SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	**1**
Service	**Care Navigators New Forest**
Commissioner Lead	**West Hampshire CCG**
Provider Lead	**Eastleigh Southern Parishes Network Limited**
Period	**18 Months 1 May 2017 – 31st October 2018**
Date of Review	**Quarterly through contract meeting**

1. Population Needs

1.1 National/local context and evidence base

A wide range of Care Navigator models have been piloted and implemented across the country and have proved to be an invaluable service impacting on quality of care, social isolation and service provision. Following a review of a range of services and an evaluation of two pilot schemes in West Hampshire (Eastleigh Southern Parishes and New Forest) the Provider is required to provide the Service in accordance with this Service Specification.

The aim of the service is, through a social prescribing model to support people to remain safe and independent in their own homes, improve health and wellbeing and facilitate appropriate utilisation of existing services and support mechanisms, thus impacting positively on quality of care and sustainability of services.

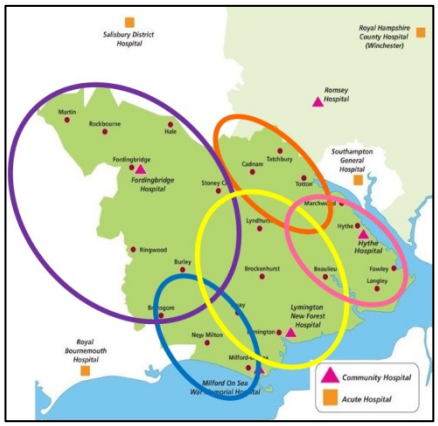
This non-clinical service supports patients and carers to 'navigate' their way around health, social care, community and voluntary services, ensuring people receive the right services in the right place, tailored to individual need, by providing information, advice and coordinated care. The service also strengthens links between the different services supporting a patient (or carer), thereby contributing to joined up care.

1.2 Population

The Provider will provide the Service to patient living in New Forest who are registered with a West Hampshire Clinical Commissioning Group GP practice.

- The area comprises:
- 188,832 patients;
- > 50,000 patients aged 65yrs +
- 17 GP practices
- Totton and Waterside and West New Forest localities
- 5 Natural Communities of Care (Totton, Waterside, Lymington, New Milton, Avon Valley)
- Pockets of social isolation and deprivation both of which are predictors of poor health outcomes especially in older people
- Rurality, especially in the West

Fig 1 Area of Commissioned Service – New Forest



Natural Communities of Care

- Totton
- Waterside
- Lymington
- New Milton
- Avon Valley

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

The service is an integral part of the Commissioner's Out of Hospital Strategy, Operating Plan and relevant locality plans, including development of sustainable primary care, by achieving the following outcomes for the specified target group:

- improved quality of life / sense of wellbeing
- decreased social isolation
- appropriate use of health, social and voluntary sector services, resulting in a reduction in avoidable non-elective activity (within urgent, acute and primary providers) and reduction in Delayed Transfers of Care and Excess Bed Days
- identification of gaps in service and opportunities for pathway improvement
- improving community networks
- improved quality of life for patients/carers*
- increased ability of patients/carers to self-manage*
- high level staff satisfaction
- high level satisfaction amongst referring organisations
- volunteer engagement
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**Measured by R-Outcomes*

The Service will achieve the outcomes by accepting appropriate referrals from health, social care and voluntary agencies and by working with patients/carers to identify needs and goals. Patients/carers will be signposted or referred to appropriate health, social, voluntary and other services to ensure their needs and goals are met as fully as possible.

3. Scope

3.1 Population covered

The Service will be provided to adults who are registered with one of the 17 GP practices in West New Forest or Totton and Waterside localities (including patients living outside Hampshire) on either a permanent or temporary basis and are considered to be likely to benefit from the Care Navigator service.

3.2 Service description/care pathway

Referral criteria for the service will be patients or their carers experiencing or considered likely to experience in the near future one or more of the following:

- social Isolation
- a crisis impacting on their ability to cope in the immediate future..
- difficulties with day to day living and running their home
- problems accessing services and advice (including but not limited to) health, social care, financial, housing
- problems managing day to day tasks or caring (eg shopping, cooking, attending appointment)
- high or increasingly likely (potentially inappropriate) use of primary or secondary care or other services (whether routine, urgent, emergency or admission)
- poor medicine compliance
- delay in being discharged from hospital due to issues that are not addressed by statutory health or social services
- high use of health or social care services not addressing patient need

Care Navigators will work to empower patients/carers to take an active role in managing their own care and wellbeing. Care Navigators will achieve this by working in partnership with the patient/carer to ascertain the patient / carer's needs and goals, identify support, services and necessary actions and, with the patient/carer and significant others develop a plan to achieve relevant goals.

The aim is for the Service to be patient/carer focused, thus each plan will require different levels of Care Navigator/volunteer input, from straight forward signposting or referral, to other services, to the Care Navigator assisting the patient/carer with the completion of forms and liaising with a range of organisations to identify blocks in the patient's care/wellbeing. Care Navigators will hold a caseload of patients/carers and inform the patient's/carer's GP and other relevant agencies when the patient/carer has been discharged from the caseload

3.3 Service Model

Each team of care navigators will cover one or more of the following Natural Communities of Care.

- Totton
- Waterside
- Lymington
- New Milton (and Bransgore)
- Avon Valley (and Bransgore)

Care Navigators will be key members of relevant Integrated Care Teams (ICT) / Extended Primary Care Teams (EPCT) for that community.

Each care navigator will be attached to one or more GP practices. GP practices will be required to provide Care Navigators with limited access to clinical systems to record an agreed level of key actions, attach care plans etc. The Provider will ensure necessary governance arrangements are in place with each practice. Care Navigators will be required to travel within and sometimes beyond the natural community of care, for example to an acute hospital.

The service model will allow for cover across the Care Navigator team to enable continuity of service during periods of leave etc.

The Provider shall recruit volunteers to support care navigators to deliver and maximise the impact of the service.

Patients/carers will be referred to the service. The Care Navigator will hold a caseload and the patient's/carer's GP and other key organisations will be provided with a discharge summary which will include the patient/carer owned care plan.

Geographical and population coverage

The Service shall cover the registered patient population of the 17 practices in the New Forest area (Totton & Waterside and West New Forest localities).One full time wte care navigator will be commissioned for every 20,000 registered patient populations. Each Care Navigator will be attached to one or more GP practices.

Hours

In each natural community of care the Service will be available as a minimum from 9.00am to 5.30pm Monday to Friday. Outside of these hours and when a care navigator is not working clear information about Care Navigator availability and relevant Out of Hours/Emergency services must be provided on telephone answer machines, relevant websites and given to caseload patients/carers

A reduced level 'on call' service will be available for 4 hours on Saturday and 4 hours on Sunday and on bank holidays in each natural community of care. Two Care Navigators will be available during each of these sessions and provide appropriate cover across the New Forest.

Access to the service

Access to a Care Navigator will be via referral from GPs, other members of the ICT/EPCT, CCG commissioned providers, voluntary and other services. The provider will ensure that all relevant organisations are aware of referral routes and criteria. Patients/carers will not be able to self-refer.

A standard referral form will be made available on DXS for use by GPs; for other organisations referral will be via secure nhs.net email or telephone with email confirmation.

If a Care Navigator is unavailable and outside service hours the provider will ensure that patients and referrers have appropriate contact numbers such as but not limited to another Care Navigator, Out of Hours, 111. These calls / contacts need to be responded to in the required time frames.

Service Response and Communications

Routine Referrals: The care navigator service will contact the referred patient / carer within 2 working days of referral and will arrange to visit/consult with them within 5 working days of contact (unless patient / carer is unavailable during this period). The provider will acknowledge referrals (to the referrer) within 3 working days of referral ensuring an audit trail is visible

Urgent referrals: For example admissions avoidance, The Care Navigator service will contact the referred patient / carer within 4 hours of referral and will action as appropriate the same day if required. The provider will acknowledge referrals (to the referrer) within 24 hours of referral ensuring an audit trail is visible

For both routine and urgent referrals, key interventions and documentation such as initial contact made with patient/carer, referrals, and care plan will be entered onto the patient's/carer's GP clinical system. The GP and referrer will be provided with a summary of actions once the patient has been discharged from the active care navigator caseload. A co-produced care plan (or updated existing care plan) will be shared with the patient and the patient's GP.

Care Navigator Intervention

The Care Navigator will meet with (or telephone) the patient/carer in a mutually convenient location including, but not restricted to the patient's/carer's home, hospital or GP surgery. If required consideration should be given to visiting/ liaising with the patient/carer outside core hours if this provides an opportunity to meet with relevant family, carers etc.

The patient/carer's needs and goals will be jointly identified by the patient/carer and Care Navigator and take into account information from other relevant and appropriate stakeholders for example family, GP, Dementia Advisor. A Commissioner agreed (action/care/wellbeing) plan will be co-produced by the patient/carer and Care Navigator following which, the care navigator will assist the patient/carer in actioning the plan. This is likely to include signposting or referring to services, obtaining and discussing information eg on services, arranging initial transport to a support group. The following are examples of services and support the patient /carer may be signposted to:

- Social / meeting / lunch clubs / community groups
- Home maintenance services / grants etc
- Specialist support services such as Carers' Groups and Dementia Advisors
- GP
- CAB, benefits agencies etc
- Volunteering schemes
- Leisure services
- Housing services including care homes
- Befriending schemes
- Social care, Community independence team etc.

Care Navigators will not refer patients/carers for clinical support without the specific and documented direction of the patient's/carer's GP.

The patient/carer will remain on the Care Navigator service's caseload until agreed actions have been completed.

The Care Navigator will be required to:

- Accept appropriate referrals from health, social care and voluntary agencies and continually review potential sources of referrals
- Proactively identify patients/carers who may require intervention for example acute provider non-elective admission reports, risk stratification tools, SCAS VHIU (Very High Intensity Users) lists, housing and other council teams (and seek such referrals from these sources)
- Assess each patient/carer individual needs and jointly agree goals
- In conjunction with the patient (and relevant others) develop a plan to access appropriate services and other support
- Signpost and refer patients/carers to appropriate services and support including GPs, social care, voluntary agencies
- Act as the coordinator between different agencies involved with the patients/carers to ensure joined up and seamless care

- Attend practice ward, ICT, and other relevant meetings such has hospital discharge meetings as required
- Input relevant information into the patient's GP clinical system
- Co-produce a relevant care plan with the patient/carer and ensure updated care plans are shared with relevant organisations

This list is not exhaustive and the Provider is encouraged to be innovative in the scope and development of both the service and the navigator roles themselves.

The service is required to highlight poor quality practice for example patient discharged with no support, inadequate information etc. to the West Hampshire Clinical Commissioning Group Quality Team so that improvement opportunities can be addressed.

Staffing

The Provider will provide a service model that will deliver a safe, effective and high quality service ensuring continuity of care. This will include the provision of one care navigator per 20,000 patients.

The Provider will ensure that all Care Navigators have the appropriate checks, skills, qualifications, experience and competencies including a proven knowledge and understanding of local services to deliver a high quality service. Ongoing training and education is expected including sharing good practice with other care navigator services.

Effective and robust plans to manage staff absence will be required ensuring that all leave including maternity, sickness and annual is covered by a flexible workforce. In addition, the provider will be expected to adhere to best practice HR performance measures relating to establishment, turnover, sickness and vacancy factor rates.

The Provider will be required to recruit and develop a team of volunteers who will support the service.

The Provider will enable all employees to complete training in line with the regulatory bodies and good practice outlined in the relevant sections of the NHS national standard contract and its local specifications: e.g. this could be (and is not limited to); Monitor; NHSTDA; NHS England; the Department of Health; Healthwatch England and Local Healthwatch and Public Health England. The providor is also required to ensure all Care Navigators undertake Dementia Friendly training within 6 months of starting with the organisation

The Care Environment

Services may be provided in a wide range of care environments which may include:

- A GP practice in agreement with the practice team
- The patient's own home
- Other CQC approved settings
- Neutral setting agreed by patient / care navigator for example Dementia Cafe

3.4 Interdependence with other services/providers

Each care navigator (and volunteer) will be attached to one or more GP practices and will play a key role within the relevant ICT/EPCT. In addition the service will develop and maintain close working relationships with other organisations in secondary and social care, voluntary agencies and other key partners. The service will also link with other care navigator services commissioned by WHCCG to share learning and best practice**.** Key relationships / interdependencies include:

- GP practices
- All members of the ICT/EPCT
- Providers of urgent and acute care

- Emergency Services
- Hampshire County Council (and other county councils if required)
- Dementia services
- New Forest District Council (and others if appropriate) eg alarm lines, housing, environmental health
- Community organisations (eg support groups, social clubs, transport, home improvement, advocacy)
- Places of worship
- Carers' organisations
- Voluntary Services
- WHCCG Quality Team

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards