SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	
Service	Social Prescribing Tier 2 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 early 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 infrastructure support providers operating within it. Information held by public sectors on VCSE however has often been patchy with relationships between sectors not as good as could be. 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 the 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 Northern Lincolnshire transformational change programme, Healthy Lives, Healthy Futures, 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 aim of the service is to provide interventions to improve the health and wellbeing of patients utilising the Social Prescribing service. The interventions will be assessed through one measure, performance in which will determine the outcome payments made. The other key measure that will be tracked is reduced usage of secondary care services (in terms of non-elective admissions, A&E and elective admissions) linked to the Long Term Conditions of patients participating in the programme although payments to Tier 2 providers will not be made on this metric.

Measure:

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/

3.2 Service description/care pathway

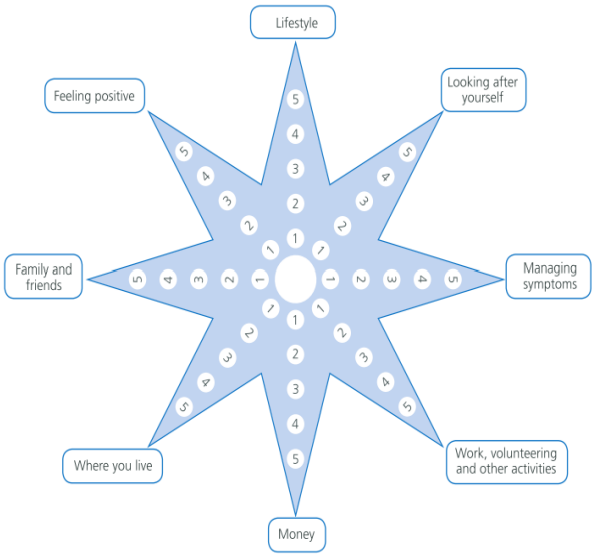
A patient's pathway will begin with a referral from a GP or a Health and Social Care professional. They will be referred to a Tier 1 provider which will be the single point of access, working closely with the beneficiary, eliciting barriers and action planning as well as completing the Wellbeing Star throughout the intervention. The Tier 1 provider will refer the patient to an intervention or series of interventions known as the Tier 2 providers. A range of Tier 2 providers will offer interventions that will enable an improvement in health and well-being for the individuals referred and contribute towards the overall reduction in use of primary and secondary care health services.

Patient Target Cohort:
Adult (18-65) population of North East Lincolnshire who has been diagnosed with one(or more) of the following long term conditions:-

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

The assessed needs and outcomes of the individual will be formally identified by the Tier 1 provider 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)

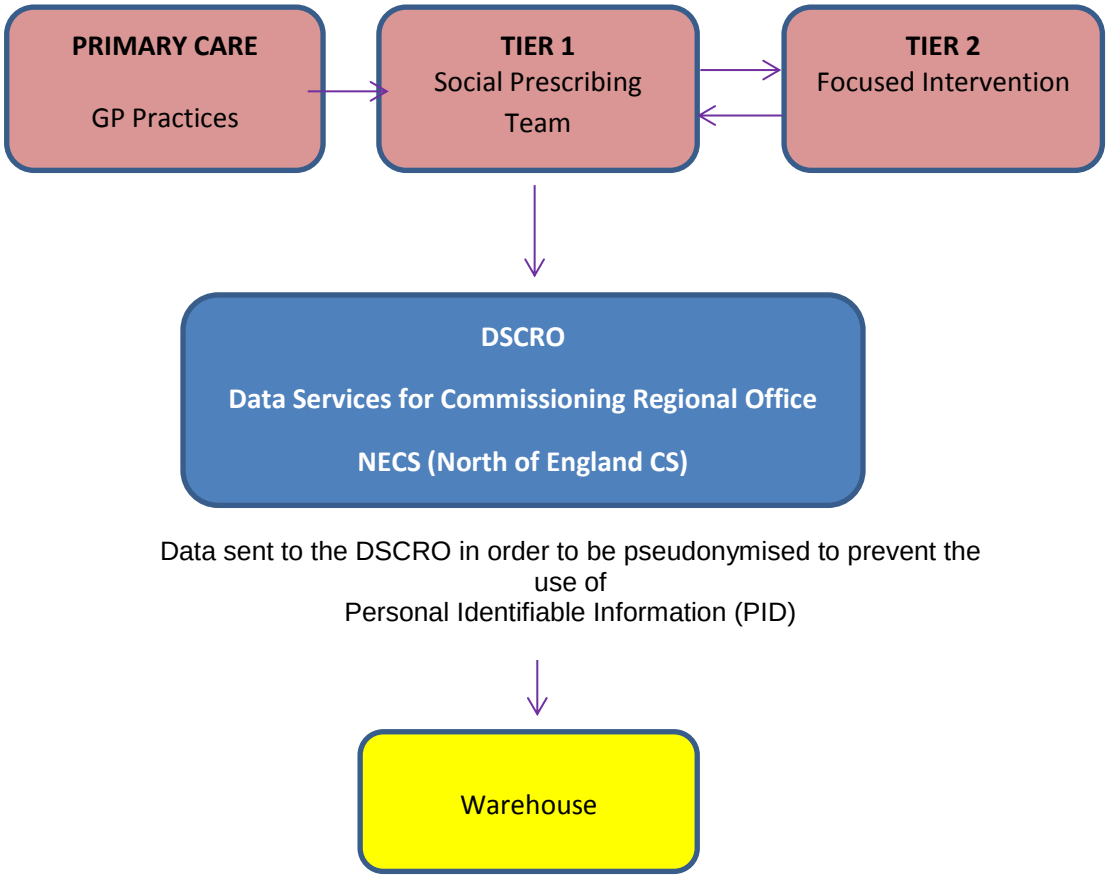


The full range of Tier 2/ VCSE services available will be explored and matched to the needs of the individual by Tier 1 in order to achieve the goals identified. Individual packages of support pertinent to their personal needs will be agreed and formalised in an action plan, through which referrals to Tier 2 will be made.

Interventions

Given the nature of our target cohort we recognise that in the majority of cases a single intervention will not be sufficient and there will be a requirement for a series of linked interventions (some of which will be provided by services already commissioned) in order to address beneficiary needs and achieve project outcomes. Given that most beneficiaries will be in receipt of a series of linked interventions we fully expect these to be variable in line with individual needs and requirements but all will be targeted to ensure that they achieve desired project outcomes. Interventions will be based on the needs of the beneficiary and targeted to both improve self-management of their condition and remove the barriers to improved health and wellbeing and ultimately reducing hospital admissions. Interventions could include for example exercise, diet and weight loss, healthy eating, housing, debt advice, confidence building, smoking cessation or a combination of these.

Service Data flow



Data sent to the DSCRO in order to be pseudonymised to prevent the use of
Personal Identifiable Information (PID)

As the data sets will now be pseudonymised, no clear data will be analysed by , 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.

The provider will be required to comply with any data requests required by the Tier 1 Provider.

The Tier 2 provider will adhere to submitting a dataset under agreed timescales, based upon a set of data fields approved, to the Tier 1 provider via a secure transfer method, (preferably via an NHS mail account).

The Tier 1 provider will share relevant information in accordance with any data sharing agreement in order for the Tier 2 service to begin to undertake any intervention.

Any data that is to be sent to the Tier 1 provider will have a key in order to allow the linking of data anonymously within the current IG guidelines. It will be possible for Tier 2 submission to include any flags in their data if this facilitates the monitoring and analysis of the data.

Marketing

Tier 2 providers will be responsible for ensuring that the Tier 1 provider has a good understanding of the range of services that they offer and the type of individuals services are suited to.

Identifying Gaps/Improvements

Throughout the period of this contract Tier 2 providers 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 the Tier 1 provider and commissioners 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 (including attendance data) 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 intervention	80%	Annual feedback survey to be conducted by the service and shared with the commissioner
Average overall improvement in assessed patient wellbeing (using the Wellbeing Star)	2	Quarterly Audit
Patient contacted within 5 working days after referral	95%	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 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 staff 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 needs 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 behaves 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, appropriate 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

Procurement is for an approved listof multiple Tier 2 providers, to which service users will be referred by the Tier 1 provider using an appropriate, transparent and fair assessment process,

Each service user will require a different mix of services, and so each Tier 2 provider is likely to work with different volumes of patients for varying lengths of time.
Service users may also as part of their action plan be referred to VCSE services that are not on the Tier 2 framework.

Each service user may be referred to more than one Tier 2 provider.

8. Payment details

Payments:

Schedule of Rates

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

1. Payment for each service user who starts on this programme
2. Payment for improvement in Wellbeing star score for each service user (6months after the service user starts on this programme)
3. 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

Tariff - per service user
£135

Payment Trigger 2

Wellbeing Star improvement vs. score at initial assessment	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 3 (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: £425 (£135 Trigger 1 + £110 Trigger 2 + £180 Trigger 3) if highest improvement score is achieved for a service user on the programme for 2 years

The tariffs listed above reflect payments per service user not per Tier 2 provider. If an individual works with more than one Tier 2 provider the tariffs will be split between the relevant providers. For example if an individual works with equally with two Tier 2 providers, each will receive a payment of £67.50 (half of £135) for Trigger 1. The exact details of how payments will be split between providers will be negotiated and finalised in contracting).

Volumes

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

The estimated number of individuals achieving payment triggers 2 and 3 are likely to be lower than this due to service user attrition.

Note that these are volumes across all Tier 2/ VCSE services and volumes per individual Tier 2 provider will likely be less than these:

	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, 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.