with interdependencies/co-dependencies with other services
- Development of a Self-Management Framework to inform the service specification.

Building on the work undertaken by the Task & Finish Group and with reference to the Dorset Self-Management Framework. Personalised care and support for people and carers with a LTC(s) – Non-Clinical Health Coaching, Social Prescription and Voluntary Sector Navigation (appendix 1), this specification aims to pull services together around a Practice and Locality Multi-Disciplinary Team (MDT)

model of care to avoid duplication of services and complement existing care and support offers, with the added value of linking people to their own communities using voluntary sector organisations.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
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	

### 2.2 Local defined outcomes

The aim of bringing these service offers together within Primary Care is to improve individual outcomes and also to free up Health and Social Care services allowing clinicians and support staff time to deliver the care they are trained for.

Person level

- An improvement in a person's knowledge, skills and confidence, health literacy and wellbeing
- An improvement in activation to change
- Promotion of independence, health and wellbeing
- Outcomes will be Patient and carer centred
- Service user feedback will be acted upon

Health Utilisation level

It is expected to see a reduction or more informed/appropriate use of Health and Social care services.

## 3. Scope

### 3.1 Aims and objectives of service

This service will bring together the key elements of a person-centred approach for a specific cohort of patients, offering self-management to support individuals living with one or more long-term condition/s and their carers as shown in tier 2 of the STP triangle diagram of support needs below: people with moderate or recurring health needs (30% of the registered population).

	Baseline		Projected 2021	
Cx	16,000	2%	16,359	2%
LTC – high risk	24,000	3%	24,539	3%
LTC – low risk	213,000	27%	220,847	27%
Mostly healthy	536,000	68%	556,207	68%
	<b>789,000</b>		<b>817,952</b>	

- People living in Dorset, Poole or Bournemouth
- Over 18 years old
- One or more long-term health conditions (physical or mental), or a carer
- Non-medical support to manage their health and its impact on their life

The focus of the service model development is on Tier 2 of the STP, for people managing long-term conditions



Fig.2 Focus of Service Model

For illustrative purposes, in a population model of 50,000 (Primary Care Home model), it is estimated that 27% (13,500 patients) would be registered as having long term health conditions and therefore a potential beneficiary of self-care services.

Of these we would expect;

- 20% (2,700) to have very low support needs
- 50% (6,750) who may benefit from access to lighter touch support
- 30% (4,050) who would benefit from targeted support identified through personalised care and support planning

It is well recognised that personalised and supported self-management will enable people to further develop their skills, knowledge and confidence to manage their own health and wellbeing, and the impact this has on their daily lives. This approach involves the individual's family, close circle of friends, carer/s and wider network of support as early in a disease process as possible with a focus on prevention. It will be provided within an Integrated Community and Primary Care model.

### 3.2 Service description/care pathway

There are three key elements of the service; Identification, Access and Service Offer. See pathway (appendix 2)

#### Identification

Referral into the service is many faceted, thereby enabling easy access. People with long term conditions and their carers will be able to self-refer, be referred by their identified health or social care professional (key worker) or through proactive case finding, utilising a combination of clinical knowledge/hospital admission data/GP visit data/Read (SNOMED) Codes via NHS personal identification number and the Patient Activation Measure (PAM). There is a strong interface with Primary Care and Integrated Locality Teams, through MDT's/Community Hubs/Huddles to access information, activities and services to support service user's non-medical needs. Referral may be made by services outside of Primary care e.g. NHS 111, social/community/secondary care service and community voluntary organisations.

#### Access

Access to the service for people with LTC's and carers registered with a Dorset GP will be through a Single Point of Access (SPOA). The SPOA will be available electronically on SystemOne/Emis. Referrals

from outside Primary Care will enter the service via a gateway linking into the Single Point of Access; this includes one telephone number, email address and paper referral.

Referrals will be triaged for referral to the Link Worker/Voluntary sector coordinators for the service to undertake a Personalised Care and Support Conversation with the individual, or to signpost on to other services or offers of support; including access to a self-management digital platform will be password protected.

### **Service offer**

People with long term conditions and people who are carers will be referred to a link worker/ voluntary sector coordinators allocated to a designated practice base/locality area who will provide support to identified people with additional health and care needs, providing an essential link to local community and voluntary services. This support and improved way of working forms part of personalised care. It requires a self-management approach to support people to build their knowledge, skills and confidence to manage their own health and care more effectively.

The Link Worker/Voluntary sector coordinators and service user will undertake a Personalised Care and Support Conversation including the PAM, where appropriate. The concept of patient activation (and its corresponding measurement tool, PAM) underpins the approach that supports people to develop their capability to manage their own health and care by providing information they can understand (health literacy) and act on, tailoring support to their individual needs. Patients with higher levels of activation report greater levels of confidence and health outcomes, satisfaction with services and can have lower costs for the wider system e.g. fewer hospital admissions and A&E attendances.

The outcomes of the conversation will be recorded in a Personalised Care and Support Plan and will identify the level of self-management support suited to individual needs.

**Personalised Care and Support Planning (PCSP)** is a proactive and transparent process, supported by preparation, that enables conversations between people and practitioners, focused on what matters most to the person; so that they are involved in decisions about their health and wellbeing, and are more in control of living their life with their conditions. The process brings together all of the persons physical and mental health and wellbeing as well as social needs within a single conversation and coordinates access to personalised care and treatment, psychological support and supportive community activities. It replaces current approaches to routine care and is a continuous not a one-off process. The location and method of delivery will be context specific.

The suite of support available needs to be accessible and easy to navigate. This will include a digital offer for patients/carers to identify the support required for self-management alongside a local directory of non-clinical support and services. There is a role for the link worker/voluntary sector coordinators in supporting and enabling the individual to interact with this digital offer.

The person will be signposted to one of the following; Non-Clinical Health Coaching (one to one or group courses), Social Prescription (Active Signposting or supported navigation) or Self-Management digital offer.

NB. Individuals are able to utilise all of these services and they are not provided in a linear approach. Likewise, if none of these offers are appropriate, they will be signposted on to other services, resources, groups, activities and community support outside of this offer.

All elements of the service offer will work within the principles of adult safeguarding; empowerment, prevention, protection, partnership, proportionality and accountability and are embraced as core elements of the service.

### **Digital offer**

The digital offer for health and care and voluntary sector professionals within SystmOne/Emis will enable;

- referral to the service
- recording of PCSP
- collection of service level data

- collection of patient level data
- collection of service outcomes
- collection of patient reported outcomes and stories

Together, this will inform future service design and evaluation.

The **digital offer** for service users will consist of a Self-Management digital platform or app to;

- provide hints, tips and education on self-management
- identify the individualised support required for self-management including circles of support (family members, friends, acquaintances, healthcare professionals, local groups, even pets) and identifying what is important.
- provide a local directory of non-clinical support and services offering a variety of locally mapped services which are up-to-date and offer choice and are accessible to specific needs of the person (disability/mental impairment)
- be accessible via the Citizens' Portal of the Dorset Care Record (DCR), (as this is developed)

**Non-Clinical Health Coaching** consists of:

- **One to One Non-Clinical Health Coaching** to support and help the individual to develop the confidence, knowledge and skills to manage their condition, its emotional impact and practical day to day impact, tackling symptoms such as immobility, breathlessness, anxiety or daily pain. The role of the coach is purely to support the individual to make a difference to their health. They are non-clinical, specifically trained coaches who focus on the non-clinical aspects of managing LTC's (alongside and integrated with the MDT) as required, that may be stopping Individuals from living their life in the way they would like to.
- **Self-Management Groups** are run by Non-Clinical Health Coaches and typically provide a six-week structured course of support, the course covers specific self-management skills and provides an opportunity for peer support.

**Social Prescribing** consists of:

- **Active Sign-Posting** (low level need) i.e. 'information for all', activities and universal services to support individuals with non-medical needs through;
  - Telephone and written information and advice, sign-posting and support to people to navigate non-medical Voluntary Community Services (VCS) and statutory support.
  - Telephone and email information and advice and sign-posting for health and social care professionals to enable them to navigate non-medical VCS and statutory support for their patients' / clients.
- **Supported Navigation** (moderate/high level needs) i.e. when active sign-posting (as above) is not sufficient to meet the more complex needs of individuals who may require more support or time than provided through active signposting to help them access information, activities and services to meet their non-medical needs.

### **Review**

People with long-term conditions and carers will be offered a review (at a time and place to suit the individual as agreed during the PCSP) by the Link worker/Voluntary sector coordinators who undertook their PCSP, where person-centred outcomes can be assessed including a review of the PAM, if appropriate. A further refreshed plan of support may be required. The outcome is reported on SystemOne/Emis

### **Access Times**

Referrals will be received and triaged at the SPOA 5 days per week, Monday – Friday.

There will be a named Link Worker/Voluntary sector coordinators and Non-Clinical Health Coach identified for each Practice within a Locality. Working days and WTE hours will be agreed for local need.

**Digital**

All service users will be offered support via the digital platform/app as an adjunct to other offers of support or as a stand-alone option.

**Non-Clinical Health Coaching**

Initial contact will be made with the service user within 48 hours of receipt of referral

The time-frame assignment of coach to initial contact with coach will be two weeks

The time-frame from initial contact with a coach to start of coaching (face to face, telephone or group) will be four weeks

**Social Prescription**

Initial contact with the individual will be within 48 hours of receipt of referral

Referrals will be allocated according to the priority of the individual's needs.

**Onward Referral**

The provider will ensure a person-centered approach to signposting and onward referral to a full range of local VCSE and statutory services, utilising the extended NHS pathways- Directory of Support (DoS) and local knowledge. This includes the identification and referral of any safeguarding concerns. This will be reported on SystemOne/Emis

**Discharge**

Service users will receive a review prior to discharge. The outcome will be reported on SystemOne/Emis

**Training**

As this is a new way of working, initial training will be offered at the outset of the new service delivery and will be integral to service provision going forward. Ongoing support of the Primary Care and Voluntary and Community Service workforce will be required to ensure that the service becomes embedded in the shortest possible time and that people with identified needs are referred in a timely manner to the service, thereby achieving the best outcomes for individuals.

The training will encompass;

- An introduction to the individual elements of the service
- An in-depth training on carrying out effective Personalised Care and Support Planning and patient-led conversations to empower patients to proactively self-manage their health and care
- Information and how to access local community assets and services
- The role of volunteers and volunteer led community groups

Particular emphasis will be placed on the six principles of adult safeguarding; empowerment, prevention, protection, partnership, proportionality and accountability as core elements of the service.

A separate service specification has been procured to be delivered by local VCSE providers to deliver Primary care training as follows;

- An introduction to Personalised Care and Support Planning
- An introduction to Non-Clinical Health Coaching
- An introduction to Social Prescription including Active Signposting and Voluntary Sector Navigation

The training is delivered in line with the following;

Health Education England and Skills for Care: Person Centred Approaches, and Care Navigation: A Competency Framework

Health Education England Health Coaching – Quality Framework

Further training on Personalised Care and Support Conversations and Planning will be supported by NHS England.



The service provider will work closely with external organisations to ensure a local Dorset approach to all externally delivered training.

### 3.3 Population Covered

The service is offered to service users aged 18yrs+ with one or more LTC and carers at Primary Care locality level across Dorset;

- North Dorset
- Mid Dorset
- West Dorset
- Weymouth and Portland
- Purbeck
- East Dorset/Poole North
- Poole Central
- Poole Bay
- North Bournemouth
- Central Bournemouth
- East Bournemouth
- Christchurch

### 3.4 Any acceptance and exclusion criteria.

The service will not accept referrals for;

- Patients/carers with severe substance misuse
- Patients/carers with severe mental health issues
- Patients with severe dementia

### 3.5 Interdependence with other services/providers

It is important that the individual accesses the right service at the right time and in the right place for their individual needs.

The PCSP enables this to be achieved in a more coherent and user-friendly manner. However, as an individual's needs changes, so may their support requirements. It is therefore important to understand the local and national offers which are not directly linked to this service offer and to understand where this service offer fits within an individual's pathway of care and support i.e. where they step down from a higher level of support e.g. Steps2Wellbeing or step up to more disease specific support e.g. pulmonary rehabilitation.

Equally, an individual's circle of support may change thereby causing them to fall into crisis with the possibility of A&E attendance for a non-clinical reason. This will require a very different support e.g. Befriending Service, Advocacy Service or specific support with issues of social isolation and loneliness. With consideration of the six principles of adult safeguarding; empowerment, prevention, protection, partnership, proportionality and accountability as core elements of the service.

In addition, the following list of services have close interdependencies and connections with the service although this is not exhaustive;

Carers, Family, Live Well Dorset, My Life My Care, Altogether Better, Care Voluntary sector coordinators (You Trust), Dementia Voluntary sector coordinators/Champions, Condition specific education for Diabetes, Respiratory, Cardiology, Stroke, Specialist Health Services e.g. Macmillan support, Falls and Balance groups, Musculoskeletal (MSK) Services, Steps2Wellbeing, Learning Disabilities, Community Alcohol Drug Advisory Service (CADAS), Personal Health Budgets (PHB's), Primary Care voluntary sector coordinators, Housing Departments, Transport, National Charities, independent domestic abuse services,

trading standards, fraud, Statutory Services, Community Champions/Development Workers and commissioners enabling people to build sustainable, local, flexible, individual and community solutions.

Signposting to Community and Voluntary Sector support groups/peer support, and development of Community Champions, play an important part in a self-management approach. This in turn strengthens individual resilience and supports community sustainability as people who receive voluntary support services often then volunteer their time to support others.

#### **4. Applicable Service Standards**

##### **4.1 Applicable national standards (e.g. NICE)**

##### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

Health Education England and Skills for Care: Person Centred Approaches, and Care Navigation: A Competency Framework

Health Education England Health Coaching – Quality Framework

Patient Activation Measure Tool

##### **4.3 Applicable local standards**

Pan Dorset Carers Strategy 2016 – 20

MDT working within the Integrated Community and Primary Care models of Care

#### **5. Applicable quality requirements and CQUIN goals**

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

##### **5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

CQUIN 11 (Personalised Care and Support Planning).

#### **6. Location of Provider Premises**

**The Provider's Premises are located at:**

#### **7. Individual Service User Placement**

**Pathway for non-clinical, personalised care & support planning (PCSP), social prescribing and health coaching for people with long-term conditions and carers**

**8. Appendix 1: Pathway**

