SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

Service Specification No.	
Service	**Halton Social Prescribing Link-Worker Service**
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

By understanding that people's health is determined primarily by a range of social, economic and environmental factors, the term social prescribing has been described as a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services[1]. Such interventions and community activities can impact positively on an individual's wellbeing and resilience, providing a mechanism for people to stay well and to get, empowering individuals and communities to make long lasting changes in behaviors to support their health and wellbeing.

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. The main principle being to promote health and wellbeing.

The NHS England's Five-Year Forward View[2] supported local models of social prescribing to enable primary care teams to access practical, community-based support for their patients, including access to advice on employment, housing and debt. This recognition that having the options for health and social care professionals to refer people to non-clinical services with the aim of addressing peoples needs in a holistic way, fits with the wider prevention agenda, and communities can play a greater role in health and wellbeing in the future. This is further substantiated in Halton's strategic plan; One Halton.

The current UK Secretary of State for Health and Social Care, has stated that social prescribing is a priority and will be available in every GP practice by 2024[3]. NHS England's Long Term Plan has highlighted that Social Prescribing is a key element in the prevention workstream and has stated that there will be funding available for social prescribing link workers in every newly created Primary Care Network, stating that "within five years over 2.5 million more people will benefit from social prescribing"[4]. This clearly sends a signal that the

[1] The Kings Fund; 2017

[2] NHS England FYFV XXXX

[3] Hancock,2018

[4] NHS Long Term Plan; NHS England, 2018

creation of a comprehensive social prescribing infrastructure within a primary care/community setting, will be required for every PCN

It is well documented that an individual with a chronic 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; and it is therefore vital 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.

The evidence base demonstrating how a person's social networks can have a significant impact on their health. Social networks have been shown to be as powerful predictors of mortality as common lifestyle and clinical risks such as moderate smoking, excessive alcohol consumption, obesity and high cholesterol and blood pressure.[5] This is of particular importance since in the most deprived communities, often report a severe lack of support, further exacerbating their situation at a time of social and economic disadvantage.

1.2 Locally

The Population of Halton in 2019 was estimated to be 128,432 (MYE), with 48.5% of its residents living in the top 20% most deprived areas of England. This unfortunately presents further challenges as it is recognized that often people living in more deprived areas will experience multiple health problems, 10–15 years earlier than people in more affluent areas. One Halton strategic plan is seeking to address the health inequalities that exist in Halton by pledging to work at every level across Health and Social care, and address the social factors which influence and individual and populations' health for Halton as a whole.

An opportunity exists with the National DES-to build on the existing social prescribing service in Halton, and through agreeing a new model which incorporates the multi-agencies operating across Halton, the social prescribing service will be better placed for the anticipated growing demand.

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

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**	
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

[5] Pantell et al Am JPH, 2013, Social Isolation: A Predictor of Mortality Comparable to Traditional Clinical Risk Factors; Holt-Lunstad et al PLOS medicine 2010, Social Relationships and Mortality Risk-meta Analysis.

2.2 Local defined outcomes

Key outcomes for service users include:

- Improvement in levels of patient activation (as measured by assessment of Patient Activation Measure, PAM, scores)
- Improvement in self-reported levels of wellbeing (as measured by assessment of pre and post scores on the ONS4)
- Increased knowledge, skills and understanding of their health and wellbeing;
- Improved confidence, motivation and ability to take part in valued activities;
- Improved levels of resilience and capacity to deal with challenges and crisis situations;
- Reduced loneliness and social isolation; and
- Reduced levels of dependency and reliance on statutory services, for example; primary care (as measured by primary care usage analysis).

Key outcomes for the wider health / social care system include:

- Increase in the number of VCFSE organisations supporting social prescribing
- Better integration with the wider system; One Halton
- Improved connection to other stakeholders that can impact the wider determinates of health, such as housing, financial support, food poverty, employment

3. Scope

3.1 Aims of the Social Prescribing Service include:

- 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.

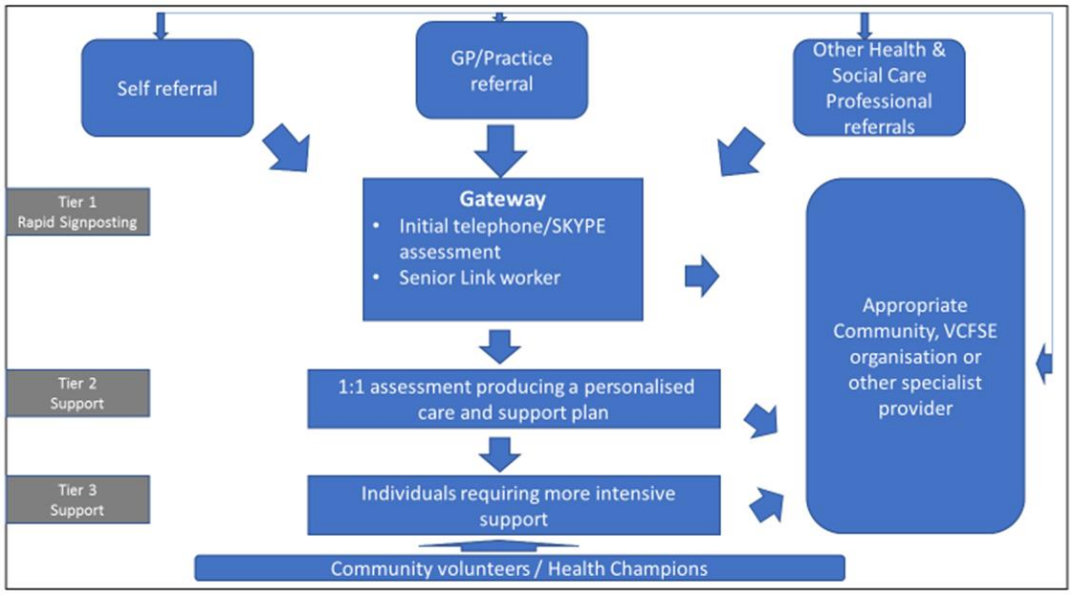
3.11 **Key objectives of the Social Prescribing Service include:**

- To provide personalised information, advice and support to people using the service
- To signpost or refer people to appropriate activities, services and support which will help to meet their needs.
- To support service users and provide a range of accessible and flexible information in a manner that is responsive to their individual needs, preferences and wishes
- To ensure service users are supported by staff who have the required knowledge, skills and competencies.
- To build, develop and maintain relationships with and knowledge of local statutory and non-statutory organisations, services and groups to support the effective operation of the service.
- To promote and increase awareness of the service in the borough.
- To deliver the service in a way that represents value for money.
- To utilise effective methods to gather service user feedback in order to evaluate the quality of the service.
- To provide robust and timely information on service quality and utilisation.

3.2 Service description/care pathway

The provider will ensure the Social Prescribing Service delivered is to a high-quality trusted service which will help people to access local activities, services and support in order to improve health and wellbeing across Halton. Individuals who access the service should receive relevant, coordinated and effective information, guidance and support.

Diagram 1: Halton Social Prescribing Service:



As illustrated in diagram 1 above, the service will comprise of a single point of access, 'gateway'. All referral routes; received from primary care; from allied healthcare professionals, or through self-referral, will all enter this gateway. This entry point will determine eligibility and expertly elicit the underlying principle 'challenge' presenting by the individual and identify which tier of the social prescribing service would be most suitable for the individual at that point in time.

Tier 1 – Rapid Signposting
On understanding the individual's 'primary challenge' and concluding this can be more appropriately addressed by another service within the community; for example, to resolve a housing issue or a welfare benefits complication, the link worker will a) Complete the personalised care & support plan to confirm the interaction. b) Refer the individual to the relevant agency, by using the social prescribing IT platform.

Tier 2 – A 1:1 Assessment with a link worker.
During the initial telephone assessment, where the link worker identifies the individual would benefit from a 1:1 interaction, the individual will be offered an appointment. This will comprise of a 45min-1 hour guided conversation, where using the personalised care and support plan, an individual is taken through a process whereby:

a) The Link worker seeks to understand the challenges each individual presenting has
b) Collectively, identify what is most important for the individual to address
c) Agree an action plan

Tier 3 – Additional follow-up support

There will be in some incidences, the necessity for the link worker to agree additional follow-up 1:1 support. This may be for individuals presenting with particularly complex situations, requiring additional time to resolve of additional information to be gathered, prior to an action plan to be agreed. In such circumstances, individuals may qualify for up to two further 1:1 interactions. The final criteria will be agreed by the PCN clinical directors and commissioners.

The Service user Journey

- The service user will have the ability to look at a description of the community activities under consideration, venue, and locations to help them decide which activity they will select to use.
- The service user is supported in reviewing activities most suitable to their identified needs & they chose an initial activity with the support of the link worker
- The community provider selected is then alerted by the IT referral platform and the service user will receive notification via their preferred route; email/text message or phone call phones, of a date for them to attend their first session.
- The provider will ensure there is a tracking system in place to create an alert if the service user has not been contacted or not attended the first session

Consent

Consent is sought by the referrer to make patient referrals to Social Prescribing link workers. Where the Social Prescribers making the referral have access to EMIS, consent is sought from patients for Social Prescribers to access patient information on EMIS relevant to the management of their case, following agreed information governance protocols. Social Prescribers will also seek consent from patients to feedback details of their consultation to the referrer.

Link-worker development

The service provider will be responsible for the the training and development of the link workers, ensuring they are fully compliant with the DES service specification, and additionally receive a comprehensive programme to understand the vast array of services offered through the Voluntary community and faith and social enterprise sector (VCFSE) across Halton.

Capacity Development

Consideration on ensuring the service makes best use of existing opportunities and resources within local communities. The challenge is not necessarily to create 'new' interventions but to help key partners work more effectively together with the shared purpose supporting the health and wellbeing for Halton.

- (Scoping of the existing VCA service line.)
- Forging partnerships: cooperation, coordination and communication between services, through the One Halton strategy-whereby all partners have aligned behind specific outcomes-including prevention.
    - Health Improvement team
    - Community development officers
    - Social care teams
    - CCG's Well Halton initiatives
    - 3rd sector organisations

Governance

The service provider will be part of a Social Prescribing Steering Group that will comprise of representation from NHS Halton CCG, Halton Local Authority including Public health, Runcorn and Widnes PCN's and the VCFS.

IT Requirements

In order for the provider to track service users as they progress through the pathway, and have the ability to track referrals and outcomes, a robust case management software platform is required. All data must be held on a database that can be accessed remotely by an invited third party. The database must have agreed security measures for data protection and conform to the information governance requirements of the NHS.

As part of this service contract, the provider, in partnership with the CCG and wider stakeholders, will procure an IT platform which will offer the following capabilities:

- Making community-based and online support more accessible through digital pathways
- Developing an online triage function for social prescribing, so those with the most appropriate needs are directed to a link worker
- Developing community directories so that they are accurate, up-to-date, and provide a baseline source of knowledge of the local area
- Case management software, which enables a social prescribing service to understand the impact of their referrals on their client and the local voluntary and community sector
- Ability to provide reporting and analytical dashboards which will offer referral and monitoring capabilities

3.3 Population covered

This service is for individuals who:

a) Are registered at one of the participating general practices served by NHS HALTON CCG AND

b) Would benefit from accessing local activities, services and support in order to improve their health and wellbeing.
c) Meet the specified inclusion/exclusion criteria

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 Inclusion Criteria

- People over 18 years old (depending on LA discussions)
- People who have complex social needs which affect their wellbeing. (Will need a definition agreed)
- People who are socially excluded, disadvantaged, lonely, isolated and vulnerable
- People with one or more long-term conditions
- People who need support with their mental health (low level-wording agreed with PCNs & PH)

3.4.2 Exclusion Criteria:

- People who do not fall into one of the above groups listed
- People with severe and enduring mental health conditions unless it's part of a package of care and has been discussed between the referrer and SPLW and agreed as a suitable referral
- People in palliative care
- People who do not want to engage with the Social prescribing service

- People who are being referred mainly for clinical reasons, e.g. Addictions, etc. where more appropriate services exist which do not place either other service users or the providers at risk
- Service users who display unreasonable behavior unacceptable to the provider(s) and members of staff

3.5 Interdependence with other services/providers

- Primary Care Networks, GP practices and primary health care teams
- Secondary health care services
- Community and voluntary sector organisations
- Halton Borough Council services provided by the local authority
- Halton Public Health

3.6 Monitoring and Evaluation

The provider will be required to attend quarterly contract meeting with commissioners and produce quarterly update reports based on both the Service monitoring and evaluation requirements Appendix XX and the Quality Standards outlined in Appendix XX.

It is the expectation that both Service user information and outcomes will be recorded via an online data software solution, and will be made available to the Commissioners on a quarterly basis via an Outcome Dashboard. The precise template will be agreed by commissioners, prior to the service commencing.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

N/A

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

The provider will be expected to adhere to and comply with relevant legislation, policies, regulations, guidelines, codes and standards. Such publications may be produced by organisations such as NHS-E, professional organisations, standard setting bodies and regulatory bodies

4.3 Applicable local standards

SEE Appx A

Appendix A Service Monitoring and eva

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

SEE Appx B

Appendix X Quality Standards.docx

5.2 Applicable CQUIN goals (See Schedule 4D)

TBC
6. Location of Provider Premises
The Provider's Premises are located at: TBC
7. Individual Service User Placement
N/A