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# Service Specification

# Personal Independence Coordinator Service

# Soft market testing V2

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   The Better Care Fund (BCF) Policy Framework (2016/17) sets the mandate for health and social care to work together to deliver against the Delivering the Forward View: NHS Planning Guidance (2016/17 – 2020/21). Performance against the BCF Programme includes achievement of performance indicators that include reductions in non-elective admissions and facilitating early discharge, and a need to ensure a joint approach to assessments and care planning through provision of case management and supporting self-management.  The Croydon CCG Out of Hospital Strategy (2016/17 – 2020/21), and Prevention, Self-Care and Shared Decision Making Strategy (2013) both set out the need to improve proactive preventative support and management for frail and vulnerable people to enable them to take greater responsibility for their health, as evidence indicates that such interventions can help to reduce demand on healthcare services and therefore support reductions in avoidable admissions.  The Croydon CCG and Croydon Council Outcome Based Commissioning (OBC) framework implemented in October 2016 set out the requirement to significantly improve health and wellbeing outcomes for the over 65s. The model of care developed by Accountable Provider Alliance (APA) to support delivery against the OBC outcome measures emphasised the key role to be undertaken by the Personal Independence Coordinator as part of the Integrated Community Network (ICNs) model putting people at the centre of their care.  The Out of Hospital Business Case signed by the Croydon Alliance in June 2017 identifies the need to focus on proactive, preventative care through care planning and support to access voluntary and community services. This will enable individuals to receive the right health and social care to meet their needs, with the service model focusing on improving self-management wherever possible. The model endorsed by the Business Case ensures that vulnerable individuals at medium and high risk of admissions are better supported in the community through integrated, multi-agency working from health, social care, mental health and voluntary sector services; and through increased promotion of prevention, self-care and the use of social prescribing, telecare and telehealth technology, coupled with wider engagement with community groups. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **X** | | **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** | **X** |   **2.2 Local defined outcomes**  Supporting people to:   * stay healthy, active and independent for as long as possible * get access to the best quality care so people can live how they choose * have support from professionals with specialist knowledge to understand how health and social care affects individuals * get more care and support tailored to individuals’ needs * have reduced instances of unnecessary hospital attendances or admissions |
| **3. Scope** |
| **3.1 Aims and objectives of service**  The Personal Independence Coordinator service provides personalised care support to individuals who are frail, vulnerable and in need of proactive, preventative planning; and/or support to improve self-management and access to voluntary and community services. This will enable individuals to receive the right health and social care to meet their needs, with the service model focusing on improving self-management wherever possible.  Personal Independence Coordinators (PICS) are core members of the Integrated Community Network (ICN)’s multi-agency GP Huddles. They bring together the local voluntary sector and health and care organisations to support people and represent the person’s wishes. PICs ensure that care planning is influenced by the wishes identified by the individuals themselves, so that independence can be improved or maintained, ensuring that people have a stronger voice in relation to issues that affect their lives.  PICs work alongside health and care professionals, adopting a multidisciplinary approach to working with older people who have long term health and social care needs. The PICs provide critical links between formal health and social care services and the wider community support networks to provide a holistic integrated care programme.  The PICs will work with volunteer support workers and the core ICN team to help avoid medium to high risk people attending hospital unnecessarily. They will also help medium risk people become better informed about how to maintain their health through the development of their own person-led preventative care plans.  The objectives of the service are as follows:   * To recruit a team of 18 Personal Independence Coordinators who will support delivery of the ambitions set out in the Croydon Out-of-Hospital Business case * To ensure that individual throughput of the service is aligned with the minimum level set out in the Out-of-Hospital Business case, in line with the KPIs * To support individuals to be cared for in the most appropriate care setting as close to their home as possible * To undertake face to face assessments & guided conversations with individuals and their carers * To work in partnership with individuals and their carers to agree appropriate goals and plans to achieve them * To signpost to services that can best meet the patients’ needs in the community * To support multi-agency and multidisciplinary team working (e.g. multi-agency GP Huddles) to reduce the risk of individuals being admitted unnecessarily to hospital * To work collaboratively with all necessary providers to ensure safe, seamless transfer of care for individuals and to ensure excellent communication occurs between providers * To send discharge summaries (PIC Summary) to the individual’s General Practitioner on discharge from the service within the timeframes specified in the key performance indicators * Where a shared care plan is available, to ensure that the sections of the individual’s plan relevant to the activities of the PIC are completed and updated regularly using the CCG’s approach to proactive care identification and planning and agreed recording tools. * To assist individuals in overcoming the barriers that may occasionally arise in gaining access to their shared care plans should this be required * To assess and manage risk appropriately to safeguard individuals and carers * To undertake robust data collection to enable appropriate reporting of service indicators and information requirements as outlined in the service contract.   **3.2 Service description/care pathway**  The service will provide care coordination and / or case management for frail and vulnerable individuals who are eligible for the service. This includes:   * Provision of a service Monday to Friday, 09:00 – 17:30pm or as appropriate. * Attending GP Huddles weekly or fortnightly as agreed with GP practices. Where, on occasions, attendance in person is not possible, PICs will attend remotely using conference call facilities   **The model**   * Undertaking a holistic, person-centred assessment and guided conversation in partnership with the individual, supporting the individual to consider and set their own goals with encouragement to recognise what is important to them * Working collaboratively with GP Practices, Hospital, Community Health, Social Care, Mental Health and Voluntary sector partners in an integrated, whole system approach to support holistic care management including how to support “Making Every Contact Count” * Liaising with GP Huddle Network Facilitators\* GPs and other ICN core team members to proactively identify individuals who might benefit from being discussed at GP Huddles. This will include proactively using available risk stratification tools to support the identification of vulnerable people who might benefit from support from the service * Provide case management support, depending on need. This should address: * Access to other services which could include providing hospital appointment management support as required through telephone reminder or arranging for the individual to be physically accompanied to hospital especially for people with dementia, * Proactively managing communication with the Patient’s GP include discharge letters or PIC Summary) to the individual’s GP practice within the target time indicated in the service key performance indicators following discharge   \**Network Facilitators support and facilitate the development of Integrated Community Networks (ICNs) and embed the administration systems for the role out of the weekly/fortnightly Huddle meetings.*  **Ways of working**   * Case managing individuals for up to 6 or 12 weeks, depending on the level of need of the client. The service will adopt a flexible approach to case management as it is recognised that some clients may need support for over 12 weeks. However, this should be in line with the agreed service performance indicators. PICs caseload will be monitored regularly as part of the KPI review to ensure capacity meets demand * Monitoring progress and achievement of goals with individuals by reviewing and, where appropriate, agreeing ‘stretch’ goals to increase confidence and acknowledgement of progress made * Forming proactive relationships with individuals and their families and carers where appropriate * Demonstrating good local knowledge of the range of voluntary and community services available to support people * Facilitating timely access to appropriate services for individuals through signposting or assisting individuals to navigate appropriate services as required * Promoting health and wellbeing and self-care / self-management approaches to enable greater independence and a better health and care experience * Acting as a key advocate for the individuals as and when required or signposting to advocacy services in that particular area of interest * Contributing to the reduction of preventable A&E attendances and unplanned emergency hospital admissions by supporting and enabling individuals, their family and carers to become better at self-management and accessing self-management support * Undertaking customer feedback and using peoples experience to inform improvements and in future service developments and design. * Ensuring that the individual’s GP Huddle Core Team and Network Facilitators are notified about the referral to the service if the referral did not originate from the GP Huddle in the first instance   **New developments**   * Develop a new modular approach to case management, offering new shorter 6 week programmes where appropriate (ie patients requiring help with losing weight) * Use a health coaching approach which aims to motivate and empower people to improve their health and wellbeing using evidence based health coaching techniques * Organise and provide sessional group consultation sessions within GP practices on a network basis * Developing approach for social prescribing as an integral part of the PICs service offer. * Proposals to invest in community backed initiatives * Support the process of upskilling/training volunteers as part of a wider sustainability and social value strategy.   **3.3 Population covered**  The service will be available to all adults registered with a Croydon GP and resident in the London Borough of Croydon, who meet the eligibility criteria for the service.  GP Huddles, like all NHS services, are open to any adult registered with a Croydon GP. Occasionally individuals discussed at GP Huddles may be resident outside the London Borough of Croydon boundaries, whilst maintaining their registration with a Croydon GP. Although it is anticipated that such instances will be rare, they must be flagged at GP Huddles and to Commissioners and dealt with flexibly on a case by case basis, as appropriate, to avoid a “postcode lottery”.  **3.4 Acceptance and exclusion criteria and thresholds**  The majority of referrals for the PIC service will be made using predictive risk stratification and through GP Huddles. However the service may also receive referrals from:   * GP Practices * Rapid Response * Community Nursing (including community matrons, Health Visitors for Older People and District Nurses) * Adult Social Care * Mental Health Services * Integrated Community Networks’ Point of Access and Information   **Acceptance criteria**  The following individuals are deemed suitable to be accepted by the service:   1. Adults identified from GP practices through risk stratification as having had a minimum of two non-elective hospital admissions within the last year and two long term conditions. Typically these adults will be over 65. However, the service will be flexible and accommodate other age groups depending on individual needs, in agreement with the GP Huddle Core team. 2. Adults identified by the GP or core members of the ICN Huddles who are frail, vulnerable and at risk of a hospital admission or have had a hospital admission, who need assistance with:  * Social Isolation * Emotional needs * Financial support * Improving ability to self-manage * Improving ability to manage at home * Carer support  1. Adults that are cause of concern for a member of the GP Huddle Core Team and who would benefit from the service.   **Exclusion criteria**   * Adults not registered with a Croydon GP. * Adults who are registered with a Croydon GP but not resident in Croydon will be dealt with on a case by case basis as outlined in section 3.3. * Adults who do not wish to engage with the service.   Referrers should use their professional judgment to exclude people less likely to be able to participate and benefit from the service, for example:   * People who are too frail to engage with the service * People who have a significant mental health condition or drug and alcohol dependency that is not being managed, or for which support has been refused * No mental capacity to engage or set goals.   **3.5 Interdependence with other services/providers**  The Personal Independence Coordinator service will work with a range of other key services including:   * GPs and Primary Care * Croydon Adult Social Care Services * Croydon Health Services (Community and Acute) * Croydon CCG’s ICN Pharmacists (Medicines Optimisation Team) * Croydon Urgent Care Centre * Voluntary Sector Agencies * South London and Maudsley NHS Foundation Trust |
| **4. Applicable Service Standards** |
| * 1. **Applicable national standards (eg NICE)**   MDT Development – Working toward an effective multidisciplinary/multiagency team (NHS England 2014)   * 1. **Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**   N/A   * 1. **Applicable local standards**   Age UK Croydon policies and guidelines for best practice. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-C)**   2. **Applicable CQUIN goals (See Schedule 4D)** |
| **6. Location of Provider Premises** |
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**Metrics and KPIs**

|  | **Activity** | **Source** | **KPI (Target)** | **Notes** |
| --- | --- | --- | --- | --- |
| 1 | Number of new referrals to the service by month | MDS | Target number of people seen in a year (=2026) | Target per business case |
| 2 | Number of new referrals to the service by practice | MDS |  |  |
| 3 | Breakdown of source of referrals | MDS |  |  |
| 4 | Number of first visits by month | MDS |  |  |
| 5 | Average number of face to face visits (at discharge) | MDS |  |  |
| 6 | Average number of face to face follow ups (at discharge) | MDS |  |  |
| 7 | Average number of non-face to face contacts (at discharge) | MDS |  |  |
| 8 | First to follow up visit ratio (face to face) | MDS |  |  |
| 9 | Time from referral to first contact | MDS |  |  |
| 10 | Time from referral to first visit (face to face) | MDS | Percentage of visits undertaken within 4 weeks of referral (95%) | As in current contract |
| 11 | Number of discharged clients by month | MDS |  |  |
| 12 | Number of declined service per practice | MDS | Percentage of declined service provision (TBC) | Need to baseline this metric to set a target |
| 13 | Breakdown of age of clients at referrals | MDS |  |  |
| 14 | Time from discharge to discharge letter sent to GP | MDS | Percentage of discharge communication sent to GP within 48 hours of discharge (90%) | As in current contract |
| 15 | Breakdown in health conditions (primary) | MDS |  |  |
| 16 | Breakdown of interventions provided (at discharge) | MDS |  |  |
| 17 | Breakdown of onward referrals | MDS |  |  |
| 18 | Number of people referred to other services | MDS |  |  |
| 19 | Percentage of initial visits with no follow up | MDS |  |  |
| 20 | Percentage of huddles attended in a month | Huddle sheet | Percentage of huddles attended in a month either face to face or remotely (95%) | This information will be collected from the huddle sheets |
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|  | **Quality** |  |  |  |
| 1 | Number of Complaints Received by month | Report |  |  |
| 2 | Thematic complaints report including lessons learnt and actions to improve | Report |  |  |
| 3 | Number of safeguarding concerns raised | Report |  |  |
| 4 | Friends and family test report | Patient feedback | Percentage of clients who would recommend the service (TBC) | Wording available as per standard Friends and Family Test |
| 5 | Number of patients who feel proactively managed (To be reviewed) | Patient feedback |  | Need to review and agree wording - possibly add to Friends and Family test |
| 6 | Number of patients who feel the service is effective (To be reviewed) |  |
| 7 | Number of Vacancies | Report |  |  |
| 8 | Staffing report | Report |  |  |
| 9 | Caseload by PIC | Report | Caseload per PIC (Target 28) | Target from Business Case |
| 10 | Time on caseload (days) at point of discharge | MDS | Percentage of clients on caseload over 12 weeks (target 20-25%) | Target from Service Model |
| 11 | Average number of hours per client (at discharge) | MDS |  |  |
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|  | **Outcomes** |  |  |  |
| 1 | Number of clients showing an improvement in Wellness score at review since guided conversation | MDS |  | Target to be agreed following baseline review |
| 2 | Percentage of clients who achieve their goals | MDS |  | Target to be agreed following baseline review |