SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	
Service	Social Prescribing Tier 1 Provider - North East Lincolnshire
Commissioner Lead	Lisa Hilder – **Healthy Lives Together** (Special Purpose Vehicle)
Provider Lead	
Period	January 2018 – January 2020
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Nationally, there is a recognition that health and social care services are under strain through increases in demand and a flattening off of resources available, whether in the form of money or staffing.

In 2006 a report by the Department of Health recommended the use and increased uptake of social prescribing to promote good health and independence. The NHS England Five Year Forward View, published in October 2014 set out an ambition towards enabling people to take responsibility for managing their own health and social care needs and for the NHS to work in partnership with all stakeholders to enable this to happen.

A projection of people living with one long-term condition is expected to remain stable until 2018 however the number of people living with multiple long term conditions appears to be rising. Long term conditions are much more common in people from the poorest social class with a 60% higher prevalence and 30% increased severity compared to the richest. Those living in deprived areas are more likely to have multiple long term health problems 10-15 years earlier than people living in affluent areas. It is believed that due to the ageing population and increased prevalence of long term conditions an extra £5 billion of additional expenditure may be required by 2018. The Department of Health estimates that long term conditions account for 7 out of every 10 pounds spent on health and social care.

Around 30% of all people with a long term physical health condition, approximately 4.6 million, also have a mental health problem. Mental health can seriously exacerbate physical illness and it is estimated the effect of poor mental health on physical illness costs the NHS £8 billion a year. There is a need for a more holistic person centred approach taking into account social factors as well as physical factors.

Locally, North East Lincolnshire (NEL) has a population of 167 000 with a predicted rise in the percentage of the population which will be over 65 in the coming years. In NEL the proportion of older people represents a higher percentage of the total population (20.7) than seen in Yorkshire and Humber and England as a whole. There is a predicted dramatic increase expected in the local older population of NEL to 46.79% by 2035. The resultant demands that will need to be managed will need to encompass a degree of self-care and self-management of long term conditions and general health and wellbeing.

NEL has high levels of deprivation with 4 LSOA's in the top 1% for deprivation and 31 LSOA's in the top 10% in England. Nearly 40% of the residents of NEL live in the most deprived quintile and life expectancy in the most deprived areas is 12.7 years lower for men and 9.3 years lower for women when compared to the least deprived.

A review on the Voluntary, Community and Social Enterprise (VCSE) sector within North East Lincolnshire showed there is an appetite for growth with a good number of providers operating within it. Recent collaborative working between statutory and voluntary agencies has resulted in a strengthening of local provision and the co-production of a social prescribing model as described here. There is currently no service providing social prescribing in NEL so this will be a new way of working in the area.

The general strategic direction of travel for the local health and social care economy is articulated in North East Lincolnshire CCG's five year strategic plan which is making a shift to the left; moving away from delivering services in hospital to more community and home based care where possible. There is an increasing focus on prevention and encouraging people to self-manage their own health and maintain independent living.

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**	√
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**	√

2.2 Local defined outcomes

- Improve the wider health and wellbeing of service users
- Timely response to social prescribing referrals
- To support reduction in primary and secondary care attendances for people with long-term conditions, complex conditions and frailty
- Improve service user's self-reported wellbeing and ability to self-manage their condition

These outcomes contribute to the prevention agenda outlined in the Humber, Coast and Vale Sustainability and Transformation Plan, through enabling people to live independently without recourse to formal NHS or social care provision.

3. Scope

3.1 Aims and objectives of service

The overall aims of the service are to ensure delivery of the Social Prescribing service which will:

- Increase the number of referrals made by GPs and Health & Social Care professionals to local community activity provision.
- Increase the number of local people accessing local community activity provision.
- Improve the social support available for individuals by supporting, signposting and connecting people to community groups, activity and provision in the local area.
- Improve the welfare of the local community by providing general information and advice.
- Reduce social isolation and improve community connectiveness to contribute to overall improvements in health and wellbeing.

Measure 1:

Improved patient wellbeing and self-management of their long term condition
Measured improvement of patient self-reported score on the Wellbeing Star completed on referral (baseline) and again after 6 months and every 6 months thereafter whilst the patient remains on the programme (up to 2 years).
http://www.outcomesstar.org.uk/well-being-star/

Measure 2:

Reduced usage of secondary care services, linked to their Long Term Condition, for the patients participating in the programme.

Reduced usage, and cost, of secondary care services per patient in terms of non-elective admissions, A&E and elective admissions. Outcomes will be evidenced at 12 and 24 months after the individual's initial engagement with the programme. Reductions on usage and cost will be demonstrated against a historic usage baseline for the 12 months prior to the individual's initial engagement.

3.2 Service description/care pathway

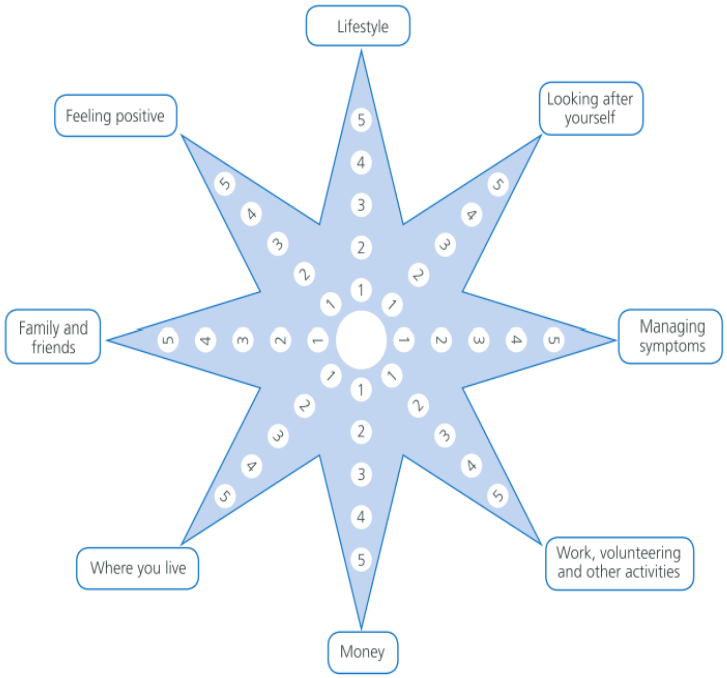
The Social Prescribing Team (Tier 1 service) will be a single point of access for patients to be referred to by GPs, other agencies and themselves. The service will be provided to the adult (18-65) population of North East Lincolnshire who have been diagnosed with one or more of the following long term conditions:- **Asthma, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD),Diabetes and Hypertension.**

Social prescribing is about utilising and linking up with the VCSE (Voluntary, Community and Social Enterprise) sector including providers who have been commissioned by Healthy Lives Together (Tier 2 service) to provide non-medical support to improve health and wellbeing for social, emotional and practical problems. It is about treating the causes behind the symptoms rather than focusing on a medical treatment pathway.
The social prescribing initiative will expand the options available for patients when attending a primary care (GP practice) consultation. It is envisaged that the Tier 1 team will consist of a co-ordinator as well as several 'key workers', some paid and some volunteers, who will need to have a high awareness of the local VCSE services available as well as form strong relationship with the General Practices and the communities they serve. Should the provider wish to suggest an alternative structure for the team, this will be considered. The team will act as a bridge between primary care professionals and the wide range of social prescribing opportunities available. The team will also be required to establish effective working relationships with the Social Prescribing Tier 2 providers and be able to confirm (through effective monitoring mechanisms) that their input has contributed to the wellbeing of the patient.

In most cases the patient's pathway starts when they are referred to the service by a GP or practice nurse. They will be referred to the Tier 1 provider which will be the single point of access, working closely with the beneficiary, coaching and motivating the beneficiary, eliciting barriers and action planning as well as completing the Wellbeing Star throughout the intervention. The GP/nurse will identify patients as being in need of social prescribing on their best judgement and according to established referral criteria for the long term conditions being addressed by this service. People will also be able to self-refer into the service as well as be referred from other locally available services, e.g. CAB. These self referrals will need to be validated by the Tier 1 provider in conjunction with the individual's GP to ensure the individual meets the referral criteria.

The Tier 1 provider will make contact with the patient and arrange an appointment at the earliest opportunity, to assess the needs of the individual. The needs assessment will be undertaken by an assigned key worker who will support the individual and develop a personal wellbeing plan. Objectives and goals through discussion with the individual will be identified and recorded.
The assessed needs and outcomes of the individual will be formally identified using the "Wellbeing Star" for Long Term Conditions. This is a requirement of the contract. Individuals will have a 6 monthly review, at which point improvements and any outcomes achieved will be assessed.

The Wellbeing Star (long-term conditions)



The full range of VCSE or Tier 2 services available will be explored and matched to the needs of the individual in order to achieve the goals identified. Individual packages of support pertinent to their personal needs will be agreed and formalised in an action plan.

Services can range from physical activity, social groups, skills support, creative activities, support for lifestyle changes, relationship support or wider determinant support such as debt management.

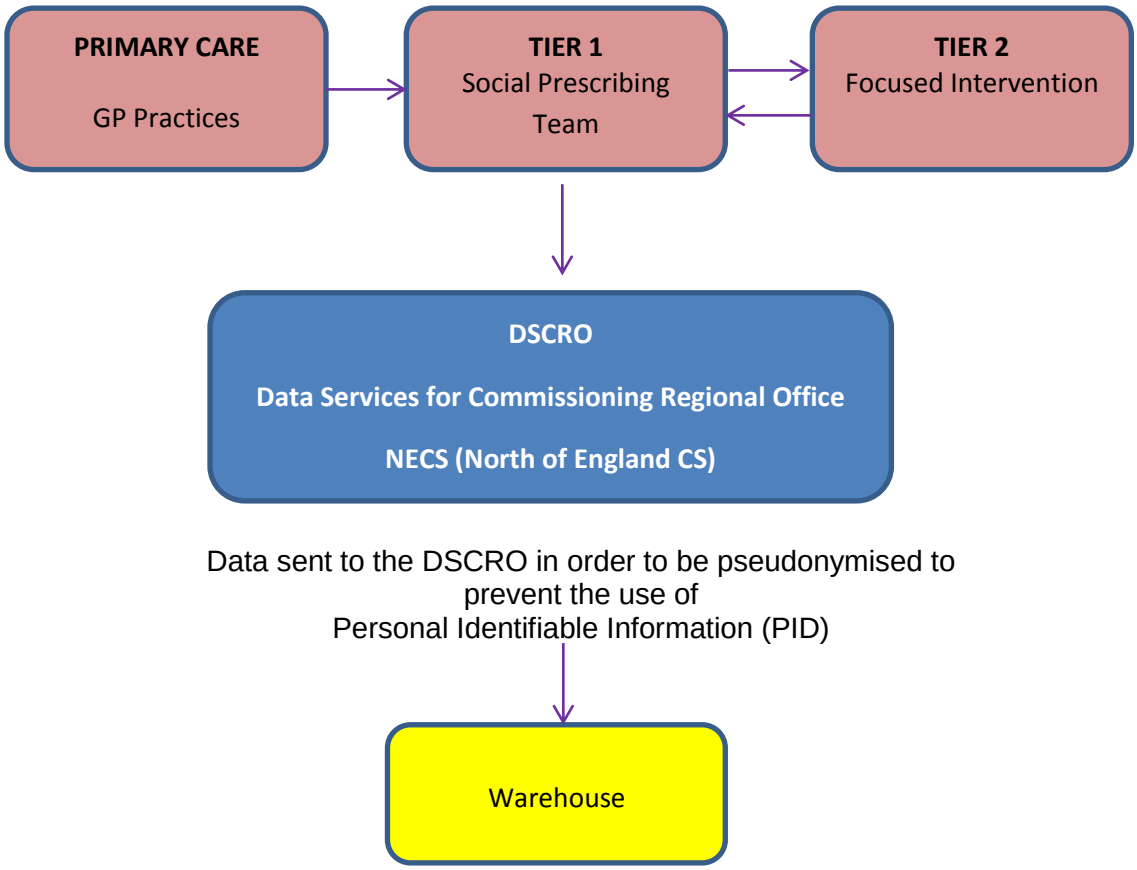
The key worker will support the patient in a manner that best suits them including those that need extra support, and will provide coaching and motivation to support the patient to engage and sustain engagement with Tier 2/ VCSE services. This not only includes emotional support but may involve attending some sessions with the individual until they feel comfortable. The patient will follow their plan, and will attend the 6 monthly review to assess any improvements or progress made against the

identified outcomes, and goals, measuring and recording progress for the individual. The review could create new goals or discharge the individual from the service.

The patient can continue to attend the VCSE service(s) as desired and if necessary return to the Social Prescribing Team for further support.

The service operating times will be **Monday to Friday, 9am to 5pm** (excluding bank holidays) and as arranged in consultation with the GP practices through patient involvement and local intelligence.

Service Data Flow diagram



As the data sets will now be pseudonymised, no clear data will be analysed by Healthy Lives Together but the key field in each dataset will allow the data to be linked together and to secondary care data from SUS. This will allow analysis and monitoring within the current IG guidelines.

Data Sharing arrangements

The Tier 1 provider will adhere to submitting a dataset under agreed timescales, based upon a set of data fields approved, to the relevant DSCRO (Data Service for Commissioners Regional Office). For North East Lincolnshire, this will be NECS (North of England Commissioning Support), via the Data Landing Portal (DLP), which is administered by NHS England.

The Tier 1 provider will have an agreed dataset sent to it by Primary Care, via a one stop referral in. There will also be a flow of data to the Tier 2 service to ensure they have the necessary information to best support the patient, with the Tier 1 provider receiving an agreed dataset in return to enable the monitoring of patient care. All flows of data with Tier 1 will be in accordance with any data

sharing agreements to support the aims of the service.

The data is to be sent to the DSCRO by the Tier 1 provider with a key, likely to be NHS number, which allows the linking of data anonymously within the current IG guidelines. It will be possible for Tier 1 submission to include any flags in their data if this facilitates the monitoring and analysis of the data.

NECS will then flow the pseudonymised data back to Healthy Lives Together, who will then manage the data within a data warehouse. At no point will Healthy Lives Together see any clear data.

Marketing

The provider will be required to develop a robust marketing and engagement plan promoting the use of the Social Prescribing Team in conjunction with Healthy Lives Together. The provider is responsible for marketing the services to GPs and to other sources of referrals in the Health and Social Care sector and for generating referrals.

Service and health information should be available in the main languages spoken across North East Lincolnshire and in other languages upon request. The provider should actively engage with community groups to ensure access to the service.

The provider is required to produce a service information leaflet. The leaflet should include as a minimum: the name of the provider; the name of the service; a description of the service; information about the service including location and opening times; access and referral information; and contact information. An electronic version of the leaflet will also be required. The service information leaflet will require the approval of the commissioner before issuing.

Branding of the service will be agreed with the commissioner and all communication will require the commissioner's approval before issuing.

Identifying Gaps/Improvements

Throughout the period of this contract the Tier 1 provider will develop a range of methods to identify service gaps and potential areas for improvement.
The Provider will work pro-actively with Healthy Lives Together and partner organisations in continually reviewing and developing services to address any gaps.

Learning and Improvement

The service will identify areas for improvement and work with commissioners and Tier 2 providers to develop and implement solutions. This will include sharing any appropriate learning with the relevant care providers as well as identifying where an audit would be beneficial and facilitating this. This will also include providing information required for monthly reviews held by the commissioner (providing a reasonable lead time is given to gather the information).

3.3 Population covered

The service will be provided to the adult (18-65) population of North East Lincolnshire who have been diagnosed with one or more of the following long term conditions:-

Asthma
Atrial Fibrillation
Chronic Obstructive Pulmonary Disease (COPD)
Diabetes
Hypertension

The service will be to support anyone with an unmet social need however levels are expected to be higher in the most deprived communities and the service will need to respond to this level of need appropriately.

3.4 Any acceptance and exclusion criteria and thresholds

Exclusion criteria:

- Under the age of 18
- Service users who are acutely ill at point of referral
- Service users who display unreasonable behavior unacceptable to provider and staff
- Service users who have not consented to care and support offered

3.5 Interdependence with other services/providers

The service will need to link with:

- General Practices
- Voluntary, Community and Social Enterprise sector
- Community Pharmacies

A provider can bid to be either a Tier 1 or a Tier 2 provider, but if successful will only be successful in one of these.

4. Applicable Service Standards

4.1 Applicable national standards

- NICE Standards
- Our Health, Our Care, Our Say (Department of Health)
- Improving General Practice (NHS England)

4.2 Applicable standards set out in Guidance and/or issued by a competent body

- Evidence to inform the commissioning of social prescribing (The University of York)

5. Applicable Performance requirements

5.1 Applicable quality requirements

Performance Requirement	Threshold	Method of Measurement
Satisfaction rate of patients using the Social Prescribing Team	80%	Annual feedback survey to be conducted by the service and shared with the commissioner
Satisfaction rate of GPs referring to the service	80%	Annual feedback survey to be conducted by the service and shared with the commissioner
Patient start volumes vs. estimate (see Section 8)	95%	Quarterly Audit
Patient contacted within 3 working days after referral	95%	Quarterly Audit
Met with patient 5 working days after first contact	90%	Quarterly Audit
Average time to completion of Wellbeing Star 10 working days after first contact http://www.outcomesstar.org.uk/well-being-star/	90%	Quarterly Audit
Average time to completion of Action Plan 15 working days after first contact	90%	Quarterly Audit
Average overall improvement in assessed patient wellbeing (using the Wellbeing Star)	2	Quarterly Audit
Average overall improvement in self-reported management of Long Term Conditions (e.g. LT6)	TBC	Quarterly Audit

6. Corporate and Clinical Governance

6.1 Responsibilities of the provider

The Provider will:

- Apply the principles of sound clinical and corporate governance;
- Actively support all employees and unpaid volunteers to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;
- Undertake systematic risk assessment and risk management to meet requirements monitored by Care Quality Commission;

- Ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;
- Challenge discrimination, promote equality and respect human rights;
- Develop, implement and adhere to quality standards and protocols;

The Provider will ensure that:

- The key workers and co-ordinators delivering the service are appropriately trained and experienced

6.2 Safeguarding

The provider has a duty to work within the Local Safeguarding Policies

Patients with Special Needs

The Provider will comply with procedures for the treatment and management of patients with special needs (including vulnerable patients). The Provider must demonstrate that procedures and policies are in place to ensure that such patients receive good care.

The Provider must demonstrate that it is aware of and follows local and national policies and guidelines in the care of patients with special needs. Providers must also make appropriate provision for patients with impaired hearing or sight.

6.3 Complaints policy

The service is expected to operate and promote an effective complaints policy. Any person wishing to make a complaint has the right to complain either to the provider or the Commissioner (in this case, Healthy Lives Together). Providers are required to provide a quarterly report to the Commissioner detailing all complaints received, The procedure should aim to meet the following objectives:

- Be well publicised;
- Be consistent;
- Be easy to access, simple to understand and use;
- Be fair and impartial to staff and complainants alike;
- Ensure that the care of patients will not be adversely affected if they or their advocate make a complaint;
- Ensure that rights to confidentiality and privacy are respected;
- Provide a thorough and effective mechanism for resolving complaints and satisfying the concerns of the complainant;
- Provide answers or explanations promptly and within agreed time limits;
- Keep the complainant or their representative informed of progress;
- Enable lessons learnt to be used, and evidenced, to improve the quality of services to patients;
- Regularly review the complaints procedure and amend if found to be lacking in any respect.

6.4 Equality & Diversity

Services will be provided that are sensitive to a patients gender, sexual orientation, race, religion, culture, ethnic origin and disability. All statutory and Standards for better health obligations must be met including the Human Rights Acts

The Provider must ensure that all service provided genuinely meet the needs of people from diverse and vulnerable groups

Equality Impact Assessments which need to be undertaken on all policies, procedures and processes

Make reasonable provision for patients identified with a sensory disability in line with the scope of the Disability Discrimination Act to enable them to access the services

Work in partnership with the Commissioner to help all non-English speaking users access professional translation services during all consultations and translations of materials describing procedures and clinical prognosis for the languages as being the most common languages spoken by patients who are likely to use the services;

Subject to its obligations under the Data Protection Act 1998 record details of any patients who have special requirements in relation to accessing the services; and

We as commissioners need to ensure those we commission comply with those standards which should be published as part of the Annual Report, including an employee demographic report. The provider should demonstrate how it complies with the Public Sector Equality Duty

Patient Respect and Dignity

The Provider must:

Deliver services from an environment that treats every Patient and Carer as a valued individual, with respect for their dignity and privacy

Allow patients to have their personal clinical details discussed with them by a person of the same gender, where required by the Patient and if reasonably practicable

Ensure that all Staff behave professionally and with discretion towards all patients and visitors at all times.

6.4 Providers Premises

The service must provide access to an adequate number of rooms, arrangements for reception, waiting and toilets, accessibility for people whose mobility is impaired, and the arrangements for staff safety in the premises

The Provider must deliver the Services within a clean and pleasant environment and ensure a safe and hygienic environment for clients, staff and any other visitors. The Provider must ensure that clients are always treated with confidentiality, dignity and respect.

7. Individual Service User Placement

7.1 **Assessment**

The provider, should, by using an appropriate, transparent and fair assessment process, make an appropriate referral to the Tier 2/ VCSE service(s).

8. Payment details

Payments:

Schedule of Rates

The payment mechanism for the outcome contract is comprised of four elements:

Payment Trigger 1
Annual block payments (paid monthly, providing the service meets the operational milestones that will be agreed between the provider and the commissioner)
Payment Trigger 2
Payment for each service user who starts on this programme (upon completion of an initial Wellbeing star assessment and action plan)
Payment Trigger 3
Payment for improvement in Wellbeing star score for each service user (6months after the service user starts on this programme)
Payment Trigger 4
Payment for improvement in Wellbeing star score for each service user (at 12, 18 and 24 months after the service user starts on this programme)

Payment Trigger 1

Year	Maximum Annual Tariff
1	£66,000
2	£45,000

Payment Trigger 2

Maximum tariff - per service user
£185

Payment Trigger 3

Wellbeing Star improvement vs. score at initial assessment	Maximum tariff - per service user
Av improvement of 2.0 or more	£110.00
Less than 2.0 but at least 1.5	£99.00
Less than 1.5 but at least 1.0	£88.00
Less than 1.0 but at least 0.5	£44.00
Less than 0.5 improvement	£0.00

Payment Trigger 4 (paid up to 3 times per service user)

Wellbeing Star improvement vs. score at initial assessment	Maximum tariff - per service user
Av improvement of 2.0 or more	£60.00
Less than 2.0 but at least 1.5	£54.00

Less than 1.5 but at least 1.0	£48.00
Less than 1.0 but at least 0.5	£24.00
Less than 0.5 improvement	£0.00

Maximum payment per service user (excluding block payments): £475 (£185 Trigger 2 + £110 Trigger 3 + £180 Trigger 4) if highest improvement score is achieved for a service user on the programme for 2 years.

Volumes

Estimated volumes for the service are as follows (number of starts):

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Year 1	8	8	8	20	20	20	25	25	25	30	30	30	**248**
Year 2	31	31	31	31	31	31							**187**

Notes

A. Payments will be made monthly in arrears upon receipt of an invoice listing outcomes achieved.
B. The contract length is 2 years initially, with 18 months of referrals and 2 years of delivery. Subject to successful delivery of outcomes, the contract may be extended for up to an additional 5 years. This would mean up to an additional 3.5 years of referrals and up to a total of 7 years of delivery. If extended, a payment will be introduced based on secondary care outcomes.