SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	11J/0235 v2
Service	Non-Clinical Health Coaching and Social Prescription in Primary Care for People with Long Term Conditions and Carers (Dorset Self-Management Service)
Commissioner Lead	Strategic Commissioning and Place Directorate
Provider Lead	Help and Care
Period	1 April 2023 – 31 October 2023 (v1 01 April 2019 – 31 March 2023)
Date of Review	July 2023

1. Population Needs

1.1 National/local context and evidence base

Background

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. Increasingly, people are affected by living with long-term health conditions (LTCs), growing unmet health needs and the effects of wider social determinants of health. The impact of Covid-19 and the cost-of-living crisis is adding to these needs and placing health services under pressure. It has been estimated that 20% of appointments in Primary Care are for non-medical reasons (Citizens Advice, 2016). Dorset was an early adopter of non-clinical care models, recognising that the NHS cannot meet these needs alone. In early 2019 several services were brought under this county-wide service.

Personalised Care

Since 2019 significant national and local strategic changes that have and continue to impact on our emerging non-clinical care models in Dorset, of which this service plays a key part. The NHSE Long Term Plan (2019) identified personalised care as one of the top actions needed to transform health care and the ***Comprehensive Universal Personalised Care (UPC) Model*** provides a blueprint for delivery. By adopting personalised care approaches, support can be tailored based on the person's individual assets, needs and preferences, as well as taking account of any inequalities and accessibility barriers. It also helps to ensure that the right approaches for the person, based on '*what matters to them'*, are systematically put in place to help build knowledge, skills and confidence, and to support them to transition from passive to resourceful patients. The introduction of the UPC as national policy is welcomed as it supports our ambitions and direction of travel to systematically embed personalised care.

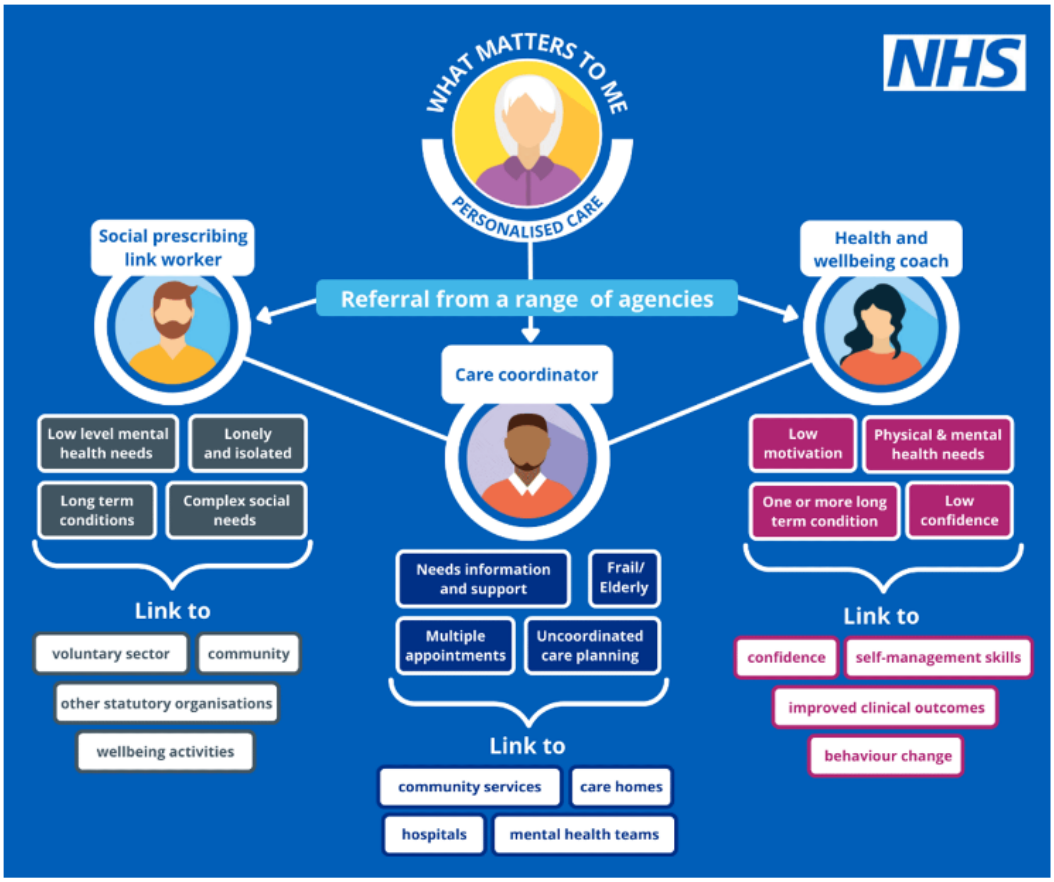
Integrated Care

In February 2022 the Department of Health and Social Care published a white paper, ***'Joining up care for people, places and populations'*** which sets out a clear vision to join up planning, commissioning and delivery across health and social care. The principles, philosophy and approaches are centred around personalised care and focuses on bringing about two key shifts:

- the cultural shift to a model of care that takes a holistic approach to supporting the health and wellbeing of people and communities, and
- realignment of the wider health and care system to a population-based approach

Within this context, the landscape of primary care is changing; the introduction of Primary Care Networks (PCNs) brings together a ***'one neighbourhood team of teams'*** from across the broader health and care system. The NHS Long Term Plan made a significant commitment to this with the introduction of a range of new roles and dedicated funding through the **Additional Roles Reimbursement Scheme** (ARRS). This

has enabled Dorset to expand non-clinical roles, building on the progress and investment made through DSMS.



Together, the non-clinical roles within the DSMS contract and the ARRS have become integral to multi-disciplinary teams, freeing up time to delivery clinical care. Continued integration of these collective assets and breaking down organisational boundaries at place and neighbourhood level is vital if we are to fully realise their value. The publication of the ***Fuller Report: Next Steps for Integrating Primary Care (2022)*** gives a clear mandate for the contribution of non-clinical services in achieving the objectives of:

- Streamlining **access** to care and advice
- Providing more **proactive, personalised care** supported through a neighbourhood **Integrated Team**
- Helping people **to stay well** for longer.

Proactive Population Health Management (PHM)

PHM approaches are increasingly being used to identifying people who might benefit from a non-clinical support offer and in tackling health inequalities. With some of the most advanced population Health analytics in the UK (***Dorset Insights and Intelligence Service – DiiS***), we are now able to better identify and understand needs by 'population' and then target and tailor support.

Wellbeing Ecosystem

As a system there is clear commitment to strengthen our wellbeing ecosystem and improve access to physical and mental health and wellbeing support; this is reflected in the development of hub style spaces, with an overall aim to empower communities, leading to earlier support and prevention. The strategy is for VCSE, Local Authorities and Health services to work together to deliver integrated pathways, reduce duplication and adopt a '*no wrong door'* approach. This will strengthen our capacity and capability to support people to access individualised help and community-based support to address the social determinants of health. This service contributes to bridging the gap between this support and the health and care system.

Local Strategy Context

Locally, the Dorset Integrated Care Partnership (ICP) Strategy, 2022-23 identifies three core priorities: Prevention and Early Help; Thriving Communities; and, Working Well Together. Through our work programmes and commissioned services, NHS Dorset aims to:

- improve ***outcomes*** in population health and healthcare
- tackle ***inequalities*** in health outcomes, experience and access
- enhance ***productivity*** and value for money
- support broader ***social*** and ***economic development.***

Within this context, we want to put people and place at the centre; co-creating services that people really need so we can support people to live healthy and happy lives. The empowerment of Service Users to manage their own health and wellbeing throughout their pathway of care, is a key priority. This is the main driver for this specification.

- 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

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 Integrated Primary Care Teams is to improve individual outcomes and free up Health and Social Care services allowing clinicians and support staff time to deliver the care they are trained for. The desired outcomes for the service are:

- An improvement in a person's knowledge, skills and confidence and health literacy
- Improved health and wellbeing
- A reduction in social isolation and loneliness
- Improved access to support and information to help them live well with their LTC(s)
- Service user satisfaction
- 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

The aim of the service is to support people with long-term conditions and their carers, to manage their own health and wellbeing, live well with their condition and reduce demand on health services, through a reactive and proactive health coaching and social prescribing.

Scope: The Service aligns to the Comprehensive model of Personalised Care to support the top 30% of the population with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health condition. The NHS England operating model provides a framework to understand where this service fits and how it contributes to the emerging non-clinical care models in Dorset.

For illustrative purposes, in a population model of 50,000, 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

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

People with long-term health conditions and their carers who may benefit from this non-clinical support offer will be identified at the point of care (reactive) by a health or care practitioner or through case finding approaches (proactive) using a combination of clinical knowledge/hospital admission data/GP visit data/Read (SNOMED) Codes via NHS personal identification number and DiiS data.

People who would benefit from the service may be identified in a wide range of settings. There is a strong interface with PCNs and Practices through Integrated Neighbourhood Teams / MDT's / Community Hubs / Huddles etc. In addition, Health and Care service across Dorset Integrated Care Partnership (ICP) including NHS 111, Local Authorities (Adult Social Care, Public Health, Housing etc.), Community Health Services, Secondary Care and the VCSE, may identify potential beneficiaries.

ACCESS

Primary Care - Access will be via SystmOne. The referred person will be triaged and sign-posted to support or allocated to a SPLW or Health and Wellbeing Coach, for further support as appropriate.

Outside Primary Care – Referrals from health and care practitioners or self-referrals will enter the service via a gateway Single Point of Access; this includes one telephone number, email address and paper referral. Referrals will be triaged, based on a Personalised Care Conversation, to either:

- signpost on to other services or support, including access to self-management digital platforms, or
- refer to a Social Prescribing Link Worker (SPLW) or Health Coach aligned to the practice where the person is registered, for people needing more support.

SERVICE OFFER

The **Supported Self-Management** offer consists of:

- **One to One Non-Clinical Health Coaching** to support people with physical and/or mental health long-term conditions (alongside MDTs). They focus on improving health related outcomes by working with people to set personalised goals. Health and wellbeing coaches offer people support to increase their self-efficacy, motivation and commitment to make changes to their lifestyle and improve their health. Health coaches are experts in behaviour change. A HWBC will typically see a patient for 6-12 contacts over a 3-month period. It is expected that a full-time worker would have an annual caseload of 200-250 (this may vary depending on the complexity of people's needs, the maturity of the neighbourhood / PCN and wider work they may be undertaking, such as self-management groups, community development activity or outreach.
- **Self-Management Groups** are run by Non-Clinical HWBC and typically provide a six- week structured course of support, the course covers specific self-management skills and provides an opportunity for peer support and self-management education. The preferred evidenced-based model in Dorset is the 'Help to Overcome Problems Effectively (HOPE) programme.

The **Social Prescribing** offer consists of**:**

- **Active Signposting** (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, signposting and support to people to navigate non-medical Voluntary Community Services (VCS) and statutory support.
  - Telephone and email information and advice and signposting for health and social care professionals to enable them to navigate non-medical VCSE and statutory support for their patients'/ clients.
- **Supported Navigation** (moderate/high level needs) i.e., when active signposting (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.

The **Digital** offer consists of:

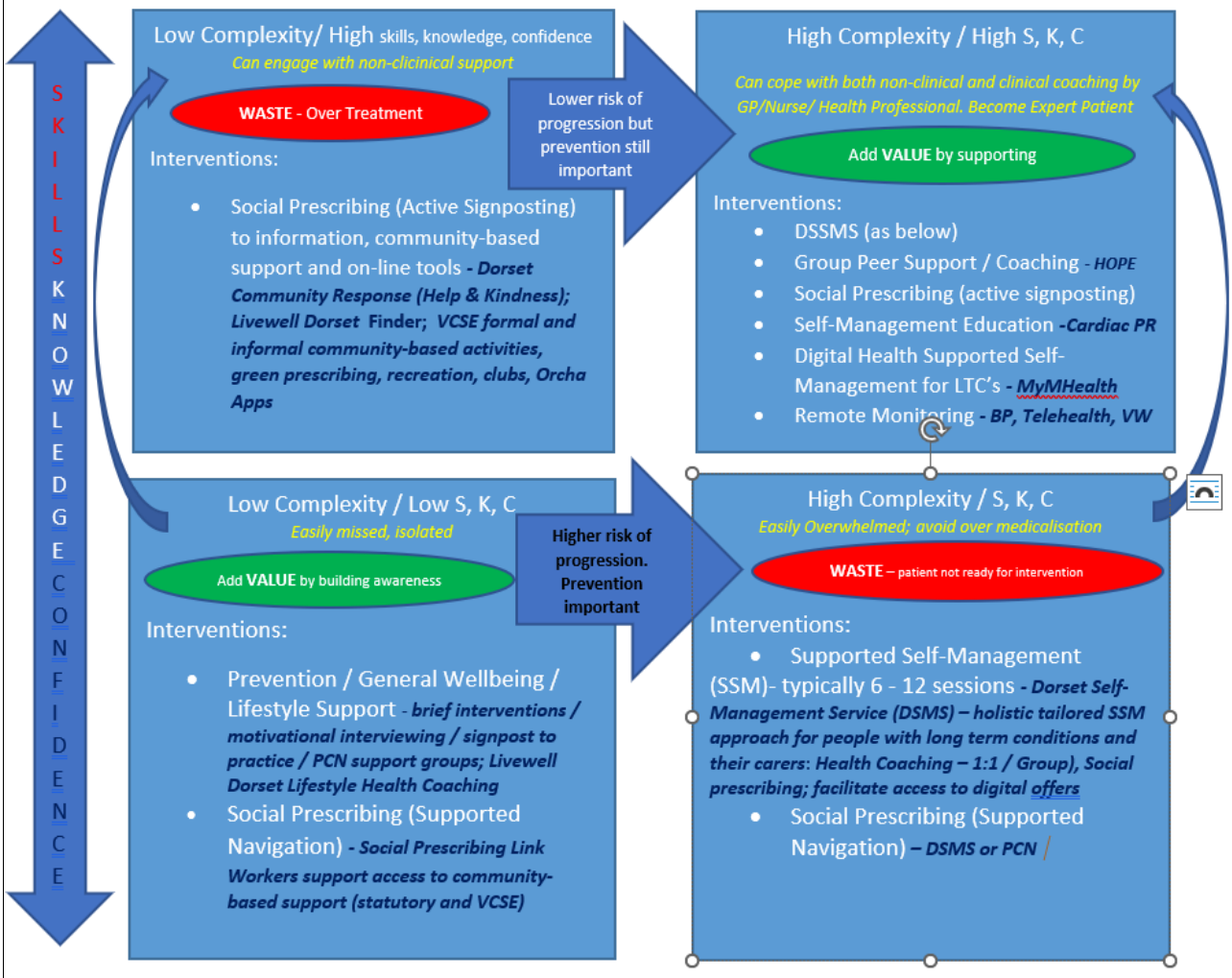
- All service users will be offered support via digital platforms/apps as an adjunct to other offers of support or as a stand-alone option. The service will facilitate access to **digital offers** including:
- Local Directories of Services and non-clinical support
- Orcha Health App library
- MyMHealth digital SSM pathways
- Support access to non-clinical operating platforms as they develop.

NB. Individuals should be able to use all 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. Patients will be offered a choice of face-to-face, group, online or telephone appointments. Typically, a client will receive 4 to 6 sessions, however, occasionally some people will require more depending on individual circumstances.

The service offer is underpinned by a **Personalised Care and Support Planning** (PCSP) approach. The service provider will ensure PCSP best practice. Consideration will be given to the person's level of skills, knowledge and confidence to manage their own health and wellbeing (health efficacy) and the complexity of their needs, to tailor the support offer. The concept of health efficacy underpins the approach to support people to develop their capability to manage their own health and care by providing information they can understand (health literacy) and act on and tailoring support to their individual needs (see Dorset Non-Clinical Support Model below). Greater skills, knowledge and confidence is linked to better health outcomes, satisfaction with services and lower costs for the wider system, such as fewer GP appointments, hospital admissions and A&E attendances.

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.

Dorset System Non-Clinical Support Offer



Review

People using the service will be offered a review with the SPLW or Health Coach (at a time and place to suit the individual as agreed during the PCSP) where person-centered outcomes can be assessed. A further refreshed plan of support may be required. The outcome will be recorded on SystmOne.

Access Times

Referrals via SystmOne or the Gateway SPOA will be received and triaged 5 days per week, Monday – Friday.

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.

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 timeframe from initial contact with a coach to start of coaching (face-to-face, on-line, telephone or group) will be four weeks.

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, using the extended NHS pathways - Directory of

Support (DoS), other local Directories of Services and local knowledge. This includes the identification and referral of any safeguarding concerns. This will be reported on SystmOne.

Discharge

Service users will receive a review prior to discharge. The outcome will be reported on SystmOne.

Offer to PCNs

SPLW and Health Coach resources will be aligned to each PCN to provide access to both the reactive and proactive service offer for all practices. Working days and WTE hours will be agreed for local need. The provider will work with each PCN to agree local working arrangements and how this resource will be used for reactive and proactive work. The proactive targeted work will depend on local needs and priorities of the PCN and practices within it.

The **digital offer for health and care practitioners within SystmOne:**

- referral to the service
- recording of PCSP
- collection and coding of service level data (in line with non-clinical Snomed coding requirements)
- 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.

Workforce Training and Development

The provider is required to ensure that all staff employed to deliver the service receive high quality training and supervision. This must be in line with the national guidance and the Personalised Care Institute (PCI) curriculum requirements for non-clinical roles and provided by an accredited PCI training provider. The service provider will work closely with other commissioned non-clinical training, supervision and peer support offers.

Ongoing support of the Primary Care and wider health and care workforce will be required to ensure on-going awareness of the service and how to access / refer into the service for people with identified needs who may benefit, in a timely manner.

3.3 Population Covered

The service is offered to people aged 18yrs+ with one or more long-term condition and their carers registered with a GP in Dorset

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 need, therefore, it is important to understand the local and national offers and to understand where this service offer fits within an individual's pathway of care and support. The service has close interdependencies and connections with a wide range of services and providers across:

- PCNs
- Community Health Service
- Secondary Care Services
- VCSE Infrastructure Organisations
- Local Authorities

- Fire and Rescue Service
- Ambulance Service and 111

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)

NHSE **Health Coaching** guide and technical annexes

NHSE Social Prescribing guide and technical annexes.

NHSE Workforce development standards for Social Prescribing and Health and Wellbeing Coaches:
https://www.england.nhs.uk/publication/workforce-development-framework-social-prescribing-link-workers/

NHS England » Workforce development framework for health and wellbeing coaches

The Social Prescribing Information Standard:
DAPB4066: Social Prescribing Information Standard - NHS Digital.

4.3 Applicable local standards

Dorset Information Sharing Charter (DISC)

Pan Dorset Carers Strategy 2016 – 20

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

8. Appendix 1: Pathway

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