

Service Specification No.	
Service	Shropshire Community & Care Coordinators
Commissioner Lead	NHS Shropshire CCG
Provider Lead	GP Practice
Period	1st April 2020 to 31st March 2021
Date of Review	October 2020

1. Population Needs

1.1 National/local context and evidence base

Shropshire Clinical Commissioning Group has a population of approximately 312,000. It consists of 41 GP member practices that are working together to ensure the local population has high quality healthcare services which are sustainable.

Shropshire has a demographic profile which demonstrates a higher level of older people than the national average. The number of people over 65yrs with a life limiting illness is 29,464 which is approximately 10% of the total population. This number is predicted to rise to 45,590 by 2030 (POPPI, 2012). Shropshire also currently has one of the highest levels of people living in long term care.

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	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	

2.2 Local defined outcomes

- Reduce GP appointments
- Reduce A&E attendance
- Reduce hospital admissions
- Reduce Shropdoc / NHS111 calls
- Reduce the costs associated with dependency across the health and social care economy
- Improve health and well-being for patients and carers
- Improve communication with and sign posting to the voluntary and statutory sectors
- Increase the number of volunteer groups and CoCo
- To empower patients to take control of their own decision making and to maximize their levels of independence

3. Scope

3.1 Aims of service

- 3.1.1 To demonstrate the potential of non-clinical individuals, working as a part of the practice team, to proactively support those patients at risk of loss of independence and hospital admission as a consequence of unmet social care needs.

- 3.1.2 To explore the potential of such an individual supporting collaborative working between the practice, the voluntary sector, community groups, the local authority and volunteers, both recognising and creating links with existing resources in the community and supporting its growth and further development for the benefit of the practices frail and vulnerable patients.

3.2 Objectives of service

- 3.2.1 Increase the practice team's awareness of the services and skills provided by the voluntary sector and by volunteers in the community.
- 3.2.2 Improve communication between the local authority, voluntary sector, community groups and the practice.
- 3.2.3 Support the practice to identify frail and vulnerable patients at risk of inappropriate admission, opportunistically and proactively, through computer searches, risk stratification and communication with the wider community. These will often include patients toward the end of life, patients with dementia, patients who are lonely, isolated or who have minimal or no family or social support.
- 3.2.4 Where considered appropriate by the MDT or lead clinician to sign post individuals to statutory, non-statutory and voluntary services and to co-ordinate the unmet social care needs of those individuals who continue to struggle to navigate the system.
- 3.2.5 Introduce an assessment process for frail and vulnerable patients that will begin to record and code non clinical information relevant to their holistic needs.
- 3.2.6 Support the community in the development of peer groups, carers groups and volunteers including the compassionate communities' movement.
- 3.2.7 Make links between these developments and those who might benefit from what they offer.

3.3 Service description/care pathway

- 3.3.1 To take appropriate referrals for patients registered with the medical practice – this may include representatives from other organisations including self-referrals
- 3.3.2 Working with the lead GP and the practice manager, utilising risk stratification information, to identify people at risk of loss of independence or admission as a result of inadequate social support including those on the Carers Register
- 3.3.3 Work with individuals, their families, Carers and existing social networks to link the voluntary services in the community to the needs of the individuals
- 3.3.4 Sign post where necessary to statutory services in partnership with the individual, GP or nurse

3.5 Population covered

- 3.5.1 Service users registered with a GP in Shropshire and for whom NHS Shropshire CCG has responsibility for commissioning services.

3.6 Any acceptance and exclusion criteria and thresholds

- 3.6.1 There are no specific exclusions; however the particular focus is on frail and vulnerable individuals at risk of loss of independence and admission and individuals coming toward the end of their lives.

3.7 Interdependence with other services/providers

- 3.7.1 On behalf of the practice, supported by the lead GP and the practice manager, to work in partnership with the patient group, the community and Severn Hospice in the development of "The Compassionate Communities Model"
- 3.7.2 Co-ordinate and support the development of networks for individuals with long term conditions within the community
- 3.7.3 Enable these networks to access advice and education from experts.
- 3.7.4 Link with existing initiatives and facilitate broader networks.

3.8 Data Collection

The practice will work with the CCG to complete and submit monthly recording templates on activity, referrals, frail and elderly patients etc.

3.9 Annual Review

All practices providing this service shall conduct an annual review to include:

- Register of patients
- Patient outcomes
- Referral rates

4. Applicable Service Standards

4.1 Applicable national standards (e.g NICE)

None indicated

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

None indicated

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

3.10 Applicable Quality Requirements (See Schedule 4A-C)

3.11 Applicable CQUIN goals (See Schedule 4D)

Not applicable.

6. Location of Provider Premises

The services will be provided from the GP Practice premises.